UNIVERSITY OF CAPE COAST, GHANA/ORGANISATION CAPACITY IMPROVEMENT CONSULTANTS, UK PARTNERSHIP MA IN ORGANISATION DEVELOPMENT PROGRAMME

IMPACT OF NATIONAL HEALTH INSURANCE POLICY ON ACCESS TO BASIC HEALTH CARE IN KINTAMPO MUNICIPALITY

BY

JACOB AMOAKO ADOESOM

DISSERTATION SUBMITTED TO FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF CAPE COAST IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS IN ORGANIZATION development

AUGUST, 2012

DEDICATION

I dedicate this work to my wife, Elizabeth Amoako Adoesom and lovely Children; Erica Yaa Adoesom, Edwin Amoako Adoesom, Elvina Amoako Adoesom and Ellis Amoako Adoesom.

ABSTRACT

The study assessed the impact of Kintampo Municipal Mutual Health Insurance Scheme on access to basic health care services in the Municipality since established in October, 2004

Questionnaire, interview and focus group discussion were the data collection instruments employed to gather relevant information from Heads of Health Institutions, Health Insurance workers/agents, Caregivers and other opinion leaders. The data were analyzed using tables, graphs, charts, percentages and diagrams.

The study revealed that a lot of people especially the poor, vulnerable and the marginalized were getting access to basic healthcare in the Municipality through the National Health Insurance policy. Factors such as untimely release of funds by NHIA, abuse of the system by clients, limited health facilities and inadequate qualified health personnel were hindering the smooth implementation of the policy.

The study recommends that the Scheme should intensify education on the concept of NHIS policy. In addition, more health facilities should be established and existing ones up-graded to increase access to health care delivery. Finally, it is recommended that health personnel should be sponsored, bonded and motivated to service in rural communities in the Municipality.

ACKNOWLEDGEMENTS

I am greatly indebted in gratitude to the under listed personalities for their deep involvement in providing support, words of encouragement, materials needed, guidance and necessary feedback in the course of the research work.

My first gratitude goes to Dr. E. O. Agyenim-Boateng, my supervisor for his untiring effort, useful corrections and suggestions as well as the excellent manner in which he approached and handled the supervision of this dissertation work.

My next gratitude goes to the Municipal Health Director Dr. Osei Kuffour Affreh and the entire municipal health service team for providing relevant and necessary data for the successful completion of this piece.

I am also highly indebted to the management and staff of Kintampo Municipal Mutual Health Insurance Scheme, especially Ms. Gladys Dondo for typesetting this work.

I also wish to extend my sincere gratitude to Dr. Demien Punguyere (Medical Supt. – Kintampo Municipal Hospital), Mr. Jeremiah Tiimob, Municipal Hospital Administrator and the entire Hospital staff for their numerous support.

Finally, my gratitude goes to all those who have in diverse ways assisted me to bring this piece to fruition.

DECLARATION

Candidate's Declaration

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

Name: JACOB AMOAKO ADOESOM (MR)

Candidate's Signature:…… Date……

Supervision's declaration

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

Supervisor's Name: E.O. AGYENIM-BOATENG (Ph.D.)

Signature:……Date…….

TABLE OF CONTENTS

LISTS OF TABLES

LISTS OF FIGURES

ABBREVIATIONS

AIDS	- Acquired Immune Deficiency Syndrome
ANC	- Antenatal Care
ART	- Anti-Retroviral Therapy
CHPS	- Community Based Health Planning and Services
C.S.M	- Cerebrospinal meningitis
D+C	- Development and Cooperation
DHMT	- District Health Management Teams
FGD	- Focus Group Discussion
G.E.S	- Ghana Education Service
GHS	- Ghana Health Service
GDRG	- Ghana Diagnostic Related Grouping
HIV	- Human Immuno-deficiency Virus
IGF	- Internally Generated funds
INSURED	- A person registered with the Health Insurance Scheme
IPD	- Inpatient Department
KiMA	-Kintampo Municipal Assembly

KMHD - Kintampo Municipal Health Directorate

KMMHIS - Kintampo Municipal Mutual Health Insurance Scheme

LI - Legislative Instrument

LEAP - Livelihood Empowerment Against Poverty

MOFA - Ministry of Food and Agriculture

MOH - Ministry of Health

NHI - National Health Insurance

NHIA - National Health Insurance Authority

NHIS - National Health Insurance Scheme

NONINSURED - A person who has not registered with the Scheme

OPD - Out Patient Department

PREMIUM - Money used to pay only claims

TBA - Traditional Birth Attendant

UNICEF - United Nations International Children's Emergency Fund

USAID - United State Agency for International Development

WHO - World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

One major challenge facing the global community in achieving the Millennium Development Goal (MDG) on healthis increasing access to basic health care. Especially, insouth Sahara Africa, health service delivery has not been adequate and encouraging. This has resulted in a deteriorating health status and low level of economic development. The level of development of every nation is greatly determined by the health status of the people. However, in most developing countries, health service delivery is not easily accessible to most people especially the most vulnerable because they cannot afford it (WHO, 2000). This situation therefore necessitated the need for a more user friendly and cost effective means of health care financing mechanism and so the idea of mutual pooling of health risks was given a global attention.

Globally, the health insurance system has been seen as an important tool to financing health care in many countries (WHO, 2000). Due to the high latent demand for high quality health care services and the extreme underutilization of health services in several countries, it is believed that health insurance will improve access to quality health care. Whereas alternative forms of health care financing and cost recovery strategies like user fees have been heavily criticized

because they fail to address the health needs of the poor and the marginalized, the health insurance option seems to be a more promising alternative as it is seen as a way of risks pooling, transferring unforeseeable health care cost to fixed premiums (NHIS, 2003).

In spite of this, there is strong evidence that neither purely statutory social health insurance nor commercial insurance schemes alone can significantly contribute to increase coverage rates and thereby improve access to health care, especially in rural communities, where unit transaction cost of contract are too high, often leading to a state of market failure(Jutting, 2000). The consequence is that in low income countries, majority of the people remain uncovered against the risks of illness (World Bank, 1994).

In most part of Africa, user fee in health service delivery has been the main source of financing health care apart from the central government's support. However, this system, for the past few years has been severely criticized by civil societies as not pro-poor. This is because a lot of people are denied access for their inability to pay for the services provided in the health facilities and as a result, they either do not access health care at all or resort to other available alternative treatment sources. The World Bank, working with the IMF, has aggressively promoted user fees since the late 1980s and more recently, has pressed central governments to give local governments the responsibility to deliver basic services including health care (World Bank, 1994). As part of the reforms, local governments are then forced to raise revenues through new charges on basic services. In the 1998, Internal Review of the World Bank Health,

Nutrition and Population (HNP, 1998**)** lending, the Bank's operations department, 40% of all projects in Sub-Saharan Africa included establishment or expansion of user fees. A study conducted by the World Bank on better health in Africa in1994 proposed several reforms for health systems and among them was to increase spending on health care from $8 per capita to $13 per capita (Griffin, 1992).

However, the introduction of the health facility user fee has compelled all categories of people to also pay for almost all services rendered at the health facility. The vision of health for all brought about the idea of community financing and private sector participation in health service delivery, therefore the health insurance system was called for in the World Bank's Agenda for Reform in 1987 in a bid to ameliorate the burden of health care. Again, the Bamako Initiative which was agreed on by health ministers in Africa in 1988 highlighted on financing health care through community involvement (Griffin, 1992).

In Ghana, cost recovery has always been a problem in health care financing to governments since independence. Several options have been piloted to finance health care. The First Republic sought to provide free medical care to all Ghanaians (MOH, 2008). Since then, the main financing methods have been from public funds which come directly from the central government, private contributions through user charges at the facility level, internally generated funds (IGF) and external aid**.** The major funding source comes from the annual budgetary allocation proposed by the Ministry of Finance and approved by Parliament. However, financing health care entirely from the central government has not been adequate. As a result, health institutions do not have adequate budget

for their activities. The end result has been a decline in the quality of health service delivery. The problem became even more compounded during 1982-1984 when resources became woefully inadequate to support the health institutions in Ghana. Government spending on health therefore suffered a severe drop to less than 20% of the pre-1975 levels (Smithson, 1994). According to Ministry of Health Report (1995), the proportion of government's annual budget allocated to the health sector for health service delivery are often inadequate. Currently, in Ghana, central government budgetary allocation to health care delivery is as low as 9% of the government's total budget and salaries of health workers alone consume about 75% of the recurrent budget of the Ministry of Health. This leaves smaller budget for other health activities. The consequences are poor health facilities, inadequate motivation and low morale of health workers resulting in poor provider-clients relationship leading to limited access (MOH, 1995).

Hospital fees were therefore, introduced in 1985 to help improve care to patients and these fees were to recover 15% of recurrent cost. The legislative instrument which established the Hospital Fee Regulation aimed at ensuring full cost recovery of drugs supply and health facilities were asked to retain 100% of all hospital fees to augment the annual budgetary support from government to run health care delivery (Smithson, 1994).

Due to drug shortage and inefficient distribution system, there was the need to ensure adequate and timely supply of essential drugs and so the cash and carry system with the aim of establishing a revolving fund for drugs supply through user financing and full cost recovery for essential drugs supply was

introduced in 1992. Like every other country in Africa, the cash and carry system of health care financing was seen as the most relevant and practical means of mobilizing funds to support the health service delivery.

Through bilateral and multilateral donor agencies, external sources of funds for the health sector have been quite considerable. Institutions such as UNICEF have been providing vaccines for immunization exercises, diarrhoea disease control and nutrition programmes. Furthermore, USAID provides assistance in the area of family planning whilst the World Bank also provides loans for the improvement of the health sector (Primary Health Care Series 1, 1982).

In Ghana, most of the communities have been putting up their own buildings to be used as community clinics and health posts. All these sources of health care financing, together, have not been adequate to take care of the increasing demand of quality health care to the people. The situation is further worsened because of the polarization in the distribution of health care facilities. This has created a situation where only the urban dwellers and the affluent are able to afford health care of acceptable quality. All these problems necessitated the need for community participation in the provision of health care, hence the idea of health insurance.

Poverty is a predominant feature in rural areas and the urban fringes. Gross national income per capita is below $400 which is far below the average for low income countries. The net effect is that health complications developed leading to poor health; man hours lost, and death which could be prevented as

well as low productivity. It is therefore believed that through the health insurance system, quality health care delivery will be accessible to all people irrespective of social status.

Problem statement

Good health is an important ingredient of socio-economic development. Therefore, limited access to quality health is undoubtedly unacceptable in the quest of most sub-Saharan African countries, including Ghana, to attain middle income status. Access to quality health care rests on the availability of qualified health personnel at all levels of care, availability of drugs and other health care consumables, availability of health facilities (both private and public), availability and proper storage of clients information, increase access to health information, education on rational use of drugs, affordable health cost to the marginalized and poor in society and speedy health delivery system. Before the introduction of National Health Insurance Policy, access to quality health in rural Ghana, was limited.

Most communities in the Kintampo Municipality are rural and most people live on scattered farmlands or smaller collections of compounds completely cut off from the district capital, which is virtually the centre of all social activities. Several health problems such as reproductive health complications, child health problems, malaria, guinea worm infestations are common. This, according to Health Directorate Annual Review Report, 2009, is due mainly to unsafe sources of drinking water, lack of access to public health education, especially, in the northern part of the Municipality (KMHD, 2009).

These problems are aggravated during the rainy season when most of these smaller communities are cut off from the rest of the Municipality. Furthermore, most people are peasant farmers, and earn low incomes. They are therefore unable to afford health care from the formal sector. Besides, there are only thirteen (13) public health facilities in the Municipality to provide basic health care which is inadequate. These facilities sometimes do not have the qualified personnel to deliver the requisite quality health care to the people in the rural communities. In addition, there is the problem of long distances from most communities to health facilities making access to these facilities a problem. The health insurance concept was then introduced in the Municipality in 2004 to help address most of these health delivery problems in the area. Unfortunately, there has not been adequate, comprehensive and qualitative study on impact of the national health insurance scheme on access to health service delivery in Kintampo Municipality since its inception. This study therefore was designed to investigate into the issues of effectiveness of NHIS on access to quality basic health care delivery in the Municipality in order to make recommendations for policy update.

Purpose of the study

The purpose of the study was to assess the impact of National Health Insurance Scheme on access to health service delivery in Kintampo Municipality with the aim of recommending measures to improve coverage, utilization, maternal health outcomes and other health care issues and make policy update in the Kintampo Municipality. Specifically, the study was:

- To assess the coverage of NHIS in the Kintampo Municipal Population.
- To assess NHIS policy on the coverage of the marginalized and poor in the Kintampo Municipality.
- To compare the difference in health facility utilization between insured and non-insured.
- To assess the mortality rate and morbidity in health service facilities in the Kintampo Municipality.
- To assess the ratio of qualified personnel per patients in the health facilities
- To explore the impact of NHIS on maternal health outcome in the Kintampo Municipality.
- To make recommendations for policy update.

Research questions

Based on the problem and the objectives of the study, the following research questions guided the study.

- What is the coverage of the NHIS scheme in the Kintampo Municipality?
- What policies do NHIS have for the coverage of the marginalized and poor in the Kintampo Municipality?
- What is the rate of utilization of health facility between insured and non-insured in the Kintampo Municipality?
- What is patient-personnel ratio in health facilities in the Kintampo Municipality?

- What are the mortality rates and morbidity in health service facilities in the Kintampo Municipality?
- What impact is the free maternal healthcare policy having on maternal health outcome in the Kintampo Municipality?

Significance of the study

The research would be of tremendous value to various individuals, major stakeholders and institutions in Ghana and beyond. For instance, the results of the study would serve as a teaching material to some researchers who would want to research into the operations of Health Insurance Schemes and Ghana Health Service. The findings would benefit management of Health Insurance Schemes, Kintampo Municipal Health Management Team, Ghana Health Service, National Health Insurance Authority, Government and other stakeholders on effective strategies to adopt to achieve access to health care in the country as being heighted in the study.

Scope and limitations of the study

Geographically, the study was to carry out in all the health facilities in the Kintampo Municipality, Municipal Health Insurance Office and Municipal Health Directorate. The main focus was on the impact of national health insurance scheme on access to basic health care service in the Municipality. As a result of time constraint, not all the workers were interviewed but rather limited to a sample of twenty percent of the target population of two hundred.

Organization of the study

This report is organized in five chapters. Chapter one looks at the background of the study, problem statement, the purpose of the study, research questions, significance of the study, scope and limitations of the study and the organization of the study. Chapter Two considers the review of some related and relevant literature in the form of research works done by other researchers, educationists, organizations and committees. It also looks at health facility user fees and their effects on access to basic health care in Africa; health insurance in some Sub-Saharan African countries and health insurance experience in Ghana. Chapter Three deals with the method used for the data collection. It describes the study area, the scope of the study, sampling and sampling procedure, data collection techniques and tools, pretesting of study instruments, ethical considerations, data handling and data analysis techniques. Chapter Four presents the results of the study in the form of tables, graphs, diagrams and charts. While chapter Five gives the summary, conclusions and recommendations of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter reviews some related literature in the form of research works done by researchers, educationists, organizations and committees. It looks at health facility user fees and their effects on access to basic health care in Africa; health insurance in some Sub-Saharan African countries and health insurance experience in Ghana. It further considers the impact of national health insurance scheme on access to quality basic healthcare delivery in Ghana; determinants of effective implementation of health insurance scheme; health insurance coverage; coverage for the vulnerable and problems in the health insurance market and health insurance scheme in the Kintampo Municipality.

The Effect of User Fee on Access to quality Health Care in Africa

The World Bank (1985) recommended user fee as part of cost recovery in health care delivery. The Alma Ata Declaration in 1978 required that primary health care should include the participation of local communities in health care financing. According to Arhin- Tenkorang (1995), in poor African countries, individuals in the informal sector, regardless of their position in the income

ranking, are unable to access appropriate health care, particularly curative care, at the time of need.

Enyimayew et al (1989) studied the trend of health facility usage and came up with the finding that hospital attendance at the district and regional levels recorded a sharp decline during the first week of the introduction of user fees. Again, in Zimbabwe, UNICEF (1993) reported that the quality of health services had fallen by 30%. What was the reason? Since 1990, twice as many women were dying in child birth in Harare Hospital as before 1990 and that fewer people were visiting clinics and hospitals because they cannot afford to pay hospital fees. In the north east of the country (Zimbabwe), clinic attendance dropped from 1,200 in March 1991 to 450 in December 1991 due to the introduction of user charges in health facilities. UNICEF (1993) again reported that in Kenya, the introduction of user charges for patients of Nairobi Special Treatment Clinic for Sexually Transmitted Diseases (STD) recorded a decline in attendance of 40% for men and 65% for women over a nine month period.

According to Enyimayew et al (1989), this access problem led to a drop in rates of facility utilization and delays in care seeking during the first period of its introduction. People show up in health facilities only when they were severely ill. However, when referred to hospitals, they often turn up only after several days because they needed enough time to mobilize funds from elsewhere**.** UNICEF (2000) reported on a study in Zambia where a researcher observed a 14 year old boy die at the hospital of acute malaria because the parents could not afford to pay the registration fee of ZK300, which is equivalent to $0.33.

The result of user fees on health care financing turned out to be far smaller than expected and hospitals were increasingly facing the problem of high debts because a greater proportion of patients left the health facilities after recovery without ever paying their bills. Many countries in Africa have a policy to exempt the poor from user fees. In spite of this, there appears to be numerous informational, administrative, economic and political constraints in the effective implementation of the policy (Russel et al 1997). The negative impact of the user fee system on facility utilization necessitated the need for a more sustainable and user-friendly means of seeking health care, hence the idea of community involvement which is mutual pooling of health risks was agitated for.

Health insurance concept in some Sub-Saharan African Countries

The health insurance concept is an emerging movement since majority of these schemes came into the scene in the 1990s in Sub-Saharan Africa. These health insurance schemes have taken the form of local initiatives of rather small size that are community-based with voluntary membership. They have either been initiated by health facilities, local communities or cooperatives. Some of the schemes are small and only cover few beneficiaries and mostly limited to local craftsmen or traders. In some instances, some of these schemes cover a whole nation and many communities and include up to about one million or even more beneficiaries. These schemes are commonly known as community-based health insurance schemes. They are mostly established outside of the formal employment sector. These schemes are mostly based in urban settings in countries

such as Tanzania and Cote d'Ivoire. However, in other countries such as Uganda and Benin, these schemes are mostly based in rural settings. In the Thies Region of Senegal, Jutting (2001); however found out that community-based health insurance schemes cover both rural and urban populations (Jutting 2001).

In the second half of the 1980s, health insurance schemes for the first time emerged in the Democratic Republic of Congo, formerly Zaire. Again, in the 1990s health insurance schemes sprouted in countries such as Ghana, Benin, Mali and Kenya. Creese and Bennet (1997), found out in Kenya and Ghana that the health insurance schemes originated from the search for new sources of financing health care by mission hospitals. In Sub-Saharan Africa, most of the people who are in the informal sector and live in rural areas and have never had access to wage-based social health insurance or privately- run health insurance. The actual implementation of the few community–based health insurance schemes in Sub Saharan Africa has had mixed results. So far, the viability and acceptance of this new concept largely depends on several factors such as the design and management of the schemes, full community participation, regulation at the level of the health care provider, quality of service and on the socio-economic and cultural context.

Health Insurance- Ghana's Experience

Prior to 2003, Ghana financed its health care system through tax revenues and user fees charged to patients at the time of service. User fees, however, were found to substantially decrease access to health services, particularly among the

poor, and exemptions for vulnerable and priority populations were unevenly applied. Community-based health insurance schemes began to emerge — growing from 47 in 2001 to 168 by 2003 - but these schemes only covered about onepercent of the population by 2003 and often excluded antenatal care and normal deliveries. As a result, the government explored the feasibility of abolishing user fees and introduced a national health insurance scheme to be implemented at the district level (USAID, 2009).

In September 2003, the government introduced a policy of exempting women from delivery fees in public, private, and mission health facilities in the four most deprived regions of Ghana, namely; Upper East, Upper West, Northern and Central Regions and expanded the policy to the remaining six regions in April 2005. An evaluation of the fee exemption policy in two regions found that there was an increase in facility deliveries, earlier care seeking for complications, and a decrease in out-of-pocket expenditures for delivery; whereas there was no change or worsening of service quality. However, there was severe under-funding for the policy from 2005 onwards and exemptions for deliveries were effectively suspended in many areas (USAID, 2009).

In August 2003, the National Health Insurance Act, Act 650 was passed, aiming to provide universal coverage of all Ghanaians within five (5) years through nationally mandated district-wide health insurance schemes. By the end of 2007, 42% of the population was covered by the NHIS (USAID, 2009).

The NHIS provides coverage for basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation,

maternity care (normal and cesarean delivery), eye care, dental care, and emergency care. Certain public health services intended to be provided for free by the government, such as family planning and immunizations, were not included in the benefits package. The initial registration fee was Two Ghana Cedis (GH¢2.00), while the annual premiums are theoretically income based, with a minimum set at Seven Ghana Cedis, Twenty Ghana Pesewas (GH¢7.20) per adult. Children are automatically covered and exempted from premium payment as long as both parents enroll, and those over 70 years and pensioners are also exempt from premiums. (NHIS POLICY FRAMEWORK, 2003) In addition to registration fees and premiums, the NHIS is also funded via a national 2.5% sales tax and 2.5% of social security contributions from formal sector workers. Schemes are managed at the district level, and districts are authorized to set exemption policies according to local circumstances and context (USAID, 2009).

Impact of National Health Insurance Scheme on Access to Health Delivery in Ghana

The various policy measures by the MoH (free maternal care and the NHIS) resulted in an increase in access to health care by the general population especially the pregnant women, mothers and children. The effect of the NHIS can be seen with the year on year increase in the number of insured clients and the per capita OPD attendance (Ghana Health Service, 2008).In all categories (insured/non-insured/total), women accessed more services than men. Again more women in both insured and uninsured accessed more health services due to the free maternal care policy. Comparatively, more women access health services

using the NHIS than men (62% versus 55%) and more men are relatively uninsured than their female counterparts (45% versus 38%). The evidence points to the fact that this deliberate policy of making healthcare available and accessible to mothers is yielding results (Ghana Health Service, 2008)."

The insured patronize health facilities more, and have better outcomes than the uninsured. Overall, 3% of all admissions experience a fatal outcome. This poor outcome is however higher in the uninsured group, 5%, and is much lower for the insured 2%. Relatively, more males die in both the insured and the uninsured groups, (53% versus 47% in the insured group, 56% versus 44% in the uninsured group, 55% versus 45% overall). Furthermore, in relative terms, more men die uninsured than insured. Sixty-two percent (62%) more men die uninsured versus 38% insured, compared with women 59% uninsured versus 41% insured (Ghana Health Service, 2008).

One possible explanation to this observation could be that whereas more women are admitted into health facilities, they are more likely to come out with a better outcome than the men. This observation demands a more in-depth analysis to identify the issues that promote this outcome and reinforce them for an even better outcome.

Determinants of Effective Implementation of Health Insurance Schemes

Health insurance schemes cannot be implemented in isolation. The success of their implementation depends on several factors including the following: Community involvement, proximity to health facilities, quality of health care and

affordable premium among others. These factors are discussed in the sections that follow.

Involvement of Local Communities in Designing a Health Insurance Scheme

According to Bliss et al (2002), for a micro health insurance scheme to succeed, right from the onset, there should be participation of the local population in the design stage. This allows the local people to formulate for themselves the goals needed to improve their situation according to their own set criteria. This gives them the opportunity to play a meaningful role in the achievement of these goals. Bliss et al (2002) gave a recommendation: Let them realize that they are solving their own problem and that they are responsible for their actions and omissions this can be achieved when the local population is involved in the feasibility studies. When they have the opportunity to discuss the health services they want and possible contribution payments there is a real opportunity for a sense of ownership of the scheme.

Proximity to the Nearest Health Facility

Desmet et al (1999) studies have shown that in order to ensure high community involvement in health insurance scheme, health service providers should be located in the vicinity. If people have to travel days and pay for expensive transport in order to get to a health centre they are hardly prepared to become members. Desmet et al (1999) studies also showed that membership rates are often determined by the distance of the households' home from the nearest health facility where services are provided for the insured. In addition, the study

found that membership among the two lowest socio economic groups appeared to be related to distance. It was observed that up to 90% of the target population from the nearby villages in Meliando in Guinea subscribed whereas only 35% did so in the distant villages.

Quality of Health Care

Desmet et al (1999) studies showed that quality of care equally plays an important role in willingness to join a scheme. In 12 focus group discussions (FGDs) organized to evaluate the Meliando Scheme in Guinea with 137 persons, quality of care defined in terms of rapid recovery, good health personnel, good drugs and nice welcoming was mentioned 383 times by participants as an important factor which determine to a large extent the willingness to join a scheme**.** Desmet et al (1999) studies have also shown that in some settings, it is not possible to set up viable insurance schemes and mobilize demand if the people feel that they cannot get the best health care services possible. The implication is that the benefit package should include basic services designed to take into account the health care needs and preferences of the target populations. Health facilities will also have to be well equipped to collect patient data for reimbursement. Experiences with exemption policy for under- five year old and aged being treated at the hospital for free have not been pleasant. There have been difficulties in reimbursement of monies and resources spent on this category of people to the health facilities.

Affordability of Premium

One other important determinant of willingness to join schemes is affordability of the premiums which often depends on the time of collection. Because the health insurance scheme is to target the marginalized in the society, the premium rates need to be affordable. It has been found out that health insurance schemes which target formal sector workers most of the time, collect monthly contributions from members while in the informal sector collection of contributions is done during harvest season when cash incomes are regular. Because widespread absolute poverty is believed to restrict potential members from joining health insurance schemes, there should be flexibility in payment of premiums by the poor. It also implies that collection of premiums should be done during the seasons when cash incomes are highest (Development and Corporation, 2001).

Public Information on the Health Insurance Schemes

It has also been found out that public information on health insurance schemes play a pivotal role in willingness to join a health insurance scheme. People in rural areas are often unable to read and write therefore careful thought has to be given to what information the members need in other to be convinced. Jutting et al (2001) studies in the Thies Region of Senegal showed that 70% of members studied had become members of the insurance scheme because they had received clear and persuasive information about the benefits of becoming members of the scheme. Public information can come in various forms as simple

handouts, posters, video films and discussion groups. However, in most part of Africa where most people cannot read and write the use of handouts and posters may tend to give different interpretations to the message designed for the target population. In such an instance, focus group discussions may be more important to allow the target population to share their views on the scheme.

Traditional Solidarity in the Community Setting

In the same Region (Thies) in Senegal, it was found out that traditional solidarity in the community setting plays a major role in the success of a health insurance scheme. Jutting et al (2001) realized that 15% of those studied became members of the scheme for the sake of solidarity.

Effects of Income and Formal Education on Enrolment

In Senegal, an analysis of the effectiveness of micro health insurance schemes showed a statistically significant under representation of the poorest in the membership. Members with better education and those with higher incomes were by contrast much more frequently represented. Jutting (2002) survey found out that enrollment was positively correlated with literacy and income. On the other hand in Bangladesh, a scheme enrolled 80% of destitute, 46% poor, but only 20% of the middle class and 10% of the wealthiest class.

Health Insurance Scheme in Kintampo Municipal

Kintampo Municipal Mutual Health Insurance Scheme (KMMHIS), initially known as Kintampo District Mutual Health Insurance Scheme(KMMHIS), was established under the National Health Insurance Act

2003 (Act 650) which set-up all District–Wide Mutual Health Schemes to cater for the health needs of all the residents of their respective districts. The Kintampo Municipal Assembly initiated the establishment of the Scheme. A Steering Committee made up of key stakeholders in the Municipality was set-up to educate and sensitize the people in the Municipality on the need to establish health insurance scheme in the District in 2003.The Steering Committee, as part of their mandate, established a five member Health Insurance Committee in each community in the Municipality. The membership of the Committee included a Chairman, Secretary, PRO, Treasure and Adviser who were trained to handle all health insurance related issues in their respective communities.

The 1st General Assembly was organized on 7th October, 2004 to elect Board of Directors, set premium and registration fee and to adopt the constitution and bye-laws of the scheme. A fifteen (15) member Board of Directors was inaugurated on the 20th November, 2004. The Board confirmed the appointment of asix(6) member core staff appointed by the Municipal Assembly. The Scheme obtained a Certificate of Incorporation on 14th May, 2005 and a Certificate to Commence Business on 15th June, 2005.The Scheme's first administrative office was the old post office building. With a total enrolment of 16,873 (North & South District), the Scheme commenced claims administration on 14th September, 2005. An initial approved fees paid by members were: informal sector to (18-69 years) Ten Ghana Cedis (GH¢10.00) for both Premium and Registration Fees. The premium was Nine Ghana Cedis, Twenty pesewas (GH¢ 9.20) and the registration fee was Eighty pesewas (80 GHp). All the exempt categories paid only

registration fee of Eighty Ghana Pesewas (80 GHp). The new fee payment as at 2011stands at;

All exempt categories	Four Ghana Cedis (GH¢4.00)
Informal (new registration)	Seventeen Ghana Cedis (GH¢17.00)
Informal (Renewal)	Fourteen Ghana Cedis (GH¢ 14.00)

The Scheme as at 2010had a total membership of 90,589 as against an initial enrolment of 16,873 in 2005.The exempt category (children below 18yrs, pregnant women, SSNIT Pensioners and indigents) constitute the greater percentage of the total registrants. There are Fifteen (15) Health Facilities accredited in the Municipality to provide Health care services to the people. The benefit coverage is about 95% of all disease conditions prevalence in the Municipality (KMMHIS, 2010).

Health Insurance Coverage

Most health insurance schemes in Africa which covered people in the informal sector begun with low enrolment rates at the beginning of their implementation but recorded encouraging enrolment rates with time. An extensive WHO review was made in 1998 concerning 82 nonprofit health insurance schemes for people outside the formal sector employment in developing countries. However, according to Bennet et al (1998), very few of these schemes covered large populations or did not even cover high proportions of the eligible populations. From a subset of 44 of these schemes the median value of the percentage of the eligible population covered was 24.9%, 13 schemes had a

coverage rate below 15% and 12 schemes had a coverage rate above 50%. It was realized that adverse selection was more affecting the schemes that insured against high cost low frequency events than schemes that covered low cost, high frequency events. One of the main reasons was that many people tended to sign up with the community health insurance schemes at the moment of illness.

In a study of health Insurance coverage conducted in Ghana and Mali, it was found out that 53% and 25% of the target population of 25,000 and 200,000 was covered respectively. In Senegal, one health insurance scheme recorded a coverage rate of 26% after three years of operation. In the Maliando Health Organization in Guinea, subscription of membership dropped from 8% to 6% of the target population (Criel, 1998). Musau (1999) observed low percentage enrolment rates in a study on five community-based health insurance schemes in Eastern and Southern Africa. In other four schemes, percentage varied between 0.3% to 6.5% of the target population. According to Schneider et al (2001)**,** a project was launched in Rwanda, establishing 54 schemes in three districts in July 1999. By the end of the first year of operation the enrolment rate reached in the three districts was 7.9% (88,303 members out of a total target population of 1,115,509).

All these experiences have supported the fact that quite often membership rates may be too low in the beginning but might increase as schemes improve management and design**.**

Coverage for the Poor

Health insurance schemes are designed to target the core poor. However; it has been observed that most times the target population is not well represented. Moens (1990) found out in a study that very few schemes reach the vulnerable population groups unless government facilitated their membership through subsidies. The very poor and the high income groups were in fact less well represented in the member population. The very low income group was 14.9%, while it was 5.9% in the high income group. In another study in Rwanda in 2001 on the other hand Schneider et al (2001) did not find any statistically significant difference as to enrolment across the different income groups**.** Even though, it has been established that the poor can insure themselves against risks of illness, studies in Senegal found out that the poorest of the poor do not participate in the scheme for lack of financial resources to be able to pay premiums regularly. This is due to the seasonal income variations in rural remote settings (Waddington, 1989; and Asenso Okyere, et al, 1999).

Exclusive List of the National Health Insurance Package

Certain diseases are however, excluded from the benefit package. This is mainly because it may be too expensive to treat those diseases and therefore, other arrangements are being considered to enable people get these diseases treated. Diseases currently not covered are: optical aids, hearing aids, orthopedic aids, dentures, beautification surgery, supply of AIDS drugs, treatment of chronic renal

failure, heart and brain surgery, etc. All these constitute only 5% of the total number of diseases that attack us, (NHI Act 650 and LI 1809, 2003).

Problems in the Health Insurance Market

One particular problem of insurance market is covariant risk. This means that a person's risk of needing care is not independent of his or her neighbours' health. This is because the risks of falling ill are correlated especially in cases where natural disasters or epidemics hit a geographical area. This can present the problem of depletion of resources of insurance schemes.

For instance, a malaria epidemic in South Western Uganda cost the Kisiizi Hospital Health Society around 8.5 million Ugandan Shillings (about $6,500) between January and December, 1998, about 64% of treatment expenditures were covered by the schemes revenue. Again, moral hazard behaviours of the insured present a potential threat to the financial sustainability of schemes. This will occur when insured members abuse the use of health facilities than they would have under user fee system. Experience from studies in other areas have shown that to prevent insurance market failures due to adverse selection people should be made to join schemes as groups so as to ensure that both healthy and sick people are enrolled.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter deals with the method used for the study. It describes the study area, the scope of the study, sampling and sampling procedure, data collection techniques and instruments, ethical considerations, data handling and data analysis techniques.

Study Methods and Design

The study was descriptive and cross-sectional and employed both qualitative and quantitative methods for data collection. The qualitative methods included the use of in-depth interviews with field workers and workers of health insurance and focus group discussions with caregivers. The quantitative part involved the use of structured questionnaires for heads of institution.

Profile of the Study Area

The profile comprised the following: the geographical location and size, population growth and spatial distribution, climate and vegetation, relief and drainage, major economic activities, transportation system, telecommunication,

ethnicity and religion, health service delivery, common diseases in the district and issues of public health importance.

Geographical Location and Size

The then Kintampo District was established in 1988 under Legislative Instrument 1480. However, in 2004 the Kintampo South District was carved out from the then kintampo District and it was renamed the Kintampo North District by Legislative Instrument of the Local government Act, Act 462, LI 1762, now KintampoMunicipal by Legislative Instrument of the Local government Act, Act 462, LI 1871. The Kintampo Municipal is one of the Twenty-two (22) Municipals/Districts in the BrongAhafo Region (BAR) of Ghana.It is located between latitudes 8º45'N and 7º45'N and Longitudes 1º20'W and 2°1'E and shares boundaries with five other districts in the Country namely; Central Gonja District to the North; Bole District to the West; East Gonja District to the North-East (all in the Northern Region); Kintampo South District to the South; and Pru District to the South- East (all in the BrongAhafo Region). The Municipal Capital, Kintampo, is about 130km away by road from the regional capital and lies east ofSunyani. The Municipal has a surface area of about 5,108square km, thus occupying a land area of about 12.9% of the total land area of BrongAhafo Region (39,557km^2).

In terms of location and size, the Municipality is strategically located at the centre of Ghana and serves as a transit point between the northern and southern sectors of the country. It is hoped that the construction of the Kunsu-Ntankro, Prang – Kintampo - Wa roads will further open and enhance vehicular

traffic on these roads as well as interaction between the southern and northern parts of Ghana.

The vast nature of the Municipality (about 5,108km^2), with an estimated population of 111,263, gives a low density of 21.75 persons per square kilometre. The implication in terms of agriculture is that there could be abundant land for farming and other socio-economic activities. This is further buttressed by the comparatively easy acquisition of agricultural land in the area.

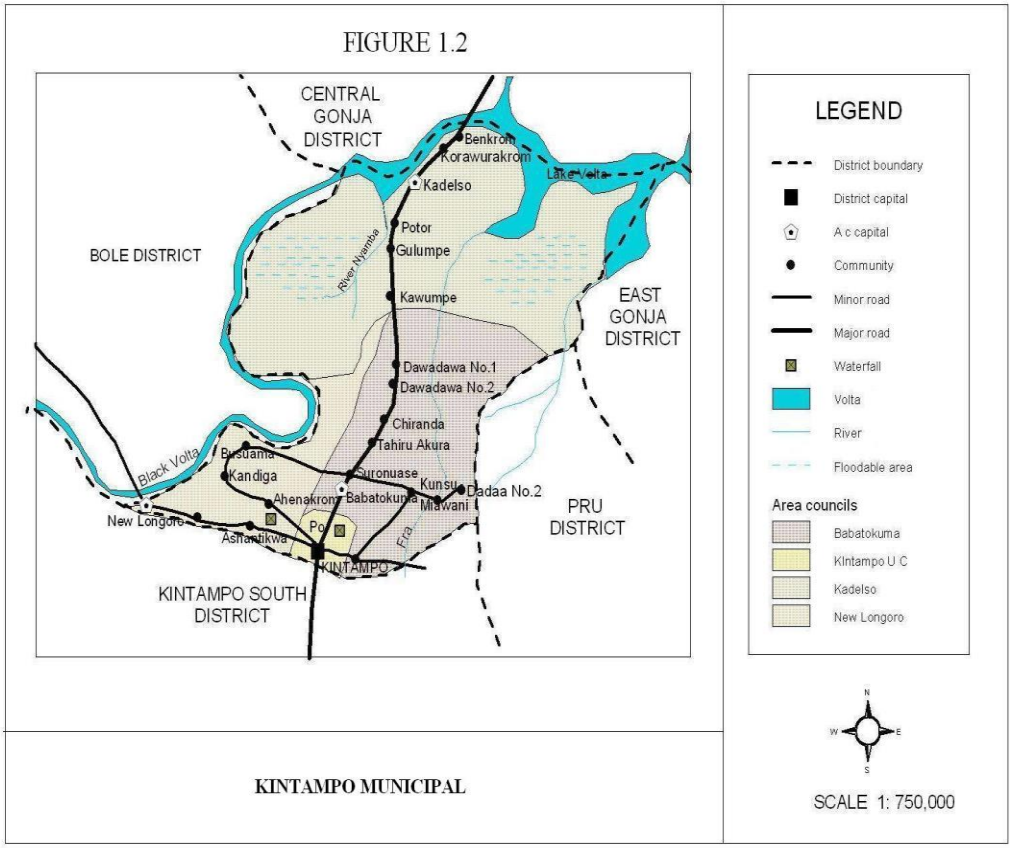


Figure1: Kintampo Municipal Map

Population Growth and Spatial Distribution

Table 1: Distribution of Population

Area/Community	Male	Female	Total
Kintampo	17,264	19,462	36,726
Babatokuma	3,842	3,825	7,667
Busuama	1,162	1,205	2,367
Dawadawa No.1 & 2	4,266	4,422	8,688
Gulumpe	10,763	11,158	21,921
Kadelso	4,416	4,575	8,991
Kunsu	5,976	6,199	12,175
New Longoro	2,145	2,228	4,373
Portor	2,042	2,117	4,159
Others	2,060	2,136	4,196
TOTAL	53,936	57,327	111,263

Source: MPCU Projections, December, 2010

Kintampo Municipal has an estimated population of 111,263 comprising 48.48% males and 51.52% females, with a growth rate of 2.6%. The area has a potential of population explosion due to the fertile nature of the land. Migrant farmers from the north move to settle on arable lands where they can get enough farm produce. There is therefore the need to put strategic measures to manage the population in the area. Table1contains the spatial distribution of the population in the major towns in the Municipality

From Table1, it may be concluded that most of the major settlements have population over 5,000. At a glance, one may say that these settlements are urban, based on the national standard. The population figures however include other smaller settlements around these major settlements. Only Kintampo, Babatorkuma, Gulumpe and Kunsu are of urban status. These communities, except Kintampo, are more rural than urban settlements.

Climate and Vegetation

The municipality experiences the tropical continental or interior savannah type of climate, which is a modified form of the tropical continental or the wet-semi equatorial type of climate. This is due largely to the fact that the municipality is in the transitional zone between the two major climatic regions in Ghana. The mean annual rainfall is between 1,400mm to 1,800mm and occurs in two seasons; from May to July and from September to October with the minor season (May to July) sometimes being obscured. However, because of the transitional nature of the area, the distinction between the two peaks is often not

so marked. The mean monthly temperature ranging from 30°c in March to 24°c in August with mean annual temperatures between 26.5°c and 27.2°c. These conditions give rise to sunny conditions for most parts of the year. Relative humidity is light varying from 90% to 95% in the rainy season to 75% and 80% in the dry season. The climate of the municipality has the tendency to change and be inclined more to the drier tropical continental conditions or to the wet semi-equatorial conditions.(KiMA Profile, 2010)

The municipality comes under the interior wooded savannah or tree savannah. However, owing to its transitional nature, the area does not totally exhibit typical savannah conditions. Thus, the savannah here is heavily wooded, though most of the trees are not as tall and gigantic as those in the most deciduous forest. It is believed that the transitional zone was once forested and that the savannah conditions currently prevailing have been the result of man's activities. This may be evidenced by the existence of 'fringe forest' found along the banks of major rivers and streams and other areas where the impact of man's activities are minimal. Only trees such as the Mahogany, Wawa, Odum, Onyina, Boabab, Dawadawa, Acacia, and the Sheanut trees, which have adapted to this environment are found in the vegetation zone. They are few and scattered except along the margins of the moist deciduous forest where the trees often grow quite close together. Grass grows in tussocks and can reach a height of about 10 feet. (KiMA Profile, 2010)

Relief and Drainage

The Kintampo Municipal which falls within the Voltain Basin and the Southern Plateau Physiographic regions is a plain with rolling and undulating land surface with a general elevation between 60 and 150m above sea level. The southern Voltain Plateau occupying the southern part of the Municipal is characterized by series of escarpments. The municipal which falls within the Voltain Basin is endowed with a lot of water resources. The major water bodies include the Fra,Urukwain, and the Nyamba rivers. Others are rivers Oyoko, Pumpum and Tanfi. These water bodies flow through the west of the municipal and join the Black Volta at Buipe. The slopes through which the rivers flow have given rise to water falls. The major ones include the Fular Falls on the Oyoko River and the Kintampo Water Falls on the Pumpum River. Most of these rivers are intermittent and the large ones like Urukwain and Pumpum fluctuate in volume. This makes them unreliable for irrigation purpose.

In terms of relief and drainage, the vast expanse of flat land especially the northern part makes it suitable for large scale mechanized farming. Road construction and other activities are also relatively cheaper. The vast water resources in the western part of the municipal could be harnessed for irrigation purposes especially rice cultivation and dry season gardening as well as domestic supply of potable water. Fishing which is already an important activity on the Black Volta can be promoted if measures are put in place to ensure sustainable operations by the fishermen.

Major Economic Activities

The Kintampo Municipal economy can be described as purely agrarian in that almost every resident in the area is a farmer. About 71.1% of the population is engaged in agriculture and its related activities as their main economic activity. The remaining 28.9% are distributed among commerce, industry and services. Agriculture being the major economic activity constitutes the main source of household income in the area. The major food crops produced in the area are yam, maize, cowpea, cassava, rice, plantain, egushie, groundnut and beans. Cashew, mango, tomatoes, onions, water mellon, garden eggs and soya beans have potential to increase the incomes of farmers. Despite the efforts of the farmers, frequent bush-fires, high cost of inputs, inadequate extension services, prevalence of pests and diseases, lack of access to credit, poor market prices and market facilities account for the low yield of farm produce in the area.

Transportation System

There is one second class road running from the southern boundary through the district capital to the northern boundary at Central Gonja District. The roads linking the district capital and other communities in the district are of the third class category. With the onset of rains the conditions of these roads deteriorate. Various communities are however linked by foot paths. Vehicles plying between the sub-districts and the district capital are mostly old and ill-maintained. This makes accessibility to the district hospital and the other health centers and clinics a problem especially, in times of emergencies.

Telecommunication

There are presently the Vodafone, Tigo, MTN and Expresso GSM networks in the area. These however cover about 60% of the Municipal area. There is also few fixed line by Ghana telecommunication available in the Municipal. Presently, there is only one Post Office in the Municipal located at Kintampo.

Ethnicity and Religion

The ethnic composition of the municipal is heterogeneous with the Mos and Nkoranzas being the indigenous custodians of the land. There are however, a large proportion of northern tribes which forms the third force in the Municipal not forgetting of other Akan tribes, Ewes, Gas and others. In terms of religion, Christians dominate, comprising 62.2% of the total population and the Muslim Community 29.6%. This may be due to immigration of settler farmers from the north who are mostly Muslims. Traditional religion still has a place in the district and is practiced by 8.2% of the population.

Health Services Delivery

For administrative convenience of health services delivery, the Kintampo Municipal has been demarcated into 10 sub-districts. Each sub-district has a health facility that supports the provision of health care to the rural populations. Other service providers such as private midwives, private medical practitioners, chemical sellers, traditional healers, community-based surveillance volunteers and

traditional birth attendants are also involved in health service provision, particularly in remote communities throughout the district.

Table 2 Distribution of Health Facilities in the KintampoMunicipality

	HEALTH FACILITY	NUMBER	OWNERSHIP
1	Kintampo Municipal Hospital	1	Government.
2	AnnorAsare Memorial Clinic	1	Private
3	KintampoDental Clinic	1	Government
4	Ayamba Initiative Diagnostic Centre	1	Private
5	Kunsu Health Centre	1	Government
6	Kadelso Health Centre	1	Government
7	Dawadawa Health Centre	1	Government
8	Newlongoro Health Centre	1	Government
9	Busuama Rural Clinic	1	Government
10	Prince of Peace Maternity Home	1	Private
11	KintampoSunkwa Clinic	1	Private
12	Yuzela Hospital	1	Private

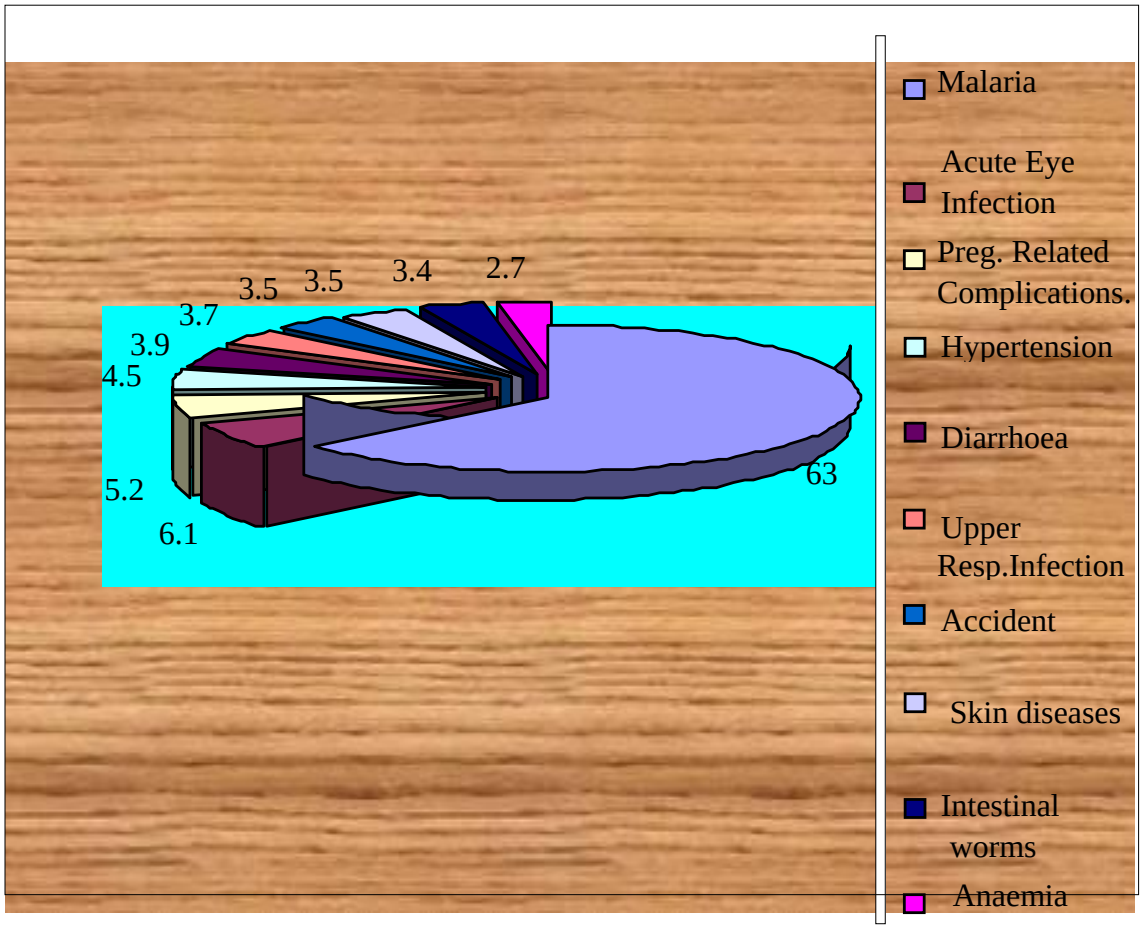
Source: Annual Review Report. KMHD (2010)

The Kintampo municipal hospital serves as the referral point for the smaller facilities in the sub-districts whilst at the same time playing the role of a 'practicing hospital' for the Rural Health Training School located at Kintampo. There are seven government health facilities and the Kintampo Municipal Hospital while there are five private health facilities in the district. The Kintampo

Health Research Centre also undertakes studies on micro nutrients supplementation especially VITAMIN A and other drug trials.

Common Diseases in the Municipality

The Municipality recorded a total of 72,450 Out Patient Department cases for the year 2010. The Figure below shows the ten most important health problems in the Municipality:

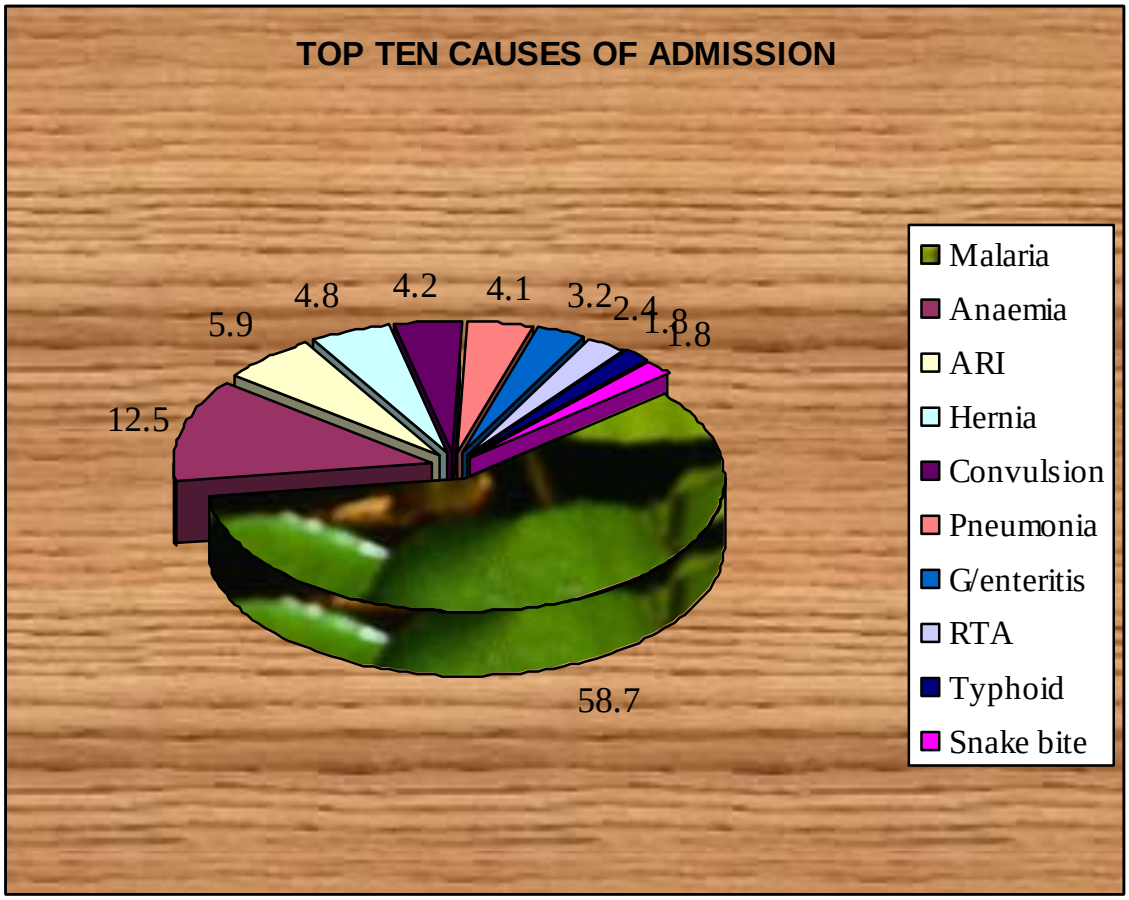


: Source: Annual Review Report KMHD, 2010

Figure2: Top Ten Causes of OPD Attendance in the Municipality.

The data found in the Figure 2 imply that these diseases constitute the main causes of outpatients' attendance at the health facilities in the Municipality.

The Figure 3shows the top ten diseases of the admissions at the health facilities in the KintampoMunicipality.



Source: Annual Review Report KMHD, 2010

Figure 3: Top Ten Causes of Hospital Admissions in the Municipality.

Data on the Figure 3 above imply that these are the main diseases which constitute the burden of health care cost for the scheme.

Issues of Public Health Importance

Over 50% of the population use streams and ponds as sources of drinking water. In addition to this, there is indiscriminate defecation and disposal of

household waste. Another problem is the large immigrant population from the Northern Region as a result of the 1994 northern conflict putting pressure on the existing health facilities. However, the Municipal Hospital is not adequately equipped and staffed to take care of all these problems as well as serve as an effective referral facility for the other peripheral facilities (KMHD, 2010).

Study Population

The study population included 108health workers, 12 heads of health institutions, 80 scheme workers and field agents; all totaling 200.

Sampling and Sampling Method

A multistage sampling technique was employed in selecting the Municipalhealth facilities and participants. The Municipality was clustered into seven sub-districts based on the Municipal Health Management Teams (MHMT)demarcation. All the Sub-Districts were selected for the study. For the selection of field agents, the study used the Kintampo Health Research Centre's Demographic Surveillance system data on all the field agents in the Municipality. The respondents were then selected using random numbers. Purposive sampling method was employed to select the health staff and scheme workerson the assumption that they had adequate knowledge on the topic under investigation, whiles complete enumeration was done on the heads of institution. Ten focus group discussions were also conducted with caregivers in all the Sub-Districts, one each in a Sub-District. In all, forty (40) people were interviewed.

A sampling size was drawn from all the seven sub-districts in the Municipality as shown in table 3. This was spread throughout the study areas using proportionate quota and was obtained scientifically from the statistical model:

$$n = \frac{N}{1+N(\alpha^2)}$$ where n= the sample size, N= the sample frame, 1= a constant, and α is the margin of error. Thus, N= 200 and α= 0.1.

Table 3Sample of Respondents by Category

Variable	Population	Sample	Percentage
Heads of Health Institutions	12	12	100
Scheme Workers and Field Agents	80	16	20
Caregivers/Other Health Workers	108	12	11
Total	200	40	20

Source: Field survey, 2011

The sub-districts representation was to ascertain how the local communities were involved in assessing the impact of NHIS on access to basic quality healthcare in the Municipality. As recommended by Bliss et al, (2002), Health Insurance Scheme must make to contributors paraphrase feel that they are solving their own problem and that they are responsible for their actions and omissions. This can be achieved when the local population is involved in the feasibility studies. When they have the opportunity to discuss the health services

they want and possible contribution payments, there is a real opportunity for a sense of ownership of the scheme. Table 4 depicts how respondents were selected across the various sub-districts in the Municipality. The Municipality had seven (7) sub- districts. With the exception of Kintampo sub-district which had 16 respondents (40%), the remaining sub-districts had equal respondents' representation of four (10%) each.

Table 4 Distribution of Respondents by Sub-Districts

Sub-District	Frequency	Percentage
Kintampo	16	40
Busuama	4	10
New Longoro	4	10
Kunsu	4	10
Kadelso	4	10
Dawadawa	4	10
Gulumpe	4	10
TOTAL	40	100

Source: Field survey, 2011

Data Collection Techniques and Tools

Prior to field work, two research assistants were trained on the rudiments of research. At the training, the objectives of the study were explained and information on data collection translated to the local dialect. Focus groups

discussions were held with caregivers while in-depth interviews were held with health workers, scheme workers and field agents. Besides, structured questionnaires were also administered on all the heads of health institutions.

Pretesting of Study Instruments

Pre-testing of data collection tools were done in two health facilities, thus, NewLongoro Health Centre (government facility) and AnnorAsare Memorial Clinic(private facility), and two field agents – one at Kunsu and the other at Kadelso. The pretesting exercise involved the principal investigator and two other field supervisors. A day was used to complete the pre-test. The experiences from the pre-testing were incorporated into finalizing on the data collection tools to get accurate results.

Ethical Consideration

Consent was sought from the Municipal Health Management Team (MHMT), the management of health insurance scheme and the Municipal Health Directorate, as well as study participants. Confidentiality of respondents was assured. The study was expected to pose no physical or psychological harm to the study participants.

Data Handling/Field Work

The field work started in February and ended in April, 2011. Two field assistants were employed to assist in the fieldwork. Data collection was done in seven days. During the period, a lot of supports such as motor bikes and

laptopswere given to the field assistants for easily collection of data. Sorting was done to ensure quality control of data. Other quality control measures were checks for completeness, internal consistency and accuracy of data processing (categorizing and coding of data). Data were double entered by two data entry clerks.

Data Analysis Technique

Data analysis started soon after data collection was completed. The analysis was done by the principal investigator with the help of the two field assistance at the KintampoMunicipal Mutual Health Insurance Office. Data entry and report writing were done in Microsoft word and excel. The results were presented in tables, charts and graphs.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

This chapter presents the results of the study in the form of tables, graphs, diagrams and charts.The analysis was guided by the research questions and the objectives set out in the study. The socio-demographic data of respondents were undertaken to gather information relevant to help in the analysis of the results.

Socio-Demographic Characteristics

The following variables constitute the socio-demographic characteristics of the study: age, sex, occupation, educational status, marital status, religion and sub-districts.

Age Distribution

To determine the impact of National Health Insurance Scheme on access to basic healthcare services, the ages of the respondents would be an important input. Age grouping (thus, the number of years the person attains) depicts levels of education, income, social responsibilities, healthcare needs and hence healthcare cost implications. It is therefore important at all times to take age groupings into consideration in analyzing the impact of NHIS on access to healthcare in the Municipality.

Table 5Age Distribution of the Respondents

Variable	Frequency	Percent (%)
Below 20 years	4	10
20 – 29 years	10	25
30 - 39	16	40
40 – 59	8	20
60 and above	2	5
Total	40	100.0

Source: Field work, May, 2011.

From Table 5, 95% of the respondents were below 50 years of age. This group had long life expectancy and demands quality health financing system for healthy living. While Respondents aged 60 years and above constituted 5%. This means that the greater proportion of the respondents represented the majority of the inhabitants who could appreciate the impact of National Health Insurance on access to basic quality health care in the Municipality.

Sex Composition

To get comprehensive view from the respondents on the impact of NHIS on access to quality health care delivery in the Municipality, their gender composition was also determined. This was to ensure that both sexes had equal opportunity in this study. The table below depicts the composition.

Table 6 Sex Composition of Respondents

Gender	Frequency	Percent (%)
Male	24	60
Female	16	40
Total	40	100.0

Source: Fieldwork, May, 2011.

From Table 6, 60% of the respondents were males while 40% were females. The proportion of male to female in the study sample only showed the sex composition of respondents sampled and contacted in this study.This sex disparity came about because of the fact that most women felt issues concerning access to health care in the Kintampo Municipality were related to men.Another reason was that males dominated in areas such as heads of health facilities, field agents and Health Insurance workers where respondents were sampled. The difference notwithstanding, there was sufficient representation of both sexes for the assessment of the impact of National Health Insurance Scheme on access to basic qality health care in the Municipality.

Educational Background of the Respondents

The educational background of the respondents was also crucial to the analysis of the data.Table 7 shows how far the respondents had gone in terms of

educational ladder.The data portray that, 40% of respondents had completed their tertiary education, 20% had either technical/commercial/SHS/O Level, 35% had middle/JSH education while 5% forming the minority, had either primary/informal education. The above composition of respondents shows their ability to appreciate the impact of National Health Insurance Scheme on the access to healthcare services and the role of field agents in the sustainability of the health insurance.

Table 7 Educational Background of Respondents

Educational level	Frequency	Percentage (%)
Tertiary	16	40
Technical/Commercial/SHS/O Level	8	20
Middle/JHS	14	35
Primary/Informal	2	5
Total	40	100

Source: Field work, May, 2011.

Marital Status

The marital status of the respondents formed an integral part of the research. Table8shows the composition of the marital status.

Table 8 Marital Status of the Respondents

Marital Status	Frequency	Percentage (%)
Married	20	50
Single	18	45
Divorce/Widow/Widower	2	5
Total	40	100

Source: Field work, May, 2011.

The marital status statistics indicates that 50% of the sampled populations were married people while only 5% were divorced/widow/widower and 45% of them were single. This means majority of the respondents had additional responsibilities in their homes with regard to health care financing for spouse, children and other dependents. They would therefore be in a better position to assess the impact of National Health Insurance on access to basic quality health care in the Municipality.

Religious Affiliation

The religious aspect was also taken into consideration to ascertain the respondents' background in terms of their system of belief. This is presented in Table 9.The Table 9 shows that 20% of the respondents were Muslims while 70% were Christians. Those in traditional religions formed only 5% while another 5% constituted the respondents in other forms of religion. The determination of the religious background of the respondents was crucial because in the Thies Region

in Senegal, it was revealed that traditional solidarity in the community setting played a major role in the success of health insurance (Jutting et al, 2001).

Table 9 Religious Affiliationof the Respondents

Religion	Frequency	Percentage (%)
Islam	8	20
Christianity	28	70
Traditional	2	5
Others	2	5
Total	40	100

Source: Field work, May, 2011.

Occupation of the Respondents

The analysis of the occupation of the respondents in this work is important in considering the premium to be collected and appropriate time for collection especially when dealing with informal sector as captured in research work. A studyby Development and Cooperation (2001), showed that one other important determinant of willingness to join schemes was affordability of the premiums which often depended on the time of collection. The study also showed this was because the health insurance scheme is to target the marginalized in the society, the premium rates needed to be affordable. It has been found out that health insurance schemes which target formal sector workers most of the time, collect monthly contributions from members while in the informal sector collection of

contributions is done during harvest season when cash incomes are regular. This among other things, isbecause widespread absolute poverty is believed to restrict potential members from joining health insurance schemes, hence there should be flexibility in payment of premiums by the poor. It also implies that collection of premiums should be done during the seasons when cash incomes are highest (Development Corporation, 2001). The occupational distribution of the respondents from Table 10 shows that the greater proportions of the respondents, 45%, were in civil/public service. Those in farming formed 15%, self/other employment were 30%, apprentices and unemployed constituted 5% each.

Table: 10Occupations of the respondents

Occupation	Frequency	Percentage (%)
Farming	6	15
Public Servants	18	45
Self-employment	12	30
Apprentices	2	5
Unemployed	2	5
Total	40	100

Source: Field work, May 2011.

Coverage and Utilization of the Scheme

As part of the study objectives, information on the number of people registered and issued with NHIS card to have access to basic health care services in the Municipality was gathered. Again, information on clients who utilized the

services was sought for. This was necessary because the more people got enrolled and received NHIS cards, the easier they had access to basic quality health care services to improve upon their health status and increase productivity in the Municipality.

Coverage of the Scheme in the Municipality

To know the number of people registered and issued with NHIS cards, the Management Information Systems Unit of the Scheme was contacted for enrolment data from 2006 to 2010. Though the enrolment figures at the beginning were low as compared with Municipal population, there was a tremendous improvement year after year. With an initial low enrolment of 21,189 in 2006, the figure rose to 90,824 in 2010. The enrolment report for the period iscaptured in Table 11. This confirmed a study conducted by WHO in 1998 which revealed that most health insurance schemes in Africa which cover people in the informal sector began with low enrolment rates at the beginning of their implementation but recorded encouraging enrolment rates with time. The implication was that as more and more people got enrolled and were issued with NHIS cards, the more easily they accessed free health care services.

Table 11 Coverage of the Scheme from 2006 to 2010

Enrolment Category	2006	2007	2008	2009	2010
Informal	6415	10449	24270	24539	10617
SSNIT Cont	1717	1713	3070	3316	3795
SSNIT Pens	117	197	367	1079	1152
Below 18yrs 11515	16910	38528	42274	58170	
70 and above	1328	1990	4613	7090	8576
Indigents/ Leap	37	61	208	1675	1813
Pregnant Women	0	0	1235	3712	6701
Total Registration	21,189	31,020	72,291	83,200	90,824

Source: Fieldwork, 2011

From Table 11, it can be seen that 81.6% of the total population of the Municipality had joined the Scheme as at the end of 2010 and were therefore accessing the health care in the Municipality and beyond. The total coverage points to the fact that people are conscious of their health needs and given that the coverage was over 81% of the Municipal population suggested that the peoplewere satisfied andwilling to access health care under the National Health Insurance Scheme. Thus, as years go by, many morepeople joined the Scheme.

The study further revealed that enrolment increased was as a result of an increase in the number of service providers (especially, the accreditation of private providers and pharmaceutical shops from one to five) as well as an increase in qualified health personnel in both public and private healthcare facilities which enhanced quality of care. As demonstrated by Desmet et al (1999) quality of care equally plays an important role in willingness to join a scheme. In 12 focus group discussions (FGDs) organized to evaluate the Meliando Scheme in Guinea with 137 persons, quality of care defined in terms of rapid recovery, good health personnel, good drugs and nice welcoming were mentioned 383 times by participants as an important factor which determined to a large extent, the willingness to join a scheme.

Coverage for the Poor and the Marginalized

The core objective of the NHIS policy is to pool risk, reduce individuals' burden of health expenditure and achieve better health services utilization rate. It is important to note that under the policy, the rich subsidize the poor; the healthy subsidize the sick and the economically active pays for children, the aged and the indigents. The NHIS policy was therefore intended to protect the poor and vulnerable in our Ghanaian society through the principles of equity, solidarity, risk sharing, cross-subsidization, re-insurance, subscriber/community ownership, good governance and accountability in health care delivery (NHIS, 2003).

Table 12: Coverage for the Poor and Marginalized

Enrolment Category	2006	2007	2008	2009	2010
Informal	6415	10449	24270	24539	10617
SSNIT Cont	1717	1713	3070	3316	3795
SSNIT Pens	117	197	367	1079	1152
Below 18yrs	11515	16910	38528	42274	58170
70 and above	1328	1990	4613	7090	8576
Indigents/ Leap	37	61	208	1675	1813
Pregnant Women	0	0	1235	3712	6701
Total Exempt	14,714	20,871	48,021	59,146	80,207
Total Registration	21,189	31,020	72,291	83,200	90,824
Percentage of Exempt	69.4	67.3	66.4	71.1	88.3

Source: Field Study, 2011.

An investigation into how the Scheme is implementing the policy objective and the underlying principles revealed that the poor and the vulnerable referred to as the exempt category constituted the greater percentage of the

Scheme's enrolment from 2006 to 2010 and have free access to health care. The total exempt category registered from 2006 to 2010 is as indicated in Table 11.

The analysis of the enrolment data showed that there are two (2) categories of the exempt group. The first category is made up of SSNIT contributors, SSNIT pensioners, children below 18 years, and aged 70 years and above. This category is exempted from paying premium. They however paid the registration and processing fees. The second category made up of Indigents/LEAP beneficiaries and pregnant women were completely exempted from any fee payment. All the two categories of individuals under the NHIS policy had free access to basic health care with little or no payment in terms of premium and registration fees.

The enrollment analysis indicated that the percentage of the poor and the vulnerable on year by year enrollment ranged between 66.45%and 88.3% (see Table 12). The policy therefore provided coverage for over 60% of the total enrolled on yearly basis to access health care. This signifies that poor and marginalized are being catered for under the health insurance.

Health Care Facilities in the Municipality

To ensure that card bearers of the Scheme had easy access to health care services, information was gathered from health insurance claims unit on the number of health care facilities available to provide health care services to the Scheme. The Table 13 depicts the health facilities in the Municipality where insured clients sought health care.

Table 13 Contracted Health Facilities in the Municipality.

Health Facility	Location	Ownership
Kintampo Municipal Hospital	Kintampo	Government
AnnorAsare Memorial Clinic	Kintampo	Private
Kintampo Dental Clinic	Kintampo	Government
Ayamba Initiative Diagnostic Centre	Kintampo	Private
Kunsu Health Centre	Kunsu	Government
Kadelso Health Centre	Kadelso	Government
Dawadawa Health Centre	Dawadawa	Government
Newlongoro Health Centre	New Longoro	Government
Busuama Rural Clinic	Busuama	Government
Prince of Peace Maternity Home	Kintampo	Private
KintampoSunkwa Clinic	Kintampo	Private
Yuzela Hospital	Kintampo	Private

Source: Field work, 2011.

It is seen from Table 13 that there were five private health care institutions as against seven government health care providers in Kintampo Municipality. Before 2006, there were only two private health care providers-AnnorAsare Memorial Clinic and Glory Prince of Peace Maternity Home. Between 2006

2010, three additional private clinics were established.This shows how individuals were willing to provide health care in the Municipality. This is an indication that with the introduction of National Health Insurance Scheme, more Private Health Care Institutions had been opened in the Municipality as they were sure of making profit in that venture.

Utilization and Claims Payment

The level of utilization of Health Insurance clients and claims payment were also assessed to know how the Scheme was impacting on access to basic quality healthcare of the people in the Municipality. The Table 14 shows the trend of utilization and claims payment by the Scheme to the contracted health providers. From the Table 14, it can be seen that 394,624 attendances had been made by the registered clients within the health facilities in the Municipality with the total claims payment of GH¢5,323,416.78 as at the end of 2010. It can also be seen that 94.86% visits were for Out Patient Department (OPD) cases whiles 5.14% were admission cases with yearly increment in cases. It was realized from the study that as the registration increased year after year, attendance at the health facilities also went up with corresponding increase in claims payment. This indicates that marginalized and poor in the Municipality were getting access to health care through National Health Insurance Scheme.

Table 14: Utilization and Claims Payment by the Scheme

	Claims Received					
YEAR	OPD	IPD	Total Claims Received	Total Amount (OPD)- GH¢	Total Amount (IPD) –GH¢	Grant Total (GH¢)
2006	30,057	1,749	31,806	142,904.96	69,747.39	212,652.35
2007	59,643	3,030	62,673	326,609.32	126,610.63	453,219.95
2008	76,715	4,117	80,832	822,194.39	267,931.91	1,090,126.30
2009	97,675	5,503	103,178	1,309,921.78	337,287.78	1,647,209.56
2010	110,257	5,878	116,135	1,528,505.11	391,703.51	1,920,208.62
TOTAL	374,347	20,277	394,624	4,130,135.56	1,193,281.22	5,323,416.78

Source: Field Work, 2011.

It is seen from Figures 4a and 4b that as more people registered with the Scheme, the attendance at the health facilities alsowent up with corresponding increase in claims payment.It is realized that even though there were not sharp differences in attendance in 2007, 2008, 2009 and 2010, ther e was vast differences in claims payment between these years. This was attributed to the revision in tariffs and medicine lists in 2008 which improved the benefit package and enhanced quality of care. As shown in Demet et al (1999) studies, in some settings, it is not possible to set up viable insurance schemes and mobilize demand if the people feel that they cannot get the best health care services possible. The implication is that the benefit package should include basic services designed to take into account the health care needs and preferences of the target populations. Health facilities will also have to be well equipped to collect patient data for reimbursement.

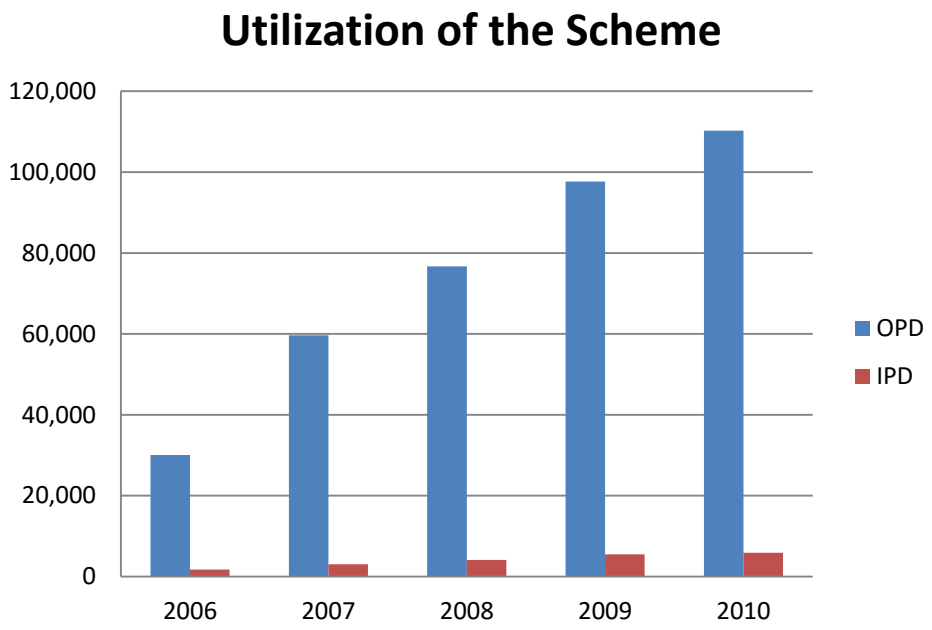


Figure 4a: Utilization of the Scheme by the Clients

Source: Field Work, 2011

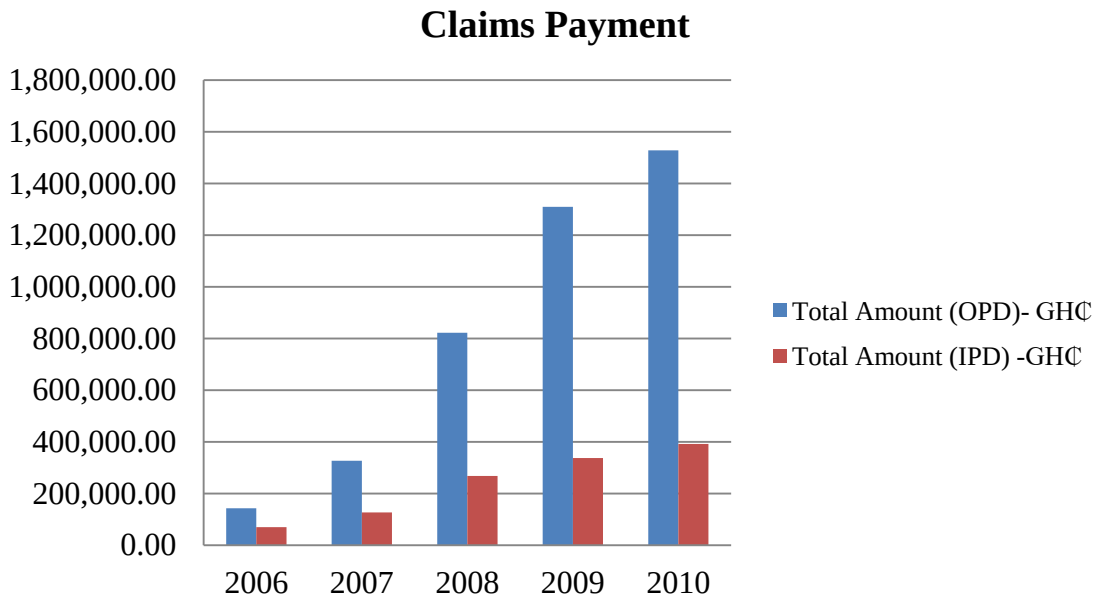


Figure 4b: Claims Payment at the Scheme

Source: Field Work, 2011

Rate of Health Facility Utilization between Insured and Non-insured

To know the extent to which the health insurance was making an impact on access to health service delivery in the Municipality, health institutions were asked to indicate the rate of utilization of their facilities between insured and non-insured and the benefits people derived from registering with the Scheme. The utilization rate is depicted in figure 5.

The study of the OPD utilization pattern from 2007 to 2010 revealedsteady increase in attendance for the insured. The rate of utilization of health facilities between insured and noninsured were: 2007, 64% versus 36%; 2008, 79% versus 21%; 2009, 89% versus 11%; 2010, 90% versus 10% respectively. More insured clients accessed the facilities more than noninsured as years went by. This was as a result of the removal of the financial barrier for the insured clients and thereby creating an access for rapid healthcare services and health review. As confirmed by Ghana Health Service in their 2008 Report, the effect of the NHIS can be seen with the year on year increase in the number of insured clients and the per capita OPD attendance (Ghana Health Service, 2008).There had been consistence decrease in OPD attendance by noninsured from 2007 to 2010 but increase in the insured group as can be seen from Figure 5. This means more people were utilizing the health facilities with their insurance cards. As years go by, more people registered with the insurance Scheme leaving a small proportion of the population remaining noninsured, hence the decrease in the attendance for the noninsured.

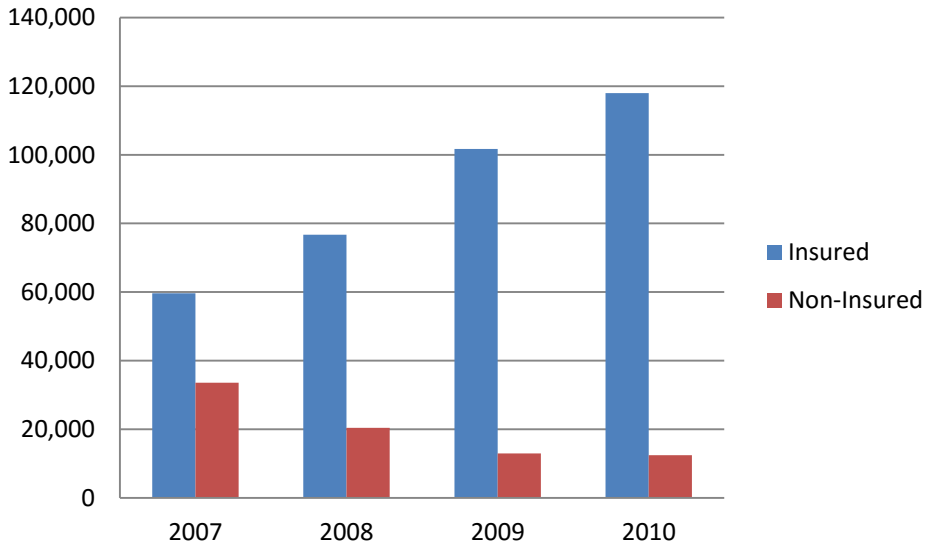


Figure 5: OPD Attendance between Insured and Noninsured (2007-2010)
Source: Field study, 2011

Mortality Rate and Morbidity in the Health Facilities

The mortality rate and morbidity between insured and noninsured in all the health facilities in the Kintampo Municipality were assessed. Morbidity was looked at in terms of admission rate in the Municipality. Table 15 presents the morbidity while Table 16 depicts the mortality rates in the Municipality.

Morbidity in the Municipal Health Facilities

The Table 15 shows the trend of admissions and deaths in the municipality between insured and noninsured that occurred from 2007 to 2010.

Table 15: Trend of Admission and Death Cases 2007 – 2010

Year	2007		2008		2009		2010	
	Insured	Noninsured	Insured	Noninsured	Insured	Noninsured	Insured	Noninsured
Indicator								
Admissions	3,032	1,121	4,118	670	5,505	971	5,879	1,119
Deaths	49	74	61	74	93	68	75	82
Death Rate	1.61	6.60	1.48	11.04	1.68	7.00	1.28	7.33

Source: Field survey: 2011

From the study, it became clear that though admissions were low with the non-insured, death rates were high as compared with the insured. For instance, in the year2010, while total admission for the insured was 5,879, the non-insured had 1,119 admissions. Out of these admissions, 75 deaths occurred among the insured constituting about 1.28%while 82 deaths (7.33%) for the non-insured. The average death rate was 1:100 for the insured and 7:100 for the non- insured as captured in Table 4.13. The implication is that for every hundred insured persons admitted; only one person was expected to die, while in every hundred non-insured persons admitted, seven persons were expected to die. The reason being that while the insured could access health care at the early stages of ill-heath, the non-insured had to wait till the situation became more complicated

Causes of Deaths in the Municipal Health Facilities

The Table 16 depicts the deaths that occurred in the Municipality and the causes of those deaths.

Table 16: Causes of Deaths 2007 - 2010

2007		2008		2009		2010	
Cases	No	Cases	No	Cases	No	Cases	No
Malaria	56	Malaria	36	Malaria	64	Malaria	55
Viral Hepatitis	8	HIV/AIDS	13	Anaemia	25	HIV/AIDS	28
HIV/AIDS	7	Anaemia	12	HIV/AIDS	20	Anaemia	27
Anaemia	7	Pneumonia	9	Septicemia	18	Pneumonia	20
Typhoid	5	Hypertension	8	Hypertension	17	Septicemia	7
Pneumonia	4	Meningitis	6	Others	17	Others	20
Total	123		135		161	Total	157

Source: Field study, 2011

Malaria accounted for about 46% of the number of people who died in 2007, whiles the rate reduced to about 27% in 2008. It can also be seen from Table 16 that HIV/AIDS accounted for about 6%, 10%, 12% and 18% of the people who died in 2007, 2008, 2009 and 2010 respectively. This means HIV/AIDS was prevalent in the Municipality. Anaemia also accounted

for 16% of death cases in 2009. The institutional mortality rate between insured and noninsured in 2007 were 40% and 60% respectively, while in 2008, the rates were 45% and 55% in the same category. In 2009, the rates were 58% and 42% between insured and noninsured respectively, while in 2010, the rates were 48% and 52% between insured and noninsured respectively. The overall institutional rates were 1.10%, 1.19% and 0.98% in 2008, 2009 and 2010 respectively. This shows reduction in mortality rate in 2010 in the Municipality.

The Figure 6 shows the morbidity and mortality rates between insured and noninsured in the municipality.

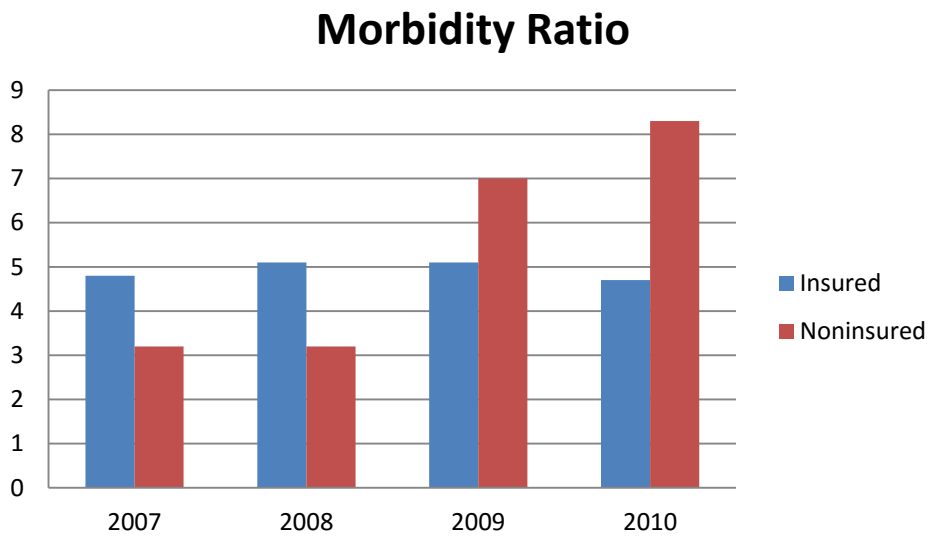


Figure 6: Morbidity Ratio between Insured and Non-insured

Source: field study, 2011

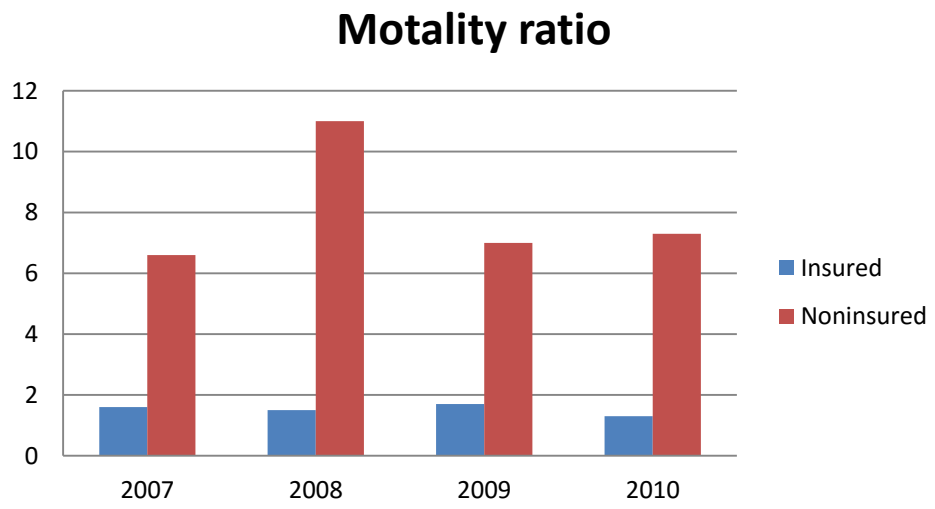


Figure 7: Mortality Ratio between Insured and Non-insured

Source: Field study, 2011

From Figure 7, it was seen that the rate of admission is higher in the noninsured group than the insured group. Even though there might be other reason(s) but the major reason being that those who were insured reported minor cases at the health facilities early whiles the noninsured had to wait till the condition became worse before they reported to the health facilities. Again, it is seen from Figure 4.3 that the morbidity was higher in the noninsured group than the insured. This means more noninsured people died than those who were insured. According to Ghana Health Service (2008), the insured patronize health facilities more, and have better outcomes than the uninsured. The Report says overall, 3% of all admissions experienced a fatal outcome. It continues that this poor outcome was however higher in the uninsured group, 5%, and was much lower for the insured 2%. Relatively, more males died in both the insured and the

uninsured groups (53% versus 47% in the insured group, 56% versus 44% in the uninsured group, 55% versus 45% overall). Furthermore, in relative terms, more men died uninsured than insured. Sixty-two percent (62%) more men die uninsured versus 38% insured, compared with women 59% uninsured versus 41% insured.

Qualified Health Personnel in the Municipality

The availability of qualified health personnel in health care delivery system is a fundamental requirement to ensure the provision of quality basic healthcare at all times. It is important to note that the number of qualified health personnel in a facility determines the type of services the facility could render. It is also argued that the more the qualified personnel, the better healthcare services they render to the clients.

It is on this basis that the study sought for information on the available health personnel in the areas of Doctors, Nurses, Medical Assistants, Midwives, Pharmacists, Dispensary Technicians, and Laboratory Technicians in the Municipality from 2006 to 2010 and its impact on access to quality basic health care services in the Municipality. Table 17 depicts the number of qualified healthcare practitioners in the Municipality from 2006 to 2010. Statistics of qualified personnel from Table 17 indicates that there was a rapid increase in the engagement of Doctors, Nurses and Medical Assistants from 2008 to 2010. All other categories showed a slight increase with Laboratory Technicians dropping within that period.

Table 17 Qualified Healthcare Practitioners

NO	QUALIFIED PERSONNEL	2006	2007	2008	2009	2010
1.	Doctors	3	2	3	7	6
2.	Nurses	28	33	51	52	58
3.	Midwives	14	14	12	15	15
4.	Medical Assistants	2	2	2	1	5
5.	Pharmacists	1	1	2	2	2
6.	Dispensary Technicians	2	2	2	2	2
7.	Laboratory Technicians	1	2	2	1	1

Source: field study, 2011.

A Focus Group Discussion (FGD) held with caregivers revealed that the sharp increase in the engagement of some technical health personnel was as a result of the NHIS accreditation requirement. The NHIS accreditation process required all health care providers to maintain a certain level of qualified health practitioners before they are accredited to render services to the insured clients.

On how the increased in personnel impacted on access to quality health care, the FGD maintained that the ratio between Doctors, Medical Assistants, Nurses and Midwives reduced with an increase in personnel which enhanced quality of care. From Table 17 it is observed that in 2006 the Doctor-Patient ratio was 3: 111,263 (1:37088) implying that every one Doctor had 37,088 patients to care for in the Municipality. In 2010 the ratio reduced to 1:18544. It also reduced for Medical Assistants, Nurses and Midwives as the number of personnel

increased. The implication therefore is that health practitioners had enough time to conduct investigations and assessment of client which enhanced quality of care.

Maternal Health Outcome in the Municipality

To explore the impact of National Health Insurance Scheme on maternal health care, the health service providers were asked to provide records on antenatal care and skilled delivery within the past five years. The Tables and Figures below depict the trend of antenatal care and skilled delivery.

Antenatal Care

To know the extent to which the pregnant women were making use of the free maternal health care policy by the government, records on their attendance at the various health care facilities in the Municipality were ascertained. Figure 8 bring to light such information.

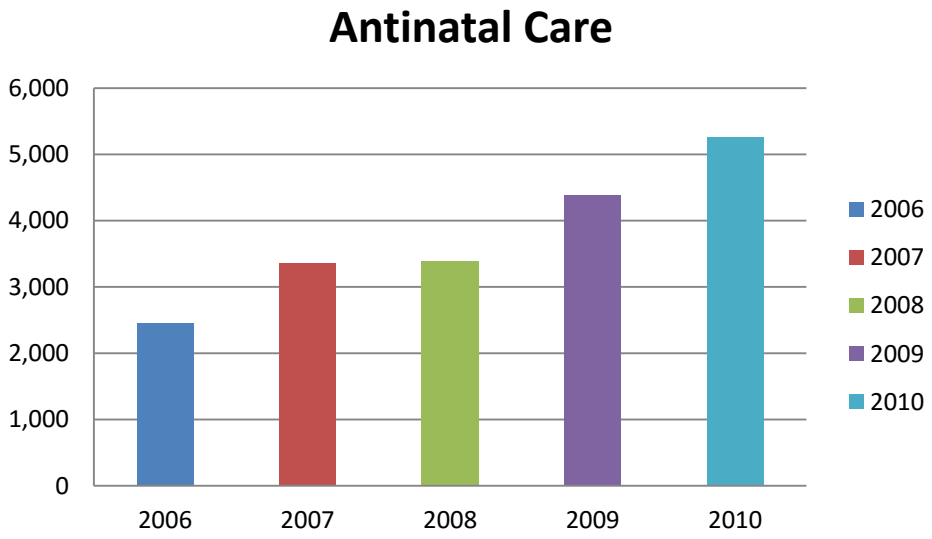


Figure 8: ANC Registrants by Year

Source: Field study, 2011.

The study revealed that antenatal coverage showed significant progress between 2006 and 2010. Most of the increases could be attributed to the revised management of the free maternal health policy through the National Health Insurance Scheme. The percentage increase from 2006 to 2007 was 37% and dropped to 0.8% in 2007 and then rose to 29% in 2009. The percentage increase from 2009 to 2010 was 20%. The impact was that more pregnant women could access healthcare under NHIS free maternal policy hence a sharp reduction in maternal death in the Municipality. The 2008 Report of Ghana Health Service revealed that, in all categories (insured/non-insured/total), women accessed more services than men. Again, more women in both insured and uninsured categories accessed more health services due to the free maternal care policy. Comparatively, more women accessed health services using the NHIS than men (62% versus 55%) and more men were relatively uninsured than their female counterparts (45% versus 38%). The evidence points to the fact that this deliberate policy of making healthcare available and accessible to mothers was yielding results (Ghana Health Service, 2008).

Supervised (Skilled) Delivery and TBA Delivery in the Municipality

The trend of skilled delivery and TBA delivery were also ascertained, Table 4.16 and Figure 4.5 show such trends.

Table 18: Trend of Skilled and TBA Delivery in the Municipality

Years	2006	2007	2008	2009	2010
Supervised Deliveries	1,432	1,468	1,655	2,105	2,263
TBA Delivery	986	1,535	3,189	1,232	807
Total Delivery	2418	3003	4844	3337	3070

Source: Field study, 2011.

Table 18 was used to capture trend of delivery between Skilled Practitioners and TBAs. Total TBAs increased from 2006 to 2008 when pregnant women had to register and pay their health insurance fees before accessing health care. However, with the introduction of free maternal policy in health insurance at the latter part of 2008, deliveries by TBAs started to decline. This pointed to the fact that many pregnant women could not even affordto register with the Scheme. With the free maternal policy, all pregnant were women encouraged to access health care during pregnancy free of charge thereby encouraging supervised delivery in the Municipality.

From Table 18, it can be seen that supervised delivery by skilled attendants and TBAs were: 2007, 39% versus 61%; 2008, 43% versus 57%; and 2009, 36% versus 64% respectively. Figure 9 shows that as years went by more people gave birth at the health facilities. The Figure 9 shows the delivery ratio between skilled practitioners and TBAs in the district from 2007 to 2010.

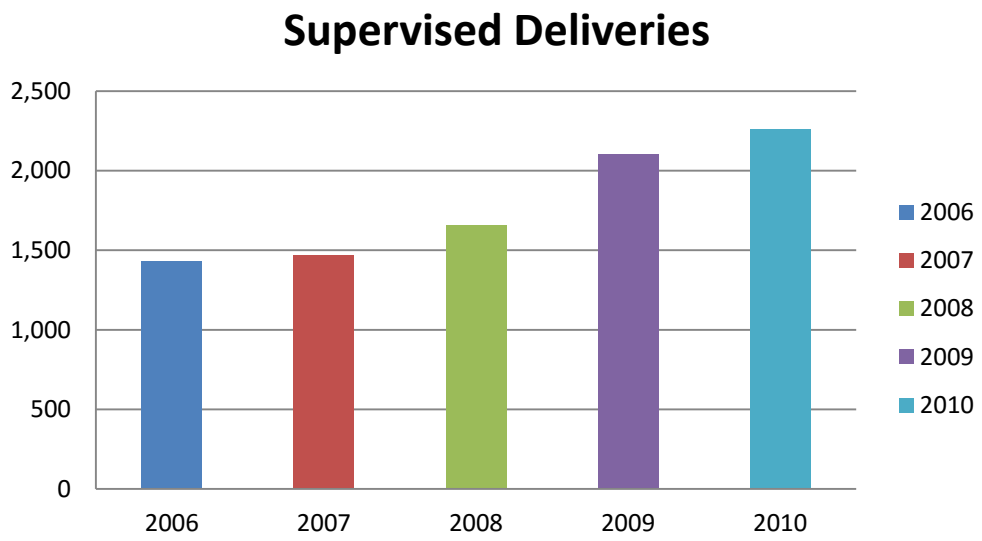


Figure 9: Supervised Delivery by Years

Source: Field study, 2011.

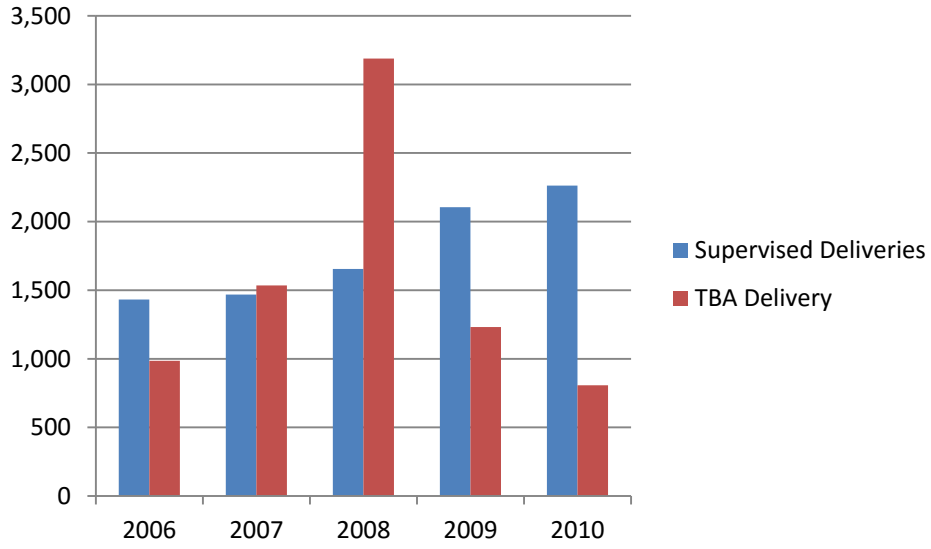


Figure 10: Delivery ratio by skilled practitioners and TBAs

Source: Field study, 2011

It can be seen from Figure 10 that TBA delivery ratio was far higher than the skilled delivery from 2006 to 2008. This means more people delivered in their homes (with TBAs) rather than delivering at the health facilities. The reasons were attributable to economic factors such as income level of the people, educational level, road network, access to health facilities and availability of midwives in the health facilities. Other issues might be the belief system of the people in the Municipality and attitude of some midwives and other health workers at the health facilities.

Upon the introduction of the NHIS accreditation policy which required some qualified personnel to man the Health Centers in the rural communities coupled with the introduction of the free maternal policy and establishment of CHIPS Compounds in some of the remote communities, supervised delivery increased while TBAs dropped. The reasons were that pregnant women could access health care closer to them, the facilities were now manned by qualified midwives and registration of NHIS was free.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter has three sections; the first is devoted to the summary. The conclusions are presented in the second section whiles section three deals with the recommendations to address the issues raised in the study.

Summary

The study was undertaken with the view to assessing the impact of National Health Insurance Scheme on access to basic health service delivery in the Kintampo Municipality of Ghana. With this aim, all the health facilities and Health Insurance Scheme in the Municipality were included in the study. Sample of forty (40) out of the study population of two hundred (200) were either interviewed or requested to fill in questionnaires for appropriate data to be gathered.

For data collection, both probability and non-probability methods were employed. Under the probability method, simple random sampling was used to select health workers, opinion leaders and workers of health insurance scheme, whilst purposive sampling was used to select the heads of health institutions. Frequency distribution, simple percentages, tables, diagrams and charts were used for the analyses and interpretation of the data.

Summary of Main Findings

The following are the major findings from the study:

- It was realized that 81.60% of the Municipal population had enrolled unto the Scheme from 2006 to 2010 signifying the willingness of people access health care throughScheme.
- The study revealed that those who paid premium (informal sector) were only 27.67% of the registered population as against 72.33% of the exempt categories. This means that more people had been exempted from paying the premium thereby encouraging the poor and the vulnerable to join the Scheme and to have access to basic quality health care services in the Municipality.
- The Scheme paidonly 7.91% of claims received from contracted health facilities, whiles government paid 92.09% of the bills. In addition, the Scheme financed 10.21% of its total expenditure whiles government sponsored 89.79%.
- The National Health Insurance Policy had improved the financial status of service providers tremendously over the period of its operation. However,the contracted health facilities were not enough to meet the growing population of the Municipality.
- Most of the health facilities in the Municipalitywere manned by health assistants and few midwives, which in the long run demeanedthe quality health care in the Municipality.
- The concept of health insurance was not well understood by the residence of the Municipality. Many people got to health facilities either to collect

drugs for their relatives who were not insured or kept the drugs for future ailment. Majority of the people also registered only when they were ill.

- People with health insurance cards accessed health care more than those without health insurance.For example, in2007, 64% insured versus 36% noninsured; 2008, 79% insured versus 21% noninsured; 2009, 89% insured versus 11% noninsured; 2010, 90%insured versus 10% noninsured assessed health care in the various facilities in the Municipality.
- The insured patronized health facilities more, and had better outcome than the noninsured. This led to the year on year increase in the number of insured clients and the per capita OPD attendance.
- More health care facilities, especially the private owned ones,were been established and accredited to provide health care services to the insured clients thereby reducing patient- personnel ratio in public health facilities in the Municipality.
- Out of the total of 18,538 insured clients admitted from 2007 to 2010, a total of 278 (1.50%) deaths occurred and out of 3,881 admission cases for the non- insured, a total of 298 (7.68%) deaths occurred. The study revealed that more non- insured died on admission than the insured clients.
- Relatively, more males diedamong both the insured and noninsured (58% versus 42% in the insured group, 71% versus 29% in the noninsured group, 65% versus 35% overall). In relative terms, more men died noninsured than insured.

- In general, there was decrease in mortality rate in the Municipality as more female were enrolled into the National Health Insurance Scheme.
- Antenatal care increased year after year. Most of the increase could be attributed to the revised management of the free maternal health policy through the National Health Insurance Scheme.
- There was no maternal death in all the health facilities from 2007 to 2010. This supports the use of health insurance as an effective health financing tool in providing protection for women seeking delivery care in health facilities.
- Supervised deliveries by skilled health personnel increased year after year.
- Even though Antenatal Care (ANC) registrants increased year after year, majority of them delivered in their homes.
- More women were insured than men (thus, 64% versus 36%) and women accessed health services using the NHIS than men (61% versus 39%). The evidence points to the fact that this deliberate policy of making health care available, affordable and accessible to mothers was yielding results.
- In communities where health facilities were available and easily accessible, Health Insurance registration was very high as compared with communities distanced from health facilities.
- As part of the social policy of the Scheme, over one thousand inhabitants of communities such as Portor, Gulumpe, Kawampe, Atta Akura, AlhassanAkura etc. in the northern zone of the Municipality affected by

flood were registered into the Scheme free of charge to enable them access free healthcare.

- Inhabitants who were registered as Livelihood Empowerment Against Poverty (LEAP) beneficiaries were automatically registered into the Scheme free of charge.
- There were delays in submission of claims by health facilities to the Scheme as a lot of processes needed to be carried out before claims could be submitted.
- There were undue delays in claims payment by Scheme to the health facilities. It took at times about six months before claims bills were paid. This impeded against smooth health care delivery in the Municipality.
- The high claims bills payment was attributable partly to high Ghana Diagnostic Related Grouping (GDRG) Tariffs.
- There were excessive workload at both Scheme and facilities level. Thus, few people were catered for the growing population.
- There was lack of motivation of both health insurance and health facilities staff.

Conclusions

The study in conclusion revealed that

- The coverage of the scheme as at 2010 stood at 81.6% of the total Municipal population. This meant that a lot of people understood and appreciated the benefit package of the NHIS policy in the Municipality.

- 72.3% of the total registered members did not pay premium. This implied that people who were poor and marginalized are being catered for by the policy.
- The trend of utilization from the study indicated that out of every 10 patients in a given facility in the municipality the registered NHIS members constitute 9 (90%) in OPD attendance. Registered NHIS members therefore had easy access as compared with the non-insured. However, appropriate measures needed to be employed to avoid abuse of the policy by the registered clients.
- Patient-personnel ratio has improved even at the lower facilities in the Municipality primarily due to NHIS accreditation requirement. That notwithstanding more health personnel heeded to be sponsored and motivated to accept posting to the rural communities in the Municipality.
- The study also revealed that though more registered clients attended facility as compared with non-insured, the admission and deaths rates were fewer as compared with non-insured. The reason being that the insured report to facility regularly due to easy access. The non-insured may have to wait till the health condition becomes critical.
- The study again indicated that the maternal health policy under the NHIS made a significant progress in terms maternal health outcomes from 2006 to the early part of 2008, TBAs outnumbered supervised delivery. However, upon the introduction of free maternal policy in June, 2008 TBAs dropped while supervised delivery kept on increasing. There is

evident based on the study that NHIS registered clients have access to basic health care service in the municipality. The scheme can improved on the access and benefit immensely, if the under listed recommendations are put into practice.

Recommendations

From the study, the following recommendations are made based on personal observation and those suggestions by respondents.

- More health facilities, especially CHIPS Compounds, should be opened in the various communities to reduce the incidence of travelling long distance to access health care.This will also encourage more people in places without health facilities to register onto the Scheme.
- The accredited health facilities should be monitored regularly to ensure that the facilities and personnel present during accreditation were always present and functional to ensure quality of care.
- National Health Insurance Authority (NHIA) and Ministry of Health (MOH) should collaborate and operate mobile services using accredited health facilities in communities where it is genuinely difficult to post and maintain qualified health personnel.
- If the Scheme and the health facilities could operate effectively and efficiently, funds should be released early enough by the National Health Insurance Authority.

- Intensive education should be carried out in the Municipality about the concept of health insurance and health delivery to minimize abuse on the part of subscribers.
- The operations of the Scheme should be devoid of political interferences to ensure trust in the system.
- More health personnel should be sponsored and bonded by the Municipal Assembly to serve in the Municipality to enhance quality of service.
- Diagnosis should be linked to the drugs in the national software being used by the Scheme in claims processing.
- For smooth and faster claims processing, all the health facilities in the Municipality should be hooked to the national ICT platform and be made to process claims electronically.
- The GDRG Tariffs should be revised to do away with the anomalies identified by Claims Officers and also to reduce unnecessary health facility attendance by the scheme clients.
- There is alsothe need to emphasize the role of continuing education and refresher courses for all staff, especially those who have been working for many years in relative isolation in rural health centers and hospitals if acceptable standards of clinical care are to be maintained.
- The activities of TBAs should be factored into the Ghana Health Service Programme.

- Students, researchers and institutions should be encouraged and assisted to conduct more research into the operations of National Health Insurance Scheme

REFERENCES

Arkutu, A. (2007).*Delivery Care Policy: Service Delivery and Quality of Care,* FRCOG, Accra – Ghana

Atim, C. and Sock, M. (2000).*An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana.*Technical Report No. 50. Bethesda, MD. Partnership for Health Reform, Abt. Associates Inc.

Bennet, B.Creese, A. and Monash, R. (1998).*Health Insurance Schemes for People outside Formal Sector Employment.*ARA Paper No 16, WHO Geneva.

Creese, A. Bennet, S. (1997).*Rural Risks Sharing Strategies.* In: G. (Ed)

Criel,B. (1998).*District Based Health Insurance in Sub Saharan Africa*. Part 1: Case studies in health services organization and policy 10, Antwerp.

(D+C) Development and Cooperation (No, 6 Nov/Dec, 2001, P. 4-5)

Desmet, M.Chowdury, A. and Islam, M. (1999).*The Potential for Social Mobilization in Bangladesh and Functioning of Two Health Insurance Schemes.*Social Science and Medicine. Volume 48, pp 925-938

Frempong, G. (2009).*An Evaluation of National Health Insurance Program in Ghana*.Presented at the Global Development NetWork (GDN) Dissemination Workshop at Pretoria, South Africa.

Ghana Health Service (2008).*Annual Report.2008*.KARA print, Accra

Jutting, J. (2000).*Social Security Systems in Low Income Countries: Concepts, Constraints and the Need for Cooperation*. International social security review, 4/2000, PP.3-25

Jütting, J. (2001). *The Impact of Health Insurance on the Access to Health Care and Financial Protection in Rural Developing Countries.The Example of Senegal*.HNP Discussion Paper (Washington: World Bank).

Jutting, J. and Justine, T. (2001).*Micro Insurance Scheme and Health Care Provision in Developing Countries:* An Empirical Analysis of the Impact of Mutual Health Insurance Schemes in Rural Senegal .p, 23.

KintampoMunicipal Health Directorate (2009).*Annual Review Report 2009*.Unpublished.

KintampoMunicipal Mutual Health Insurance Scheme (2010).*The Profile of the Scheme 2010*.Unpublished.

Lee J. L. (2004).*The Impact of National Health Insurance Scheme on People's Health Status in Taiwan*.China Medical University (Taiwan), Health Care Administration, 91 Hsueh Shih Road, Taichung.

Ministry of Health (2007).*Legal and Policy Frame Work for Health Information and Health Data Reporting.*Draft.

Ministry of Health (1995).*Medium Term Health Strategy,* Accra.p.35

Moens (1990).*Design Implementation of and Evaluation of a Community Financing Schemes for Hospital Care in Developing Countries:* A prepaid health plan in the Bwamanda Health Zone, Zaire. Social Science and Medicine.Volume 30, pp.1319-1327.

MPCU (2010).*Profile of Kintampo Municipality*.Government of the Republic of Ghana, Ministry of Local Government and Rural Development, Kintampo Municipal Assembly.

Musau, S. (1999).*Community-Based Health Insurance; Experiences and Lessons Learned East Africa*. Technical report no 34. Partnership for health reforms project, Abt Associates Inc. Bethesda, MD.

National Health Insurance Act 2003 (Act 650) and National Health Insurance Regulation 2004 (L.I 1809).

Primary health care Series 1, 1982

Russel and Duke (1997).*Constraints to User Fee Policy*.Washington DC, P.352.

ShneiderDiop, F. (2001).*Impact of Prepayment Pilot on Health Care Utilization and Financing in Rwanda.*Findings from Household's Survey for Health Reform/Plus Technical Paper, Bethesda, Maryland: Abt Associates.

Schneider P. Schott W. Bhawalkar M. Nandakumar A.K.Diop F. & Butera D. (2001). *Paying for HIV/AIDS services.Lessons from National Health Accounts and community-based health insurance in Rwanda 1998-1999.* UNAIDS case study (Geneva:UNAIDS)

UNICEF (2000).*Absorbing social shocks, Protecting Children and Reducing Poverty.*

USAID (2005).*Evaluating the Effects of the National Health Insurance Act in Ghana:* Baseline Report, Sara Sulzbach, MPH Abt Associates Inc.

USAID (2009).*MaternalHealth in Ghana: Investigating the Impact of the National Health Insurance Scheme on Maternal Health Indicators*. www.healthsystems2020.org. Accessed on 25th February, 2010.

Enyimayew V and Waddington, C.(1989).*A Price to Pay. Part 1: The Impact of User Charges in Ashanti Akim District, Ghana*. International Journal of Health Planning and Management pp. 417-447.

World Bank (1994).*Better Health in Africa; Experiences and Lessons learned.* Bethesda

APPENDICES

Appendix "1" .The Contribution Payable by the Social Groupings in the Informal Sector

Name of group		Who they are	Minimum Contributions Payable Annually
Core Poor	A	Adults who are unemployed and do not receive any identifiable and constant support from elsewhere for survival	Free
Very Poor	B	Adults who are unemployed and receive identifiable and consistent financial support from source of low income. Adults who are employed but receive low returns for their efforts and are unable to meet their basic needs	GH¢7.20
Poor	C		
Middle Income	D	Adults who are employed and able to meet their basic needs	GH¢18.00
Rich	E	Adults who are able to meet their basic needs and some of their wants	GH¢48.00
Very Rich	F	Adults who are able to meet their basic needs and most of their wants	

Appendix '2' Interview Schedule for Opinion Leaders and Focal Persons

UNIVERSITY OF CAPE COAST/ORGANISATION CAPACITY IMPROVEMENT CONSULTANCY PROGRAMME-MA IN ORGANISATION DEVELOPMENT

The Impact of National Health Insurance on Access to Quality Basic Health Care service in Ghana. A case study in the Kintampo Municipality.

Indepth Interview for Community Opinion Leaders and Focal persons

INTRODUCTION

A study is being conducted into the impact of National Health Insurance Policy on access to quality healthcare in Ghana. A case study of the Kintampo Municipal. I am happy to inform you that you have been selected to participate in the programme by providing answers to the following questions that any information you provide will be very important for the successful implementation of the Health Insurance Scheme in the Municipality. This is also part of an academic exercise. The interview will take not more than 30minutes of yourtime. Your participation will be very much appreciated. Any information provided will be treated confidential.

1. Sex	Male	Female

2. Age group	below 24	25 – 29	30 – 34	35 – 39	40+

3. Religion	Muslim	Traditionalist	Christian	Others

4. Occupation	Farming	Civil Servant	Servant/Public	Apprentice	Unemployed
	Self employed, Trader/businessman, Tradesman				Others

5. Marital status……	Married	Single	Divorced	Widowed

6. Community …… Sub – District ……

7. Education background:

None	Primary school	Middle/JSS
Technical/Commercial/SSS/'O' Level	Tertiary	Not Known

8. Have you heard about the NHIS?	Yes	No
9. Have you registered to the Scheme?	Yes	No

10. If yes, what is your status of registration?

a) Informal b) SSNIT Contribution

c) SSNIT Pensioner d) 70+

12. Have the majority of people in this community registered to the scheme?

Yes □No □

13. If Yes, why have they registered?

a) _____ b) _____

c) _____ d) _____

14. If No, why have they not registered?

a) _____ b) _____

c) _____ d) _____

15. How far is the Community from the health facility?

a) Very far b) Not far

16. How often do you access health care in a year under NHIS?

No. per year	Nil	1 – 3	4 – 6	7 - 10	11 and above

17. How often do you used to access healthcare before registering with NHIS?

No.per year	Nil	1 – 3	4 – 6	7 - 10	11 and above

18. Do Community members know the benefit of NHIS? Yes □ No □

19. If yes, mention some of the benefits?

a) _____ b) _____

c) _____ d) _____

20. Are you satisfied with the attitude of health personnel toward NHIS clients?

Yes □ No □

21. In your opinion, do NHIS clients get good services at the health facility in the Municipality?

Yes □ No □

22. If yes, how?

_____

_____

23. If no, why?

_____

_____

24. Are you satisfied with the number of Personnel available in health facilities in the Municipality?

a) Very much satisfied b) Satisfied c) not satisfied

25. Do you always receive all drugs prescribed at the facility? Yes □ No □

26. If no, how do you get the remaining?

_____

27. What impact do you think health insurance is making on access to quality healthcare in the Municipality?

a) _____ b) _____

c) _____ d) _____

28. What in your opinion do you think can discourage people from joining the scheme in this community?

a) _____ b) _____

c) _____ d) _____

29. In your opinion should the health insurance continue to operate in the Municipality? Yes □ No □

30. What suggestion(s) do you have for the scheme management and policy makers to improve upon access health service delivery in the Municipality?

a) _____ b) _____

c) _____ d) _____

END OF INTERVIEW. THANK YOU

Appendix '3' Questionnaires for Heads of Health Institutions

UNVERSITY OF CAPE COAST/ORGANISATION CAPACITY IMPROVEMENTCONSULTANCY PROGRAMME

MA IN ORGANISATION DEVELOPMENT

The Impact of National Health Scheme on Access to Basic Health Care Service in Ghana.Case Study in the Kintampo Municipality.

INTRODUCTION

A study is being conducted into impact of National Health Insurance Scheme on acess to quality healthcare in Ghana. A case study of the Kintampo Municipal. I am happy to inform you that you have been selected to participate in the programmed by providing answers to the following questions. You are assured that any information you provide will be very important for the successful implementation of the Health Insurance Scheme in the Municipal. This is also part of an academic exercise. The interview will take not more than 30 minutes of

your time. Your participation will be very much appreciated. Any information provided will be treated confidential.

1. Sex	Male	Female

2. Age group	below 24	25 – 29	30 – 34	35 – 39	40+

3. Religion	Muslim	Traditionalist	Christian	Others

4. Occupation	Farming	Civil Servant	Servant/Public	Apprentice	Unemployed
	Self employed, Trader/businessman	Tradesman	Others		

5. Marital status _____	Married	Single	Divorced	Widowed

6. Community _____Sub-District_____

7. Educational background:

None	Primary School	Middle/JSS
Technical/Commercial/SSS/'O' Level	Tertiary	Not Known

a) _____ b) _____

c) _____ d) _____

8. Department_____

9. Rank of Respondent _____

10. Health Facility _____

11. Does your institution have any role to play in the implementation of the Health Insurance Scheme? Yes □No □

12. If yes to question (11) what specific roles are you playing in the implementation of the scheme?

a)_____ b) _____

c) _____ d) _____

e) _____ f) _____

13. What are some of the main policies that your institution has put in place for the implementation of the Scheme?

14. What is the rate of utilization of your facility between insured and noninsured?

_____

15. Is health insurance playing any role in the morbidity rate in this Municipality?

Yes□ No □

16. If yes to question 15, what are the roles?

a) _____ b) _____

c) _____ d) _____

17. What is the rate of mortality rate between the insured and noninsured in this facility?

_____

_____

18. In your opinion, has the NHIS policy increase access to health service delivery in the Municipality? Yes □ No □

19. In yes to question 18, to what extend?

a) _____ b) _____

b) _____ d) _____

20. What benefits does your facility derive from the free maternal health policy?

a) _____ b) _____

c) _____ d) _____

21. What benefits do the pregnant women get from the free maternal health policy?

a) _____ b) _____

c) _____ d) _____

d) _____ f) _____

22. Does your facility manage all the health problems defined in the health insurance benefit package? Yes □ No □

23. If no to question 12, what is the management of the hospital/clinic doing to address the problem?

a) _____ b) _____

c) _____ d) _____

24. What problem(s) do you face in taking care of health insurance clients?

a) _____ b) _____

c) ---------- d) ----------

25. What in your opinion do you think are the main problems hindering the progress of the health insurance scheme in the Municipality?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

26. Should the health insurance be made to continue to operate in the Municipality? Yes □ No □

27. What suggestion(s) do you have for the scheme management and policy makers to improve upon access to quality health delivery in the Municipality?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

END OF INTERVIEW. THANK YOU

Appendix '4' Interview Schedule for Health Insurance Workers

UNIVERSITY OF CAPE COAST/ORGANISATION CAPACITY IMPROVEMENT CONSULTANCY PROGRAMME-MA IN ORGANISATION DEVELOPMENT (OD)

The Impact of National Health Insurance Scheme on Access toQuality Basic Health Care Service in Ghana.A case study of the Kintampo Municipality.

INTRODUCTION

A study is being conducted into the impact of National Health Insurance Policy on access to quality Healthcare in Ghana. A case study of the Kintampo Municipal. I am happy to inform you that you have been selected to participate in the programmed by providing answers to the following questions. You are assured that any information you provide will be very important for the successful implementation of the Health Insurance Scheme in the Municipality. This is also part of an academic exercise. The interview will take not more than 30 minutes of your time. Your participation will be very much appreciated. Any information provided will be treated confidential.

1. Sex	Male	Female

2. Age group	below 24	25 – 29	30 – 34	35 – 39	40+

3. Religion	Muslim	Traditionalist	Christian	Others

4. Occupation	Farming	Civil Servant/Public Servant	Apprentice	Unemployed
	Self employed, trader/businessman Tradesman			Others

5. Marital status _____	Married	Single	Divorced	Widowed

6. Community _____ Sub – District _____

7. Educational background:

None	Primary School	Middle/JSS
Technical/Commercial/SSS/'O' Level	Tertiary	Not Known

8. Department

_____

9. Rank of respondent

_____

10. Insurance Scheme

_____

11. Year of establishing the Scheme

_____

12. Objective(s) of establishing the scheme.

a) _____ b) _____

c) _____ d) _____

13. What is the enrolment of the scheme by category from 2005 to 2010?

_____

14. How long does it take a registered client to get NHIS ID card?

_____

15. What policies does the scheme have to encourage the registration of the poor and the marginalized in the Municipality?

_____

16. How many health facilities have NHIS accreditation in the Municipality?

_____

17. How many Public Health facilities are accredited?

_____

18. How many Private Health facilities are accredited?

_____

19. What service(s) do these facilities provide to the registered members?

_____

20. Do registered clients have access to all these facilities? Yes □ No □

21. If yes, by what means?

_____

22. If No to question 20, why?

_____

23. What are the rates of utilization and claims payment of insured clients from 2005 to 2010?

_____

_____

_____

24. Can you tell some of the main diseases that are covered in the health insurance package?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

25. How does the scheme ensure that its registered clients get access to quality base healthcare?

_____

_____

_____

26. Do the health institutions in the Municipality benefit from the scheme? Yes □ No □

27. If yes to question 26, what benefit(s) do the health facilities derive from the scheme?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

28. What benefit(s) does the scheme derive from the health facilities?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

29. What benefits do the pregnant women get from the free maternal health policy?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

30. How does the scheme pay the bills of the registered clients?

a) _____ b) _____

c) _____ d) _____

31. What problem(s) do you face in taking care of insured clients?

a) _____ b) _____

c) _____ d) _____

32. What in your opinion do you think are the main problems hindering the progress of the health insurance scheme in the Municipality?

a) _____ b) _____

b) _____ c) _____

e) _____ f) _____

33. Should the health insurance be made to continue to operate in the Municipality?

Yes □ No □

34. What suggestion(s) do you have for the policy makers to improve upon health service delivery through health insurance in the Municipality?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

END OF INTERVIEW. THANK YOU

Appendix '6' Interview Schedule for Health Staff

UNIVERSITY OF CAPE COAST/ORGANISATION CAPACITY IMPROVEMENT CONSULTANCY PROGRAMME-MA IN ORGANISATION DEVELOPMENT

The Impact of National Health Insurance Policy on Access to Quality Basic Health Care Service in Ghana.A case study of the Kintampo Municipality.

INTRODUCTION

A study is being conducted into the impact of National Health Insurance Policy on access to quality Basic Healthcare in Ghana. A case study of the Kintampo Municipal. I am happy to inform you that you been selected to participate in the programme by providing answers to the following questions. You are assured that any information you provide will be very important for the successful implementation of the health insurance scheme in the Municipality. This is also part of an academic exercise. The interview will take not more than 30 minutes of you time. Your participation will be very much appreciated. Any information provided will be treated confidential.

1. Sex	Male	Female

2. Age group	below 24	25 – 29	30 – 34	35 – 39	40+

3. Religion	Muslim	Traditionalist	Christian	Others

4. Occupation	Farming	Civil Servant/Public Servant	Apprentice	Unemployed
	Self employed, trader/businessman	Tradesman	Others	

5. Marital status _____	Married	Single	Divorced	Widowed

6. Community _____Sub – District _____

7. Educational background:

None	Primary School	Middle/JSS
Technical/Commercial/SSS/'O' Level	Tertiary	Not Known

8. Department

_____

9. Rank of respondent

_____

10. Health facility

_____

11. Have you registered with scheme? Yes □No□

12. If yes, why have you registered?

_____

13. Is your facility accredited by NHIA? Yes □ No □

14. If yes, when?

_____

15. What services does your facility render under NHIA?

_____

16. What is the strength of staff of your facility?

_____

17. a. How many are professional health personnel?

_____

b. Indicate the category?

_____

18. What is the average monthly rate of utilization of your facility between insured and non-

insured?_____

19. Are your qualified personnel adequate for the total utilization?

_____

20. Can you tell how beneficial the scheme has been to you and other staff in your facility?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

21. Do people come to you for more information on the insurance scheme?

Yes □ No□

22. If yes, what are some of the questions they ask about?

a) _____ b) _____

c) _____ d) _____

23. What impact do you think health insurance is making in the health service delivery in the Municipality?

a) _____ b) _____

c) _____ d) _____

24. Are there any problem(s) that your department is encountering in taking care of health insurance clients? Yes □ No □

25. If yes, what are the problems?

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

26. Is your department well equipped with the needed resources to face the challenges of the health insurance scheme? Yes □ No □

27. If no, what are some of the things that your office need to support the scheme?

a) _____ b) _____

c) _____ d) _____

28. In your opinion should the health insurance continue to operate in the district? Yes □ No □

29. If yes, why should the scheme continue to operate in the Municipality?

a) _____ b) _____

c) _____ d) _____

30. If No, why should the scheme not continue to operate?

a) _____ b) _____

c) _____ d) _____

31. What suggestion(s) do you have for the scheme management and policy makers to improve upon health service delivery in the Municipality?

_____