UNIVERSITY OF CAPE COAST

CHALLENGES FACING EFFECTIVE IMPLEMENTATION OF THE HEALTH INSURANCE SCHEME IN THE ASSIN NORTH MUNICIPALITY

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BY

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DECLARATION

Candidate's Declaration

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

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

Name: Samuel Kwasi Oppong Nkansah

Supervisor's Declaration

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

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

Name: Mr. Kissi Korsah

ABSTRACT

The study sought to analyse the implementation of the National Health Insurance Scheme (NHIS) in Assin North Municipal Assembly. In all, 138 NHIS subscribers and three key informants comprising the manager of Assin North NHIS, the head of one accredited NHIS pharmacy and the head of one accredited NHIS health centre were selected for the study. Questionnaires and interview guide were the research instruments that were used to collect data from the field. In addition to this, purposive and convenient sampling techniques were used to select the respondents for the study.

The study found that the level of registration of the NHIS in Assin North Municipality was high. Two main factors namely trust in the NHIS and the affordability of the NHIS premium accounted for this. Perception of the implementation of the NHIS in Assin North Municipality was good. Poor delivery of services by NHIS service providers, corruption in the activities of NHIS service providers and untimely disbursement of funds to NHIS service providers were the main factors that affect the implementation of NHIS.

It is recommended that National Health Insurance Council (NHIC) should form finance committees at the district, regional and national levels to check the financial activities of NHIS service providers. The council should make sure that funds covering the cost of drugs are timely disbursed to NHIS service providers. In addition, the NHIC should also institute award scheme for the best NHIS service providers to encourage service providers offering poor services to improve upon their services.

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DEDICATION

To my late mother, Madam Afua Kontoh.

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LIST OF ACRONYMS

CHI	Community based Health Insurance
CID	Centre for Integrated Development
DMHIS	District Mutual Health Insurance Scheme
HIPC	Highly Indebted Poor Country
IDI	In-depth Interview
ILO	International Labour Organisation
IMF	International Monetary Fund
JHS	Junior High School
NHI	National Health Insurance
NHIA	National Health Insurance Act
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NVTI	National Vocational Technical Institute
OPD	Out Patient Department
OTC	Over The Counter
PCHIS	Private Commercial Health Insurance Scheme
PMHIS	Private Mutual Health Insurance Scheme
SHS	Senior High School
SSNIT	Social Security and National Insurance Trust

UC	Universal Health Care Scheme
VAT	Value Added Tax
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the study

National Health Insurance (NHI) can be defined as any system of socialization insurance benefit covering all or nearly all of the citizens of a country, established by its federal law, administered by its federal government and supported or subsidized by taxation (Afriyie, 2004). In other words, it is a form of health insurance that insures a population against meeting the cost associated with ill health. There are several types of health insurance schemes depending on whether they are initiated by the population, health care providers, micro finance institutions, or other social groups. Examples of health insurance schemes include District Mutual Health Insurance Scheme (DMHIS), Private Mutual Health Insurance Scheme (PMHIS) and Community based Health Insurance (CHI). The form of health insurance may also depend on the involvement of the state and development assistant agencies (Anderson, Hurst, Hussey & Jee-Hughes, 2000).

Some countries implement national health insurance through taxation and or by legislation, requiring compulsory contributions to the health insurance fund operated by the government from which medical expenses are provided to private entities, for example hospitals (Stienmo & Watts, 1995). By sharing health related risk, the system improves access to health care for beneficiaries who contribute to

it. Members pay a contribution (monthly or yearly) which entitles them to a package of services at partner health facilities. Despite the good intents of NHI their development in many developing countries are inhibited by distrust and scanty knowledge of the insurance practices as well as lack of know-how, high transaction cost, lack of financial and cash intermediaries, high dropout rates, lack of competition and unsustainability of the scheme because of lack of funds (Carrin, 2001).

Developing or middle income countries such as Nigeria and the Philippines have pursued vigorously National Health Insurance programmes. However, the issue of financing and delivering effectively have made those programmes a mirage (Witter, Arhinful, Kusi & Zakariah-Akoto, 2007). The National Health Insurance Programme implemented by the Philippines in 1999, which aimed at universal coverage by the year 2010, was engulfed with several challenges and difficulties. For instance in 2001, the scheme covered only 43 percent of the population (Philippine Health Insurance Corporation, 2001). Coverage of the formal sector seemed fairly extensive while coverage of the indigenes and workers in the informal sector was still very limited. That is, getting the (unsalaried poor) members of the informal sector into the national health insurance coverage remained a big challenge. Other challenges found mainly in developing countries concerning health insurance are increasing out-patient care to increase membership base and the possibility for interfacing with the local community schemes as sustainable outreach strategy (Nyonator & Kutzin, 1999).

Nigeria (with similar health insurance arrangement as the Philippines and Ghana) has also met numerous challenges and problems limiting the successful implementation of the health insurance scheme. The managing Director and Chief Executive Officer of Clearline International, a Health Management Organization under the Nigeria Health Insurance Scheme, revealed several hindrances and bottlenecks inhibiting the Nigerians Health Insurance. Among these challenges are lack of confidence in the scheme, lack of funds to keep the scheme in operation and poor service delivery of the schemes service providers (Nyonator & Kutzin, 1999).

In Ghana, The National Health Insurance Act, 2003 (Act 650) established the National Health Insurance Scheme (NHIS) with the aim of increasing access to health care and improving the quality of basic health care services for all citizens, especially the poor and vulnerable. The law establishing the scheme allows for the concurrently operation of District-Wide (Public) Mutual Health Insurance schemes, Private Mutual Health Insurance schemes and Private Commercial Health Insurance schemes. However the schemes only financially support District-Wide (public) Mutual Health Insurance Schemes (Sulzbach, Garshong & Owusu-Banahene, 2005). The initially defined benefit package under the scheme includes inpatient hospital care, outpatient care at primary and secondary levels, and emergency and transfer services. Each district mutual health insurance scheme also uses its discretion to determine additional benefits a scheme could provide (Sulzbach, Garshong & Owusu-Banahene, 2005).

Ghana's National Health Insurance Scheme, although still in operation are associated with many challenges (National Development Planning Commission, 2009). These challenges are not making the scheme to function as expected.

Statement of the problem

In Ghana, The National Health Insurance Act 650 of 2003 seeks the provision of basic health services to persons resident in the country through mutual and private health schemes, to put in place credit and monitor healthcare providers operating under health insurance schemes, to establish a National Health Insurance Fund that will provide subsidy to licensed district mutual health insurance schemes, and to provide for the purposes connected with these. Ghana's National Health Insurance Scheme (NHIS) is one of the few schemes in the world that does not require co-payment for services accessed by members (Afriyie, 2004). An estimated 95 percent of diseases that commonly afflict Ghanaians are covered by the NHIS benefit package (Armah, 2002). The benefit packages of the NHIS include full out-patient department (OPD) and admissions treatment (surgery and medical) cost including feeding, full payment of medicines within the NHIS approved list and payment of referrals (gatekeeper system) to teaching hospitals.

Despite the good intents of the NHIS, there have been varying challenges confronting the scheme, the providers and the members of the scheme. According to Amponsah-Bediako (2004), the challenges facing the Ghana's NHIS include: weak gatekeeper system, weak claim management, delayed payment to service

providers, low technical skills in the management of the NHIS, delays in ID card production and distribution and non conformance to NHIS approved drug list. Other challenges are accreditation issues (few drug stores, service providers etc.) resulting in pressure on the NHIS beneficiaries, misconception of the process, misunderstanding of the NHIS concept and abuse of the scheme leading to over utilization of the scheme.

Even though there have been efforts by the scheme authorities (Government, Ministry of Health, National Health Insurance Council (NHIC), and the scheme providers) to curb or at least alleviate some of the problems linked with the implementation of the NHIS but still most of these problems are eminent is most part of the country (Amankwah, 2007). It is in view of this that this study seeks to investigate the challenges hindering the proper implementation of the NHIS in Assin North Municipality in the Central Region of Ghana.

Objectives of the study

The main objective of this study was to analyse the implementation of the NHIS in Assin North Municipality.

The specific objectives of the study were to:

- Examine the level of coverage of the NHIS.
- Assess the factors that influence the level of registration of the NHIS.
- Assess the perceptions of NHIS subscribers on the implementation of NHIS.
- Examine the challenges facing the implementation of the NHIS.

- Make recommendations to improve NHIS implementation

Research questions

The research questions that the study sought to answer were:

- What level of coverage has been achieved under the NHIS?
- What factors have influence the level of registration of the NHIS?
- How do NHIS subscribers perceive the implementation of the NHIS?
- What are the challenges that face the implementation of the NHIS?

Significance of the study

The provision of healthcare for the citizens of any country is very important. As the former USA president, Harry Truman (1971) noted "a healthy citizenry is the most important element in America's national strength" and therefore it is necessary for America to "develop a national health programme which will furnish adequate public health services, and ample medical care facilities for all areas of the country and all groups of people". Embarking on this research will help to bring to bare the level of registration of NHIS in Assin North Municipality and the various factors that have accounted for such registration levels.

The study will help to show the perception of NHIS subscribers on the implementation of the NHIS. The study will also help to show the nature of challenges hindering the NHIS in Assin North Municipality. Another area of significance of this study lies in the fact that the overall findings of this study will

add to existing literature on health insurance system and also serve as a basis for further research on Ghana's NHIS. Data collected can also be a source of information for those who intend to pursue the issue of NHIS

Organisation of the study

The study is organized into five chapters. Chapter One comprised the background to the study, statement of the problem, objectives of the study, research questions, significance of the study and organization of the study. Chapter Two reviewed relevant literature related to the study; this includes health financing, funding of health, coverage/enrolment of health insurance scheme, perceptions of health insurance scheme, and benefit packages of health insurance scheme.

Chapter Three described the study area, study design, target population, sample size, sampling procedure, ethical issues, research instruments, data and sources, fieldwork, and data processing and analysis of the study. Chapter Four concerned itself with results and discussion while Chapter Five provided the summary, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The previous chapter presented a general overview of the study. This chapter reviews available and relevant literature that informs the study. Issues discussed in this chapter include health financing, funding of health, coverage/enrolment of health insurance scheme, perception of health insurance schemes, factors affecting enrolment levels of health insurance schemes, benefit packages of health insurance schemes and implementation of health insurance schemes.

Health financing

Policy-makers continue to review the way their health systems are financed – either in the way the funds are collected, how they are pooled to spread risks, what services are provided or purchased, and how providers should be paid (World Health Organization, 2003). The objectives vary, but common concerns are the need to generate sufficient funds for health, improving efficiency or reducing costs, reducing the financial risks involved in obtaining care, and ensuring that the cost of health care does not prevent people from receiving needed services (Knaul & Frenk, 2005). According to Knaul and Frenk (2005), health insurance policies are passed into laws and given legal backing to make them effective.

In other parts of the world, new social health insurance to cater for the health needs of the poor. Governmental institutions are created in such situations to ensure that those who are to benefit from the programme really benefit (Tein, 2005; Arhinful, 2003). It has been observed that in many developing countries, governments switched from out-of-pocket payment to tax based financing after independence. Such services were provided for in state funded hospitals and clinics while private sector health services continued to be paid for by those who sought for services there.

By the early 1970s, general tax revenue in many countries in Africa, with its stagnating economy, could not support a tax-based health financing system. In 1972, very low out-of-pocket fees were introduced in the public sector to discourage frivolous use. The stagnation of the economy of many countries in the world were followed by a decline and in the health sector there were widespread shortages of essential medicines, supplies and equipment, and poor quality of care (Ministry of Health, 2001).

In 1983, the government of many countries adopted a traditional International Monetary Fund (IMF) and World Bank economic recovery programme. Since a key component of the economic recovery programme was to reduce government expenditure to the barest minimum, the full burden of paying for health care was borne by patients. The public sector user fees for health care were raised significantly as part of structural adjustment policies and became known as ‘cash and carry’. The aim of the user fees was to recover at least 15 percent of recurrent expenditure for quality improvements. The financial aims were achieved (Ministry of Health, 2001).

In the later part of the 1980's, shortages of essential medicines and some supplies improved across many countries. However, these achievements were accompanied by inequities in financial access to basic and essential clinical services (Waddington & Enyimayew, 1990). Assensoh-Okyere and Dzator (1997) observed that costs of medicine alone accounted for over 60 percent of treatment of malaria, one of the commonest illnesses in Africa.

As many people could not afford to pay the requisite fees at point of delivery to seek medical attention, they avoided going to hospitals and health centres; instead they engaged in self-medication or other cost-saving behaviours or practices. As a result, by 2003 some countries introduced and passed into law a National Health Insurance Scheme (NHIS) bill, designed to cover all their citizens who join the program (Wahab, 2008).

In general, the National Health Insurance Act (NHIA) in many countries establishes three main types of health insurance namely District Mutual Health Insurance Scheme (DMHIS), Private Mutual Health Insurance Schemes (PMHIS), and Private Commercial Health Insurance Scheme (PCHIS). The DMHIS is district focused. The district mutual health insurance scheme is a public/non-commercial scheme that anyone resident in any given country can register under the scheme. If you register in 'District A' and move to 'District B', you can easily transfer your insurance cover and still be covered. The district mutual health insurance scheme also covers people considered to be indigent – that is too poor, lacking a job and the basic necessities of life to be able to afford to pay insurance premium. Apart from the premium paid by members, the district mutual health

insurance schemes receive regular funding from central government. This central government funding is drawn from the national health insurance fund.

In most developing countries, workers pay two-and-a-half percent of social security contributions into the national health insurance fund. To sign up for the district mutual health insurance scheme, you need to get to the district assembly where you stay or look for the offices of the scheme and register. You will fill a form, offering some basic personal information and you will be asked to present at least two passport pictures. You will also need to fill forms for dependants who are below 18 (National Development Planning Commission, 2009).

Unlike the DMHIS, the PMHIS may be established and operated by any group of persons, community, occupation, or religious group. Not only would it be not-for-profit, the PMHIS would not receive government subvention and may not have a district focus. The PCHIS would be established and operated for profit and therefore premiums of subscribers would be based on the calculated risks of the subscribers, and would not have a district focus. The stated goal of NHIS is to assure a specified minimum healthcare benefit package to all people at the point of service within five years following its implementation (Wahab, 2008).

The aim of the health insurance scheme in Ghana is to enable the government achieve its set goal within the context of the Ghana Poverty Reduction Strategy and the Health sector Five Year Programme of Work, 2002-2006. Specifically, it is to provide a more humane and a sustainable health financial mechanism that focuses on the poor. To this end, a policy document was

developed with the objective of providing accessible, affordable and good quality service to all people living in Ghana and especially the poor and the most vulnerable in society (Appiah-Denkyira & Preker, 2005).

The policy makes it compulsory for residents in Ghana to belong to a scheme and hopes to achieve 10 percent in the first year rising to 30 percent within five years and 50 percent within 10 years. Government has elected to support the DMHIS to serve as a strategy to deliver its pro poor policy to the underprivileged segment of the society. The DHMIS is therefore a fusion of two concepts - the traditional Social Insurance Scheme for the formal sector workers and the traditional mutual health organisation for the informal sector of the society. The mixed membership from both sides as well as the universality of its coverage is meant to provide a spirit of belongingness, solidarity and social responsibility (Appiah-Denkyira & Preker, 2005).

The unique design of the DHMIS is based on the principles of equity, risk equalisation, cross subsidisation, solidarity, quality care, efficiency in premium collection, community or subscriber ownership, partnership, reinsurance, and sustainability. It is meant to be district- wide, managed locally by management teams and supported by a governing board to bring about best managerial practices, good governance and democracy. The schemes will be regulated by a National Health Insurance Council, a body formed under Act 650 to register, license and regulate health insurance schemes, and to accredit and monitor health care providers (public and private) operating under the scheme. This body is also responsible for the management of the National Health Insurance Funds into

which the levy is deposited (Appiah-Denkyira & Preker, 2005).

Funding of Health

A lot amount of money is spent on health globally, but this amount is unevenly distributed and shows a high reliance on out-of-pocket payments in many countries. Financial contributions to the health system are raised in most countries from households and businesses, although external flows such as official assistance are an important source in many settings. Recent increases in the availability of external funding for health have the potential to stimulate major health improvements in poor countries (Evans, 2005). On the other hand, multilateral financial institutions and some ministries of finance have expressed concern that these inflows could affect macroeconomic stability. In addition, these funds are sometimes used to finance specific programmes, more or less independent of efforts under way to build long-term sustainable financing systems and institutions for the health system as a whole. It is important that inflows of external funds for particular activities are managed in a way that is consistent with the broader objective of developing sustainable financing systems and institutions and moving towards universal coverage (Evans, 2005).

Rosa and Scheil-Adlung (2007) have indicated that a Universal Health Care Scheme (UC), with funding from general tax revenue has been introduced elsewhere. Civil servants who have retired are funded from general taxes while Social Security Health Insurance scheme or SSO scheme (for private formal

sector employees) is financed through contributions from the insured, the employer and the government.

Tein (2005) has observed that the funding rate of Vietnam health insurance rate is 3 percent for salaried workers (employees pay 1 % and employers 2 %). The rate of funding for those who cannot count on a regular income is fixed at 3 percent of the national minimum salary and paid from the state budget. The temporary contribution of the poor is subsidised by the Heath Care Fund for the Poor and amounts to €2.4.

Health care financing in Ghana started with a universal tax-funded system immediately after independence that could not be sustained over the years. In response to this non-sustainability, the government in 1985 introduced user fees at public health facilities, but this resulted in a fall in utilisation of health care services. An exemption policy introduced in 1987 to remedy this situation did not achieve its intended purpose of providing a safety net for the vulnerable who could not afford to pay for health care services.

It is this state of affairs that prompted some communities in Ghana to find alternative ways of meeting their healthcare financing need, key among which was the establishment of Community Based Health Insurance Schemes (CBHIS). In 1992, the first CBHIS was launched and thereafter, several similar schemes sprung up. However, these schemes were fragmented and were not co-ordinated in such a way as to achieve the principles of social insurance which guided their set up , nor were they supported with tax-funds too enable them cater for the poor and the needy

In Ghana, funding for the National Health Insurance Scheme is largely obtained from three sources: 2.5 per cent value added tax (VAT) on goods and services, a health levy with some exclusions; 2.5 per cent from payroll tax imposed on the formal sector employees to support the social security and pensions scheme; and an annual premium of GH¢7.2 for adult members of working age (formal sector employees who contribute to the social security do not have to pay the annual premium). In addition, there are also transfers from the state budget apportioned to the fund by the parliament, returns on investments made by the NHIC and contributions to the fund (e.g. grants, donations and other sources). Support from international donors and agencies help subsidize the health insurance premiums of selected indigents or those who cannot afford the full amount of the premium, mostly comprising of pregnant women and mothers with young children. An adult family member pays GH¢7.2 for premium to access a comprehensive benefit package for inpatient and outpatient care (Government of Ghana, 2004).

Children under 18 years old, those above 70 years old, indigents and pensioners in Ghana are exempted from paying the premiums. The formal sector members are also excluded because 2.5 per cent of their salaries go the National Health Insurance Fund (NHIF) via the social security and pension scheme. The minimum benefit package covers most diseases in Ghana. Additional benefits may vary depending on the scheme but are most often dependent on the premiums. Provider payment is done through fee for service following an agreed upon tariff structure (Government of Ghana, 2004).

Coverage/enrolment of health insurance schemes

World Health Organisation (WHO, 1998) reviewed 82 non-profit health insurance schemes for people outside formal sector employment in developing countries (Bennett, Creese & Monasch, 1998). It was observed that very few of these schemes covered large populations. Many of these schemes therefore had low level of enrollment rates.

According to WHO (1998), Community base Health Insurance (CHI) have different enrollment rates in different countries. For instance, enrollment rates that ranged between 8 percent and more than 90 percent have been achieved in different countries (Criel & Waelkens, 2003; Criel, 1998). In Senegal, one CHI reached a coverage rate of 26 percent after 3 years of operation whereas another achieved an enrollment rate of 82 percent; the target population was 13,650 and 1,200 respectively. In two CHI schemes in Ghana and Mali, 53 percent and 25 percent of the target population of 25,000 and 200,000 respectively were covered (Criel & Waelkens, 2003; Jutting, 2001).

In the Maliando Mutual Health Organization in Guinea-Conakry, subscription dropped from 8 percent to 6 percent of the target population mainly because of huge disappointment with the quality of care offered at health centre level (Criel & Waelkens, 2003). However, membership rates might be low in the beginning, but might increase as the performance of the CHI convinces the population that subscribing may be profitable. Bwamanda Hospital Insurance Scheme in the D.R. Congo shows that in 1986 when the scheme was established, 32,600 people or 28 percent of the district population joined within 4 weeks. Over

the years, membership increased to 66 percent in 1993 and seems to have stabilized at 61 percent in 1997 (Criel, 1998). Another study on the Lalitpur Scheme in Nepal shows that population coverage in the target areas rose from 19–20 percent in 1983 to 27–48 percent in 1995 (Harding, 1996).

The 2008 NHIS progress report in Ghana indicates that the number of people registered under the NHIS has increased from 1,797,140 in 2005 to 12,518,560 as at end of 2008, representing about 61.3 percent of the country's population. According to the report, about 30 percent of the current subscribers to the scheme are from the informal sector, and the Social Security and National Insurance Trust (SSNIT) contributors to the scheme constitute about 7 percent. Overall, the vulnerable group including pregnant women, children, the aged (70 and above) and indigents constitute 63.2 percent of the total number of people registered under the scheme (Nation Development Planning Commission, 2009).

Perceptions of health insurance scheme

A study by Sanusi and Awe (2009) on perceptions about NHIS revealed that the perception of people on NHIS differs from place to place and even within the same place it differs from one age group to another. For example, in Oyo state it has been found out that majority of the registered members of NHIS have bad perception of the NHIS (Sanusi & Awe, 2009). Most of the NHIS subscribers indicated that the drugs under the NHIS are not good, insufficient and many people also complained that they are not promptly attended to by the NHIS service providers. Other people who were registered under the scheme also

recommended that the scheme should be discontinued because of poor services provided by scheme's service providers (Sanusi & Awe, 2009).

In South Africa, many people were not happy with the services provided by NHIS health centres. A large percentage of participants thought it more important to have improved health care coverage and services even if it meant raising taxes, while a small percentage said it is better to hold down taxes despite lack of access to health care for some South Africans. Almost a quarter of participants were unable to comment on questions posed to them, indicating the need for improved public education and communication (Shisana, Rehle, Louw, Zungu-Dirwayi, Dana, & Rispel, 2005).

Factors affecting enrollment levels of health insurance schemes

A variety of factors influence people's decision to join the schemes given the voluntary character of CHI. Affordability of premiums or contributions is often mentioned as one of the main determinants of membership. A number of schemes in the WHO Study had addressed the issue of affordability. For instance in the Nkoranza Scheme, the estimated cost of contributions varied from 5 percent to 10 percent of annual household budgets (Atim, 1998). It was recognized that such contributions could be a financial obstacle to membership. The technical arrangements made by the scheme management may influence people's perception of personal benefits. One example is the unit of enrollment.

In the WHO Study, almost half of the schemes surveyed had the family as the unit of membership, a measure introduced to avoid the problem of adverse

selection. In the Rwandan Project Study, large households with more than five members had a greater probability to enroll in the CHIs than others did (Schneider & Diop, 2001). The explanation given is that contributions were kept flat, irrespective of household size up to seven members; the average contribution per household member was therefore less than for smaller families, inducing greater enrollment.

The timing of collecting the contributions may also matter for membership. From the WHO study, it was observed that schemes in urban areas were more inclined to establish monthly or quarterly contributions so as to match the income patterns of urban informal sector workers. Annual contributions, collected at the time of harvest of cash crops, seem to be prevalent among schemes in rural areas (Bennett, Creese & Monasch, 1998). However, in some schemes, payment schedules were held flexible, with monthly, quarterly or semi-annual payments (Ron, 1999). Other schemes link the time of payment of the contribution with a suitable event in the community. For instance, burial communities in Uganda use their monthly meetings for the collection of premiums, either for the first-time members or for those who renew their membership (Carrin, Desmet & Basaza, 2001).

Trust in the integrity and competence of the managers of the CHI may affect enrollment. The existence of entry points in the community, such as a micro-credit scheme, a development co-operative or other social groups, may facilitate the establishment of CHI. If such existing initiatives have won the trust of a population (Ginneken, 1999a), it may become easier to start up a CHI. For

instance, the development co-operative in Bwamanda, initiated by the local Catholic mission, transformed into an integrated development project at the end of the 1960s.

This resulted in fairly stable economic conditions in the Bwamanda region throughout the 1970s and 1980s, which has enhanced the capacity and willingness of the population to enroll in the Bwamanda Scheme initiated by the CID. Trust can be enhanced when people see that their preferences matter. When the scheme administrators tend to be responsive to the community's preference, people's overall satisfaction with the community scheme's services is likely to increase.

An important amount of evidence was recently reported by the International Labour Organisation (ILO) in a study about the role of CHI in the extension of social protection (Baeza, Montenegro & Nunez, 2002) (henceforth called ILO Study). A total of 258 community-based health schemes were reviewed. Out of 100 schemes with information, 57 schemes included participation of the community related to the benefit package. And in 51 schemes of 104 with information, the community was a partner in discussing the level of the premiums (Baeza, Montenegro & Nunez, 2002). Trust was also considered as a factor in the development of health insurance among informal workers in Dar es Salaam, Tanzania. Informal sector workers constituted their own associations, which proved to constitute a good basis for building trust among members. Subsequently, health insurance was easier to develop (Ginneken, 1999b). Djan (2010) has found out that NHIS coverage in Ghana has shot up from 1.3 million

people in 2005 to about 16 million in 2010 due to peoples' confidence in the scheme.

The quality of care offered through the CHI is another factor to be considered. The latter was highlighted in an evaluation of the Maliando scheme in Guinea-Conakry (Criel & Waelkens, 2003). Focus group discussions were organized with 137 persons sampled from the member and non-member population. Participants referred to rapid recovery, good health personnel, good drugs and a nice welcome at the health facility as the most important features of quality. When membership was discussed specifically, lack of quality of care was cited as the most important cause of non-enrolment.

The household's geographical location is yet another determinant of the enrolment of CHI. For instance, in the Gonosasthya Kendra (GK) Scheme in Bangladesh, membership among the two lowest socio-economic groups appeared to be related to distance: up to 90 percent of that target population from nearby villages subscribed, whereas only 35 percent did so for the target population in the distant villages (Desmet, Chowdury & Islam, 1999). In the Rwandan Project Study, it was also found that households who lived 30 minutes from the participating health facility had a much larger probability to enroll in the CHIs than those who lived 60 minutes away (Schneider & Diop, 2001).

Benefit packages of health insurance schemes

Various benefits or opportunities can be obtained from health insurance schemes. These benefits normally vary from one country to another. In Nigeria,

the benefits derived from participation in their national health insurance scheme defined by law include; Hospital in-patient and out-patient care, general practitioner services in the communities, physician specialist services, medicaments, ancillary Services (such as x-ray, laboratory tests, vision test and spectacles, prostheses, appliances and rehabilitation) , basic dental maintenances, reconstructive dental care and preventive care including immunization, family planning, ante-natal care, post -natal care and, health education (Adesina, 2009).

The National Health Insurance (NHI) benefits can be comprehensive and may include in-patient care, ambulatory care, laboratory tests, diagnostic imaging, prescription and certain over-the-counter (OTC) drugs, dental care, traditional Chinese medicine, day care for the mentally ill, limited home health care, and certain preventive medicine (pediatric immunizations, adult health exams including pap smears, prenatal care, and well-child checkups). In many countries, treatment for HIV/AIDS and organ transplants are also covered (Cheng, 2003).

In Sub-Saharan Africa, every enrollee in any of the NHIS is entitled to some minimum health care benefits. These benefits include out-patient services - general and specialist consultations reviews, general and specialist diagnostic testing including, laboratory investigation, X-rays, ultrasound scanning, medicines on the NHIS Medicines list, surgical operation such as hernia repair and physiotherapy. In-patient Services - General and specialist in patient care, diagnostic tests, medication-prescribed medicines on the NHIS medicines list, blood and blood products, surgical operations, in patient physiotherapy,

accommodation in the general ward and feeding (where available) (Sulzbach, Garshong & Owusu-Banahene, 2005).

Other benefits are oral health - pain relief (tooth extraction, temporary incision and drainage), dental restoration (simple amalgam filling, temporary dressing), maternity care-antenatal care, deliveries (normal and assisted), caesarean section, post-natal care. Eye care services including cataract removal and eyelid surgery and emergencies - these refer to crises in health situations that demand urgent attention such as medical emergencies, surgical emergencies, paediatric emergencies, obstetric and gynecological emergencies and road traffic accidents (Sulzbach, Garshong & Owusu-Banahene, 2005).

Implementation of health insurance schemes

Implementation of national health insurance schemes all over the world, are confronted with problems which limit their services to the general public. High cost of health insurance premium is among the key challenges that prevent many people from registering under many national health insurance schemes. For example, the cost of health insurance in the United States of America rose 6.1 percent in 2007, outpacing both the 3.7 percent average increase in workers' wages and the 2.6 percent inflation rate, according to a September 2007 Kaiser Family Foundation report. Workers now pay an average of $3,281 a year to cover their share of a family policy, this has resulted in low level of enrollment (Daza & Collins, 2008). In a similar way, Cheng (2003) stressed that in 2002 premium rate for Taiwan NHIS increase of about 7 percent, from 4.25 percent of assessable income to 4.55 percent. For 90 percent of the insured public, this premium

increase represents an average of NTD$40 (US$1.14) per month which is too high for them to bear.

Funding of National Health Insurance Schemes is yet another challenge confronting many countries. In most NHIS's, governments have to spent huge sums of money on regular basis to get the scheme going. However, due to financial constraints government of many countries find it difficult to raise high amount of money for such schemes which in to some extent affect the quality of services rendered by these schemes.

There is also a problem of inadequate logistics. This problem cut across almost all the health insurance schemes in the world. In most countries there has been report on shortages of logistics especially health personal and facilities not matching up with people which patronise the scheme. In Nigeria, critical appraisal of their NHIS reveals that the problem of inadequate human capacity does not help to drive the NHIS, as there is a dearth of professionals grounded in healthcare financing whose input cannot be done away with (Falegan, 2008). In other parts of Africa such as Ghana and Senegal, the story is not different, according to Kennedy (2009) while the NHIS increased out-patient attendance by about 50 percent and doubled in-patients for many hospitals, there were no corresponding increases in staff and equipment. The result is that the capacity of most hospitals, already strained before NHIS, is now at breaking point.

Other challenges faced with NHIS are untimely disbursement of funds to service providers and poor provision of service by the NHIS service providers (Kennedy, 2009). These providers include hospitals and pharmacies. Many a

time's registered members of NHIS complained about the poor treatments that are given to them when they visit any of the NHIS service providers. Registered members normally complained about not been attended to and also spending much time in hospitals whenever they go to the hospitals. Others also stressed on the shortages of drugs by the pharmacies (Yamikeh, 2007).

Lack of understanding of the scheme by people also affects the performance of NHIS (Amadi, 2007). According to the National president, Healthcare Providers Association of Nigeria (HCPAN), Iseoluwa Aworinde the biggest challenge confronting Nigeria's NHIS is lack of understanding about the scheme. Elaborating more on this problem, Aworinde said that the problem of understanding between the stakeholders created more problems in implementation of the scheme. The problem of understanding within the stakeholders, and the inter-relationship between one group to the other is also a major problem. He also stressed that another major clog in the wheel of progress of the scheme was the problem of the public not understanding the scheme as this will empower them to be able to reap the benefits clog on the wheel of progress of the scheme. These and many other problems limited the operations of the scheme as only very few Nigerians are benefiting from the scheme at present (Amadi, 2007).

Corruption is another challenge that affects the smooth running of NHIS's. Koomson (2009) has found out there are many corrupt practices in Ghana's NHIS which is affecting the operation of the NHIS in many parts of Ghana. These corrupt practices include pilfering and over billing of drugs by NHIS service providers.

CHAPTER THREE

METHODOLOGY

Introduction

Having reviewed empirical literature related to the study in chapter two, this chapter outlines the research procedures used in the collection of data and data analysis. It covers the study design, target population, sample size, sampling procedure, ethical issues, research instruments, data and sources, fieldwork, and data processing and analysis of the study.

Study area

Location

The Assin North Municipal Area is among the thirteen (13) districts of the Central Region of Ghana out of which Assin South District Assembly was carved in August 2009. It lies within Longitudes 1° 05′ East and 1° 25′ West and Latitudes 6 ° 05′ North and 6° 40′ South. The municipal area shares common boundaries with Twifo Hemang Lower Denkyira district on the West, Assin South District on the South, Asikuma Odoben-Brakwa district and Ajumako Enyan-Esiam district on the East, Upper Denkyira East Municipal area on the North-West and Ashanti Region on the North (Ghanadistrict.com, 2006a). The Municipality covers an area of about 1,500 sq. km. and comprises about 1000 settlements including Assin Fosu (the Municipal Capital), Assin Nyankumasi, Assin Akonfudi, Assin Bereku, Assin Praso, Assin Kushea and others.

Economic activity

The major economic activity in the district is agriculture which employs 69.4 per cent of the labour force. About fifty-two (52) percent of those engaged in other economic activities still take up agriculture as a minor economic activity. Crop farming is undertaken at a subsistence level. Small-scale fishing also takes place in the Pra River and fishponds. The second highest occupation is commerce. It employs about 19.1 per cent of the working population. This indicates a very strong commercial set up in the district considering the fact that it is a rural district. Women dominate this sector. About fifty-four (45) per cent of the goods sold are industrial hardware bought from Kumasi and Accra and sold within and outside the district (Ghanadistricts.com, 2006c).

Another important economic activity is the provision of services. It employs about 8.3 per cent of the labour force. This sector comprises government employees, private employees and other service workers. Another category in the occupational sector is industry which employs about 4.6 per cent of the working force. Industrial activities are undertaken in both small and medium scale. The problem with the industrial sector is its weak background and forward linkages with the agriculture sector; only about 31 per cent is agro-based. Even though it would be very difficult to assess real unemployment, seasonal or disguised unemployment forms about 6 per cent of the working age group. Although, the district is described as a rural district in terms of population and social amenities, its economic characteristics show some urban features (Ghanadistricts.com, 2006c).

Settlements

The Municipality contains about 1203 settlements (Ghana Statistical Service, 2002). Most of the major settlements are located along the main Cape Coast - Kumasi Highway in the district. The Municipal capital, Assin Foso was the only urban settlement in 1960 and 1970 with population of 5284 and 7239 respectively. By 1984, Assin Foso was the only community that had population over 5,000. As at 2000 two settlements could be described as urban. These are Assin Foso (22,837) and Assin Bereku (5,985). The rest of the settlements may be described as rural with only nine (9) of them having population between 3,762 and 1809. The rest have populations below 1000.

Health

Development planning is for and with the people, and since they constitute the most important resources, the importance of good health for the people cannot be overemphasized. The municipality has only one hospital, St. Francis Xavier Catholic Hospital at Assin Foso. The Foso hospital caters for all referral cases in the district. The health needs of the people are provided by various health institutions. It is evident that the district is not well served with health facilities considering its size of population (Ghanadistricts.com, 2006b). The proximity of the district to Cape Coast affords the population access to health services provided in the hospitals and polyclinics within the city. In spite of these facilities, the people still have a problem with access to health facilities. This is due to the poor

physical conditions of the roads in most parts of the district (Ghanadistricts.com, 2006b).

Education

In terms of education, in the 2006/2007 academic year, the district have 85 Pre-schools, 103 Primary Schools, 73 Junior High Schools (JHS), 4 Senior High Schools (SHS) and one college of education. The teacher - pupil ratios of public pre-school, primary, JHS's, SHS's, and college of educations were found to be 1:55, 1:43, 1:24, 1:24 and 1:14 respectively. The ratios for the pre-schools and primary are above the national ratios of 1:45, 1:35. These figures show that quite a number of school going age children are attending school yet the number of teachers are inadequate (Ghanadistricts.com, 2006d).

In terms of enrolment, in the 2006/2007 academic year, the district had a total of 85 nursery schools with an enrolment of 8,481,103 primary schools with enrolment of 24,743, and 73 JHS's with an enrolment of 8,839 students. These schools are evenly distributed in the district, compared to the SHS's where there are only 2 public schools in the district, which are located at Assin Fosu, and Assin Praso. In addition to the SHS, the District has one college of education in Assin Fosu The educational status of the population showed that about 66 per cent of the population have attained formal education up to primary level, 7 per cent up to secondary level, 3 per cent up to tertiary level, and 24 per cent have had no formal education (Ghanadistricts.com, 2006d). With this situation, the illiteracy rate is estimated to be 60 per cent. This figure is comparatively higher as against

the 46.9 per cent acceptable rate for the country. As a result, the educational level of the population is quite low which does not auger well for development, since development is education-driven.

The National Vocational Technical Institute (NVTI) at Foso may be the only avenue for acquiring formal technical skills in the district. This is inadequate and leaves most JHS leavers with no skill for job acquisition or self-employment. The physical state of most of the school buildings especially the primary schools and J.S.S are not in good condition. Supportive facilities like water and toilet, and equipment is inadequate and in some places even completely lacking. In the case of J.S.S, majority of them do not have workshops, while those that have do not have the necessary facilities for run them. The European Union, the GETFUND, and the Highly Indebted Poor Country (HIPC) Relief Fund have constructed JHS and primary school blocks for the district. The Assin North Municipal Assembly of urgency needs to rehabilitate some of the deplorable schools in the district (Ghanadistricts.com, 2006d).

Study design

The research plan is a cross sectional survey that adopted the mixed method approach. This method involved triangulating both quantitative and qualitative methods to collect and analyse data at the same time. Creswell (2003) supports the use of mixed method approach in social sciences, because the technique has become increasingly popular as a legitimate research technique. According to Neuman (2003), mixed method technique is the best method that

should be used in a study. This is because combining different methods in a study will help one to look at something better from several angles than to look at it from only one way. The rational for adopting the mixed method technique was based on the distinctive advantage it offers. It helps one to gained better understanding of the phenomenon under study and also helped to complement the strength of qualitative and quantitative methods (Depoy & Gitlin, 2005).

Study population

The study population for the study comprised the following group of people:

- Beneficiaries (registered members of NHIS)
- Service Providers (assigned hospital and a pharmacy)
- Head of NHIS in Assin North municipality

Beneficiaries were involved in the study because they are the people who benefit from or access the services of NHIS. Their inclusion helped to know the challenges that are making it difficult for them to access NHIS easily. Service provides on the other hand play vital role in NHIS. Some of the roles played by service providers include providing health services in hospitals for patients and provision of drugs to NHIS beneficiaries. The involvement of NHIS service providers enriched the study. It helped the study to know some of the challenges facing NHIS service providers in Assin North Municipality. Furthermore, the overall operation of NHIS in Assin North Municipality is headed by a district

manager. The engagement of the Municipal Manager also helped to unearth the challenges facing the smooth running of NHIS in Assin North Municipality.

Sample size

In order to fairly capture a representative view of the entire people of Assin North Municipality, the Fisher, Laing, Stoeckel and Townsend (1998) formula for determining sample size for the study was adopted.

$$n = \frac{z^2 pq}{d^2}$$

Where:

n= the desired sample size (when the population is greater than 10,000)

z= the standard normal deviation, usually set at 1.96 which corresponds to 95 percent confidence level;

p= the proportion in the target population estimated to have particular characteristics (similar views on effectiveness of NHIS);

q= 1.0-p; (with 1.0 as constant) and

d= the degree of accuracy desired, usually set at 0.05

With the (z) statistic being 1.96, degree of accuracy (d) set at 0.05 percent and the proportion of the study population with similar characteristics in respect of their views on the effectiveness of the NHIS in Assin North Municipality (p) at 90% which is equivalent to 0.90, then the sample size is:

$$n = \frac{(1.96)^2 (0.90) (0.10)}{0.05^2}$$

$$n = 138.297$$

A desired sample size of 138 respondents was obtained. In view of this, 138 NHIS subscribers or registered members were selected. In addition to this, three key informants comprising the manager of Assin North NHIS, the head of one accredited NHIS pharmacy and the head of one accredited NHIS health centre were purposely selected.

Sampling procedure

Non probability sampling techniques were used to select respondents for the study because there was no adequate sampling frame that covered all the respondents. As a result of this given each individual equal chance of being selected was impossible. Purposive sampling which is an example of non probability sampling was used to select communities under Assin North Municipal area to participate in the study. Under this type of sampling, the researcher purposively chooses subjects that would serve the best purpose of the study. Using this sampling technique, four communities namely Assin Fosu (capital of Assin North district), Assin Breku, Assin Akropong and Assin Akonfudi were selected. These communities were selected based on the grounds that they have health centres which administers or deliver the services of NHIS. Purposive sampling techniques was also used to select the head of one accredited NHIS health centre, the head of one accredited NHIS pharmacy, and the

municipal manager of NHIS in Assin North municipal area to participate in the study.

The total sample size of 138 NHIS subscribers for the study was proportionately shared among the four selected communities in line with the size of their population as indicated in Table 1.

Table 1: Sample size for selected communities

Town	Sample size	Percentage
Assin Fosu	88	64
Assin Breku	23	16
Assin Akonfudi	14	11
Assin Akropong	13	9
Total	138	100

Source: Ghana Statistical Service, 2008

In getting the shortlisted NHIS subscribers for the study, convenient sampling technique was used. In convenient sampling, subjects are selected based on their convenient accessibility and proximity to the researcher. In view of this, since NHIS subscribers visit NHIS accredited health centres to seek health services, one accredited NHIS health centre in each of the selected communities was used as reference point to get the selected NHIS subscribers for the study. At each health centre in the shortlisted communities, the NHIS subscribers were conveniently selected and interviewed until the sample size assigned to the community was obtained.

Ethical issues

Much attention was given to ethical issues when collecting data from the field. Ethical issues that were involved in this study were:

(a) Informed consent

Under this ethical issue the researcher identified himself to respondents and other stakeholders including the community chiefs, elders, assembly members and the municipal office of the NHIS to avoid all kinds of false impression been created in the minds of respondents. In addition to this, the purpose of the study or the reason why the research was being conducted were also explained to respondents for them to get clear understanding of the study.

Lastly, the nature of the questionnaires and interviews were made known to the respondents for them to have clear picture and idea about how to answer the questionnaires and participate fully in the study.

(b) Confidentiality

With reference to this ethical issue the respondents were informed and promised that the information given by them will solely be used for the purpose of the study but not for other matters. Furthermore, respondents were informed that the information given will not be made available for other people for any reason.

(c) *Anonymity*

All forms of identification including respondent names, addresses and telephone numbers on the questionnaires and interview guides were avoided during the study.

Research instruments

In line with the mixed method technique which is guiding this study, both interview guide for interviewing (qualitative method) and questionnaire (quantitative method) were used to collect data from the field. The interviewing was conducted in a face-to-face situation in a congenial atmosphere with the researcher (interviewer) asking questions and the respondent (interviewee) given answers to them. Tape recorders were used to record the interviews which later on were transcribed for the analysis of the study. Three interviews were conducted for the study. These were made up of the head of NHIS in Assin North municipality, head of one pharmacy and head of one hospital. The interviews were in a semi-structured format. This is because according to Hockey, Robinson and Meah (2005), semi-structured interviews are flexible and also provide a scope for pursuing and probing for relevant information through additional questions often noted as prompts on the schedule.

Questionnaires were administered to the selected NHIS subscribers. The questionnaires were personally administered the respondents. In situations where the respondents could not read or write in English, the questions were translated to Twi for the respondents to answer. In order to facilitate easy administration of the questionnaires, quantification, comparison of responses and avoidance of irrelevant answers, the questionnaires involved many closed ended questions and few open-ended questions.

Data and sources

Two sources of data were relied upon for the study. These included primary and secondary sources. The primary data were obtained from the questionnaires that were administered to the selected NHIS subscribers and in-depth interviews that were conducted for some key informants. Data such as perception about NHIS, enrollment of NHIS and challenges facing the implementation of NHIS in Assin North municipality were collected from the selected respondents.

Secondary sources of information on the other hand that were used for the study were books, journals, reports, news papers, articles and information from the internet that treated the topic under study.

Fieldwork

The fieldwork for the study took place between 4th October and 2nd November, 2010. In all, about one-month was used to collect data from the field. The first three weeks were used to administer the questionnaires to the selected NHIS registered members or subscribers in the study area. The administration of the questionnaires was done at accredited NHIS health centres and took place in the morning especially between 6.00 am and 12.00 pm. This was because it was around this time that more people go to health centres to seek health services. The remaining one week was used to conduct three in-depth interviews. The in-depth interviews were conducted round 3.00 pm to 4:30 pm where most of the interviewees were free.

Data processing and analysis

The collected data were examined for consistency of responses. The completed questionnaires were edited, coded and fed in the computer with descriptive statistical techniques being used in the analysis. Statistical Product and Service Solutions (SPSS version 16) was employed to analyse the data and highlight significant features associated with the challenges facing effective implementation of NHIS in Assin North municipality. The in-depth interviews were analysed manually. They were first transcribed, categorized under specific themes and used for the analysis. Summations, percentages, chart, graph and specific quotations from respondents were used to present views of the respondents

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The previous chapter outlined the methodology employed in the study. This chapter discusses the results and analysis for the study. Five broad areas are covered in this chapter. These areas are the socio-demographic characteristics of respondents, the level of registration of NHIS, factors influencing the level of registration of NHIS, respondents' perceptions on the activities of NHIS and the challenges facing the operation of NHIS in Assin North Municipality.

Socio-demographic characteristics of respondents

Socio-demographic characteristics help to give a true picture of the characteristics that the respondents possess. Although the study is not geared towards analysing the socio-demographic characteristics of registered members of NHIS in Assin North Municipality but this background characteristic will help to reveal the basic characteristics of NHIS registered members in Assin North Municipality. This will facilitate comparison with other registered members of NHIS in Ghana and other African and European countries. Socio-demographic characteristics covered in this study are sex, age, education, education.

Sex of respondents

Sex is one of the variables that are considered in analyzing the level of enrollment of the beneficiaries of NHIS across the world. The sex component gives an idea about the distribution of NHIS enrollment data taken by males and female. According to World Health Organization (2003), females take greater share of NHIS beneficiaries in both developing and developed countries because of their large population and their easily susceptible to health problems. Figure 1 shows the sex distribution of the selected NHIS beneficiaries at Assin North Municipality.

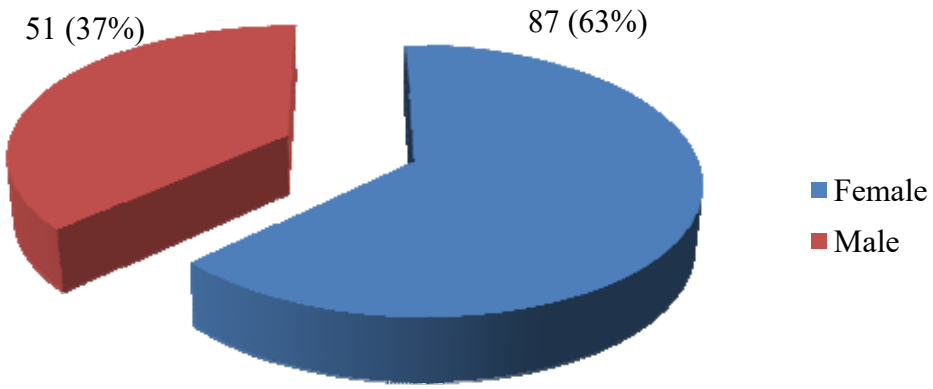

Figure 1: Sex distribution of respondents

Source: Fieldwork, 2010

Out of the total sample size of 138 respondents (Fig. 1), 63 percent were females and 37 percent were males. This observation supports World health Organization's (2003) findings of females out numbering their male counterparts in NHIS enrollments.

Age of respondents

After knowing the sex distribution of the respondents with respect to NHIS enrollment at Assin North, it was vital to find out the ages of the selected respondent to know the age category that contain the highest NHIS registered members. The age of the respondents were categorised into five year intervals in line with the 2008 Ghana Demographic and Health Survey's (GDHS) categorisation of the age-groups of Ghanaians (Table 2).

Table 2: Age Distribution of respondents

Age	Frequency	Percent
Up to 18	15	10.9
19 – 28	19	13.7
29 – 38	50	36.2
39 – 48	25	18.2
49 – 58	17	12.3
59 – 68	12	8.7
Total	138	100.0

Source: Fieldwork, 2010 N = 138

In Ghana, records shows people up to 18 years and those above 70 years take substantial part of the NHIS enrollment (Djan, 2010). This is because such people access the health insurance scheme for free. However, the situation found in Assin North Municipality was different (Table 1). The majority of the respondents were within the age category of 29-38 years (36.2%). It was followed

by respondents within the age brackets of 29-48 years (18.1%) and 19-28 18 years (13.7%) respectively. Respondents within 59-68 age brackets had the lowest responses (8.7%). The high rate of respondents within the age bracket of 29-38 years might be due to the fact that such people have much trust for NHIS and also have the money to pay the necessary premium.

Level of education

Education plays a significant role in the level of enrollment of health insurance schemes. In developed countries, it has been observed by W.H.O (2003) that the enrollment of people in health insurance schemes is high because of high level of education. In developing countries, many of the health insurance schemes have low enrollment which in part has been attributed to the low level of education of the people. The level of education of the respondent is presented in Table 3.

Table 3: Level of education of respondents

Level of education	Frequency	Percent
No formal education	18	13.0
Basic	61	44.2
Secondary	39	28.3
Tertiary	20	14.5
Total	138	100.0

Source: Fieldwork, 2010; N = 138

In Assin North Municipality (Table 3), the majority of the selected NHIS subscribers have had only basic education (44.2%) with few having no formal

education (13.0%). The education distribution of the respondents is in line with the 2008 Ghana Living Standard Survey which indicated that in terms of education level, 57.9 percent of Ghanaians have basic level of education (Ghana Statistical Service, 2008).

Occupation of respondents

Informal sector employees or workers have been found to be the dominant subscribers of NHIS in Ghana (National Development Planning Commission, 2009). Informal sector employments are non-government employment. That is employment opportunities that are not created by government. To find out the employment status of the selected NHIS subscribers for the study, the respondents were asked to indicate the economic activity they engage in for a living. Table 4 gives a detail account of the occupation background of respondents.

Table 4: Occupation of respondents

Occupation	Frequency	Percent
Unemployed	11	8.0
Informal sector	86	62.3
Formal sector	27	19.6
Pensioner	14	10.1
Total	138	100.0

Source: Fieldwork, 2010; N = 138

As indicated in Table 4, most of the respondents were in the informal sector (62.3%). Many of the respondents indicated that they are either engaged in agricultural activities or their own created job opportunities for living. The formal

sector employees were 19.6 percent and only 8 percent of the respondents were unemployed. This result corroborates with the National Development Planning Commission's findings on the occupation background of NHIS subscribers in Ghana.

Level of registration of NHIS

Findings on the level of subscription of the NHIS in Ghana by the National Development Planning Commission (2009) shows that the number of people registered under the NHIS has increased greatly since the operation of the NHIS in 2005. To find out the level of registration of NHIS in Assin North Municipality, the selected NHIS subscribers were asked to indicate the year they registered for the NHIS. It was realized that the number of people who register for the NHIS go up each year as indicated in Table 5.

Table 5: Year of registration of NHIS

Year	Frequency	Percent
2005	4	2.9
2006	11	8.0
2007	22	16.0
2008	26	18.8
2009	29	21.0
2010	46	33.3
Total	138	100.0

Source: Fieldwork, 2010; N =138

The results from Table 5, shows clearly that the level of registration of the NHIS is high in Assin North Municipality. In 2005, when the NHIS was introduced, only 4(2.9%) of the respondents registered. The number of subscribers got increased year by year to its present high level of 46 (33.3%) respondents in 2010. To get more information about the level of registration of the NHIS, the Assin North manager of NHIS and the heads of two NHIS service providers were interviewed. The Assin North manager of NHIS had this to say:

> *The level of registration of NHIS is very high. The number of people registered under NHIS in Assin North Municipality has increased from about 90,000 to about 130,000 as at November, 2010. In fact we are close in achieving a full coverage of all people in Assin North district to the NHIS. This is because the 2010 report on NHIS from the Ministry of Health shows that the total number of people in Assin North Municipal Assembly is about 152,000.*

The head of one accredited NHIS pharmaceutical shop remarked:

> *The number of NHIS subscribers who patronize our services is now very high. Previous on the average, about 30-40 NHIS subscribers visit our outfit daily but now close to 100 NHIS subscribers visit our shop daily.*

A similar story was said by the head of one accredited NHIS health centre. The head said this:

Previously, although the number of NHIS subscribers that visited our health centre was high but now the number is so high that we find it difficult to even find enough space to contain NHIS subscribers. Due to this high number, we have increased the number of doctors that attend to the NHIS subscribers but still many of the NHIS subscribers visit our health centre early in the morning but leave late in the afternoon.

The comments from the Assin North NHIS manager and the heads of the two service providers clearly show that the level of registration of NHIS is very high. This is in line with the increased level of NHIS subscribers in Ghana. This finding however, contradicts (Bennett, Creese & Monasch, 1998).) assertion of health insurance schemes in developing countries having low enrolment rates.

Factors influencing the level of registration of NHIS

Several factors have been raised worldwide to influence the level of registration of health insurance schemes. However, factors that lead to high or low level of enrollment of health insurance scheme in a particular country or area is not the same everywhere, it varies. To ascertain the reasons for high level of registration of NHIS in Assin North Municipality, the selected NHIS subscribers were asked to indicate the factors that influenced them to register under the NHIS. Table 6 gives full account of the responses indicated by the respondents.

Table 6: Factors for high level of registration of NHIS

Factor	Frequency	Percent
Trust in the scheme	77	55.8
Affordability of premium	34	24.6
Proximity to NHIS service providers	18	13.1
Quality of services by NHIS service providers	9	6.5
Total	138	100.0

Source: Fieldwork, 2010; N = 138

In Assin North Municipal Assembly, trust in the NHIS was the main reason for many people been registered under the NHIS (Table 6). About 56 percent (55.8%) of the NHIS subscribers said that it was as a result of the trust they have in the scheme that motivated them to subscribe to the scheme. In probing further for more answers many of the subscribers made it clear that the NHIS has come to stay and they now have much trust for it that is why they have registered for it. Next to trust in the NHIS scheme is the affordability of the premium (24.6%) that encouraged them to register for the NHIS. The last factor that influenced people to subscribe to the NHIS in Assin North Municipality was the quality of service provided by NHIS service providers (6.5%). This shows that the NHIS registered members are not satisfied with the kind of services rendered by NHIS service providers in Assin North Municipality.

The views of the three key informants that were interviewed on the high level of NHIS registration were similar to the selected NHIS subscribers. All the

three key informants attributed the high level of NHIS registration in Assin North to the trust the public have had in the NHIS scheme. For example, the head of Assin North NHIS said:

> *At first, the level of NHIS registration was low. This was because most of the general public thought the NHIS will fail along the line and those registered under it will have their monies been lost. When the general public realized that after change of government the NHIS is still going on smoothly, they have come to believed that NHIS is a permanent policy that when you invest in it you will not lose.*

Trust in the NHIS been the dominant factor for the increment in NHIS coverage in Assin North Municipality support van Ginneken's (1999b) observation of the coverage of health insurance scheme in Tanzania. According to van Ginneken, the level of coverage of health insurance scheme in Tanzania has increased because of the trust people have in the health insurance scheme.

Perception of the activities of NHIS

In assessing the respondents' perceptions of the activities of NHIS, the respondents were asked to express their views on the activities of NHIS (accredited health centres, pharmacies and registration officials). They were also asked to give their views on the overall performance of NHIS and also give their views on whether they want the operation of NHIS to continue in Assin North Municipality.

With respect to the respondents' perception of NHIS activities, the respondents were asked to grade the performance of accredited NHIS health centres, pharmacies and NHIS registration officials based on their own opinion (Table 7).

Table 7: Respondents' perception of the activities of NHIS

NHIS service providers	Grade (%)					Total
	A	B	C	D	E	
Health centres	53.0	15.2	10.1	11.6	10.1	100.0
Pharmacies	8.0	13.0	56.6	10.1	12.3	100.0
Registration officials	16.7	14.5	50.0	12.3	8.0	100.0

A = Very good, B = Good, C = Average, D = Bad, E = Very bad

Source: Fieldwork, 2010; N = 138

The respondents' perception on NHIS health centres was very good. More than half of the respondent (53%) graded NHIS health centres in Assin North Municipality "A" for the services they provide (Table 7). This was contrary to the Shisana et al.'s (2005) findings of many NHIS subscribers in South Africa not happy with the services provided by NHIS health centres. Some of the reasons the respondents gave for the very good services provided by the NHIS health centres Assin North district were that the workers of the NHIS health centres do not

discriminate in the services they offer to the patients that visit their centres. They give equal attention to both registered and non registered members of NHIS. The respondents also said that they do not pay any bribes before they are attended to in any NHIS health centre in Assin North Municipality. Few respondents graded NHIS health centres "E" for the services they provide. The reasons given to this was that on many occasions they spent much time at the health centres.

On the NHIS accredited pharmacies, the respondents' perception was normal. About 57 percent (56.6%) awarded grade "C" for the services provided by NHIS accredited pharmacies in Assin North district (Table 7). The reason given for the average performance of NHIS accredited pharmacies was that on many occasions the pharmacies run out of or do not have the drugs prescribed by doctors. This finding is in line Sanusi and Awe's (2009) observation of insufficient drugs in most of the health insurance schemes in Nigeria.

Respondents' perception on NHIS registration officials was also normal. Exactly half of the respondents (50%) gave grade "C" to the services provided by the NHIS registration officials (Table 7). Many of the respondents said that it takes a longer time before one can get a NHIS card. This support Sanusi and Awe's (2009) view of health insurance subscribers not promptly attended to at Oyo state in Nigeria.

Apart from the respondent perception on the individual activities of NHIS in Assin North Municipality, the respondents over all perception of the performance of NHIS were assessed. This is shown in Figure 2. The majority of the respondents were satisfied with the overall performance of NHIS (Fig. 2).

About 60 percent (60.1%) of the respondents rated the overall performance of NHIS in Assin North district satisfactory with few respondents rating the overall performance of NHIS very poor. The reasons the respondents gave for the satisfactory performance of NHIS were that is has helped the poor to get quality health treatment when they are sick and it has also helped children to get free healthcare. The respondents who were dissatisfied with the overall performance of NHIS and rated it very poor (3.6%) cited delays in accessing the services of NHIS service providers and frequent shortages of drugs by accredited NHIS pharmacies as reasons behind their decision (Fig. 2).

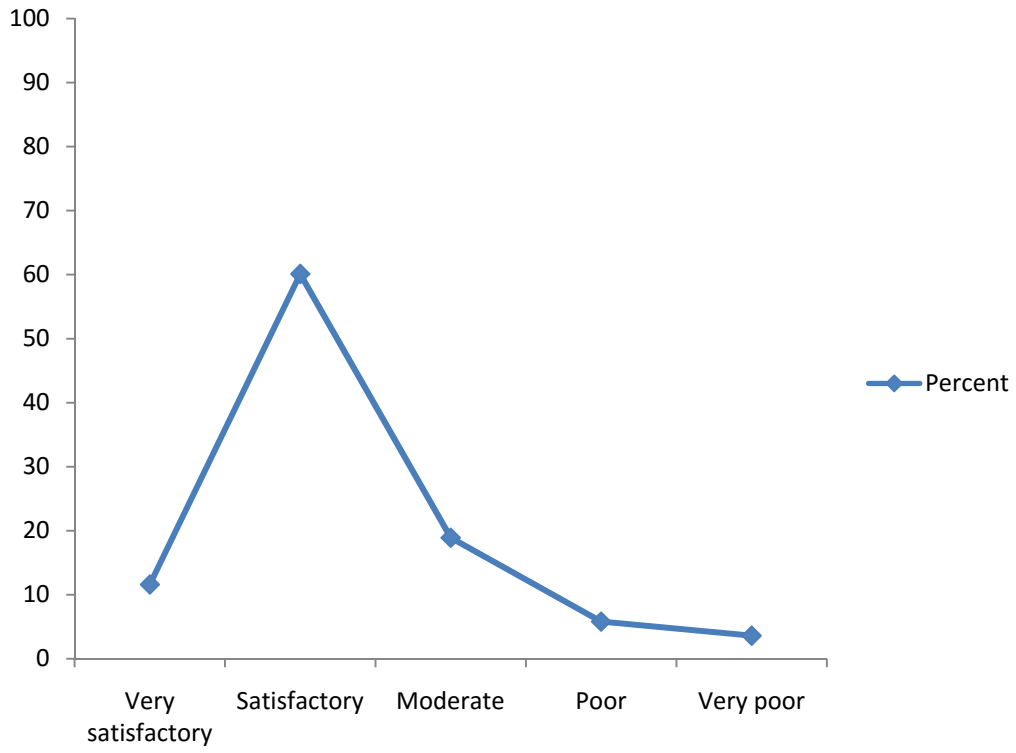

Figure 2: Respondents' perception of the overall performance of NHIS

Source: Fieldwork, 2010; N=138

After knowing the perception of the performance of NHIS, the perception of the continuation of the NHIS in Assin North Municipality was assessed. The respondents were asked to express their views on whether they want NHIS to continue or not. The respondents' perception of the continuation of NHIS was good. Table 8 gives a full account of the respondents' decision.

Table 8: Perception on continuity of the NHIS

Continuity	Frequency	Percent
Yes	136	98.6
No	2	1.4
Total	138	100.0

Source: Fieldwork, 2010; N = 138

Almost all the respondents wanted the NHIS to continue. About 99 percent (98.6%) of the respondents said "YES" (Table 8). Most of the respondents were of the view that the NHIS is good because it helps them to go to hospital any time they want without paying any money. Others also believed that the NHIS has helped them to save money which would have been spent on their health care. The respondents' good perception of the continuation of the NHIS contradicts Sanusi and Awe's (2009) findings on the health insurance scheme of Oyo state where many of the beneficiaries wanted the health insurance scheme to be discontinued because of poor service provided by the scheme's service providers.

Challenges facing the operation of the NHIS

Many challenges militate against the effective implementation of health insurance schemes across the world. According to Cheng (2003), high cost of premium is one of the main challenges that affects Taiwan's health insurance scheme. In Assin North district, the story was different. High cost of premium was not among the main challenges affecting the effective operation of the NHIS. Poor delivery of services by NHIS service providers, corruption in the activities of NHIS service providers and untimely disbursement of funds to NHIS service providers were the main challenges that were pointed out by the respondents (Table 9).

Table 9: Challenges affecting operation of the NHIS

Challenges	VH (%)	H (%)	N (%)	L (%)	VL (%)	Total
High cost of premium	15.2	5.8	67.5	7.2	4.3	100.0
Inadequate financing of NHIS	27.5	15.2	34.1	18.1	5.1	100.0
Inadequate logistics	37.6	22.5	31.2	5.1	3.6	100.0
Untimely disbursement of funds To NHIS service providers	57.3	24.6	12.3	2.9	2.9	100.0
Poor delivery of services by NHIS service providers	66.8	17.4	10.1	4.3	1.4	100.0
Corruption in the activities Of NHIS service providers	60.2	10.9	18.8	8.7	1.4	100.0
Lack of understanding about NHIS by the general public	29.7	10.9	30.4	16.7	12.3	100.0

VH = Very high, H = High, N = Normal, L = Low, VL = Very low
Source: Fieldwork, 2010; N=138

From Table 9, poor delivery of services by NHIS service providers, corruption in the activities of NHIS service providers and untimely disbursement of funds to NHIS service providers had more than half of the respondents indicating that they are very high in Assin North Municipality. Poor delivery of services by NHIS service providers had the highest responses (66.8%). This supports Yamikeh's (2007) findings of poor service delivery by NHIS service providers as the main problem affecting the effective implementation of the NHIS in Ghana. It was followed by corruption in the activities of NHIS service providers (60.2%) and untimely disbursement of funds to NHIS service providers (57.3%). The remaining challenges in Table 8 although had some responses from the respondents but it was not high. For example, high cost of premium, inadequate logistics and inadequate financing of the NHIS had only 15.2 percent, 37.6 percent and 27.5 percent of the respondents respectively indicating that they are very high.

The views of the key informants were not the same as the selected NHIS subscribers. Unlike the NHIS subscribers, the challenge that was very high to the key informants was the untimely disbursement of funds to the NHIS service providers. For example, the head of one NHIS accredited pharmacy had this to say:

> *The National Health Insurance Authority has not paid for all the drugs we have issued to NHIS beneficiaries. Up till now, the cost of drugs supplied to NHIS beneficiaries for the last three months are in arrears. This is worrying us dearly.*

Similar concern was raised by the head of one accredited NHIS health centre. The head remarked:

> *The authorities of NHIS owe our health centre huge sums of money which accrued as a result of the health services we delivered to NHIS beneficiaries. The hospital bills of many NHIS beneficiaries who visited our centre for the last four months are not paid yet.*

The views of the key informant support Kennedy's (2009) findings of delays in payment of monies to NHIS services providers by the authorities of NHIS hindering the success of Ghana's NHIS.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The previous chapter presented and discussed the results obtained from the field. This chapter sums up the whole study on the challenges facing effective implementation of the NHIS in Assin North Municipal Assembly. It contains a summary of the study, objectives of the study, methodology and major findings as well as conclusions from the findings and recommendations to improve the effective implementation of the NHIS in Assin North Municipal Assembly.

Summary of the Study

The main objective of this study was to analyse the implementation of the NHIS in Assin North Municipal Assembly.

The specific objectives of the study were to:

- Examine the level of coverage of the NHIS.
- Assess the factors that have influence the level of registration of the NHIS.
- Assess the perception of NHIS subscribers on the implementation of NHIS.
- Examine the challenges facing the implementation of the NHIS.

Questionnaires and interview guide were the research instruments that were used to collect data from the field. Examples of the data collected from the field were the level of registration of NHIS, factors that has accounted for the

level of NHIS registration, perception of the NHIS implementation and the challenges confronting the implementation of the NHIS in Assin North Municipality. Three categories of people constituted the target population for the study. These were the NHIS subscribers or beneficiaries, NHIS service providers (the heads of one health centre and one pharmacy) and the head of Assin North NHIS. The questionnaires were used to collect data from the NHIS subscribers whilst interview guide was use to gather information from the key informants through IDIs.

Over all, 138 NHIS subscribers and three key informants were selected for the study. The three key informants were the manager of Assin North NHIS, the head of one accredited NHIS pharmacy and the head of one accredited NHIS health centre. Purposive and convenient sampling techniques were used to select the respondents for the study. The SPSS (version 16) was used to process the data for analysis whilst the analysis of the data were presented using summations, percentages, chart, graph and specific quotations from the respondents.

The major findings of the study include the following:

- The majority of people who were registered under the NHIS were from the informal sector. Out of the 138 NHIS subscribers who were selected for the study, 86 (62.3%) were informal sector workers while 27 (19.6%) were formal sector workers. Most of the NHIS subscribers are in agricultural activities or depend on their own created jobs for living.
- The level of registration of the NHIS in Assin North Municipality was high. Each year the number of people that gets registered under the NHIS

increases. In 2005, the number of the respondents that had registered under the NHIS was 4 (2.9%) but in 2010 it increased to 46 (33.3%).

- Two main factors have accounted for the high level of NHIS subscribers in Assin North Municipality. These factors are trust in the NHIS and the affordability of the NHIS premium. Trust in the NHIS had the highest responses of 55.8 percent.
- The respondents' perception of the activities of the NHIS was fairly good. Most of the respondents were satisfied with the services delivered by accredited NHIS health centres but had an average level of satisfaction of the services delivered by accredited NHIS pharmacies and the NHIS registration officials.
- The respondents' perception of the overall performance of the implementation of the NHIS in Assin North Municipality was good. About 60 percent of the respondents rated the implementation of the NHIS satisfactory.
- Almost all the respondents perceived the NHIS to be a good health policy and wanted it to continue. About 99 percent (98.6%) of the respondents supported the continuation of the NHIS in Assin North Municipality.
- Three main challenges affect the effective implementation of the NHIS in Assin North Municipality. These challenges were Poor delivery of services by NHIS service providers, corruption in the activities of NHIS service providers and untimely disbursement of funds to NHIS service providers.

Conclusions

Based on the findings of the study, the following conclusions could be drawn from the study:

- There is a high level of registration of the NHIS in Assin North Municipality. Large number of people registers under the NHIS every year and most of these people are from the informal sector.
- The high level of registration of the NHIS in Assin North Municipality is as a result of mainly the trust people have had in the NHIS and the low cost of NHIS premium.
- There is a good perception of the activities of the NHIS in Assin North Municipality. Most of the people are satisfied with the overall performance of the NHIS and want it to be continued in the area.
- Poor delivery of services by NHIS service providers, corruption in the activities of NHIS service providers and untimely disbursement of funds to NHIS service providers are the main challenges that affects the effective implementation of the NHIS in Assin North Municipality.

Recommendations

In relation to the findings and conclusion of the study the following recommendations have be suggested:

- The National Health Insurance Council NHIC should hold constant meeting with the NHIS service providers to discuss the NHIS beneficiaries consent about the kind services they received from the NHIS service

providers. Such meetings will make the heads of the NHIS service providers aware of the various forms of problems that NHIS subscribers go through when they seek their services and come out with strategies curtail them.

- The NHIC should institute award scheme for the best NHIS service providers. Such awards should be done at the district, regional and national level. In deciding for the award winners, the NHIS subscribers should be given a larger share of the decision making because they are the actual stakeholders that access the services of the NHIS service providers. The awards can be organised every six month or on yearly basis. This measure will encourage the NHIS service providers to improve upon their services for the betterment of effective implementation of the NHIS.
- The disbursement of funds to NHIS service providers for the cost of drugs and other services rendered to NHIS subscribers should be done timely by the NHIC. The disbursement of such funds should be done at the end of every month or few days after every month. This will enable the accredited NHIS service providers to provide better health care services to NHIS subscribers.
- The NHIC should form finance committees at the district, regional and national levels to check the financial activities of NHIS service providers. These committees should closely monitor the finances of NHIS service providers every four months or quarterly. This will help to eliminate or cut down the fraudulent activities among the NHIS service providers.

Areas for future research

The current study looked at the challenges facing the effective implementation of NHIS in only one area that is the Assin North Municipality. Future studies can look at two or more districts to know the similarities and the differences in the challenges facing the implementation of the NHIS.

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APPENDICES

APPENDIX I

UNIVERSITY OF CAPE COAST

INSTITUTE FOR DEVELOPMENT STUDIES

QUESTIONNAIRE FOR REGISTERED MEMBERS OF NHIS

The main aim of this research is to examine the challenges facing National Health Scheme (NHIS) in Assin North District in Central Region. This questionnaire is designed to elicit information regarding this research work. Information given will solely be used for this research. You are also assured of full confidentiality, privacy and anonymity of all the information that will be given by you. You should therefore feel free to give me the right information to ensure the success of this work.

Module A: Personal information on respondents

1. Sex: Male [ ] Female [ ]
2. Age: .....
3. Level of education:
   (a) No formal education [ ]
   (b) Primary education [ ]
   (c) Secondary education [ ]
   (d) Tertiary education [ ]
   (e) Other [ ],
   Specify.....

4. Occupation;.....

5. Religion:

   (a) Christian [ ]

   (b) Muslim [ ]

   (c) Traditional [ ]

   (d) Buddhist [ ]

   (e) Other [ ]

   Specify.....

6. Ethnicity.....

7. Marital status.

   (a) Single [ ] (b) Married [ ] (c) Divorced [ ] (d) Widowed [ ] (f) Separated [ ]

Module B: Perception about NHIS

8. Are you aware of NHIS ? Yes [ ] No [ ]

9. If yes, where did you hear it from?

   (a) Television [ ]

   (b) Radio [ ]

(c) News paper [ ]

(d) From friends [ ]

(e) Other [ ]

Specify.....

10. Using grade A= very satisfactory, B= satisfactory, C= moderate, D= poor, E=very poor, how will your rate the performance of the following aspects of National Health Insurance Scheme (NHIS) in Assin North district?

	Grade	Reason
NHIS registered hospitals		
NHIS registered pharmacies		
NHIS registration workers		

11. How do you see the overall performance of NHIS?

(a) Very satisfactory [ ]

(a) Satisfactory [ ]

(b) Moderate [ ]

(c) Poor [ ]

(d) Very poor [ ]

12. Give reasons.....

.....

13. Do you want NHIS to be continued? Yes [ ] No [ ]

14. Why ?.....

Module C: Registration of NHIS

15. Have you registered for NHIS? Yes [ ] No [ ]

16. If yes, when did you register?.....

17. Which factor encouraged you to register?

(a) Affordability of premium [ ]

(b) Trust in the scheme [ ]

(c) Good quality of services provided by NHIS service providers [ ]

(d) Close location of my house to NHIS service providers [ ]

(e) Other [ ]

Specify.....

18. If No, which factor discouraged you from registering?

(a). High cost of premium [ ]

(b).Lack of trust in the scheme [ ]

(c) Poor quality of services provided by NHIS service providers [ ]

(d) Far location of my house to NHIS service providers [ ]

(e) Others [ ]

Specify.....

19. How can you rate the level of registration of NHIS in Assin North District?

(a) Very high [ ]

(b) High [ ]

(c) Moderate [ ]

(d) Low [ ]

(e) Very low [ ]

20. In your opinion what have accounted for your answer in q19?

.....

.....

Module D: Challenges facing the operation of NHIS

21. To what extent do the following challenges affect the smooth operation of NHIS in Assin North district?

Challenges	**Very high**	**High**	**Normal**	**Low**	**Very low**
High cost of Premium					
Inadequate financing of NHIS					

Inadequate logistics					
Untimely disbursement of funds to NHIS service providers (eg. Hospitals and Pharmacies)					
Poor delivery of services by NHIS service providers.					
Corruption					
Lack of understanding about NHIS					

22. What do you think should be done to improve the operation of NHIS in Assin North district?

.....

.....

Thank you

APPENDIX II

UNIVERSITY OF CAPE COAST

INSTITUTE FOR DEVELOPMENT STUDIES

IN-DEPTH INTERVIEW GUIDE FOR KEY INFORMANTS

Date of interview:

Place of interview:

Interviewer name:

Interviewee Gender:

Organisation/Institution:

Position/title:

Introduction

The main aim of this research is to examine the challenges facing National Health Scheme (NHIS) in Assin North Municipalility in Central Region. This interview guide is designed to elicit information regarding this research work. Information given will solely be used for this research. You are also assured of full confidentiality, privacy and anonymity of all the information that will be given by you. You should therefore feel free to give me the right information to ensure the success of this work.

- Rating from very good, good, moderate, bad and very bad how do you assess the operation of NHIS in Assin North district?
- In your view has NHIS been able to live up to expectation? Why

- Are you satisfied with the level of registration/coverage of NHIS?
- What are some of the factors that you think encourage people to register for NHIS in Assin North district?
- On the opposite, what are some of the factors that discourage people from registering for NHIS?
- What are the challenge facing NHIS in Assin North district?
- Among these challenges which one does it affect your outfit greatly and why?

- What effect does this challenge have on the performance of your outfit?
- What effect does this challenge have on the general public?

- What are the measures that you think can be put in place to address these challenges to improve the operation of NHIS in Assin North district?

Thanks for your cooperation