UNIVERSITY OF CAPE COAST

PERFORMANCE OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE HO MUNICIPALITY

BY

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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: Jacob Yao Quarranttey

Supervisor's Declaration

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

Supervisor's signature:…… Date:…….

Name: Dr. E. K. Ekumah

ABSTRACT

This study focused on assessing the performance of the Ho Mutual Health Insurance Scheme and considered factors including; availability of administrative structures and logistical support, quality of care, attitude of hospital staff towards insured persons, claim processing, etc.

There have been some concerns over the quality of treatment under the health reform compared to cash and carry system hitherto, practiced. For instance, questions have been raised about the attitude of hospital staff towards insured persons as well as the quality of treatment expected.

The study used a sample size of 380 respondents, obtained through appropriate statistical instruments. About 96% of the respondents were accessed though quota sampling from the three health felicities and the general public and only 4% of employees of the mutual health insurance scheme were interviewed. A triangulation of quantitative and qualitative methodologies and analysis of results were employed to explore perceptions of research participants on the performance of the scheme. The perception of the insured persons accessed was that, the health reform was a good intervention but was not functioning too well, for instance, the quality of care was satisfactory and claim processing was manually done delaying government reimbursement to the healthcare providers.

It suggested, for example, that revenue sources should be diversified to sustain the scheme and also, claim processing by the scheme computerised for high level performance.

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DEDICATION

To my wife, Ephraim Quarranttey and my children.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

CHA	-	Christian Health Association
CHAG	-	Christian Health Association of Ghana
DANIDA	-	Danish International Development Agency
DFID	-	United Kingdom Department for International Development
DMHIS	-	District Mutual Health Insurance Scheme
GDP	-	Gross Domestic Product
GNP	-	Gross National Product
GPRS	-	Ghana Poverty Reduction Strategy
GST	-	Global Social Trust
HIPC	-	Highly Indebted Poor Countries
ICT	-	Information and Communication Technology
ILO	-	International Labour Organisation
IMF	-	International Monetary Fund
MDGS	-	Millennium Development Goals
MHO	-	Mutual Health Organisation
NHIF	-	National Health Insurance Fund
PHR	-	Partnership for Health Reform
SHI	-	Social Health Insurance
SSNIT	-	Social Security and National Insurance Trust
USAID	-	United States Agency for International Development
USHI	-	United States Health Insurance

WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background of the study

The world has reached a stage where strident calls are being made to the global community to adopt concerted efforts to solving global challenges that face it. It is unpleasant to note that about 1.2 billion people – one person in five are living on less than one dollar a day and half of the world's population (3 billion) live on less than two dollars a day (Bloom, 2007).

However, the International Convention on Economic, Social and Cultural Rights recognizes the right of everyone to "an adequate standard of living… including adequate food, clothing and housing, and to the continuous improvement of living conditions (Bloom, 2007).

Health is a major indicator of poverty. The United Nations Millennium Development Goals (MDGs) adopted in the year 2000, elaborated enough on health and sought ways to pool intellectual and financial resources to assist poor countries out of a number of problems (Bloom, 2007). However, a complex and uncoordinated donor and government organisations render major health problems unresolved. Financing an efficient functioning and performing health system is difficult and subject to few short-cut measures in developing countries. Factors responsible for this problem may be due to scarce economic resources, low or

modest economic growth, constraints on public sector and low organisational capacity, among others (Carrin et al., 2001). It is now obvious to suggest to governments of the developing world that, mobilizing resources to finance and establish a functioning, socially accepted health systems is a major way forward of coming out of such challenges.

The government of Ghana budget for social programmes for poverty reduction and in the area of health constitutes about 7.0% of her GDP of which substantial amount is used for personnel emoluments and administration, thus, inhibit adequate functioning of health systems. However, public expenditure on health at the end of the 1990s was only about US$11 per capita, when the country's population was well about 20 million people, during which user fee payments for health services utilization was significant (International Labour Organisation, 2002).

Access to and use of health facilities have been low and declining, particularly since a shift some twenty years ago from a universally accessible national health service to the introduction of user fees. A survey conducted by the Ghana Statistical Services in 1998 suggest that, around 43.8% of those who were ill had consulted a medical practitioner; this ranged from around 65% in Accra to only 37.7% in rural savannah areas(Ghana Statistical Services, 2000). This trend can be associated with increasing user fees over the years and declining public health service provision as one move to the peripheral regions of the country.

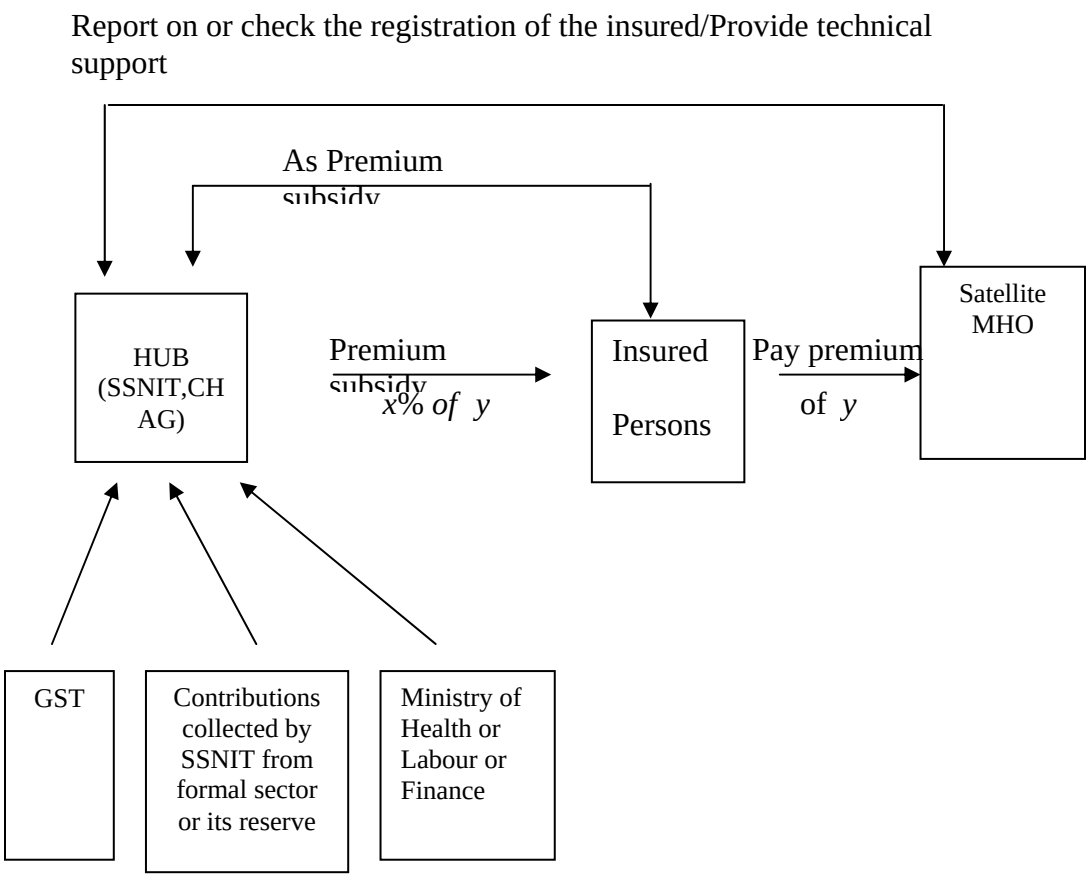
It has been observed that even though government covered 80% of the health care cost under the pay-as-you-go system (cash and carry) and the end

utilizer takes care of the rest 20%, the prevalent social deprivation limits access to health care and invariably excluding the poor, especially, the core poor (Government of Ghana, Ministry Of Health, 2004).

Various governments over the years have proposed a social protection health system but were limited at sound policy formulation and implementation. However, some formal sector workers established a number of voluntary Mutual Health Organisations (MHOs) with the help of donor funding and in 2002, there were already 159 MHOs in Ghana (Atim et al., 2001). Nkoranza in the Brong Ahafo region is the oldest of them all, established in 1989 and assisted by a Dutch Christian non-governmental organisation, Memisa (Atim et al., 2001). The performance of the Nkoranza scheme in particular, and few others piloted were successful and did actually, to a large extent, meet the health needs of the communities involved and thus, set the premise for replication across the nation to provide health needs and ultimately reduce poverty.

These developments, in addition to the campaign pledge of the New Patriotic Party government in the year 2000, compelled the introduction of the National Health Insurance Scheme in August, 2003 which is expected to be anchored on the policies operated by the Mutual Health Organisations already in place, to pool risks, reduce individual burden, achieve better utilization rates and extend coverage to at least 50-60% of all residents in Ghana within the next 5-10 years of the scheme's inception (Government of Ghana, Ministry of Health , 2004).

A National Health Insurance Council is established to harmonies activities of social health insurance schemes to include private schemes to monitor and offer technical advice and resources as appropriate to scheme providers (Government of Ghana, Ministry of Health, 2004). It is in this light that the performance of the national health insurance schemes thereof, is important if the Millennium Development Goals on health could be achieved.



Note: GST – Ghana Social Trust

CHAG – Christian Health Association of Ghana

Figure 1: A tentative outline of a satellite health insurance system in Ghana

Source: ILO (2003)

Under the Ghana Social Trust concept of development, there was an attempt to link the formal and informal sectors schemes in a "hub-satellite relationship" where the functioning formal sector will partner and sponsor smaller community based social security schemes of the informal sector and also sought compatibility with the vision, on the future National Health Insurance Scheme (International Labour Organisation, 2003).

The model explains a hub, satellite and benefit to insurers' relationship. The hub is to provide funds and technical support to the satellite (MHOs) which would also provide insured individuals social protection to access quality and affordable health care. The criteria for the satellite was that it should have sound administrative and technical capacity; and that it should have a benefit package and structure which would make it comparatively simple to attain access (International Labour Organisation, 2003).

The Ho Mutual Health Insurance Scheme is one of such newly created satellites in the country and by way of administering questionnaires and interviewing of respondents, data could be obtained for analysis of the processes and functioning of the system since it took-off among others in, 2003. The focus would help investigate the performance of the health insurance scheme in the Ho municipality.

Statement of the problem

The introduction of the National Health Insurance Scheme in 2003 has received many plausible comments from politicians and civil society

organisations across the population profile. Many individuals are now relieved as the infamous, pocket draining and energy sapping "cash and carry" system of health care delivery is replaced with a more humane social protection health system. However, given the socio – economic dispensation vis-à-vis high incidence of poverty and the political will of leadership, can the recent health reform attract the necessary financial and material support to ensure sustainable adequate performance that meets the health requirements as pertains elsewhere?

Normand(1994) confirmed that the uncertainties surrounding the incidence of ill health and the inefficiency of treatment mean that health care is an appropriate case for insurance.

By accepting premiums, insurance companies promise policy holders compensation if certain unspecified events occur. The prices of the insurance according to Cichon et al, (1999) constitute the premium paid.

Once paid, individuals shift medical expenses to the insurer in exchange for the premium and the insurer assumes the risk. A World Health Organisation study of Nkoranza scheme in Ghana estimated the cost of contribution (premia) varied from 5% - 10% of annual household budgets (World Health Organisation, 2000).

This raises financial burden to membership, especially, where most citizen of Nkoranza are farmers.

Again, an International Labour Organisation study of the Dangme West Health Insurance revealed that, there were some difficulties that arose within the registration process, notably, in collecting photos of beneficiaries for the identity

cards even after a government subsidy for photo ID was enforced. It came to light that while people were apparently keen to participate, they were less keen to take the time for registration (International Labour Organisation, 2004).

Additionally, there are growing concerns about increased perceptions of low levels of treatments received under some schemes, general apathy towards membership registration, complaints about acceptance of the identity cards at the health institutions and the general different rates of District Mutual Health Organisations (MHOs) take-offs in the country.

The purpose of the study is to investigate the performance of the Ho Municipal Mutual Health Insurance Scheme and to explore the factors that affect the performance of the scheme and suggest possible ways forward to ensure that the scheme is viable.

Objectives of the study

The main objective of this study is to review the performance of the National Health Insurance Scheme in the Ho Municipality.

Specifically, the objectives were to:

- Investigate the availability of administrative structures and logistical support and their effects on the performance of the Mutual Health Insurance Scheme.
- Examine the quality of health care under the Mutual Health Insurance Scheme.

- Assess the attitude of hospital staff towards the insured individuals under the Mutual Health Insurance Scheme.
- Examine the rate of government re-imbursement to health care providers and its effects on the performance of the Mutual Health Insurance Scheme.
- Evaluate the perceptions of the population on the performance of the Mutual Health Insurance Scheme.
- Suggest ways to improve on the performance of the Mutual Health Insurance Scheme.

Research questions

- What is the satisfaction with the performance of the Mutual Health Insurance Scheme?
- What relationship exists between availability of administrative structures and logistical support, on one hand, and the performance of the Mutual Health Insurance Scheme?
- Can we consider the quality of health care, under the Mutual Health Insurance Scheme, as of high standards?
- Can the attitude of hospital staff towards the insured individuals affect performance of the Mutual Health Insurance Scheme?
- Can delays in government reimbursement to health care providers affect the performance of the Mutual Health Insurance?

Hypothesis

Ho: perceptions of the two populations are the same.

Hi: perceptions of the two populations are not the same.

Significance of the study

This work is intended to identify the strengths and weaknesses of the Mutual Health Insurance Scheme in Ho municipality and relate it to the future vision, mission and goals of the National Health Insurance in order to attract appropriate attention for redress. Financing health is very difficult and therefore requires appropriate policy formulation, often with the help of international expertise, to ensure constant flow of financial and technical resources from donors and internal sources.

Mutual health care echoes collective benefit through pooling mechanism that reduces health risks in terms of cost and treatment. Thus, the abolition of the 'Cash and Carry' system and replacement with a social protection mechanism is in tune with the Ghana Poverty Reduction Strategy, a major policy of the government, designed to implement programmes, especially, in deprived communities to provide economic opportunities in order to enhance living standards.

Another purpose of the study is to extend the frontiers of literature and study, at least, at this level. It is an undeniable fact that health insurance scheme is quite new to health systems in the country, and has therefore, received jerky efforts for implementation in most developing countries and therefore, much work

is yet to be done by students and academics, in general. A cursory observation of the operations of the Mutual Health Organisations exposes structural conditions such as poverty, gender inequality, among others, all of which result in poor health.

Finally, the study is being conducted to help raise public awareness of the plight of the programme in order to arouse collective effort of providing tangible solutions and also sensitize readers of the need for mass registration and participation to enhance good performance of the scheme.

Scope of the study

The National Health Insurance Scheme is introduced to replace the pay-as-you-go system, otherwise, known as the "Cash and Carry system". The scheme is of three social health insurance types:

- District Mutual Health Insurance Scheme
- Private Mutual Health Insurance Scheme
- Private commercial Health Insurance Scheme

The Private Mutual Health Insurance scheme is associated with any group of individuals who operate a health insurance scheme on small scale either by community, occupation or faith. It is a social type that seeks to pool resources from members for mutual benefit in times of illness. However, even though, such associations do not operate on profit motives, they do not receive subsidies from government (Government of Ghana, Ministry of Health, 2004).

The Private Commercial Health Insurance Scheme is characterized by payment of premia based on market forces which members may join according to affordability. Usually, Private Commercial Health Insurance Scheme is associated with a company and shares and stocks can be traded on the market. The scheme operates like the stocks of the producers of any other commodities. The scheme offers minimum benefit packages and supplementary insurance plans as an addition for those who so desire and can actually, afford to pay (Government of Ghana, Ministry of Health, 2004). However, the focus is on the District Mutual Health Insurance Scheme (DMHIS) which is a social type, where the society is stratified into a socio-economic grouping for risk pooling to a national insurance fund as a safe guard against health risks. This implies that District Mutual Health Insurance Schemes receive subsidies from government. It is well structured in terms of organisation, thus, having a District Health Insurance Assembly comprising of a health insurance committee constituting a chairman, secretary, publicity coordinator, contribution collector and one other member (Government of Ghana, Ministry of Health, 2004). The study is narrowed on the Ho municipality in the Volta Region to the east of Ghana to facilitate speedy and in-depth study of the scheme's performance.

The population size of the area is about 197,933 out of which about 109,715 (i.e. 55 % of target population) are beneficiaries of the Mutual Health Insurance Scheme (obtained from the Ho Mutual Health Insurance Scheme at the time the study was being conducted).

Limitations of the study

The work is scheduled to consider only 380 samples which are drawn from the target population of about 109,715 people, using appropriate statistical methodology. However, the researcher is unable to obtain the number of insured members of the various suburbs of the municipality due to the young nature of the scheme in the country and therefore, unavailability of specific detailed data. This is what necessitated the researcher to employ quota sampling, randomly assigning reasonable numbers to the suburbs considered for the study based on size and importance.

To facilitate the research work, the researcher would administer questionnaires on related areas of the study, employing interviewing skills to elicit responses from the research participants to enhance the work. Unfortunately, due to material resource constraints, the study may not be able to cover non-registered members to the scheme and to do in-depth study for understanding reasons behind non inclusion in order to suggest some possible solutions. However, where the study necessitates inferential analysis between the insured and non insured, the researcher would readily point out or highlight.

It is important to note that related literature has been scarce due to the novelty of the social health programme in most parts of developing countries even though a number of pilot projects have been in operation hence the need to rely much on survey reports, internet, news paper reports and discussions with personnel of health organisations for information.

Organisation of the study

Chapter one is the introduction to the study. It provides the background to the study and explicitly states the focus of the work. The objectives, significance and the scope of the study are also outlined in this chapter.

Chapter two reviews the relevant literature on the performance of the national health insurance scheme, of which six research questions constitute the parameters for empirical investigation by a hybrid of qualitative and quantitative analysis in the Ho municipality.

The third chapter talks about the entire process of the empirical investigation by discussing the data collection methods used. The fourth chapter deals with the analysis and discussion of the major findings. The summary, conclusion, recommendations and suggestions for further research are discussed in the fifth chapter.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

The basic aim of the National Health Insurance Scheme is to institute equitable universal access to health care and an acceptable package of quality service for all residents of Ghana (Akor, 2002). The government has announced plans to support the development of the District Mutual Health Insurance Scheme to serve as a strategy for delivering its pro-poor policy to the underprivileged segment of the society. It is compulsory for every person living in Ghana to belong to a health insurance scheme. This is in the light of the spirit of solidarity, social responsibility, equity, and a sense of belongingness in the building of a healthy and prosperous nation (Government of Ghana, Ministry of Health, 2004).

This chapter reviews the related literature on global social protection mechanisms of accessing healthcare, as well as, some specific efforts made in Ghana to increase health care utilisation. Where necessary, empirical observation had been drawn to context, to help assess the performance of the Mutual Health Insurance Scheme of the Ho municipality.

Funding health care

Health finance is one major determinant of global health care improvement if the three millennium development goals of reducing child mortality by two-thirds, reducing maternal mortality by three-fourths and eradicating malaria and tuberculosis and other infectious diseases by the year, 2015 is achievable (Bloom, 2007).

There are many differential approaches to financing health care provision among nations of the world. Some nations such as Germany, France and Japan adopt a multi-payer system in which health care is funded by private and public contributions (http://en.wikipedia.org/wiki/Health Care Economics). The United Kingdom is the only country that adopts a single spine tax paying system through which the government reimburses the medical centres for services, allocates resources for medical facilities and ensures a reduction in administrative cost (http://en.wikipedia.org/wiki/Health Care in United Kingdom). Singapore's system uses a contribution of compulsory savings from payroll deductions funded by both employers and workers and government subsidies as well as "activity regulating the supply and prices of health care services in the country" to keep cost in check (http://en.wikipedia.org/wiki/Health Care Systems).

Contrast to the giant strides made by the developed countries for health care provision, the less developed countries are yet to come to terms with due to slow economic growth, constraint on the public sector and low institutional development (Carrin et al., 2001).

Health systems in most developing countries are near collapse and, therefore, the need for urgent measures to salvage the situation.

Some measures adopted by developing countries are direct payments by end users of health care services and few exemptions enforced by central governments. Exemption systems include exempting the aged persons, exemption from certain communicable diseases and in some countries, emergency cases are not required to pay charges. The direct payment for health care as a measure to reduce constraints on government budgets in most parts of developing countries has led to innumerable social cost in terms of health services utilization and effects on such societies. However, a more general and responsible means of financing health systems de-linking utilization from direct payments and protecting the most vulnerable groups from adopting various coping mechanisms is by a health insurance system and / or by tax revenues.

A major characteristic of a Social Health Insurance is by risk-pooling which enabled registered members access health care without an instant out-of-pocket payment. However, social health insurance system is difficult to operate due to low institutional capacities and lack of robust tax systems in developing countries.

Over the years, the government of Ghana has sought to find alternative forms of financing health care as a means of increasing coverage. Various policies have been pursued in this direction. According to Akor (2002), Ghana has gone through free care, co-payment, cash and carry and exemptions but none of these has yielded the desired results.

The government of Ghana sought to promote a social health care system with the assistance of Global Social Trusts and international donors like, DANIDA (Denmark), United States Agency for International Development (USAID), Department for International Development (DFID), World Health Organisation, International Labour Organisation, the European Commission, (Cichon et al., 2003). This collaboration led to the establishment of the National Health Insurance Scheme in 2003.

The government developed a legal instrument which made it mandatory for workers of the formal sector to contribute 2.5% of their 17.5% SSNIT monthly contributions to a pool of fund, i.e., the National Health Insurance Fund (NHIF) which falls under the aegis of the National Health Insurance Council which is responsible for meeting a commitment to devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for. The council is also responsible for disbursing funds from National Health Insurance Fund to support the District Mutual Health Insurance schemes through a system of subsidies to support the poor and to equalize risk. The informal sector is expected to pay premium of only GH¢0.6 each per month to the District Mutual Health Insurance schemes. In addition to these funds from both sectors, an indirect tax of 2.5% is levied on selected items purchased on the markets (Government of Ghana, Ministry of Health, 2004).

One major issue of the National Health Insurance is to ensure its financial sustainability. Thus, the expected increase in utilization by insured persons will lead to a subsequent increase in overall expenditure that will outpace the growth

of resources and, hence, create a financing gap. Out of 18% of population who access health facility, only 20% access it (Government of Ghana, Ministry of Health, 2004). The faster the extension of actual insurance coverage, the earlier the imbalance could emerge. However, with realistic expectations as to the achievable progress of population coverage and a realistic assumption regarding the increase in the utilization of insured persons, there would be a period of around four to five years during which the overall system would remain in surplus. This could provide a breathing space to fine-tune the financing system and install effective cost containment mechanisms. A critical condition for financial equilibrium during the coming years is that the government will not reduce its financial commitment to the health sector and hence, all new sources of revenue (SSNIT, health insurance levy and premiums of the insured persons) are truly additional resources (Yankah et al., 2004).

It is apparent that, should there be a drop in government financial support to the health sector, it is feared that the situation could undermine quality of care that could further trigger ad hoc measures such as increasing premiums of the District Health Insurance Schemes, SSNIT contributions of the formal sector worker or the health insurance levy, notwithstanding its possible inadvertent effect on price and income stabilisation.

The situation, therefore, poses limitation to health care accessibility and affordability. To this end, a commitment to support the health sector by government health budget must not reduce. The Deputy Minister of Health, Mr. Moses Danni Baah, confirmed that despite plans to introduce health insurance

scheme, the government will still bear the cost of improving hospital infrastructure, payment of salaries of medical personnel, provision of equipment, all amounts to about 80% of health budget (Kwarteng, 2002).

The Ghana Poverty Reduction Strategy (GPRS) has allocated US $ 121.46m from 2003 to 2005 for ensuring sustainable financing arrangements that protect the poor within the health sector of which Highly Indebted Poor Countries' funds constitute US $17.45m (International Labour Organisation, 2004). The government of Ghana has also created an exemption fund of about $2.65m per annum (International Labour Organisation, 2004). The policy of exempting women from paying delivery fees was funded through Highly Indebted Poor Country (HIPC) debt relief funds channeled to the districts to reimburse public, mission and private facilities according to the number and type of deliveries attended monthly (Witter et al., 2007).

The Government of Ghana, Ministry of Health (2004), establishes that 40% of Ghanaians are poor and about 70% of Ghanaians work in the informal sector. The problem with the informal sector is that contributions are difficult to collect and much of the poverty by percentage live within this sector.

The Ho Mutual Health Insurance Scheme is one of such satellites of the National Health Insurance System which is financed through the Municipal Authority for its operation. It is important to assess the system of funding to ascertain its effect on performance and reliability.

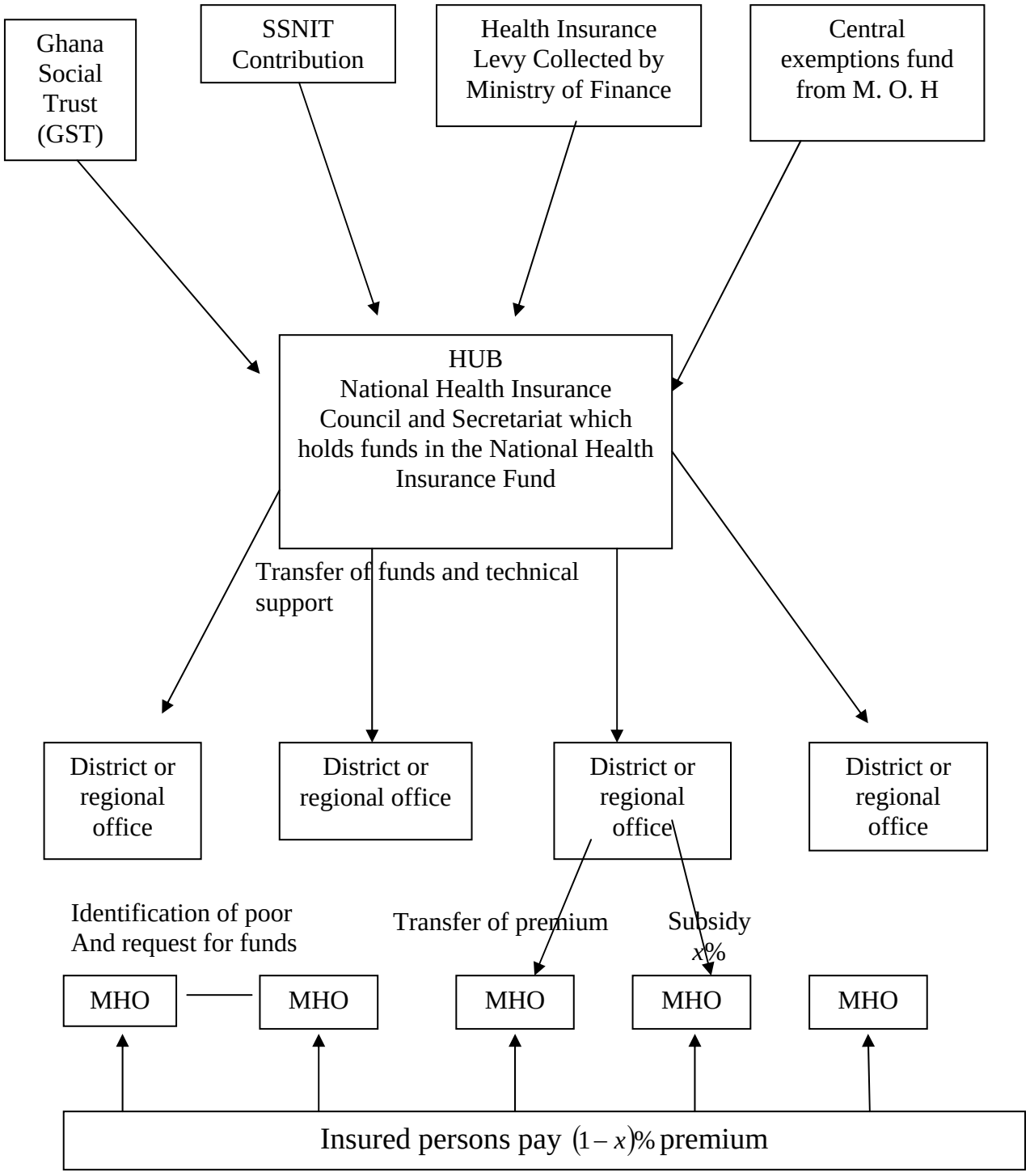


Figure 2: A revised model for a satellite health insurance system in Ghana

Source: ILO (2003)

Relationship between administrative structures and logistical support, and the performance of the scheme

The provision of an orderly administrative structures and logistics is an integral aspect of a proper functioning health care system, the failure of which could result in huge healthcare expenditure that could threaten the success of the system.

Included in the functions of a health system are provision of health services, resource generation for health in terms of; human resources, expenditure and equipment, health financing and government stewardship. Insurance schemes would have to either be set up or adapt their existing structures to fit the national system (Yankah et al., 2004). The cost of paying rent to private owners and general maintenance to add value, for the sake of work operations and the creation of congenial work environment that could not immediately make possible for removal in times of relocation and also the whole issue of morality could be avoided. It is believed that putting up own building structures for administrative purposes would conserve scarce resources otherwise lost to rent which could have been used to procure other needs, for instance, logistics that enhances performance; and the real cost of inconvenience much desired by workers and insured persons would be addressed. This is why a cost effective administration of health is most crucial.

The United States, for instance, established USNHI Advisory Board comprising of health care professionals and representatives of health advocacy

groups to see to the management of health in the country (http://en.wikipedia.org/wiki/United States National Health Insurance Act).

The government of Ghana also established the National Health Insurance Council mandated with monitoring and evaluation functions over all health institutions accredited by it to operate the health insurance system. An Executive Secretary is appointed by the president to oversee implementation of policy directives (Government of Ghana, Ministry of Health, 2004).

Administrative and management capacity is very essential for the setting of contributions, collection of contributions and compliance, determination of the benefit packages, marketing and communication, contracting with providers, management of information systems and accounting (Carrin et al., 2001).

The government of Ghana supports the health sector by providing unconditional stewardship in terms of infrastructure, logistic and personnel for the expansion of administrative capacity (Kwarteng et al., 2002). However, resource constraints limit government efforts towards the provision of quality health care resulting in relatively low performance of some Mutual Health Organisations.

Subjective criteria knowledge highlights the fact that, the Ho Mutual Health Organisation is not operating from its own building but is in a residential accommodation not constructed for office use and also yet to be furnished, the location of the office not in the most accessible place for clientele patronage, lacks adequate means of transportation not to mention, especially an ambulance services for possible referral purposes and also needed an ICT professional who

could develop software database system for processing claims either than the manual means currently in use.

Coverage of the scheme

Statutory mandated social insurance schemes anywhere in the developing world suffer from low compliance. This is due to the many poor who cannot afford the premia. However, a guaranteed access to good quality of care and mass educational campaign to highlight the relevance and benefits of a Social Health Insurance (SHI) would do the trick (Normand et al., 1994).

Normand (1994) mentioned that members who consider premia to be high may withdraw. A cross subsidization between the formal sector's mandatory contribution and premia from the informal sector would increase coverage. However, a small resource contribution from the cross subsidization relation would be detrimental to coverage.

Affordability of premiums or contributions is one major determinant of membership. A World Health Organisation study of Nkoranza scheme in Ghana estimated the cost of contribution varied from 5% to 10% of annual household budgets. It was concluded that such contributions could pose financial obstacle to membership (World Health Organisation, 2000).

It is important to state that flat rate contributions is regressive and affects the core poor more than the non-poor. This is because a flat sum marked for payments by all members of a scheme creates greater burden, percentage wise, on the resources of the poor than the non- poor.

The International Labour Organisation commissioned a survey of usage of, and attitude to, healthcare and health insurance in Dangme West and Kwahu South districts. A sample of 1000 people interviewed on demographics; employment and incomes of households, access to health care provision, awareness of health insurance, especially, MHOs and factors affecting membership etc. The outcomes showed high awareness of District Mutual Health Insurance schemes (DMHI); and people viewed them positively and wanted to join but were inhibited by the cost of premiums and lack of knowledge or understanding of how health insurance worked (International Labour Organisation, 2004).

Government subsidy of the social health system is necessary to ensure extensive coverage for the scheme's sustainability. Exemptions are already in place for instance, women in delivery, the aged and communicable diseases. However, (Witter et al., 2007) found out that under-funding of exemptions meant that exemptions are available in theory but not always in practice if the provider is not reimbursed for lost income. Donor funding and support expected to be channeled through suitable body like Social Security and National Insurance Trust (SSNIT) or directly to the Mutual Health Organisations would mitigate cost, especially, to premium paying insurers due to the high elasticity of demand for insurance cover to the price of such cover and coverage is expected to increase considerably (International Labour Organisation, 2003).

Witter et al, (2007) estimated the effective coverage of the National Health Insurance Scheme at just fewer than 20% nationwide. The Government of Ghana,

Ministry of Health (2004), reveals that the programme has witnessed varied growths across the districts and municipalities. There are speculations that national coverage is on the increase and that people are encouraged by the beneficiaries who have already enjoyed minimum packages and are willing to testify.

The Kumasi Metropolitan Health Directorate Annual Report (2007), made available to the Daily Graphic, indicated that "non-insured patients have apparently declined slightly by 26.3 percent". The report considered the decline as tangible and encouraged other health care providers to intensify efforts to get more people to register with the scheme (Asare, 2008).

The Ho Mutual Health Scheme is not different from the likes of Kwahu South, Dangme West, Nkoranza and Okwawuman District Mutual Health Insurance Schemes which have a mean coverage of 30% (Atim et al., 2001).

People are generally reluctant to register when not ill. The combined negative effect on coverage can be reduced if there was a severe cost to non-compliance, such as very high co-payments at the point of use for non-insured patients. Such a move could be considered as an incentive to potential members rather than punitive measures.

Reimbursement of funds to health facilities

Reimbursement of funds from the National Health Insurance Fund via the National Health Insurance Council to the district and municipal authorities is very crucial if any Community Mutual Health Organisation must succeed.

A study conducted by (Witter et al., 2007) on exemption for deliveries in the Central and Volta Regions of Ghana indicated that managers were used to unpredictable erratic funding and that, the failure to reimburse adequately and promptly, had negative effects at all levels of the system. The National Health Insurance Authority released GH¢128, 578,851 between January and May 2009, to salvage most distressed medical facilities under the health insurance scheme nationwide.

A report published in the daily graphic (Anonymous, 2009) cited the chief executive officer expressed surprise at the report that operations of some National Health Insurance Scheme accredited facilities were almost grinding to a halt as a result of non payment of medical claims.

An evaluation of financial flows by (Witter et al., 2007) found that the policy of exemption was under-funded by 34% in 2004, rising to 73% in 2005 when all ten regions were covered. It is on account of such uncoordinated reimbursement rates that (Witter et al., 2007) could conclude that, exemptions are available in theory but not always in practice if the provider is not reimbursed for lost income. Comparing the delivery scheme to the National Health Insurance scheme which provides full cover for about 95% health needs (e.g. malaria, diarrhoea, upper respiratory tract infection, skin diseases, hypertension, asthma and others), through risk pooling of funds and shared responsibility of health concerns for insurers (Government of Ghana, Ministry of Health, 2004), it is disturbing to foresight reimbursement rates under health insurance to be low

which has potential for a resort to fee paying patients as in the defunct 'cash and carry' system of health care provision.

The Chief Executive Officer of the National Health Insurance Council called for uniform reimbursement mechanism to sustain the health insurance scheme (http://www.ghana.gov.gh/government-news). He pointed out that driving every health insurance system were the networks of provider systems, strong and cost effective tariff structure, and drug formulary.

Delayed claim processing protracts reimbursement to health care providers which has the potential of rendering the scheme function slowly. According to Cichon et al, (1999) and an ILO (2003) discussion paper number two, the availability and reliability of the necessary Information and Communication Technology (ICT) across the country limit the development of claim processing software linked to databases on insured persons and providers. The above revelation meant that processing claims for reimbursement by the national authorities was done by manual means.

Kyei-Boateng (2009) revealed that the Akyem Oda government hospital in the eastern region was in debt to the tune of GH¢619000 due to the inability of the National Health Insurance scheme to pay for services provided insured persons. The Birim Central Municipal Assembly alone owed GH¢482000 while Birim North and Kwaebibirem district schemes were indebted to the hospital to the tune of GH¢110,000 and GH¢27000 respectively. The hospital authorities revealed that the money represented accumulated bills from last year and if not paid by the week, the hospital was going to close down. Suppliers had also stopped supplying

the hospital with drugs and other non-consumables because the health facility could not settle debt.

An empirical observation of the Ho municipal Mutual Health Insurance Scheme revealed that the institution had no ICT specialist and, therefore, the manual processing was needed for compiling and redeeming claims and making available funds for prompt payments to keep the scheme functioning.

Quality of care

Quality of health care vary from community to community depending on the rate of flow of expected funds, availability of essential drugs, availability of skilled health personnel and attitude of hospital staff towards insured persons.

The Maliando Scheme in Guinea Conakry indicated respondents interviewed under a WHO study as citing poor quality of care and preferred private health care facilities (admittedly paying more) in order to receive quality care (Carrin et al., 2001).

A study conducted under International Labour Organisation (2003), on the Mutual Health Organisations (MHOs) of the Kwahu South and Dangme West district of the East and Grater Accra Regions respectively, showed higher satisfaction with the former (MHO) than the later. However, there were growing concerns about the quality of drugs prescribed to patients registered under the Mutual Health Organisations. That, most of the drugs prescribed were cheap rather than the more expensive drugs and, therefore, were not very effective to enhance patient's conditions (Cichon et al., 2003).

Again attitude of hospital staff discriminated against patients under the aegis of the MHOs than the more affordable private patients who paid upfront.

The reason adduced to such discrepancy was to the fact that the reimbursement for MHOs patients was not immediate and therefore constituted a disincentive to health care service providers at the personnel level (Cichon et al., 2003).

In recent times, the country had experienced brain drain at the health sector reducing the manpower needs of the sector. Many health personnel traveled abroad for greener pastures purely as a response to the harsh socio-economic conditions they faced at home.

A health forum held at Peki in the Volta region admits that, the introduction of the national health insurance scheme has greatly enhanced access to health care but said, as the numbers increased, infrastructure, human resource and other support services had remained the same. "For instance, it is the same one dispensing technician, one laboratory technician and one X-ray technician who are taking care of the increment in outpatient attendance (69%) that the National Health Insurance Scheme has brought about" (Dzamboe, 2008).

Kwarteng et al, (2002) quoted Dr. Plange Rhule as saying that "the present imbalance in the distribution of health professionals in the three northern regions and some remote parts of other districts and regions could undermine the scheme".

Information on 67 Mutual Health Organisations in the West and Central Africa, however, shows that active purchasing was not imbedded yet in

management practice. Only 4 schemes had introduced essential and generic drug policies. And only 2 of the 15 schemes whose benefit packages include primary and hospital care had introduced mandatory reference for benefits beyond the primary care level (Carrin et al., 2001).

Now most of the Mutual Health Organisations have incorporated strategic purchasing in their schemes to enhance quality of care but none is said to have an ambulatory system to boost attraction to membership and, enhance cost effectiveness. Strategic purchasing is present when there is a continuous search for the best health services to purchase, the best providers to purchase from and the best payment methods and contracting arrangements (World Bank, 2004).

The Ho Mutual Health Insurance Scheme is functioning and covers generic drugs from selected private pharmacists, and cost of inpatient care for members who suffer diverse medical conditions and the need for hospitalization.

However, the scheme has no visible control over quality of care standards, in terms of, choice of health service providers by insured persons, quality but expensive drugs accessible elsewhere, attitude of hospital staff towards members of the scheme and ambulatory services for the chronically ill insured patients for referral purposes. A negative perception of health care provision will definitely affect the scheme, especially, membership.

Attitude of hospital staff toward patients

The attitude of hospital staff towards patients, especially, those of Mutual Health Organisations is a major concern to ensure proper operation of schemes.

An evaluation of Nkoranza Community Health Insurance by Partnership for Health Reform (PHR) funded by DANIDA and WHO indicated that attitudes of hospital staff towards patients were negative (WHO, 2000).

Doctors and nurses often required patients of their insured status. The aim, as reported, was to prescribe expensive drugs, use expensive equipment and prolong their stay in hospital, because they know the scheme could pay the bills with no difficulty (WHO, 2000).

There is a perception that those who have insurance are given poor levels of treatment. It is asserted that health care providers are probably likely to give better service to those who are paying up front, rather than to those for whom they have to await reimbursement from the insurance scheme. Thus, the concerns were about the quality of assistance, either in terms of treatment or in the attitudes of hospital staff towards patients (International Labour Organisation, 2004). A survey conducted under the International Labour Organisation (2004) indicated that insured persons, in the Dangme West of the Greater Accra region were discriminated against and that patients who had money to pay for services were first attended to before the scheme members received adequate attention. The reason was that, payment by the scheme was not immediate.

Witter et al, (2007) comparing quality of care in the Central and Volta regions of Ghana found out that attitudes were less positive in Volta. The staff felt that quality of care was more or less the same and that work loads were too heavy before and had not improved.

There are unconfirmed reports in the Ho municipality that insured persons were not happy with the attitudes of some nurses towards them. That, some minor payments were done at personal levels to quicken care processes and patients were not given felicitous welcome to make them most comfortable. The manager of the scheme is reported to have accused the health workers of some hospitals of taking what he termed as 'illegal monies' from clients under the National Health Insurance scheme. He cited some instances where nurses and doctors charged GH¢50 as 'theater fees' when, in fact, insured clients are covered by the scheme (Agbesi, 2009).

A moral health hazard does occur where some health workers connived with scheme clients to feign illness or forge claims documents in order to unduly receive benefits from the scheme operators. Now, such moral hazards have the potential of aggravating inefficient use of resources across the district, so long as the incentive for such behaviour exists. If these attitudes are solved, expenses of the scheme would be more effective (Agbesi, 2009).

Political influence

Health systems in Ghana had pass through many political transitions where governments pursued different health policies to meet the health needs of the people.

Post independent governments implemented free care, co-payments, user fees and 'cash and carry' systems. But all of these did not satisfy the health needs of the people. However, democratic campaign promise made the New Patriotic

Party in the year 2003, to honour the pledge of establishing a health insurance scheme by the close of its first term in office resulted in the establishment of the National Health Insurance Scheme which is operating now (International Labour Organisation, 2004).

The political will was there, but difficulties arose at the political and institutional level. The small number of expert staff in the government has meant that, much of the policy development is concentrated in very small group of perhaps, three or four people and delays have arisen because of competing priorities. Put simply, the government knew what it wanted to achieve but in some aspects it lacked expertise to design the implementation. There is also no clear overall plan of implementation and a certain lack of transparency in general arrangements (International Labour Organisation, 2004).

Also, there was considerable opposition to the proposed NHIS from the social partners based on concerns that the transfer of funds from SSNIT would have an adverse impact on the long-term sustainability of the pension fund; and that the social partners were not sufficiently consulted (International Labour Organisation, 2004).

The Ho Mutual Health Organisation is located in a community where democratically opposing citizens may remain skeptical of the scheme's implementation and general performance, especially, where government ministers trumpeted about large coverage rate without official source, obviously for political advantage and in an election year, do not help matters.

Such attitudes compelled government officials to explain that health deliveries could not be entirely free anywhere, and often urged Ghanaians to contribute to make the scheme work effectively and disregard those who express pessimism about it to ensure success.

Supply of essential drugs

The World Health Organisation defines essential drugs as those drugs which meet the health needs of the majority of the population. The World Health Organisation considers essential drugs as drugs that are of the utmost importance and are health basic, indispensable and necessary for the health needs of the population (Pharmaceutical Business Opportunity with China, SCRIP, 1987).

To ensure availability of safe and effective drugs and vaccines of acceptable quality and at least cost in support of primary health care, the World Health Organisation in collaboration with non-governmental organisations affiliated to health needs and health personnel of the international community drafted a drug list to include antihistamines, cytostatics, cathartics, laxatives, vitamins, and diagnostics (Pharmaceutical Business Opportunity with China, SCRIP, 1987)

However, there are growing gaps for supplies of essential drugs to meet health needs and consumption between the developed and developing countries. For instance, in 1976 each inhabitant of a developed country consumed 8.5 times as many drugs as an inhabitant of developing country. A gain in 1985, he/she

consumed drugs costing 11.5 times as much compared to an individual of a developing country (Pharmaceutical Business Opportunity with China, 1987).

The worsening situation is due to financial, technical and social problems facing the least developed countries. Whilst the population growth rate of developed countries does not exceed 1% that of developing countries grows at 2.1% per annum between 1976 and 1985, UNIDO databank and estimates of the WHO Secretariat.

Most countries of the third world have gross national product (GNP) of just about US $200 and hence cannot purchase essential drugs compared to the developed counterpart. Even though there are available drug preparation methods, the developing countries lack the adequate and requisite skills to produce quality drugs of their own. This situation has culminated in huge health budgets of between (25 - 40) % of national budgets to include pharmaceuticals, UNIDO databank and estimates of the WHO Secretariat. Most new drugs with new brand names placed on them are only variations of the existing drugs and made no/little improvement in therapy (Pharmaceutical Business Opportunity with China, SCRIP, 1987). Many countries have no policy or legislation or no enforcement of them to ensure that drugs are safe for therapy.

The UNIDO databank and estimates of the WHO Secretariat asserts that, coverage with essential drugs in primary health care can be achieved for less than US $1 person per year.

Some reasons why majority in developing countries do not have access to essential drugs are as follows;

- Selection of drugs for a country's health service has been done arbitrarily with no links between drugs and health needs.
- Many non - essential drugs are still imported and paid for with scarce foreign exchange.
- Urban hospitals consume much too large a proportion of national drug bill compared to health centers and dispensaries.

Sources

- UNIDO databank and estimates of the WHO Secretariat.
- Pharmaceutical Business Opportunity with China, SCRIP (1987).

Notwithstanding the above limitations, some countries are implementing essential drugs programme by redistributing public spending to pharmaceuticals. The provision of essential drugs and vaccines forms one of the basic components of primary health care expressed in the declaration of the 1978 World Health Assembly Programme entitled "Action Programme on Essential Drugs".

The drug situation in Ghana is akin to any country of the third world except that frantic efforts are being done to improve the situation. One cannot take out availability of essential drugs from the National Health Insurance Scheme, if the programme should be successful. A study of the Dangme West Health Insurance by Cichon et al, (2003) under the sponsorship of the International Labour Organisation indicates that most insured persons under the scheme are not happy with the generic drugs prescribed to them. They believed that the drugs had

little effect on health conditions and would prefer the more expensive drugs to enhance cure of diseases or illness.

The Mutual Health Insurance Scheme of Ho municipality has not received any official complaints about the type of drugs prescribed under the scheme. Maybe it is because no such surveys had been conducted to identify whether the problem existed or not owing to the juvenile nature of the scheme. However, patients prescribed drugs at the hospitals and who could not get supplies at the dispensaries are allowed to get supplies from some designated pharmacies where the scheme is functional.

Disappointingly, the prescribed drugs which the scheme did not cover are purchased directly out of pocket even at the pharmacy department of the hospitals. Such private costs are not refunded by the scheme and therefore have the potential to generate various degrees of unmeasured coping mechanisms in search for remedy. Thus, insured persons who could not afford such drugs are invariably denied access to essential drugs which could have enhanced quality of care.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter presented a detailed discussion of the methods that were used to carry out the research. The essence was due to the fact, that all scientific work ought to be replicable and this was possible only if the research followed up an established process as to how the study was conducted so that any one at all could follow the same procedure to arrive at the same or similar outcome. This study used a triangulation of quantitative and qualitative research methodologies and analysis of results.

This was in acknowledgement of Patton (1988) claim for a post-positivist view of research. The post positivist approach emphasised on the approach which the researcher deemed most appropriate for his study, each method being adopted at the appropriate stage of the study. The chapter examined the research design, population of the study, sampling procedure, data collection and the method used to analyse the data.

Research design

This study was a basic research of an exploratory kind seeking to open up the study area to look at the facts and information about what the performance of

the Mutual Health Insurance Scheme of Ho Municipality was like, pose critical research questions and attempt to provide responses that could generate a general mental picture of the conditions that pertained and to establish causal factors and effects of the social health policy.

The use of case study for conducting social research to create new theory has been further developed by sociologists Glaser and Strauss (1967), who presented their research method, 'Grounded Theory'.

The researcher intended to collect data for the case study to link data to theory depicting evidence of performance or proper functioning of the health insurance scheme in a set of geographical unit. The ultimate goal was to compare the case unit to the national future goals by considering various factors to see if differences existed. Flyvberg (2006) argued that, rather than using large samples and following rigid protocol to examine a limited number of variables, case study methods involve in-depth, longitudinal examination of a single instance or event: a case.

They provided a systematic process of observing events, collecting data, analyzing information and reporting results. As a result, the researcher sharpened understanding of why the instance or incident occurred as it did and what might become important to look at more extensively in future research. Case studies lent themselves to both generating and testing hypotheses.

Yin (2002), on the other hand, suggested that case study should be defined as a research strategy, an empirical inquiry that investigates a phenomenon within its real-life context.

Case study research meant single and multiple case studies could include quantitative evidence, relied on several sources of evidence and benefited from the prior development of theoretical prepositions. He contended that case studies should not be confused with qualitative research and pointed out that they were based on any mix of quantitative and qualitative evidence.

Indeed, case study was a research approach situated between concrete data taking techniques and methodological paradigms.

The case study method examined one or a few area for one or two purposes. A very frequent application involved examination of a situation of special interest, with little or no interest of generalization. A second, rarer or peculiar application entailed calling into question a highly generalized or universal assertion and testing it by examining one case. This method particularly was proper for answering cause-and-effect questions about the case of concern. The correct use of case study critically, involved probing the underlying concerns in a request.

The researcher would pose descriptive research questions to gain cultural knowledge about how the scheme was functioning, perceptions of insured persons with regards to benefits obtained so far, limistations and possible suggestions for future direction of the scheme. The questions were expected to be mostly closed-ended and a few opened - ended questions and therefore would expect the utmost co-operation of research participants. However, inadequate specification of the evaluation question formed the most serious pitfall in this type of study.

Population

The target population that was considered for the research work was all beneficiaries of the National Health Insurance Scheme under the Ho Mutual Health Organisation. The area that made up the jurisdiction of the Ho Mutual Health Insurance Scheme had a population of about 1,979,333 people of various ethnic and cultural settings. However, only 109,715 individuals out of the total, constituting 55%, had signed up with the scheme and were benefiting.

However, due to constraints on time, financial and material resources, the researcher intended to draw 380 samples out of the target population using acceptable sampling methods. The researcher would organise the population into age groups of 0-15, 16-64 and 65 years upwards, in order to put study under correct perspectives.

The researcher then obtained 380 sample size of the target population at the three major health facilities in the Ho Municipality, namely; the Volta Regional Hospital, Ho Municipal Hospital and Miracle clinic (a private facility) and others from the general public in the suburbs of the Ho municipality where the scheme was mandated to operate. These were the most patronized health facilities where the health insurance system works.

Also, 4% of the sample size (i.e. 15) was purposively drawn to provide key information on the performance of the scheme from professional view points of participants, of course, after permission had been sought for interviewing, from management at the local level. The remaining 96 %(i.e. 365 interviewees) was drawn from public and private health institutions and the researcher was expected

to seek permission from hospital authorities and also adopt appropriate research skills to achieve the purpose of the research work. The elements of investigation were sub-divided into sex ratios of male and female by quota sampling technique under the various age distributions.

The research work to investigate or assess the performance of the National Health Insurance Scheme and to ascertain the extent of its success in the satellites was essential to the socio-economic growth and development of the nation. A large access to health by a social protection mechanism ensured healthy people at all times enhancing productivity for national prosperity.

Sampling procedure

The sample for the study consisted of insured persons of the Ho Mutual Health Insurance scheme who were already enjoying benefit packages of the scheme and some selected workforce of the scheme. In obtaining the sample size the statistical method for estimating the sample size for proportions was used. The formula stated that the sample size n for a given proportion at an α-value (significance level) within an allowed margin of error, W was;

$$n = \left(\frac{z_{\alpha/2}\sqrt{\hat{p}(1-\hat{p})}}{W} \right)^2$$

Taking $\alpha = 0.05, \text{and } W = 0.05$. The proportion of the insured

$$\hat{p} = \frac{109715}{197933} = 0.55$$

$$\therefore n = \left(\frac{z_{\alpha/2}\sqrt{\hat{p}(1-\hat{p})}}{W} \right)^2$$

$$\Rightarrow n = \left(\frac{1.96\sqrt{0.55(1-0.55)}}{0.05} \right)^2$$

$$\Rightarrow n = \left(\frac{1.96 \times \sqrt{0.2475}}{0.05} \right)^2$$

hence n = 380 *appromimately*

Due to difficulty in accessing respondents across the municipality, six suburbs were randomly picked out of eleven to administer questionnaires to respondents in order to exhaust the projected sample size of 380 respondents. Quota samples were assigned to the suburbs chosen according to geographical area and importance. The Ho urban was the largest in size and densely populated hence allotted 100 respondents (i.e. 26.3%), Sokode another area was allotted 60 respondents owing to its importance i.e. about 15.8% of the total, Anyirawasi was apportioned 50 respondents i.e. 13.2% of the total, Kpedze a busy border town to the republic of Togo, was allotted 70 respondents making up 18.4% of the total, Honutakpoeta was allotted 40 respondents i.e. 10.5% of the total and Amedzofe on the mountains, was allotted 45respondents constituting 11.8% of the sample size. A simple random selection procedure was adopted in selecting insured persons into age groups of 16 – 64 (adults) and 65 years above, (aged).

However, this procedure was not applied in the selection of workers of the health insurance scheme, since, their number was not large to warrant picking a sample and hence, they were individually approached to provide important information about the scheme's performance.

The samples selected by random sampling constituted 96% (365 respondents) which were gathered from the three health facilities and the general public living in the suburbs of Ho where the scheme covers, whereas, 4% (15 respondents) of the samples were gathered from the offices of the scheme.

In all 380 respondents out of a study population of 1,097,615 people were interviewed via the use of questionnaires. The researcher employed the services of six research assistants at a token fee, though, instructed them on the means of gathering data, supplied each one of them with the required logistics, i.e. questionnaires according to allotment above, pen, and a note pad, and sends them each to the communities of study for data collection

Data collection method

The study required a thorough review of relevant literature from journals, periodicals, textbooks, websites, and empirical observation, among others. This was to examine the relationship among the variables of interest and to situate the relevant literatures in context as well as generalize the study to some extent. To assist in determining the performance of the National Health Insurance Scheme in the Ho Municipality, a policy framework obtained from the Ministry of Health, with which the health insurance system operates in Ghana was used. This enabled the researcher to identify the benchmarks that the scheme hoped to achieve within specified periods, so that logical conclusions were drawn on performances.

Besides, other research instruments like the questionnaires and personal interviews were employed to gather information from research participants.

Questionnaires designed solely for the scheme operators were administered to fifteen employees of the Ho Mutual Health Organisation. The questionnaire was administered to the staff of the scheme because, it effectively eliminated interviewer biases and controlled inhibitions people, usually, have in talking openly about issues of great concerns in their organisation.

The questionnaire method was found to be ideal due to the fact that the target population for the study was always busy and hence there was no guarantee that the researcher could meet all of them if she/he desired to conduct personal interviews for all.

The study was also conducted at the Volta Regional Hospital, Ho Municipal Hospital and Miracle Clinic (a private health facility) and interviewed 100 beneficiaries of the Health Insurance Scheme. The same set of questionnaires and interviews was administered to 60 respondents from Sokode, 50 respondents from Anyirawasi, 70 respondents from Kpedze, 40 respondents from Honutakpoeta and 45 respondents from Amedzofe.

This simply involved face to face administration of instruments, checking responses to the closed - ended questions and tape recording to make sure responses were documented in respondents' own words and language.

The questionnaires consisted of both open-ended and structured items and were divided into four sections for beneficiaries of health insurance packages across the municipality and five sections were also designed for staff of the Ho Mutual Health Insurance Scheme.

The administration of questionnaires was done with the help of a representative from each health institution and from health insurance offices. The respondents were given at most two weeks to complete the questionnaires and return them through the representatives for collection and organisation.

Exactly one week after the questionnaires have been administered, follow-up telephone calls were made to remind the representatives. This ensured that the study was facilitated for early completion.

Method of data analysis

The analysis of data for this study used some aspects of grounded theory approach, Glaser and Strauss (1967) for the qualitative study, and for the quantitative study, the non-parametric techniques to include Wilcoxon rank sum test, Kruskal Wallis test, charts and figures as a descriptive statistics.

This enabled a study of data in their organised patterns to establish relationship between independent variables and the dependent variable in the social settings where this study was conducted. Each section was devoted to a separate analysis and the information was dispersed throughout each section. It should also be noted that, qualitative responses were presented verbatim in this report.

The data collected from the field was sorted into organised patterns considering conditions, causes, interactions, processes and themes of the information that was gathered. Analogous data were coded by assigning them with numbers according to the coding procedure documented in a coding book,

for instance, 1 for Yes and 2 for No or 1 for Male and 2 for Female. The information was then entered into the computer for processing into a data field by focusing the data to construct bivariate tables with percentages for the sex ratios among the independent variables to see if there existed strong associations between them and the dependent variable. This was done using non-parametric tests to establish relationships among scheme reimbursements rates, quality of care, attitude of hospital staff, political influence, among others, on one hand, and the performance of the health insurance scheme in the Ho Municipality, for instance. Data were edited by going through the coding to check if they corresponded to the coding procedure jotted in the coding book. The coding processes were repeated to ensure validity and reliability of data records. The processes were repeated to ensure validity and reliability of data records. Finally, data was formatted for use after logical and theoretical conclusions have been, scientifically, drawn.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The outcome of the statistical analysis of the data collected during the research is presented in this chapter. The research seeks to address the various objectives set out in the study bothering; availability of administrative structures and logistical support, quality of health care, attitude of hospital staff, effectiveness of government reimbursement to healthcare providers and the general perceptions of people on the performance of the scheme. Frequency distribution tables, charts and figures were used for analysis of data collected from the field to provide clear relationship that exist among the variables while non-parametric tests such as Wilcoxon rank sum test and Kruskal Wallis test were used to do further analysis to establish association that exist among the variables under study.

Overview of national health insurance scheme

Table 1, expresses the perspective of the scheme operators on the overall functioning of the Health Insurance Scheme after questionnaires were administered. When asked to express their overall view on the performance of the National Health Insurance Scheme, the respondents, who were the scheme

operators, seemed to say, that on the average the scheme was working well. Out of 15 respondents, as many as 10 respondents (66.7%) said the scheme was working above average, only 2 respondents (13.3%) said it was satisfactorily working but 3 respondents (20%) failed to enter their views.

Table 1: Perception on the performance of the National Health Insurance Scheme

Perception	Frequency	Percentage
Above average	10	66.7
Satisfaction	2	13.3
Non response	3	20
Total	15	100

Source: Fieldwork, 2008

However, when a similar questionnaire was administered to the end-users of the Health Insurance Scheme, the responses were interesting to note.

Table 2 indicates that about 19 insured persons (5.2%) said that the care provided under the scheme was excellent, about 120 others (32.9%) said the scheme was very good to them. About, 100 insured individuals (27.4%) described the scheme's intervention to their health requirements as good, while 118 others (32.3%) considered the scheme's input to their health needs as poor. In all, we can say that, 220 respondents considered the scheme's support to them as good while, 19 respondents said the scheme was an excellent intervention. Notwithstanding the responses gathered from the scheme's beneficiaries, 8 people could not

declare their views on the scheme's influence on their health needs, for reasons we cannot readily tell.

Since, the majority of respondents (220 insured persons) said, that the scheme was having a good intervention in their health requirements and 19 others said it was an excellent programme (all representing 65.5%); the view was that the scheme was a welcome intervention and that, the health system was functioning quite well.

Table 2: Perception of care provided at the hospitals under the Health Insurance Scheme

Perception	Frequency	Percentage
Excellent	19	5.2
Very good	120	32.9
Good	100	27.4
Poor	118	32.3
Non response	8	2.2
Total	365	100

Source: Fieldwork, 2008

Table 3 analyses the perception of both sexes of end users on the performance of the National Health Insurance Scheme. In all, 197 male and 155 female perceptions were gathered for this analysis.

Table 3: Wilcoxon rank sum test of the perception of sexes

	Rank Sum	Observations
Male Perception	34579.5	197
Female Perception	27548.5	155
Z Stat	-0.2015	0
P(Z<=z) one-tail	0.4201	0
Z Critical one-tail	1.6449	0
P(Z<=z) two-tail	0.8402	0
Z Critical two-tail	1.96	0

Source: Fieldwork, 2008

Taking an α - value of 0.05, the null hypothesis could not be rejected implying that, the perceptions were the same. Since the p - value of 0.84 exceeds the α - value of 0.05 we hold the view that the perceptions of the sexes were the same and that the scheme was satisfactorily operating.

Table 4 analyses the perception of the various income groups on the performance of the National Health Insurance Scheme.

Taking an α - value of 0.05, the null hypothesis could not be rejected implying that, the perceptions of the various income groups were the same, since the p-value is 0.81 is greater than an α - value of 0.05 we could conclude that all income levels express the same perception that the scheme was doing quite well.

Table 4: Kruskal-Wallis test of the perception of income levels

Group	Rank Sum	Observations
Below 100GH Cedis perception	14578.5	131
101 to 300 GH ´ Perception	1989	20
301 to 500 GH ´ Perception	2365.5	20
Above 500 GH ´ Perception	5598	50
H Stat	0	0.9254
Df	0	3
p-value	0	0.8193
Chi-squared Critical	0	7.8147

Source: Fieldwork, 2008

Impact of the scheme on the health requirements of clients

Table 5, gives responses interviewers further collected information from the scheme's clients to know their perception of the impact of the health reform on their health requirements. We could say that the health insurance programme has had a positive impact on beneficiaries as they indicated in their responses. Having elicited responses from more than 300 participants, about 246 respondents (67.4%) said 'yes', the health insurance programme had been of help to them in times of ailments, about 109 participants (29.9%) said 'no', the system had not been of much help to them when they were ill, citing numerous reasons most of which concerned efficiency. However, 10 respondents reached refused to say a word for reasons not readily available.

It is our view that, since, majority of insured persons concede that the scheme has been of much use to them, the health reform was a necessary intervention to most health conditions.

Table 5: Positive impact of the scheme on the respondents' health

Positive Impact	Frequency	Percentage
Yes	246	67.4
No	109	29.9
None response	10	2.7
Total	365	100.0

Source: Fieldwork, 2008

Availability of administrative structures and logistical support

The researcher sought the views of the employees of the scheme about the best description of the organisation's location to tell whether it was their private residence, own structures, or shared apartment with other work organisations and the responses were almost unanimous. From Table 6, out of 15 persons questioned, 13 respondents (87%) answered they were in private residence, attesting to the fact that the scheme was operating from a rented premise, which of course, might not be originally planned for use, as office. There arises a problem of inconvenience with regards to workers having to share common offices for different duties, difficulty in connecting one office to the other due to lack of adequate space, limited or loss of privacy, among others. Only one person

said that the structure was their own and with another employee declining to comment.

Table 6: Description of organisation's location

Location	Frequency	Percentage
Private residence	13	87
Own structures	1	6.5
Non response	1	6.5
Total	15	100

Source: Fieldwork, 2008

The questionnaire further asked whether they would like to consider the location as strategically located, far from town or centrally located. A test ran on the responses showed that (Table 7) about half of the workforce (7 responses, representing 46.7%) said that the workplace was located far from town, 4 individuals said that the workplace was centrally located to their clients, 2 people said the scheme was strategically located since, they were close to major health facilities in the municipality and 2 other workers failed to respond to this question.

Table 7: Description of work place

Description	Frequency	Percentage
Strategically located	2	13.3
Far from town	7	46.7
Centrally located	4	26.7
Non response	2	13.3
Total	15	100

Source: Fieldwork, 2008

To press on further, researcher asked the workers whether they were satisfied working in such a location and also whether they are supplied with all logistics to enhance work output. The responses from the 15 workforce of the scheme were displayed in a multiple response table as in (Table 8). Out of 15 persons questioned, the first set of questionnaires elicited 4 responses and only 1 person said that he was satisfied working in such a location and that all logistics are fully supplied, 2 persons said 'no' they were not supplied with logistics but were satisfied working in such a location, 1 other individual said he was also satisfied working in such a location but did not indicate whether logistics were supplied or not. The second set of questionnaires recorded 8 responses of differentiated opinions. Asked the same set of questions as in the case above, 1 person opined that he was supplied with all logistics but was not satisfied working in such a location, as though it was a common front, 7 workers said 'no' to both questions and that, they were not supplied enough logistics and therefore were not satisfied working in such a location. An additional 2 individuals responded to the

questionnaire and 1 person responded 'yes' to being supplied with logistics but not bothered about workplace satisfaction, however, the second respondent appeared not bothered to both questions asked. The final respondent to the question indicated negative response to the supply of logistics and failed to respond to satisfaction at the workplace.

Table 8: Location and supply of logistics

Satisfaction of work at the location	Supply of logistics to enhance efficiency of work				Total
	Yes	No	Not bothered	NR	
Yes	1	2	0	1	4
No	1	7	0	0	8
Not bothered	1		1	0	2
Non response	0	1	0	0	1
Total	3	10	1	0	15

Source: Fieldwork, 2008

Quality of health care enjoyed by clients at health facilities under the aegis of the Mutual Health Insurance Scheme

The quality of healthcare enjoyed by insured persons under the cover of Health Insurance Scheme was a strong component and therefore, determined its success or failure. Table 9 below, denotes responses to the question, how often the scheme operators received complaint from clients about poor health services

experienced at the various health facilities. The responses from the workers of the scheme were quite clear and objective. Seemingly, 9 responses to the questionnaire (60%) said that clients always complained about inadequate insured services expected from care providers, whereas, 6 respondents (40%) said they received complaints sometimes. The responses indicated that beneficiaries of the scheme were not always happy about how providers treated them as end users.

Table 9: Complaints about poor quality of care from clients

Responses	Frequency	Percentage
Always	9	60
Sometimes	6	40
Total	15	100

Source: Fieldwork, 2008

The questionnaire further required from the workers of the Mutual Health Insurance Scheme whether, 'the institution had a say over the quality of treatment meted out to its clients as they visited the hospital'. The responses to the questionnaire were of varied opinions, however, majority of the workers indicated that the institution had limited or no control over the quality of treatment the health providers meted out to its clients. Figure 3 below, indicates that 8 persons said that the institution had limited say over how insured persons were treated at the health facilities, 1 person attested to the notion that the organisation had no control over the quality of treatment, 1 other individual declined to respond on the matter. Notwithstanding, the sentiments expressed, 5 workers said that the scheme

had absolute say over the quality of treatment meted out to its clients. Since, many more responded in the negative to the question and coupled with the frustrations expressed by clients of the scheme about poor quality of care as in Table 9 above, it was of the view that the scheme had limited say or no control over the quality of treatment.

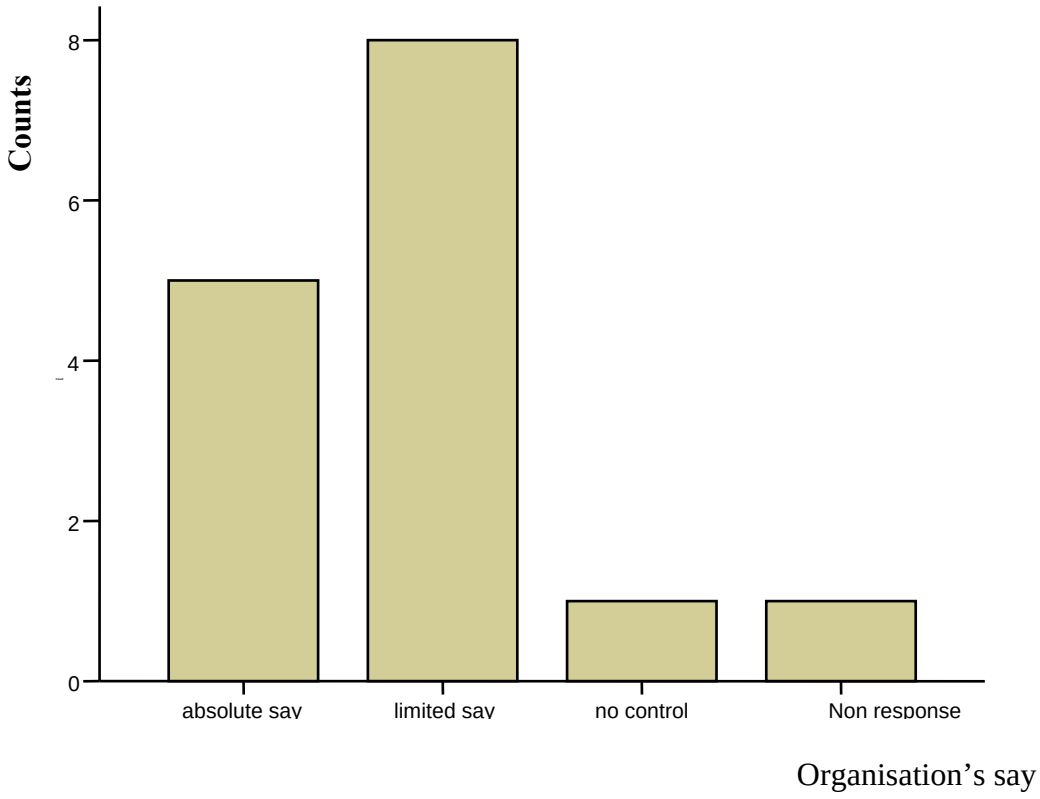


Figure 3: Organisation's say over the quality of treatment meted out to clients at the hospital

Source: Fieldwork, 2008

To prove a point, the researcher reached out to insured members in the general public and administered a questionnaire on their perception of care provided under the Health Insurance Scheme. The responses were displayed in the chart below (Table 10). The majority of respondents (250 individuals, altogether,

representing 68.5%) said that, the quality of care provided under the scheme as they visited the hospital was good. This points to the fact that, despite the limitations experienced under the health programme, the inception of such a social health programme was a necessary intervention and that somehow, expectations of registered members were being met.

Table 10: Perceptions of care provided under the cover health insurance scheme in your hospital

Perception	Frequency	Percentage
Excellent	18	4.9
Very good	124	34
Good	108	29.6
Poor	110	30.1
Non response	5	1.4
Total	365	100.0

Source: Fieldwork, 2008

Attitude of hospital staff towards the insured individuals under the scheme

It is essential to examine the attitude of health workers towards clients of the Health Insurance Scheme as this could indicate further, the success of the health reform programme or not. Data collected on the questionnaire, how members of the scheme classified the attitude of staff during the times they visited

the hospital, had been analysed and displayed in (Table 11) which gave a picture about the state of affairs as pertained in the hospitals.

About 165 respondents(45.2%) said the attitude of hospital staff was good, 110 respondents(30.1%) said attitude of hospital staff was fair; however, well about 70 respondents(19.2%) said staff attitude was poor towards them. We could, therefore, conveniently say that members of the scheme were of the views that, staff of the hospitals exhibited a fairly good attitude towards them anytime they visited the hospital.

Table 11: Attitude of hospital staff towards insured persons

Staff Attitude	Frequency	Percentage
Very Good	13	3.6
Good	165	45.2
Fair	110	30.1
Poor	70	19.2
Non Response	7	1.9
Total	365	100.0

Source: Fieldwork, 2008

The researcher posed the question to beneficiaries under the scheme's jurisdiction whether they felt discriminated against by a hospital staff as an insured individual. Notably, majority, 230 persons (63%) responded 'no' to the questionnaire. This has been displayed in Table 12 below. However, a few

respondents (123 persons constituting 33.7%), said 'yes' they had been discriminated against by a staff, before.

Table 12: Discrimination by hospital staff

Discriminated against	Frequency	Percentage
Yes	123	33.7
No	230	63.0
None response	12	3.3
Total	365	100.0

Source: Fieldwork, 2008

Government re-imbursement to health care providers

The reimbursement of funds lost to healthcare providers is very important to ensure continuity of care if the health care system put in place must succeed. Table 13 below, analyses responses of health insurance operators to the question 'how does your organisaton process claims'. Out of the total number of 15 employees questioned, 10 persons (including the claims manager) constituting 66.7%, said that claims were manually processed, 3 other employees (20%) said that claims were processed by computer, however, 2 respondents (13.3%) did not respond to the question.

Table 13: Processing of claims

Responses	Frequency	Percentage
Computer software	3	20.0
Manual means	10	66.7
Non response	2	13.3
Total	15	100.0

Source: Fieldwork, 2008

The researcher posed another question to the scheme workers to clarify the issue of reimbursement of funds to health care providers. Figure 4, provides analysis to the question, how they would describe the flow of funds for paying health providers. The respondents were expected to check among the three options; regularly timely, regularly untimely and once a while. Worth noting, 9 individuals said that the flow of funds were regularly untimely, 3 other individuals said that the flow of funds were regularly timely, 1 person said that the flow of funds was say, once a while, whereas, 2 people failed to indicate their responses. The responses observed largely, emphasize the fact that, the flow of funds was not regular for payment to health providers. This could be a major cause for the several complaints brought forward to the scheme's operations.

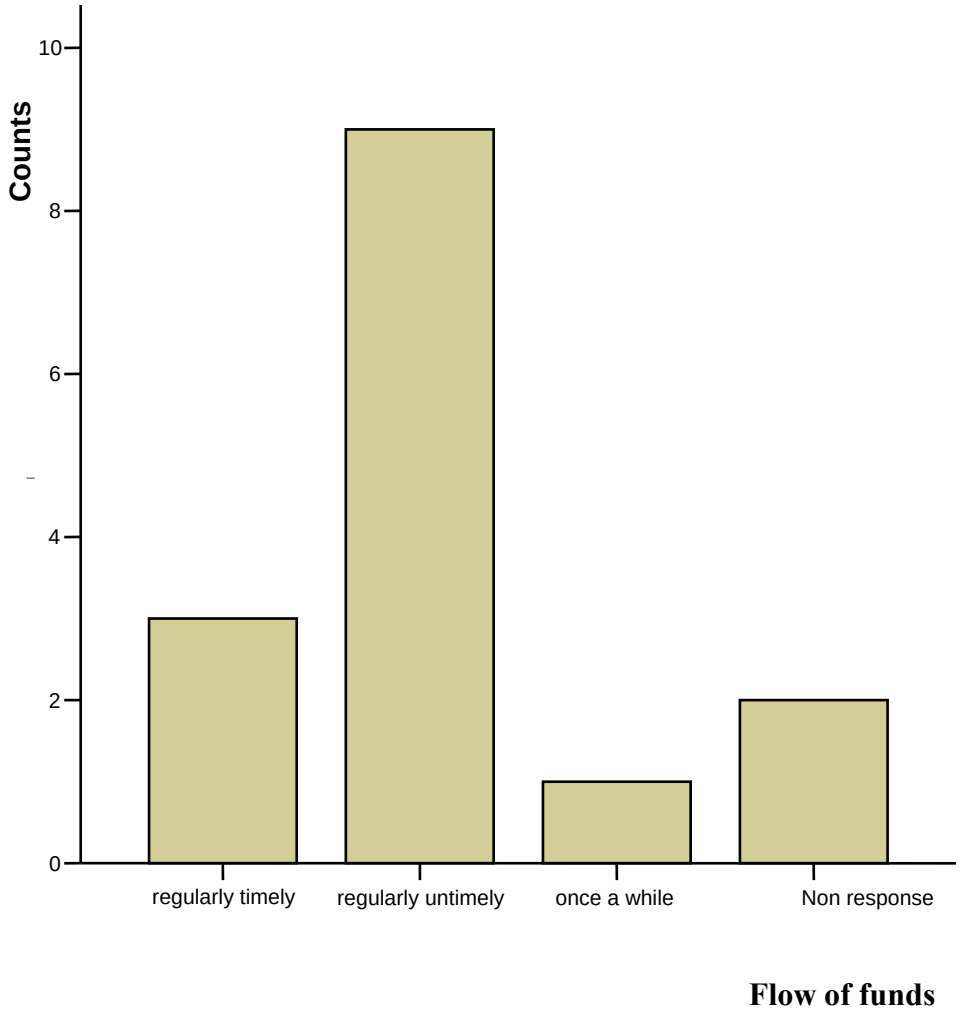


Figure 4: Flow of funds for payment of health providers

Source: Fieldwork, 2008

Responses to the question as to 'whether insured persons will be prepared to pay higher premiums to ensure sustainability of the scheme', received varied responses. Table 14, analyses the responses and displayed below. From the responses, 130 persons (35.6%) disagreed to the idea of paying higher premiums, 120 respondents (32.9%) said they were not sure of acceding to the suggestion of paying higher premiums to enable sustainability of the scheme.

However, 100 respondents (27.4%) said they agreed to pay higher premiums to support the scheme. Once more, 10 individuals (4.1%) failed to respond to the question. Generally, it was observed from the analysis that majority of the scheme's beneficiaries (68.5%) did not want to pay higher premiums to ensure sustainability of the scheme.

Table 14: Payment of a higher premium to ensure sustainability of the Health Insurance System

Pay higher premium	Frequency	Percentage
Agree	100	27.4
Disagree	130	35.6
Not sure	120	32.9
Non response	15	4.1
Total	365	100.0

Source: Fieldwork, 2008

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The policy of providing affordable and accessible social health care targeting the larger society to include the core poor in particular, who otherwise would not be able to attain quality healthcare, has come to stay. What is needed is the possibility of making the system able to work effectively.

This chapter thus, summarises the findings of the study. Conclusions are made based on the interpretation of the data generated from the research and related to the review of the literature. The chapter concludes with suggestions and recommendations for further study.

Summary

- The main findings from the study are that performance so far is generally modest certainly, with reference to perceptions of the scheme's beneficiaries. On the other hand, one should realise that most schemes are relatively young and therefore, would need more time and committed support to develop.
- Government, therefore, has the task to define her role within the context of a national health financing policy. Such a policy should steer the scheme

towards reaching the goal of financial protection and sustainability, not necessarily from higher charges to premium contributions. Since, the government of Ghana has adopted a multi-payer system of financing Health Insurance Schemes across the country by way of mandatory deductions of 2.5% of the formal sector's contribution of 17.5% to SSNIT, a GH¢0.6 monthly contribution from the informal sector, in addition to a 2.5% tax revenue from the purchases of certain items and coupled with occasional donor financial supports e.g. WHO, DANIDA and USAID, among others, there is adequate public assurance that the financial base for the scheme would not dwindle.

- The involvement of the international organisations, especially, WHO and ILO would also resolve and make non-existent the problem of low institutional capacity characteristic of most schemes in the developing countries. These donor agencies are ready to partner with the government by providing expertise and the technical know-how that would make the Social Health System work.
- The administrative structures as presented in the literature review and verified from the stakeholders indicate that the programme of universal health care was an ambitious policy but crucial to meeting the health needs and therefore, started without due concern to administrative structures in place and the logistical support. This could be one major reason why there are different rates of scheme performances across the country. Considerable distances away from health care providers as a result of

unavailability of own structure needed for the commencement of the programme, is unfortunate. Administrative structures and management is essential for estimating contribution, collection of contribution, compliance, determination of benefit packages, marketing and communication, contracting with providers, management of information systems and accounting (Carrin et al., 2001).

- Again, the quality of care enjoyed by insured persons is an important aspect of sustaining a working Mutual Health Insurance Scheme. The outcome of the study echoed, seemingly, quite a dissatisfied quality of care and indeed complaints were brought forward to scheme operators. The problem here is that there are no official measures for checking and resolving such complaints. The relation as pertains between the care providers and scheme operators is undetermined. Therefore, disappointed insured persons may not continue membership but may opt for pay as you go system which the authorities wished to discourage.
- Hospital attendants interviewed during the study declared that, attitude of hospital staff towards them is fairly good. However, there were some respondents who thought otherwise though, but were in the minority.
- The National Health Insurance Council could not execute its mandate of disbursing funds promptly to health care providers over the years due mainly to the slow pace of processing claims, they would explain. The study actually, revealed the use of manual method for processing

claims. This delayed the whole process of reimbursing health care providers for services provided and items used for the purpose. Delayed claim processing protracts reimbursement of funds to health care providers which had the potential of rending the scheme function slowly. The flow of funds, therefore, had been irregularly untimely, threatening the performance of the scheme.

Conclusions

The broad perception about the performance of the scheme in the municipality is that, the scheme is functioning well but for some few challenges for instance, the need for appropriate infrastructure strategically located for use as office, adequate supply of logistics and provision of computers and networking them for effective claim processing among others, which when given needed attention would boost confidence and hence, expand patronage for insured services.

Such a need, admittedly, could not be met by the local authorities entirely, to include the Municipal Assembly and scheme management. Certainly, the government of Ghana required some time to pool resources especially, finance and plan methodologies for the extension of the social protection health system to cover every citizen by way of progressive registration in a suitable socio-economic environment.

It is worth contributing to say that finance and goodwill alone could not make the scheme run effective unless, there were adequate expertise to design and drive forward the programme for additional protection success.

Another notable conclusion drawn from the results was that attitudes were positive, in spite of the revelation that scheme operators could not exercise adequate control over treatment meted out to its clients at the various hospitals hence, complaints brought up to it. However beneficiaries were not willing to pay more charges for better insured services.

The history of health care provision since independence had traveled through free care, co-payment, cash and carry and exemptions, and now the National Health Insurance Scheme. Though the social health insurance scheme had been piloted in Nkoranza and other places, it was a recent past democratic campaign pledge that gave birth to it on a national scale (International Labour Organisation, 2004). It is therefore, important to ensure that the political climate that made the Health Insurance System thrive is maintained to ensure further protection and sustainability.

Recommendations

- It is the strong opinion of the researcher that the government continues to diversify sources of financing the National Health Insurance Scheme. The inability to raise additional revenue through high premium charges could be avoided through diversifying the sources of revenue to ensure uninterrupted flow of funds was available for the sustenance of the

National Health Insurance Scheme. Now that government revenue is expected to improve through the discovery of crude oil, a small percentage charge could be set aside for the development of the National Health Insurance Scheme on sustainable basis. Revenues generated from patronage of sports stadiums and other major entertainment programmes could be taxed for social health security as a patriotic contribution to the scheme to make it work. Again, filing fees of political aspirants to occupying high national positions could have a very small fraction of it allocated, as social cost to support the scheme. A broad revenue base would ensure that a critical infrastructure is provided for smooth administration and management of the scheme at the district level.

- The National Health Insurance Authority should ensure that, the manual method of processing claims is replaced with computer software programming networked to the national level. This would eliminate delays in submitting claims to the National Health Insurance Council for onward reimbursement to the healthcare providers. It is the view that claim managers should undertake training in Information and Communication Technology to facilitate the process.
- Finally, even though, attitude of hospital staff towards clients of the scheme was reported positive, it is the suggested view of the researcher that efforts should be directed at improving on attitude to ensure quality treatment and maintain confidence in the system. For instance, community workshops could be organised once a year by, for instance, the District

Assembly, to include representatives from the scheme operators, healthcare providers, and insured persons to dialogue complaints and seek possible solutions to them.

A proper functioning National Health Insurance Scheme would ensure health security to the public and reflect indirectly on their work output.

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APPENDICES

APPENDIX A

RESEARCH QUESTIONNAIRE FOR HOSPITAL ATTENDANTS/PATIENTS

This questionnaire is to help the researcher gather data to examine the performance of the national health insurance scheme in the Ho municipality since its inception.

Your honest and frank participation will go a long way to enhance academic review of the scheme. The information provided will be used solely for academic purpose and shall be given the confidentiality it deserves.

Section A – Demographic Data (check √ where appropriate)

1. Sex

   a. Male b. Female

2. Age

   a. 16– 64 b. 64 and above

3. Marital status

   a. married b. never married c. divorced d. widowed

4. Number of Children

   a. none b. one c. two d. three e. four and above.

5. How many of your children are below 18 years

   a. none b. one c. two d. three. e. four and above.

6. Where are you employed?

a. public sector b. private sector c . unemployed.

7. How would you rate your income?

a. below GH¢100 b. GH¢101-300 c. GH¢301- 500 d. above GH¢500

Section B. Mutual Health Organisation: (Tick √ where appropriate)

8. Does the infrastructure befit the organisation?

a. yes b. no

9. How near is the organisation from your residence?

a. very near b. far c. very far

10. Would you prefer relocation of the Mutual Health Organisation?

a. yes b. no

11. If answer to Q10 is No, then give reasons……

Section C. (Check √ the correct response)

Quality of Care

12. Do you feel secure when you send your insurance card to the hospital?

a. yes b. no

13. Do you receive proper attention at the hospital as a card user?

a. yes b. no

14. If No, would you prefer to pay some money to receive medical attention?

a. yes b. no

15. Have you been enjoying exemptions as a card user?

a. yes b. no

16. What is your perception of care provided under the health insurance scheme in your hospital?

a. excellent b. very good c. good d .poor

Section D (Tick √ where best fits)

Attitude of hospital staff

17. How would you consider reception by a staff anytime you attend a hospital?

a. very bad b. bad c. good d. very good

18. Do you feel discriminated against by a hospital staff as an insured individual?

a. yes b. no

19. If yes, what reason (s) would you give for such a treatment?

…….

20. Is your opinion sought by hospital staff when undergoing treatment not provided by the scheme?

a. yes b. no

21. How would you classify staff attitude during the times you visited the hospitals.

a. very good b. good c. fair d. poor

APPENDIX B

RESEARCH QUESTIONNAIRE FOR HEALTH INSURANCE SCHEME STAFF

This questionnaire is to enable the researcher collect data to assess the performance of the national health insurance scheme in the Ho municipality. Your honest and frank participation will go a long way to promote academic overview of the scheme. The data collected is solely for academic purpose, hence confidentiality is assured for all responses.

Ho Mutual Health Insurance (Staff only)

Section A – Demographic data

(Tick √ where appropriate)

1. Sex

   a. male b. female

2. Age of employee

   a. 20-30 b. 30-40 c. 40-50

3. How would you rate your income since you started working with the scheme

   a. below GH¢ 100 b. GH¢101 – GH¢300 c. GH¢301 - GH¢500 d.above GH¢ 500

Section B – Administrative Structures (Tick √ where appropriate)

4. Which of the these best describe your organisation's location

a. private residence b. own structures c. shared apartment with other work organisations

5. Are you satisfied working in such a location

a. yes b. no c. not bothered

6. Would you describe your place as?

a. strategically located b. far from town c. centrally located

7. Give reasons for your choice in Q6 above…….

8. Are you supplied with all logistics to enhance efficiency of work?

a. yes b. no c. not bothered

Section C – Quality of Care (Tick √ where appropriate)

9. Would you say clients are satisfied with quality of care as they visit hospitals?

a. yes b. no c. don't know

10. How often do you receive complaints about poor quality of care from clients?

a. always b. sometimes c. none at all

11. Does your organisation have any say over the quality of treatment meted out to its clients as they visit hospital?

a. absolute say b. limited say c. no control

Section D – Essential Drugs (Tick √ where appropriate)

12. What type of drugs do your scheme offer or prefer?

a. common drugs b. essential drugs c. other

12. What percentage of prescribed drugs are covered by the scheme? ……..……..

Section E – Reimbursement (tick √ where appropriate)

14. What other sources of funding apart from the national health insurance fund? Please state…….

15. How does your organisation process claims

a. computer software b. manual means c. other specify…….]

16. How would you describe the flow of funds for paying health care providers?

a. regularly timely b. regularly untimely c. once a while

17. Would you say it is convenient to you?

a. yes b. no

18. Would you suggest any increase in premiums to solve the problem?

a. yes b. no

19. If yes, please give reasons……

20. What is your overall view on the performance of the Ho Mutual Health Insurance?

a. above average b. satisfactory