UNIVERSITY OF CAPE COAST

WORKING CONDITIONS OF HEALTH PERSONNEL: ITS IMPLICATIONS FOR THE SUSTAINABILITY OF THE NATIONAL HEALTH INSURANCE IN THE CAPE COAST METROPOLIS

BY

EMMANUEL KWABENA BADU

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DECLARATIONS

Candidate's Declaration

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

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

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Supervisor's Declaration

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

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ABSTRACT

The inadequacy of reach-all health budgets in many developing countries has usually been a matter of political and social concern in several countries affected by budgetary constraints. In a bid to achieve some level of equity in health care, Ghana officially introduced National Health Insurance Scheme (NHIS) in 2004. This study sought to investigate conditions under which health personnel work to ensure the sustainability of the NHIS.

The study used triangulation method, which involved the use of multiple sources and methods to collect data from health workers and some clients of the NHIS. Results of the study showed that health personnel had limited personal experiences with the legal framework establishing the scheme. It was also, revealed that notwithstanding the increases in patronage of health services since the introduction of the NHIS, this has not been matched with required health infrastructure. Nonetheless, most of the health personnel are relatively satisfied in responding to the needs of NHIS policyholders. Some policy holders are equally satisfied with services provided them by health workers and that they were willing to sustain their membership of the scheme.

To make the NHIS more sustainable, it is recommended that the authorities should provide some incentives to the workers as well as commit some of their proceeds to improving health infrastructural facilities that provide services to majority of their clients.

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DEDICATION

To my wife, Mrs. Benedicta Badu and my children Kwabena Dwuma Badu,

Abena Konadu Badu and Kwadwo Ntumy Badu

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CHAPTER ONE

INTRODUCTION

Background to the study

In many developing countries, a lack of adequate health care budgets is a severe problem (Asgary, Willis, Taghvaei & Rafeian, 2004). As such, many governments in a bid to meet the health needs of the population have sought to raise funds for the provision of health services. However, raising health care fees is not an adequate response to the increasing costs of health care. The aged and lower income groups especially in rural areas and the vulnerable have demonstrated their inability to meet the cost of healthcare services. Developing risk–sharing mechanisms, such as the provision of national health insurance can help alleviate the poor and vulnerable from some of the cost of receiving health care.

During the past eight years, interest in a national health insurance has heightened, and it is clear that this will be an increasingly important issue over the next few years. Former President J.A Kufour, launched the National Health Insurance Scheme (NHIS) in 2004 designed to offer affordable medical care, especially to the poor and vulnerable. Some of the provisions of the scheme extend government–financed health insurance to the aged, the poor, as well as children of parents who both subscribe to the scheme. According to Brooks

(1991), lack of access to health insurance has a negative impact on the health of households and individuals. Akin, Rucker, Hubell, Cygan, and Waitzkin (1997) buttress this known fact that lack of access to health care and unpredictable health expenditures are the primary causes of poverty and deprivation for households in developing countries

There are many obvious benefits of health insurance. First, health insurance plays an important role in reducing the influence of high costs of health care on the economic wellbeing of households because health insurance turns unpredictable health expenditures into predictable insurance payments. It also encourages longer–term investment in the wellbeing of households. It is generally accepted that insurance against large and unpredictable health expenditures is a key component of social protection and a significant factor in the economic development of rural areas. Moreover, health insurance plays an important role in rural households' access to medical care (Asgary et al., 2004).

However, since its implementation, the NHIS has not been without controversy. Though widely accepted in principle by all and sundry to replace the hitherto ‘cash and carry’ system considering the socio–economic or socio–cultural conditions of the country, the debate surrounding it depended to a large extent on what position is being advocated.

Accompanied by this controversy is the growing concern about the attitude of health workers towards the NHIS and sustainability of the scheme to addressing the heath needs of clients. Health workers may be instrumental in discouraging health care services by opposing it or exhibiting hostile behaviour

toward clients who patronise health care at accredited hospitals and health centres. According to Colombotos, Kirchner, and Millman (1975), attitude to national health insurance by health workers in the United States were less favourable and related closely to their general political views. This prompted President Harry Truman, ten years later when his proposals for a comprehensive national health insurance plan was defeated to write in his memoirs that organised medicine did not represent the true feelings of the rank–and–file physicians, but of a small group of men who professed to speak for them and who promoted lobbying by medical organisations to further their own interests (Truman 1971) cited in Colombotos et al., 1975). Health care providers, who are also members of the general community, are likely to elicit prejudicial and fearful reactions to the NHIS as members of the community. The resultant effects of such negative attitudes include poor patient management; with people, being denied most needed treatment, care and support.

According to Krech and Crutchfield (1984), attitude is an enduring organisation of motivational, emotional, perceptual, and cognitive processes with respect to aspects of our environment. Hence, attitude can be described as an overall evaluation of the way we think, feel, and act towards some aspect of our environment, such as health care service or system. Fishbein and Ajzen (1975) regard it as a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object. However, attitudes can range from being favourable (positive to negative), intensity (strong to weak), and confidence (total confidence to minimal/no confidence). Many researchers also

feel that attitudes are structured along three dimensions: the cognitive (perceptions and beliefs); the affective (likes and dislikes, based on evaluation); behavioural actions or expressed intent (McDougal & Munro, 1987). All the three views suggest that attitudes are composed of at least three components, namely affective, cognitive, and behavioural. In the context of this study attitude is defined "as the way health workers in health care hospitals and centres think, feel, and act towards clients who are currently enrolled with the NHIS". However, the dimensions are not always consistent. Knowing what someone thinks and feels about NHIS does not necessarily enable one to predict very accurately, how the person will act. One of the reasons for such inconsistencies is that although attitudes can exert a strong influence on behaviour, there are others such as working conditions, working hours and the volume of work after the implementation of NHIS. Thus, health workers attitudes towards providing health care services under the NHIS are not only the result of people's personality and predisposition to the scheme, but also because of the social situation in which they find themselves.

Statement of the problem

The NHIS has become a compelling example of government policy that has changed health care access and financing as it has effectively eliminated dependence of health care based on socioeconomic status. However, the scheme is bedevilled with some challenges as abuse of the system has resulted in over utilisation. More importantly, the high utilisation of the scheme has exposed the

acute shortage of health professionals and facilities as well as the lack of equipment in many health care centres particularly in the rural areas (GHS, 2007).

Health workers work a long week when compared with people in other professions. A memorandum of understanding (MoU) signed between the doctors and the GHS showed that physicians practised an average of 56 hours per week which breaks down to eight hours a day with a doctor to patient ratio of 1:10,000 and 1: 1,587 nurses respectively in 2006. With the removal of direct patient charges for physicians' services under the NHIS, the workload of health workers are purported to have increased with many complaints by patients of ill treatment by health care providers.

Closely connected to the above is the socio–political milieu within which political and social actors work to implement the NHIS. As previously mentioned, the introduction of the NHIS was partly triggered by partisan politics. According to Agyepong and Adjei (2007), NHIS policy decision making concerns was dominated by concerns about political relationships and stability as well as susceptibility to suggestions of attempts at political sabotage. Thus, notwithstanding the technical difficulties of implementing the NHIS there is the need to recognise and deal effectively with the political challenges.

Suffice to mention that, literature on Ghana's health care system and indeed on the NHIS is dominated with a number of impact studies that focused on the perception of residents (Arhin, 1994; 1995; Asenso–Okyere, Osei–Akoto, Anum, & Adokunu, 1995; 1997; Atim & Madjiguene, 2000; Atim, 2001; Arhinful, 2003; Agyepong, Bruce, Narh–Bana, Ansah, & Gyapong, 2006;

Agyepong & Adjei, 2007). Surprisingly, none of the studies considered the role of health workers, especially, towards the NHIS and the sustainability of the programme. Thus, the attitude of health care workers towards the NHIS as well as the sustainability of the programme as a social policy should be an aspect of intense investigation.

Objectives of the study

The main objective of the study was to examine health workers' attitude towards the National Health Insurance Scheme within the health service in Cape Coast Metropolis.

The specific objectives were to:

- Ascertain health workers' level of knowledge about NHIS;
- Identify the conditions under which health workers are working under the NHIS;
- Assess attitudes of clients and their intentions to remain subscribers; and
- Make recommendations towards successful and sustainable NHIS implementation.

Research questions

In the light of the foregoing, the study sought to answer:

- What are health workers' knowledge, attitudes, and perceptions, towards the NHIS;
- What factors are likely to induce health workers support for the NHIS;

- What are the political and ethical issues in implementing the programme in a particular health centre?

Significance of the study

In many developing countries, including most countries in Africa, policymakers do not communicate the intended benefits of social interventions to their citizenry. Although, many researchers have mentioned the need to disseminate social policies to the population, public authorities seem to be unaware of these facts or simply ignore them for political expediency. It is envisaged, the research will inform health policy about the need to involve all stakeholders in health policy formulation and not only implementation

Furthermore, it is now widely recognised that policy makers need to take the view of various stakeholders into account if social projects and interventions is to be sustainable in the end. As Colombotos et al (1975) have pointed out, health workers or 'organised medicine' may be instrumental in discouraging the social policy by opposing it or exhibiting hostile behaviour towards patients and clients under national health insurance. Hence, the outcome of investigation into factors influencing health workers' reaction to NHIS within the GHS could inform policy makers of why organised medicine support or oppose NHIS, thereby assisting them to design programmes to minimise the social impacts of such policies.

The study is consistent with the national efforts to ensure equity in health care provision by health services providers. Faced with increasing population and

insufficient government revenue, there is a search for a social welfare policy on health services that is allocated according to people's need, and not according to ability to pay. Since, the study is related to the efficient use of health care service, it will contribute to the general effort to health accessibility and financing.

Lastly, it is envisaged that a successful completion of the study would contribute to existing research works attempting at providing measures for sustaining the national health insurance. By comparing the results to others, this study would determine whether health insurance coverage and the source of that coverage affect health when more confounding factors as attitude of health workers are controlled.

Study setting

Cape Coast Metropolis is bounded on the south by the Gulf of Guinea, west by the Komenda–Edina–Eguafo–Abrem District, east by the Abura–Asebu–Kwamankese District and north by the Twifo–Hemang–Lower Denkyira District. The Metropolis is located at $5^0$7' north of the Equator and $1^0$18' west of the Greenwich Meridian. It covers an area of 122 square kilometres and it is the smallest metropolis in the country. The capital, Cape Coast served as the seat of government of the Gold Coast colony until 1877 when the capital was transferred to Accra, the present capital city of Ghana.

Historically, Cape Coast enjoyed economic prosperity especially during the cocoa boom of the 1900s. Until the building of Sekondi Harbour in the 1890s, Cape Coast was considered as the most important anchorage in the then Gold

Coast. The use of the anchorage and port facilities were closed down in 1863 following the decision of the colonial government to relocate to Accra in 1877 thereby reversing all the economic gains and prominence the town had achieved. But as Cape Coast declined in importance as a commercial centre, its importance grew as an educational centre (Hyland, 1995).

According to the 2000 Population and Housing Census, the metropolis has a population of 118,106, with more females (57,365) than males (60,741) (Ghana Statistical Service, 2000). The metropolis has an excellent array of social amenities which educational institutions like Mfantsipim School, St. Augustine's College, Wesley Girls High School, Adisadel College, and Holy Child that have produced prominent citizens in the country.

In terms of health facilities, the metropolis has both a regional and metropolitan hospitals in addition to other health centres and number of health personnel exceeding 200 and doctor/patient ratio of 1:5,905, which cater for the need of residents. Accordingly, in Cape Coast, about a fifth (20.3%) of the localities has clinic facilities but about a tenth (11.4%) has a hospital facility (Ghana Statistical Service, 2000). The metropolis also operates the NHIS programme in a number of accredited health centres (both government and private).

Health Services in the Metropolitan are a mix of both government and private institutions, and are structured along the three–tier system of health care delivery, which are primary health care, secondary health and the tertiary health deliveries (Medicine, 2009). Services to communities are delivered mainly

through outreach programmes. However, services of Traditional Birth Attendants (TBAs), chemical sellers, traditional healers and private clinics are available to community members. Nearly 50 TBAs and 48 Traditional Healers are registered and qualify to practise in the metropolis. There are also 31 Chemical Sellers, 7 Pharmacy Shops as well as 12 private clinics in the Municipality.

The Municipality is demarcated into four health sub–districts namely: Cape Coast, Ewin, Adisadel and University sub–districts. These demarcations were done around existing facilities; Cape Coast MCH/FP Centre, Ewim Urban Health Centre, Adisadel Urban Health Centre and the University of Cape Coast.

The Cape Coast Hospital (Interburton) is the Regional Hospital and is located at Abura. The forme Central Regional Hospital now serves as the Metropolitan Hospital. The University Hospital currently supplements the efforts of the two facilities cited above. The Public Health Services at this level are co–ordinated by the Metropolitan Health Management Team headed by the Metropolitan Health Director. The team focuses on providing support to sub–districts in disease prevention and control, health promotion and general education of the public on health issues. All the health facilities are located in the Cape Coast town, which serve as both regional and metropolitan capital. Owing to the relatively small land area of the metropolis, distances to health facilities are generally not a major problem.

Organisation of the study

The study has been organised into five main chapters. The first chapter introduces the study by examining the background to the study, statement of the problem, objectives of the study, research questions, rationale for the study as well as how the study has been structured.

Chapter Two presents a review of related literature on the concepts and theories of national health insurance and the role of health workers in the implementation of the NHIS. In addition, the conceptual framework guiding the study would be presented. Chapter Three introduces the methods and procedures employed in data collection from the field. Chapter Four interprets the findings and establishes a link between health care workers perceptions and attitudes and a comparison between health workers and clients' perceptions of the NHIS with the specific cases of selected health centres. Chapter Five summarises the study, concludes the discussion while suggesting steps towards improving and sustaining the NHIS programme.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Literature review is an important success driving an academic work of this nature. It helps in contextualising studies in terms of the existing body of knowledge. This provides the basis of understanding methods and conclusions in the available literature. Generation of hypothesis or research and conceptual or theoretical questions are also shaped by literature review. This phase of the study looks at options for healthcare financing, health care financing in Ghana, attitudes and behaviours and the concept of health care financing sustainability.

Health care financing

Akal and Harvey (2001) provide six possible means available to governments to raise funds to pay for health. These are health insurance (social and private), user fees (formal co–payments and formal payments), community financing, health savings accounts, tax revenue (income tax, sales tax, value added tax, etc) and overseas funds (international loans foreign aid).

Health insurance: Supakankunti (2000) defines health insurance as a means of financial protection against the risk of unexpected and expensive health care. Chawla and Berman (1996) conceptualises health insurance as a group of

persons contributing funds to a common pool, usually held by a third party. These funds are then used to pay for part or all of the costs of a defined set of health services for the members of the pool. This party can be governmental social security, a public insurance fund pool, employer–sponsored pool, or private insurance fund pool.

Health insurance may be social (community–rated) or private (risk–rated). Both are targeted at meeting the costs, or part of the costs, providing a defined range of health care to the insured population. These two can support a fee–for–service, salaried or capitation system. In the same vein, either of the two can support public, private or mixed ownership of institutions and services in the health sector. While social insurance is the commonest in some parts of Europe, risk–rated is a significant form of private insurance in the USA (Akal & Harvey, 2001).

Social insurance entails pooling resources from a whole population to meet the costs of defined health services or to reimburse individuals for all or part of the costs of services that they benefit from. In social insurance system, premiums (contributions) individuals pay is based on their ability to pay. By implication, the poor are technically supposed to pay lesser than the rich do. Premiums are not risk stratified; individuals (Akal & Harvey, 2001) do not base on the health or the individual or on the expected use of services for them.

Premiums of social health insurance are generally made through pay–roll tax mechanisms for employed people, and through established agencies for the

self–employed and the unemployed. In some cases, governments pay defined premium to the health insurance fund on behalf of poor individuals.

Private (risk–rated) health insurance pools premiums from a group of individuals who have similar characteristics that are expected to be related to the use of health services, and for paying for part of all defined health services costs borne by members. This type of insurance then pools the contributions within these risk stratified populations. In general, within each risk pool, premiums are the same for all persons regardless of income or ability to pay (Akal & Harvey, 2001).

The model in Ghana is a mixture of the two. The social aspect stems from the fact that government subsidises a greater proportion of the premiums policyholders are supposed to pay. However, its dimension of private is premised on the extent of coverage, thus not all health conditions are covered by the scheme.

The user–fee option: User–fee is that system in which all or part of the cost of services provided are paid for by the beneficiaries at the point of health care delivery. Normally the rationale for charging user–fee is to deter over–use of services. In some cases, they meant to generate extra source of funding. From another perspective, user fees are used to reduce the impact of under–the–table payments to health providers. However, its disadvantage lies in its deterrent to poor people from accessing health.

Community financing: According to Chawla and Berman (1996) is established through the common will of the people rather than the market forces.

They permit a variety of resource mobilisation methods, such as payment in cash or kind, payment in part or full, payment in the form of labour contribution, idle land, etc. This flexibility in the community–sponsored plans has been useful in limiting the effects of seasonal income fluctuations on access to care in some countries in sub–Saharan Africa.

Ligion (1998) argue that community schemes usually focus on primary care, especially drugs, but also may include referral services and often have a broad community development orientation. For example, Guinea–Bissau's Abota, Dana Sehat in Indonisia, Farmer's health insurance in Taiwan and Quang Nam Da Nang in Vietnam.

Health savings account: This provides incentives for, or compels, people to pre–pay for their own future health expenses. This means of financing health is common in Singapore. It is under experiment in China under a compulsory insurance in scheme. Ligion (1997) classify health savings account as the most systematic inter–temporal distributing mechanism such as Singapore's Medisave, an individual has earmarked medical care savings account that is available over a lifetime. This programme allows people to build up credit for healthcare when they are well as a safety net over the increasing costs of care in old age. With health savings account, there is no pooling of funds between rich and poor and between healthy and the sick.

Tax finance: This option is services funded directly by government from taxes levied on individual taxpayers and businesses. The taxes may be on income, on goods and sales excise on alcohol and tobacco, capital gains, payrolls and

many other sources. Public finance economists support the payment for public health services from taxation on theoretical grounds because public health services often provide external benefits to the whole community as well as to the individuals receiving the services (Akal & Harvey, 2001).

Levels of participation in health insurance schemes

Health insurance schemes differ in the degree of obligation on individuals to participate in the scheme. Broadly, there are four levels of participation in health insurance. These are mandatory participation in a single insurance scheme. Individuals are compelled by legal stipulation to take up insurance cover in a specified insurance scheme, for example the Dutch catastrophic medical expense scheme for long–term care and mental health (AWBZ) (OECD, 2004).

Mandatory participation in a health insurance scheme, but freedom to choose across alternative schemes or carriers occurs with multiple payer systems. For example, the 1996 Swiss Health Insurance Law mandated basic health insurance for all Swiss residents leaving them free to choose among insurers that differ for premium levels, administrative services and in part for types of cover offered. Free choice of sickness funds for the population mandated to take up insurance was made possible in Germany in 1996 and in the Netherlands in 1992. Sickness funds differ for the contribution charged to insurees. In all three cases, insurers and sickness funds compete for attracting insurees (OECD, 2004).

Participation by the conditions of employment includes health insurance schemes that are not mandatory by law, but that are included in general

agreements or employer–specific conditions. Employers are free to choose whether to offer health insurance or not. Individuals who join the company are automatically insured, or can choose to enrol into the scheme (as in the case of employer–based health insurance in the USA) (OECD, 2004).

Voluntary participation is the system that has no level of compulsion in participating or subscribing to a scheme. Even if participation is encouraged, for example through tax breaks or other fiscal incentives, it remains voluntary. Private insurers usually provide these schemes, although in less frequent cases it involves publicly owned insurers. This is for example the case of voluntary insurance provided by Medibank private in Australia (OECD, 2004).

The case of Ghana is a combination of voluntary participation and participation by conditions of employment. It is voluntary by people in the informal sector. For those in the formal sector, it depends on whether the employer pays social security on behalf of an employee. For those in government institutions they are automatic members of the scheme. The situation can differ for those in formal private sector. This is notwithstanding the legal compulsion binding all employers to pay employees' social security.

Health financing in Ghana: an overview

Most countries are committed to developing an effective health insurance system with a comprehensive coverage of population and health risks. However, there is an ongoing debate on the relative advantages of different forms of health insurance (McLaughlin & Zellers, 1994). On the other hand, there are disparities

in the factors accounting for the rising cost of assessing health care in both developing and developed countries. Whereas an ageing population in many developed countries has been identified as contributing to rising health care costs, in the developing countries', health care financing is being accelerated by the demographic and epidemiological transitions, producing rapidly rising health care costs.

Ghana like many developing countries in Sub–Saharan Africa has a long history of health financing which dates back to pre–colonial days. Prior to independence, financial access to modern health care was predominantly by out–of–pocket payments at point of service use (Arhinful, 2003). During this period, health care was free for expatriates, Gold Coast support workers and opinion leaders. After independence, health care was fully free for government officials and workers including school pupils and students. Token fee was also paid by farmers and other populations. Following independence, the government switched to tax–based financing of public sector health services and all such services were made free. Private sector health services continued to be paid for by out–of–pocket fees at point of service use. By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax–based health financing system. In 1972, token fees at point of service use were introduced in the public sector to discourage frivolous use.

The 1980s came with its challenges especially for the national economy which adversely affected provision of health care with its attendant shortages of essential medicines, supplies and equipment, and poor quality of care.

Consequently, the erstwhile Provisional National Defence Council [PNDC] administration through the dictates of the International Monetary Fund (IMF) and the World Bank in 1983 adopted the Structural Adjustment Programme (SAP). In 1985, public sector user fees for health care were raised backed by legislation became known as 'cash and carry'. The aim of the 1985 user fees was to recover at least 15 percent of recurrent expenditure through user charges but in the event, it raised an average of less than 10 percent (Asenso–Okyere et al., 1997). According to Ministry of Health (2001), the cost recovery aim of the 'cash and carry' system successful helped in the provision of essential medicines and medical supplies. However, this achievement was accompanied by inequities in financial access to basic and essential clinical services (Waddington & Enyimayew, 1989, 1990).

Even though some exemptions for vulnerable groups and diseases of public health interest were later introduced, there were induced delays in reporting sickness to health care providers, consultation at drug stores, partial purchase of prescription drugs and the sharing of prescription drugs with other household members. More pronounced was the phenomenon of drug prescribers writing prescriptions according to one's ability to purchase a drug and the inability to identify clearly those exempted (Waddington & Enyimayew, 1989; Asenso–Okyere et al., 1995 & 1997). With increasing public discontent and disaffection for accessing health care there was the need to find, an alternative system, which would facilitate cost containment in health care.

Ghana health insurance programme

According to Asgary et al (2004), universal health systems provide the most comprehensive model of health insurance provision because it ability to combine both risks across the whole population for preventative health care and reducing to a minimum the administrative costs of insurance provision. But they identified a key inherent problem with universal health insurance as relating to the constraints arising from tax financing as rising health care costs imply raising taxes. On the contrary, social health insurance has the benefit of pooling risks across homogeneous groups of persons, and it is flexible in accommodating a mix of health care provisions, since workers are usually refunded health expenditures in independent of providers (Asgary et al., 2004). In developing countries, its main disadvantage lies in the fact that coverage is restricted to formal sector workers with regular employment. It is also restricted by the administrative capacity to collect contributions and manage the health fund.

Only a few developing countries have managed to establish universal health insurance. These include some countries in the Caribbean that have followed the British national health system model and some socialist countries such as Cuba, China and Vietnam. In contrast, social health insurance is longstanding and extensive in Latin America where it is found in some of the major Asian countries such as India, Indonesia, the Philippines and Thailand, and is expanding in others. Social health insurance is also expanding in Africa; although in Latin America there appears to be a move away from social health insurance and towards private health insurance. There are divergent trends in

health insurance reforms across the world. Social health insurance is expanding in Asia and Africa, but contracting in Latin America.

Providing comprehensive health insurance for vulnerable groups remains a key challenge in the developing world. The widespread unpopularity of the 'cash and carry' system, especially its negative consequences on the poor, led the government to commission various studies into alternatives, principally insurance–based ones. Initially, many efforts were made to undertake feasibility studies of a national health insurance scheme.

Proposals to set up and run a NHIS have in fact been around for a long time. Since the early 1980s, various experts (International Labour Organisation (ILO), World Health Organisation (WHO), European Union and London School of Hygiene and Tropical Medicine) were contracted by the Ministry of Health (MOH) to study and make recommendations for setting up and running a national health insurance organisation.

In August 1995, the MOH received definite proposals from a private consultancy group in a report entitled "A Feasibility study for the establishment of a National Health Insurance Scheme in Ghana." The report proposed the set up of a National Health Insurance Company to provide a compulsory "mainstream Social Insurance Scheme" for 1) all contributors to the Social Security and National Insurance Trust (SSNIT) and, 2) all registered cocoa farmers. The report also recommended a pilot "rural–based community–financed schemes" for the non–formal sector but gave no further details or indication as to how the MOH was to do this. The major emphasis of the report was on the NHIS. The key

design features proposed were: inclusion of non–profit and for profit health facilities in the scheme reimbursement by capitation, contribution rates equivalent to 5 percent of salary for formal sector employees or a fixed levy per tonne of cocoa produced (equal to 7.19% of the producer price) and enrolees to register with a single preferred provider.

In 1997, the NHIS pilot project was formally launched in the Eastern Region, intended to cover four districts–New Juaben, Suhum/Kraboa/Coaltar, Birim South and Kwahu South. The objectives were stated in the presidential sessional address of that year: "… the National Health Insurance Scheme will contribute to resolving the cost of health care. This year, a pilot insurance scheme will be implemented in the Eastern Region to test the work done so far. Its performance will be studied, as well as the performance of existing rural health insurance schemes … so that problems can be identified and eliminated before implementation begins on a national scale" (Government of Ghana, 1997, p.24 cited in Agyepong and Adjei, 2007). By 1999, the proposed pilot insurance had died a stillbirth without insuring anybody with any public acknowledgement or explanation given for its demise (Agyepong & Adjei, 2007).

However, it appeared to be partly related to lack of leadership, consensus and direction in the MOH as to the way forward; as well as a failure to sufficiently appreciate the difficulties of implementing centralised social health insurance scheme in a low–income developing country (Atim, 2001; Arhinful 2003). Following the demise of the Eastern region pilot, SSNIT started planning for another centralised health insurance scheme to be run by a company called the

Ghana Health Care Company. Like the Eastern region pilot, it never took off despite some public expenditure on personnel, feasibility study, and software development (Agyepong & Adjei, 2007).

By 2003 just before the government's passage of the NHIS legislation, there were at least 67 district wide schemes and 159 MHOs run by communities, schools, NGOs and churches. The bill, which was to become the National Health Insurance Act of 2003 (Republic of Ghana, 2003) required the formal and the non–formal sector to enrol together in government–sponsored district MHO. This was one unique feature of the NHIS compared to many health insurance operating in many developing countries. Government sponsorship for the district MHO was automatic and not clearly tied to efficiency and policy effectiveness or responsiveness criteria. All the MHOs that were not district–wide government–sponsored (public) were classified as private. Private MHO though recognised as not–for–profit solidarity organisations, and legally entitled to operate, would not receive any financial support from the national health insurance fund or any of the subsidies to cover groups exempt from premium payments such as the elderly and the poor.

Financing of the NHIS was to be by individual premium payments and a 2.5 percent National Health Insurance Levy to be collected using the same mechanisms as the already existing 12.5 percent Value Added Tax (VAT). Two and a half per cent (2.5%) of formal sector worker contributions to the SSNIT towards retirement benefits were to be automatically transferred to the national health insurance fund on a monthly basis.

A National Health Insurance Council was to govern the NHIS. The object of the Council was 'to secure the implementation of a national health insurance policy that ensures access to basic health care services to all residents' (Republic of Ghana, 2003). Its responsibilities included registration, licensing and regulation of health insurance schemes, and supervision of their operations. It was also responsible for granting accreditation to health care providers, monitoring their performance, and ensuring that health care services rendered to beneficiaries were of good quality. A chief executive officer and supporting secretariat were to support the National Health Insurance Council in the execution of its functions.

Following the passage of the National Health Insurance Law, Act 650 as the Legislative Instrument LI 1809, Ghana Health Service (GHS) set up a National Health Insurance Oversight Support Team (GNOST) in 2005 to work out modalities of how GHS was going to support the implementation of NHIS in the country. The GHS drew up a National Health Insurance (NHI) implementation strategic plan, which outlined six broad areas of focus. These included GHS response to NHIS implementation in facilitating schemes establishment, GHS as a provider of high quality accredited services, GHS as a manager of health providers and client relationships, GHS as a manager of provider insurer relationships, GHS as an employer of health workers and, monitoring and evaluation of the process of Health Insurance implementation.

Suffice to mention that the implementation of the NHIS has chalked some successes. At the face value, its scale and significance at the national level is revealed in a brief examination of some statistics. During the past eight years, the

utilisation (measures of both geographical and financial access) of Out–Patient–Department (OPD) services has increased by the total OPD attendance as well as the attendance per capita. Total OPD attendance rose from 12,233,527 in 2006 to 15,712,070 in 2007 (GHS Report, 2007). This amounts to a 28.4 percent increase over the 2006 performance. During this period, the attendance per capita rose from 0.55 to 0.69, representing a 25.5 percent increase. This represents the highest annual increase ever experienced by NHIS since establishment and this has removed a significant financial barrier to access to health services. Further, the total number of inpatient services admissions has increased by 11.4 percent from 769,971 in 2006 to 857,848 in 2007 (GHS, 2007).

However, the scheme has had to grapple with some problems and challenges especially concerning mismanagement. An audit report of the operations of the scheme by the Auditor General sent to Parliament between 2004 and 2005 (Republic of Ghana, 2006) cited mismanagement of the scheme. From the service providers' perspective, the following challenges were identified: large/multiple utilisation/ health shopping, non conformance to NHIS approved list; accreditation issues (few Drug stores, Private Providers, Maternity Homes accredited) resulting in pressure on public providers and multiple prescriptions (poly pharmacy). Others comprised prescriptions outside NHIS approved list; non–conformity to standard treatment protocols with wide varying cost; adding unnecessary charges; inadequate and mal–distribution of providers; and, inadequate and skewed distribution of health professionals (Doctors, Nurse, Technicians) to the advantage of urban dwellers (Osei, Akazili, & Asenah, 2007).

Sustainable healthcare delivery

Since the 1980s, the term sustainability has received considerable attention. A major source of definition was the World Commission on Environment and Development in 1987, which stated that development is sustainable when it meets the needs of the present without compromising the ability of the future generations to meet their own needs. In applying this definition to other sectors or programmes, this conceptualisation requires a clearer definition. For instance, the health sector in developing countries continues to search for sustainable means of achieving the health for all agenda. This desire increased, especially with the decline in Third World economies in the 1980s, a development which led to increased debt, economic structural adjustment programmes, and reduced donor funding and government allocations to the health sector, especially in sub–Saharan countries (Abel–Smith, 1992a).

To make health delivery sustainable, several measures have been suggested by experts and various commentators. These include user charges, community management (Mandl, 1988), management reforms (Nebarro, 1990), strengthening donor assistance (World Bank, 1993) as well as compulsory health insurance for the working class (Abel–Smith, 1992b).

UNICEF (1992) defined sustainability as the ability of a system to produce benefits valued sufficiently by users and stakeholders to ensure enough resources to continue activities with long–term benefits. The Canadian Public Health Association (CPHA) following this definition identified five main components required to achieve sustainability in health. The components are

technical sustainability, social sustainability, political sustainability, financial sustainability and managerial sustainability. Health insurance sustainability depends, largely on all the indicators provided by CPHA. However, this study's focus is on financial sustainability, dependent on dropout rates of clients, which may be attributed to clients' dissatisfaction of services provided by health workers.

Brinkerhoff (1991) describes a project as sustainable if through the services it delivers; the system produces outputs, which the local community value to such an extent that they are prepared to provide time, resources and political support to sustain them so that long–term outcomes may be achieved. Sustainability and high internal performances are considered ingredients for a successful project. LaFond (1995) with insights of weaknesses from traditional concepts of sustainability conceptualises the concept as the capacity of a system to function effectively over time with a minimum of external output.

A common undertone among all these perspectives is the financial viability of projects. An insurance system that relies so much on voluntary subscription by clients can be seriously interrupted by the quality of care they receive from service providers.

Framework for analysing health system sustainability

Olsen (1998) developed a framework for assessing a health system's sustainability, largely based on UNICEF's definition of sustainability. Healthcare, programmes or projects can not normally be phased out, unlike many others.

Certain health programmes need to be sustained indefinitely to meet individual and public needs. In this vain, healthcare programme, require actors who can be depended on to sustain such services over time, to interact with clients and communities and to deal with problems and new challenges as they arise.

According to Olsen (1998), a health service product is sustainable when operated by an organisational system with the long–term ability to mobilise and allocate sufficient and appropriate resources (work force, technology, information and finance) for activities that meet individual or public health needs or demands. Olsen (1998) identifies three main clusters within which institutional or project sustainability operate. These are organisational capacity, activity profile and contextual factors. These factors operate in synergy. It is the organisations' ability to produce certain desired activities and support functions, which are relevant for sustenance.

The ability of healthcare organisations to ensure resources and the demand for services and support functions, are closely linked to the position of clients and stakeholders at the local and national levels. The availability of input resources, appropriate public policies and the responsibilities of decision–makers as well as service providers have more profound bearing on sustainability (Olsen, 1998).

Contextual factors are those often found outside the inner environment within which an institution operates. Contextual factors can hardly be manipulated by an actor, though these factors may have impacts on an organisation. Contextual variables can have strong impact on the sustainability of a project and require constant monitoring. They could be related to the broader

political (socialist or capitalist; stable or unstable), socioeconomic situation, the administrative framework and the epidemiological patterns. Olsen (1998) divides contextual factors into general and specific factors. General contextual factors include geographical, climatic conditions, the general political situation and a government's main health policy. Economic situation comprising government budgetary allocations for health, devaluation and economic mechanisms (market regulations). Specific relate to direct environmental factors that can affect health delivery, such as the general health profile of the people, use and availability of health services and the roles defined for public health and private health providers (Olsen, 1998).

In the case of health insurance, all the factors indentified above may have either direct or indirect impact on sustainability. For instance, a tropical climate may determine the frequency occurrence of a disease like malaria. This will in effect determine the financial burden on the scheme.

Activity profile is concerned with the kind of services provided, the choices made, reflecting technology and level of care and volume of work. Decisions made on activity profile usually establish the load on the health care institution and the institutional capacity required. Perceived needs and available resources to an organisation influence the choices made in this regard. In situations where there are unlimited personnel, there is often broad range of options available in terms of the type and volume of services, and the quality of care that could be offered. This is an important dimension for sustaining a health insurance system. When clients are provided satisfactory services, their interest in

the system will be continuous, even if the costs of services go up in relative terms. Quality of care then becomes an indirect motivation for patronisation (Olsen, 1998).

For example, Branch, Boyle, and Rowley (1994) found that, the two dominant inpatient ratings of quality care were characteristics of nursing services (nursing promptness) and nursing compassion; complaint dynamics was ranked third, admission smoothness was ranked fourth, and physician knowledge was ranked fifth. In an emerging economy like Ghana where people general incomes are low, it takes some of these provider services to sustain interest.

Organisational capacity represents the capability to carry out a set of tasks faced by the organisation. The aims of the organisation (policies, values, nature of services and their distribution), the required technology and the demand determine the nature of workload. The task environment and the general environment influence both workload and capacity. Within organisational capacity are also structural (decision–making processes, division of labour, roles coordination of work, etc), institutional values and behaviour (organisational culture–shared values, beliefs and loyalties). Others are manpower (encouraging personnel development through in–service training, delegation of responsibility and authority, rewarding through promotion, salary raises, recognition etc) leadership (visions, goal setting, planning, evaluation decision making, conflict handling, stress management) and resource mobilisation and financial management (Olsen, 1998).

All these factors can significantly influence how health workers will respond to the needs of patients. However, behaviour and attitudes that may be an internalised response to external phenomenon could be triggered by the aforementioned dynamics. The next section deals with some conceptual issues on attitude and behaviours that can affect the sustainability of the scheme.

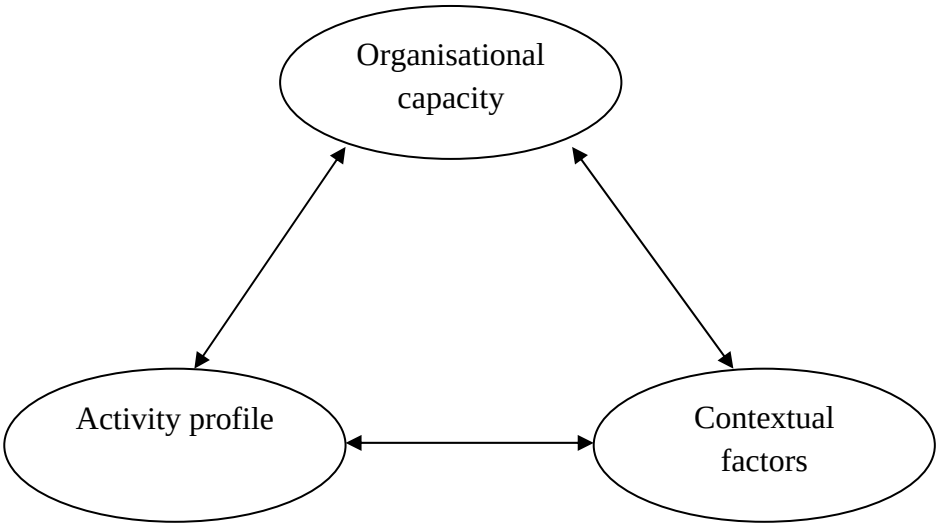

Figure 1: Conceptual framework of clusters for analysing sustainability

Source: Olsen (1998)

The concept of attitude

Green (1953) has argued that, an attitude of a person is a hypothetical or latent variable rather than an immediately observable variable. In other words, it is an abstraction. According to Green, the concept of attitude does not refer to any one specific act or response of an individual, but it is an abstraction from a large number of related acts or responses. If a person has a less favourable attitude towards insured patients, than another individual does, it implies that both words and deeds of the person are consistently less favourable to patients with health

insurance card. By extension, there is an underlying attitude that mediates between the stimuli (e.g. health insurance patient's behaviour that evokes comment or behaviour) and the response (favourable or unfavourable comments). The behaviour that may be evoked by, for example a health worker may be the function of several factors, such as an insured patient's claim of right to be given priority consultation.

Cambell (1950) emphasises the characteristics of attitude that are basic to all attitude measurement, thus response co–variation, when he defines an individual's social attitude as an enduring "syndrome of response consistency with regard to a set of social objects". Katz (1960) defines attitude as "the predisposition of an individual to evaluate some symbol or object or aspect of his world in a favourable or unfavourable manner". Whether attitudes are positive or negative are based on the intentions of the individual whose behaviour proceeds from attitudes, either learned or acquired.

Adjustive attitude (Katz, 1960) embraces those attitudes that are utilitarian in origin and intent. Very often, the object is some tangible benefit. Often, too, these attitudes are affective associations based upon previous experience. A favourable attitude towards a certain task may due to the kind of satisfaction one envisages or gets. This function of attitudes has relevance in the realm of behavioural theory and social group work. Take, for instance, the matter of 'shaping' behaviour (Katz, 1960). It follows from the nature of the adjustive function of attitudes that the clarity, consistency and nearness of rewards and punishments as they relate to the individual's attitudes and goals are important

factors in the acquisition of new utilitarian attitudes. This must be taken into account in shaping new habits. A further implication for social group work is that if the group worker is in a situation where utilitarian attitudes predominate among individuals, the group goals must be such that they will help in the satisfaction of utilitarian needs or in the avoidance of punishments.

Ego–defensive attitude (Katz, 1960) proceeds from within the person, and the objects and situation to which they are attached are merely convenient outlets for their expression. One common type of ego–defensive function is transference where an attitude adopted towards a person is not based on the reality of the situation. These ego–defensive attitudes stem from internal conflicts. One of the difficulties of ego–defensive attitudes is that the usual procedures for changing attitudes and behaviour may not cause the individual to modify but may force him to reinforce his defences, causing one to cling tenaciously to his emotionally held belief. Among the procedures for attempting to change attitudes, Katz (1960) includes invoking punishments. This has relevance in the application of behavioural theory to social group work. However, it should be noted that those who advocate the application of behavioural theory most frequently favour a system of rewards rather than punishments. This invocation of punishment implies that health workers' whose attitudes are likely to reduce subscription to the scheme are punished through appropriate sanctions.

Value–expressive function attitudes have the function of giving positive expression to central values and to the type of person an individual conceives himself to be. A case could be a health worker who might consider him or herself

as superior, and for that matter would not be prepared to attend to clients who are assigned to a junior worker. Favourable attitudes towards a group or a situation very often have a value–expressive function.

Each of the ways of expressing attitude explained above may be changed depending on (1) the importance that the subject attaches to opinion–change as a means of attaining his goal; (2) his readiness or unreadiness to accept this particular opinion; and (3) the power of the influencing agent.

CHAPTER THREE

METHODOLOGICAL ISSUES

Introduction

Research methodology is an important aspect of every study. It forms a core basis for evaluating the validity of research findings. In this direction, each aspect of the study process requires acceptable reasoning. These processes of design, sources and methods of analysing research data are usually based on techniques of data collection and data analysis plan. This notion is underlined by the purpose for which a study is conducted. What is known to be true, as opposed to what is believed to be true underpins social research. This phase of the research is an exposition on the research design, data sources, study population, sampling size and procedure, data collection methods, pre–test and data processing and analysis.

Research design

This study adopted descriptive cross–sectional (temporal dimension, of time) research approach. This was because the intentions were not meant to ascertain causalities, as this is difficult to establish in the social sciences or studies dealing with human beings. It was cross–sectional in the sense that respondents

were approached only on one occasion; there was no follow up with the respondents to result in longitudinal data.

Triangulation was employed to facilitate and enhance fieldwork on the phenomenon under study. Triangulation is a process of combining one or more data collection and analysis procedure in addressing a research problem. According to Denzin (1989), different research methods yield different types of information, and because no single research method can ever completely capture all the relevant features of any given empirical reality, the researcher should employ multiple methods in the analysis of the same empirical events. Neuman (2003) explained that triangulation presents a picture of observing something from different angles or viewpoints. The aim of triangulation is to exploit the strengths and neutralise, rather than complicate, the liabilities of each particular research method (Sarantakos, 1998).

Accordingly, the study utilised the mixed method (Creswell, 2002) of data collection to forge valid propositions that carefully consider relevant rival causal issues. In Creswell's (2002) view, combing both quantitative and qualitative methods of data collection helps to obtain statistical quantitative results from a sample and follow up with few individuals to probe or explore those results in more depth.

Study population

The study engaged two categories of respondents. First, group comprised the various categories of health workers in various health facilities in the Cape

Coast Metropolis. These were physicians, nurses and laboratory technicians. These groups of health care providers were considered because they are the first point of call by insurees. Largely, their actions and inactions, commissions or omissions can influence subscribers' interest in remaining as patrons. They are been considered so that their impressions about workload, motivation, as well as challenges about the scheme would be ascertained. The second group of healthcare providers included health administrators in the health facilities in the metropolis. The final category was clients seeking care at the facilities and have subscribed to the insurance scheme. Their opinions were sought to either collaborate the claims that would be made by the health workers or to disagree. The minimum age for inclusion in the study was eighteen (18) years. This premised is on the fact that paid subscribers are required to be 18 years and above.

Data and sources

The study used both quantitative and qualitative data. The primary quantitative data was obtained using two survey questionnaires. The first was the health workers questionnaire, which covered demographic and socio–economic background of the respondents, knowledge, perceptions and attitudes towards the NHIS. The second survey questionnaire targeted patrons or clients of the NHIS who were selected from the various health centres in the metropolis. The qualitative information was obtained through an in–depth interview (IDIs) among some selected staff members of the various health institutions and some clients of the scheme.

In addition, secondary information and data were obtained from books, journals, internet links and working papers that had treated different aspects of the topic under study. Some secondary information sources used included Ghana Health Service Reports (2007; 2008) and Ghana National Health Insurance Bill.

Sample size and sampling procedure

The study utilised different sampling procedures which were intended to produce separate information for each of the selected health service facilities in the Cape Coast Metropolis. This was to ensure that health facilities within the metropolis have an equal chance of being selected to participate in the study. From a comprehensive list of government and private accredited NHIS health facilities in the Cape Coast metropolis, five health facilities (Table 1) were purposively selected. As of 2008 when the study was designed, there were three hundred and thirty health workers in both private and public health facilities in the metropolis providing services to clients of the NHIS. Thirty percent of these workers were selected to participate in the study.

The second phase dealt with the quota allocation of the sample size based on the total workforce to ensure fair representation. As such, some health facilities had a smaller sample size. With this approach, health facilities with more health workers had more respondents participating in the study than those with low numbers. From each selected health facility, a list of names of physicians, nurses and laboratory technologists was obtained from the respective administrator. From the list, respondents were selected by quota allocation method, allocating

more samples to nurses than any other category of workers since nurses by intuition far outweigh all the others. Consequently, 68 percent was allocated to nurses, 2 percent to pharmacists, 6 percent to medical doctors while 23 percent was allocated to laboratory technicians in all the facilities. However, questionnaires dispatched to the two pharmacists were not returned.

In the case of beneficiaries, they were selected from clients who were at one public and one private health facilities at the time of the survey. These respondents were selected accidentally, totalling sixty. Since the clients were not the main targets for the study, objective hunch was used to arrive at the number 60. To ensure anonymity and confidentiality, respondents in each health facility were requested to drop their completed questionnaires devoid of personal identities into sealed boxes provided for the study.

With regards to respondents for the IDIs, purposive sampling was utilised to select participants because of their perceived exclusive knowledge of the topic as well as the critical roles they play in health delivery. These comprised two administrators, two nurses and two beneficiaries. The nurses were involved since amongst the clinical staff, they relate more with clients than the remaining professionals.

Table 1: Sample size for the selected accredited health facilities in the Cape Coast Metropolis

Accredited health centre	Number health workers	Proposed sample
Regional hospital	194	60
Metropolitan hospital	89	25
Adisadel health centre	16	5
Awim urban centre	19	5
Baiden Ghartey Hospital	17	5
Total	330	100

Source: GHS, 2008

Data collection methods

Bryman (2004) defines survey research as comprising a cross sectional design in relation to which data are collected predominantly by questionnaire or by structured interview on more than one case and at a single point in time in order to collect a body of quantitative and qualitative data. In connection with two or more variables (usually many more than two) which are then examined to detect patterns of association.

These two primary sources for collecting data were implemented on account of several reasons. First, it is generally agreed that questionnaires and interviews are the most appropriate means of primary data collection when information should come directly from 'people' and 'actors' who are actively involved and are aware of the phenomenon under investigation.

Secondly, the socio–economic and demographic characteristics of the study population were also considered. Kumar (2005) posits that in selecting a

method the researcher needs to know as much as possible about characteristics such as educational level, age structure, socio–economic status, ethnic background, the study population's interests in, and attitude toward participation in the study.

The study employed a semi–structured questionnaire to gather primary data. In designing the instrument, a thorough literature search was conducted to identify concepts and variables used in similar past studies and were modified to consistent with the present study. The instrument used comprised a mix of open–ended, close ended and Likert scale questions. Respondents' socio–demographic characteristics such as age, sex, date of birth and religious affiliation were also collected. In-depth interviews were utilised through interview guide.

Pre–test

The questionnaire and interview schedule were pre–tested on a sample of ten different categories of health workers at the Cape Coast Regional Hospital by the researcher. The pre–test survey afforded the researcher to assess the viability of the survey instrument and the necessary alterations to be made before the actual fieldwork. It also enabled the researcher appreciate some of the problems that were likely to be encountered during the data collection.

Data processing and analysis

According to Anderson (2004), analysis of data involve organising, summarising and applying appropriate statistical procedures in testing hypothesis

formulated or answering research questions. The data to be gathered were screened and edited. The completed questionnaires were then coded and stored in the computer with both descriptive and inferential statistical techniques to be used in the analysis. In relation to descriptive data, the Statistical Product for Service Solutions (SPSS version 16) was employed to analyse the data and highlight significant characteristics associated with the phenomenon under study.

The information that was generated through the IDIs were manually analysed by grouping them into themes. These themes allowed the researcher to identify the patterns that emerged.

Limitations of the study

The study could not consider all the stakeholders involved in the sustainability such as politicians (policy makers) as well as some factors included in the healthcare sustainability model. For instance, financial sustainability as a factor to make the NHIS was not studied in–depth. Again, the findings are limited to clients who had come to the various health facilities to seek care. This may bias some of their responses since at the point of seeking care; the perceived benefits could have been imputed without any objective analysis.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

To make health needs a priority of governments of countries; the argument has often been that the wealth of any nation lies in the health of its citizens. In order to achieve this priority of countries, governments of both developed and developing countries employ several interventions used in a bid to achieve this concern. The desire to promote good health and extend life expectancy of people, world leaders at the millennium summit in September 2000 agreed to implement eight goals dubbed the Millennium Development Goals (MDGs). Three of these goals were/are meant to hasten the health for all by 2015 agenda. Among programmes some countries have undertaken to achieve these targets include making health accessible to their greater populations through programmes such as national health insurance. The sustainability of this system of providing health at a relatively cheaper cost is very core to health promotion. This chapter presents results from the survey that was undertaken to solicit views from health workers and patrons of the NHIS in Cape Coast on matters of sustainability. The issues are presented in two areas: the first is about health workers while the second attempts to add some views of clients of NHIS to those provided by health workers.

Background characteristics of health workers

The survey targeted 100 health workers as respondents for the study. However, 97 responded to the questionnaires sent out. Out of this, 70.1 percent were nurses, 23.7 percent were laboratory technicians with remaining 6.2 percent being medical doctors. Females represented 78.1 percent of these health workers whereas the remaining 22 percent were males (Table 2). One of the 97 health workers did not indicate his/her sex.

Table 2: Job designation of respondents

Job designation	Frequency	Percentage
Lab tech	23	23.7
Nurse	68	70.1
Medical Doctors	6	6.2
Total	97	100.0

Source; Fieldwork, 2009

The disproportionate nature of male–female respondents is not surprising as clinical health personnel in Ghana are dominated by female nurses. This dominance by female nurses further indicates a profession that has until recently, been the preserve of females.

Table 3: Respondents by gender

Gender	Frequency	Percentage
Male	21	21.9
Female	75	78.1
Total	96	100.0

Source; Fieldwork, 2009

Another variable of interest was to consider the ages of the health workers. The direction of ages, whether the majority are young or old can have an impact on the sustainability of the scheme. In a situation where the majority of health workers will soon be due for retirement presupposes that the staff strength and quality of health delivery under the NHIS can be compromised. It is therefore imperative to assess the age group that dominates. The survey revealed that the age group with the majority respondents was 50–59 years group with 25.8 percent. They were followed by those aged 20–29 years. The minority group was workers who were 60 or more years (12.4%). The values of the other age groups are presented in Table 4.

Table 4: Age distribution of respondents

Age range	Frequency	Percentage
20–29	24	24.7
30–39	22	22.7
40–49	14	14.4
50–59	25	25.8
60+	12	12.4
Total	97	100.0

Source; Fieldwork, 2009

With the passing of time, employers, largely expect their employees to improve performance. This expectation is due, often to the fact that, employees learn from senior co–workers and experience. This was the reasoning behind adding years of service as important for investigation. As indicated in Table 1,

most (42.3%) of the workers had been in the service between one to five years. The second highest (24.7%) category had worked in the various health facilities for less than year. For the remaining, 15.5 percent had worked between six to ten years with 17.5% working for eleven or more years.

Table 5: Years worked in the service by respondents

Years worked	Frequency	Percentage
<1	24	24.7
1–5 years	41	42.3
6 years–10 years	15	15.5
11 years or more	17	17.5
Total	97	100.0

Source; Fieldwork, 2009

Knowledge of health workers about the NHIS Law

Social theorists have argued on what determines knowledge for some decades now. For instance, Pred's (1967) behavioural model discusses the extent to which the amount of information available to an individual can affect behaviour. With health workers being the first point of call for health service delivery, attempts were made to find out whether all or some of them have been privy to the law that established the NHIS. It is supposed that the law establishing the scheme has clearly defined the responsibilities of health workers as well as the rights insurance policy holders are entitled to. A greater majority of the respondents (90.4%) indicated that they had never seen the document containing the law, except 9.6 percent who had had access to the law. This could be due to

one of the following reasons: That authorities in–charge of disseminating information about the law to relevant stakeholders have taken things for granted. It may also be that the law is available and that the health workers have not been interested in accessing the law. It is, however, important to note that in dealing with legal issues, people who have individual and corporate roles to play in an issue that can generate legal struggles have to be up–to–date on such important issues. This will, consciously or unconsciously promote effective and improved relationship between service providers and service recipients.

A further question was posed to identify the proportion of these 9.6 percent who had read what they had seen. Out of this, approximately 77 percent had read the law. The 77 percent that read the law were all nurses. Given that majority of the respondents were nurses and were selected randomly, this is not so startling. This revelation is important in the sense that, often, nurses are the first point of call of patients in health centres. The fact remains that the number had both seen and read the law is abysmally low.

As a matter of interest, another question was asked to determine whether apart from the workers not having read the law personally, there has been any other means of becoming aware of relevant applicable portions. The results provided were reasonably unimpressive. Close to half, 46.1 percent indicated that even though they had not seen nor read it, they have become aware of the relevant piece applicable to them. The remaining 53.9 percent had still not been educated by any agency on their roles and responsibilities.

These results indicate some mismatch between health workers expected responsibilities and their actual roles being performed in that most of the health workers involved in the study had limited personal knowledge on what their actual roles are in the implementation of the scheme. Optimum use of knowledge, as indicated by Pred (1967), depends on the quality of information acquired. The results on extent of knowledge of health workers to make their use perfect appeared highly limited. This can have a dire consequence on the sustainability of the scheme.

Health workers knowledge of their responsibilities under NHIS

Ron et al (1990) have contended that health workers would generally have positive inclinations towards health insurance schemes. However, et al (1975) citing a former US President Truman state that health workers knowledge of their responsibilities are likely to be influenced by their political affiliations. Thus, if they share similar political opinions with implementing government, they have advanced knowledge on the programme content. Earlier issues explored on knowledge of health workers had shown that intellectual knowledge of health workers studied was limited. Attempts were made again to identify health workers perceived or actual knowledge of their responsibilities under NHIS law. The response option that was most frequent mentioned was “provision of service” (48%). Under the NHIS, some categories of health workers are supposed to submit claims to the NHIS secretariat after each month within sixty (60) working days and those who indicated this response was 18.6 percent. Some of the

respondents (16.9%) also indicated that they knew they are supposed to authenticate a client's eligibility. This responsibility of health workers is important in making NHIS sustainable, as this is the surest means of avoiding impersonation. Similarly, 16.4 percent also responded that they were supposed to observe the gatekeeper role.

Under the scheme, health workers are supposed to perform some specific responsibilities. It appeared from the study that, most of the workers were conversant with the most core functions, which is delivery of services. Two salient but silent areas which should require health workers attention and constant vigilant observation: the gatekeepers role and authentification of a person's eligibility were relatively weaker compared to provision of service and submission of claims form for reimbursement. These are very important areas for the attention of both NHIS management and health facilities management. One is therefore tempted to believe that, the massive public education undertaken by the scheme was limited to their target clients. Health workers have not been taken care of appropriately.

Table 6: Responsibilities of health workers under the NHIS

Responsibility	Frequency	Percentage
Authenticate a client's eligibility	30	16.9
Observe the gate–keeper role	29	16.4
Provision of service to clients	85	48.0
Submit claims to NHIS secretariat after the month within 60 days	33	18.6
Total	177	100.0

Source: Fieldwork, 2009: Multiple responses exist

Decision to accept NHIS policyholders

In Ghana, health facilities owned by the state and religious bodies are provided with professional personnel by the Ministry of Health on behalf of the state. Private health facilities owned by individuals have a greater autonomy than the aforementioned health facilities. The researcher therefore sought to find out how the various health facilities responded to the call to accept NHIS car holders: whether they were compelled to accept insurance policy holders or otherwise. The results show that, as much as 86.4 percent were of the opinion that management of their various facilities were compelled by the government to accept policyholders while 13.6 percent responded that their management were not compelled. Impressively, 93 percent responded that notwithstanding the fact that management were largely compelled; workers were consulted before their facilities began accepting insurance holders. This apparently was done to neutralise any negative reactions that might arise from the health workers. This

"compulsion" of the various hospital managements by government may tend to be counter–productive in sustaining a system. Olsen (1998) suggests that decision–making processes are core to sustainability. Management have to make deliberate decisions to be linked a wider context. Where they do not decide on their own volitions, by Olsen's argument, sustainability could be hampered.

The means of communicating the decision was also identified from the respondents as open forum, memos, through colleagues and radios. Open forums were the highest (84.1%) means of communicating management decisions of accepting insurance holders. This indicates a bottom–up approach and a higher involvement of lower ranks being consulted in decision–making. Memos were the second highest (8.5%). Table 5 shows other results of how other staff members in the study got information about the acceptance of NHIS in their various places of work. Communication theorists posit that the best means of communication in an organisation is the feedback approach. This entails interactive communication and is preferred to either vertical (juniors and superiors) or automatic/horizontal channels of communication (Massie, 1960). Going by Massie's argument, the various health facility managements went by the accepted management communication techniques, as open forum is one major feedback communication technique.

Table 7: Means of communicating to staff about NHIS

Response	Frequency	Percentage
Open forum	69	84.1
Memo to departments	7	8.5
Through a colleague	1	1.2
Heard on radio	5	6.1
Total	82	100.0

Source: Fieldwork, 2009

Perception of appropriate means of financing the NHIS

One question of interest in the study was to identify respondents' knowledge on how the system is financed. Out of the 77 workers who responded to this question, 77.3 percent conceded to knowing the sources of funding for the scheme, with the rest (22.7%) responding lack of knowledge on funding the NHIS. Additionally, the respondents were asked to indicate appropriate means of contribution that will make the insurance scheme sustainable. About two–thirds (60%) of health workers surveyed suggested subscription by patrons as the most sustainable as far as financial matters are concerned. Government subsidies followed with 35.3 percent. Others also suggested investment (4.7%) as another means of raising funds to make the scheme financially sustainable. In studying available means of financing healthcare in Europe, Mossialos et al (2002) argue that health workers perceived best means of financing health in many parts of Europe is monthly deduction of workers based on agreement between individual workers, employers and the various insurance brokers. The finding contradicts the

one stated above. However, the disparities are understandable if the study is juxtaposed in the larger societal context. While majority of workers in many European countries work in well organised formal and informal sectors with social security numbers, the situation is far different in Ghana. Many Ghanaians work within the informal sector without social security. This may have influenced the health workers preference for direct payment by patrons of the scheme.

Table 8: Appropriate means of contributing to the scheme

Response	Frequency	Percentage
Member subscription	51	60.0
Government subsidies	30	35.3
Investment	4	4.7
Total	85	100.0

Source: Fieldwork, 2009

Contributions to NHIS sustainability and needs of health workers

The sustainability of NHIS would partly depend on the role of health workers which is reflected through their vigilance in ensuring that actual subscribers benefit. In this direction, what they can do was explored through in–depth interviews. Under NHIS, health workers are obliged to present true and honest claims for re–imbursement. One health worker knew that the conditions under which claims will be rejected were varied. According to this worker, a claim would be rejected when the form does not have: “Signature of the prescriber or no diagnosis or non–NHIS drugs are prescribed”.

As to what happens when the claims are refused, this was what senior hospital administrative manager had to say: "We try to find out the reason in order to prevent future occurrence. Where a refused claim is significant but the reason is not serious, we discuss with the scheme to rectify the anomaly". Another health worker responded to this question in this way: "We refer to the patient folders to either authenticate the correction if found or re–submit when it is found to be correct". These responses indicate some kind of mutual respect and cooperation between health workers and the scheme managers. This is good for the sustainability of the scheme since confrontations that have the potential of discouraging service providers appears non-existing, based on the responses generated.

Workers were asked to disclose whether there were extra incentives for working under NHIS. Almost 96 percent indicated that there has not been form of rewards whatsoever provided by health facility managements, government or NHIS authority. Coupled with the fact the introduction of the NHIS has increased attendance without accompanying rewards, at least the NHIS, especially the decentralised schemes have to make re-imbursements more prompt. However, it appears that has been the reality. One of the respondents stated that, he does not find working under NHIS rewarding. This is how the worker puts it:

> "Currently, the contract is between the Mutual Health Insurance Schemes (MHIS) and the providers, not the NHIS national secretariat. So far as payment is concerned, the MHISs are over–

riding the service providers, since they determine when to reimburse".

This assertion reinforces Olsen's (1998) argument on how the context affects sustainability. A government's health policy stated in the healthcare sustainability model of Olsen becomes obvious from the results. One can infer from the claims by these workers suggest a top–bottom approach by management, where the health workers are not fully involved in decisions regarding the scheme.

Notwithstanding the fact that attendance to the various facilities had increased, the health workers, as indicated in Table 9, face some challenges. More than three–fourth (81.1%) suggested that attendance had really increased. Few of them (3.3%) indicated they could not confirm or reject any claims of increased or decreased attendance. Strongly agree or disagree constituted 15.6 percent. The specific areas of increased attendance were captured an IDI with a health worker who stated that, "Attendance has increased, especially, Out–patient Department (OPD), delivery and obstetric and gyaenacology".

Increased workload often leads to stress. As part of the coping strategies, some people redirect their frustrations to others at the least provocation. Olsen (1998) argues that workload can have a significant impact on quality of health which will then serve as an indirect motivation. In Olsen's (1998) model of health system sustainability, it is indicated clearly how activity profile influences sustainability. Available resources as epitomised in number of health personnel can limit the capacity of the insurance scheme to achieve its intended purpose. These increased workloads on the staff can arouse unfavourable behaviour as

indicated by Katz (1960). On this premise, one health worker who was asked to comment on the issue through an in–depth interview stated that: "Attitude of health workers is good but could be better, although, the workload has increased with the same staff strength that at times is frustrating". Meanwhile, Landsbergis (1988) notes that health workers negative attitude towards patients is not only determined by the extent of workload alone; factors such as quality of working tools, monetary and non–monetary rewards as well as job satisfaction have influence on how a worker would react to client. Reis et al. (2005) add that health workers have higher negative predisposition towards clients with stigmatised diseases such as HIV/AIDS, no matter their means of paying for health services.

Table 9: Level of agreement on increased clients' attendance

Response	Frequency	Percentage
Strongly disagree	51	56.7
Agree	22	24.4
Indifferent	3	3.3
Disagree	8	8.9
Strongly disagree	6	6.7
Total	90	100.0

Source: Fieldwork, 2009

Incidence of infrastructural changes

Most health workers who often migrate to some European countries and North America posit that apart from financial motivations, infrastructural limitations as one of the key reasons to migrate. With the introduction of the

NHIS leading increased attendance, investment in infrastructural should have to be commensurate with the numbers. More than half (54%) pointed out that there have not been increased infrastructural changes since the introduction of the NHIS. The remaining were indifferent (1.1%), 31 percent opined that there have been changes with 13.8 percent suggesting that they strongly disagreed with any claim of increased infrastructures.

From the results, almost all the various health facilities have not seen any improvement in infrastructure with the increased number of patients. Similarly, staff strength is overstretched due to the increased use of health facilities. These require prompt attention as this can reduce peoples' interest in the scheme if frustrations become a perpetual landmark of the scheme. However, in spite of these daunting challenges, health workers seem to be satisfied working with the scheme.

Table 10: Level of agreement on improved infrastructural changes

Response	Frequency	Percentage
Strongly agree	10	11.5
Agree	37	42.5
Indifferent	1	1.1
Disagree	27	31.0
Strongly disagree	12	13.8
Total	87	100.0

Source: Fieldwork, 2009

Policyholders need for preferential treatment

Another important trigger that can de-motivate of healthcare providers is how insurance policy holders also behave towards health workers: whether policyholders prefer preferential treatment or not. The majority of respondents (51.2%) either strongly agreed or agreed. Others who disagreed that patrons preferred special treatment at the health facilities constituted 17.4 percent while those who strongly disagreed were 26.7 percent whereas 4.7 percent were indifferent. Notwithstanding these observations, about 77.5 percent of health workers generally indicated that policyholders obey instructions while the remaining 22.5 percent responded otherwise.

Table 11: Health workers perception of policyholders need for special treatment

Response	Frequency	Percentage
Strongly agree	30	34.9
Agree	14	16.3
Indifferent	4	4.7
Disagree	15	17.4
Strongly disease	23	26.7
Total	86	100.0

Source: Fieldwork, 2009

Reactions to uncooperative client

Health workers were again asked to indicate how they would respond to clients who do not obey instructions at the facility. The responses given by the

health workers included: “refuse the person attention” (5.6%); “refer him/her to another worker” (18.3%); “provide service but reluctantly” (53.5%) whereas 22.5 percent also stated they will “provide services no matter the situation”.

Apart from the challenges health workers encounter with the introduction of the NHIS, a considerable majority of 94.2 percent were still satisfied with the performance of and attitudes of NHIS clients. The rest (5.8%) were not satisfied working in the service with the introduction of the NHIS (Table 12).

Table 12: Health workers reactions to disobedient client

Response	Frequency	Percentage
Refuse the person attention	4	5.6
Refer him/her to another worker	13	18.3
Provide service but reluctantly	38	53.5
Provide services no matter the situation	16	22.5
Total	71	100.0

Source: Fieldwork, 2009

Background characteristics of policyholders

The sustainability of the NHIS is dependent greatly on the actions or inactions of four major stakeholders: the government, workers under NHIS authority, patrons, and health workers. The government’s role is mainly to provide policy directions and management that are implemented by workers of the scheme. Health workers then serve as the agencies through whom the final

provision of service to clients of the scheme is delivered. Even though this study sought to consider how the health workers' role can make the system sustainable, it was considered appropriate to seek some thoughts from policyholders and how they accept or decline some services or behaviours of health workers.

Table 13 shows the results obtained from background investigation of policyholders. About 32.2 percent of the policy holders studied were between ages 30–39, followed by 20–29 (25.4%). Those who were 60 years or more were 23.7 percent. It also emerged that 6.8 percent were aged 40–49 while the rest (11.9%) were between 50–59 years. Meanwhile, 41.1 percent of the respondents were males with the remaining 58.6 percent being females. It has been estimated that over 50 percent of per capita health expenditure is incurred on populations over 65 years (Skinner, 2002). In the case of Ghana's NHIS law, some groups are exempted from making monetary contributions to the scheme. These include people below 18 years, adults over 60 years and SSNIT pensioners. Consequently, the preferred situation for financial sustainability is to get a situation where majority of patrons subscribe through monetary payment. At any point time therefore, clients who have paid for insurance are expected to be more for the system to be sustainable.

Table 13: Background characteristics of policyholders

Response	Frequency	Percentage
20–29	15	25.4
30–39	19	32.2
40–49	4	6.8
50–59	7	11.9
60+	14	23.7
Total	59	100.0

Source; Fieldwork, 2009

Another issue of importance to sustaining the scheme is to have more subscribers in relatively secured occupations, which also ensure regular incomes. In a situation where majority of patrons are outside these occupational environments, sustainability could be threatened in how to ensure regular inflow of funds. There was therefore a need to find out what dominant occupation the surveyed clients were engaged in. Interestingly, more of the respondents were public or civil servants. They constituted 32.7 percent. Traders and fishmongers were 26.9 percent. Students who had come to use some facilities at the time of data collection were 19.2 percent, farmers and fishermen were 17.3 percent with 3.8 percent remaining being artisans.

Table 14: Occupational background of insurance clients

Occupation	Frequency	Percentage
Farming/fishing	9	17.3
Trader/Fishmonger	14	26.9
Artisan	2	3.8
Public/Civil Servant	17	32.7
Student	10	19.2
Total	52	100.0

Source; Fieldwork, 2009

Among the policyholders, (48.3%) had gone to school up to the basic level. Those with their education ending at secondary or technical were 21.7 percent while 16.7 percent had never attended school and then 13.3 percent had attended school to a college of education, polytechnic or a university.

Table 15: Educational characteristics of respondents

Educational level	Frequency	Percentage
Never	10	16.7
Basic level	29	48.3
Secondary/Tech	13	21.7
Tertiary	8	13.3
Total	60	100.0

Source; Fieldwork, 2009

Close to fifty percent (49.1%) of clients received their cards between two to three months after registering with the scheme. Others received their cards after

six or months (26.3%). Some 15.8 percent were “fortunate” to have received their insurance cards one month after registration while it took about four to five months for 8.8 percent of those surveyed to receive their cards (Table 16).

Table 16: Card maturity period

Card maturity	Frequency	Percentage
Within a month	9	15.8
2–3 months	28	49.1
4–5 months	5	8.8
6+ months	15	26.3
Total	57	100

Source; Fieldwork, 2009

Means of contributing to the scheme by clients were also considered. As can be seen from Table 17, the majority of respondents (55.9%) had contributed to the scheme in direct form. This is a reflection the occupational of characteristic of the Ghanaian economy which has most of the population in the informal sector. Some of the respondents who were also benefiting from the system were through their Social Security National Insurance Trust contributions (23.7%). The next category was those on the exempt policy (20.3%).

Table 17: Means of contributing to the scheme

Means of paying	Frequency	Percentage
Direct contribution	33	55.9
SSNIT contribution	14	23.7
On the exempt policy	12	20.3
Total	59	100

Source; Fieldwork, 2009

Policyholders' attitudes towards health workers and intentions to continue subscription

People who have made payment for services up–front are likely to have intentions to request for exceptional privileges. This can prompt negative reactions from health workers who are supposed to provide them with services. Corollary to these possibilities, confrontations can arise. To discover of this possibility, clients were asked to find out whether they have ever had a confrontation with health workers. This generated results that are indicative of some level of positive relationship with health workers. Only four (4) of the fifty–five (55) respondents, representing 7.3 percent specified they had ever had a confrontation with a health worker.

Two reasons were given for these confrontations. One respondent stated that the cause of their confrontation was a because of a wrongful diagnosis. Two also had had a confrontation because their waiting time had become unnecessarily too long. The one remaining did not give any reason for what caused the

confrontation. Baker et al (2005) have reported of cases of negative and sometimes hostile attitude of patients towards health workers. These hostilities sometimes arise due to mistrust between providers and clients. Similarly, when clients/patients feel they are being unduly delays due to omissions or commissions of health workers, their propensity to become angry and hostile towards their health providers. Incidence of negative reactions towards health workers were found to have increased with the degree of stigma associated with the condition. However, no differences were noticed between "out–of–pocket" paying clients and insured clients. The few recorded confrontations between clients and health workers may not have arisen from mode of payment of service by patients; be they insured or not insured.

Another area of concern was to indentify from patrons whether they intend to maintain their membership of the scheme. All those who responded indicated their willingness to keep their membership. Some reasons that were given for continuous subscription included "I used to suffer without the card but now, I do not encounter any problem". Most of them also argued that, "it provides easy access to health care". Others also contended that, they are obliged to be members due to their occupations.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The desire to provide accessible and affordable health to citizens of countries is not a modern phenomenon. It has usually being with humanity. In Ghana, since independence, various governments have undertaken various measures to make health delivery sustainable. The "out–of–pocket" commonly known as "cash–and–carry" was introduced by the PNDC government in mid–80s as an indirect responsive to deteriorating economic conditions which had brought imbalances to government finance. Among the intentions was to make health delivery sustainable.

Realising the moral and socio–economic challenges associated with the "cash–and–carry" system, NPP government passed the NHIS law in 2004. The sustainability of the scheme has become an important social and political debate for discussion due to some inherent weaknesses with the scheme. This has led to several studies on the scheme; some focusing on financial sustainability whereas others have been impact studies. One neglected area relates to how health workers can contribute to make the system sustainable. This chapter presents summary of major findings, policy recommendation, conclusion, limitations and areas for further research.

Summary of findings

Based on the specific objectives of the study, the key findings are summarised as follows:

- Over 90 percent of health workers who participated in the study admitted that they have never seen the law that establishes the NHIS. However, majority of the few that had seen the law and had read it were nurses;
- Even though most of the health workers studied had not read the read law, about 46.1 percent were aware of the portions that apply to them;
- The commonest responsibility health workers knew of was their provision of service, which constituted 48 percent of the responses;
- Quite a higher proportion (86%) of those surveyed perceived that their facility managements were compelled by the government through the Ghana Health Service to sign contracts with the various district insurance schemes. The good thing about buying into this compulsion is that it was accepted using participatory management principle of consultation and open forum;
- Health workers preferred one or other means of contributing to the scheme with direct contribution (60%) topping the list of options. The next preferred means of contributing was government subsidies with investment by various schemes also being suggested;
- Regardless of the increased in OPD attendance, delivery and gyeanacological attendances, health workers brought to the fore the lack of incentives to motivate them to give off their best;

- The study also revealed that notwithstanding the increased attendance in health service use after the introduction of the NHIS, this has not been accompanied by increased infrastructure. Health facilities are still grappling with same old infrastructures they depended on before NHIS; and.
- In situations where health workers encounter disobedient clients, the probable reaction with least score was refusal of service (5.6%). Other responses included a possible referral to another worker and reluctant service provision.

Conclusions

In some developed countries such as US, both private and national insurance schemes are used extensively to provide affordable health delivery. Under Ghana's present economic, social, political and environmental circumstances, the insurance scheme provides the most suitable means of making health accessible and cheaper. Health workers, especially, clinical staff will be one of many core foundations that the sustainability will hinge. In some countries, their life expectancy has improved substantially because of the importance they have attached to the needs and welfare as well as adequate training of clinical staff. In Cuba for instance, their healthcare system has been successful due, primarily to, state strong state involvement. This has made it possible to disengage private hospitals and clinics from the health delivery continuum. By this, every citizen is provided health services at highly affordable rates due to the

pool system. To ensure the sustenance of the system in terms of personnel, efforts were made to train enough workers for the system. To make health care sustainable in Ghana with the introduction of NHIS, vigorous measures have to be taken to train the needed human resources as the study has demonstrated that notwithstanding the increase in attendance in the various facilities, staff strengths virtually remain unchanged. Another conclusion is that the infrastructural capacities have not been strengthened enough to deliver the expected outcome that would sustain the interest of patrons to remain with the scheme. If clients do not receive quality service, it would not make economic and moral sense to contribute to a system they are not satisfied with. It is therefore incumbent on all stakeholders involved with scheme to consider the needs of health workers as they represent an important element for successful scheme. It has been demonstrated clearly that the health worker has not been given the required attention and consideration by the NHIS implementing authority.

Recommendations

First, it is recommended that the NHIS authority and its decentralised agencies need to expand their sensitisation programmes and focus equally on health workers as most of them relied on secondary information to learn about their roles under the NHIS.

Second, the NHIS authority needs to institute its own reward systems for health personnel working to make the scheme sustainable. This will serve as motivation to the workers to give their best, which can serve as a significant

encouragement for more people to subscribe to the scheme. In this line, it is envisaged that more funds would be available for the scheme to expand its human and capital resources.

Thirdly, the NHIS authority has to collaborate with institutions of state, such as Ministries of Health and Finance to find practical means of expanding infrastructure in the various facilities that are limited in infrastructure.

Avenues for further research

First, interested researchers can consider studying how workers under the NHIS scheme can ensure sustainability. Equally, clients can solely be investigated to explore what they are prepared to contribute to making the scheme sustainable. Another possible area for research could be considering the implications of attitudes of health workers towards the sustainability. The whole insurance policy could be studied with the view to identify implementation weaknesses, especially human resource needs and financial constraints.

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APPENDICES

Appendix A
UNVIERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
INSTITUTE FOR DEVELOPMENT STUDIES

QUESTIONNAIRE FOR NURSES, MEDICAL DOCTORS AND LAB TECHS

This is a survey being conducted by a student of IDS, UCC as part of requirements for award of degree. You have being purposively selected to be part of this. You are again considered capable of providing the needed information to make this study successful. You are at liberty to reject to be part of the study and can terminate the interview at your discretion. The research is purely for academic purposes and nothing else whatsoever. You are however, assured of the strictest confidentiality and anonymity. Thank you!!

Socio–Demographic Information

1. Age:.....
2. Sex: Male **[1]** Female **[2]**
3. Qualification: SSSCE **[1]** Diploma **[2]** Degree **[3]**

   MD **[4]**
4. Job Designation: Nurse **[1]** Physician **[2]** Laboratory

   Technician **[3]** Administrator/Administrative Employee **[ ]**
5. How long have you worked in this department: <1 year **[1]**; 1yr–

   5yrs **[2]**; 6yrs–10yrs **[3];** >11yrs. **[4]**

Health Workers Knowledge on NHIS

6. In which year was the NHIS introduced officially in Ghana.....?
7. Have you seen the NHIS law document before? YES **[1]**

   NO **[2]**
8. Have you read the document? YES **[1]**

   NO **[2]**
9. If NO, have you through any other means become aware of the portion applicable to you? YES **[1]** NO **[2]**
10.
11. Which of the following is your responsibility under the NHIS Law (Tick as many as applicable)
    - Authentification of a client's eligibility **[ ]**
    - Observe the gate keeper role **[ ]**
    - Provision of service to clients **[ ]**
    - Submit claims to NHIS Secretariat after the month within 60 days

      [ ]
12. In which year did this facility start accepting health insurance policy holders.....?
13. Was the management of the facility compelled by the government to accept NHIS Policy holders? YES **[1]** NO **[2]**
14. Was there any form of prior consultation by management with staff before the introduction of NHIS? YES **[1]** NO **[2]**

15. If you were informed, what was the means of information?

- Open forum **[1]**
- Memo to departments **[2]**
- Informed by a colleague **[3]**
- Heard on radio **[4]**

16. Do you know the sources of income for the scheme? YES **[1]**

NO **[2]**

17. If Yes, which of the following are applicable (Tick as many as applicable)

i. Payment by subscribers **[ ]**

ii. Government subsidies **[ ]**

iii. Donations by philanthropist **[ ]**

iv. Income from investment **[ ]**

18. Which of the following would you consider most appropriate for the payment of NHIS premium?

- Payment by policy holders **[1]**
- Government subsidies **[2]**
- Donations by philanthropist **[3]**
- Income from investment **[4]**

Needs of Health Workers under NHIS

19. Before the introduction of the NHIS, what was the average number of patients/clients you were attending to per day.....?

20. After the introduction of the NHIS, what is the average number of patients you attend to in a day.....?

21. Has your work load increased after the introduction of the NHIS? YES **[1]** NO**[2]**

22. Do you get extra financial motivation for the increased work load? YES **[1]** NO**[2]**

Choose the most appropriate on a scale of 1–5, with 1=strongly agree; 2=agree; 3=indifferent; 4=disagree; 5=strongly disagree! ***Circle the applicable***

23. The introduction of the NHIS has led to increase in working tools: **[1] [2] [3] [4] [5]**

24. NHIS has brought about infrastructural change in our facility: **[1] [2] [3] [4] [5]**

25. NHIS card bearers often prefer preferential treatment: **[1] [2][3] [4] [5**

26. What is your greatest challenge with the introduction of the NHIS?

.....

.....

27. What do you suggest can be done to improve services to NHIS card bearers?

.....

.....

.....

28. Do NHIS clients to the facility obey instructions: YES [1]

NO [2]

29. How will you react to a patient who disobeys instructions?

- Refuse the person attention
  [1]
- Refer him/her to another worker
  [2]
- Provide service but reluctantly

  [3]

30. Are you satisfied working with NHIS cardholders? YES [1]

NO [2]

31. Indicate all possible responses:

- My party introduced the scheme [ ]
- I derive job satisfaction from responding to sick people [ ]
- It is my responsibility to provide those services [ ]

Appendix B

UNVIERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
INSTITUTE FOR DEVELOPMENT STUDIES

QUESTIONNAIRE FOR POLICY HOLDERS

This is a survey being conducted by a student of IDS, UCC as part of requirements for award of degree. You have being purposively selected to be part of this. You are again considered capable of providing the needed information to make this study successful. You are at liberty to reject to be part of the study and can terminate the interview at your discretion. The research is purely for academic purposes and nothing else whatsoever. You are however, assured of the strictest confidentiality and anonymity. Thank you!!

Socio–Demographic Information

1. Age.....
2. Sex: Male **[1]** Female **[2]**
3. Educational level:
    a. Never **[1]** Basic level **[2]** Secondary/Technical **[3]**
    b. Tertiary **[4]**
4. For how long have you been an insurance policy holder: <1 year **[1]**; 2yrs**[2]**; 3yrs–4yrs **[3]**; 5yrs. **[4]**
5. Occupation: Farming/Fisherman **[1]** Trader/Fishmonger **[2]** Artisan **[3]** Public/Civil Servant **[4]**

6. Concerns of patrons about NHIS

7. Name of facility.....

8. When did you register to join the NHIS: 2004 **[1]** 2005 **[2]** 2006 **[3]**

    a. 2007 **[4]** 2008 **[5]** 2009 **[6]**

9. How long did it take you to receive your ID card: Within 1 month [1]
   2–3 months [2] 4–5 months [3] 6+ months [4]

10. What is your mode of participation in the scheme:

    a. Direct contribution to the scheme's agents [1]

    b. SSNIT contribution [2]

    c. On the exempt category [3]

11. How many times have you used this facility.....?

    a. Which of the following is the reason why you prefer this facility? **Tick as many as applicable**

12. It is close to me [ ]

13. My relation works here [ ]

14. Number of clients to this facility are often few [ ]

15. Health workers here are competent [ ]

16. Health workers in this facility relate well with clients [ ]

17. I was referred by a lower facility to this centre [ ]

18. Have you ever had a confrontation with a health worker since you subscribed to the scheme? YES [1]
    NO [2]

19. What was the issue about.....?

20. Who caused/initiated the confrontation?

21. The health worker [1]

22. Myself [2]

23. Do you intend to continue your membership? YES [1]
NO [2]

24. Give your reason(s).....

.....

.....

Appendix C
UNVIERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
INSTITUTE FOR DEVELOPMENT STUDIES

IDI FOR HEALTH FACILITY ADMINISTRATORS

This is a survey being conducted by a student of IDS, UCC as part of requirements for award of degree. You have being purposively selected to be part of this. You are again considered capable of providing the needed information to make this study successful. You are at liberty to reject to be part of the study and can terminate the interview at your discretion. The research is purely for academic purposes and nothing else whatsoever. You are however, assured of the strictest confidentiality and anonymity. Thank you!!

Description of operations with NHIS: Probe;

- ⇔ Length of time of engagement;
- ⇔ How was the contract with NHIS start
- ⇔ Who brought up the initiative?
- ⇔ Obligations to the scheme;
- ⇔ The scheme's obligations to you;
- ⇔ Which party normally flouts the contractual agreements?
- ⇔ The extent of involvement of staff members in decision making in relation to NHIS

HW Contributions: Probe;

- ⇔ Under what conditions will claims be refused;

- ⇔ What happens when your claims are refused?
- ⇔ Has your claims ever been refused?
- ⇔ What accounted for the refusal?
- ⇔ Do you find working with NHIS secretariat rewarding?
- ⇔ If YES, how; If NO, why?
- ⇔ Do you have preferential treatment for NHIS members?

Challenges of Service providers: Probe;

- ⇔ Patients attendance (before and NHIS introduction),
- ⇔ Conditions of service,
- ⇔ Facilities to work with,
- ⇔ Government subsidies,
- ⇔ Political manipulations,
- ⇔ Staff strength, attitude of staff towards NHIS members