UNIVERSITY OF CAPE COAST

NATIONAL HEALTH INSURANCE SCHEME IN GHANA: EXPERIENCES AND CHALLENGES OF WASSA WEST HEALTH INSURANCE SCHEME

BY

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

JUNE 2011

UNIVERSITY OF CAPE COAST

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2011

DECLARATION

Candidate's Declaration

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

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

Name: Eric Kwarteng

Supervisor's Declaration

I hereby declare that the preparation and presentation of this 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: Professor S. B. Kendie

ABSTRACT

The Wassa West Health Insurance Scheme (WWHIS), a district health insurance scheme in the Western Region, provides insurance cards to subscribers in the district to access affordable health care from accredited health facilities. The study was carried out to find out the extent to which health care is accessible and affordable to the people and to determine the sustainability of the scheme.

Ten communities in the district were purposively selected. These communities cut across the entire district; these include both urban and rural settlements. The study adopted the descriptive survey design using the case study approach focusing on accessibility, affordability and sustainability of the health insurance scheme. In all, 120 participants were selected for the study which included scheme managers, health service providers and subscribers comprising opinion leaders, community leaders and community members. Data were collected using semi-structured interview and interview guide.

Responses were coded and analysed. Findings showed that the government and the Wassa West District are committed to the implementation of health insurance policy and provide improved health care in the district. The study recommends a strong collaboration based on understanding among the scheme management, the health service providers and the subscribers in order to achieve a successful, affordable, accessible and sustainable health care. Scheme managers are urged to make the insurance more attractive, create enhanced communication channels to promote transparency in their operations.

ACKNOWLEDGEMENTS

This work was accomplished with the help and support of several people. A number of individuals and institutions made considerable and invaluable contributions to bring this study to completion. There is no gainsay that I am indebted to all those who encouraged and assisted me, all of whom cannot be mentioned here.

I wish to express my deepest gratitude to my supervisor, Professor S. B. Kendie who meticulously and painstakingly went through the scripts and offered constructive suggestions and guidance to enhance the quality of the study. My sincere thanks go to Mr. F. K. Kyeremeh for the encouragement, suggestions and pieces of advice he offered me which greatly helped me in accomplishing this task.

I am very grateful to Mr. Francis Adjei (Scheme Manager), Wassa West Insurance Health Scheme for the invaluable assistance he offered me on the field and especially, in providing me with vital information for the study. Finally, I acknowledge the special support offered me by Lydia, my wife, and all my colleagues and friends, especially Mr. Justice Eric Baah for his unflinching support for me in the course of writing this dissertation.

DEDICATION

To Kwaku, Kwame and Yaw.

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LIST OF ACRONYMS

CBHI	Community-Based Health Insurance
DHIS	District Health Insurance Scheme
DMHIS	District Mutual Health Insurance Schemes
GHS	Ghana Health Service
GLICO	Gemini Life Insurance Company
GMA	Ghana Medical Association)
GMHIS	Goldfields Mutual Health Insurance Scheme
MHO	Mutual Health Organisation
NHIA	National Health Insurance Authority
NHIPFG	National Health Insurance Policy Framework for Ghana
NHIS	National Health Insurance Scheme
NHITF	National Health Insurance Trust Fund
NPP	New Patriotic Party
OPP	Out-of-pocket payment-
PCHIS	Private Commercial Health Insurance Schemes
PMHIS	Private Mutual Health Insurance Schemes
PNDC	Provisional National Defence Council
SHI	Social Health Insurance
SSNIT	Social Security and National Insurance Trust
WHO	World Health Organisation
WWD	Wassa West District
WWHIS	Wassa West Health Insurance Scheme

CHAPTER ONE

INTRODUCTION

Background to the study

The socio-economic development of a nation, to a very large extent, depends on a healthy population. A healthy people with the requisite skills and knowledge become the backbone through which the development agenda of any society is implemented efficiently to increase productivity. Quality human resource base is therefore cardinal to the attainment of development goals of countries. The development process of any country is stalled without the requisite human resources. It is in this light that every country in the world places much premium on ensuring an improved health condition for her citizens. The significance of health issues relating to people is further epitomized by the existence of global institutions dedicated to the promotion of human health. The World Health Organisation (WHO) is one of such global institutions dedicated to the promotion of the health of people.

Every country in the world has evolved some form of health care system aimed at ensuring that sick people are catered for efficiently and speedily without any inhibitions. Ghana is no exception to this phenomenon. Heath care facilities in the form of hospitals, clinics, polyclinics, heath care centres have been provided in the country for delivering quality health care to people. Many of these

facilities are operated by the state with a few operated by private individuals and institutions either for profit or as social service. Until the recent emergence of the private sector in the provision of health care, the state has always played a dominant and pioneering role in ensuring that people access affordable health care. It has therefore become the state's responsibility to provide health care to the people of Ghana and this responsibility comes with financial challenges in view of the difficult economic issues that confront the country.

Financing an efficient and effective health care system is of a major concern to countries all over the world. This is even more critical in developing countries where there are several developmental challenges of which limited resources and poverty are dominant. Health care financing is a general term which refers to the resources used in providing health care. These include money, and other resources such as labour, equipment and supplies (Goodman & Waddington, 1994).

In Ghana, healthcare financing has gone through several phases. After independence in 1957, Ghana adopted a socialist centralist development approach with the state taking absolute control over the provision of social services including health, which at this period, was free in public health facilities. The provision of health care was financed by the state through tax revenue. However, it became obvious that this method of financing health care was not sustainable following the economic difficulties the country experienced from the beginning of the 1960s (Osei-Akoto, 2004).

As part of efforts to revamp the Ghanaian economy, the state began to reduce expenditure on the provision of social services and the health sector witnessed considerable reduction in state funding. The erstwhile Provisional National Defence Council (PNDC) government in 1985, passed an instrument (L. I. 1313) which introduced user fees for all medical conditions except certain specified communicable diseases. The main aim of L. I. 1313 was specifically to enable hospitals to totally recover all costs involved in their operation. This system whereby people who access public health facilities pay user fees became known as 'cash and carry' and resulted in several operational challenges as well as people in the country (Asenso-Okyere, Osei-Akoto, Anum, & Adukonu, 1998).

The introduction of the user fees and the full cost recovery for drugs as a way of generating revenue led to a remarkable decline in the utilization of health service in the country. Poor people in the country who required health care were not able to access it because they could not afford the user fees. Self medication and the use of herbal drugs became common in the country. It was estimated that only 20% of people who require health care were able to access it (National Health Insurance Scheme, 2004).

In order to ameliorate the problems associated with the "cash and carry" system the then New Patriotic Party (NPP) government introduced the National Health Insurance Law, Act 650 in 2003. It sought to provide basic health care services to persons resident in Ghana through mutual and private health insurance schemes, and to establish a National Health Insurance Fund that will provide

subsidy to licensed District Mutual Health Insurance Schemes. Health Insurance is an alternative health care financing system which involves resource pooling and risk sharing among members (MOH, 2003). Prior to this, the National Democratic Congress (NDC) government started to pilot the Mutual Health Insurance Scheme in some selected districts in Ghana towards a National Health Insurance Scheme (NHIS).

The District Mutual Health Insurance schemes cover the entire geographical area of one or more administrative districts. The private Mutual Health Insurance schemes are those that are not based on administrative district boundaries, for example, workplace based, faith based and community based schemes. The private commercial schemes are those operated for purpose of profit. Section 31 of the Act grants every individual or group of individuals the right to belong to any of the three schemes identified above.

The state supports the development of the District Mutual Health Insurance Scheme (DMHIS) as a strategy for delivering its pro-poor policy to the under-privileged segment of the society, from both the formal and informal sectors. One hundred and forty – five (145) MHISs have been established all over the country. The Wassa West Health Insurance Scheme came into operation in 2004. and has been growing steadily since its inception. As at May 2008, the scheme had registered 117,506 people representing about 51% of the population of the area. The scheme's monthly report for May, 2008 indicates that, a total of 230,968 cases of clients who have accessed health care facilities at a total cost of GH¢1,351,597.96 have been submitted. Out of the total bill submitted, the scheme

has been able to pay GH¢219,478.62, with a total of GH¢1,132,119.34. yet to be paid.

Problem statement

The efficiency and sustainability of the NHIS depends on the tripartite stakeholders (the scheme, service providers and subscribers). The scheme is expected to ensure quick and timely disbursement of funds to the providers. On the part of the service providers, they must ensure quality service delivery to subscribers while the latter is expected to facilitate payment of premiums where appropriate.

The responsibilities of the scheme and the service providers are spelt out succinctly in Section 37(7) of the National Health Insurance Regulations, 2004 (L. 1 1809) as follows: "A claim for payment of health care services rendered under a scheme licensed under this Act shall be filed within sixty calendar days from the date of the discharge of the patient or rendering of the service .On the other hand, section 38 (1) of the L. 1 1809 states "A claim for payment of health care service rendered which is submitted to the scheme shall, unless there is any legal impediment, be paid by the scheme within four weeks after receipt of the claim from the health care facility.

It has been observed that, whilst health care facilities do honour section 37 (7) of L.1 1809, the scheme has not been able to comply with section 38(1) of the L.1 1809. This raises concerns about the efficiency of the scheme. As of June 2008 claims related to March, April, and May 2008 amounting to GH¢1, 132, 119. 34 which had been submitted by the health care providers had not been paid.

If the scheme owes some providers, the obvious and unanswered question is whether the scheme is sustainable enough to serve the needs of subscribers.

Meanwhile, since the inception of the scheme, no assessment of its performance in the district has been undertaken. The current study, therefore, seeks to explore the challenges that confront the scheme from the perspective of service providers and subscribers. There is however little information in the Ghanaian context on the effects of these schemes on beneficiaries in terms of equity in financial protection against economic cost of illness and access to health care services. This study seeks to provide further empirical details for the understanding of the issues, thereby contributing to the design and implementation of universal health insurance for Ghana.

Objectives of the study

The main aim of the study was to examine the challenges relating to the accessibility and the sustainability of the Mutual Health Insurance scheme in Ghana, using WWHIS as a case study. The specific objectives set to achieve the aim of the study are to:

- Explore subscribers' perceptions and opinions on the accessibility of the Wassa West Health Insurance scheme.
- Ascertain the challenges that confront the scheme in the Wassa West District.
- Examine the contribution of service providers in the provision of quality health care in the district.

- Analyse views on the sustainability of the Wassa West Health Insurance Scheme.
- Determine the extent to which accessibility to health care has changed since the inception of the NHIS.

Research questions

The study sought to find answers to the following questions:

- What are the perceptions of subscribers about the accessibility of the Wassa West Health Insurance scheme?
- What are the challenges that affect the sustainability of the scheme?
- What is the role of service providers in providing quality health care in the district?
- To what extent is the scheme accessible to subscribers?

Relevance of the study

A successful implementation of the National Health Insurance Scheme in Ghana is fundamental to ensuring access and affordability of health care services in the country by a majority of Ghanaians. Currently, a little over 50% of Ghanaians have registered with the scheme. The success or otherwise of the scheme will have a tremendous impact on the health care system in the country.

On the basis of the foregoing, a study of the Wassa West Health Insurance Scheme will provide useful information on the operations and sustainability of the district that will contribute to improving the operations of the Scheme. This study

will provide insightful empirical data that will enhance understanding of the issues, thereby contributing to the design and implementation of universal health insurance in Ghana.

Finally, the study will act as a basis to undertake further research on healthcare financing in various metropolis, municipalities and districts in Ghana. The researcher also stands to gain considerable knowledge and skills in both research and health financing issues.

Delimitation

The study is limited in scope to one District Mutual Health Insurance Scheme in the Western Region. It is limited to the Wassa West Health Insurance Scheme. The study is limited to the perceptions, challenges and experiences of people about the performance and the accessibility of the scheme in the district. The study dwells on only the opinions and experiences of people with the insurance scheme. It does not, however, seek to discuss in details the economic and political implications of the scheme The study does not seek to drawing relationships nor does it seek to compare schemes. It is only concerned with describing the views and the experiences of the stakeholders of the Wassa West Health Insurance Scheme (WWHIS).

Organisation of the study

The study is planned to cover five chapters. Chapter One is devoted to the introductory part of the study. This includes the background information of the

research work, problem statement, objectives, significance of the study, the scope and delimitation of the study, among others.

Chapter Two is on a review of the related literature. The theoretical and conceptual issues of the research work are taken care of in this chapter. The research methodology is discussed in Chapter Three. This focuses on the research design and other issues related to data collection methods and data analysis procedures are discussed in this chapter. It also looks at the socio-economic background of the study area and the sample population. Chapter Four is devoted to the analysis of the data collected from the field and the secondary sources as well. Then the discussion of the data analysed is presented here. It also looks at the findings. Chapter Five focuses on the summary, recommendations and conclusions of the study.

Definition of terms

Health Insurance: It is a form of insurance that pays for medical expenses. In a broader sense, it may include insurance covering disability or long-term nursing or custodial care needs. Health Insurance may be explained as an alternative health care financing system which involves resource pooling and risk sharing among members. It provides security against loss by illness or injury, financial protection against health related expenses and other forms of health-care. It may be a public or private provided insurance scheme which can be purchased by a group or by individual consumers.

National Health Insurance Scheme (NHIS): It is a nationwide health care financing system that seeks to provide affordable and accessible health care. . It may be provided through a government-sponsored social insurance programme, or from private insurance companies. Individuals or groups may be covered by the scheme through the payment of premiums or taxes to help protect them from high or unexpected healthcare expenses.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter deals with the review of related literature on the topic under study. The review includes concepts, theories found in literature, and empirical works documented in journals and on the internet. The review emphasises methods of health care financing.

Countries adopt different methods of collecting revenue to finance health care. Some of these methods are taxation, out-of-pocket payments, and social health insurance, among others. In 1998, nearly 30% of global expenditure on health which was estimated at US$ 3.1 trillion came from taxation, around 20-25% was from out-of-pocket payments and the same from social health insurance (SHI) contributions, with another 15% by private insurance. There is a wide variation in the sources of financing. Asian and African countries spent more from out-of-pocket than from government general revenue or social health insurance as compared to European countries (WHO, 2008).

The methods used to finance personal health care service play a major role in shaping a country's health care system. Personal health care includes services such as hospital care, physician care, dental services, and drugs that are provided directly to individuals. How this care is financed influences how people access

health care, the types of health care provided, and the mechanisms used to allocate health care services. Financing methods also influence how the costs of health care are distributed among members of society by income and by health status. This section focuses on aspects of health care financing covering sources of funds for health care services, and a discussion on the operationalization of the health insurance in Ghana.

Health insurance

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. Ghana's Ministry of Health (2003), defines health insurance as an alternative health care financing system which involves resource pooling and risk sharing among members. It provides security against loss by illness or injury, financial protection against health related expenses and coverage for out-patient and in-patient care and other specialised type of care. It may be provided through a government-sponsored social insurance programme, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programmes funded by the government. The benefit is administered by a central organisation, most often

either a government agency or a private or not-for-profit entity operating a health plan (WHO, 2008).

National health insurance systems are found in many countries, particularly in Europe. Systems of national health insurance frequently are coordinated with other national programmes of social insurance, such as pension programmes, programmes of unemployment insurance, and workers' compensation.

History and evolution of health insurance

Before the development of medical expense insurance, patients were expected to pay all health care costs out of their own pockets, under what is known as the fee-for-service business model (WHO, 2008). However, other alternatives to health care financing were fashioned out in order to make health care accessible to a majority of people who need it. This led to the introduction of health insurance as an alternative method of financing health care by patients.

The first country to provide health insurance on a national scale was Germany. The German Chancellor Prince Otto von Bismarck obtained passage of a compulsory sickness-insurance law in 1883, which was financed by a state subsidy. Various types of national health insurance were adopted by other European countries, including Austria-Hungary later in the 19th century, Norway in 1909, Sweden in 1910, and Great Britain and Russia in 1911. After World War II the growth of national systems of health insurance in Europe was extensive,

although the amount of benefits, conditions of eligibility, treatment of dependants, and provisions for maternity care varied (WHO, 2008).

In the United States, the concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlin. In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance (WHO, 2008).

According to the WHO 2008, the origins of sickness coverage in the United States effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911. The traditional disability insurance evolved into modern health insurance programmes during the middle to late 20th century. Today, most comprehensive private health insurance programmes cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case. Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organisations. Huber, Hohmann, & Reinhard (2002) found that, solidarity has always existed in African societies and a number of relationships and groupings exist, in which the members rely on each other’s solidarity or even pool risks among a larger group. These are collective mechanisms designed to face individual risks, often related to life-cycle events such as birth and death, but also illness, and encompass in a wide

range of both positive (weddings, baptism, circumcisions) and negative (funeral, illness) events. People come together when members are in financial difficulties, and for social and economic purposes (house construction, to start a business, acquisition of agricultural material, organisation of communal festivities). This contributes to the creation and reinforcement of social networks (Huber et al, 2002).

In traditional rural societies, individuals usually expect a return from any contribution they make. The informal risk-pooling arrangements are commonly based on balanced reciprocity, which is the standard for fairness. Any "gift" must be returned at some future time (Platteau, 1997 cited in Huber et al 2002). Insurance is different as it implicates that the members who will benefit within the near future remain unknown at the time of contribution. In consequence the majority of members are paying mainly for their protection without any immediate or visible return.

The concept of balanced reciprocity is not only valid for the traditional rural society. Also in modern insurance systems people expect some return to their investment. Otherwise, their willingness to pay contributions is undermined. The return is not per se a material kind. In Western societies people value insurance because it reduces their anxiety.

In African societies, provision is made for social risks but hardly ever for health risks. Money is saved to give a dowry when a girl is to be married or food is stored after harvest. It is unusual for people to protect themselves against possible illness that may occur in the future. They will not regularly contribute

money for a problem that is not visible. People do not put money aside for unforeseen illness, which is often seen as a taboo. Talking about sickness may even attract it (Platteau, 1997). Solidarity exists especially for emergency cases. But people wait until the illness occurs.

The lack of strategies to cope with health risks can be partially explained by the fact that in a situation when people are engaged in survival strategies, health assurance is not the top priority. Other priorities are more important, such as organizing food or school fees for the children. Or people prefer to invest in productive activities. They believe it is better for them to invest money at hand in small business activities than to pay the monthly insurance premium, which they perceive will give them only limited benefit .With any profits made from business investment, they may be more able to purchase directly quality care from their preferred health care provider (public or private facility), or traditional healer. A proverb from Burkina Faso states, "in an insurance the money sleeps, but in a credit and saving scheme it works for you".

The challenge for promoters of health insurance in sub-Saharan Africa is to transform the foresight for social risks into foresight for health. Huber et al, (2002) uses the following argumentation to convince community members of the benefits of health insurance. That health and illness come in pairs and instead of waiting for the problem to happen again, it is better to enlarge the cycle of people, beyond that of friends and family, who can help. Locally developed health insurance systems are often proposed to provide a solution to the specific conditions of the situation of the informal sector workers and their families. These

systems have received growing attention from donors and governments since the mid- 1990 s that has led to the emergence and rapid growth of health insurance schemes. Comparable terms used for local health insurance are: Mutual Health Organisation (MHO), Community-Based Health Insurance (CBHI), and Micro-insurance. The Mutual Heath Organisation is widely used in West and Central Africa whereas Community-Based Health Insurance has common usage in East Africa.

In their work Huber et al, (2002) indicated that development agencies have until recently concentrated their activities in improving health systems by investing in infrastructure, training and management support on the regional and district levels. They have become aware of the limitations of simply improving the level of health care on offer. When evaluating the impact of their activities, the extent of the exclusion of large population groups and the perception by the population of low quality of care on offer became apparent. The importance of developing financing mechanisms, which would enable more equitable access to health care structures, was recognized by all health care stakeholders.

Types of health insurance

Two major types of health insurance could be identified, based on source of funding. These are private health insurance and public health insurance.

Private health insurance

Saltman (2004) defines private health insurance as a mechanism for people to make financial contributions to protect themselves from the potentially extreme financial costs of medical care if they become severely ill, and ensure that they have access to health care when they need it (Saltman, 2004). Purely private enterprise health care systems are comparatively rare. Where they exist, it is usually for a comparatively well-off sub population in a poor country with a poorer standard of health care–for instance, private clinics for a small, wealthy expatriate population in an otherwise poor country. But there are countries with a majority-private health care system with residual public service.

Public health insurance

Social security health care model is where workers and their families are insured by the State. There are two types of public health insurance. These are publicly funded health insurance scheme, where the residents of the country are insured by the State and social health insurance, where the whole population or most of the population is a member of a sickness insurance company (Kashner, Muller, Richter, Hendricks, & Ray, 1998).

The publicly funded health insurance is financed through taxation. When taxation is the primary means of financing health care, everyone receives the same level of coverage regardless of their ability to pay, their level of taxation, or risk factors. Most developed countries currently have partially or fully publicly funded health systems. Examples are United Kingdom's National Health Service

(NHS), or the Medicare systems in Canada and in Australia (Kashner, et al., 1998).

Social health insurance (SHI) is financed through a (government-mandated) social insurance programme based on the collection of funds contributed by individuals, employers, and sometimes government subsidies. Social security health care model may exist under the social health insurance. This is when workers and their families are insured by the State.

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

Otto von Bismarck was the first to make social health insurance mandatory on a national scale (in Germany), but social health insurance was already common for many centuries before among guilds mainly in continental Europe. Countries with SHI systems include Austria, Belgium, Germany, France, and Luxembourg. Generally, their per capita health expenditures are higher than in tax-based systems.

Examples of health insurance in different countries

The nature of health care financing systems varies widely across developed countries. With the exception of the United States and South Africa, all of the developed countries have implemented some kind of national health insurance system; that is, they have established programmes to ensure that the majority of their citizens have access to health care services with minimal cost-sharing. Some countries (such as Germany and France) require employers to offer and employees to purchase a health insurance plan with payroll taxes as the major source of funding for this. In other countries, such as Canada, general tax revenues supply the major source of funding for their health insurance systems (WHO, 2008).

Health insurance in Canada

Most health insurance in Canada is administered by each province, under the Canada Health Act, which requires all people to have free access to basic health services. Collectively, the public provincial health insurance systems in Canada are frequently referred to as Medicare. Private health insurance is allowed, but the provincial governments allow it only for services that the public health plans do not cover; for example, semi-private or private rooms in hospitals and prescription drug plans. Canadians are free to use private insurance for elective medical services such as laser vision correction surgery, cosmetic surgery, and other non-basic medical procedures. Some 65% of Canadians have some form of supplementary private health insurance; many of them receive it

through their employers. Private-sector services not paid for by the government account for nearly 30 percent of total health care spending (WHO, 2008).

In 2005, the Supreme Court of Quebec ruled, in Chaoulli v. Quebec, that the province's prohibition on private insurance for health care already insured by the provincial plan could constitute an infringement of the right to life and security if there were long wait times for treatment as happened in this case. Certain other provinces have legislation which financially discourages but does not forbid private health insurance in areas covered by the public plans. The ruling has not changed the overall pattern of health insurance across Canada but has spurred on attempts to tackle the core issues of supply and demand and the impact of wait times (WHO, 2008).

Health insurance in the United Kingdom

The UK's National Health Service (NHS) is a publicly funded healthcare system that provides coverage to everyone normally resident in the UK. It is not strictly insurance system because (a) there are no premiums collected, (b) costs are not charged at the patient level and (c) costs are not pre-paid from a pool. However, it does achieve the main aim of insurance which is to spread financial risk arising from ill-health. The costs of running the NHS (est. £104 billion in 2007-8) are met directly from general taxation (WHO, 2008). Private health care has continued to operate parallel to the NHS, paid for largely by private insurance, but it is used by less than 8% of the population, and generally as a top-up to NHS services.

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

Health insurance in Ghana

Ghana is one of the few countries in Africa that has taken bold steps towards early efforts to establish Health Insurance Scheme in Ghana. The search for an alternative means of financing and provision of sustainable and affordable health care service for Ghanaians has been among the priorities of successive governments since independence. Between 1960 and 1966, a nation-wide health insurance funded from tax revenue was introduced in Ghana. Free health service was made available at all the country's healthcare facilities. Again, in 1970, a committee headed by Dr. Konotey-Ahulu was constituted to make proposals for the introduction of a health insurance scheme. This led to the enactment of the Hospital Fee Act 387 of 1971, which replaced the free health scheme initiated during the First Republic. However, the process of establishing a health insurance scheme for the country was aborted following the 1972 military coup. The preparation of legislative instrument to operationalise the Hospital Fee Act 387 of

1971 was started during the Third Republic but was once again thwarted by the military regime of 1981 (Adoma-Yeboah, September 14, 2005).

In July 1983, when Ghana's economy was on the verge of collapse, the then Provisional National Defence Council (PNDC) government introduced partial cost sharing of health services through the enactment of the Hospital Fee Regulation which was later updated by L. I. 1313 of 1985. The country had by then become more interested in cost recovery. In 1985, the government initiated studies into alternative means of financing healthcare by entering into a bilateral technical assistance contract with a German firm that would have studied the feasibility of creating a National Health Insurance Programme. This could not materialize, and a local consultant was engaged to carry out the studies whose report was also not followed up.

In 1997, the Ministry of Health set up its first Directorate for National Health Insurance. A national forum on health insurance scheme was convened. This resulted in the setting up of the Ghana Healthcare Company by the Social Security and National Insurance Trust (SSNIT) to provide other sources of health financing. Another effort was made by the Ministry of Health to pilot a health insurance scheme in Koforidua in the Eastern Region which did not start. However, health insurance schemes were set up in the urban areas of the country by some private for profit insurance companies. Vanguard Assurance Company instituted a scheme with the Association of Private Medical Practitioners as providers; Metropolitan Insurance Company formed the Metcare Health Insurance Scheme and Provident Insurance, the Medex Health Insurance Scheme.

Consequently, some of these schemes are reorganizing, following the passage of the National Health Insurance Law whilst others have wound up. Gemini Life Insurance Company (GLICO) is also setting up a private mutual insurance scheme. Some other non-profit private health insurance schemes such as the Mutual Health Organisations at Nkoranza, Damango, Tano, Jaman, and Dangme West districts and others mostly supported by Non-Governmental Organisations and religious bodies in various parts of the country, especially the rural areas sprang up (Adoma-Yeboah, 2005, September 14).

In April 2002, the Ministry of Health came out with a policy framework to guide the implementation of District-Wide Mutual Organisations. It selected 45 districts throughout the country including the existing Mutual Health Organisations, to pilot the National Health Insurance Scheme (MOH, 2003).

The current health insurance scheme operating in the country was established in 2003 by an Act of Parliament, Act 650 to replace out- of-pocket payment at the time of health service use. The Act makes it mandatory for all residents in the country to belong to a health insurance scheme. Two types of health insurance are in operation namely the social and private health insurance schemes. Under the private there are the Private Mutual Health Insurance Schemes (PMHIS), and the Private Commercial Health Insurance Schemes (PCHIS).

The DMHISs now established in 145 districts of the country to serve as a strategy for delivering its pro-poor policy to the under-privileged segment of the society. The DMHISs incorporate members from both formal and informal

sectors. A Ghana News Agency Report (April, 2002) shows that, total registered members to the schemes in Ghana was 11,279,678 as at the end of 2007, representing 55% of the population, and total active membership was 9,773,100 as at the end of 2007, representing 48% of the population. During the same period, number of ID card bearers stood at 8,203,855 representing 42% of the population.

Members of a scheme contribute according to the principle of ability to pay and package of health services cover of over 95% of diseases afflicting Ghanaians. There is differential contribution level both in the formal and informal sectors of the society. The formal sector workers contribute 2.5% of their 17.5% Social Security and National Insurance Trust (SSNIT) contribution whereas informal sector workers contribute at least seven cedis twenty pesewas per annum. The contribution levels have an inbuilt cross-subsidization mechanism whereby the rich pay more than the less privileged, adults pay on behalf of children, the healthy cover the sick and urban dwellers pay more than the rural dwellers. Children less than 18 years and adults over 70 years are covered free of charge (National Health Insurance Scheme, 2004).

Contribution level of the people is categorized based on their socio-economic stratification. The policy has grouped Ghanaians into six main categories: core poor, very poor, poor, middle income, rich, and very rich. All these categories of people pay in line with their ability to pay. The state instituted a 2.5% National Health Insurance Levy payable on selected goods and services. Funds raised from this source are used to subsidize the contributions of the

underprivileged in society and to pay for the contributions of the core poor and other vulnerable groups.

Service providers within the public, private and mission sectors provide the benefit package under the scheme after satisfying accreditation criteria. As at December 2007, all the Public Healthcare Providers, and 800 Private Healthcare Providers have been accredited. For a period of two years (2005 to 2007), utilization of healthcare facilities under the scheme increased from 3,213,450 to 6,835,104. A gatekeeper system is in place as a cost control measure. Gatekeeper system is a system which ensures that a visit to the secondary and tertiary health facilities is by referral from a primary health facility. There exist private mutual health insurance schemes. These are not of district focus. They are either community-based or occupational or faith-based. Goldfields Mutual Health Insurance Scheme (GMHIS) established in 2007 by the Goldfield Ghana Limited for the employees of the company is a typical example. These schemes do not receive subsidy from the government.

Sources of funds for health care

There are many sources of funds that are exploited by people and states for caring for health. The available sources of funding include user fee, state (public) funded, direct transfers and grants.

User fee

User fee otherwise called (Out-of-pocket payment-OPP) is a charge imposed on a patient or anyone who accesses health service. The fee could be for the consultation, drugs, dressing and diagnostic tests or all of these things. Since people are willing to pay for a cure, fees are mostly charged for curative service in the form of drugs and injections (Goodman & Waddington, 1994).

In many countries, especially in developing countries, the out-of-pocket payments form a major part of the total health expenditure. It is estimated that in 60% of countries with incomes below US$1, 000 per capita, OPP constituted 40% or more of the total health expenditure, whereas only 30% of middle-and high-income countries depended on this kind of financing (Kashner, et al, 1998). While people have the freedom of choice for paying out-of-pocket for health expenditure, and it might provide high satisfaction to the rich in society, there is no guarantee that the majority of the population would be able to afford health care costs through OPP. The real issue in many developing and even in developed countries is that imposing user fees at the time of service provision sometimes hinders utilization of health services.

People become impoverished due to the higher and/or rising costs of medical bills, because of the uncertainty of the amount of expenditure needed to meet the health care needs on an individual basis. In some cases, people have to incur ‘under-the-table’ expenditure for getting access to public health facilities. And, in other cases, the unskilled and unqualified private providers might exploit people by charging higher rates for their services. In order to protect the poor a

strong stewardship of government is required to rationalize the provider-consumer relationship (Kashner et al., 1998).

In Ghana, the Hospital Fee Decree (1969), later amended into the Hospital Fee Act (1971) and the Hospital Fees Regulation 1985 (L. I. 1313), introduced forms of payment for health care delivery in public health facilities in the country. These Acts specified fees to be charged for consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examination and hospital accommodation in Ghana.

The L. I. 1313 was introduced mainly to enable hospitals to totally recover all costs (except staff wages) involved in their operations and was highly successful in ensuring availability of medicines and medical supplies. It was, however, observed that, it lacked 'human face' and led to huge reduction in uptake of services as well as refusal of health professionals to treat patients, including those requiring emergency care, without upfront payment. However, an exemption scheme was introduced alongside the cost recovery to care for the poor and vulnerable. The scheme was subject to abuse, misinterpretation and arbitrary implementation. Absence of clear guidelines, lack of monitoring and supervision, transparency, ownership and knowledge of these schemes by heads of institution all contributed to the failure of the system. That is, there was no conscious system designed to prevent possible financial leakage. In the ensuing years standard of health care provision fell drastically. There was acute shortage of essential drugs in all public health facilities (National Health Insurance Scheme, 2004).

According to Asenso-Okyere et al (1999) following a chronic shortage and irrational use of drugs within the public health system, the government of Ghana introduced a national drug revolving fund scheme known as 'cash and carry'. The scheme was aimed at allowing the Ministry of Health to provide efficient pharmaceutical services at health facilities in the country. The scheme was piloted in the Greater Accra and Volta Regions in 1990 and extended to the entire country in January 1992.

Initial seed capital in terms of free drugs through the Central Medical Stores was provided to the government health facilities by the Ministry of Finance and Economic Planning. The health facilities were expected to sell the drugs to patients and the proceeds used to buy more drugs under a revolving fund scheme. This strategy brought about considerable improvement of drugs supply situation in the country (Asenso-Okyere et al 1999). As at May 1992, 22% of the items on the essential drugs list were available at Central Medical Stores. This rose to 62% in June 1993, after 18 months of nationwide implementation of the cash and carry.

It is worth noting that, before the introduction of health insurance, 80% of health financing in the public health sector was through tax revenue and donor funds. The remaining 20% was from internally generated funds through the 'cash and carry' system. The cost sharing measures were introduced into the education and health sectors as part of Ghana's economic reforms which began in 1983. Under the cost recovery legislation for health sector, fees differ by type or level of facility, treatment, location, age, nationality and type of service provided.

Asenso-Okyere et al (1999) posit that, before the introduction of the 'cash and carry' in public health facilities, private health care facilities in Ghana was operating on full cost recovery. Mission health care facilities and other non-governmental organisations charged patients with the aim of covering part of their operational costs, especially recurrent expenses. Traditional and spiritual practitioners also operate some form of cost recovery. However, the cost recovery of the traditional and spiritual practitioners often term as 'thanks offering' is informal (Asenso-Okyere et al, 1999).

Goodman and Waddington (1994) have structured user fee for curative care into three categories. The user fee charged on the actual cost plus a percentage mark-up of the drugs and dressing received. In this instance, the patient pays for exactly what is received and there are no hidden subsidies in the price. This system makes fees for treatment differ from patient to patient depending on treatment that would be received. Patients therefore have no idea in advance what they would have to pay for their treatment. Monitoring and supervision of money and drugs become difficult for service providers due to different fees for patients.

The user is charged a fixed price for treatment received. This could be done in two ways; (a) Charging the same fee for all diagnosis, and (b) diagnosis categorized into a small number of groups and each group has its own fee. Under the first scheme, a patient with malaria would pay the same as patient with pneumonia. With the second scheme, if malaria and pneumonia were in different diagnostic groups, the two patients would pay different fees. Charging for

different diagnostic groups allows for the fact that some conditions are much more costly to treat than others.

The system allows for only a small number of possible fees to pay and is therefore simple to administer. It also allows more expensive treatment to be subsidized by cheaper treatments. However, patients pay more than the cost for simple treatments.

The patient is charged a fixed fee per episode of illness. In this case, a fixed fee is paid on the first visit and nothing is paid further in the subsequent visits (to the same health facility) relating to the original diagnosis. However, different fee is charged for unforeseen complications. This charging method makes cross-subsidization of treatment possible. Prices and fees for treatment are displayed in advance. If there is no improvement in their condition, they could return to the health facility without paying additional money.

Publicly funded health care

Supporters of publicly funded health care claim that publicly funded health care has several advantages over free market provisions. Studies have found that private for-profit hospitals are more expensive and have higher death rates than private not-for-profit hospitals. The researchers attribute these patterns to the for-profit nature of the hospitals. The quality of health maintenance organisations and managed care has also been criticized by proponents of publicly funded health care. According to a 2000 study by the World Health Organisation,

publicly funded systems of industrial nations spend less on health care and enjoy superior population-based health care outcomes (WHO, 2002).

Advocates of public funded health care claim that the United States of America, which has a partial free market health care system, spends a huge proportion of its GDP on health care (15% more than many countries). It is further claimed that the need to provide profits to investors in a predominantly free market health system, and the additional administrative spending, tends to drive up costs, leading to more expensive health care provision. Some studies have found that private for-profit hospitals are more expensive and have higher death rates than private not-for-profit hospitals. The researchers have attributed this to the for-profit nature of these hospitals (Glesne, 2005).

Commentators on the political left argue that a publicly funded health care system is inherently superior because health care is seen as a human right and argue that access to health treatment should not be based on ability-to-pay (Glesne, 2005). The profit motive in medicine is also criticised as valuing money above public benefit. For example, pharmaceutical companies have reduced or dropped their research into developing new antibiotics, even as antibiotic-resistant strains of bacteria are increasing, because there's less profit to be gained there than in other drug research.

Opponents of publicly funded health care, predominantly on the political right, have pointed out a number of flaws in publicly funded health care systems, such as those which operate in Canada, the United Kingdom and Germany. Public

health care systems have been criticized for poor quality of care, long waiting lists, and slow access to new drugs.

International comparisons of health care quality are difficult and have yielded mixed results. However, an international comparison of health systems in six countries by the Commonwealth Fund ranked the UK's publicly funded system the overall best and first in quality of care. Systems in the United States and Canada tied for the lowest overall ranking and toward the bottom for quality of care (Glesne, 2005).

Overall, Canadians are quite satisfied with the quality of health care they receive. In a regularly conducted opinion poll, 70% of Canadians reported that they were either very satisfied or somewhat satisfied with the quality of care they receive compared to 30% being somewhat dissatisfied or very dissatisfied. The main factor of dissatisfaction is waiting times. According to Glesne (2005), Canadians are more likely than citizens of most other developed countries to experience long waiting lists for medical care, and that access to doctors is comparatively difficult; the study criticized the Canadian model of universal health care.

Public health care varies significantly from country to country. Many countries allow for private medicine in addition to the public health care system. Some countries, e.g. Norway, have more doctors per capita than the United States. Also, the US does not have any official record for waiting lists, but a 2005 survey by the Commonwealth Fund of sick adults in six nations found that only 47% of

US patients could get a same- or next-day appointment for a medical problem, worse than every other country except Canada.

It has also been noted that the largely free market system of health care in the United States has led to the faster development of more advanced medical treatment and new drugs, and that cancer patients in the United States for many forms of cancer, including those of the breast, thyroid and lung, have higher survival rates than their counterparts in publicly-funded health systems in Europe. Some analysts have pointed out the difficulty of comparing international health statistics. In particular, the mortality rates for cancer in the United States is at about the same level as many other countries, suggesting that the higher survival rates are a function of the way cancer is diagnosed. Many have theorized that public care systems, in which there is more bureaucratic government involvement and less financial incentive in the health care industry, lead to less motivation for medical innovation and invention.

Some commentators have pointed out that in publicly funded systems; health care workers' pay is often unrelated to quality or speed of care. Thus very long waits can occur before care is received. There is also less financial motivation for the most able people to enter health care professions. For example, in Canada, which has a broad publicly-funded health system, the average physician earns only 42 percent of the annual salary earned by their counterparts in the United States; this has led to long waiting lists for care (17.8 weeks in 2006). This difference in physician income reflects Canada's more limited spending on health care overall; in 2004, combined public and private spending

on health care consumed 15.4% of U.S. annual GDP; in Canada, 9.8% of GDP. (Glesne, 2005) By limiting the amount of money in the health care system through political mechanisms, shortages of health care resources (such as physicians, nurses, medical equipment, medical devices, pharmaceuticals, and hospitals) are more likely to occur. Opponents claim that higher salaries constitute an incentive to enter the profession and attract more qualified individuals who would otherwise choose a different profession.

Another possible criticism of publicly-funded systems cites the fairness of paying for people's poor individual decisions (smoking, drinking, drugging, etc.) as they relate to health care costs. It is argued that these costs should be incurred solely by those making those poor decisions. Some American commentators have opposed publicly-funded health systems on ideological grounds, as they argue that public health care is a step towards socialism and involves extension of state power and reduction of individual freedom.

Direct transfers and grants

Direct transfer and grants refer to the provision of a quantity of resources, whether money or supplies, which does not have to be repaid. The quantity of the transfer or grant will usually have been negotiated in advance, and it might be regular payment or a one-off gift. Grants, in particular, are often made on condition that they are utilized in a particular way, or that the money is spent on specific aspects of health programme, as determined by the donor (Goodman & Waddington, 1994). An example is the British government pledge of 42.5 million

pounds sterling support of the government of Ghana policy of free medical care for pregnant women under the National Health Insurance Scheme (Daily Graphic, July 9, 2008). Another example of a direct transfer could be the Ministry of Health providing money for the salaries of health workers, or a supply of drugs. An external donor agency might provide capital grant for the purchase of vehicle.

Models of health insurance system

There are many models of health insurance systems, but for the purpose of this study three main models have been identified. In distinguishing between the models, Huber et al (2002) identifies the two extremes of the systems as the mutualistic or participatory model and the provider-driven or technocratic models.

Mutualistic or participatory model

Communities organise themselves to establish a health insurance system. In a process of participatory bottom-up planning, priorities are defined and important decisions, such as determining the benefit package, are taken by the communities. The beneficiaries own and manage the system themselves and therefore are the financial risk bearers. A contract is signed between each individual and all the others. They collect the premiums to cover the types of care previously defined and provided by facilities contracted. The insurer and the care provider negotiate the terms of care. Well functioning schemes may play a strong role in defending the interests of households they represent. They can negotiate for better quality, such as better availability of essential drugs, or improved provider behaviour.

Provider-managed Model

Provider-managed schemes are often initiated by a hospital that is concerned about securing a stable source of revenue in a context where many patients cannot pay the bills. The health care provider is the insurer and manager of the scheme and is therefore the financial risk bearer. No intermediary structure exists between the payer of the fund and the health care provider. Priorities like defining the benefit package are usually set in a process of top-down planning. The community plays only a negligible part in the process. In some examples, a genuine concern to raise people's access to care can be the driving factor (Bwamanda/Democratic Republic of Congo). The community often perceives this technocratic top-down management approach unfavourably. The non-involvement of the community may lead to a suspicious and distrustful clientele that is likely to show all features of moral hazard behaviour. The little contact with and knowledge of the grassroots membership does not allow for necessary adjustments like taking consumer interests more into account.

An additional aspect of a provider managed health insurance is the intention to raise the hospital revenue. In consequence this may attract patients to prefer hospital services like the outpatient department instead of encouraging them using primary health care services for basic pathologies.

Prepayment Model

Another arrangement covering health risks is prepayment. Prepayment schemes are usually organised by health care providers. Risks are not shared with

other community members as in insurance schemes. A certain payment is made in advance to a health care provider or health care institution. At every consultation the prepaid amount is gradually debited, according to the consultation fee charged until the total amount is consumed. It allows the purchase of health care at a time when money is available in the household. More expensive events like hospital admissions are difficult to finance with this model. In this arrangement microcredit schemes, which are involved in individual and collective income-generating activities, include an insurance component. In case of more serious illness, the insurance prevents the misuse of the loan for paying health bills, in which case the creditor could not pay back the credit.

Theoretical framework

The theoretical perspectives or framework, upon which the present research is based, is the Traditional Concept of Solidarity and Risk Sharing. The concept of solidarity has always existed in African societies (Huber et al, 2002). A number of relationships and groupings exist, in which the members rely on each other's solidarity or even pool risks among a larger group. These are collective social mechanisms designed to meet individual risks, often related to life-cycle events such as birth and death, but also illness, and encompass in a wide range of both positive (weddings, baptism, circumcisions) and negative (funeral, illness) events. People come together when members are in financial difficulties, and for social and economic purposes (house construction, to start a business,

acquisition of agricultural material, organisation of communal festivities). This contributes to the creation and reinforcement of social networks (Criel, 1998)

According to Huber et al, (2002) the history of traditional risk sharing scheme shows that people have organised and managed cash-based risk sharing mechanisms for high expenditure (“catastrophic”) events, often quite complex contributions and benefit arrangements schemes. Membership is tightly limited, though. Indeed, “kinships” and “trust” feature in descriptions of these schemes. Membership is usually by individuals (rather than by household) and voluntary. Additionally, it should be noted that such schemes depend on a high degree of social homogeneity among participants and their trust in one another.

In traditional rural societies, when individuals make contributions, they usually expect a return, especially when the need arises. The informal risk-pooling arrangements are commonly based on balanced reciprocity, which is the standard for fairness. Any "gift” must be returned at some future time (Platteau, 1997). This implies that solidarity for social and economic risks involve the principle of balanced reciprocity.

Criel explains that the concept of balanced reciprocity is not only valid for the traditional rural society, but also in modern insurance systems where people expect some return to their investment (Criel, 1998). However, unlike the modern health insurance system, the solidarity and risks sharing in African societies made provisions for social risks but not necessarily for health risks. For instance, money is saved for payment of a dowry or food to be stored after harvest. Usually, people will not contribute money for a problem that is not visible. People do not put

money aside for unforeseen illness, which is often seen as a taboo (Huber et al, 2002). Such lack of strategies to cope with health risks can be partially explained by the fact that in a situation when people are engaged in survival strategies, health assurance is not the top priority.

Conclusion

It could be said that, theoretically the SHI and MHOs as well as the Mutual Health Insurance Schemes seem to be interesting solutions with great potential to enhance access to quality health care. Also, to mobilize funds, improve efficiency in the health sector, encourage dialogue and democratic governance for the health sector and thus contribute to the social and institutional development of society. However, an implication of the concepts of traditional solidarity and risks sharing to modern health insurance is that of a challenge for promoters of health insurance in Ghana as well as in sub-Saharan Africa to transform the foresight for social risks into foresight for health care.

CHAPTER THREE

METHODOLOGY

Introduction

The various methods used to collect and analyse data are discussed in this chapter. It also describes the research design, the study area, sources of data, instrument for data collection, the data collection procedure, the target population, sampling, sample size, data analysis, and finally, the problems encountered during data collection are presented and discussed in this chapter.

Research design

The study adopted the descriptive survey design using the case study approach. The descriptive survey design was chosen due to its merit. The fact is that it makes it possible to make generalizations from a sample to a population so that inferences can be made about some characteristics or behaviour of the population. This is important because the study is exploratory that allows for a careful investigation of a study or a case. A case study is the "development of detailed, intensive knowledge about a single 'case' or a small number of related issues. Using this method, a researcher can gain rich understanding of the context of the research and the process being enacted.

The descriptive survey offers the chance of gathering data from a relatively large number of classes at a particular time so as to make inferences and generalisations from the study of the sample. It is essentially cross-sectional (Best & Kahn, 1995; Gay, 1990; Osuala, 1993).

Gay, (1990) perceives the descriptive survey as a research design that attempts to describe existing situations without actually analysing relationships among variables. This design was chosen because it has the advantage of producing a good amount of responses from a wide range of people. It also provides a clear picture of events and people's behaviour on the basis of data gathered at a point in time.

The method was used to enable the researcher to be able to find out the perception, challenges and the experiences of stakeholders of the Wassa West Health Insurance Scheme in the Western Region. According to Cooper and Schindler (2001), descriptive study has become popular because of its versatility across disciplines. They further explained that descriptive investigations have a broad appeal to the administrator and policy analyst for planning, monitoring, and evaluating.

Study area

The Wassa West District was selected as the research site. The district is currently made up of the Tarkwa-Nsuaem Municipality and the Prestea-Huni Valley District. It covers a total land area of 2,334 square kilometres is located in the Western Region of Ghana. The District is bounded on the north by the Wassa

Amenfi West District. Ahanta West District on the east and Nzima East District on the south western boundary while Wassa Amenfi East District is on the north west boundary. Wassa West District lies within the South Western Equatorial Zone and has an annual mean rainfall of 187.83 millimetres and its temperature usually ranges between 26 ^{0}C in August and 30 ^{0}C in March. It has relative humidity ranging between 70% - 80% in the dry season and 75% - 85% in the wet season.

The District has a population of 232,699 (Ghana Statistical Service, 2003.). Out of this number of people, it is estimated that 56,321 are living in Tarkwa. The district has a population density of 96.26 persons per square kilometre and has population growth rate of 2.97%. The male-female ratio is estimated to be 103: 100 (Ghana Statistical Service, 2003). The district has 11 decentralized departments. Major occupations include agriculture, which employs majority of rural folks. and mining which also employs a significant number of people. Other occupations include commerce and services. Agricultural products in the area include cash crops like cocoa, rubber, oil palm and sugar cane and food crops such as maize, cocoyam, yam, cassava, plantain and vegetables. There is also livestock like sheep, goats, pigs and cattle.

The district also boasts of some rich mineral deposits. As a result of this, there are mining activities taking place in the district. The mining activities involve extraction of minerals like gold, manganese, silica and diamond. Manganese is mined at Nsuta, gold at Tarkwa, Prestea, Bogoso and Damang. Silica is mined at Kuran and diamond at Huni-Valley, Agona and Dompim.

Mining services are also provided by about 25 companies in the area to the mineral extraction companies. Other services provided in the area include educations, health and transport. There is also an airstrip at Tarkwa, specifically at Goldfields Ghana Limited (one of the gold extraction companies) for lifting of gold and other services.

There is high incidence of diseases such as acute respiratory infections, tuberculosis, skin diseases, acute eye infections and malaria in the district due to environmental pollution resulting from the mining activities. The mining has led to influx of people from all walks of life to the area including commercial sex workers. As a result HIV/AIDS prevalence rate in the district is 3.0% which is higher than the national figure of 1.7% (Wassa West District Health Directorate Annual Report, 2008).

The main objective for selecting this district is to obtain views and perceptions of resident subscribers on the accessibility and efficiency of the scheme and its impact on the quality of life of both urban and rural dwellers in the district. Secondly, as a worker with the scheme, this student researcher has substantial networking capabilities with colleagues working in the district, and this facilitated access to a wide variety of stakeholders of the scheme in the district who will be interviewed.

Study population

The target population for this study was the Wassa West Health Insurance subscribers, providers and the management team. Ten communities were

purposively selected in order to obtain the needed information on the perception, challenges and experiences of the people with the insurance scheme. The ten communities were selected in order to offer the investigator the basis for easy comparison and for the purpose of cross checking facts and also to ensure representativeness. Thus, the key informants who provided answers, views and opinions on the issue of challenges and experiences of the insurance scheme, were purposively selected from the ten communities to reflect the views of different stakeholders namely, subscribers, health service providers and scheme managers.

Sampling

Generally, the purposive sampling procedure was employed in selecting the communities and the research participants. The purposive and snowball sampling procedures were considered the best options for selecting the samples in this study. Purposive sampling enabled the researcher, first of all, to select ten communities spread across the district; and also to sample views from different categories of people with unique characteristics and location. This sampling technique enabled the investigator to target those perceived to have some important and useful information for the study. Thus, all persons in the targeted groups that were considered critical to the study were interviewed. The different groups that were contacted included the service providers, scheme management and subscribers. This group of people were easily identified in their communities. Once one was contacted, the rest were reached through snowballing technique. They were contacted for consent to take part in the research.

Sample size

In all, the study covered 120 respondents. This involved five management team members, 15 service providers and 100 subscribers. This sample size was chosen in order to have a number that was representative enough of the target population. Dealing with a smaller sample size might not produce results that were representative of the true situation in the locality since the communities were quite large. Unlike large sample size the sample of 120 respondents was not so cumbersome to work with or analyse and did not affect the validity of the data.

The data for the study were collected from 100 subscribers (beneficiaries of the scheme) selected from 10 towns and communities drawn from both rural and urban settings. The communities were Aboso, Tarkwa, Prestea, Bogoso, Huni-Valley, Nsuaem, Beppo, Awudua, Daman and Benso. These communities were the major settlements and were chosen due to their strategic locations and significance in the district; they are scattered all over the district. Table 1 shows the distribution of the respondents selected from the various communities in the Wassa West District. Figure1 is a map of the Wassa West District.

At least ten subscribers were chosen from each of the 10 communities. Some communities such as Daman and Beppo do not have service providers. As a result, card-bearers in those communities visit health facilities in a nearby town or community that has service providers. All members of the scheme management team are at Tarkwa, the head office of the WWHIS.

Table 1: Distribution of respondents

Communities	Subscriber (Card bearers)	Service Providers	Management Staff
Aboso	10	1	-
Bogoso	10	3	-
Daman	10	-	-
Huni Valley	10	2	-
Benso	10	1	-
Beppo	10	-	-
Nsuaem	10	1	-
Prestea	10	2	-
Awudua	10	-	-
Tarkwa	10	5	5
Total	100	15	5

Source: Fieldwork, 2009

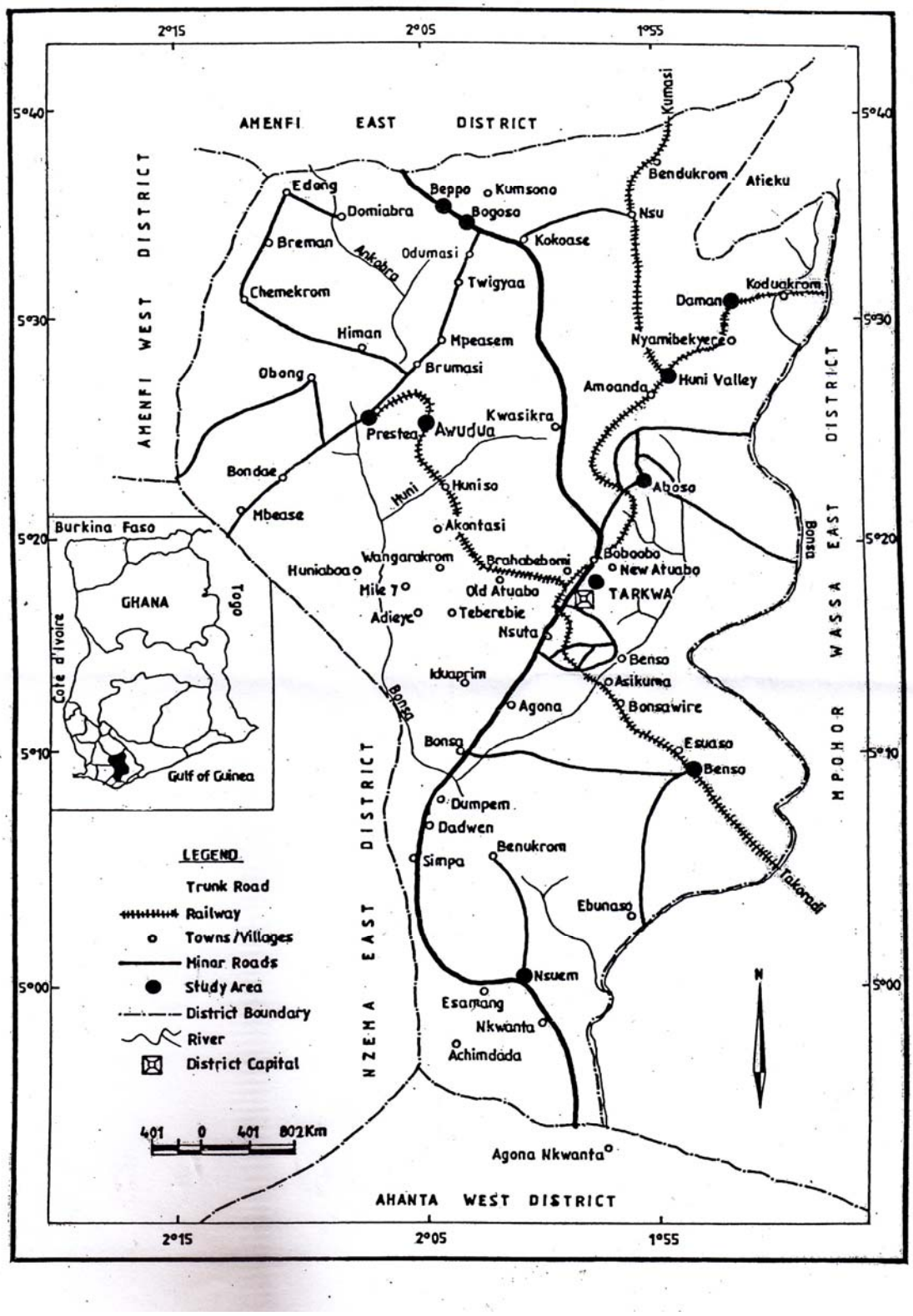

Figure 1: Wassa West District Assembly

Source: Office of the Town and Country Planning, Wassa West District, 2009

Sources of data

Data were obtained from different sources for the study. However, the main data for the study were gathered from primary and secondary sources. The primary data were obtained from the responses and views collected from the study participants that included some subscribers from different locations of the district, the main service providers in each town or village and the staff of the scheme at the district office. Additionally, participant observation also provided valuable and useful data for the study.

The review of secondary data helped in obtaining information on the National Health Insurance Scheme, the District Health Insurance Scheme and other mutual health insurance schemes in Ghana and else where. The secondary sources included data from journals, reports, the internet and other publications.

Data collection instruments

The research adopted the triangulation method. This enabled the researcher to have access to a variety of information on the same issue thereby overcoming the deficiency of a single method and achieving a higher degree of validity and reliability (Sarantakos, 1998). The basic data that were collected for the study were gathered through the use of interview guide, questionnaire, observation and document review. The interview guide was used to interview all the research participants on one-on-one basis to solicit responses, views and opinions on the Wassa West Health Insurance Scheme, its accessibility and challenges. This approach was adopted because it offered the opportunity to the

interviewees who contribute freely to emerging issues in confidence and at their own convenience. Follow up questions were raised to clarify issues or verify any view given. The method placed the investigator at a learning position and helped to build up confidence in the people, given the mixed feelings /mistrust that the people had about the scheme. It also allowed for collecting as much information as possible within the short period available for the study.

The interview guide was used to obtain information on a wide variety of issues on the topic. This also provided the researcher the opportunity to give further clarification to the questions, observed non-verbal behaviour and corrected misunderstanding of the respondents. It was also the expectation of the researcher that this process would reduce biases associated with other methods of data collection.

The interview guide was developed as semi-structured questionnaire with both open and close ended items with statements where respondents are to make choices, the four-point Likert Scale response format was used. The Likert scale is a series of statements each followed by response alternatives. Four alternative responses were provided for each statement. An advantage of the Likert scale is that a higher response rate for questionnaires is obtained because they can be completed in a short time. A weakness of the scale is that respondents are forced to choose one of the alternatives provided (Sarantakos, 1998). To minimize this weakness, at least one open ended item was placed at the end of the alternative responses provided, asking respondents for other comments or suggestions. The open-ended items provided opportunities for respondents to provide a wide range

of responses that offered useful information for the study. However, some of the responses were not relevant for the study, and were also difficult to analyse. The identities of respondents were protected and treated with respect and the confidentiality that they deserved.

Data processing and analysis

Data gathered from the field for the study were edited and coded to ensure that all inferring schedules were complete and contained accurate information. All questionnaires were given serial numbers to facilitate easy identification for scoring. Simple statistical software, that is the Statistical Package for Social Scientists (SPSS version 12.0), was used in the data analysis.

Challenges encountered during field work

The study was beset with a number of challenges that may affect the interpretation of the data gathered. Nevertheless this does not affect the validity of the findings. The most significant challenges that were encountered included the fact that local residents seemed to exhibit “research fatigue”. This was apparently prominent in Tarkwa and Prestea. Most of the participants lamented that no significant improvement had taken place in their living condition in spite of the numerous research work that had been conducted in the area which they participated.

There were frequent interruptions during the process of interviewing the participants, especially with some of the subscribers. They were often called to

attend to one or the other chore. This situation impeded or broke the smooth flow of thought of the respondents and at times, it became very difficult to get that particular respondent to continue with the interview, which resulted in the researcher spending valuable time.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results obtained from the review of documents, observations, and the questionnaire administered. The objective of this study was to examine the perceptions of some stakeholders on the challenges relating to the accessibility and the sustainability of the mutual health insurance scheme in the Wassa West District (WWD) in Ghana. The research questions provided a framework for this study. To provide a quick reference, the research questions enquired specifically about:

- The perceptions of subscribers on the accessibility of the scheme;
- The challenges that affect the sustainability of the scheme ;
- The roles of service providers in providing quality health care in the district;
- The extent to which the scheme is accessible to subscribers; and
- Any improvement in health care since the inception of the health insurance scheme in the WWD

In this chapter, the data collected on the above themes and on pertinent issues related to the mutual health insurance scheme in the WWD were analysed, discussed and presented. The chapter provides detailed description of the themes

and concepts that emerged from the study. It presents an analysis that focuses on the experiences and the perspectives of the research participants on the mutual health insurance Scheme in the Wassa West District.

Socio-demographic information of respondents

The study participants comprised 100 subscribers, 15 service providers and five scheme managers. The scheme managers are all based in Tarkwa, the head office of the District Health Insurance Scheme (DHIS). The health service providers were selected from various, towns and communities where the health facility has been accredited by the scheme to provide health services.

All the five scheme management team members who took part in the study were males and had served the scheme for two to six years. All of them also indicated that they had been educated to the tertiary level. All the five members of the scheme management team were relatively young: two of the management team members indicated their ages to be within the 20-29 age cohort. Another 2 indicated their ages to be within 30-39 and the remaining one was within 40-49 age group. Coincidentally those within the 20-29 age group were those who indicated that they were not married.

On the other hand, the ages of the card-bearers cut across all the age groups. Thus seven people representing 7% were under 20 years, while 10% representing 10 people were above 60 years old. From Table 2, majority of the subscribers who took part in the study were from two age groups of 20-29 and 30-39 representing 33% and 30% respectively. On the whole, the youth constituted

70 percent of the respondents. This implies that the resources of the scheme would not be over stretched since the youth are less prone to sickness.

Table 2: Age distribution of subscribers

Age	Percent
under 20	7
20-29	33
30-39	30
40-49	12
50-59	8
60 and above	10
Total	100

N=100'

Source: Fieldwork, 2009

However, none of the service providers' age was under 30 years. Table 3 shows that the majority of the providers were within the age groups of 40-49 (53.4%) and 50-59 (33.3%) respectively. It could be said that the majority of the service providers were matured and experienced. For that matter, are likely to provide quality health care.

It was found out from the study that majority (55%) of the subscribers were married as against 38% who indicated that they were single, while the remaining 7% were made up of those individuals who were 'widowed' or 'divorced (Table 4)

Table 3: Age distribution of service providers of the scheme

Age	Frequency	Percent
30-39	2	13.3
40-49	8	53.4
50-59	5	33.3
Total	15	100.0

Source: Fieldwork, 2009

Since the majority of the subscribers were married, it could imply that their dependants aged below 18 years were also beneficiaries of the scheme. These minors benefited from the scheme without payment of the premium. Moreover, minors below five years are prone to diseases. The minors could therefore put financial stress on the scheme.

Table 4: Marital status of subscribers

Marital status	Percentage
Single	38
Married	55
Divorced	5
Widowed	2
Total	100

'N=100 '

Source: Fieldwork, 2009

Educational level of scheme managers and subscribers

All five managers had been educated to the tertiary level. Additionally, it was only the scheme manager who has a Post Graduate Certificate in Public Administration. Thus apart from the Public Relations Officer who had a diploma, all the rest had at least a bachelor's degree from different fields of endeavour.

The study showed that the educational level for the majority of subscribers who took part in the study was quite low. This low educational background of the subscribers which reflected the general educational level of the people in the district was not seen as healthy for national development. A good number (22%) of the subscribers who took part in the study indicated that they had no formal education. More than half (70%) of the subscribers who responded to the questionnaire had not been educated beyond secondary level (Table 5).

Table 5: Educational background of subscribers

Level	Percentage
No formal education.	22
Basic education	28
MLSC	8
Secondary	15
Tertiary	25
Others	2
Total	100

'N=100'

Source: Fieldwork, 2009

Thus only few (30%) were educated beyond the secondary level. It is believed that people with little or no education are more likely to fall sick easily than those who are well educated. This is because those who are well educated are more conscious of their health and may pay more attention to preventive health care than the less educated. This implies that the scheme may pay high bill on the account of the majority who have little or no education.

Occupational background of respondents

With the exception of the subscribers, the other two categories of respondents (the scheme managers and the service providers) had similar background and related job experiences. The scheme management team was working with the scheme while the service providers also were working in a health or health related facility. Unlike the scheme managers and the providers, the subscribers to the scheme indicated a wide range of jobs. The occupational backgrounds indicated by the respondents included: driving, pensioners, students, assembly members, private business, civil servants, mining, teaching and farming.

It was found that the three most common occupations among the subscribers were trading/private business (33%), farming (18%) and civil/public servants (14%) (Table 6). Farming and trading constituted 42% of the respondents as compared to the civil /public servants who formed only 14%, while unemployment accounted for 7% of the subscribers. It could be said that this finding reflected the low educational background of the subscribers in the district. As a result, civil and public services which invariably required higher educational

qualification were not very common in the district (14%) compared to trading which registered 24 percent.

Perceptions and opinions on the accessibility of the scheme

The study showed that the health insurance scheme in the Wassa West District is performing well. Opinions about the accessibility of the health insurance scheme did not differ greatly among scheme managers, service providers and the subscribers. The dominant view expressed was that the scheme has made health care affordable and accessible in the district. When respondents were asked to rate the performance of the scheme on a four point likert scale, 40% representing two of the management team members rated the performance were asked to rate the performance of the scheme on a four point likert scale, 40% representing two of the management team members rated the performance as good, while the rest representing 60% (frequency) rated the performance of the scheme as very good. The study confirmed that in recent times, the scheme has witnessed some significant increase in the number of subscribers joining the scheme. Subsequently, many subscribers have benefited from affordable and accessible health care. For instance, by the end of 2008, 2036 people had subscribed to the scheme, a number which increased by 5% to 3238 by the end of 2009 (WWHIS Annual Report, 2009). This was evident in the responses of the research participants; the scheme managers and service providers as well as the subscribers indicated that there had been an increase in subscriber membership in the district.

Table 6: Occupation of subscribers

Occupation	Percentage
Student	15
Unemployed	7
Farming	18
Trading	24
Civil/Public service	14
Self-employed	9
Pensioner	5
Driver	2
Mining	3
Others	3
Total	100

N= 100

Source: Fieldwork, 2009

The study showed that health providers think that the performance is good. None of the providers rated the performance of the scheme as poor or unsatisfactory. Thus, 30% and 70% of the providers rated the performance “very good” and “good”, respectively. Almost all of them mentioned that there had been increased access to health care. Moreover, the affordability of health care especially to the rural poor was another reason for rating the performance of the scheme as very good.

The point of view of subscribers was not very different from that of the providers and the managers in their perception of the performance of the scheme. Subscribers were of the opinion that the scheme was performing very well in terms of accessibility, affordability and reliability. It was found that none of the subscribers rated the performance of the scheme as poor (Table 7). It could be said from the responses that both male and female have good perception about the performance of the scheme. It is likely, therefore, that they would maintain their membership with the scheme and ensure its sustainability.

Table 7: Subscribers' perceptions on the performance of the scheme by gender

Performance	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Excellent	4	9.1	6	10.7	10	10
Very good	21	47.7	39	69.6	60	60
Good	12	27.3	8	14.3	20	20
Fairly good	7	15.9	3	5.4	10	10
Total	44	100	56	100	100	100

N = 100

Source: Fieldwork, 2009

However, some of the subscribers expressed misgivings about corrupt practices by some scheme staff. They were of the view that these fraudulent acts

were a threat to the sustainability of the scheme. They explained that money was collected without issuing receipts as directed.

This was confirmed by the managers of the scheme who explained that there had been a number of cases where some card bearers could not access health care because their data was not captured by the scheme. This implied that such cards had been illegally issued out.

Challenges affecting the sustainability of the scheme

The scheme is beset with a number of challenges. The following were some of the nagging challenges that were mentioned during the interview with the management team. The most dominant challenges included, ineffective claims management and control, lack of effective mechanism for tracking claims, inconsistent billing system, undue delay of payment of claims due to providers. Low billing rate introduced by the scheme is a great disincentive to the provision of quality health service delivery to those who actually need their services.

Another serious challenge mentioned was the abuse of the system by subscribers. It was revealed from the study that the scheme had been suffering abuses from subscribers. They abused the system apparently because they think they have paid (irrespective of the amount paid) and would like to maximize their benefit at all cost even if there is no need to use a facility. This finding was centrally to the Traditional Concept of Solidarity and Risk Sharing in African communities, the theoretical framework, upon which the research was based. With this concept of solidarity, (Gueye, 1971, cited in Huber et al, 2002) a

number of relationships and groupings existed, in which the members rely on each other's solidarity or even pool risks among a larger group. People came together when members were in financial difficulties, and for social and economic purposes. This contributed to the creation and reinforcement of social networks (Criel, 2000 cited in Huber et al, 2002). Notably, this system was devoid of cheating since in the traditional rural societies when individuals made contributions, they expected a return only when the need arose. The informal risk-pooling arrangements were commonly based on balanced reciprocity, which is the standard for fairness.

The scheme manager complained that subscribers moved from one health facility to another with the same sickness and without completing treatment with the first facility visited. Moreover, multiple diagnoses of a particular sickness by some providers leading to a situation termed as "poly-pharmacy" and thereby increasing cost of health service delivery. This was seen by the scheme managers as threatening the sustainability of the health insurance scheme in the district.

Other challenges mentioned by the scheme managers that affect the effectiveness and efficiency of the smooth operation of the scheme included the following: lack of accommodation for staff, inadequate logistical support for running the office, unattractive remuneration and incentive packages for staff.

Even though the core management team for the scheme had lamented over a litany of challenges, they shared a positive attitude towards their job. It was important to note that all of the scheme management staff indicated that they enjoyed working with the scheme. As a matter of fact, all the five core staff of

the scheme responded in the affirmative when asked whether they enjoyed working with the Health Insurance Scheme in the district. They indicated that they enjoyed working with the Wassa West Insurance Scheme for various reasons. The reasons assigned for the positive attitude were that they had been working to promote a good cause – implementing a good health policy, job satisfaction in working with the scheme, serving the needs of subscribers and working to enhance access to quality health care.

Another disturbing issue was related to the operational ICT platform introduced in 2008 to improve the flow of information from the local level to the national level by the health insurance authority. This concept was excellent but the Authority acquired a low speed broadband which was incapable of transmitting information sent by all the schemes to the national level. The platform was used to transmit both claims entries and data entry to the national level. The resultant effect of this was that it had slowed down operations and correspondence between the districts and the national head office. Difficulty in sending such data had led to the inability of the schemes to fulfill their promise of getting any person who pays the premium a card within three months since the cards were all produced at the Headquarters in Accra and its readiness for use was dependent on when the transmitted information got to Accra. Owing to the low speed of the broadband, there was backlog of client data at all the scheme levels.

Challenges facing health care providers

When the service providers were asked about the challenges that affect their operations, they mentioned undue delay of payment of claims, exclusion of some drugs from approved list and low tariff. The dominant problem mentioned by the providers was the delay in the payment of claims by the scheme. Almost all (95%) of the service providers mentioned this as the major problem they face. The remaining 5% stated undue delay of payment of claims as the second or the third major problem affecting their operations. Consequently, the service providers mentioned that these challenges affected the quality of service delivery in the district. They explained that the system of limiting providers to certain prescribed medicines has not been helpful. This is because there are people for whom the alternative drugs may simply not work for them due to certain peculiar conditions.

They also expressed the view that the Health Insurance, notwithstanding its numerous benefits, was facing management crisis for non-payment of claims submitted to the National Secretariat of the Scheme. There have been complaints from health care providers about non-payment of outstanding claims for about six months. Meanwhile, the authority at the national level gives the local scheme a specific amount of money to manage for one quarter of the year. However, what is released does not meet even half of the claims submitted for the same period.

The situation worsened in 2008 due to the tripling in claims submitted by health care providers as a result of the authority changing from “itemized billing” to the current “diagnostic related grouping” This was further worsened by the

introduction of free delivery services to pregnant women. There is therefore a great difference between monies given to the schemes and claims submitted by service providers.

Table 8: Monthly payment schedule (2009)

Month	Claims Submitted Gh¢	Payment Gh¢	Deductions Gh¢	Indebtedness Gh¢
JAN	484,693.65	473,231.56	9,439.29	2,022.80
FEB	457,536.36	448,021.99	9,514.37	-
MAR	545,474.49	533,221.69	8,303.14	3,949.66
APR	548,495.93	538,752.22	5,469.88	4,273.83
MAY	577,519.34	561,496.26	9,903.30	6,119.78
JUN	658,937.56	626,620.00	10,459.94	21,857.62
JUL	622,815.87	586,352.74	8,944.80	27,518.33
AUG	594,235.69	72,678.50	-	521,557.19
SEP	489,530.88	2,272.54	-	487,258.34
OCT	462,891.34	2,031.56	-	460,859.78
NOV	331,134.66	-	-	331,134.66
DEC	549,045.18	-	-	549,045.18
Total	6,322,310.95	3,844,679.06	62,034.72	2,415,597.17

Source: WWDMHIS Annual Report, 2009

Table 8 provides an overview of the indebtedness of the WWHIS in 2009. By the end of December the scheme was owing providers to the tune of GH¢ 2,415,597.17. Similarly, for a period of eleven months, the scheme was able to save an amount of GH¢ 62,034.72 which were deductions from claims submitted by service providers. This therefore reveals that submitted claims contained some errors.

The findings of the study have been confirmed by a report in the Daily Graphic by Sodzi-Tettey, June 1, 2010. It was reported that the failure of mutual health insurance schemes in the Kumasi metropolis to pay claims to health service providers in their catchment area was seriously undermining quality health delivery. According to the Kumasi Metropolitan Director of Health Services, Dr Kwasi Yeboah-Awudzi, mutual health insurance schemes in the metropolis had not paid claims to accredited hospitals and pharmacy shops since May 2009, making it difficult for the health service providers to generate the requisite revenue to replenish drugs and other medical supplies needed to enhance quality service delivery. It was said that the schemes owed about GH 4,574,571 to some hospitals and clinics in the Kumasi metropolis and its environs. Thus, hospitals in Kumasi were running out of consumables and drugs and their managements were also being constantly harassed by those who supply them with medical consumables to run the hospitals (Sodzi-Tettey, June 1, 2010). Expressing concern on the situation, Dr Yeboah-Awudzi said, in December 2009, medical superintendents in the metropolis complained bitterly about the undue delay in paying claims and appealed to the government to intervene as a matter of urgency.

The foregoing discussion provides evidence that the scheme has not been able to comply with section 38(1) of the L.1 1809 whilst health care providers do honour section 37 (7) of L.1 1809. This raises concerns about the efficiency of the scheme. If the scheme owes some providers, then the obvious and unanswered question is whether the scheme is sustainable enough to serve the needs of subscribers.

Apart from the non-payment of claims to service providers, the scheme also has not been paying claims regularly to accredited pharmacy shops. As a result, they also refuse to give the requisite drugs to members of the scheme who present prescriptions, thus undermining quality health care delivery. This therefore threatens the *reason d'être* of the establishment of the scheme to provide affordable and accessible quality health care delivery to all subscribers.

Additionally, the health insurance drug price list has not been reviewed since 2008. As a result of the non review, there are a number of drugs on the health insurance list that is cheaper than the cost price in the market. This implied that supplying such drugs to clients would be at a loss to the providers.

According to the Ghana Medical Association (GMA), as a result of non payment of claims, most health care facilities owe substantial amounts of money in medicines and consumables procured on credit. Due to the indebtedness, supplies were no longer willing to supply on credit. In its statement, the GMA said the Korle-Bu Teaching Hospital was owed 2.7 million Ghana cedis, the Central Regional Hospital – GH¢ 694,000, the Eastern Regional Hospital GH¢1,090,000 with similar example elsewhere. This situation, the association stated had enormously affected the ability of those facilities to provide quality service to their clients including shortage of drugs and other essential supplies (Sodzi-Tettey, 2010, June 1).

Challenges facing subscribers

A number of problems were enumerated by the subscribers as affecting access to quality health care. Dominant among the problems were: delays at health facilities due to increased attendance; inadequate equipment and personnel as well as long distance to facilities (Table 9). As many as 33% of the subscribers complained that there have been frequent prescriptions of drugs and quite often, expensive drugs which the scheme did not cover.

Table 9: Problems with card bearers

Response	Percentage
Unfriendly practitioners	5
Prescription of medicine outside the drug list	33
Delay due to increased attendance	15
Inadequate equipment and personnel	10
No problem	12
Unauthorized money collection	5
Long distances to facilities	20
Total	100

N = 100

Source: Fieldwork, 2009

The prescription of drugs outside the price list was worrisome phenomenon. Subscribers explained that card-bearers were denied or were not allowed to be administered certain kinds of drugs irrespective of the disease or

needs of the patient. The study confirmed service providers' assertion that this policy did not promote quality health delivery in the district.

From Table 9, 15% of the subscribers mentioned delay at health facilities as one of the major challenges they encounter as recipients of health care. The respondents attributed the apparent increased number of people accessing health care in the district to the introduction of the District Health Insurance Scheme (DHIS).

The table also shows that a form of unauthorised money is being collected by some health personnel, especially in public health facilities. At least five percent of the subscribers stated this as a practice which mitigates the principle of providing affordable and accessible health care.

Role of service providers in providing quality health care

Service providers play a critical role in ensuring the provision of quality health care. Quality health delivery depends on the good will and cooperation of all stakeholders such as the government, the scheme, the providers and the subscribers.

The study confirmed the fact that health providers have a critical role to play in ensuring quality health delivery in the Wassa West District. Measured on a four point Likert scale, 3 out of 5 (60%) of the scheme managers, "strongly agreed" to the key role of health providers. Similarly, 70% of the subscribers who participated in the study indicated that they "strongly agree" to the statement, while the remaining 30% of the respondents "agreed." This implied that none of

the respondents disagreed with the fact that providers play critical role in providing quality health care in the district. This underlined the fact that the subscribers, irrespective of their sexes, appreciated the quality health care that they enjoyed is largely depended on the health providers who work in collaboration with all stakeholders. This implies that both male and female have confidence in the scheme and hence their increasing patronage.

On the question of how providers served card bearers, respondents were unanimous that their services are good. This means that they had done their best in the circumstances to serve card bearers in spite of the constraints that they faced.

It emerged from the study that “card bearers” and “non-card bearers” more often than not are treated differently. In the estimation of the members of the scheme management, some doctors, nurses and other health providers react to card bearers and non-card bearers differently. Reasons given for the apparent discrimination in reaction were as follows:

- Since non-card bearers pay cash instantly, health providers feel at home and very much at ease with that. Non-card bearers and the use of cash and carry promote swift and efficient service delivery.
- The scheme has placed some limitation on the type of drugs that can be prescribed for card bearers; this is discriminatory.

However, the providers stated that the effectiveness of their role is to a large extent depended on how well the nagging challenges that confront the scheme were addressed. Service providers outlined a number of factors that may

enhance their role in the scheme. Prominent among them were: regular and full payment of claims, cooperation from other stakeholders, education and free flow of information.

The study found out that service providers are capable of cheating the system through omission and commission that may affect the sustainability of the health insurance scheme. When the scheme managers were asked in what ways they think service providers can cheat the system, they mentioned the following as dominant: writing of multiple diagnoses leading to prescription of many drugs, inflating the attendance list, substituting less expensive drugs with expensive ones on the claims forms and inflating drug quantity, among others.

Access to and use of health facilities

Almost all respondents (97 percent) had access to a health facility in their own town or village, and 91 percent had access to a facility within 3km of their home. For most people (89 percent), however, the nearest facility was a chemist or pharmacist. Fifty-eight percent had access to herbalist and 57 per cent to a government clinic. Only one quarter had access to a government hospital, and about 20 percent had access to a private clinic and 19 percent to a mission hospital.

Table 10 presents an overview of the most common diseases reported at the health facilities for medical attention. For 2009, malaria accounted for almost 60 percent of the ten top diseases that were reported to the facilities. It stands to reason, therefore, that if the preventable diseases such as malaria, diarrhea and

typhoid fever are reduced through education and good health practices, bills submitted to the scheme would also be reduced.

Table 10: Top ten causes of OPD attendance (2008 & 2009)

	2008			2009	
Diseases	Cases	%	Diseases	Cases	%
Malaria	85,855	40.3	Malaria	127,101	59.9
Acute respiratory infections	17,517	8.2	Acute respiratory infections	22,837	10.6
Rheumatism and joint pains	9,111	4.3	Rheumatism and joint pains	12,143	5.7
Skin diseases and ulcers	8,072	3.8	Skin diseases and ulcers	11,985	5.6
Diarrhoea	7,179	3.4	Diarrhoea	10,381	4.9
Hypertension	6,781	3.2	Hypertension	9,096	4.3
Pregnancy and related	4,618	2.2	Acute eye infection	7,581	3.6
Acute eye infection	4,501	2.1	Vaginal discharge	4,346	2
Chicken pox	3,630	1.7	Typhoid/enteric fever	3,472	1.7
Dental caries	3,545	1.6	Intestinal worms	3,378	1.5
Sub total	150,809	70.9	Sub-total	212,320	75.3
All others	61,759	29.1	All others	69,660	24.7
Grand total	212,568	100	Grand total	281,980	100

Source: Wassa West District Health Directorate (WWDHD), 2009

A cursory look at Table 10 shows an increase in the number of attendances to the ‘out-patient-department’ (OPD) in 2009. This confirms the fact that access to health care in the district has increased.

Accessibility of scheme to subscribers

It was evident from the responses given by the management team that the scheme has improved access to quality health care in the Wassa West District. With the card in hand, people who previously could not visit any health facility can now receive that service. Moreover, they mentioned that subscribers are more frequently and more often using health facilities now than before. They substantiated their claim by mentioning that there has been significant increase in the number of patients who use the health facilities in the district in recent times. Accordingly, the service providers mentioned "card-bearers" as now forming the majority of their clients.

Table 11: Hospital attendance in the Wassa West District from 2001 to 2009

Year	Hospital attendance
2001	77, 377
2002	122,933
2003	131,508
2004	174,202
2005	195,970
2006	219,950
2007	242,406
2008	337,685
2009	415,048

Source: Wassa West District Health Directorate (WWDHD), 2009

It was thus, evident from the study that since the inception of the mutual health insurance scheme in the district, attendance to health facilities has been increasing and subscribers to the scheme form the bulk of the people who access health care in the district (Table 11).

It could be deduced from this that the health insurance scheme is capable of promoting access to quality health care in the district. Further more, when the scheme managers were asked whether in their estimation, the premium paid by subscribers was affordable, they all responded in the affirmative. To them the premium paid by subscribers was moderate and very affordable. Perhaps they were informed by the increasing number of subscribers joining the scheme on daily basis. On the other hand, the subscribers shared divergent views on the affordability of the scheme. According to the responses, 65% of the subscribers indicated that the premium paid as very affordable. However, the remaining 35% indicated that the premium was not affordable and that they expected it to be free. The results show that those who thought the premium was expensive were made up of petty traders, farmers and the unemployed.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The main objective of this study was to examine the experiences and expectations of stakeholders of the National Health Insurance Scheme (NHIS) in Ghana, specifically the Wassa West Health Insurance Scheme of the Western Region. By examining lived experiences and expectations as expressed by the scheme managers, health providers, and subscribers, shared realities emerged. This chapter presents summary of findings, conclusions and implications for policy and theory.

Summary

The study sought to examine the experiences and perceptions of scheme managers, subscribers and service providers on health insurance in the district. In addition, it examined the challenges and opportunities that scheme managers, subscribers and providers face.

Findings from the study showed that the government and Wassa West District are committed to the implementation of health policy and the principles of the Mutual Health Insurance. The DMHIS was established as a means of providing accessible and affordable quality health delivery. The majority of

respondents stated that the Health Insurance Scheme has occasioned significant increases in attendance at the out patients departments of the various accredited health facilities throughout the district.

People who hitherto could not afford health care as it was considered expensive and inaccessible to the poor can now patronize any health facility of their choice any time they are ill. As a result some private health posts accredited to the scheme have been receiving larger patronage and a boost to their operations.

The findings further show that claims are submitted timely by service providers to the scheme. However, reimbursement of claims is always delayed. As a result, hospitals and clinics are faced with severe challenges of delayed reimbursement and it has crippling effects on health service delivery. Hospitals are not able to pay for medicines and consumables purchased on credit. Some supplies, therefore, have opted to supply goods to hospitals on a purely cash-and-carry basis.

The findings indicate that the scheme has been suffering abuses from subscribers and service providers. Subscribers abuse the system apparently because they think they have paid (irrespective of the amount paid) and would like to maximize their benefit at all cost even if there is no need to use a facility. This is centrally to the concept of the traditional solidarity and risk sharing in African communities upon which the health insurance scheme is based. The service providers also abuse the system by preparing and presenting fraudulent and illegitimate claims for reimbursement.

Conclusions

Mutual health insurance scheme is now being considered as a key to providing affordable and accessible quality health care for the majority of Ghanaians. The scheme has made health care more accessible and affordable to both rich and the poor in both urban and rural communities. People who previously could not access health facilities can now receive medical attention early enough to avoid complications. In practice, health insurance scheme covers out-patient and in-patient cases, including accidents and investigations.

Through a combination of survey, non-participant observation, and documentary review, this research reveals site specific problems such as fraudulent claims, undue delay in the payment of claims submitted for refund, delay in accessing health care due to increasing number of attendants to health facilities. Also limited and inadequate logistics, equipment and personnel are often some difficulties that confront both the scheme management and accredited health providers in the district.

In spite of all the challenges, the findings of the study establish the optimism that the scheme has a future and would rise above its challenges to provide affordable, accessible, quality service delivery in the district. It could be said that the health insurance policy is a good one and it is worth pursuing and needs the support and cooperation of all the stakeholders. It is also expected that all the stakeholders uphold and maintain integrity, transparency and accountability in the relationships among them in order to achieve the aims and objectives for which the scheme was established.

The broad conclusions drawn from these results are that attitudes were positive and people wanted to join health insurance schemes, but some were inhibited by the cost of the premium and a lack of knowledge or understanding of how health insurance works.

Recommendations

Based on the findings and the conclusions of the study, the following recommendations are made:

- There is the need to enhance cordial collaboration between the scheme management and the accredited service providers so that subscribers would enjoy quality and accessible health care in the Wassa West District.
- Subscribers should desist from moving from one health facility to another with the same sickness without completing treatment with the first facility visited. They should be made to understand that, such behaviour is a threat to the sustainability of the scheme which has become beneficial to every subscriber.
- To ensure sustainability of the Scheme, subscribers should access the health facilities only when they are sick. It should not be their intention that they are accessing the health facilities because they have paid premium for which they have to benefit from by all means.
- Service providers should uphold honesty by submitting claims on subscribers who have truly accessed their facilities. They should not have a mind of milking the scheme to enrich themselves.

- “Poly-pharmacy” (Poly-pharmacy refers to prescription of many drugs to a patient.) as a result of multiple diagnoses should be avoided. Providers are entreated to adhere to the Standard Treatment Guideline of the Ghana Health Services.
- Collection of unauthorised money from subscribers at the point of service delivery by some health personnel make subscribers lose confidence in the scheme. Heads of various health facilities should be vigilant and whenever a case of such malpractice is reported to them, they should bring the perpetrator to book.
- Management of the scheme should educate the entire society on the need for everybody to subscribe to the scheme. This could be achieved through the organisation of seminars and radio programmes for all stakeholders on the place or role and importance of the national health insurance scheme to the socio-economic development of the country.
- Management should be vigilant and expose any provider who would try to defraud the scheme. They should as well be disciplined by putting in place measures to check and minimise corrupt practices of the staff of the scheme.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE FOR SUBSCRIBERS (BENEFICIARY)

Introduction: This questionnaire forms part of an M. A. research work being carried out at the Institute for Development Studies (IDS), University of Cape Coast. The study seeks to solicit information, opinions and perceptions on the performance and accessibility of the Wassa West District Health Insurance Scheme in the Western Region of Ghana.

I would be seeking your views and perspectives on the performance and the accessibility of the health insurance scheme. The study is purely for academic purposes and the information you provide will be kept in strict confidence and that your name will not in any way be associated with the comments you make.

A. Socio-demographic information of respondent

Age group: under 20 { }, 20-29 { }, 30-39 { }, 40-49 { }, 50- 59 { }, 60 and above { }

Gender: Male { }, Female { }

Electoral area: ……..…….

Town/Village: ……

Marital Status: single { }, married {}, divorced { }, separated {}, Cohabitation { }

Number of children: …… Number of dependants: …….

Educational level: No formal education { }, Basic Education {}, Secondary { }, Tertiary { }, Others, Specify:……

Occupation: ……..

B. Perceptions and opinions of subscribers on the accessibility of the scheme?

What do you think about the Health Insurance Scheme?

Normally, what do you do when you are sick?

Why did you join the health insurance scheme?

How many members of your household have registered?

How often were you going to hospital before you registered?

To what extent has the scheme benefited you?

C. Accessibility of scheme to subscribers?

How often do you use your card to access health care?

How much premium did you pay?

Do you think it is affordable?

How much do you think you can pay?

D. Challenges that can affect the sustainability of the scheme?

What problems do you face when you go the hospital, the pharmacy shops or the clinic with your card?

How can these problems be solved?

Do you think the scheme has a future? Yes { }, No { }. Either way explain

E. Roles of service providers in providing quality health care?

How would you assess the way providers serve “card bearers”

Do you think health providers prefer “card bearers” to “non-card bearers?

Yes { }, No {} Give reasons.

Are you happy with the services of the health providers?

Do you think service providers can cheat the system?

APPENDIX B

INTERVIEW GUIDE FOR SERVICE PROVIDERS

Introduction: This questionnaire forms part of an M. A. research work being carried out at the Institute for Development Studies (IDS), University of Cape Coast. The study seeks to solicit information, opinions and perceptions on the performance and accessibility of the Wassa West District Health Insurance Scheme in the Western Region of Ghana.

I would be seeking your views and perspectives on the performance and the accessibility of the health insurance scheme. The study is purely for academic purposes and the information you provide will be kept in strict confidence and that your name will not in any way be associated with the comments you make.

A. Socio-demographic information of respondent

Age group: under 20 { }, 20-29 { }, 30-39 { }, 40-49 { }, 50- 59 { }, 60 and above { }

Gender: Male { }, Female { }

Electoral area: ……..…… …….

Town/Village: ……

Marital Status: single { }, married { }, divorced { }, separated { },

Cohabitation { }.

Educational level: Basic Education {}, Secondary { }, Tertiary { },

Others, Specify:……..……

Occupation: …… Position: ……..

Perceptions and opinions on the accessibility of the scheme?

What do you think about the general performance of the scheme?

When did your outfit become health provider for the scheme?

In your opinion how beneficial is the Insurance Scheme?

"Card bearers" and "non-card bearers" which of them mostly patronise your service?

Challenges that can affect the sustainability of the scheme

What are the main challenges that affect the services you provide?

Which of the above challenges can affect quality service delivery?

What can be done to mitigate some of the challenges?

Before you became a service provider for the scheme, what was the patronage as compared to now?

What don't you like about the management of the Scheme?

Roles of service providers in providing quality health care?

How can you contribute to the sustainability of the scheme?

What do you think is the future of scheme?

How can you promote quality health service to meet the health needs of subscribers?

Are subscribers happy with the services you provide them? How?

In what ways do you think service providers benefit from the scheme?

Accessibility of scheme to subscribers

Do you encourage “non-card bearers” to register with the scheme?

Do you think there has been an increase in the number of patients who visit your health facility?

Is the premium paid by subscribers affordable? Yes {}, No {}

If No, how much do you think is affordable?

What do you think about the tariff and the medicine list?

Please kindly provide suggestions or recommendations that will help to improve the performance of the scheme.

APPENDIX C

INTERVIEW GUIDE FOR SCHEME MANAGERS

Introduction: This questionnaire forms part of an M. A. research work being carried out at the Institute for Development Studies (IDS), University of Cape Coast. The study seeks to solicit information, opinions and perceptions on the performance and accessibility of the Wassa West District Health Insurance Scheme in the Western Region of Ghana.

I would be seeking your views and perspectives on the performance and the accessibility of the health insurance scheme. The study is purely for academic purposes and the information you provide will be kept in strict confidence and that your name will not in any way be associated with the comments you make.

A. Socio-demographic information of respondent

Age group: under 20 { }, 20-29 { }, 30-39 { }, 40-49 { }, 50- 59 { }, 60 and above { }

Gender: Male { }, Female { }

Marital Status: single { }, married { }, divorced { }, separated { }

Educational level: Basic Education { }, Secondary { }, Tertiary { },

Others, Specify:……

Occupation: …….

Position: …….. No years at post: ……..

B. Perceptions and opinions on the accessibility of the scheme?

How would you assess the general performance of the scheme?

Very good{}, Good{}, Average {}, Below average {}.

Do you enjoy working with the health insurance scheme? Explain your answer.

In your opinion how beneficial is the Insurance Scheme?

What has been your experience with the District Health Insurance Scheme?

C. Challenges that can affect the sustainability of the scheme?

What are the main challenges that confront the scheme?

Which of the above challenges actually affect quality of service delivery?

What can be done to mitigate some of the challenges?

How can the scheme be abused by any of the stakeholders?

What don't you like about the District Health Insurance Scheme?

How can the sustainability of the scheme be ensured?

How do you assess the performance of service providers

In what ways do you think service providers can cheat the system?

D. Roles of service providers in providing quality health care

1. Service providers have critical roles to play in ensuring quality health care. Strongly agree {}, Agree {}, Disagree {}, Strongly disagree {}.

How would you assess the way providers serve "card bearers". Very good { }

Good { }, Average { }, Below average { }

How differently do doctors, nurses and other health providers react to card bearers and non card bearers?

How can we ensure quality health care delivery?

How do providers see their role in attending to subscribers' health needs?

Are subscribers happy with the services of the service providers?

In what ways do you think service providers can cheat the system?

Accessibility of scheme to subscribers

How often are subscribers using the health facilities? Very often {}, often seldom, very seldom.

Has there been any increase in the number of patients who use the health facilities in the district?

Is the premium paid by subscribers affordable /adequate? Yes {}, No {}

Explain your answer

If No, how much do you think will be affordable?

How has access to health facilities improved since the inception of the district health insurance scheme?