UNIVERSITY OF CAPE COAST

THE OPERATION OF THE GHANA HEALTH INSURANCE SCHEME AMONG THE PEOPLE OF CHOGGO, A SUBURB OF TAMALE

BY

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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: ……..

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Supervisor's Declaration

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

Supervisor's Signature: …… Date: ……..

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ABSTRACT

In most recent times the issue of the Ghana National Insurance scheme has preoccupied many a mind. Whereas some see in it a saviour others exercise their scepticism seeing it as another very big white elephant. The efforts made in this study have sought to digest some concepts of the Health Insurance as well as trace the origin of the Insurance with a commitment to ensuring that the emerging scheme is devoid of bottlenecks as it appears to be harbouring now.

Two main tools were employed to elicit the relevant data in its primary and secondary forms and analysed by the use of the SPSS version 16 statistical software. Additionally the Chi-Square statistic, the Pearson correlation coefficient, Regression analysis together with the regular descriptive essay have been applied to infer on some specific relatedness. The results are fascinating yet quite explainable. In one form it reveals that almost everybody hails the new health delivery system but mindful that its operations are beset with so many problems. Without really prioritising them various remedial measures have been recommended along a constructive background.

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ACRONYMS

AGM	Annual General Meeting
AIDS	Acquired Immune Deficiency Syndrome
AREPI	Association of Representatives of Ethical
DMHIS	District Mutual Health Insurance Scheme
FBS	Pharmaceutical benefit
GDP	Gross Domestic Product
GNA	Ghana News Agency
GNHIS	Ghana National Health Insurance Scheme
GPRS	Ghana Poverty Reduction Strategy
HIPC	Highly Indebted Poor Country
HIV	Human immune virus
MHO	Mutual Health Organisation
MOH	Ministry of Health
NHIC	National Health Insurance Council
	Pharmaceutical Industries
PHI	Private Health insurance
SAP	Structural Adjustment Program
SDA	Social Dimensions of Adjustment
SSNIT	Social Security and National Insurance Trust
UDS	University of Development Studies
UNICEF	United Nations Cultural and Educational Fund
VRA	Volta River Authority
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the study

There is no gainsaying that the health of a nation forms a solid resource base of the country's economic wellbeing. It behooves the powers that be in any nation to put the concerns of the health of the people far above anything else and perhaps that is why governments upon governments devise prudent ways of dealing with the situation in a form that suggests that no other sector of governance surpasses it. In Ghana, though the health sector has always been one of the top priorities of any government, the stories have remained fairly the same with the era immediately preceding the emergence of the National Health Insurance regime falling out of the normal. This should in more than one way offer a reason for why this has so much preoccupied the minds of many scholars as well as any well meaning citizen.

Dubbed as the most effective poverty alleviation strategy in recent times, the national health insurance scheme has attracted so much attention of many scholars. The reason for this is not farfetched if one takes a bit of pain to follow the trend of the nation's health delivery system for a period spanning about half a century since attainment of independence. The verity or otherwise of this assertion will become evident if one acquaints oneself with what the health policy, vision, mission, targets as well as the goals have been through these years.

Various socio-economic stresses prevailed on the health budgets making forcing the health sector to adopt very checkered health practices. The health sector had been run on a low budget compounding the problems that are inherent therein. The health practices since independence have metamorphosed as much as our economy and political gains have done over the years. Our colonial masters left us with the free medical service system which prevailed as long as there were economic and political stabilities. As soon as there was the slightest stress the system was prone to collapsing. It did not last for too long when political upheavals befell the country and the mess we were thrown in culminated into a dwindled /shuttered economy. The economy could indeed make room for only a very small allocation for the health sector but as the volume of facility users increased and the cost of health services and drugs escalated, this posed a huge burden on government and many well meaning Ghanaians as to how to sustain the free health delivery system. Successive regimes (military and civilian) had to grapple with this checkered system until 1985 when the government introduced the "cash-carry-system". From then up till the early years of the second millennium, the Ghanaian has had to cope with the not- too- popular system by which one had to foot a sizeable proportion of ones own medical expenses. In accordance with the government's health policy that was in force just before the introduction of the GNHIS there were to be a number of exemptions covering the children, very poor and the aged. Reports have it that such exemptions were either bluntly ignored or grossly abused. If that was a way of recouping the recurrent expenses incurred by the government health facilities that did succeed but not without deepening the woes of the poor, the

aged and in fact the vulnerable. As the economy was passing through some turbulent stages, so were the statuses of very able citizens thus accounting for the disproportional swelling in the number of people in the vulnerable class during those turbulent days.

As if that was not enough, agitations for further reforms were on the way around the beginning of the last decade of the twentieth century. As Agyepong (1999:59-60.) puts it, "They were the reforms known as the medium term health strategy (1996-2000.)" They were aimed at improving access to standard health care, quality and efficiency of the care and strengthening links with other sectors such as the ministry of agriculture and education which also have similar activities. The introduction of user fees was brought into the scene. The other parts of the package of changes included clearly specifying the criteria for exemption and provision for close monitoring of the system.

The system as outlined persisted for some time but not without complaints and reports of several loopholes which thwarted the ministry's efforts. This contradicted sharply with the government's policy of including the poor in the provision for health. In the ensuring years the quality of health care fell drastically. There was an acute shortage of essential drugs in all government health centres. More importantly, there was a big fall in the numbers of people who used government health facilities in the country. It is, however, shocking to note that in spite of all these the government of the NDC saw wisdom in increasing the user fees over and above what appeared to be too much for the ordinary Ghanaian. The full cost recovery concept came into force as a harsh measure to generate enough revenue to solve the issue of the

dwindling stock of drugs. This came to be known as the "cash and-carry-system" which is most unpopular because it was responsible (some feel) for the widening the gap between the poor and the rich bringing about a further drop in the facility utilization. For example a survey by the statistical survey department in 1998 (Ghana Demographic and Health survey, 1998) suggested that only 43.8 % of those who were ill could afford to see a medical practitioner, a trend which could be linked in part to the high health care user fees. In this system, 80% of the full cost of medical treatment was borne by the government and only 20 % had to be paid by the end user at the point and time of the treatment. This was instituted as far back as 1992 at a time the poverty index was quite high all over the country in general but more pronounced in the rural communities than in the cities and towns. In realistic terms less than 20% of the Ghana's population could afford to use the government health facilities, a situation which could not be allowed to persist for too long for fear of the telling repercussions on the health of the working masses of the nation.

Health policy change in Ghana

The user fees in public facilities came into being in 1971 (Agyepong, 1999). This was very low mainly because it was aimed at controlling the use of health services and not necessarily as a poverty alleviation strategy. There was a slight adjustment in 1995 and under a military regime the idea was to recoup 15% of operational cost (Agyepong, 1999). This late development had a component of retaining varying fractions of the revenue collected at the clinics, health centres and hospitals where it was collected for its operational

cost. Then in 1999 an amendment was made which allowed some public health institutions to retain all the revenue generated (as a pilot programme). This decentralization system of charging fees as in existence in all public facilities as well as the private ones but whereas the private ones found it adequate to sustain their services the public ones kept enjoying big subsidies from the central government (Agyepong, 1999).

Worsening health situation in Ghana

This paved the way for the introduction for the cash and carry system in 1992 as a full cost recovering system of health delivery which, primarily, was intended to recover cost fully to replenish the dwindling stock of drugs. Such retained revenue was used to replenish any depleted stock. This latter amendment made provision for exemption of the poor and the aged but studies by Agyepong, 1999, Nyonator and Kuntzin 1999 and Russell et al.,(1999) suggested that there were gross abuses and side stepping of the exemption clause by policy implementers. The poor and the aged were simply ignored with the implementation agents claiming it was too difficult to adopt, a clear situation of lack of monitoring and supervision. Subsequently, the effect of this very hash health policy brought about the following;

- A dwindling number of people attending government health facilities with an eventual fall in revenue and general health status of the ordinary citizenry.
- The drug stock got depleted as the unwholesome alliance of health personnel and private drug dealers raged on. (It was a practice in which health workers gave false alarms of scarcity of some particular drugs

and intentionally referred desperate patients to private favoured drug suppliers in town. People cashed it big at the expense of suffering patients)

- A rise in maternal and child death rate across the country but with bigger records coming from the rural communities.

Studies in Ghana by Agyepong (1999) in Dangme west district in greater Accra region suggested that there were a few instances of budget surpluses reported but hardly were such surpluses translated into replenishment of stock of drugs nor did that call for more exemptions for the poor and aged. As for the issue of exemption various studies done by Nyonator and Kuntzin in Volta region had a style in which multivariate data collection was used together with a community based discussion group had the following finding Analysis showed that exemptions of the vulnerable in most cases was non-operative and benefited the health workers more than any one else. Records revealed that less than 1 in 1000 patients were granted exemptions with two thirds up to three quarters of the non-salary expenses being borne by revenue accruing from fees. At the same time in mission hospitals such revenues were enough to take care of all of the non-salary operating expenses. The research appeared to suggest that the exemption hardly ever worked in the form that the policy makers envisaged. Facility implementers failed to use their discretion correctly and to worsen the situation, the government's declining budget allocations rather forced the policy managers to be too preoccupied with collecting enough revenue to supplement small allocations other than thinking about the beneficiaries of exemption.

The frightening aspect was that the system of full cost recovery was able to gather enough revenue but instead of the system making room for subsidising for the poor or generally reducing the cost of treatment it operated virtually unmindful of the concerns of the most vulnerable. The poverty index was high but many research findings pointed to the fact that it was greater amongst the rural folk than the town dwellers in every region of the nation. Similar findings established a direct relationship between poverty and disease burden. The foregone relationship was extrapolated to state that the "cash and carry" system excluded almost all the rural dwellers. This and similar pathetic situations provoked the international outcry and as part of a poverty reduction strategy the idea of a national health insurance scheme was mooted at the beginning of the last decade of the third millennium. The government of the day encouraged by the international donors put in place a series of debates, symposia, public discussions on the feasibility of adopting a national health insurance scheme which can solve the problem of low utilization of government health facilities in the beginning of the third millennium. This was primarily to ease the situation of the poor but equally importantly to help the government achieve its set of health goals within the context of the Ghana Poverty Reduction Strategy (GPRS) as well as the health sector five year programme of work (2002-2006).The underlying principle and vision of the government being that every citizen shall have equitable and universal access to an acceptable quality package of essential health care. The Government's target being that within the next 5 years after its introduction, every citizen in Ghana shall belong to one insurance scheme so as to be shielded against the impact of the cash and carry system. The announcement of government's

intention to introduce the NHIS was formerly announced in 2002 by the then finance minister. Soon afterwards, the government machinery put in place a series of lecturers, public debates, parliamentary sessions, discussions on the issue culminating into the passing of the national health insurance bill on March 18 2004 (Unlik FM Radio Station,6pm News). Though the introduction of such a scheme would be expected to be slow since it involves a number of transition stages and implementation precautions it has taken a considerably long time and a number of issues have come to the fore.

- This study among other things would consider such issues as mentioned above with the view to helping to evolve a system devoid of some of the mistakes of the former systems. The researcher seeks to carry out very simple academic exercises in order to be in the position to answer such questions as;
- Has the take- off of the system been safe and smooth?
- Is there something missing that could be provided to streamline the operation of such a system?
- Is the system the very best we can achieve under our present circumstances or is it still possible we could do a little more to improve upon its performance?
- In Choggo, is it solving the problems in for which it was instituted?
- What is the relative ease of registering and belonging to the scheme in Choggo?

The study area

The area under study is Choggo, one of 14 suburbs that make up the township of Tamale metropolis the capital of Northern region. Tamale is the third largest city in Ghana. It lies between latitude 09^{o} 24 00N and 00o 49 59W. By the 2000 Ghana population and housing census, Tamale municipal population was 360579 and by the year 2007 it was 55,000 (projected with the national population growth rate). Though a predominantly Dagomba settlement Choggo is a cosmopolitan township. It also enjoys a good deal of the good road net work that Tamale is made up of. The inhabitants of this suburb would not have been insulated from the great illiteracy and generally high poverty index which has become one of the cankers of the northern region and the whole country, for that matter, but for the fact that it is home to several educational institutions. Choggo community has a good spread of government workers as well as the well established company workers. It is made up of quite a broad spectrum society with a high literacy rate which enjoys the presence of a great cluster of schools ranging from day nurseries through junior high, senior high, Post secondary, polytechnic to University offices. It has been chosen from among the lot not only because of its accessibility to the researcher but mainly because it offers a population with a wide variety of inhabitants. Its boundary starts right from the heart of the business district of the Tamale metropolis, engulfing the whole of the education ridge at the northern end of the metropolis extending into Choggo Yepalsi where there are typical indigenous environments. This definition of the area has been calved out by the management of the GNHIS for the purpose of effective checking and/or monitoring. By the above definition, Choggo

zone includes Choggo Hill-Top, Choggo-Nmanaayii, the whole of the Education Ridge community, engulfing Wurishe, Gbolo-Kpalsi the Filling-Point and Yepalsi environs.

Statement of the problem

The GNHIS is the brain child of a very carefully thought of poverty elevation strategy but from its piloting stages in 2001 in a few selected districts through its full scale implementation in all districts in 2004 up to now has the country registered any significant transformation in the poverty levels?. If this gives a positive answer then how come that there are reports of such low membership registration figures? (As contained in the Daily Graphic of Feb.8 2007 a report by the executive secretary of the NHIS, Ras Mensah). If the answer to this is in the negative, is it because the good ideas behind the adoption of this scheme have not caught up well with the general populace of the country or is there still something that implementers have done or failed to do?

An equally burning issue is one that is related to the percentage coverage in registration. Figures taken from the 8th February 2007 issue of the Daily Graphic have it that almost two and a half years after official take off of the scheme, three million, (3,000,000) people have registered but could not as at then get their membership cards. These figures were released by Mr. Ras Mensah the executive secretary of the NHIS, in the Feb. 8 2007 issue of the daily Graphic. He said, 'December 2006, the percentage registration was low in the various regions with slight variations but it averaged to give 38% as the national coverage. That is; out of the population of 20,425,239 only 7,673,998

had registered with 411,696 having been issued with their membership cards.' Considering the era we are emerging from (the harsh cash-and-carry system) one would have imagined that there are huge gains associated with the scheme but the trend in the figures appear to be reversing the perceptions. This calls for a thorough investigation to establish the reasons that can account for the low registration.

Within a few years of its inception some people who should know better about its operation appear very adamant about what appears to be a great blessing. In some circumstances it appears to be a deliberate refusal and in others there is evidence to believe that there is some amount of inability and/or ignorance on the part of the prospective members. What could the problem be?

Following its inception in a number of districts, there has been increased agitation for better working conditions from a number of sectors of the health ministry. Subsequent upon this, various categories of health workers have started enjoying better pay packages. Some people have, however, been quick at linking this improvement to the benefits of the National Health Insurance Scheme. The truth or otherwise of this contention are left for posterity to prove but be it as it may, a credit is still reserved for the system for at least being able to absorb the colossal increases in the working allowances among the health workers this far.

The issue of the bottle necks associated with the exercise is a big problem. Reports indicate that the processes that one has to go through before finally laying hands on the membership registration card are rather so tedious that many are scared off. In some cases one needs to take the passport size

photograph as many as 4 times before a card is finally issued. There are also situations of cards carrying photographs with mismatched names. It is also a common observation that at drug collection points pharmacists or counter servers appear to sympathise more with those who hold cash other than holders of GNHIS cards, a development that seems to negate the intended benefits. There are yet some others who have been patient enough to take the photos but here again their claim is that registration officers have kept them waiting for far too long. At the hospital, users of the GNHIS card have yet another ordeal while their cards and folders are being sorted out from among the pool of unserialised lot. The issues as enumerated here are but a few and these call for some rethinking of the system in order that corrections and/or remedies can be sort for them in attempt get a system which is devoid of such bottle necks.

Objectives of the study

Generally, the study primarily sought to examine the major factors that confront the Ghana National Health Insurance Scheme (GNHIS) in Choggo, a suburb of Tamale.

Specifically, the objectives are to:

- Determine whether or not the registration procedure is a factor hindering the pace of registration so far in the Choggo health insurance zone.
- Examine how the individual's educational level and/or income level influences his/her willingness to register and the rate of registration for that matter.

- Explore the problems which are so far inherent in the operation of the scheme and their impact on the quality of service of the new scheme in the Choggo zone.
- Recommend to the appropriate bodies the possible solutions to some of the challenges of the health insurance scheme.

Research questions

- Is the Ghana National Health Insurance Scheme (GNHIS) acceptable to majority of the general Choggo populace?
- Is the percentage of people registered in Choggo so far influenced by the registration procedure?
- What are the most important problems affecting the NHIS?
- Do the other factors apart from the a person's highest academic/income influence the rate of registration significantly?

Hypothesis

- Hi: There is a relationship between the individual's academic level/income level and the readiness to acquire the GNHIS membership card.

Definition of terms

Premium: The amount the policy-holder pays to the health plan each month to purchase heath coverage.

Deductible: The amount that the policy-holder must pay out-of-pocket before the health plan pays its share. For example, a policy- holder might have to pay a $500 deductible per year, before any of their health care is covered by the health plan. It may take several doctor's visits or prescription refills before the policy-holder reaches the deductible and the health plan starts to pay for care.

Co-payment: The amount that the policy-holder must pay out of pocket before the health plan pays for a particular visit or service. For example, a policy-holder might pay a $45 co-payment for doctor's visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.

Coinsurance: Instead of paying a fixed amount up front (a co-payment, the policy-holder must pay a percentage of the total cost. For example, the member might have to pay 20% of the cost of a surgery, while the health plan pays the other 80%. Because there is no upper limit on coinsurance, the policy-holder can end up owing very little, or a significant amount, depending on the actual costs of the services they obtain.

Exclusions: Not all services are covered. The policy-holder is generally expected to pay the full cost of non-covered services out of their own pocket.

Covered limits: Some health plans only pay for health care up to a certain dollar amount. The policy-holder may be expected to pay any charges in excess of the health plan maximum payment for a specific service. In addition, some plans have annual or lifetime coverage maximums. In these cases, the health plan will stop payment when they reach the benefit maximum, and he policy-holder must pay all remaining costs.

Out-of-Pocket Maximums: Similar to coverage limits, except that in this case, the member's payment obligation ends when they reach the out-of-pocket maximum, and the health plan pays all further covered costs. Out-of-pocket maximums can be limited to a specific benefit year. (Such as prescription drugs) or can apply to all coverage provided during a specific benefit year.

Capitation: An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.

In-network Provider: A health care provide on a list of providers pre-selected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to charges the insurer pays to out-of-network providers see an in-network provider. Generally, providers in network are providers who have a contract with the insurer to accept rates further discounted from the "usual and customary"

Significance of the study

The study apart from being a topic of great concern especially as the problems of the infamous cash-and-carry system are still fresh on the minds of the ordinary Ghanaian, will add knowledge to the stock already piled up on health insurance systems.

This health insurance being a novelty requires that as much knowledge as possible about its operations, its drawbacks as well as its effectiveness are known in advance.

It will among other things bring to the fore as many of the factors as possible that could possibly be hindering the smooth running of the recently

adopted health insurance policy. This information may come in handy when it comes to making recommendations for its improvement or suspense.

This could in turn lead to nurturing initiatives or a systematic rethinking of the health insurance policy along lines of relevance and effectiveness for a poverty alleviation strategy for a nation at the threshold of economic emancipation.

Scope of study

The scope of this study is to use the Choggo community as a case study to examine the major factors that could be hindering the smooth take off of the GNHIS. The study is centred on the Choggo community and especially from the education ridge in Tamale which has a large literate population.

Organisatioin of the study

The study has been organized into five Chapters. The first chapter introduces the study, outlines the statement of the problem and focuses the research approach. That includes the background to the study, statement of the problem, research objectives and questions, significance, scope and organization of the study.

Chapter two reviews the related literature on health insurance concepts and other events that shaped Ghana's quest for the institution of the Health insurance scheme. In this chapter comparisons with some schemes of other nations have been made. Chapter outlines the methodology of the study. Its subtopics includes: the study design, the population distribution, the sample frame and sampling procedure, instrument and its administration ,data entering

techniques and their analysis. Chapter four contains the results and discussion of the work. In this chapter elaborate SPSS charts tables and their interpretations have been done. Chapter five consists of the summary and the necessary conclusions drawn, some recommendations and suggestions as to how to sustain the scheme

CHAPTER TWO

REVIEW OF LITERATURE

1ntroduction

In this chapter attempts will be made to explore the meaning and some working definitions of 'health', examine the some concepts of insurance and in particular view the issue of health insurance. Efforts will be made to examine the driving factors that brought into existence the GNHIS. It will be put under the following headings; The Models of Health, The concepts of Insurance and Health Insurance, The history of Insurance /Health Insurance, Some problems encountered in Health Insurance, Some challenges in the Ghanaian experience, Experience from some Countries, The way forward and Build up to the implementation.

Models of health

Throughout history, various philosophers have made various attempts to find a definition to the word health from their various standpoints each succeeding to draw society's attention to something in its belief system. A few of the well known modes have been cited.

The medical structure model

The word health is derived from a Greek word which literally means 'whole'. Notably in the class of philosophers for the meaning of health

includes a Greek man called Asclepius. He together with his followers at that time saw health as something related to *wholeness* and that the chief role of a physician was to treat disease thus restore wholeness by correcting any imperfections caused by accidents of birth (Bubos, 1960) Later, the structure of the practice of medicine as a profession helped to sustain this view because contemporary treatment also aims at attaining normalcy, which is, wholeness. Though from thence wider definitions of the term emerged holding major implications for the organisation of society and the pattern of life from which personal life may be modelled, this view of health, the medical structure/model is the widely accepted and acknowledged.

The social model of Health

Health could also be viewed in the social realm where it assumes a 'social model'. Here health is perceived as a social phenomenon. Conceptions of health and illness vary among different groups within a single society and between societies as well as in any single society over time. (Morris, 1975) It is partly because of this reason that (Mechanic et al 1968) have shown that illness behaviour is the response to symptoms and the tendency or reluctance to define any symptom as a. health problem and requires one to seek medical care which varies between cultural and social groups. Conceptions are in constant process of adaptation or revision. There are considerable cultural differences between the developing and market, or planned societies. Changes occur by virtue of scientific discovery and innovations and the development in professional judgment of objectives needs and the status of different diseases and treatments. They also occur in response to the pressure of established

interests and the extent of public anxiety about illness, or safety as well as current level of health demand for health, environment and social services.

The functional model of health

According to David et al., (2005), Galen, the celebrated Greek physician who lived between 200-129AD accepted that health in the abstract was an ideal state to which nobody attained yet he found difficulty regarding as unhealthy all who did not function perfectly. He therefore was prepared to overlook small ailments and to consider health as a state of reasonable functioning, freedom from pain. He says 'the state in which we need not suffer pain and we are not impeded in the activities of life, we call health ,and if any one wishes to call it by any other name he will accomplish nothing more by this than those who call life perpetual suffering'.

The Holistic/Modern View Model

WHO says that 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'? This definition that is contained in the preamble to the constitution of the World Health Organisation, as adopted by the international health Conference, New York 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 states (official records of the World health Organisation., No.2 page 100) and entered into force on April 7 1946 (The definition has remained unchanged since 1948). This therefore suggests that according to the UN convention being in a state of good health is not necessarily the absence of disease but it includes being not only in a sound physical mental and psychological state but

also in a good financial state as well. Suffice it to say that claiming to be healthy no more looks real but merely relative to the some other situations. Improving upon the health of a people will therefore demand a holistic approach. It calls for an encompassing outlook on the very basis of human existence. The advantages that accrue to a healthy populace are so enormous that it cannot be substituted for anything else. No wonder health improvement is the focus of all forms of development and inextricably webbed up with economic strides that a country makes.

The Equilibrium Approach Model

In 1990 point committee on health education, terminology and sociology focused the definition of health as being functional; it is a situation on which the individual is oriented towards measuring the potentials of which the individual is capable. It requires that the individual maintains the continuum of balance and purposeful direction with the environment where he /she is functioning

The concept of insurance

Definition: Insurance in Law and in economics is a form of risk management primarily used to hedge against the risk of a contingent loss. Insurance is defined as the equitable transfer of the risk of loss from one entity to another in exchange for a premium and can be taught of as a guaranteed small loss to prevent a large, possibly devastating loss. An insurer is a company's selling the insurance. The insurance rate is a factor used to determine the amount called the premium to be charged for a certain amount

of insurance coverage. Risk management, the practice of appraising and controlling risk has involved as a discreet field of study and practice. In other words, it can be summarized into the following equation often referred to as the insurer's business formula:

Profit = (Earned Premium + Investment Income –Insured Loss – Undertaking Expenses).

Bringing this concept into the health field, insurance in health of various forms have sprang up through out the world , it therefore takes several forms in various countries but the core function of insurance is the equitable transfer of risk and a guaranteed insulation against an individual's total collapse or loss.

Health insurance

It is a contract between an insurance company and an individual. The contract can be renewable annually or monthly. The type and amount of health care costs that will be covered by the health plan are specified in advance, in the member contract or Evidence of Coverage booklet. The individual policy-holder's payment obligations may take several forms.

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long term nursing or custodial care needs. It may be provided through a government -sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g. by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or

taxes to help protect themselves from high or expected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government.

Health insurance works by estimating the overall risk of health care expenses and developing a routine finance structure (such as a monthly premium or annual tax) that will ensure that money is available to pay for the healthcare benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan.

History of insurance

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

Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the US by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the US effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.

Before the development of medical expense insurance, patients were expected to pay all other health care costs out of their own pockets, under what is known as the Fee-for-service business model. During the middle to late 20th century, traditional disability insurance evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergence health care procedures, and also most prescription drugs, but this was not always the case. Hospitals and medical expense policies were introduced during the first half of the 20th century. During the 1920's individual hospital began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organization. The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II.

Problems encountered with insurance

Insurance systems must typically deal with two inherent challenges: adverse selection, which affects any voluntary system, and ex-post moral hazard, which affects any insurance system in which a third party bears major responsibility for payment, whether that is an employer or the government. Some national systems with compulsory insurance utilize systems such as risk equalization and community rating to overcome these inherent problems.

Adverse selection

Insurance companies use the term "adverse selection" to describe the tendency for only those who will benefit from insurance to buy it. Specifically

when talking about health insurance, unhealthy people are more likely to purchase health insurance because they anticipate large medical bills. On the other side, people who consider themselves to be reasonably health may decide that medical insurance is an unnecessary expense; if they see the doctor once a year and it costs$250, that's much better than making monthly insurance payments of $40 (Figures meant for only examples).

The fundamental concept of insurance is that it balances costs across a large, random sample of individuals as explained under risk pool. For instance, an insurance company has a pool of 100 randomly selected subscribers, each paying $100 per month. One person becomes very ill while the others stay healthy, allowing the insurance company to use the money paid by the healthy people to pay for the treatment costs of the sick person. However, when the pool is self-selecting rather than random, as is the case with individuals seeking to purchase health insurance directly, adverse selection is a greater concern.

A disproportionate share of health care spending is attributed to individuals with high healthcare costs. In the US the 1% of the population with the highest spending accounted for 27% of aggregate health care spending in 1996. The highest-spending 5% of the population accounted for more than half of all spending. These patterns were stable through the 1970's and 1980s, and some data suggest that they may have been typical of the mid-to-early 20th century as well. A few individuals have extremely high medical expenses, in extreme cases totaling a half million dollars or more. Adverse selection could have an insurance company with primarily sick subscribers and no way to

balance out the cost of their medical expenses with a large number of healthy subscribers.

Because of adverse selection, insurance companies employ medical underwriting, using a patient's medical history to screen out those whose pre-existing medical conditions pose too great a risk for the risk pool. Before buying health insurance, a person typically fills out a comprehensive medical history form that asks whether the person smokes, how much the person weighs, whether the person has been treated for any of a long list of diseases and so on. In general, those who present large financial burdens are denied covered or charged high premiums to compensate. One large US industry survey found that roughly 13 percent of applicants for comprehensive, individually purchased health insurance who went through the medical underwriting in 2004 were denied coverage. Declination rates increased significantly with age, rising from 5 percent for individuals 18 and under to just under a third for individuals aged 60 to64. Among those who were offered coverage, the study found that 76% received offers at standard premium rates, and 22% were offered higher rates. On the other side, applicants can get discounts if they do not smoke and are healthy.

Moral hazard

Moral hazard occurs when an insured or a consumer for that matter enters into a contract under symmetric information, but one party takes action, which is not covered in the contract, which changes the value of the insurance. A common example of moral hazard is third-party payment – when the parties involved in making a decision are not responsible for bearing costs arising

from the decision. An example is where doctors and insured patients agree to extra tests which may or may not be necessary. Doctors benefit by avoiding possible malpractice suits, and patients benefit by the insurance company, which may have had little say in the decision. Co-payments, deductibles, and less generous insurance for services with more elastic demand attempt to combat moral hazard, as they hold the consumer responsible.

Other problems

A recent study by Price Waterhouse Coopers examining the drivers of rising health care costs in the US pointed to increased utilization created by increased consumer demand, new treatments, and more intensive diagnostic testing, as the most significant driver. People in developed countries are living longer. The population of those countries is aging, and a larger group of senior citizens requires more intensive medical care than a young healthier population. Advances in medicine and medical technology can also increase the cost of medical treatment. Lifestyle-related factors can increase utilization and therefore insurance prices, such as: increases in obesity caused by insufficient exercise and unhealthy food choices; excessive alcohol use, smoking, and use of street drugs. Other factors noted by the PWC study included the movement to broader-access plans, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private payers.

The build-up to the implementation

Ghana, like any other developing African nation has been grappling with some fairly chequered health delivery system ever since the cost sharing

policy was adopted in the 1970s. Given the situation that prevailed then, one sees a justification of such an adoption of the policy. This consequently culminated into the charging of user fees for health services in the face of stagnating economy and their associated budgetary constraints as increasing gaps between supply and demand for basic social services that have been characteristic of African countries since the 1970s (Russell,1996).

The generally shattered African economies brought about acute budgetary constraints. Many countries including Ghana were forced into the cost sharing concept not only in the health sector but in many other walks of life. This had the benefit of enjoying some foreign support as it emanated from the Bamako (Mali) initiative adopted by WHO in the 37th regional committee session in 1987. This was in recognition of the financial inability of many African states to guarantee a minimum level of health care for their populations. This was endorsed by UNICEF. International forces that were brought to bear on the countries in question influenced the adoption of such a user fee policy. In 1998, the Alma-Ata declaration of health for all by the year 2000 and the Dakar consensus forced the international communities to set goals and targets that ultimately met the challenges of improving the lives of women and children as a vulnerable class of the society. This brought about expanded immunization programmes in many developing countries including Ghana. It thus served as a guiding principle for many developing countries, making them vote more money for maternal and child care with the immediate results being a fall in maternal and child death rate, African population studies (2004). Consequent upon the adoption of the user fee policy various effects were realized in various countries

Comparison of health practices elsewhere in Africa

The findings of research done in some developing African nations which had implemented the user fee policy indicated varying consequences. In Mali (Uadibert & Mathonnat, 2000) and the Niger (Chawla & Pellis, 2000) the availability of the drugs led to an improvement in health services. For some of the countries as in Tanzania (Tibandebage & Mackintosh, 2001), in Ghana (Waddington & Enyinayew, 1989-1990) as well as (Gilson and Mills 1995), in Zimbabwe (Dlodio,1995) and in several countries, the trend showed that the financial access of the poor to the health services dwindled though a lot of revenue was generated. Strange though this appeared to be, Ghana, as many other countries was forced to consider policies that exempted the poor. This had the effect of minimizing the reduced access of the poor to health facilities while maintaining equity loss as well. This ushered in the provisions known as Social Dimensions of Adjustments (SDA) and the Structural Adjustment Policies (SAPs). The introduction of the latter brought in its wake the 'new poor', the victims of the SDA. In Ghana, the health sector has had to under go many reforms as seen by Agyepong in his work (Agyepong, 1999).

Since 1990 as a medium term health strategy 1996-2000, it sought to improve access to health services, quality health care, efficiency of delivery and strengthening links with other sectors like ministry of Agriculture and Education which have health components in their activities. Hence the introduction of the user fees as part of a broad set of public sector reforms and initiatives otherwise known as the 'New Public Management'. This included other policies as decentralization of the health sector, introduction of autonomous hospital boards and deregulation, and enablement and regulation

of the private sector. All these were especially aimed at attaining a sustainable financing of health services, quality improvement and equity in terms of health care and its access (Russell, 1996).

The Zimbabwean experience

To bring the Zimbabwean experience into the scene, one sees a similar trend. In that country at about the same time as worsening health situation in Ghana, Dlodlo did a piece of work (Dlodlo,1995) which also suggested that the poor were resentful about the user fee policy especially as it did not result in any improved health care. In Zimbabwe it rather resulted in the non-poor reaping the benefit of increased drug availability. To this effect Nyonator and Kuntzin (1999) in a study they did in the Volta region suggested that there had been the unpleasant perpetration of what they called “sustainable inequality” with fees enabling service to continue while concurrently preventing the poor from using such facilities. The comparison appeared to suggest that among the developing African countries exemption was simply not workable.

The Israeli experience

This has been called to play here to draw experience and inspiration from one of the world’s healthiest nations to learn the first steps in the move towards increasing life expectancy. Reporting under the heading,’ Public health in Israel’, Israel’s foreign ministry wrote in August 2002 thus ‘Israel has been a pioneer in the contemporary concept and practice of Public Health and as a result has one of the world’s healthiest populations. The country's success in pursuing effective Public Health policies is reflected in the fact that

a nation of immigrants, who have arrived during the past 54 years principally from North Africa, the former Soviet entrances in the world. This has been accomplished despite the fact that Israel has absorbed Holocaust survivors and a large proportion of immigrants suffering from tuberculosis, malnutrition, heart disease and every type of cancer. At present, 25% of all cancer patients in Israel are newcomers from the former Soviet Union including tens of thousands from parts of the Ukraine and Belorussia who were exposed to radiation from the Chernobyl nuclear plant melt-down in 1987.

High average life expectances

According to the Ministry of Health yearbook for 2001, the life expectancy of 76.6 years was topped only in Japan. Israeli women live longer than men, but do not fair as well in international statistical comparisons.

Despite Israel's commitment to providing health services for all of its citizens, by the early 90's some six percent of Israelis were not insured through one of the four existing health funds - Kupat Holim Clalit, Maccabi, Me'uhedet and Le'umit. In 1994, the National Health Insurance Law was enacted and it was implemented the following year, rectifying this situation. Since then, all citizens have their health insurance paid by a tax on income (up to 4.8% while their employer's portion is collected by the National Insurance Institute and passed on to the health insurance fund of the individual's choice

Israel's national expenditure on health is typical for a western country. In 1999, the country spent 8.3% of its Gross Domestic Product (GDP) on health, down from a peak of 8.8% in 1994; the United States spent13.6% of its GDP on health care, Canada 9.5%, Japan 6.9% and the UK 7.6%. Of the Israeli expenditure, 41% was for hospitals and research, 39% for public clinics

and preventive medicine and 9% for dental care. Israel spent $1,555 per capita on medicine.

University research results are put into practice by the public health system, while the Israel Council for Public Health runs campaigns to raise public awareness of relevant issues. In addition to increasing longevity and reducing infant mortality, Israel has completely eradicated a range of diseases, such as malaria, polio and diphtheria, which had plagued the country in its formative years. Other diseases such as tuberculosis have been virtually eliminated but sporadically reappear brought in by waves of new immigrants (http/www.google health insurance in Israel.

Health insurance in Canada

Most health insurance in Canada is administered by each province, under the Canada Health act, which requires all people to have free access to basic health services, collectively, the public provincial health insurance systems in Canada are frequently referred to as Medicare. Private health insurance is allowed, but the provincial governments allow it only for services that the public health plans do not cover; for example, semi-private or private rooms in hospitals and prescription drug plans. Canadians are free to use private insurance for elective medical services such as laser vision correction surgery, cosmetic surgery, and other non-basic medical procedures. Some 65% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers. Private-sector services not paid for by the government account for nearly 30 percent of what could constitute an infringement of the right to life and security if there were long

wait times for treatment. Certain other provinces have legislation which financially discourages but does not forbid private health insurance in area covered total health care spending (http//www.google.healthinsurace in Canada). These and several other examples of flourishing health covers in the world would seem to give support and impetus to the drive for a vibrant health insurance cover.

Rethinking of the Ghanaian health policy

There was the need the pause for a while to compare the Ghanaian situation to those of other countries not only to have an idea of where we were but also to see how ours could be fashioned along such lines. It became necessary to examine the Ghanaian past experience further with the view to unearthing any loophole that may have been overlooked.

The failure of the exemption provision could be attributed to a number of reasons including;

- The absence of specification of the criteria of the poor.
- The attitude of the health workers towards the beneficiaries of the exemption was poor.
- Those who qualified for the exemption appeared to be too many.
- The government's reduced allocation for the health sector had the effect of making the health managers over emphasize the revenue collection aspect of the policy.
- The policy in itself lacked a proper monitoring mechanism.

The sum effect of the multiplicity of debilitative factors resulted in a drastic reduction in the numbers that used government health facilities with its attendant consequences of higher death rates running through the different age groupings. The moment was rife to rethink the policy on which the cash and carry system.

The yawning gap between the southern and the northern parts of the country also had a telling effect on the system. The poverty index was quite high all over the country but was much higher in the three northern regions and in the central region than the average of the other regions. This reflected in the great disproportion in the socio-economic development and the marked differences in the distribution of disease burden among the regions in Ghana. Independent work has established that the disease burden was more pronounced in the poor communities' .According to the 1998/99 demographic survey of the country, the figures quoted put the poverty indices at 5% for the Greater Accra region rising steadily up to 88% in the upper West and East regions. The survey further indicated that between 1991 through to1999 the prevalence rates were declining in the south regions but indicated only a slight drop as far as the north was concerned. The survey further indicated that the figures were higher in the rural than in urban areas.

This in turn found expression in the mortality rates in the under five year olds .It showed a lower rate for the southern sector then for the northern sector and it rose steadily from the rich urban centres to great heights in the poorest communities in the rural areas. This therefore established a firm relationship between disease and poverty and eventually death rates. The poor, by their conditions of living are more prone to diseases and therefore carry a

bigger disease burden. In much the same way malnutrition figures showed a similar trend raging from 11% in the greater Accra region to an average of 40% in the northern regions. The user fees therefore served to push the vulnerable (the poor) even deeper in the doldrums suggesting that a health policy that denies the poor access to health services will worsen the health status of a nation.

In the 2000-2004 poverty reduction strategy (PRS) in Ghana emphasis were placed on equity health care with special focus on reducing geographical disparities and addressing diseases like malaria, guinea worm and other health conditions malnutrition all of which affect the poor quite adversely .(In the republic of Ghana,2002). On the basis of this the three northern regions together with the central region were earmarked for a very special attention in the PRS. The government paper further recommended waivers for all mothers, under five year old children and the aged above 75 years. This was aimed at lowering the impact of the reduced access of mothers, children and the aged to government health facilities in line with the Dakar consensus.

This proved difficult for the government to cater for considering the large number of people in the exemption class. The exemption itself had the problem of exclusion and inclusion. Inclusion here refers to those who could afford but still countered themselves in the exemption class and the exclusion refers to counting the genuinely needy people out of the exemption net. In the ensuring years the standard of health care provision fell drastically. There was acute shortage of drugs in all public health facilities. Most importantly the introduction of the user-fee policy resulted in the first observed decline in the utilization of health services in the country These factors and similar ones

agitated the minds of policy makers to change for a policy that could be more friendly to the poor. Perhaps when Ghana opted to adapt the HIPC status it was indicating its readiness to have a structural change that could hold supreme the fact that ill health is both a cause and consequence of poverty.

This gave a clear direction to the debate as to whether to adapt an affordable health insurance scheme or not. Taking cue from various countries which had treaded that path with remarkable success like Sri Lanka, Ghana accepted the challenge to introduce a flexible insurance scheme. This came as a result of several health surveys, public debates and high powered consultations. Since the adoption of the HIPIC the health policy has rather changed drastically. The government of Ghana has been making strenuous efforts to introduce new health policy in the country that can make quality health care more available to the general citizenry (Here, lots of commendations are due the sector minister's untiring efforts) Encouraged by some external powers of good will the Ghana government's efforts resulted into some pilot programmes in ten selected districts in the country. The results of the pilot programmes paved the way for the announcement by the finance minister in 2002, government's intention to start an affordable health insurance scheme. This had to undergo a little debating in parliament bringing about a few amendments and/or modifications in the policy. Then finally, the national health insurance bill was passed in March 2004 as contained in the (Unlik Fm radio station news on March 18, 2004 at 6 pm).

The underlying policy of Ghana National Health Insurance Scheme

The design of the health insurance in Ghana has been described as being a fusion of the concepts of social health insurance and mutual health organisation. It is based on a district-wide mutual health Organisation (MHO) approach. The district-wide MHOs will provide cover for both the formal and non- formal sectors and the scheme will be a multiple-not –for-profit scheme to community level and the non-formal occupational group MHOs will be encouraged and supported to collect premiums from the non-formal sector into the district –wide MHOs. There will be a single system at the national level to collect the formal sector premiums. To ensure cross subsidisation and risk equalization, a formula is being developed and used to allocate the centralised funds to the district-wide MHOs.

The bill only operates with the two types of health insurance schemes; the district-wide MHOs and private health insurance which are further classified into private commercial health insurance schemes and private mutual health insurance schemes.

The policy stemmed from a more general move to reduce poverty through the Ghana Poverty Reduction Strategy (GPRS) a major component of the GPRS was to provide and deliver accessible and affordable health care to all the citizenry in Ghana. Special concern was for the poor and vulnerable who qualified under previous policies for exemptions. This had to be properly planned especially taking into consideration the transition of the famous cash and carry systems which recorded a rock bottom numbers of health facility users.

It is primarily poverty Reduction Strategy with its emphasis on the accessibility and affordability. Before its introduction 80% of health budget in the public sector was realised through tax revenue and donor funds and 20% from internally generated funds through the cash-and-carry systems. The aim among other things is to enable Government achieve its health goals as enshrined in the millennium goals and by the UN standards good health is inextricably webbed up with all of them. Their brief forms include the following as carried by Aduamah, (2007) Towards the millennium goals (2000-2015) in Ghanaian Times of Monday 19 of November 2007 and further discussed by the same author in Aduamah, (2007) Myths, super myths and the millennium goals in Ghanaian Times of Friday 30 of November 2007.

Millennium Goal I, To eradicate the extreme case of poverty by the year 2015 with the target being to reduce by half the total number of those who live on less than 1 dollar per day by the year 2015. To be able to attain this health status of the Ghanaian should be raised considerably.

Millennium Goal II, Goal is to achieve universal primary education. The target is to get all children to complete a course of basic education by the end of the period but this high target is not likely to be met. Records at hand are indicative of very low performance in this area. A good performance of the national insurance scheme is very likely reverse the not too pleasant trend.

Millennium Goal III, Promoting gender equality and woman empowerment. Target is to eliminate gender d, Disparity in primary and secondary education no later than 2015.

Millennium Goal IV, Reduce child mortality with the target being to reduce the less than five mortality rate by two-thirds between 1990 and 2005.

Millennium Goal V, Improve maternal health and the target is to reduce the maternal death rate by tree-quarters between 1990 and 2015.For this to be achieved a very vibrant health insurance scheme is required to do the drastic transformation of both habit and thinking and the exemption is very called for.

Millennium Goal VI, Combat HIV/AIDS, malaria and other diseases. The target set was to have halted and begun to reverse the spread of HIV/AIDS by the target year of 2015.Though this target looks gloomy a functioning health insurance is capable of turning things around as expected.

Millennium Goal VII, Ensure environmental sustainability. The target borders on halving, by 2015 the proportion of the population without access to good drinking water and basic sanitation. The essential requirements in this sector if attained will rather put less train on the health insurance budget.

Millennium Goal VIII, Ensure Sufficient international linkages for trade and cooperation.

Targets and goals

The ultimate intention of government is to replace the out of pocket payments by providing an alternative package of health care which is affordable to all irrespective of the individual's social or financial state. Provision is made for every body in the scheme the rich or well-to-do paying something slightly higher to subsidize for the poor and disabled. Membership is optional. The target is that within five years after its inception every citizen in Ghana shall belong to one or the other health insurance scheme covering him or her against the effect of the harsh cash- and- carry system. It therefore means that various bodies concerned will create the necessary awareness and

convenience for everybody to belong to one scheme or the other in order that the government's vision of providing equitable universal health services becomes a reality. The health insurance scheme is made affordable to all. The benefit package is protection against a wide range of common tropical diseases.

Modus operandi of The Ghana National Health Insurance Scheme

Unique as the scheme is expected to be it has structures which fall in pattern more than 287 other schemes reported to be in operation throughout the world .It is basically an insurance scheme in which the individuals have to commit themselves to periodical payments of money (premium) to a centrally controlled agency which has designed a disbursement scheme made up of protection against a set of selected diseases and medical services. The amount the individual pays varies according to age and financial status but the benefit package is uniform for all.

It requires that every person above the age of 18 pays a minimum of 72 thousand cedis for the non formal sector and for those in the formal sector, an amount equivalent to 2 and a half % of one's 17 and a half % of the SSNIT contribution has been set aside for kick- starting the scheme. A fully paid up member and all his or her children aged up to 17years get the chance of enjoying the minimum benefit package of protection that has been designed. This really suggests that all children from 0-17years are covered by either of his/her fully registered parent. The aged above 72 years of age are covered and qualify for the minimum package of protection. Indigents and other categories of persons as specified by law Funds from the central from central source shall

be allocated to each district to make outright payment of contributions into the DMHIS on behalf of such persons. Health insurance regulations respectively shall be exempted from contributions. This exemption clause for the aged has been well specified this time round with such beneficiaries being identified by the local agents. To start enjoying the benefits, one as well as the children would have gone through the registration process. The scheme provides for the existence of two or more types of schemes in operation; the social type and the made up of the district mutual health insurance scheme and the private mutual health insurance scheme. Since it is a strategy for delivering the poor and the vulnerable fraction of the society, the government has undertaken to support the development of the district mutual insurance scheme by fusing the two concepts; the traditional social health insurance scheme for the formal sector workers, and the traditional mutual health insurance schemes for the informal sector. This suggests that in the district mutual health insurance scheme there will be have 2 types of membership; the formal workers and the informal type of workers.

Contribution levels will be made to reflect the general socio-economic stratification. On the basis of this the contributing members have been put into 6 categories as listed below:

- The core poor,
- The very poor,
- The poor,
- The middle income group,
- The rich and

- The very poor.

An individual in the formal sector has to contribute 2 and a half % of his 17 and a half % of the SSNIT contribution while an individual in the informal sector contributes 72 thousand cedes annually. Room has been made for cross-subsidization mechanism with the rich subsidising for the poor, the healthy for the sick and their children and the rich urban dwellers for the poor rural folk who can afford only a little.

Benefit package

The district mutual health insurance council has defined the minimum benefit package of health services to be provided by all the various types of schemes. This has been made quite flexible and a compromise between what one's health needs are and what can be realistically provided under our peculiar circumstances taking into consideration the total amount contributed and its sustainability. Such realistic needs are to subjected to the economic constraints with limitations placed on what can be practically provided. It is however subject to periodic review by the council .The factors that can influence the nature of the package will include the following;

- The health needs of the people (morbidity pattern can show this)
- Service available at the various level of care
- Service affordable
- Existing infrastructure
- Quality care
- Availability of finance

- Cost of health care

The package has been designed so as to make room for the every person and ensure its sustainability. The main focus is to ensure that people are well covered at least for 80% of all diseases make up of the 10 most frequently accruing diseases. Each district can absorb a little more according to what their coffer can support.

Sources of funding

Funding the scheme is done mainly with funds from contributions of members. Right from the onset three sources of continual type of funding were earmarked to form a buffering pool for the scheme. Viz, the two and half percent of the VAT money, another two and a half percent SSNIT contribution by every SSNIT contributor as well as the premium accruing from private participation. The sum accruing from these three sources would serve as a solid base for the smooth takeoff of the scheme. Apart from payment of contributions, a national health insurance fund shall be created at the central level to play a reinsurance role especially for catastrophic events equalize the varying risk levels of disease that exist from one geographical area to another and to make outright contribution on behalf of the core poor and vulnerable groups. The council will monitor and evaluate the operations of all health insurance schemes in the country. They will also insure that the efforts of the scheme are properly coordinated to bring about ultimate realization of the policy goals of the government. A risk-equalization formula will be developed to allocate central funds to the scheme in order to subsidize the contribution

levels of the poor and vulnerable groups. The entire DMHIS scheme will have to meet the following conditions.

- Cover the poor and vulnerable
- Public accountability to their members
- Transparency in their financial dealings
- Regular annual external audit of all their financial transactions to verify that standard financial management procedures are followed

A report given by executive secretary of National Health Insurance Council (NHIC), Mr. Ras Mensah "Over 3 million people can not get their NHIS registration cards (story by Lucy Adoma Yeboah) as at Feb 8 2007, two and half years after official take off the scheme". The story continues to suggest a number of reasons for this lapse and to prescribe remedial steps to avert any further anomalies. The figures are shown in Appendix 1.

CHAPTER THREE

METHODOLOGY

Introduction

The field survey for valuable information has been done in the form of questionnaires administration with a little supplementary data coming from interviews with some particularly and specially selected individuals from the target population. Some secondary data coming from the records of the relevant ministries have been used in this study.

Study design

The work has adopted the non-intervention type of research considering the nature of the questions posed by the study. A descriptive look has been adopted. Since findings found herewith have been generated by the analysis of this piece of investigation, the research is deemed to be cross–sectional. The work has among other things considered the effects of the extent of publicity, income levels, the level of lack of information, the quality of the health package, the ease of acquiring the membership card, in coming out with the concrete suggestions as to its acceptability or otherwise as an alternative health insurance for this nation and at this stage of its development.

Study population

The study population appears to have been put into non overlapping communities.viz;

- Choggo Hill Top Township,
- Choggo Nmanaayili community,
- Choggo- Yepalsi and Filling point environs,
- The Post Secondary Training Colleges,
- The Tamale Senior High community,
- Choggo low-cost bungalows and Fulera Maternity community,
- The school quarters dwellers of the teachers' bungalows of the Education ridge,
- The Polytechnic community including the
- The residents of the Agricultural officers,
- Dwellers of the Gbolo Kpalsi and Wurishe new settlements.

Separate interviews have been conducted with the members of the following communities some of whom have been purposely sampled to include;

- Representative from the metropolitan GNHIS registration office to provide on the ground reports on the situation.
- Representation from the MOH to assess the extent of collaboration and the degree of coordination and cooperation between the two health institutions.

- Representation from the Metropolitan assembly from whom we could be guarded along the major policy implications binding the Health sector
- Representation from the traditional rulers who was expected to examine the implication of the health practice and traditional governance
- One adult male and one adult female who have ever benefited from the scheme to share their experience and impressions with the whole group,
- One adult male an adult female, who have not yet registered to be members of the scheme to help establish the reasons for their refusal or reluctance to register or any other directly or remotely related reason/s.

Sampling procedure

Proportional representation of the various sections of the population to a total sample size has been worked out as outlined. The sample frame has been drawn taking into account the various shades of opinions that could emanate from the floor. Since each area may present its own peculiar situation it calls for a special effort to capture those differences. Once the various proportions have been established and the sample frame developed the method of simple random sampling was used to select the individuals to constitute the sample to which the instrument of research was administered. An 8-member team made up of members purposively sampled from the population

constituted the discussion group that was engaged on the focus group discussion.

There was a bit of difficulty identify the difference between the boundaries of Choggo as a traditional division. The researcher under such conditions of ambiguity has had to settle for the mapping out done by the management of NHIS for the purpose of identification. In the domain, choggo zone has been calved out to include, Choggo Hill-Top, Choggo-Nmanaayii, the whole of the Education Ridge community, engulfing Wurishe, Gibolo-Kpalsi the Filling-Point and Yepalsi evirons. The population figures for the described areas were looked out in the Ghana Population and Housing Census, 2000 supplied by the Statistical Service in Tamale. Their respective populations were summed up to 25850 individuals. This figure had to be projected to 2009 working with the national population growth rate of 2.4% Rigorous calculation done on the quoted figure brought the projected population to 32000

$$25850 \times (1 + 2.4/100)^{9}$$

$$25850 \times (1.024)^{9}$$

$$32{,}000$$

This projected figure was worked with to get a fairly reasonable sample size. Working with 90% confidence estimated sample size is

$$n = \frac{N}{1 + e^{2} N}$$

$$= \frac{32{,}000}{48}$$

$$1 + 0.1^{2} \times 32,000$$

$$= \quad 99.99$$

$$= \quad \underline{100}$$

A total number of 100 questionnaires were made and to a fairly large extent distributed in the study area according to the numbers proportionally allotted to the following listed strata. A simple mathematical relationship was worked out for the various portions of the population as follows.

Choggo –HillTop = (4480/32000) =	14 similarly
Nmanaayili = (3840/32000) x 100 =	12
Filling-Point = (3200/32000) x 100 =	10
Tamasco Community= (2240/32000) x100 =	7
Tatco Community =(192/32000)x100 =	6
Bagabga Training College = (2240/32000)x 100 =	7
Tamale Polytechnic = (3840/32000) x 100 =	12
Wurishe = (4160/32000) x 100 =	13
Gbolo-Kpatsi (2560/32000) x100 =	8
Yepalsi (3200/32000) x 100 =	10

The survey exercise was carried out in this suburb of Tamale in late May into early June 2009 within a period spanning two weeks. The recovery rate was fairly low yielding only 83% recovery. The reasons or possible causes for this type of recovery are not far- fetched. Research assistants who were trained and used were mainly the researcher's students who had a very few selected times of getting to the field, to the communities for that matter. At areas where agents had difficulty getting access to, they relied on

representatives and / or friends over whom they had very little control if any at all.

The retrieved questionnaires were gathered and sorted out. They were further coded and finally keyed into the computer to be further processed with the help of the SPSS 16 statistical software package.

Data entry techniques

The data analysed was mainly the primary type from the administration of the instrument of research which in this exercise of mine was the filling of questionnaires together with the results of the interviews granted to some carefully selected individuals. These were analysed alongside some relevant secondary data that came in handy from records from the offices of the Metropolitan National health Insurance scheme. Occasionally, some very relevant data was picked from the public news papers like the daily Graphic, radio stations like GBC1, the national Television channels and the Internet media as well.

Administration of the instrument

The questionnaires were pre-tested to find if they were potent instruments to illicit the relevant data for the study. A few hard working research assistants were given some brief but effective orientation on the mode of administration of the instrument before they embarked upon the exercise. With the help of the assembly-man of the Choggo electoral area interviews with certain personalities within the communities were conducted.

Data analysis

All the kinds of data, the secondary as well as the primary, were analysed. SPSS16 was used to analyse the data from the issue of questionnaire where comparative statistical schemes were used to do the relative deductions. The Chi-Square, Pearson's relatedness tests were carried out to draw the necessary conclusions and subsequent recommendations. As regards the effectiveness and/or influence based outcomes, the regression tests proved quite handy. Generalizations were inferred by having a close scrutiny at the ANOVA of the various tests.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter seeks to use some mathematical concepts to process the data so far obtained to see how they could either directly or deductively lead the researcher to find some answers to some questions posed by this study. In many of the issues that we encounter in this exercise, some rather deductive methods may be resorted to. This part of the study has been treated under the following headings.

The Characteristics of Respondents, Rate of Registration, Answering research questions I and II on The level of Acceptability and Factors influencing the rate of registration, Testing Hypothesis I and II on Income level/level of Education and Relief, Views of respondents on serious problems facing the scheme, Quality of Service of the scheme, The administrative set-up of the scheme and a brief picture of what respondents recommend for the scheme.

Characteristics of respondents

The researcher did not particularly indicate that teenage and orphans should be left out but by some sheer coincidence this category of people were left out. Whereas it is true that no teenagers endeavoured to register for him or her self, it might not be same in the case of age group 60 and beyond. Quite a

sizeable number of this class of people are complacent in that late stage of their development and would go ahead and register outright.

By sex, the same reason could be assigned. Through the random selection a smaller number of female respondents were obtained 30:70 This is to be expected because in all the homes it worked out that the females were more occupied with household chores at the hours of visits. The sample was however skewed towards the working class. This is to be expected since the registrations were/are being done by the bread winners.

As to the distribution into dependents through to heads, it is clear that many more people who helped in filling the questionnaires were from the working class and mainly heads of households.

Another striking feature about the composition of respondents was the literacy aspect. There were only a few of the respondents (0.37%) who indicated that they could neither read nor write. It is striking because it does not reflect the national or regional illiteracy rate. The possible reason for this observation stems from the fact that the GNHIS zone under consideration engulfs the whole of the education ridge where there is a much above average literacy rate. This area has a great cluster of schools ranging from day-nurseries through Junior and Senior High schools to colleges and the Polytechnic. This zone is a quite vast one and most of the inhabitants have had some form of formal education. As expected, not a single member of this suburb indicated his or her belongingness to the illiterate class thereby making the literacy rate high. A remarkable observation is the very small number of the above sixty-year-olds. It is partly because in the education Ridge there are many people who are in the active working life. The effect of this drop in the

figures of the aged and/or the exempt is to cause a slight departure from the general registration pattern.

Table 1: Distribution of age groups of respondents

Age Range	Frequency	Percent
>20	3	3.7
20-29	36	43.2
30-39	14	19.8
40-49	8	9.9
50-59	17	19.8
60+	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

A run of frequencies, a statistical operation designed to study the distribution of the population with respect to the, questions posed yielded the following tables.

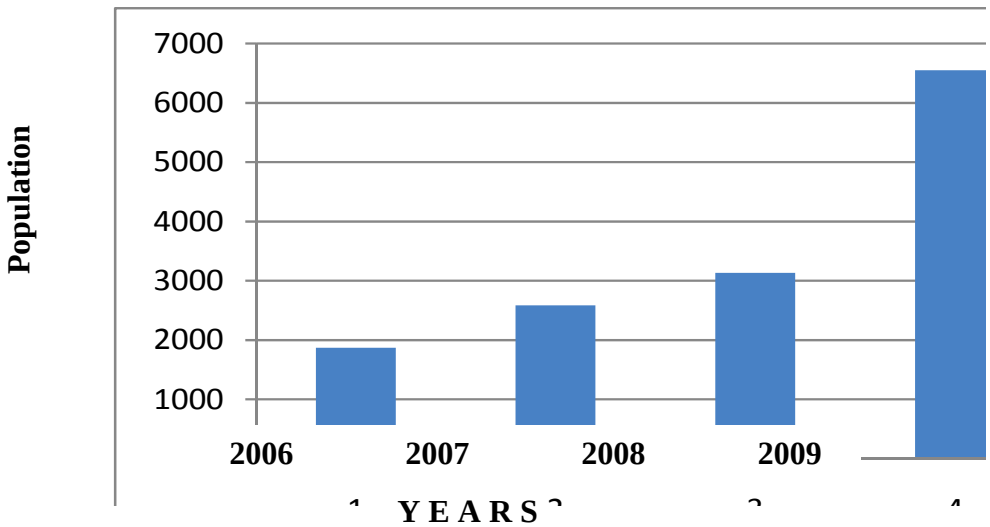

Figure 1: Yearly registration figures in Choggo from 2006-2009

Source: NHIS Tamale Metro, 2009

As can be seen in Figure1, there has been a steady rise in registration since 2006 with the figure for 2009 falling out of pattern. This is to be expected because as people begin to enjoy the benefits of the belongingness, there is bound to be desire to register to the scheme.

Table 2: Duration of registration of respondents

Status of registration	Frequency	Percent
Yet to get	18	22.2
Not up to a year	3	3.7
Over a year now	21	25.9
Over 2yrs	39	48.1
Total	81	100.0

Source: Field data, 2009

The percentage registration figures were obtained from the metropolitan health insurance office in Tamale and as at the time that this survey was being conducted, it stood at 72.22% with the unprojected population quotations from the 2000 population and housing census but at 58.3% when the populations are projected by a factor of 2.4% (UN estimate of the growth rate for Ghana). From the table of frequencies obtained herein, the percentage registration can be inferred thus;

Item Q3 from section B of the questionnaire elicits information which can be used to get a very direct idea about the percentage registration so far. From the frequency table only 22.2% are yet to be get registered as found by the survey. This does suggest that the percentage registration stands at 100 - 22.2 = 77.8%.The disparity between these two figures one from records of the

GNHIS and the other from the survey with projected population appear to have some discrepancy but is to be understood in the context of the timing and the location. The Choggo community is one which engulfs whole of the education ridge a great fraction of are literates and placed in society by the existing standards of living in Tamale for that matter. It has been established here that higher the level of education the better a person is poised to registering. Since this section of the northern region has such a dense population of literates it goes to offer some fairly reasonable explanation for the difference in the figures. The regional figure does include those in the hinterlands where the affordability as well as appreciation are so far on low ebb.

Level of acceptability of the GNHIS among the people of Choggo

This is to be dealt with by seeking an answer to the research question. Efforts were made to discover whether the scheme in operation so far has been acceptable by the Choggo populace as a alternative health insurance or not. People would accept something which has been proven to be a good replacement of the existing system. Attempts have therefore been made to find out whether beneficiaries found the system effective or otherwise. Quite a great majority of respondents sided with the assertion that access to health facilities was quite effective and indicated their acceptance of the scheme as a better health delivery.

Table 3: Distribution of the reasons for the individual's inability to register for The Ghana Health Insurance Scheme

Registration Status	Frequency	Percent
Yet to appreciate it	17	21
Premium too high	21	25.9
Its cumbersome	38	46.9
It takes too long	2	2.5
Not aware early	2	2.5
Missing system	1	1.2
Total	80	100.0

Source: Fieldwork, 2009

The rate of registration and the registration procedure

In trying to answer the question 'Is the percentage registration so far a function of the registration procedure?' the following approximations had to be made. In the tool to elicit the necessary data Q5 seeks to know from respondents as to why they or any other person are not yet registered with the GNHIS. Among the options included some items that boardered on the cost of the premium and the complexity of the process of registration. The total numbers of respondents in either of these options were added together and the frequency test conducted. The combined factor now called registration difficulty occupies the largest bars in the bar chart as shown below. There were only 2% of the respondents admitting to the fact that they had not heard of the scheme early enough. Another 17% were yet to appreciate the benefits associated with the scheme. Those who contended that their failure to get

registered so was due to the high premium demanded of them were 21% 1.0.

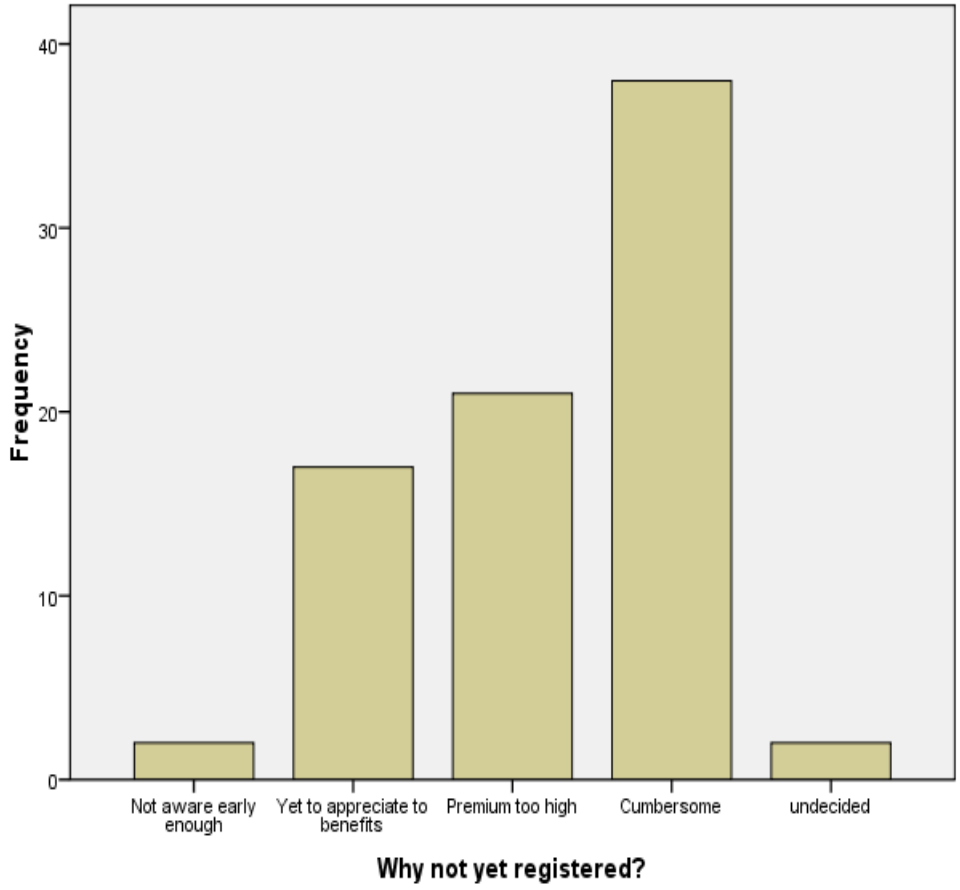

Figure 2: Reasons for not registering

Source: Fieldwork, 2009

The largest group was those who insisted that the cumbersome nature of the registration process was responsible for their inability to get registered so far. Since the high premium rate and the cumbersome registration process are both factors bordering on the registration procedure, the two factors when combined yielded a third factor, registration difficulty and this alone is occupied by 21+38 =59%. This suggests that in 59 out of 80 respondents we can expect the general public blaming their inability to be full beneficiaries of

the scheme on various registration related issues. The answer to the question becomes glaring if proportions are called to play here.

The relationship between the individual's income level/academic qualification and the willingness to acquire the membership card of the Ghana national Health Insurance Scheme

H_1: There is a significant relationship between a person's income level and his/her willingness to acquire the GNHIS membership card.

In the survey a lot of care was taken to avoid asking people about their salary levels. A very close, almost equivalent factor was found in the variable that boarded on the individual's highest academic level.

Almost invariably in Ghana, with the exception of a few artisans and self-styled businessmen, a person's highest academic level determines the kind of position and income level given him. This in turn gives an idea about a person's readiness to register to be a member of the GNHIS. A person's highest level of education contains six graded levels of responses.

Such a variable, 'the highest educational levels', is regressed with the variable registration status which also goes with 4 graded responses. This in turn is a direct reflection of the individual's readiness to register. The outcome of the regression operation is shown in Appendix 2, Appendix 3, Appendix 4, and Appendix 5.

As can be read off from the ANOVA in appendix 4 registration status= 1.709 x 0.325 (Educational level) Suggesting that the education level of a person really influences the registration status, because for every unit rise in the education level the registration status increases by 0.325.units of measure.

Adjusted R square value shows that 0.094 i.e. 094 x100=9.4% This implies that up to 9.4% of the variation in the independent variable (education level) can be explained or can be accounted for by changes in the dependent variable (registration status) of the individual.

For the hypothesis, a look at the ANOVA, appendix 4 shows that the significance value is 0.003. The calculated significance value is 0.003, but 0.05 > 0.003. This suggests that we can reject the null hypotheses as insignificant and therefore state that at 95% confidence level there is a significant relationship between a person's Educational level and his/her ability to register.

Problems facing the scheme

The questionnaire item 19 was posed to illicit the respondents' views on what they thought were the biggest problems facing the GNHIS as at now or since its inception. Table 4 summarises the pattern of their responses. Thirty-two (32) representing 39.5% of the respondents, which is the biggest frequency, supported the claim that management is yet too disorganised. This could further be explained off by remembering that it is a novelty in the system which is really designed not to follow the old dogmatic channels. With time, the excitement may find expression in the form of real dedication.

Table 4: The biggest problems facing the health insurance scheme

Problems	Frequency	Percent
Management is too 'liaisez-faire'	32	39.5
There are too many exempts	6	7.4
Drugs are in frequent shortage	24	29.6
Disease range is too narrow	16	19.8
Reg. Figures are yet too low	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

Six people representing 7.4% of the respondents were of the opinion that the scheme is full of exempts. The figure though small can be a very significant. Another set of 24 respondents representing 29.6% of all respondents chose to say that the most serious problem encountered so far is in the form of shortage of the essential or selected drugs, while 16 respondents representing 19.8% were of the view that the disease coverage of the scheme was/is too narrow. There were only three (3) who represented 3.7% of respondents siding with the observation that the registration figures were yet too low. Whether this is an advantage or disadvantage to the scheme, it effectively endorsed by the fact that there are many others who have not yet been roped unto the scheme. In an earlier analysis the possible reason for such low registration figures have been considered and suggestions offered. Such suggestions amount to the assertion that registration figures so far are a function of the registration procedure which in itself may vary greatly from place to place.

In summary therefore there has not yet been a single clear problem standing out above the others therefore the bottle necks enumerated here, as representing the views of the general populace in Choggo, could possibly be holding the infantile scheme to ransom.

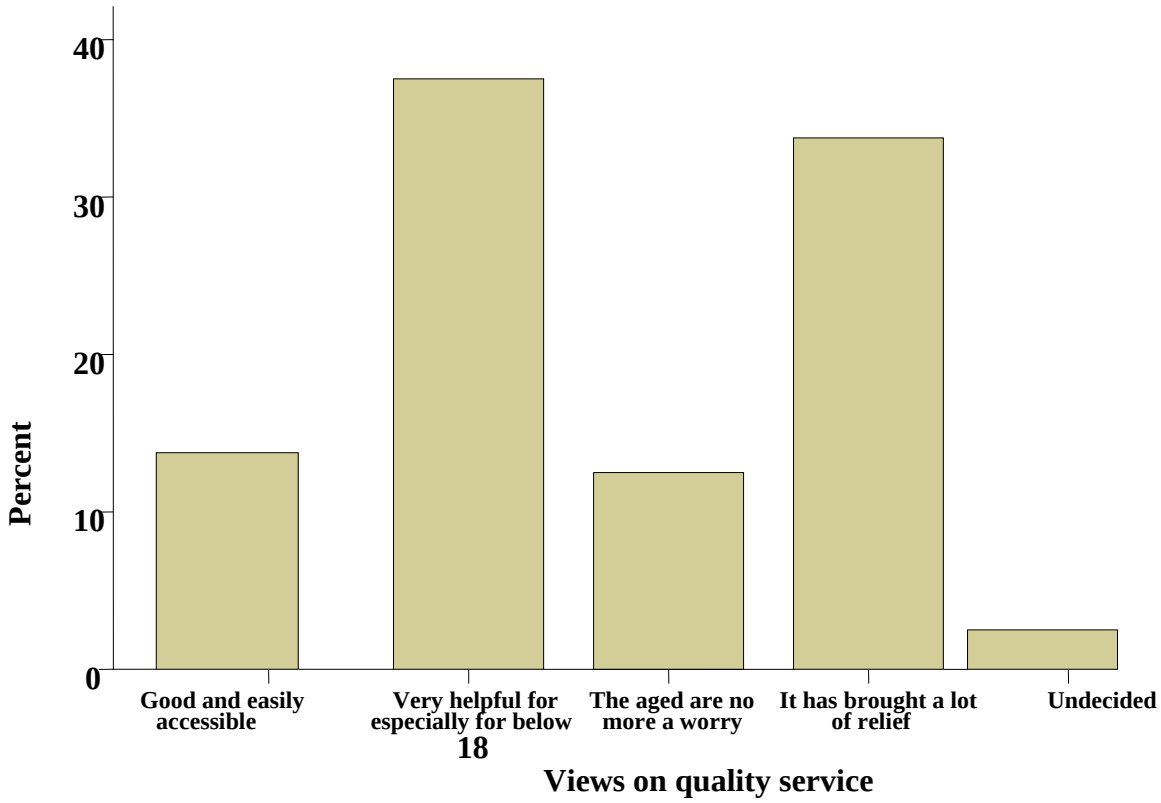

Figure 3: Views on quality service

Source: Fieldwork, 2009

Here, a similar situation was encountered with the respondents having split opinions. Those who indicated that it has brought relief to the general citizenry were equally as many as those who indicated that the scheme is very good especially for those who have dependents under 18 years of age. The

percentages were 33.3% and 37.5% respectfully. Twelve percent (12.0 %) were siding with the impression that the scheme is good and easily accessible while 11% maintained that the aged are no more a great worry. The overall impression can be projected to mean that the general citizenry in Choggo find the GNHIS quite acceptable and a good replacement of the famous cash-and carry system of health.

Table 5: Respondents' views on whether or not the workers are inexperience

Views	Frequency	Percent
Strongly disagree	6	7.4
Disagree	22	27.2
Neutral	7	8.6
Agree	27	33.3
Strongly agree	15	18.5
Sub-total	78	96.3
No Response	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

As far as the issue of the employees in the administrative set up of the metropolitan office the GNHIS is concerned 7.4% of respondents were of a strong conviction that they are not too youthful for that all too important assignment, 27.2% disagreed with this assessment, 8.6% remained neutral

33.3% agreed with that assessment while18.5% took the extreme stance that the set-up was full of people of youthful exuberance. All together 51.8% held a positive view about this assessment.

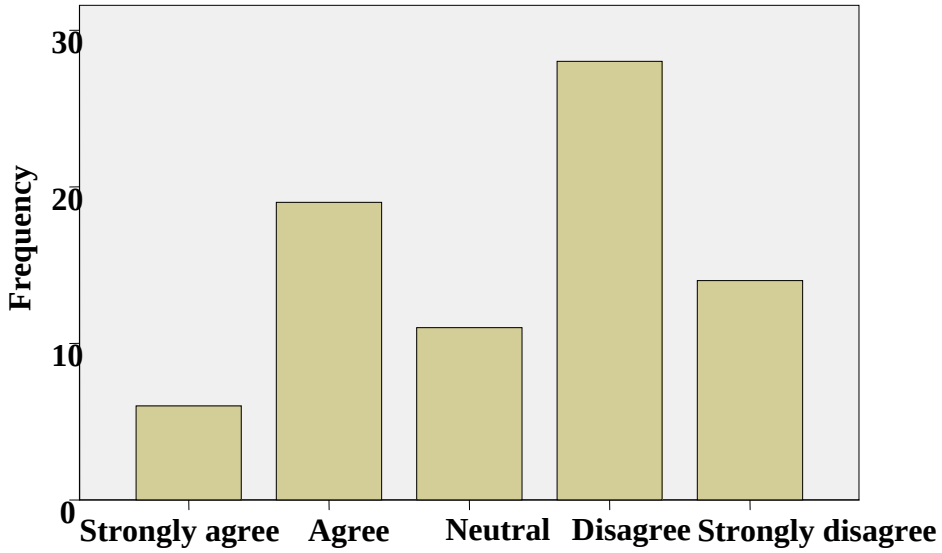

Figure 4: Views on whether or not the workers have poor qualification

Source: Fieldwork, 2009

Item numbered 15B seeks respondents impressions on the assertion that the workers of the GNHIS are not qualified enough for their job schedule. The various responses are in Figure 4. Whereas 7.4% agreed strongly with this assertion that the set-up entertains people of low academic standing, another 23.5% held a similar view but to a lesser Extent, 13.6% remained neutral, 34.6% would not buy that outright impression and 17.3 just vehemently disagreed with that conception about the GNHIS in Choggo. In all, 51.9% would not assess the scheme as entertaining personnel of poor qualification.

Table 6: Respondents' views on the assertion that there is political favouritism in the appointment of staff to the positions at the GNHIS

Responses	Frequency	Percent
Valid strongly agree	8	9.9
Agree	17	21
Neutral	10	12.3
Disagree strongly	20	24.7
Disagree	23	28.4
Sub-total	78	96.3
No response	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

Item 15C of the questionnaire was intended to collect various impressions on the claim that the employees of the GNHIS are all political favourites.

On this controversial issue there was 9.9% dismissing it strongly, 21.0% simply disagreed, 12.3% stayed on a neutral ground while 24.7% would not agree, 28.4% strongly disagreed with this political alignment overall, 53.1% did not share the view that the scheme has some political inclination in its recruitment of their work force.

Item 15D probed into to whether or not the coordination with hospital management is poor or not. The responses were as in Figure 7: The majority made up of 49.3% that is 12.3% strongly disagreeing and 37.0% simply disagreeing contend that this was not a true reflection of the situation at hand with 11.1% remaining neutral and 34.5% agreeing to the assertion.

Table 7: Respondents' views on "the poor coordination between hospital management and GNHIS staff"

Responses	Frequency	Percent
Valid strongly agree	4	4.9
Agree	24	29.6
Neutral	9	11.1
Disagree	30	37
Strongly disagree	10	12.3
Sub-total	78	96.3
Missing system	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

To the suggestion that management of the scheme required more experienced hands than we have in place now, respondents reacted in the following manner. A total of 72.9% disagreed with this notion of the infantile scheme. Of these, 30.9 simply disagreed but 402.0% registered a very strong disagreement to that suggestion. While just 6.2% appeared neutral about the suggestion, 14.3% went along with this suggestion. The generalised responses can be summarised thus.

Whereas the greater majority of the Choggo people are of the impression that the employees of the GNHIS in the Tamale metropolis are rather too youthful for their job description, they disagree with the assertion that there is poor coordination between the management of the scheme and the main Hospital administration. Item 15E was intended to illicit information on

the impression that the scheme requires more experienced workers than they have now. The responses to that have been put in Table 8.

Table 8: Responses' on the view that more experienced personnel are needed to manage the scheme Item

Impressions	Frequency	Percent
Strongly agree	11	13.6
Agree	3	3.7
Neutral	5	6.2
Disagree	25	30.9
Strongly disagree	34	42
Sub-total	78	96.3
No response	3	3.7
Total	81	100.0

Source: Fieldwork, 2009

Table 9: Respondents' views on exempting the pregnant from payments

Individual feelings	Frequency	Percent
Fair gesture	31	38.3
Too big a stress on the budget	11	13.6
Gov. should absorb the excess	20	24.7
There is no need as they all belong to the families	11	13.6
It's good so let's increase the renewal dues	7	8.6
Total	81	100.0

Source: Fieldwork, 2009

The statistics on this issue stood as follows; 38.3% of respondents contended that it was/is good or simply a fair gesture, 24.7% that it requires the government to absorb the excess bills accumulated. An equal proportion of 13.6% each of respondents shared the impression that there was no need for that level of kindness and it is too big a stress on the infantile scheme. The smallest group of respondents indicated that the scheme would have to increase the renewal fee in order that it can cope with this extra stress.

Analysis of some free style recommendations/advice by respondents

Respondents were given the chance to offer their various free unguided advice and/or recommendations (item 21) on what could help improve the system. Table 10 summarizes their concerns.

Table 10: Various recommendations made by respondents

Recommendations	Frequency	Percent
Premium to be increased	7	8.6
Permanent cards to be used	7	8.6
Prompt payments of debts	11	13.6
Maturation time decreased	15	18.5
Disease cover to be widened	4	4.9
Enough Cover drugs needed	13	16.0
Proper supervision needed	7	8.6
Competent people to be used	8	9.9
Computerized sorting of cards	3	3.7
Should be free from politics	2	2.5
sub-districts advocated	2	2.5
Sum	79	97.5
No response	2	2.5
Total	81	100.0

Source: Fieldwork, 2009

An attempt was also made at finding any correlation or otherwise between such advice and the serious problems as outlined by the same respondents. Results from the SPSS Chi-Square test (Appendix 8) could not be used to draw very concrete relationships. Appendix 8, Chi-Square test a 0 cells (0%) have expected frequencies less than 5. The minimum expected cell frequency is 7.2. b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 16.2. There cannot be any meaningful conclusion on relatedness drawn here with Chi-Square test since the minimum cell frequency is 16.2 more than 15 as in Appendix 8 on correlations.

Summary of analysis

From the study it is evident that the rate of registration into the national insurance scheme is rather slow. Though a person's highest education level does influence the registration process greatly, there are a host of other factors which also contribute quite significantly.

The effects that people put into the registration process are a clear sign that the scheme is acceptable. Everybody welcomes the idea of a health insurance scheme. Some people have done so not without some reservations. The study has also established that such a class of individuals is in a very small proportion that it might not hamper the smooth take off of the scheme. Quite a good number of respondents only believe and are hopeful that it will take care of their health needs.

There is yet another class who have endeavoured to subject the Ghanaian version of Health insurance to scrutiny especially by examining it in relationship to other vibrant schemes existing else where and are full of

admiration and suggestions as to the way forward. There are still others and by this study in the great majority, who simply admitted that the scheme was introduced timely at this stage of the country's developmental profile to bring the relief for many people.

Another thing established is that the scheme is currently beset with several teething problems. Such problems have been thought of to be many and varied but the study has failed to identify one issue standing out above the others. Though the greatest percentage of respondents sided with the point that the maturation period for the activation of the membership card is too long, nearly as big a proportion as above are of opinion that the scheme still grapples with the problem of narrow range of drug coverage. Equally close in proportion are those who have advised that the scheme should be more prompt at settling their indebtedness to drug houses in good enough time. Ranking next to this class from below are those who contend that the scheme can only strive if qualified workers are used they hold to the notion that those at post now are too useful and inexperienced.

The other classes that feature with very small proportions include those advocating for permanent cards of registration (8.6%) and those who feel that the activities at the various GNHIS centres leave much to be desired. The class sizes dwindle through 4.9 for those who feel disease coverage is too narrow down to 3.7% for those who will want the sorting system of the folders to be computerized. Those who would like the further decentralization of the sub zones are sharing similar positions with those who read a little politics into the operations of the scheme with a percentage of 2.5 a peace.

From the analysis above it can safely be concluded that the recommendations have a great relationship to the problems and also that no problem has stood out far above the rest. The recommendations have also assumed a similar pattern as the correlation can show (Appendix 9).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This segment was designed to provide a summary of the findings and based on such findings some conclusions have been arrived at. The chapter also contains some recommendations that could help solve some of the problems

Summary

The study examined the operations of the GNHIS in Choggo.The main objective was to examine the main factors confronting it. A simple random sample of one hundred respondents answered questionnaires and interviews were granted to a purposively selected group of individuals. Among such the major factors included the cumbersome registration procedure. In both the interviews and the regression analysis, many respondents held to the view that the cumbersome nature of the registration procedure did deny many people the chance of getting registered. The percentage coverage so far quoted by the offices of GNHIS is at variance with the calculated rate from the projected population. The possible reason is that Choggo as a suburb has a greater concentration of government employees than other suburbs mainly because of the inclusion of the Education ridge where there is nearly a hundred percent literacy rate. It should not be surprising that Choggo as a Suburb has a much

higher registration rate than the regionally averaged percentage registration. Though other debilitating factors exist, the issue of cumbersome registration procedure still remains a biggest issue to grapple with.

As to whether the readiness or willingness to register into the scheme was influenced by a person's academic level, or not was examined using regression analysis. The findings point to the truth of the assertion. There was quite a high correlation between the readiness to register and a person's academic qualification. The explanation should not be far-fetched. The academic higher-ups happen to be prompter at realizing the benefits that a health insurance scheme can offer them and perhaps their regular income gives them the urge to freely register. This is more so as the initial premium was deducted as source. The percentage registration for Choggo is much higher than the regional average mainly because of the higher concentration of government workers there.

The issue of quality of service was also tested. The efforts were to determine whether or not the scheme's operations so far were of quality service A great majority of respondents sided with the impression that the quality of service is very good and given time it will stand the test of time.

During the interviews some efforts were also made at discovering what ordeals that awaited the beneficiaries at the various treatment centres. At the treatment centres the problems that come up are either one and/or a combination of the following:

- Difficulty (sometimes impossibility) or unnecessarily long delays in finding a patient's folder.

- The health workers lackadaisical attitude towards those holding the GNHIS cards.
- Shortage or complete absence of some of the enlisted drugs.
- The scheme does not cover the patient's type of disease.

Exemptions and the teaming number of members who flock the treatment centres, they are things to be expected in the initial stages because as many more of the disorders are nipped in the bud, more dangerous ones are avoided paving the way for cutting on money spent on hospital bills leading to better economic growth. As many as 38.3 +24.7+8.6=71.6% of the respondents are of the view that the exemptions are indeed called for and out of the lot a little less than half feel the Government should provide the excess funding involved in that order the system does not grind to a halt.

Whether the system requires over hauling with more experienced health workers or not is one of the issues affecting the smooth take-off of the scheme. Views of the general public were taken with the questionnaires as well as during the interview sessions. The finding in the study indicated the negative. Up to 72.9% of the respondents do not support the suggestion. During the interview sessions it came to light that the few people who have so far benefited from it also have various success stories to tell, stories that suggest they have been saved by the scheme and can testify on the efficiency and in effect the efficiency of the workers. It therefore stays as a controversial issue for a higher research to unravel

Conclusions

The findings show that Choggo dwellers have accepted the scheme as a good replacement of the payment system though quite apprehensive about the strides that the scheme has made so far. Responds are of the view that the teething problems, have lingered for a little too long. Many of the teething problems had to do with the registration procedure but with better registration methods coming up as suggestions from various quarters, the operation of the scheme is expected to streamline soon.

As regards various additional functions that are now being imposed on the scheme especially the one that has to do with free medical care for the pregnant women, the general view is that it will be quite a strain but it is humanly incumbent on every citizen to sacrifice a little for the expecting mothers. Perhaps it is a forward march towards attaining one of the very important millennium goals.

There is, however, such a great difficulty measuring the extent of relief that the scheme has been to people that one can only expect that with time this will translate into an increase in productivity in all spheres of human endeavour. During the survey the researcher heard this controversial pronouncement and would like to share it. It was/is from some respondent, an ex-serviceman who was asked to share his impression on the scheme's operations so far. He said, 'Next to Kwame Nkrumah's Akosombo dam, perhaps the next good thing that has come Ghana's way is the implementation of the National health insurance scheme.' he added, 'To let it slip pass the general citizenry will merely be suicidal on the part of we the ordinary people.

Recommendations

That Ghana has gone through the economic, social and a political storm to evolve such a system of health delivery is a blessing and we should do all there is within our power to sustain it to nourish it and to treasure it. After going through a study of this dimension one is poised to make a few recommendations.

- The registration procedure has not proven to be the best. Several people have punched many holes into the registration procedures. It should therefore be looked at critically by the implementing bodies with the view to easing it for people. As at now the ease of acquiring one's membership card is suspect so the bottle necks in the registration system should be gotten rid off. One wonders how and why there is an easy mechanism for capturing people for the purpose of voting and yet so difficult doing so to get them registered to enjoy very good health package. Registration into the scheme should no longer be the responsibility of only the NHIS staff but every able person who can help in cash or kind. It therefore behooves the traditional leaders, the Political leaders, the religious leaders and all others influential groups to as a matter of urgency to rally forces and get everybody in each community properly registered in the scheme.
- One of the important complaints unearthed has to do with the high premium to be paid. If this is the lowest the scheme can go for the time being, then, the various churches, religious bodies, philanthropists and voluntary missions should come in support of the poor to help them invest in their lives effectively. It has also come up that there is

unnecessarily long delay in the processing of the registration card. From this study a possible solution could be in the form of a further decentralization in the registration card collection process. This has the effect of greatly reducing the congestion that has become characteristic of the operation of the scheme.

- The complaint about the narrow range of ailments and drug lists requires the managers of the scheme to look into the coffers of the scheme and increase the premium reasonably in order that the disease coverage and drug range be increased to take care of the people's needs adequately. This I should imagine requires an intimate consultation with the governing authorities of the moment
- On the issue of the partisan nature of the workers in the scheme the findings here dismissed political favouritism as any serious problem.
- It is however, noteworthy that though the proportion of respondents that entertains this notion is small it is still quite significant and the management of the scheme should take firm steps to nip such impressions in the bud.
- The poor or no coordination between the operations of the scheme and the operation of the existing hospitals and other treatment centres is an issue that needs to be looked into dispassionately to ensure that people (patients) are not made to suffer unduly. If this is an issue observed by the general public then implementers should devote some attention to establish the much needed cooperation between the two very important bodies.

- The sorting system has undergone a few metamorphoses since the GNHIS started its operations. Each passing day sees an improvement of the folder searching task all the same there are still a host of complaints.
- An automatic (or) computerized system could help to reduce the long hours of waiting at the O.P.D. Some accredited agencies should be invited in by the policy implementers or efficient software purchased with the little money that has accrued so far to restructure the card sorting system at the OPD.
- The researcher is silent about the financial issues about the scheme as if he is oblivious of the issues of mismanagement that have been reported in a few districts already. This is part of a general canker in the society so it behooves the powers that be to examine such issues dispassionately for such threats have the potential of crippling the scheme.
- It is quite a laudable idea to exempt the pregnant, the aged and children. The finding is that it is good but not without its implications. From the few interviews that I conducted it surfaced that some feel that before long the scheme will be running bankrupt if we do not find a way of increasing the premium payable to ensure that the money in coffers suffices for all these encumbrances. According to such people if we keep glossing over this we will soon pay the price of our kindness because as envisaged, and before long, various malpractices related to the issue of exemptions will start showing their ugly faces on

the scheme. Management should put in place a very efficient system by which the exempted individuals are selected taking cue from other nations who have treaded that path.

In conclusion therefore, as an impact, it may be too early to be making such impact assessment studies. It is however, worth noting that the scheme has made its indelible mark, most especially as compared to the just ended cash-and-carry system. This finding has surfaced quite clearly in this case study. As a people seeking answers to our questing minds we will have to vote more money and attention for the survey the carried out in a few more places to be in the position to make any furthers generalisations. May be it is too early to see the realistic advances that the nation as a whole has made .The strides are in the form of relief that the below average income earners are currently enjoying. Such relief as can be seen on the face of many a beneficiary is not easily quantifiable. The number of lives it has saved so far is not easy to measure since the gains can be eroded by just one or two road accidents. For the well-to-do the difference it makes appears so small that it can be taken for granted but for the peasant dwellers the gains are so enormous that they see in GNHIS a source of big relief. Eventually the yawning gap between the rich and the poor is likely to close up and the disease burden which as at now is more entrenched among the poor will slowly recede.

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APPENDICES

APPENDIX 1

TABLE OF REGISTRATION DISTRIBUTION AS AT FEBRUARY 8, 2007

Regions	Populations	Number Registered	% Coverage
Greater	3,576,312	688,737	19
Eastern	2,2744,53	836,752	37
Western	2,042,320	713 ,488	35
Central	1,687,310	747,769	44
Ashanti	3,924,425	1,722,968	44
Brong Ahafo	1,968,205	1,191,330	61
Volta	1,636,462	587,640	36
Northern	1,790,417	712,554	40
Upper East	963,448	364,600	38
Upper West	166,001	54,866	30

Source: Report in Daily Graphic, February 8, 2007

APPENDIX 2

CORRELATION OF REGISTRATION STATUS WITH THE HIGHEST EDUCATIONAL LEVEL

Correlations

		Registration status	Highest Edu level
Pearson Correlation	Registration status	1.000	.325
	Highest Edu level	.325	1.000
Sig. (1-tailed)	Registration status	.	.002
	Highest Edu level	.002	.
N	Registration status	81	81
	Highest Edu level	81	81

APPENDIX 3

MODEL SUMMARY OF HIGHEST EDUCATIONAL LEVEL AND REGISTRATION STATUS OF RESPONDENTS

Model Summary[b]

					Change Statistics				
Mode	R	R Square	Adjusted R Square	Std. Error of he Estimate	R Square Change	F Change	df1	df2	ig. F Change
1	.325[a]	.105	.094	1.13621	.105	9.306	1	79	.003

a. Predictors: (Constant), Highest Edu level

b. Dependent Variable: Registration status

APPENDIX 4

ANOVA OF REGRESSION OF HIGHEST EDUCATIONAL LEVEL ON REGISTRATION STATUS

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	12.014	1	12.014	9.306	.003[a]
	Residual	101.986	79	1.291		
	Total	114.000	80			

a. Predictors: (Constant), Highest Edu level

b. Dependent Variable: Registration status

APPENDIX 5

COEFFICIENTS OF DEPENDENT VARIABLE REGISTRATION AND INDEPENDENT VARIABLE HIGHEST EDUCATIONAL LEVEL OF RESPONDENTS

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95% Confidence Interval		Correlations		
		B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	1.709	.442		3.871	.000	.830	2.588			
	Highest Edu level	.325	.106	.325	3.051	.003	.113	.537	.325	.325	.325

a. Dependent Variable: Registration status

APPENDIX 6

DESCRIPTIVE STATISTICS INVOLVING RELIEF AND REGISTRATION

Descriptive Statistics

	Mean	Std. Deviation	N
Relief	11.1803	6.78112	61
Registration	17.0492	4.76244	61

APPENDIX 7

PEARSON'S CORRELATION OF RELIEF AND REGISTRATION STATUS

Correlations

		Relief	Registration
Pearson Correlation	Relief	1.000	-.009
	Registration	-.009	1.000
Sig. (1-tailed)	Relief	.	.474
	Registration	.474	.
N	Relief	61	61
	Registration	61	61

APPENDIX 8

MODEL SUMMARY OF REGISTRATION AND EDUCATIONAL STATUS OF RESPONDENTS

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.009[a]	.000	-.017	6.83810	.000	.004	1	59	.948

a. Predictors: (Constant), Registration

APPENDIX 9

ANOVA OF REGISTRATION STATUS OF RESPONDENTS AND RELIEF

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.201	1	.201	.004	.948[a]
	Residual	2758.815	59	46.760		
	Total	2759.016	60			

a. Predictors: (Constant), Registration

b. Dependent Variable: Relief

APPENDIX 10

QUESTIONNAIRE

Introduction

Thank you in advance for deciding to spend so much of your time to help me accomplish this important academic exercise. Be assured that your responses shall be treated with utmost confidentiality in accordance with the ethics of this field. The responses are being elicited to help the researcher conclude the academic exercise cantered on the Ghana National Health Insurance Scheme.

A- Biographic Data

Please tick (√) in the appropriate box and provide responses where spaces are provided**.**

1. Name of the institution/locality……..

2. Sex : Male [ ] Female[ ]

3. How old are you?

   [ ] >20 [ ] 20-29 [ ] 30-39 [ ]40-49

   [ ] 50-59 [ ] 60+

4. What is your position in your household?

   [ ] head [ ] spouse to head [ ] dependent

5. What is your highest academic qualification?

   [ ] MSLC/BECE [ ] No formal Education

   [ ] SC/(WA)SSCE [ ] Diploma

   [ ] Degree [ ] Masters/PHD

Section B: Registration of GHNIS

1 When you fall sick, what is your usual way of treating such ailment?

[ ] Herbal treatment [ ] Private clime

[ ] Hospital on my own [ ] Hospital with the GNHIS card

2 Have you ever heard of the GNHIS and what is your registration status**?**

[ ] yes, I am a member

[ ] yes, but I have no yet registered my membership

[ ] yes but they bore me

[ ] No, what could it be?

[ ] yes but it is NPP campaign strategy

3 For how long have you been a registered member of GNHIS?

[ ] over 2 years now [ ] above 1 year

[ ] not up to a year [ ] yet to collect my membership card

4 What was the most difficult step (aspect) in the efforts to get registered?

[ ] initial registration of my name [ ] paying the subscription fee

[ ] the passport taking stage [ ] the ordeal of waiting for the maturation period.

5. Why in your opinion are you or some people are not yet registered.

[ ] did not hear about early enough

[ ] they are yet to appreciate any gains in belonging to the scheme.

[ ] money involved is too much for me when officials came around.

[ ] the delay is from the registration system/procedure especially in the passport picture taking stage.

6. Are all your dependents registered?

[ ] none is registered [ ] some are but not all yet

[ ] all are registered

7. Are there any aged in your household?

[ ] Yes [ ] No

8. Are they registered into the scheme?

[ ] Yes [ ] No

9. Is there any reason why they (aged) are not yet roped on board?

[ ] no money to do it for them [ ] they are not interested [ ] they feel it is a waste of time

C. **Operation of GNHIS**

10. How many times have you used your membership card to access medical care ever since you acquired it?

[ ] More than 2 times [ ] only twice

[ ] only once [ ] not even once

11. Why have you not yet made use of your membership card to access health care?

[ ] I simply have not yet fallen ill.

[ ] I feel the process of getting treatment with the card is cumbersome.

[ ] We are too far away from the hospital and/or designated climes.

[ ] I don't always remember to carry my card along to the hospital

12. For those who have taken the trouble to go through the process of getting registered, rate the following statements as it applies to you

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Registration officials are simply not available					
The cost of registering is too much for me					
Registration official mix up the pp pictures					
The maturation time is to long					
All the stages are too cumbersome					

13. Which of the recommendations would you like to put forth, if you had a chance.

    [ ] Simplify the registration process [ ] Reduce the maturation time

    [ ] Reduce the premium fee

    [ ] leave the scheme for only the poor and aged.

14. For those who have enjoyed using the scheme for sometime now, rate the following comments/statements.

Comment/Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
It is very easy accessing your health needs with membership card.					
Sorting out of the card/form/folder appears to be cumbersome and frustrating.					
Doctors and other health workers give the attention to those who came to pay cash.					
Very often the drugs needed are not available even though they are covered.					
The drugs needed are often not those covered by the scheme.					
Despite some abnormalities, the treatment is effective and easy to access.					
Many more report their illnesses early to the doctors than before.					
Even though many people flock the hospitals and clinics, the cost of treatment will eventually reduce.					

D. The administrative set up

What can you say about the efficiency of the administration so far?

Comment/Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The GNHIS officials are full of inexperienced youth.					
Registration officials are not qualified and so are not up to the task.					
There is a fear that it is full of political favourites and activists.					
There is little or no coordination between their work and the operations of the hospitals.					
Such a sensitive unit requires more experienced personnel than are at post now.					

E. Quality of service

16. How would you rate the quality of service that is being offered now as against what it was before the inception of the scheme?

[ ] The quality of service is quite good and easily assessable to those registered.

[ ] It is very helpful especially for those who have dependents below the age of 18

[ ] The aged are no more a problem to their families in terms of their health needs

[ ] That brought a lot of relief to many people in the country**.**

F. Sustenance

17. In view of the fact that this can constitute a heavy expenditure for the government, which of the following suggestions will you opt for to ensure the sustenance of the system?

[ ] the premium should be increased for the rich.

[ ] the premium should be reviewed upwards for every beneficiary.

[ ] government should rather source more funds to sustain it and improve upon the quality.

[ ] the government should scrap it and use the more to build more schools.

G. Recommendations

18. Here you are required to rate the statements that follow as a recommendation aimed at ensuring that the scheme succeeds

Statement	Strongly	Agree	Neutral	Disagree	Strongly disagree
The GNHIS scheme is rather prematurely implemented and its operation leaves room to be desired.					
There are too many exemptions in					

the scheme for a poor nation like ours and so funding will be difficult for the government.					
There are very few alternative health schemes available so the monopoly will bring about poor quality of service.					
The premium needs to be increased for the system to achieve sustainability.					
The system in operation compares well with the system in other countries so it will withstand all other pressures on it.					
The ministry of health should take pains to buy all the enlisted drugs and save the system from drug traders.					
Many individuals are cutting down their health bills so it is imply commendable					
The GNHIS will eventually improve productivity.					
The economy of the nation, will					

eventually improve if the system operates effectively.					
I recommend that the system be maintained with slight notifications.					

19. Which of the following would you put down as the biggest problem facing the scheme { } The scheme's inability to settle their bills with the hospitals.

[ ] The scheme's management is rather too liaisez-faire.

[ ] There are too many exempts for the infantile scheme.

[ ] The selected drugs are often in short supply and no substitution is done.

[ ] The ailments that are covered by the benefit package are too few.

[ ] the registration figures are yet too low.

20. Of late many exempts including pregnant women have been absorbed by the scheme can you share your views on this development?

[ ] I think it is only fair to treat the toiling expectant ladies that way.

[ ] I feel it is a big stress on the young budget of the scheme

[ ] Since the Government absorbs any excess bills made by the Scheme, it will not reduce its operations significantly.

[ ] Since pregnant ladies belong to families their family membership cover should take care of them and allow the scheme to grow.

[ ] It's good so it calls for an increase in the premium and renewal fees

21. Here, you are invited to suggest at least one modification to the scheme in operation, with the view to achieving greater efficiency.

……

……