

UNIVERSITY OF GHANA

**THE SOCIO-ECONOMIC FACTORS THAT AFFECT UTILISATION OF
HEALTH CARE SERVICES BY THE EXEMPT GROUPS UNDER THE
NATIONAL HEALTH INSURANCE SCHEME IN GHANA**

BY

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF M.PHIL DEVELOPMENT STUDIES DEGREE**

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DECLARATION

I hereby certify that this thesis is my original work and that neither part nor whole of this work has ever been presented in this University or in any other institution for the award of any academic degree. All references of others made in this work have duly been acknowledged.

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We, the undersigned supervisors, certify that this is an original work we supervised the candidate to produce. We are also convinced that it (the thesis) meets all required standards set by the University of Ghana for the award of a Master of Philosophy Degree.

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DEDICATION

This thesis is dedicated to my lovely wife, Rebecca Baah-Ofori for the inspiration and encouragement when I started this programme.

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ABSTRACT

Health financing has become a topical issue among development practitioners in most developing countries. This has necessitated some countries introducing social health insurance schemes as a way of financing health. Health insurance schemes are recognized as a tool to finance health care provision in developing countries including Ghana. The health insurance scheme was introduced in Ghana with the purpose of reducing catastrophic health expenditures, improving access and also ensuring equity in health service delivery. The beneficiaries of the NHIS include informal sector workers, Social Security and National Insurance Trust (SSNIT) contributors, SSNIT pensioners, children under 18 years, pregnant women, the aged (70 years & above) and the indigent (core poor). Among these categories of people, the scheme provides exemption packages for some of them such as children below 18 years, pregnant women, the indigent, SSNIT pensioners, SSNIT contributors and older people (above 70 years).

Using secondary household data collected within the three ecological zones in Ghana as well as data from qualitative interviews conducted, this study investigated two categories of the exempt group – those below 18 years and those above 70 years, to unravel some of the socio-economic factors that influence utilization of health care services. The results of both the regression analysis and the focus group discussions suggest the toddlers (0-5 years) and the very old (80+) utilize health care more than the other age groups. Besides, although these groups are exempted from paying premium, some still pay premiums and also make out of pocket (OOP) payments at the health facilities. The results seem to confirm the outcome of several studies on Ghana which identified inequality in the payment of premium and OOP payments. Therefore, an efficient monitoring and supervision on the part of NHIA of the various schemes is recommended while a critical examination of the extent of OOP at the service delivery facilities is suggested.

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LIST OF ABBREVIATIONS

AMA	Accra Metropolitan Assembly
CHBIs	Community-Based Insurance Schemes
CHPS	Community-Based Health Planning Services
DMHIS	District Mutual Health Insurance Schemes
FFS	Fee for Service
GDHS	Ghana Demographic and Health Survey
G-DRGs	Ghana Diagnostics Related Groupings
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV /AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
ISSER	Institute of Statistical, Social and Economic Research
JHS	Junior High School
LDCs	Least Developed Countries
MOH	Ministry of Health
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHS	National Health Service
OECD	Organization of Economic Co-operation and Development
OOP	Out of Pocket Payment
OPD	Out Patients Department
PNDC	Provisional National Defence Council
RCH	Reproductive and Child Health
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
UNICEF	United Nations International Children's Emergency Fund
WB/IMF	World Bank/International Monetary Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background

Health insurance schemes are increasingly recognized as a tool to finance health care provision in developing countries. Indeed, this has the potential to increase utilization and better protect people against health expenses (catastrophic) and also address issues of equity (WHO, 2000). Health insurance according to the World Health Organization is undeniably one of the avenues by which developing and middle income countries can achieve universal coverage in health care (WHO, 2010). Yet, health care financing continues to stir debates around the world. Many low and middle income countries particularly, keep on exploring diverse ways of financing their health systems. This is due to the constant and persistent under-funding confronting the health systems (Dalinjong & Laar, 2012).

Poor households in developing countries have reckoned health insurance as an essential intervention which provides relief to their healthcare expenditures. However, the overwhelming evidence suggests that user fees constitute a strong barrier to the utilization of healthcare services, as well as preventing adherence to long term treatment among poor and vulnerable groups (Palmer et al., 2004).

In Sub-Saharan Africa, Ghana is among the first countries to introduce and implement the National Health Insurance Scheme (NHIS). The health insurance scheme appears to provide a solution to the long standing healthcare financing problem which has been a considerable constraint to the accessibility of healthcare, especially by the poor and the vulnerable (Osei-Akoto & Adamba, 2011; Aryeteey, 2012).

Healthcare financing in Ghana has witnessed a number of reforms over the years. Firstly, during the pre-independence era, financing of health care was mainly out-of-pocket (OOP) payments at service points (Arhinful, 2003). Following the introduction of cost sharing as part of health sector reforms in Ghana, user fee exemptions were introduced for poor and vulnerable groups as part of an overall effort to address equity in public healthcare delivery (Derbile & Geest, 2012).

Since parliamentary enactment of the Hospital Fees Act 1971 which introduced user charges (Shaw & Griffin 1995; Coleman, 1997), exemptions have been part of Ghana's health care system and have changed in various forms through successive governments. However, the history of exemptions date back to the 1960s under Nkrumah's Socialist Government that sought to provide free health care to the populace after independence (Senah, 1989). After independence, the National Health Service (NHS) was established and the state was the sole financier of healthcare. This was known as the "free health for all" and the source of funding was largely tax-based. The NHS provided health services to everybody without any cost and protected poor people in the event of financial shocks. In fact, existing user charges in public health facilities were totally abolished (Nyonator & Kutzin, 1999; Owusu et al., 2008; Ghana Health Service & Abt Associates Inc., 2009; Adamba, 2011; Rosner et al., 2012).

As part of health sector financing reforms, the Government of Ghana passed the National Health Insurance Law in 2003. The rationale behind this was to eliminate the financial barriers posed by the user fees (cash and carry) at the point of service and then limit the out of pocket cash payment to enhance access and improve quality healthcare services in Ghana (NHIS Act 650, 2003; Derbile & Geest, 2012). The policy objective for establishing the NHIS in Ghana as cited in Aryeetey (2012 p.10) states that:

“Ultimately, the vision of the government in instituting a health insurance scheme... is to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare. The policy objective is that “within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him / her against the need to pay out of pocket at the point of service use in order to obtain access to a defined package of acceptable quality of health service”.

At the beginning of the year 2000, the share of households out of pocket (OOP) payment to total health expenditure in Ghana was considerably higher than the regional average for Sub-Saharan Africa (50 percent versus 39 percent respectively in 2006) according to WHO (2010).

Over the past 10 years, the Government of Ghana has been implementing the NHIS as a replacement to the user fee system; yet, the scheme is still bedevilled with the problem of exemption for the poor and vulnerable (Aryteetey, 2012). This gave rise to a new era of exemptions where the poor and vulnerable were to be enrolled into the scheme without paying premium. This new policy shift according to Derbile and Geest (2012), was not preceded by adequate conceptualization of how to deal with exemptions for vulnerable groups and the poor under the National Health Insurance Scheme (NHIS). Due to this inadequacy, there was a risk that the poor would be excluded from voluntary social insurance (Kunfaa, 1996; Arhinful, 2003). Thus, the shift in policy to an “insurance-based system of exemptions” gives rise to outstanding questions on how to address equity concerns that the former exemption regimes failed to adequately deal with (Derbile & Geest, 2012).

Concerning benefits, the National Health Insurance Authority (NHIA) mandates a pre-defined benefits package that covers 95% of the disease burden in Ghana. Services

covered include outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and caesarean delivery), eye care, dental care and emergency care. Currently, the NHIS reimburses providers based on the Ghana Diagnostic Related Groupings (G-DRGs) and fee for-service (FFS) for medicines using a medicines tariff list (Ministry of Health, 2009).

The members or beneficiaries of the NHIS comprise informal sector workers, that is, those who are not Social Security and National Insurance Trust (SSNIT) contributors; SSNIT contributors who are mainly formal sector workers; SSNIT pensioners; children under 18 years; pregnant women; people who are 70 years and above and lastly the indigents (National Development Planning Commission, 2008; 2009; 2010 and 2011). The number of registered subscribers has increased over time as illustrated in Table 1.1

Table 1.1: Aggregate NHIS Subscribers Ever Registered, 2008 – 2010

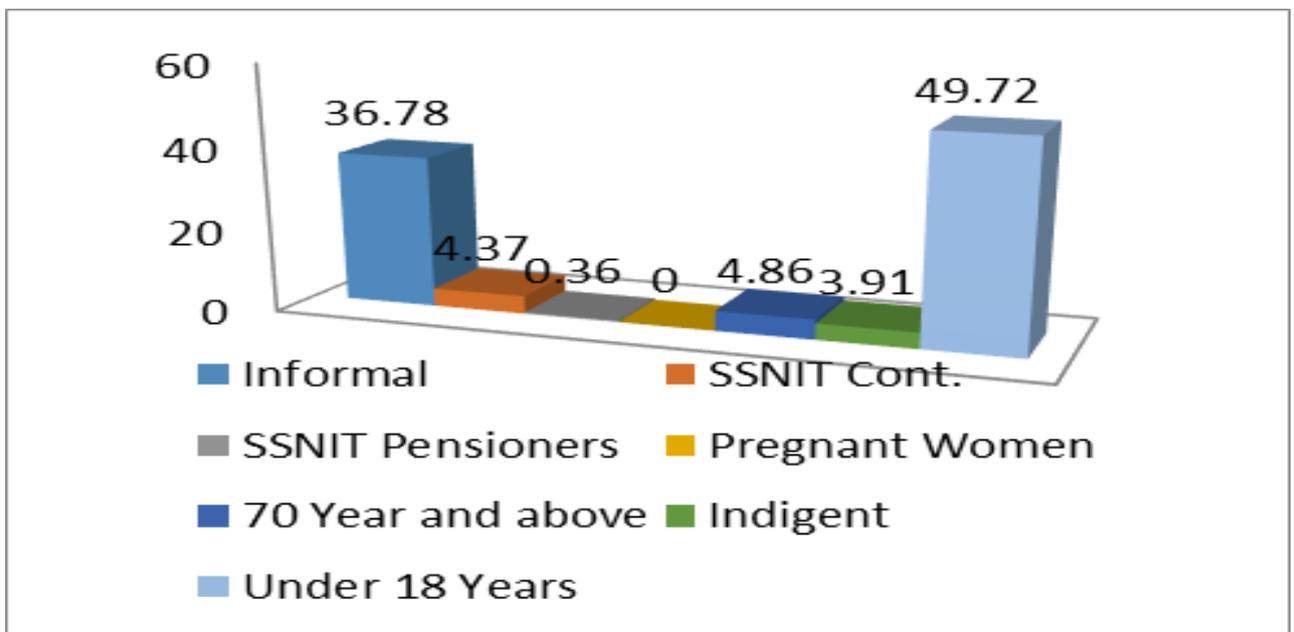
Category	No. Registered as at Dec. 2008	% of total Pop. in 2008	No. Registered as at Dec. 2009	% of total Pop. in 2009	No. Registered as at Dec. 2010	% of total Pop. in 2010
Informal	3,725,965	29.76	4,266,051	29.40	5,282,258	29.3
SSNIT Cont.	798,573	6.38	884,666	6.10	1,036,883	5.8
SSNIT Pensioners.	65,653	0.52	76,974	0.53	89,639	0.5
Under 18 years	6,324,487	50.52	7,175,085	49.44	8,709,389	48.3
Pregnant women	881,725	7.04	967,401	6.67	1,394,445	7.7
70 years and above	300,923	2.40	337,150	2.32	1,140,549	6.3
Indigent	421,234	3.36	804,450	5.54	378,204	2.1
Total	12,518,560	54.66	14,511,777	61.97	18,031,366	74.5

Source: Annual Progress Reports National Development Planning Commission, 2009 and 2011

Table 1.1 points out to the trend of membership of the NHIS between 2008 and 2010. The data shows that the population of the ever registered has been going up since 2008 and out of the total population ever registered, the exempt group (children below 18 years, adults 70 years and above, SSNIT contributors, SSNIT pensioners, pregnant women and the indigents) consist of about 65 percent.

Nonetheless in order to discontinue the cumulative approach of calculating the membership, the National Health Insurance Authority (NHIA) in 2011 decided to consider active membership.

Figure 1.1: NHIS Active Membership in 2011



Source: Annual Progress Report NDPC, 2012.

In defining active membership, the NHIA considered those with valid I.D cards (that is newly registered and renewals). This was to forestall the cumulative process of counting membership in order to achieve a credible membership data base. In this regard, active membership constituted about 34 percent of the country’s population in 2011 (NDPC, 2012). Active membership went up to 10.2 million subscribers representing 38 percent of the national population in 2011 (NHIA, 2014; NDPC, 2013). Among the active

membership of NHIA subscribers in 2013, 62 percent were exempted from paying premiums (i.e. children under 18 years, persons 70 years and older, and indigents), Social Security and National Insurance Trust (SSNIT) contributors and SSNIT Pensioners constituted 4.0% and 0.24% of membership, respectively and the Military, Police and other Security Services constituted 0.243% of membership (NDPC, 2013).

As a departure from a normal insurance system, increase in membership does not necessarily produce increased income from premium to the scheme. The income from the National Health Insurance Levy (NHIL) is by far the largest source of income (70%), followed by Social Security taxes (23%), premiums (5%) and other sources (2%) (Blanchet, Fink & Osei-Akoto, 2012). Therefore, the bulk of income to the NHIS will grow with national income rather than growth in membership (Witter & Garshong, 2009). Exemptions can however make up for the equity related limitations of the NHIS. Yet, based on empirical evidence, community health insurance has been less effective in achieving equity (Jütting, 2004). Nevertheless in Nigeria, there is a similar advocacy for subsidies and exemptions to improve healthcare for the poorest under community-based health insurance schemes (CBHIs) (Onwujekwe et. al., 2010). However, by taking out financial blockades at the points of service through resource and risk sharing, health insurance's purpose to overcome inequalities associated with access to healthcare by the poor can be achieved (Preker & Carrin, 2004).

Suffice to say that while health insurance can facilitate utilization and offer financial protection regarding the cost of illness (Aryeetey et al., 2012), evidence indicates that health insurance has been less effective in achieving this core purpose of equity (Jütting, 2004; Sulzbach, Garshong, & Owusu-Banahene, 2005; De Allegri et al., 2006). However, literature suggests the poor and indigent who should be exempted as a form of greater protection against catastrophic health expenditures are reluctant to enrol in such schemes

in most African countries with the exception of Rwanda, (Arhin-Tenkorang, 1994; Criel & Waelkens, 2003; Jütting, 2004; Jehu-Appiah et al., 2011).

1.2 Problem Statement

User fee exemptions have been part of various packages for promoting equity in Ghana's health delivery system since the 1960s. To underscore this, four distinctive periods of exemptions have evolved. The initial concession on exemptions was an almost free health care policy granted to a major percentage of the populace under Nkrumah's government (Senah, 1989). The second era of exemptions came under the 1971 Legislative Instrument (LI) 701 where Busia's government exempted clients who attended rural health centres and health posts from the payment of user fees (Adamba, 2011).

The third era of exemptions was introduced by the Provisional National Defence Council (PNDC) government in 1985 under LI 1313 of the 1985 Hospital Fees Regulation. Under this, two categories of exemptions were promulgated with the first being patients suffering from leprosy or tuberculosis and other special diseases. Such patients were exempted from the payment of all fees. The second type came into being in 1997 when the Government of Ghana in a renewed effort extended the exemption policy as stated in LI 1313 to include antenatal care, those aged 70 years and above, children under 5 years and later the poor (Government of Ghana, 1999). To do away with the user fee or cash and carry system, the NHIS was instituted in 2003 as the new policy framework for health financing in Ghana setting out the fourth era of exemptions.

The National Health Insurance Scheme Act 650 was promulgated in 2003 with the primary purpose of reducing the inequalities in healthcare provision especially for the poor and the vulnerable. The NHIS in its design has an in-built mechanism for equity in

financial contributions with subscribers paying income-adjusted premiums. The Act 650 mandated all district schemes to charge a minimum premium of roughly GH¢ 7.20 and a maximum of GH¢ 48 per adult from the informal sector based on the ability to pay and this was determined by the individual's declared income or job position. However, given that accurate income measures are not generally available, many District Mutual Health Insurance Schemes (DMHIS) have moved to charging a constant premium from all, typically in the range of GH¢ 8 – GH¢10. In their paper on healthcare utilization in the Accra Metropolitan Area (AMA), Blanchet, Fink and Osei-Akoto (2012) observed that the average premium reported by respondents was GH¢ 21.

The National Health Insurance Act 650 has made provision for certain categories of people to be exempted from payment of premiums. This group include children under 18 years, the aged 70 years and above, pregnant women, SSNIT contributors, SSNIT pensioners and the indigents (core poor). All these categories of people who are exempted are made to pay for the processing of their insurance cards except the indigent who do not pay anything whatsoever. In 2012, the NHIS Act 650 was repealed and replaced with the new National Health Insurance Act 852. This new Act mandates all residents in Ghana to register with the National Health Insurance Scheme (NHIS) and this is to help achieve the universal coverage objective of the NHIA. The Act 852 also seeks to harmonize the operations of the NHIA to ensure efficient and effective service delivery (NHIA, 2012).

Nevertheless, the scope has been expanded further under the new NHIS Act where children under 18 years have been de-coupled from their parents. Additionally, the Act has included persons with acute mental disorder, leprosy and HIV/AIDS under the

exemptions. Although these patients were not paying for their treatment initially, they have now been subsumed under the NHIS.

The numbers that are exempted from payment of premium keeps on increasing every year. For instance in 2011, out of the total active membership of 8.2 million, about 63 percent (5.2 million) were classified as part of the exempt group (NDPC, 2012) and this figure went up to about 68 percent in 2012 (Saleh, 2012). Various studies have shown that there has been an increase in the utilization of health services by means of out-patient visitations and reduction in out-of-pocket payments (OOP) by the insured (including exempt) as compared to the uninsured (Ranson, 2002; Jakab & Krishman, 2004; Diop, Sulzbach & Slavea, 2006; Derbile & Geest, 2012; NDPC, 2012).

In order to access healthcare under the NHIS, the National Health Insurance Regulations, L.I. 1809, requires a beneficiary to first report to a primary care facility, and subsequently to second and third levels of care by way of referral. However, poor gate-keeping in the health delivery system in general has led to clients having preferences for higher level facilities which results in higher cost and delayed re-imburement to the service providers (Ghana Health Service, 2007).

Generally, the NHIS has improved access to and utilization of healthcare services but not without challenges. Anecdotal examples of poor quality of care include provider discrimination against insured patients, long waiting time, low likelihood of being seen by a doctor and the uncertainty of receiving all drugs prescribed. It has therefore been reported that providers commonly solicit informal payments from the patients by asking them to pay for drugs, which are said to be out of stock or pay for “better” drugs, not provided under the NHIS (Ministry of Health, 2009).

Majority of the membership of the NHIS (68%) are considered exempt and are mostly in the lower income bracket; therefore, this study tries to identify some of the socio-economic challenges that affect the exempt groups when it comes to utilization of healthcare services.

What are the real challenges that confront the exempt in their attempt at utilising healthcare services under the NHIS? Are these challenges the same everywhere? Or are some challenges specific to localities? Do these challenges vary by way of sex among the exempt?

1.3 Research Questions

The study seeks to explore the following questions:

- What are some of the socio-economic factors that affect utilization of healthcare services by the exempt group?
- What are the health seeking behaviours of the exempt group?
- To what extent does the exempt group make OOPs at the point of service delivery?

1.4 Objectives of the study

The main aim of this study is to investigate the socio-economic challenges that affect the exempt groups in utilization of healthcare under the NHIS. Specifically the study seeks:

- To investigate the socio-economic factors that affect utilization of healthcare services by the exempt group.
- To examine health seeking behaviours among the exempt group
- To explore the extent to which the exempt group make OOPs at the point of service delivery.

1.5 Relevance of the study

A lot of studies have been conducted regarding the health insurance scheme and those that looked at the exemption categories focused more on free maternal delivery and the exemption of the poor (indigent). Yet, none of them have delved specifically into the under 18 years and the aged (70 years and above). This study sought to unravel the socio-economic burden these groups, which constitute over 55 percent of the insured, encounter when it comes to healthcare utilization. The elderly and children under 18 years tend to utilize health care resources more often than those who fall within the working category (18 – 59 years).

In Japan for instance, the entire population is enrolled in mandatory health insurance, known as "Health-insurance-for-all". It has been estimated that the medical expenditure for the elderly is already taking one-third of national health expenditure, and is projected to reach half of national health expenditure by the year 2025. Therefore this study can better inform policy for improving the implementation of exemptions under national health insurance scheme.

1.6 Organization of Thesis

This study has been categorised into five chapters. The first chapter looks at the background of the study, then to the problem statement. The research questions, objectives of the study and the relevance of the study. Chapter two reviews the relevant literature that are beneficial to the study both empirical and theoretical. The chapter also explains the theories under-pining the study. The third chapter explains the background characteristics of the study areas and the methodology that was employed in this study. Chapter four

presents the analysis and discussions of results and chapter five contains the summary, conclusion and the recommendations from the study for policy.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The aim of healthcare financing is to improve access to health services especially for those belonging to low-income households. Globally, countries are using different modes to reduce the burden posed by out-of-pocket payment (OOP) especially for the poor in particularly, Least Developed countries (LDCs). This is because direct payments create financial hardships for some people especially the poor and thereby reduce access to health services. Healthcare financing according to the World Health Organization (WHO) is to ensure sustained funding, as well as to set the right financial incentives for providers, to guarantee that all individuals have access to effective public health service which is the *raison d'être* for better personal health care. This is to reduce or eliminate the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so (WHO, 2006).

This chapter discusses the literature that has guided the debate over healthcare financing in general and specifically on health insurance exemptions and utilization. This chapter is divided into six sections. It has an introduction followed by a review of literature covering the genesis of healthcare financing from a global perspective. Then healthcare financing in Africa and the case of Ghana are discussed. The fifth section discusses the challenges of Social Health Insurance in some developing countries and the Challenges of NHIS exemptions in Ghana. The final part of the chapter discusses the theoretical framework that underpin this study.

2.1 The Genesis of Global Health Care Financing

Health financing is an important part of broader efforts to ensure social protection in health. Recognizing this, the WHO in 2005, committed to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as universal health coverage which states that there should be universal access to health care service by everybody without any hindrances whatsoever (WHO, 2005).

The basic idea of pooling resources to spread economic risk dated back to the ancient Greek where the citizens benefited from tax-supported public physicians. Later on, the first compulsory health insurance law was enacted by the state of Prussia and years later under the new Germany, health insurance was made mandatory for all workers throughout the state. Later in the United Kingdom around 1911, the health insurance act was passed and this covered direct cash payment in the event of maternity or disability. Also, it covered the medical services of a worker who becomes ill. The success of the German health insurance scheme motivated other countries in Europe to emulate the model (Mladovsk & Mossialos, 2007).

However, countries had to undergo reforms in their health financing to meet the growing financial burden that governments were saddled with. Private health insurance evolved dramatically in the mid-20th century in the U.S.A and the purpose was to improve the social conditions of the working class. Yet, the contemporary system differs significantly from the 20th century system because of universality and sustainability of the current systems (Mladovsk & Mossialos, 2007).

In recent years, the call for universal health coverage has spurred on a global movement and this in 2005 led the World Health Assembly to appeal to governments to develop their

health systems, so that all people will have access to services and not suffer financial hardships (Cortez & Ramiro, 2013). This invitation was to underscore the urgency with which access and utilization was paramount to the WHO. Consequently, the General Assembly of the UN in December 2012, also called on governments to urgently scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services and this inspired some 30 middle and lower income countries to implement programmes with the objective to advance this transition to Universal Healthcare (Cortez & Ramiro, 2013).

In view of this, some countries have even enshrined the right to healthcare in their constitution and a typical example is Columbia where the right to healthcare is tagged the subsidize regime (SR) and this is being championed by the central government which is mandated to ensure that health service is available to the entire population. This therefore has improved healthcare services considerably for the past 20 years albeit all the difficulties.

Healthcare financing has become so imperative that most countries are particularly using unique methodologies such as taxation, social health insurance, voluntary and private insurance, out-of-pocket (OOP) or user fees and donations to finance their health care (Mossialos et al., 2002). These forms of health financing seek to ensure that citizenry have access to affordable healthcare.

However, a recent comparative study of healthcare financing in Asian countries showed that OOP payments were concentrated among the higher income groups. The richest quintile contributed more than half of OOP payments in Bangladesh, Indonesia, the Philippines, Sri Lanka and Thailand (Equity in Asia-Pacific Health Systems, 2005). Another study by O'Donnell, van Doorslaer et al. (2008), indicated that in some Asian

countries, the poor did not only pay less in absolute terms but less as a proportion of household resources. However, the study also found out that in countries such as Japan, Kyrgyz and Taiwan, OOP payment by people in the poorest quintile exceeded the share of their ability to pay, thus making OOP payments mildly progressive or proportional in most of these Asian countries. This therefore contradicts the common assertion that OOP payments are regressive (O'Donnell, van Doorslaer et al. 2008).

2.2 HealthCare Financing in Africa

Healthcare financing in Africa has gained a lot of prominence and gone through several phases with governments promising different forms and mechanisms to achieve equity and access (Leighton, 1995). Undoubtedly, many methods of health financing mechanisms practiced in Europe were geared towards containing costs, yet in developing countries particularly Africa, health financing reforms emanated as a result of growing demand for improved healthcare when governments could no longer provide free healthcare with shrinking resources (Korankye, 2012).

Given the emphasis on cost recovery in Africa, it is often argued whether cost recovery affects access to healthcare. It is however posited that user-fees serve as a blockade to utilization notably in the primary and preventive healthcare services. A study by Leighton (1995), in Cameroon found that the tendency for a sick person to visit a government hospital was 25 percent higher when fees were charged and quality improved. Yet this could hinder access to the service by the poor households because they have less money and may not borrow funds or trade-off any asset to pay for health cost, so African countries must consequently find alternative healthcare financing methods to deal with the mounting healthcare issues (Mwabu, 2008).

As a way of financing healthcare, social and private mutual health insurance schemes are some of the financing options being practiced in Africa. This involves spreading risk and cost of medical care by pooling resources mainly through premiums or tax related payments (Ndiaye, 2006). Individual financing in Sub-Saharan Africa prevailed in traditional healthcare, with social financing predominating in the western medical care; although in Africa, government provides and finances healthcare through taxation for the whole population (Vogel, 1990; Ekman, 2004). In countries such as Senegal and Mali, health financing has been made mandatory for all formal sector workers via social security. Kenya practices the National Hospital Insurance Funds for formal employees, which has been replicated in other countries like Zambia, Nigeria, Liberia and DR Congo (Vogel, 1990). Yet countries like Burkina Faso, Ghana, Tanzania and Rwanda have reviewed and revised their financing mechanisms and have moved towards a more public social protection measure (Rosner et. al, 2012). Social insurance financing, when successful, can ensure equitable accesses to quality care by keeping premiums affordable to enhance utilization for all especially the poor.

2.3 Health Care Financing in Ghana

In Ghana, healthcare financing has gone through a plethora of changes since independence. The fact is that health financing is designed to cover all aspects of society: formal and informal sectors, rich and poor as well as rural and urban locations. It becomes more critical and overwhelming as developing countries seek to design and operate efficient health financing systems that can benefit all citizens and Ghana is no exception (Addae-Korankye, 2013).

The foundation of Ghana's healthcare system was laid by the British in the 19th century with the sole intention of preserving the health of the colonial masters to combat and overcome the many tropical diseases in Ghana (Aidoo, 1982). Health care during this period was free for the colonial masters, support workers and various opinion leaders (Twumasi, 1981).

After independence through the 1970s, various governments tried several policies to ensure sustainable healthcare financing in the country (Abuosi, 2004). At independence, health facility attendance was free and patients were not required to do any out-of-pocket payment at points of health care delivery. This free healthcare service was financed solely through tax. However, during the 1970s, the proposal for user-fee regime was introduced and this was to enable government to cut down on her fiscal expenditure. Therefore before 1989, health facilities were permitted to retain some of the revenue accrued from the fees collected to improve upon their services (Baah, 1994). This user-fee regime introduced exemptions for citizens with particularly severe diseases.

However, the post 1989 period saw the health institutions retaining all the fees collected to facilitate capitalization for the "Cash and Carry" scheme. This scheme was implemented in 1992 and was formerly known as the Revolving Drug Fund (Yevutsey & Aikins, 2010). The "cash and carry" system saw government withdrawing all subsidies on healthcare delivery; thus, patients had to pay for full cost of drug purchases and services at the health facility. Under this system, patients were attended to by health professionals only after initial payment for the service was made. Even patients on emergencies had to pay at every point of service delivery. This certainly resulted in unnecessary deaths which provoked public outcry for the scheme to be abolished (Agbeve, 1997).

Although the “cash and carry” system demanded full cost recovery, exemptions were provided for patients suffering from leprosy, tuberculosis and other special diseases. Besides antenatal care, the aged (70 years and above), children under 5 years and the poor were all exempted (Government of Ghana, 1999). Yet these people were still making out-of-pocket payments whenever they utilized health services out of ignorance.

These exemptions under the user-fees (cash and carry) system were fraught with problems both from the service providers and the beneficiaries. One of such challenges from the service providers according to Nyanator and Kuzin (1999) was the pricing and collection systems that were decentralized by the Ministry of Health which made it difficult for the Ministry to monitor the effect of these fees. In their study in the Volta Region, Nyanator and Kuzin (1999) found out that exemptions were non-functional and with a population of about 30% living in poverty, the failure of the exemptions meant that fees were inhibiting access to the poor or had brought huge financial burden on this portion of the population.

Besides user-fees, there was also full cost recovery for drugs which were introduced in 1992 and that also added up to the term “cash and carry”. Inasmuch as this drugs policy contributed to the provision of improved and effective drugs, not all patients could bear the cost of the drugs. Therefore, poorer patients either took sub-standard drugs or smaller quantities of drugs than prescribed or resorted to self-medication and this posed great danger to their lives (Asenso-Okyere et al., 1999).

The attitude of the health workers towards the patients also contributed to the challenges that bedevilled the cash and carry system. Among them were the incessant insults, clear evidence of polypharmacy, exodus of health workers as the number of patients out grew health workers and the collection of un-approved consultation fees. All these challenges

precluded the poorer population from accessing health services (Asenso-Okyere et al., 1999).

These challenges that emanated from the various financing systems encouraged policy makers, academia and civil society organizations to search for an alternative and more sustainable health financing mechanism. Therefore in 2003, the National Health Insurance Act (Act 560) was passed and it was perceived as the antidote to eradicating financial barriers that hinder people to access healthcare. The Act (650) created Ghana's National Health Insurance Scheme (NHIS), with the mission to ensure that all Ghanaians had equitable universal access to an acceptable quality of essential health services without out-of-pocket payment being required at the point of service use (Ghana Ministry of Health, 2004). The scheme therefore became operational in 2004 (Hsiao & Shaw, 2007). However, the principle of universal coverage revolves around both financial protection and unimpeded access to healthcare for all citizens as a necessary condition for health system equity (WHO 2008).

The new system establishes that the informal workers' pay annual premium and this has been graduated according to one's earnings, yet subscribers mostly pay flat rates. Besides, the NHIS premium has been heavily subsidized to ensure affordability to healthcare and financial access for the vulnerable groups. Also, enrolment for the informal sector workers is voluntary under the NHIS and is subject to adverse selection of this potential group.

The government under this scheme has exempted some groups of people from paying premium. However several vulnerable groups including the poor are not well targeted under the exempt category; causing them not to register (Saleh, 2012). The implication of this is that the risk pool of the NHIS is fractured, resulting in high cost and limited contribution from these vulnerable groups.

The removal of such fees as has been advocated by some as the way forward. Even though the removal of user fees in general often results in increased utilization, user fees removal in countries such as Uganda, Burundi, South Africa, Kenya, Sudan, Senegal, Liberia, Niger, Lesotho and Zambia have discovered serious issues related to quality and the high burden of increased utilization on the few existing healthcare professionals and facilities (Yates 2009).

To assume that the removal of user fees will solve a country's healthcare financing problem is naive. Gilson and McIntyre (2005) argue that doing away with user fees should not be seen as a panacea that can be implemented easily. Rather, the policy should be thought of as part of a broader package of health system reforms to move towards universal coverage (Akazili, 2010).

Besides, the government under the National Health Insurance Scheme aimed at providing quality, accessible, efficient and equitable health services to about 60% of Ghanaians by 2015 and subsequently attaining universal coverage throughout the country (Ministerial Task Team, 2002).

In terms of funding the National Health Insurance Scheme, (NHIS), the National Health Insurance levy (2.5 % of VAT) accounts for about 75% of the total NHIS funds and premium by the informal sector accounts for about 5%. The rest (20%) is by Social Security and National Insurance Trust (SSNIT) contributions for formal sector workers (NHIS ACT, 650; Akazili et.al 2012). The NHIS contributions is generally progressive; however, contributions by those in the informal sector is regressive. This is due to the fact that the premiums are mostly flat rate and this is a violation of the NHIS Act (650), yet due to the difficulty in ascertaining the income levels of the informal sector, the districts are compelled to resort to this channel (Akazili et.al 2012).

2.4 Challenges of Social health Insurance in some Developing Countries

Recently, interest has been growing among development policy-makers with regard to social protection as a way of tackling poverty reduction in most developing countries. Health care is one of the determinants of an individual's welfare and as the need for health care grows, there is also a massive growth of healthcare services to match – up the growing demand (Swani et.al, 2012). In their work on Equity financing and the use of health care in Ghana, Tanzania and South Africa, Mills et al, (2012) opined that out-of-pocket payments are continuously regressive in most Organization of Economic Co-operation and Development (OECD) countries and yet progressive in several Asian countries. The progressivity of the OOP is because poorer households cannot afford to pay and access health care services and therefore the rich pay higher to cushion that of the poor.

However, the exempt groups in the various health insurance schemes (HIS) across the world face many challenges when accessing health services. According to Russell and Gilson (1997), countries with official exemption policies for the poor and vulnerable are faced with numerous obstacles such as information to create the awareness as well as administrative, economic, and political challenges all of which affect these exemption groups (Russell & Gilson, 1997).

The beneficiaries who are exempted from payment of premiums has resulted in increased utilization of the health care services, leading to increase in workload for the service providers. According to Liem, Duc and Axelson (2008), after 15 years of health reforms in Vietnam, almost half of the population are benefiting from some form of insurance and this has increased utilization of health services tremendously. Similarly, in China, D.R Congo and Kenya the use of health care at the in-patient care has doubled for members in voluntary insurance as compared to the non-insured population (Criels & Kegels, 1997).

The positive side of the increased utilization of health services means that ailments that hitherto beneficiaries would not have sought medical care for are now being reported at the hospitals during the initial stages and this has reduced mortality rate in most of developing countries. According to Anderson (2004), without good health, people may experience debilitating diseases and an unnecessarily short life span. Fortunately, social health insurance has become one panacea to this concern.

Yet, the burden of workload on the healthcare practitioners and other ancillary staff have increased tremendously and this has caused the waiting times at health centres to be extremely high. According to Swami et al (2012), who looked at the problems and prospects of micro health insurance in Botswana, increased utilization of health services has led to an increased workload for hospital staff. Thus, patients who visit public health care facilities are made to wait for a considerable longer time before they are attended to by a doctor and this affects the quality of care received. Therefore, most of the people joined the Itekanele scheme to enjoy the services that came with it. The waiting time in this regard was not disaggregated according to sex. However, in terms of the differences in waiting time between men and women at the service centres, Kazanjian, Morettin and Cho (2004), asserted that women wait much longer than men when accessing healthcare. They studied Canadian women and healthcare utilization and concluded that women wait longer when it comes to treatment of diseases like asthma and waiting time is longer for men concerning mental health sickness.

In some situations, the exempt and even the insured are unable to access healthcare because of distance to these health facilities, coupled with the bad nature of the roads mostly in the rural communities. A study conducted by Ali, Bhatti and Kuroiwa (2008) in Pakistan on challenges to and utilization of reproductive healthcare in Pakistan used a cross-sectional survey to enrol 170 health facilities from nineteen randomly selected

districts in the Punjab and North-West Frontier Province (NWFP). Their findings indicate that geographical remoteness, (distance) hinders access and also delays the process of transferring seriously ill patients to higher level care facilities for treatment. Ali et al., (2008) further posited that many maternal deaths would be avoided if geographical obstacles and timely access to health facilities is addressed.

According to Onokerhoraye (1999), private and public health facilities are unevenly distributed and that regions with hard terrain and rough physical environment are mostly neglected. The implication is that distance between the rural dwellers and health centers are farther apart with its attendant problems of high transportation fares and longer travel times. Using 160 rural households through randomly selected agricultural zones in Kogi state, Awoyemi, Obayelu and Opaluwa (2011) in their study on distance and utilization of health care services in rural Kogi state of Nigeria recommended that to improve patronage of health services, distance to health facilities and the total cost of seeking health attention needs to be reduced to the barest minimum to enhance access to improved health services by various socio-economic groups in the area.

The practice of taking unapproved fees from the exempt and insured by hospital staff leaves much to be desired and poses a huge challenge to the smooth implementation of the scheme. Beneficiaries have reported of nurses and other para-hospital staff taking money from them before proper care is administered to them. In a study conducted by Sharma, Smith, Sonneveldt, Pine, Dayaratna and Sanders (2005) on formal and informal fees in maternal health in five countries: Egypt, Peru, Kenya, India and Vietnam, it was discovered that staff members usually demand payment from patients when they are discharged. Indeed, all the women interviewed resented these informal costs; yet, in order to make peace, they reluctantly paid to avoid any distasteful experiences. Sharma et al (2005) also indicated that in Egypt, nurses and other health facility workers were more

aggressive and straightforward with their demand. They concluded that generally, in all the five countries, women were not cognizant of the waivers and the exemptions for maternal health services. For instance they found out that in Peru, beneficiaries were aware of the existence of exemptions; yet, they consistently had to pay for laboratory tests. All these informal fees have become a burden on these poor households and has alienated some of them from accessing formal health care.

In conclusion, user fees payment throughout the world and especially in developing countries constitute a significant health care barrier and measures to abolish it has also enhanced access to and utilization of health care services notably among poor households (Ataguba & McIntyre, 2012; Witter, Garshong & Ridde, 2013). Certain concerns expressed by service providers include the indiscriminate use of health facilities by beneficiaries who at times abuse the system as well as the late reimbursement of claims by the regulators to the service providers which affect the smooth operations of the health facilities and hence influences providers' behaviour towards the insured (Dalinjong & Laar, 2012).

2.5 Challenges of the Exemptions Policy in Ghana

The elderly population globally is experiencing incremental growth of about 11.5 percent of the world's total population and it is projected to increase to about 2 billion by 2050 (UNFPA, 2012). Majority of this elderly population are found in developed countries compared to developing countries such as Ghana which has a relatively young population.

The elderly population of Ghana rose incredibly from about 215 thousand in 1960 to 1.6 million in 2010. However, the general population is considerably youthful according to the population pyramid (GSS, 2013). The dichotomy of these age categories (elderly and

young), concerning their health, leaves much to be desired. These two groups constituted about 56 percent of the total membership of the National Health Insurance Scheme (below 18 years: 51.2 %; 70 years and above: 4.5 %) in 2011 (NHIA Report, 2012). These cohort age groups have different health needs and this is evident in the kinds of diseases that affect them. For instance about 53 percent of deaths in Ghana are related to communicable, infectious and parasitic disease like malaria and pneumonia which are the leading causes of mortality and morbidity among children under 14 years. Regarding adults over 60 years, 67 percent of deaths are mostly from non-communicable diseases like cardiovascular, high blood pressure and others (World Bank Health Report, 2011). The implication is that the use of health services amongst these groups would go up significantly.

There has been an extensive coverage given to health insurance especially in Ghana by various studies (Blanchet, Fink & Osei-Akoto, 2012; Owusu et al., 2012; Blaese, 2012). However, few studies have devoted attention to the issue of exemptions (Aryeetey et al., 2010; Jehu-Appiah et al., 2010). Besides, the debate as to whether exemptions address equity concerns is still lingering on (Derbile & Geest, 2012; Jehu-Appiah, 2010). An evaluation study by Witter et al., (2007: 61) observed that although exemptions enjoy wide popularity, there are ‘important problems with disbursing and sustaining ... funding, and with budgeting and management.’

Another disturbing factor is the lack of public awareness about exemption packages. In a study conducted in the three northern regions in Ghana, Derbile and Geest (2012) from their survey on exemptions, observed that 61% of respondents did not know about exemptions for the poor unlike that of antenatal exemptions (84%), under-five exemptions

(79%) and exemptions for the aged (62%). According to their results, majority did not know the modalities for accessing exemptions.

Similarly, limited public awareness of specific categories of exemptions has been observed by others (Garshong et al., 2002; Aikins & Arhinful, 2005). In the Volta Region for instance, people generally lacked knowledge or did not believe that exemptions were granted at health facilities (Nyonator et al., 1994). The lack of public awareness about the specific exemptions categories may be emanating from the nature of education on exemptions by the various institutions. Besides, excessive demand by the under-fives and ante-natal exemptions has accounted for a lot of financial burden on the health care system and this undoubtedly serves as a disincentive for exemption education (Derbile & Geest, 2012).

Exemptions indeed have reduced delays in accessing care for pregnant women, yet workloads of health workers have increased tremendously and this has really affected quality of care negatively (Witter, Garshong & Ridde, 2013). Moreover, in order to accrue the full reimbursement from the NHIA, service providers are reluctant to refer patients to other hospitals. In their exploratory study of the policy process of early implementation of the free NHIS coverage for pregnant women in Ghana, Witter, Garshong and Ridde (2013) further concluded that maternal utilization and other health indicators are improving, yet supervised deliveries remain low.

Based on the ongoing discussions and other literature, very limited studies have addressed exemptions and the socio-economic challenges when it comes to utilization. This study attempts to contribute to filling this knowledge gap.

2.6 Utilization of HealthCare Services – The Theoretical Framework

Health Insurance Schemes (HIS) have improved utilization of the health services all over the world. Indeed, in most developing countries, HIS has become the panacea in dealing with access and utilization. This section therefore examines some of the theories and models that have underpinned health care utilization. There are a lot of determinants that affect a person's ability to utilize health care. Prominent among them are culture, economics, access, perception, knowledge, belief / efficacy, age, gender roles and social status (Rebhan, 2011).

In studying health care utilization, various scholars have propounded several theories that examine this phenomenon and among them is the Parsons' Sick Role theory (1951). This theory basically postulates that "any sick person adopt a role of being ill". This theory has four tenets and these are that:

- The individual is not liable for being ill and cannot be well without any assistance
- The person is exempted from normal duties
- The general situation of being ill is an undesirable state
- To get well, the individual has to seek medical care and follow the treatment regime

Generally, this theory typifies the behaviour of a sick person or individual (Rebhan, 2011) and cannot be used for this study because it only describes the role of a sick person without recourse to the obstacles in seeking treatment.

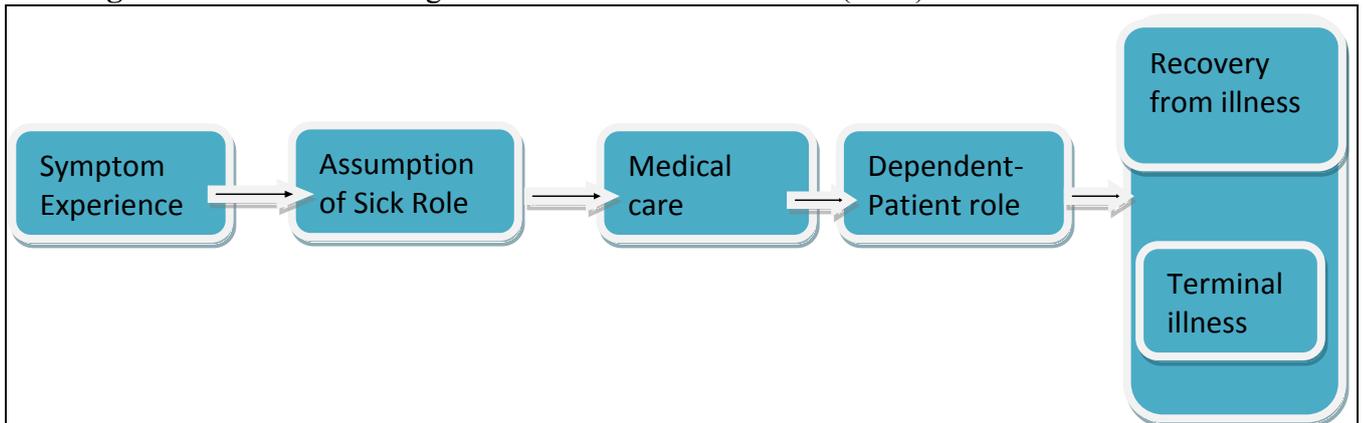
The next theory which has been used to explain healthcare utilization is Suchman's (1965) stages of medical care. This theory proposes five stages which can inform an individual's decision to utilize healthcare or otherwise. These stages are:

- The individual's symptoms experience (pain, feeling sick) as indicative of illness.

- The individual's assumption of a sick role where they explore all the treatment options
- The medical care contact. At this stage, the individual looks for a professional healthcare system and according to Suchman, this is affected by their social networks, which may be either "parochial or cosmopolitan". That is a person whose social network is parochial may delay medical care as compared to the one with a cosmopolitan social network (Wolinsky, 1988).
- The assumption of a dependent-patient role and the acceptance of a professional healthcare treatment. Situations where the patient and the professional have different opinions about the illness can disrupt this stage (Wolinsky, 1988).
- The final stage is the individual's recovery from illness and this is contingent on the person moving from the position as patient. Where the illness is terminal, then he /she may assume a persistently sick role.

These stages are represented in figure 2.1 below:

Figure 2. 1 Suchman's Stages of Illness and Medical Care (1965)



Source: Adapted from Rabhan (2011)

This theory was also not appropriate for this study because the focus was limited to stages of illness and medical care but did not dwell so much on access and utilization. Mechanic (1978) propounded a theory of healthcare utilisation from a psychological perspective and proposed ten (10) determinants of illness behaviour including the following:

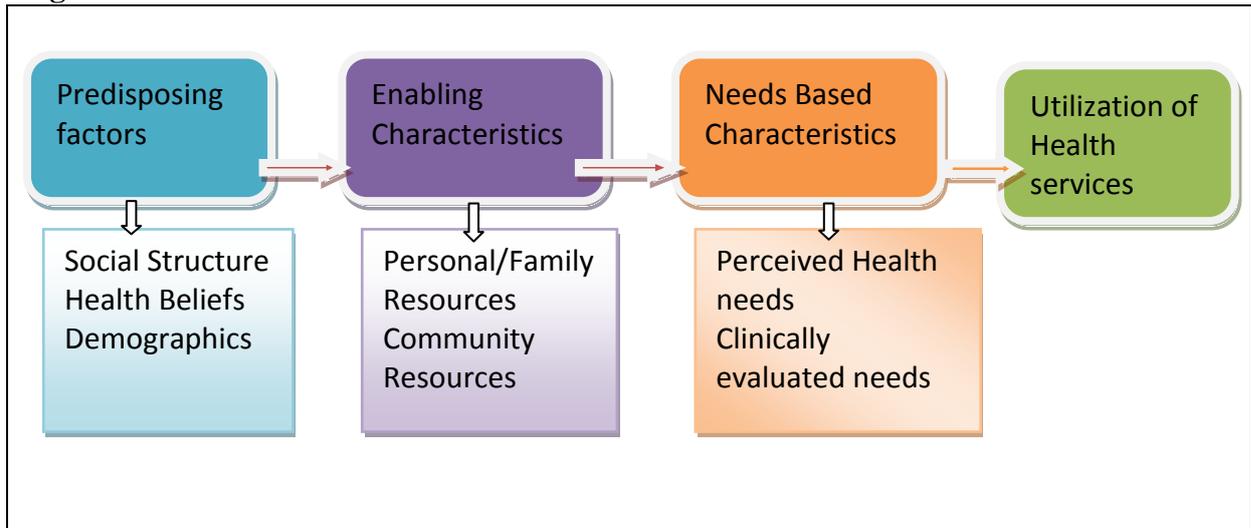
- The importance of deviant signs and symptoms
- Individual's perception of symptoms and its severity
- Disruptions caused by the illness to the normal routine
- Frequency of symptoms and their persistence
- Individual tolerance of symptoms
- Knowledge and cultural assumptions of the illness
- The denial of illness emanating from basic needs
- Assumption of illness disrupting needs
- Alternative interpretation of symptom expression
- Availability of treatment with consideration on location, economic cost, psychological and treatment cost

Consequently, this theory articulates that “autonomy and heteronomy” influence health care utilization. Yet what it failed to discuss was the determining factors that can influence or affect an individual in accessing healthcare when all these signs and symptoms evolve.

The behavioural model of healthcare utilization developed by Andersen (1968) was the final theory to be considered. This is one of the most frequently used frameworks for analysing the factors associated with patient utilization of healthcare service. This theory is what underpins this study. The initial purpose of Andersen’s behavioural model was to understand why some families’ use health services, define equitable access to healthcare and assist in developing policies to promote equity (Andersen 1968). He posits that an individual’s access to and use of healthcare services is dependent on three factors:

- The predisposing factors: issues that influence the use of health care services and these are categorised into three determinants: the social structure (education, occupation, ethnicity, social networks, social interactions, and culture), the health beliefs (attitudes, values, and knowledge that people have towards the health care system) and lastly the demographics (age and sex).
- The second is the enabling factors such as the logistical aspects that may boost or impede one from obtaining healthcare (access to health services, income, health insurance, and a regular source of care, travel, extent and quality of social relationships; available health personnel and facilities, and waiting time).
- Lastly the need factors: the most immediate cause of health service utilization (self-perceived health status, chronic and acute illness).

Figure 2.2: Andersen's Health Utilization Model



Source: Adapted from Wolinsky (1988)

The assumption is that the interactions that exist between these complex factors can produce a utilization outcome which may be at variance across socio-economic groups. This is because vulnerability of a given population inadvertently affects healthcare access and usage (Andersen, 1995; Jehu-Appiah, Aryeetey, Spaan, Agyepong & Baltussen, 2012).

This model is appropriate for this study as compared to the others in the sense that it considers all the factors ranging from predisposing, enabling and needs based which either influence or hinder one from utilizing health services. Besides, considering the exempt group in general and below 18 years and the 70 years and above in particular, the interaction of these factors may affect the utilization of healthcare which may reduce the benefit of the insurance coverage (Aryeetey et al., 2012).

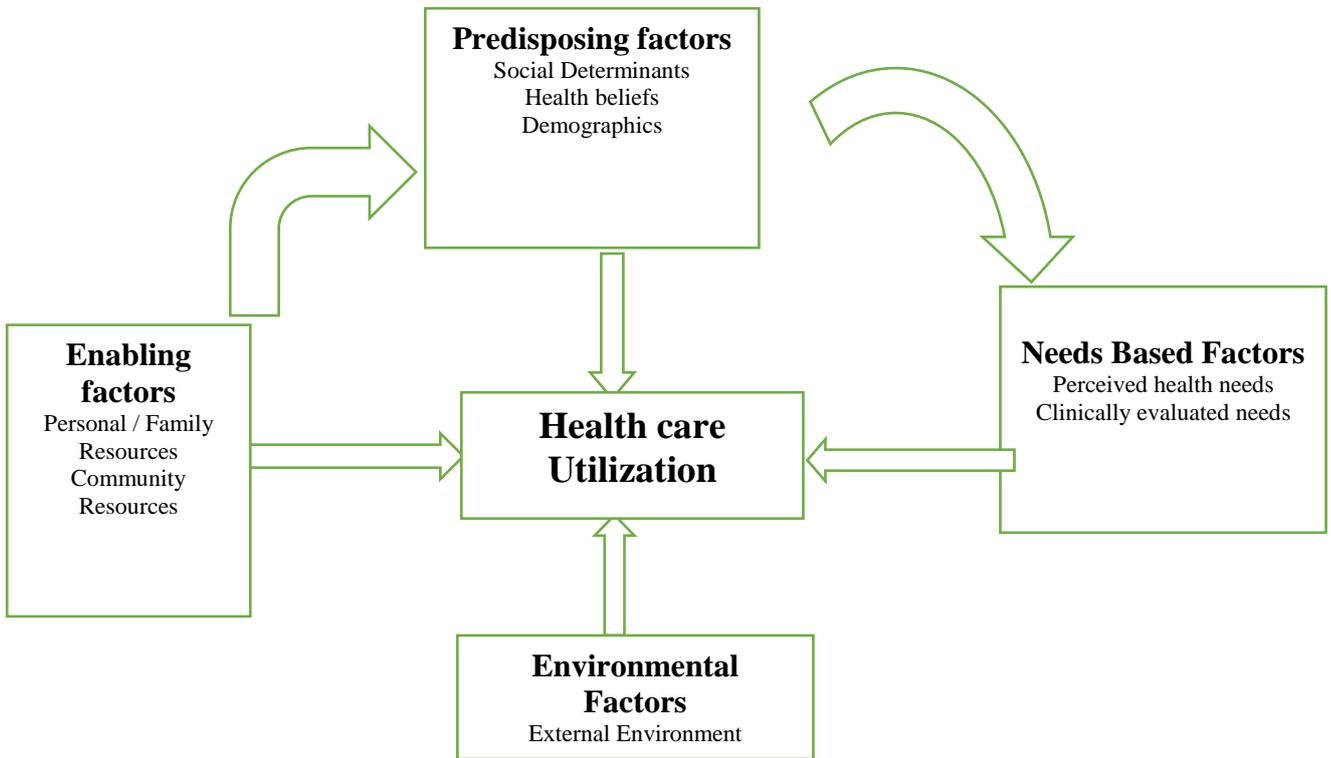
The behavioural model, from the time it was first developed (Andersen 1968), has been extensively critiqued. Yet, its use for examining the context within which utilization occurs has not been reviewed. Nonetheless the model has been criticized for lack of focus on social interactions, social networks and culture (Bass & Noelker, 1987; Guendelman, 1991; Portes, Kyle & Eaton, 1992).

However, in their work on “understanding the context of health care utilization”, Phillips, Morrison, Andersen, and Aday (1998), examined how the context within which utilization occurs (the role of environment and provider-related factors) has been largely neglected. They considered studies that have utilised the behavioural model during a 20 year period to ascertain whether these studies included the environmental and provider related variable (contextual variables) and how these variables were measured. Furthermore “environment” and “provider-related” factors are the new variables added to the original utilization model by Anderson. Yet, understanding the interactions between beneficiaries and service providers is of great essence to health programme and policy managers to ascertain the level and extent of utilization (Phillips et al., 1998) and this is the crux of this study.

2.7 Conceptual Framework

Conceptually, the determining factors of health care utilization can be grouped under three main themes - environmental, population characteristics and individual health behavioural factors (Andersen, 1995; Phillips, Morrison, Andersen & Aday, 1998) (see figure 2.3). The environmental factors comprise factors that reflect the economic climate, relative wealth, politics, level of stress and prevailing norms of the society health care systems (Phillips, Morrison, Andersen & Aday, 1998). The effect of environmental factors on health care utilization according to Wan (1981), has a positive relationship to the amount and type of utilization.

Figure 2.3: Determinants of Healthcare Utilization



Source: Adapted from Andersen (1995); Phillips, Morrison, Andersen & Aday, (1998)

The population characteristics comprises of predisposing, enabling and need factors as can be seen in figure 2.3. The predisposing factors impact on the attitudes concerning insurance which either motivate or hinder one's access to health care. These factors include education, occupation, ethnicity, family size, age, sex, attitudes to health care, values and knowledge as far as health related issues are concerned. The enabling factors aid or impede one from obtaining healthcare and comprise variables such as place of residence, knowledge of health insurance, regular source of care, travel time, availability of health personnel, facilities and waiting time. Self-perceived health status, chronic and acute illness as need factors represent the immediate cause of health care utilization. The interactions among the major themes as identified, although may differ across socio-

economic groups can affect health insurance enrolment and access to health care utilization (Aryeteey, 2012).

2.8 Summary and Conclusion

The chapter started with the review of literature on the genesis of healthcare financing; how it began with the ancient Greeks and trickled down to Germany in Europe and then the U.S.A. Health insurance and how it is being practiced in this contemporary era was also discussed citing examples from South America and Asia. The consideration of the African context regarding healthcare financing was also discussed and the Ghanaian context was the final issue under this first part. Then the final part considered some of the challenges with regard to social health insurance in some developing countries and exemptions under the NHIS in Ghana. The review established that healthcare financing through social and mutual health insurance schemes have indeed brought relief to the poor when it comes to OOP and other catastrophic payments. Besides, as governments consider the best mechanism to finance health, utilization has also improved considerably among poor households. However, countries have tried different forms of health financing such as establishing National Hospital Insurance funds as is the case in Kenya, Zambia, Nigeria, Liberia and D.R. Congo or establishing National Health Insurance Schemes as is found in Ghana, Tanzania and Rwanda.

The review also established that Ghana's healthcare financing has gone through numerous changes from independence to the present. Besides, the NHIS which is currently being implemented was promulgated to bridge the gap between the rich and the poor in terms of access to healthcare and also to reduce OOP at the service centres. However the exemptions under the scheme are confronted with some challenges when accessing

healthcare. Some of these challenges are as a result of the limited knowledge of their exemptions and the financial relief that comes with it. According to the literature, about 34 percent of Ghanaians are currently enrolled unto the scheme (NHIA Report, 2011) and this includes the exempt who constitute about 70 percent of the total subscriber base of the NHIS.

After the literature review, the theory to be used for the study was discussed after assessing three theories. The main theory used for this study was the behavioural model by Andersen (1968) which posits that there are three determinants that affect one's behaviour towards healthcare and these are the predisposing, enabling and needs factors.

CHAPTER THREE

STUDY AREA AND METHODOLOGY

3.0 Introduction

This chapter gives an insight into the study areas and the methodology that was used to carry out this study. The study was conducted in three districts across three main agro-ecological zones in Ghana, namely Kwaebibirim in the coastal zone, Asutifi and Savelugu / Nanton districts representing the forest and savannah zones respectively.

3.1 The Study Area

3.1.1 Kwaebibirm District

The Kwaebibirim is one of the 22 districts in the Eastern Region with Kade being the capital which is about 85km from Koforidua the Regional capital.

3.1.1.1 Location and Size

The Kwaebibirim district was carved out of the West Akim district in 1988 by a Legislative Instrument (L.I) 1425. There are 212 communities in the district with Kade as the capital. There are about six urban areas in the district and the rest of the settlements are very small rural communities. The District is located in the South-western corner of the Eastern Region of Ghana, between Latitudes 1 degree 0'W and 0 degree 35.'E and Longitudes 6 degrees 22'N and 5 degrees 75'S. On the North, it is bounded by the Birim North District, on the East by Atiwa District and East Akim Municipal, on the south East by Suhum Kraboa Coaltar District, and West Akim Municipal, and on the South-west by the Birim Central Municipal and on the West by Akyemansa District. The District has a surface area of about 1, 230 square kilometers.

3.1.1.2 Climate & vegetation

The District lies within the semi-equatorial climate zone and experiences double maxima rainfall pattern. The District's maximum rainfall period coincides with the planting season which is ideal for agricultural activities. Regarding the vegetation of the area, it lies within the semi-deciduous forest region with low-lying species of hard wood. Also, the district has two forest reserves, which is the East-Ayaola Forest and the West Atiwa Forest Reserves. These reserves cover a very large area and in addition, large plantations of teak have been planted outside the forest (Kwaebibrim District Assembly, 2013; Ghana Districts, 2014).

3.1.1.3 Population Size

The district is one of the highly populated ones in the region with a population of 192,562 according to the 2010 population and housing census with inter-censal growth rate of 1.9%. Over two thirds of the population lives in rural areas. Concerning the sex distribution of the population, there are more females (98,002) about 51 percent than males 49 per cent (94,560) (Ghana Districts, 2014; Ghana Statistical Service, 2012). The population has not had any major growth as compared to other districts and this can be attributed to the deprived nature of the district with no major industries and companies except small scale mining and agriculture.

3.1.1.4 Migration

The presence of abundant potentials in mining and agriculture has become a recipe for the influx of people from other parts of Ghana. This is evident in the settlement of different kinds of ethnic orientations. The Akans constitute 67 percent of the ethnic group in the district. In addition, there are Northerners, Ewes, Gas-Adangmes and other minority tribes,

who have all settled in the district and are engaged in farming and mining activities (Ghana Districts, 2014; Kwaebibrim District Assembly, 2013)

3.1.1.5 District Economy

The district is endowed with both mineral and forest resources and has one of the best terrains for agriculture in the entire country. The various species of timber such as mahogany, emire, odum and wawa are widely available in the district's expansive forest areas. The district can boast of diamonds and gold deposits. Crop farming is the predominant economic activity and thus serves as the source of livelihood for over 72% of the population. The district produces a wide variety of both cash crops such as cocoa, cola, oil palm and citrus and food crops including plantain, cocoyam, cassava and cereals, as well as vegetables. The main industrial activity of the local economy is agro-based. Arguably, the district can boast of the largest oil palm mill in West Africa at Kwaie, operated by the Ghana Oil Palm Plantation Development Company Limited (Kwaebibrim District Assembly, 2013).

3.1.1.6 Health

The health delivery system in the Kwaebibirem District consists of 2 hospitals, 4 health centres, 3 community clinics, 1 maternity home, 6 Reproductive and Child Health (RCH) centres and 4 Community-based Health Planning Services (CHPS) compounds. In addition to the above, outreach clinical activities are organized in most communities which lack established health facilities. Access to health care services in the district is impeded by the poor road network which hampers smooth health delivery in the district. The district hospital is located at Kade and it also serves as a referral point. Yet, the St.

Dominic hospital at Akwatia which is a mission hospital, offers specialized treatment in the district (Kwaebibrim District Assembly, 2013).

3.1.2 Asutifi District

The Asutifi district is one of the twenty two (22) municipal and district assemblies in the Brong Ahafo Region and was carved out of the larger Ahafo District by LI 1485 in 1988. Kenyasi is the district capital and it is about 50 kilometres away from Sunyani, the regional capital of the Brong Ahafo Region (Ghana Districts, 2014). The district is however endowed with a variety of resources which when properly managed would help develop the area and improve the standard of living for the people.

3.1.2.1 Location and Size

Asutifi District is located between latitudes 6°40' and 7°15' North and Longitudes 2°15' and 2°45' West. It shares boundaries with Sunyani District in the North, Tano District to the North East, Dormaa District to North West, Asunafo District in the South West and Ahafo Ano District (Ashanti Region) in the South East. The district is made up of 117 settlements and is typically rural with a total land surface area of 1,500 Sqkm (Ghana Districts; Asutifi District Assembly, 2013).

3.1.2.2 Climate and Vegetation

The district lies within the wet semi-equatorial zone marked by double rainfall maxima with a mean annual rainfall which is also ideal for crop cultivation. The district has a moist semi-deciduous forest. Man's activities notably farming, lumbering and occasional bush fires have however disturbed this vegetation. This has changed some areas into a derived wooded savannah; however, large areas of forest reserves still exist and these include the following:

- Biaso Shelter Belt: 29.5 km²
- Bia Tam Forest Reserve: 91.4 km²
- Asukese Forest Reserve: 180.1 km²
- Goa Forest Reserve: 23.8 km²
- Desiri Forest Reserve: 151.0 km²

These forest reserves together cover a total of about 475.6 square kilometres about 30% of the entire land surface area of the district. Traditional authority plays an important role in the southern part of Ghana where most minerals deposits are located. At the local level where traditional status continues to command respect, chiefs and sub chiefs exert control and power over land and land resources through land allocations as they are regarded as the custodians of the land (Asutifi District Development Plan, 2002; Newmont Ghana, 2005).

3.1.2.3 Population Size

The population of the district is estimated to be about 105,843 with a growth rate of 2.5 per cent per annum (GSS, 2012). Regarding the population distribution, there are more females 51 % (50,797) than males 49% (50,046) and this is consistent with the national distribution where the female population is more than the male population. The need to target women in any development programme in the district can therefore not be over-emphasized. The high rate of increase in the population in the district is as a result of the emergence of Newmont Mining Company and its ancillary activities like illegal mining (galamsey) which is accelerating uncontrollably. This has brought a lot of people into the district which hitherto, was one of the lowly populated areas.

3.1.2.4 Migration

Ethnic diversity is high, due to immigration over the past 50 years of persons seeking land to farm. About 54 percent of the people are migrants (mainly Ashantis), with Bonos the indigenes constituting only 9 percent of the population (Asutifi District Development Plan, 2004). These immigrants have however stayed in the district since time immemorial and hence do identify with the area. With the advent of Newmont Gold Ghana Limited, the migration pattern has changed drastically with people migrating to the district from all over the country. However, the Ashantis remain the dominant ethnic group followed by the Bonos and other minority ethnic groups like the Gas, Ewes and people from the Northern Ghana (Asutifi District Development Plan, 2004).

3.1.2.5 District Economy

The predominant economic activity in the District is subsistence agriculture (mostly farming) which engages about 77 percent of the economically active labour force with limited income due to the low output. About 96 percent of those engaged in other occupations outside agriculture still take up agriculture as a minor activity. The service sector accounts for 21 percent of the active labour force consisting mainly of trading and this leaves the industrial sector with only one percent (Asutifi District Development Plan, 2004). Besides, non-farming sources of income are limited and two-thirds (2/3) of adults have no employable skills other than farming. However with the advent of New Mount Ghana Limited, the situation has changed. About 65% are now engaged in agriculture and the service sector accounts for about 30 percent. Women occupy a large part of the agricultural workforce and generate the majority of the non-farm income (Newmont Ghana, 2005).

3.1.2.6 Health

The district has one major hospital which also serves as a referral centre: the Saint Elizabeth District Hospital located at Hwidiem and owned and managed by the Roman Catholic Church. Also, there are five other health centres managed by the Ministry of Health, seven CHPS Compounds, three Private Maternity homes; three Homeopathic clinics and sixty trained Traditional Birth Attendants (TBAs) all rendering varying degrees of health services in the district (DHMT Report, 2010). Yet the district indeed has challenges that affect the smooth health care delivery, such as lack of qualified personnel, inadequate medical staff at the community clinics and lack of medical officers for the hospitals (GhanaDistricts.com, 2014; Asutifi District Assembly, 2013).

3.1.3 Savelugu-Nanton District

Savelugu/ Nanton is one of the 20 districts in the Northern Region with Savelugu as the capital. It is located about 30km from Tamale the regional capital and is used in this study to represent the savannah zone.

3.1.3.1 Location and Size

The District is one of the twenty (20) administrative districts of the Northern Region. It was established by PNDC Law 207 under the Legislative Instrument of 1988. It was carved out of the then Western Dagomba District Council, which included Tolon/Kumbungu and Tamale Metropolitan Assembly. It shares boundaries with West Mamprusi in the North, Karaga to the East, Tolon/Kumbungu in the West and Tamale Metropolitan Assembly to the South. The District's total land area is 1,790.70 sq. km and is made up of 149 communities (GhanaDistricts.com, 2014)

3.1.3.2 Climate and Vegetation

The area experiences single maxima rainfall and is prone to periodic flooding during the wet season; thus, making the land convenient for rice cultivation. The annual rainfall pattern is erratic at the beginning of the raining season and intensifies as the season progresses. Temperatures are usually high, averaging 34°C. The generally high temperatures as well as the low humidity is brought about by the dry harmattan. The area finds itself in the interior guinea Savannah woodland with the capacity to sustain large-scale livestock farming as well as cultivation of staples like rice, groundnuts, yams, cassava, maize, cowpea and sorghum. The trees found in the area are drought resistant and hardly shed their leaves completely during the long dry season. Notable among them is the Shea tree (Savelugu-Nanton District, 2013; GhanaDistricts.com, 2014).

3.1.3.3 Population Size and Growth

The district has a population of 139, 283, made up of 49% males (67,531) and 51% females (71,752) according to the 2010 population and housing census. The average household size is about 9. The district has a land area of 1,790.7sq.km with a population density of 61 persons per sq. km (GSS, 2012).

3.1.3.4 Migration

There are 149 communities in the District; yet, only six can be described as urban while the other 143 communities can be described as rural. Nearly 80% of the populace resides in these rural communities and 20% in the few urban towns. The dominant ethnic groups located in the district are the Dagombas. However, there are other minority tribes like the Fulanis and Ewes who are mostly engaged in cattle rearing and fishing (GhanaDistricts.com, 2014).

3.1.3.5 District Economy

The district economy is predominantly agrarian based and employs about 97 percent of the economically active population, which is between 18-54 years. The major food crops cultivated include maize, rice, yam, soya beans, cowpea and groundnut. The potential to increase food production is very high if modernized agriculture is effectively practiced. Yet, there are problems of erratic rainfall, post-harvest losses, and high cost of farm inputs. Only about three percent of the population is involved in industrial activities, trade and service sectors and gainful employment. This has culminated into low income levels in the area and women are poorer than the men because men have access to and control over resources such as land compared to the women (Savelugu-Nanton District, 2013; GhanaDistricts.com, 2014).

3.1.3.6 Health

The major health facility in the district is the Savelugu Hospital which is manned by a doctor and other health professionals. Also, there is one health centre, two health posts, three community clinics and two CHPS Compounds, all under the auspices of the District Health Directorate. In addition there are two private clinics and Traditional Birth Attendants (TBAs). Generally, health service delivery in the district is not encouraging because of the limited number of clinics and also the poor nature of the roads which makes accessing healthcare very difficult for people who are located in the hinterlands. This has encouraged the people to indulge in self-medication which is prevalent in the district (Savelugu-Nanton District, 2013).

3.2 Methodology

This section discusses the methods and approaches that were used to undertake this study. The study employed both qualitative and quantitative methods for data collection and analysis. Moreover, the study shares the opinion expressed by many researchers such as Chigunta (2006) that qualitative and quantitative research methods are not alternatives to each other, but rather complement each other in addressing particular problems. This study used two main sets of data, that is a secondary data set and a set of primary data collected through in-depth interviews and focus group discussions (FGDs).

The quantitative data which served as the secondary data was conducted in three districts across the three main ecological zones of Ghana.

3.2.1 Sampling Technique

3.2.1.1 Quantitative Sampling

The quantitative data was collected through a cross-sectional district representative household survey between January and April, 2011 involving 2,430 households randomly sampled from 81 Enumeration Areas (EAs) based on the 2000 Ghana population and housing census. A household questionnaire was developed and administered to the household heads or any knowledgeable person in the house. Children were not interviewed directly, rather their parents responded on their behalfs. For each district, 28 E.As were sampled taking into consideration urban, peri-urban and rural communities. Listing of all households in each E.A was done after which respondents were selected using random sampling method. After using the simple random sampling method to select the households, systematic approach was used to select the Nth respondents in each structure.

Therefore in each district, people from 840 households were interviewed, that is 30 households per E.A.

3.2.1.2 Qualitative Sampling

Although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly use group interaction as part of the method (Kitzinger, 1995). FGDs have several merits. For instance by gathering people with different backgrounds and experiences under one roof with the aim of eliciting responses on an event or a concept, a particular comment or gesture by a participant can help remind others to better explain their feeling. Thus, through FGDs, participants get the needed opportunity to listen and interact with others and their verbalized experiences and this enhances the quality of the data. Lindlof and Taylor (2002:182) described this as “the group effect where group members engage in a kind of ‘chaining’ or ‘cascading’ effect; talk links to, or tumbles out of, the topics and expressions preceding it”. Ultimately, researchers stand to gain a better understanding of the participants’ perceptions on an issue at stake. Again, group members discover a common language to describe similar experiences. This enables the capture of a form of “native language” or “vernacular speech” to understand the situation¹.

Yet, FGDs also have demerits. For instance in FGDs, group control can be problematic in some cases compared to a one-on-one interview (Tracy, Lutgen-Sandvik, & Alberts, 2006). Also there can be considerable loss of time as group members tend to digress and talk about unrelated issues. Additionally, data from qualitative interviews is usually difficult to analyse because participants tend to confuse the main discussion topic with other irrelevant issues. Careful analysis is therefore required at the analysis stage to sieve

¹ <http://qualitative.research/FGD> (retrieved on 20th April, 2014)

out the comments which are not useful. Again, since focus group membership is not large enough to be a representative sample of a population, it is often difficult to make generalization based on the data obtained from the groups (Tracy, Lutgen-Sandvik, & Alberts, 2006).

In spite of the shortcomings of the FGDs, it was still considered appropriate for the study. For instance concerning the FGDs, panellists who were initially observed as not being too active were encouraged to give out their best. This, to some extent, prevented few panellists from ‘hijacking’ the discussions. Again, the participants were allowed to freely express their natural feelings about an issue while the moderator only stepped in to tactfully manage digressions.

The selection of the participants for the qualitative data particularly the focus group discussions was done using convenient and random sampling techniques. The convenient sampling was used to select the participants for the FGDs; however, concerning the selection of the communities, the simple random sampling was used. A list of all the communities accessed by the districts NHIS were obtained from the NHIA district offices and the prevailing subscribers at these various communities, those ever registered, those registered and those eligible. Then the communities where the FGDs were conducted were randomly selected. At the community level, the convenience sampling technique was used to identify and gather the respondents for the discussions. The selection was done after careful explanation of the rationale behind the study to the opinion leaders and the type of participants needed prior to the day of the discussions. On the day of the focus group discussions, the research team and some members of the Unit Committee or the District Assembly went to arrange a venue to set the place in order. The FGDs mostly took place in either a chapel or a classroom.

The research team was then led by an opinion leader to the houses of the participants to officially invite them for the discussion. After an opening prayer and self-introduction by the participants, the researcher set the tone of the discussion by giving a brief introduction to the study. The participants were selected based on their health insurance status at the time of the interview. That is, those who were insured and this included people who were registered yet had not got their identity cards. The other category were people who had not renewed their membership, the next category were those who had ever registered but had now withdrawn their membership. The difference between non-renewal and withdrawn membership is that the former may renew their membership when they get the resources while the latter will not renew their membership whether they get the resources or not. The last category of respondents were those who had never been insured. In each district, an average of eight (8) FGDs were conducted and this organised either exclusively for men and women or by mixing both groups.

On the other hand the in-depth interviews (IDI) were done purposively based on the knowledge, experiences and profession of the stakeholders. The identification process was done with the help of the Assembly member or the chairperson of the Unit Committee of the areas that were visited after which the respondents were selected and the researcher and his team alone conducted the interviews. Apart from the communities, some of the IDIs were mainly from the government sectors such as the hospitals and clinics, the NHIA scheme managers, district directors of health and some private practitioners. Therefore for each of the districts, an average of ten (10) in-depth interviews were conducted.

3.2.2 Quantitative Data Collection

The main data collection tool was a household questionnaire and it had modules which covered households' demographic profile, socioeconomic status, health insurance status, general health of household members and household expenditures. The health module collected information on all reported illnesses and injuries which occurred in the household in the last 4 weeks preceding the survey. For households which reported an illness/injury, information was collected on the symptoms or type of illness/injury experienced, perceived severity and associated treatment seeking behaviours. All direct payment expenditures associated with treatment seeking for the reported illness/injury were recorded. The direct payment of health expenditures included fees for consultation, diagnostic tests, medicines, medical supplies and all non-medical expenses including travel expenses, subsistence cost at the facility and all other related payments.

3.2.3 Primary Data collection Tool

3.2.3.1 The Qualitative Analysis

As already stated, the study adopted qualitative interviews as a form of digging deeper into some of the issues raised in the questionnaire. Expert Interviews (in-depth) and FGDs were the main techniques used to assess the issues on exemptions and some of the challenges associated with it.

First, semi-structured interview guides were designed and administered to in-depth interviewees (IDIs) both public and private officials at the institutional level. The interviewees included government officials (District Chief Executive officers and Coordinating Directors), owners of private hospitals and clinics, experts/academicians in the health insurance sector, scheme managers and community/opinion leaders and health practitioners. This approach was used to elicit information on the effects the exemption

has brought on health service utilization; whether these groups of people are made to pay, some of the challenges faced by both users and service providers and how the exempt groups can be made more viable to improve quality and ultimately enhance the effectiveness and sustenance of the NHIS.

The next approach was the focus group discussion (FGDs) and with this, opinion leaders, both men and women, were purposively sampled for separate discussions. In all, three FGDs were conducted per district (men and women exclusive; and a mixed group). On average, each focus group discussion lasted for about two hours and all participants were encouraged to share their thoughts on all issues raised. Also, refreshments were given to the participants of each focus group discussion conducted as opined by Kitzinger (1995), that FGD sessions should be relaxed.

The interviews from both the FGDs and In-depth were all transcribed verbatim from the recording devices. The transcribed interviews were categorized and content analysis done according to the themes.

3.2.4 Quantitative Analysis

The quantitative approach used the following analytical approach for the econometric analyses: Probit regression (for examining the determinants of socio-economic factors of the exempt group).

Quantitative data which is the secondary data was collected through a household survey conducted by the Institute of Statistical, Social and Economic Research in 2011. This study looked at two categories of the exempt that is children below 18 years and adults of 70 years and above. The study employed cross-tabulations and chi-squares to answer the first objective which is the socio-economic factors that affect utilization of healthcare.

Probit regression was then used to examine the determinants of socio-economic factors of the exempt group.

The exempt groups were conceptualized in the study as people who were exempted by law from payment of NHIS premium. In this study only two of them were considered and that is children below 18 years and the aged (70 years and above).

Probit models were designed to take care of the dependent variables. The model has a dependent variable Y_i , which is dichotomous, defined as 1 if a respondent is in the exempt category and 0 if otherwise. That is, those below 18 years or above 70 years. Two estimations were undertaken with the exempt groups being divided into two and regressed on the same set of explanatory variables. Thus, the general form of the model to be estimated is:

$$Pr(Y_i = 1) = Pr(\beta X + \mu_i) \quad (1)$$

Where $Y_i = 1$ if the individual meets the exempt category criteria for the group being investigated. Two different exempt groups were identified and would be regressed on the same set of explanatory variables represented by X_i . The first dependent variable is defined as $Y_i = 1$ if the respondent is in the exempt group and less than 18 years or 0 otherwise. The second dependent variable is defined as $Y_i = 1$ if the respondent is in the exempt group and is 70 years and above. As noted earlier, the X_i is a set of socio-economic and household specific determinants that influence the utilization of healthcare services by the exempt groups. These variables include the age of the respondent; whether the respondent lives in male or female-headed households; religion; source of treatment for illness; marital status; educational level; employment status; size of household, non-working adults; received remittances; cost of OPD treatment and sources of financing health care; current status of respondent with respect to registration of NHIS and the last annual premium paid.

β represents the coefficient of the explanatory variables with μ_i being the random error term.

3.2.5 Selected explanatory variables for the probit regression

The explanatory variables included in the probit model includes the sex, age, current NHIS status, if respondents have ever registered as members of NHIS, district of residence, employment status and religion of the respondents.

3.2.5.1 Justification and Explanation of Explanatory Variables

In order to capture the effect of age on the exempt group in health care utilization, the ages were categorised with members of households in the age group 0-5 years as the benchmark being represented by a dummy variable 0. The others included those within the ages of 6-14 years, 15 – 17 years, 70 - 80 years and above 80 being represented by designated dummy variables. This was to capture the effect of each particular age group on determining their health care utilization behaviour. Each age group is identified with unique characteristics and may be prone or otherwise to diseases thereby increasing their utilization.

To capture the dynamic effect of age, age is squared to ascertain the effect of aging on health care utilization. Thus, the individual ages of the respondents were squared. This has been used in similar studies by Baffour and Osei (2006) and Young (2012). It is expected that age squared will have a positive effect on the utilization of health care by the exempt group.

Another important variable used is the current NHIS status of the respondent and how it affects health care utilization of the exempt group. Thus, 0 was used to represent respondents who were not currently registered and 1 for those who were registered.

In addition, the study also sought to ascertain the effect of those who have ever registered with the NHIS on health care utilization. Those who have ever been registered were represented by 1 and those who had never been registered were represented by 0.

The gender (sex) of the respondent is also crucial in determining the health care utilization by the NHIS exempt group. The study used 0 to represent females and 1 to represent males. It is expected that the utilization of females will exceed that of the males and as such a negative sign for the coefficient. This is supported by Wooden, (1993), Findeis et al., (2000), Wilkins (2004) and Baffour and Osei (2006).

Another factor considered for this is the type of illness experienced by the respondents in the exempt group. This study considered illness including fevers/malaria, heart related diseases, injuries/arthritis, stomach related diseases, acute infections and other diseases. The type of disease will influence the level of utilization of health care by the exempt group.

Other explanatory variables included the employment status of the household head, the religious background and district of residence of the respondent.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSIONS

4.0 Introduction

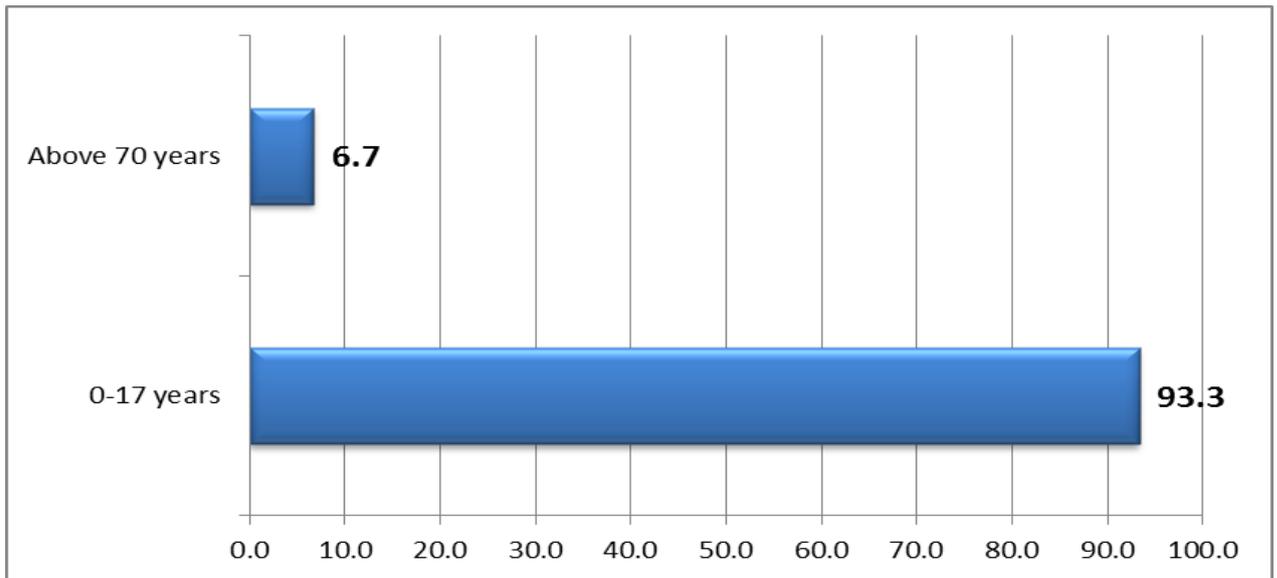
This chapter presents and discusses the analysed data. The chapter has been divided into three parts in line with the objectives of the study. The first part deals with the socio-economic factors that affect utilization of the NHIS, the second deals with the health seeking behaviour of the exempt group and the third part of the discussion addresses the extent to which the exempt group make OOP payments at the point of service.

4.1 The Socio-Economic Characteristics

4.1.1 Age and Age Groups

The exemption policy of the NHIS states that certain categories of people are exempted from paying premiums. These groups include SSNIT contributors, SSNIT pensioners, pregnant women, children below 18 years, the aged (70 years and above) and the indigent (core poor). However, this study as indicated earlier is about the exempt group, specifically, children below 18 years and the aged (70 years and above). Hitherto, children were only eligible when both parents had registered and were eligible members of the NHIS; however, this situation has changed as the previous eligibility criterion has been removed from the new NHI Act 2012 (Act 852). The distribution of this group is indicated in Figure 4.1.

Figure 4.1: Proportion of the exempt by age category



Source: Study data, 2011

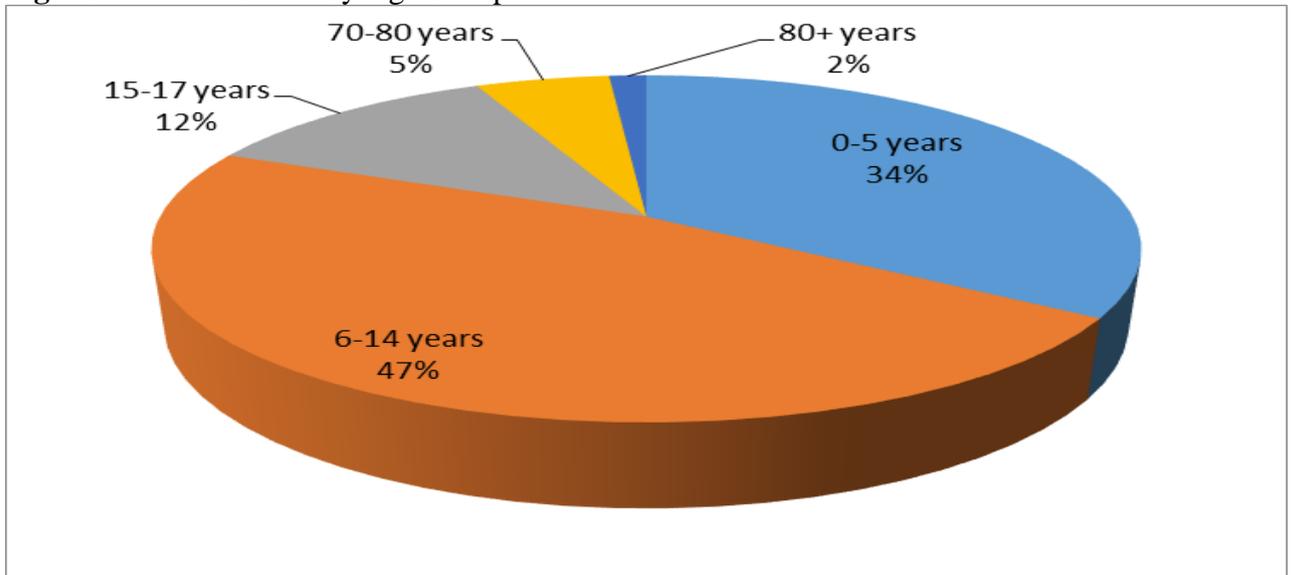
Figure 4.1 indicates that the children (0-17 years) constitute the majority (93%) and the aged (70 years and above) about 7 percent. According to the GSS (2012), children in Ghana constitute about 50 percent of the total population while the aged constitute about 2 percent. Andersen's utilization model (1968) identifies age as a predisposing factor and this constitutes an important variable in the study as the age of someone determines his /her probability of utilizing health care services.

Children younger than 15 years in developing countries according to UNICEF (2009) have higher rates of mortality (98%) and Ghana is no exception. Besides communicable diseases, perinatal and nutritional disorders have been cited as leading causes of mortality in these developing countries (Murray & Lopez, 1997). In Ghana, about 28 percent of children who are below five years are stunted or considered as too small or too short for their age (GDHS, 2008). Thus, these two cohort ages (below 18 years and 70 years and above) were grouped to ascertain the variations in terms of utilization. From Figure 4.2, children between 6 – 14 years have the highest percentage (47%), followed by the toddlers (34%), 15-17 years (12%), 70 – 80 years (5%) and the least 80+ years (2%). The total of

all these studied age groups constitute about 56 percent of the total beneficiaries of the NHIS. Yet, two age groups among the study population can be singled out (0-5 years and above 80 years) as those who mostly utilized healthcare services (36%). The period between 0 – 5 years is the most critical in a child’s life. It is characterized with high mortality rate (about 80 deaths per 1000 live births in Ghana) although this figure is considered as a reduction from previous years (NDPC, 2011).

Those above 80 years, aside their frailties, are also beset with diseases of old age and are therefore considered to be highly vulnerable.

Figure 4.2: Distribution by Age Groups



Source: Study data, 2011

The study areas were also considered in terms the distribution of these age groups to find out the dynamics and according to Table 4.1, Kwaebirem district had the highest population of the aged (29.1%) with Savelugu having the least number (21%). Besides, Savelugu had the highest number of children less than 5 years (30%) and this is indicative of the fact that there are more infants in Savelugu than in the other districts which were studied; a suggestion that the birth rate is high in this district.

Table 4.1: Age Group according to the Study Districts

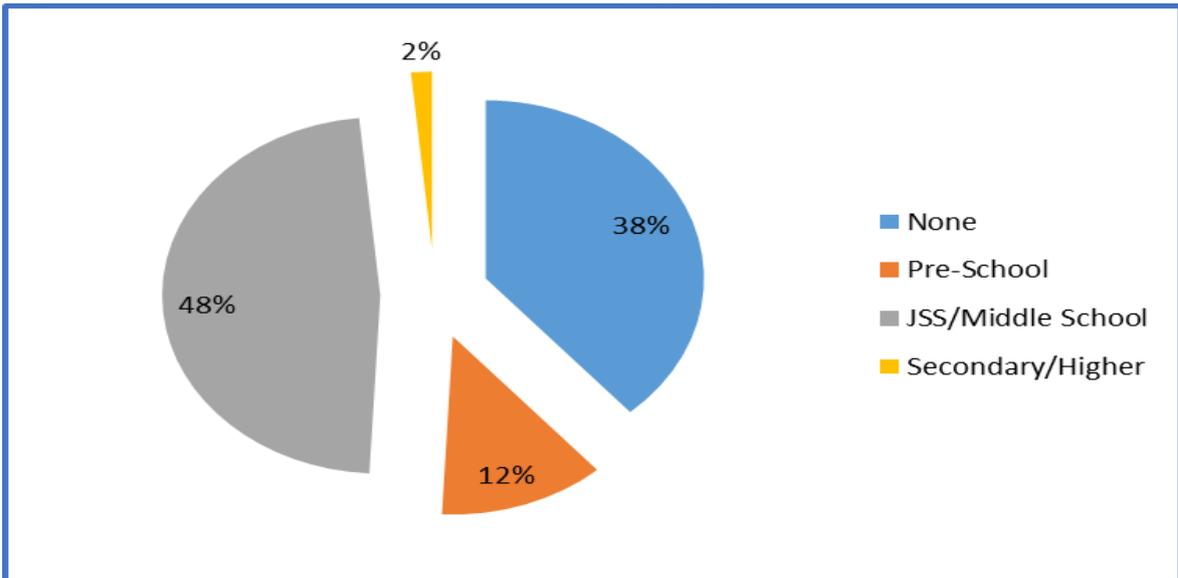
Age Group	Kwaebibirem	Asutifi	Savelugu-Nanton	All
0 - 5 years	22.2	20.7	29.7	24.9
6 - 14 years	38.3	39.2	37.2	38.1
15 - 17 years	10.3	11.7	12.3	11.6
70 - 80 years	23.1	21.2	16.8	19.8
Above 80 years	6.0	7.2	4.1	5.6

Source: Study data, 2011

4.1.2 Education Attainment of the Exempt Group

Research has shown that education enhances one's ability to utilise health care and female literacy notably among rural women is the lowest in the world as compared to males (Moazzam, Bhatti & Kuroiwa, 2008). The study therefore considered the educational attainment of the exempt group (under 18 years and 70 years and above) as a key variable to determine how they utilize health care. Figure 4.3 indicates that about 48 percent of the exempt group had completed Junior High or Middle school, 38 percent had not been to school and 12 percent were in pre-school.

Figure 4.3: Educational Attainment of the exempt group



Source: Study data, 2011

Figure 4.3 gives a clear indication among the study groups with regard to their educational attainment and the grouping was done according to that of the Ghana Demographic and Health Survey (DHS, 2014). 38 percent of respondents were mostly children under 4 years who were yet to be enrolled in pre-school. The educational reforms in 2006 underscored that kindergarten, which hitherto was not considered as part of basic education, should be included as the genesis of basic education in Ghana. Thus, though, children under 4 years are mostly enrolled in nursery and crèche, those levels are not included as part of the formal education process. Consequently, all such children are classified as having no education and hence placed under the category “none” in the chart. The gross enrolment for children in KG keeps on increasing. For instance, it rose from about 97 percent in the 2009/2010 academic year to 98 percent in the 2010/2011 academic year (NDPC, 2011). This figure also went up from 99 percent in the 2011/2012 academic year to 114 percent in 2012/2013 (MoE, Education Sector Performance Report, 2013, EMIS Data as cited in NDPC, 2013). The reason for the increase is that about 38 percent of pre-school attendance has been identified to be children aged six years and above and by implication,

these children are over the appropriate age group of 4-5 years for KG 2011 (Multiple Indicator Cluster Survey, 2011). Also 48 percent were mostly those at the basic school level and it does not come as a surprise because most of the children had either completed basic school or were near completion. Most of the aged had also completed the previous middle school which is equivalent to the present JHS.

Education, according to Andersen’s utilization model, influences one’s attitude towards health care utilization. Therefore, education was disaggregated at the districts for a better understanding of what is happening at the district levels. Taking out the children under 5 years, Table 4.2 indicates that Savelugu-Nanton lags behind in all the stages of education from pre-school to secondary/higher. Nationally, the northern region has the highest illiteracy rate in the country (NDPC, 2011), and at every stage of the discussion the north still lags behind the other districts when it comes to education.

Table 4.2: Educational Attainment of the Exempt Group by the Study Districts

Educational Attainment	Kwaebibirem	Asutifi	Savelugu-Nanton	All
None	24.2	37.1	48.8	38.5
Pre-School	13.7	12.1	11.6	12.3
JSS/Middle School	59.0	49.3	39.1	47.7
Secondary/Higher	3.2	1.5	0.5	1.5
Total	100	100	100	100

Source: Study data, 2011

Another interesting observation in almost all the districts was that most children commute long distances from their communities to their schools (about an hour or more). Apart from getting to school late and weary, these children are also exposed to vehicular dangers as the recklessness of some drivers has resulted in fatalities. A family recounted their ordeal at Asutifi district during the focus group discussion (FGD):

..... last year an articulator truck ran into our children who were walking home from school. Unfortunately our son died and others sustained serious injuries. If we had schools within the community all these would not have happened. So government should construct one for us {a discussant at Yawkrah at Asutifi, 28th May, 2012}.

4.1.3 Main Occupation

The age groups under study can be said to be pensioners who are not in active service and students. However, to ascertain the veracity of this, respondents were asked their main occupation in the last twelve months and this was limited to children from 15 years and above. Agriculture recorded the highest of about 25 percent followed by students who are about 9 percent and 8 percent for sales and services. According to Table 4.3, the aged (70 years and above) were mostly involved in agriculture (49.4%) and these people were not in active public service therefore agriculture (farming) had become the alternative source of livelihood. The high incidents of the response: not applicable (43%) is because there were more children in the study group who were mostly at the basic level of education and therefore were not in the main working class. People's occupation influence them to utilize health care. This is partly because they have the ability to pay (Andersen, 1968). Even though this study is looking at the exempt group, who in principle are eligible to utilize health services, the ability to pay for the other ancillary services like transport, purchasing of drugs outside the hospitals and even food can hinder these people from utilizing health care facilities.

Table 4.3: Main Occupation in the last 12 months by Age Group

Types of Occupation	Below 18 years	Above 70 years
Professional/technical/managerial	0.1	0.5
Clerical	0.0	0.8
Sales and services	0.2	7.0
Skilled manual	0.1	0.5
Unskilled manual	0.1	2.7
Agriculture	1.1	49.4
Student	9.9	0.0
Retired	0.0	31.7
Unemployed	0.7	6.0
Other	0.0	0.3
Not applicable	87.9	1.3
Total	100	100

Source: Study data, 2011

Table 4.4 shows the occupation of respondents according to the districts and it is certain that farming permeated in all the areas of study (26.9%, 14% and 31.5%) respectively. Yet, more people were engaged in farming in Savelugu (31.5%) than the other areas. Also there were more people who were into the service industry at Kwaebibirem (12.3%) than in the other areas. This can be attributed to the fact that there is more money in southern Ghana than in there is in the north. Also, there were more respondents who were students in Asutifi (10%), Kwaebibirem, (9%) with Savelugu having the least respondents who were students (7.7%). The results affirm the earlier assertion of southern Ghana being more literate than the northern part of the country. According to the Ghana Statistical Service (2013), Northern Ghana recorded the highest proportion of children with no education as compared to the Greater Accra Region. The large incidence of the response: not applicable (43.5%) is because of the age group being studied. That is children who are not even of school going age and old people who are out of school.

Table 4.4: Main Occupation of the Exempt Group by the Study Districts

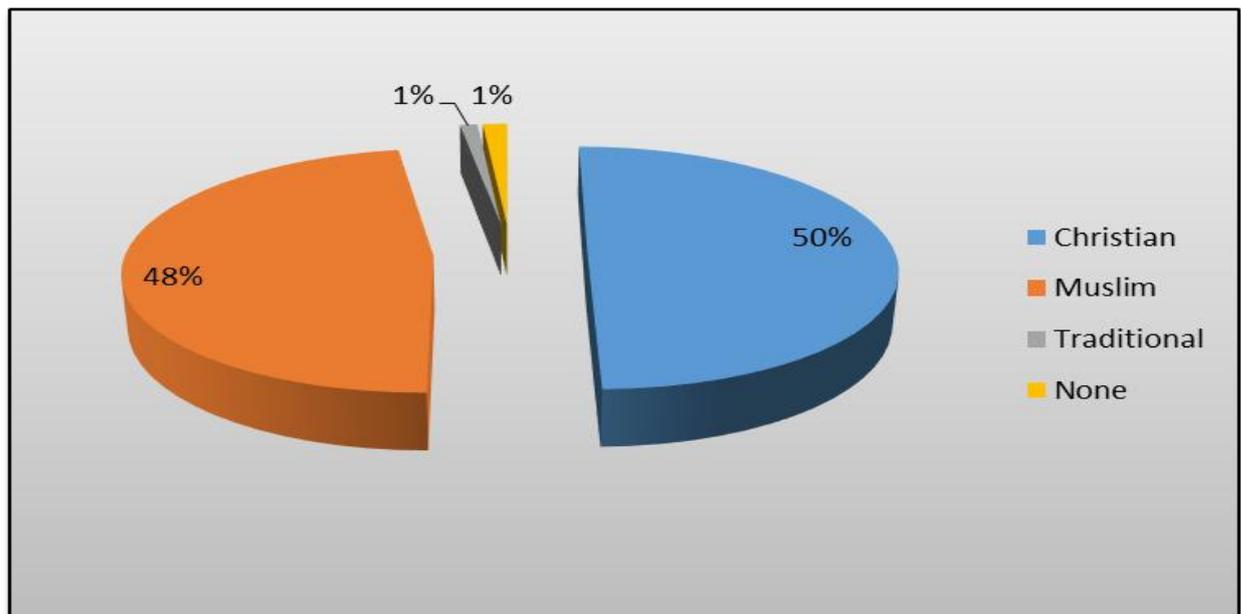
Main Occupation	Districts			Total
	Asutifi	Kwaebibirem	Savelugu-Nanton	
Professional/technical/managerial	1.5	1.8	0.7	1.2
Clerical	0.2	0.6	0.2	0.3
Sales and services	7.3	12.3	6.4	8.2
Skilled manual	4.1	7.0	2.2	4.0
Unskilled manual	1.9	7.4	1.8	3.3
Agriculture	26.9	14.0	31.5	25.5
Student	9.9	9.0	7.7	8.7
Retired	1.3	2.4	1.1	1.5
Unemployed	4.0	3.9	2.9	3.5
Other	0.2	0.6	0.1	0.3
Not applicable	42.8	41.1	45.5	43.5
Total	100.0	100.0	100.0	100.0

Source: Study data, 2011

4.1.4 Religion

It is a truism that the African is very religious and believes that religion contributes significantly in determining whatever he/she does and this is inclusive of whether to seek healthcare and even where to go for such healthcare services (Schieber et al., 2012). According to Andersen (1968), religion is a predisposing factor with regard to social networks and interactions. Indeed, one's religion may even influence the type of health services that a household accessed. Based on this assertion, religion therefore became an important variable in this study as shown below:

Figure 4.4: Religious Affiliation



Source: Study data, 2011

Figure 4.4 indicates that Christians were the majority (50%) followed by Muslims (48%). Although Christians were more than the other religions, the percentage gap was not consistent with the national statistics which put the Christian population at about 71 percent, Muslims at about 18 percent and traditionalists at about 5 percent (GSS, 2013). The higher proportion of Muslims in this case can be attributed to the selection of Savelugu-Nanton which has a predominantly Muslim population (86%), with about 13 percent as Christians and less than 1 percent for other religions and this is depicted in Table 4.5.

Table 4.5: Religion of the Exempt Group by Study Districts

District	Christian	Muslim	Tradition	None	Total
Kwaebibirem	78.6	18.6	1.8	1.0	100
Asutifi	74.8	20.8	0.9	3.5	100
Savelugu-Nanton	13.2	85.9	0.7	0.2	100
All	49.8	47.7	1.1	1.5	100

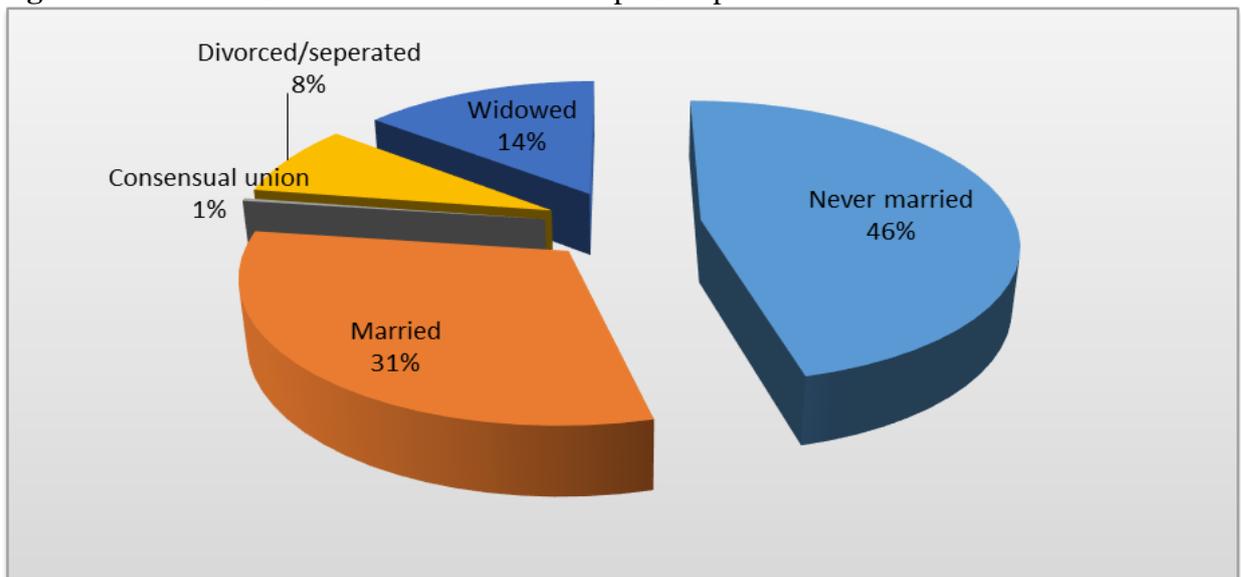
Source: Study data, 2011

The district disaggregation also follow the national pattern in the sense that Christians are dominant in the costal and the middle belt (Kwaebibirem and Asutifi) than in the Savanna belt (Savelugu-Nanton) which is predominantly Muslim (GSS, 2013). According to the Ghana Statistical Service, the dominant religion in seven out of the ten regions in Ghana is Christianity. Also, three out of five residents in the Northern region have their allegiance to Islam (GSS, 2013). From Table 4.5, the Asutifi district has the highest percentage of people belonging to no religion (3.5%). This indeed confirms the national picture, which posits that Brong Ahafo Region was the region with the highest proportion of persons with no religion (7.3%) (GSS, 2013).

4.1.5 Marital characteristics

The marital status of households is very essential as it predicts a wide range of socio-economic situations. In this study, questions on marriage were addressed to people from 15 years and above and the results are displayed in Figure 4.5.

Figure 4.5: Marital Characteristics of the Exempt Group



Source: Study data, 2011

The percentage of never married respondents according to the data was 46 percent, those married (including consensual) was 32 percent and the widowed was 14 percent. The variables in the distribution were however anticipated because of the age groups for this study. Yet, some disturbing issue identified in the results is that some of the children below 18 years were married.

Disaggregating further according to the districts still confirms the fact that the percentage of never married is high in all the districts. However regarding the married, Savelugu-Nanton recorded the highest number (42.8%) and between Kwaebibirem and Asutifi there was not much significant difference in the percentage of married people (24.9% and 23.8% respectively). Yet, the Asutifi and Kwaebibirem districts recorded a higher proportion of divorced (11.4 and 11.3 respectively) and Savelugu had the lowest (3%) as depicted in Table 4.6

Table 4.6: Marital Characteristics of the Exempt Group by the Study Districts

District	Never married	Married	Consensual	Divorced	Widowed
Kwaebibirem	43.8	24.9	1.1	11.3	18.8
Asutifi	47.2	23.8	0.0	11.4	17.6
Savelugu-Nanton	46.6	42.8	0.0	3.0	7.6
All	46.0	31.2	0.3	8.2	14.3

Source: Study data, 2011

The results indicate high marriage in the Savelugu-Nanton district (42.8%) and this can be attributed to various reasons such as people marrying at early ages especially girls below 18 years. Early marriage refers to any form of marriage before the child attains the age of 18 years as posited by the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). Child marriage has negative repercussions on the education, health and general psychological well-being of girls who marry early (Nguyen & Wodon,

2012). Besides, girls are forced into marriage by parents because of their inability to cater for their education so the only solution is to give them out into marriage as a way of reducing their financial burden (Alhassan, 2013). Also, poverty is the underlying factor that compels parents to force their girls into marriages and that has perpetuated the poverty in these areas (Otoo-Oyortey & Pobi, 2003).

All these socio-economic variables were put into a model using utilization as the dependent variable. The results is presented in Table 4.7

Table 4.7: Socioeconomic Factors Influencing Utilization of Health care among the

Exempt Group

	Seek help for this illness
Sex	-0.2791 (-1.07)
<i>Age</i>	
0-5years	
6-14years	-0.0508 (-0.16)
15-17 years	-0.3044 (-0.76)
70-80 years	2.5172 (1.09)
81-99years	0.8777* (2.25)
Age^2	-0.0005 (-1.26)
Current NHIS Status	0.8591*** (2.82)
Ever registered with any NHIS	-0.7010* (-1.92)
<i>Type of illness experienced</i> -Fevers/Malaria	
Heart Related	-0.9214** (-2.55)
Injuries/Arthritis	-0.2445 (-0.44)
Stomach Related	-0.6830* (-1.68)
Acute Infections	-0.6612 (-1.11)
Others	-0.3597 (-0.96)
<i>District</i>	
Asutifi	
Kwaebibirem	-0.4763* (-1.67)
Savelugu	0.8531 (1.58)
<i>Religion</i>	
Christianity	-0.1590
Moslem	(-2.66)**
Traditional	-0.9915 (-2.17)
Employed	-1.3701* (0.075)
Constant	2.7155*** (5.40)
Observations	534
Log lik.	-62.0361
Chi-squared	26.5850
Prob	0.0463
r2	0.1765

t statistics in parentheses* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$

Table 4.7 shows that the major socioeconomic factors such as current NHIS status, some types of illness, district, religious affiliation and employment status can influence the exempt group to seek medical services. The results show that even though statistically insignificant, the probability that females will utilize healthcare services was higher than males. It was also found out that within the age category, children under five were less likely to utilize healthcare services than the very old (81 -99). This is statistically significant at a 10% level. Even though children under five years utilize health care services more than other children below 18 years, the aged (70 years and above) tend to utilize health services more than the children due to the plethora of diseases associated with old age.

The results also show that the probability that those who are exempt and insured will seek medical services is higher than those who are not exempted and not insured. This is statistically significant at the 5 percent level of significance. Individuals who are enrolled in the insurance scheme are more likely to seek formal care when they are sick (Blanchet, Fink & Osei-Akoto, 2012). According to Schieber et al, (2012), people with insurance utilize healthcare services more than the uninsured. In other words, “being insured had the strongest effect on utilization of health facilities for the lowest quintiles” (Pp: 41)

Fever/malaria tended to have the highest probability of sending people to seek medical services compared to other forms of sicknesses which the exempt group suffer from. In terms of statistical significance, heart related and stomach related diseases were significant but had a lower probability of sending members within the exempt group to the hospital compared with malaria and fever. The disease burden in Ghana will gradually move from communicable to non-communicable diseases in the next 20 years. Yet, malaria continues to be the number one killer in Ghana especially in infants (Schieber et al, 2012).

With respect to the district of respondents, the probability that the exempt person living in Kwaebibirem will seek medical services tends to be lower than those living in Asutifi. This high utilization among subscribers in the Asutifi district can be attributed to the success of the first mutual insurance scheme in Ghana (the Nkoranza mutual scheme) which started in that region (Owusu, Kala & Afutu-Kotey, 2012). However, even though it was more likely for people living in Savelugu to seek medical attention than those living in Kwaebibirem, this was statistically insignificant.

In terms of religion, Christians tends to have a higher probability of seeking medical attention than Muslims and traditional believers. Also, employment is a determining factor in utilizing health care and according to the regression results, those who are employed tended to have a higher likelihood of seeking medical attention than the unemployed. This may also be as a result of the measurement of the employed and unemployed in the study. In this study, the employed comprised those who were self-employed while the unemployed were mostly the aged (pensioners) and the children. These were the groups who were more likely to seek medical attention frequently because of their exemption status and not because of their employment status.

The chi-square for the entire regression analysis is significant at a 5 percent level of significance while 17 percent of the variation in changes in the likelihood of accessing medical services is explained by the variables used in the model.

4.2 Health Seeking Behaviour of the Exempt Group

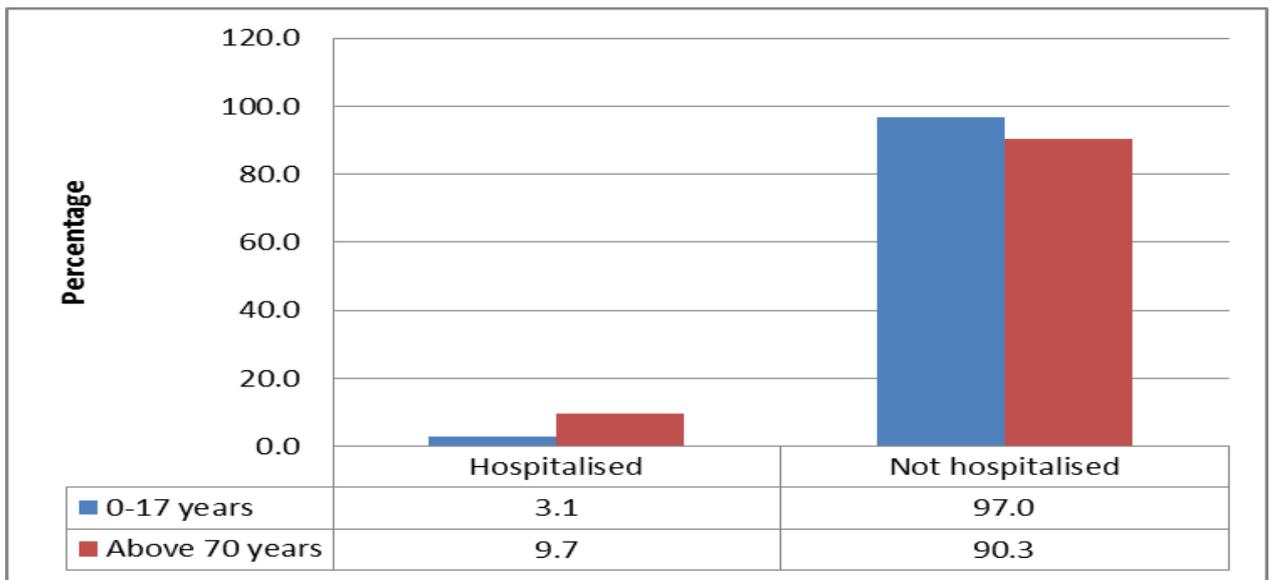
Health seeking behaviour according to Kasl and Cobb (1966) is any activity undertaken for the purpose of preventing diseases or illness in an asymptomatic stage and illness behaviour is seeking solutions for an ailment or sickness. They also posit that sick role

behaviour is any activity undertaken by a person who considers him / herself to be sick and wants to get well. The study examined health seeking behaviour using indicators such as the health status of households, hospitalization, current health conditions of household members and whether a household member (the exempt) had been told of having any chronic disease. Also, information about where households sought healthcare and the reason for their choices was considered. Finally, the overall quality of healthcare services received from the various facilities was also assessed.

4.2.1 Hospitalization

Being hospitalized in the Ghanaian parlance especially in the rural areas seems like one has been sentenced to death and this influences the decision to access health care services or not. Therefore, the study inquired from respondents whether any member of their households had been hospitalized in the six months preceding the time of the study and the result is presented in Figure 4.6. The results as presented have the aged (70 years and above) recording the highest percentage of hospitalization (10%), and the children (below 18 years) recording 3 percent. This result was also expected because the aged are mostly hospitalized due to the numerous infirmities that come with old age.

Figure 4.6: Hospitalization among the Exempt Groups



Source: Study data, 2011

4.2.2 Knowledge of health problems / conditions

The knowledge of one's health condition(s) is a key determining factor that affects a person's utilization of healthcare services. According to Table 4.8, peoples knowledge about their health conditions among the aged (70 years and above) is prevalent than that of the children. Savelugu-Nanton had the least percentage of the aged (12%) who knew about their health conditions, followed by Asutifi (31%) and Kwaebibirem (35%). This dynamics especially in Savelugu, can be attributed to factors such as the frequency with which these people undertake medical reviews and also the distribution of the health centres. Lack of knowledge of one's health conditions by the children was anticipated because they are young and most importantly it is the parents who are furnished with such information.

Table 4.8: Knowledge of Health Conditions among the Exempt by Study Districts

Study districts	Yes	No	Total
<i>Asutifi</i>			
0-17 years	1.0	99.0	100
70 years and above	31.6	68.4	100
<i>Kwaebibirem</i>			
0-17 years	0.7	99.3	100
70 years and above	35.3	64.7	100
<i>Savelugu-Nanton</i>			
0-17 years	0.2	99.8	100
70 years and above	11.9	88.1	100

Source: Study data, 2011

The results indicate a fair distribution across the districts regarding households' knowledge of their health conditions and it is a true reflection of what is happening nationally. Most Ghanaians do not know about their health status except when they fall sick and this permeates gender, class and even ethnic group. This can be attributed to a plethora of factors such as irregular medical examination, distance to health centres and poverty, which prevents people from undertaking regular health examinations because they cannot cater for the cost involved.

4.2.3 Current Health Status of Respondents

Apart from finding out whether people know their health conditions, household members were also asked about their health status with the rationale of studying their health status. This is because according to Andersen's model (1968) current health status is a need factor that is an immediate cause for someone to seek health care.

Figure 4.7: Health Status of Respondents



Source: Study data, 2011

The results as presented in Figure 4.7 indicate that more children (about 97 percent) had good health and about 62 percent of the aged also had good health. This climate of good health among these groups looks quite encouraging; however, the assumption is that, this might look like the normal Ghanaian mantra where everything is fine when in actual sense things may be on the decline. Moreover, there are more aged who have poor health (38.4%) than the young ones (3.2%). It is possible that the aged are mostly living sedentary lifestyles and are also attacked by sicknesses of old age as compared to the children who are mostly active throughout the day.

The health status of the household members was disaggregated according to the districts and this portrayed a very interesting picture. Savelugu-Nanton district had the highest percentage of people who claimed that their current health status was good (96.7%) followed by Asutifi district (93.2%) and Kwaebibirem district (90.4%).

Probing further through the focus group discussions (FGDs), it became clear that people have different worldview regarding health status. This is what some respondents recounted during the FGDs:

All of us in the house are doing very well, just that my little girl is the one whom we have been sending to the hospital on a regular basis because of her health condition (A discussant at Nanton, 16th July Savelugu).

My husband is sick and cannot do anything, but I can't say anything better but to respond that all of us are doing well, since God has given us life (a discussant at Langa at Savelugu, 18th July, 2012).

These examples attest to the fact that in Ghana, culturally, when one is not well and you try to find out how that person is doing, the response has always been in the affirmative as portrayed by the FGDs. The belief is that as one responds in the affirmative, it goes a long way to assuage the situation or fears.

4.2.4 Types of illness

After the advent of the NHIS, out-patient visits have increased considerably in Ghana; indeed, people now report the slightest injury or illness to the clinics or hospitals which hitherto was not so (Witter & Garshong, 2009; NHIA, 2010). Consequently, in order to find out how people access the health services, we asked respondents whether they had reported any injury or illness within four weeks preceding the data collection. The results indicate that majority of the respondents (91%) had not reported injury or sickness and only (9%) reported some ailments to the various health facilities. The study tried to ascertain the types of diseases they mostly report to the health facilities and the result is presented in Table 4.9.

Table 4.9: Types of Illness/Injuries Experienced by the Exempt

Diseases	0-17 years	Above 70 years	Total
Arthritis	1.1	20.6	4.8
Acute infections	4.1	9.4	5.1
Fevers	56.6	12.2	48.2
Heart related	1.5	22.4	5.5
Injuries	2.6	0.9	2.3
Skin diseases	7.4	2.8	6.5
Stomach related	15.5	8.4	14.1
Others	11.1	23.4	13.4
Total	100	100	100

Source: Study data, 2011

The various diseases have been grouped in Table 4.9 and this portrays that fevers/malaria constituted the highest of about 48 percent of the entire disease burden the vulnerable group are the children (57%) and the aged (12%). This confirms the position by WHO that malaria is the leading cause of death in Sub-Saharan countries like Ghana with the region bearing about 25 percent of the global disease burden with fevers/malaria being the leading cause of child mortality (0-5 years). They attributed this to poverty, low level of education, lack of potable water, poor health facilities and sometimes the distance from people's homes to health facilities (WHO, 2008).

Heart related diseases among the aged is higher (22%) than among children (2%) and this is followed by arthritis which is (21%) prevalent among the aged and 1 percent prevalent among children. Heart related diseases and arthritis are some of the frequently reported sickness by the aged to the health centres (GDHS, 2008). Stomach related disease affect children more (16%) than the aged (8%) and Savelugu-Nanton recorded the high number of respondents who contracted stomach related disease and this can be attributed to the poor source of drinking water in the district in particular and the Savanna ecological zone in general. In certain places during the dry season, people trek long distance for about two

hours or more just to get water and the more horrific is the situation where humans and cattle drink from the same water source in some communities in the Savelugu-Nanton district. The “other” response constituted about 13 percent, the aged about 23 percent and the children about 11 percent. The diseases under the other response included chronic diseases such as sickle cell anaemia, HIV/AIDS, liver problems, eye problems, depression among others. The percentage distribution was expected because most of these diseases are contracted through lifestyles and the aged are more inclined to contract them as compared to the children. Furthermore, heart or cardiac disease gradually, is becoming a silent killer currently in Ghana and this can be attributed primarily to changing lifestyles (Akins, 2007).

4.2.5 Sources of Seeking Treatment

Where people access healthcare affects their health seeking behaviour either positively or negatively. Therefore this variable of sources of treatment was considered to ascertain where respondents access medical care. However, before these questions, respondents were asked whether they had been told of any household member suffering from any chronic disease. The results indicate that the aged were more diagnosed of chronic diseases as compared to the children. Regarding whether any of them had sought care prior to the study, both age groups answered affirmatively. Fortunately, people at the time of the study sought early treatment to their ailments as compared to the years before the introduction of the NHIS where people reluctantly sought healthcare.

Table 4.10: Sources of Treatment of the Exempt Group by the Study Districts

Facilities	Asutifi	Kwaebibirem	Savelugu-Nanton	Total
Regional public hospital	2.6	0.8	2.5	2.0
District hospital- public	5.0	16.8	27.7	14.5
District hospital – mission	21.5	17.7	0.8	15.3
private hospital	3.6	11.5	2.1	6.0
Public health Centre	33.5	21.3	10.1	23.7
Private clinic	2.9	1.4	12.2	4.5
Mission/NGO clinic	1.2	3.1	0.8	1.8
CHPS	4.6	2.5	0.4	2.9
Private pharmacies	0.2	0.3	0.0	0.2
Drug store	21.1	22.4	33.2	24.4
Tradition/spiritual healers	1.9	2.0	3.4	2.3
Self-medication	1.9	0.3	6.7	2.5
Total	100	100	100	100

Source: Study data, 2011

Table 4.10 reveals a very interesting phenomenon with regard to where people seek health care. Across all the districts, most people sought health care from the drug store with Savelugu having the highest percentage (33.2%), followed by Kwaebibirem and Asutifi (22.4% and 21.1%) respectively. Most of these people purchased drugs which were mostly not prescribed by medical officers from drugstores. This can be linked to self-medication in the districts and Savelugu ranked the highest. Self-medication according to Asenso-Okyere et al., (1997) is a common way of coping with disease because patients are conscious of the symptoms in most prevalent diseases, like malaria, headache and so buy medicine without prescription by a doctor.

Generally, the respondents attended both public and mission hospitals. Asutifi had about 22 percent of respondents reportedly seeking medical care from the district mission hospital. This became apparent because of St. Elizabeth Hospital which is the biggest and most accessed hospital in the enclave, and also serves as the district hospital. Kwaebibirem (17.7%) also had the St. Dominic Hospital, another mission hospital that served as the point for referral and specialized treatment in the district. While Savelugu-

Nanton does not have any mission hospital, it has a district hospital and some private clinics.

Apart from drug stores, the next place of accessing healthcare for most respondents was the health center (24%) and Asutifi district recorded the highest percentage (33%), Kwaebibirem, (21%) and Savelugu about 10 percent. This result is indicative of the fact that clinics and CHPS compounds are helping especially in the rural areas when utilization of health care is concerned. In fact in some of the districts, people had to travel for a long time before they got to the nearest clinic or CHPS compound, and thus encouraging the dangerous act of self-medication.

Another revelation from this study is that people still consult traditional/spiritual healers instead of medical officers. According to the data, the highest number of respondents (3.2%) who consulted traditional/spiritual healers was from the Savelugu-Nanton district while Kwaebibirem recorded the lowest (1.9%). This resorting to traditional and spiritual healers affects general healthcare because patients often refrain from visiting the hospitals or clinics until the situation becomes serious and deteriorates completely. At such stages, there is often very little medical personnel can do to salvage the situation.

4.2.6 Rationale for Choice of Facility

In Ghana, people have different reasons and motives for patronizing certain health centres to seek medical care. Respondents were asked to indicate the rationale for patronizing certain facilities. Most of them attributed their choice of facility to proximity (42%). This was followed by the place being the regular source of treatment (14.4%). This regular source of treatment transcends proximity and location. Once people become affiliated to a facility, distance and cost become auxiliary. The next factor determining the choice of

facility was the availability of drugs (8.7%). The inability of the health facilities to give out the needed drugs can affect peoples' affinity to such facilities. Shojo, Tsimpo and Wodon, (2012), posit that some patients even describe a facility as having improved upon their services because of the availability of drugs and medical equipment.

Table 4.11: Rationale for Choice of Health Facility

Reasons	Asutifi	Kwaebibirem	Savelugu-Nanton	Total
Proximity	42.4	39.1	45.8	42.0
Only facility available	3.3	3.0	0.4	2.5
NHIS provider	1.0	1.6	0.4	1.1
Good reputation	4.1	3.3	0.4	2.9
Availability of modern facilities	1.9	1.6	0.8	1.6
Short waiting time	0.5	2.2	0.8	1.2
Availability of drugs	8.3	6.8	12.1	8.7
Nice health workers	0.0	0.3	0.4	0.2
Good quality of care	6.4	10.9	5.0	7.7
Low charges	3.1	3.8	2.5	3.2
Regular source of treatment	13.3	17.5	11.7	14.4
More likely to be attended by a doctor	1.4	1.6	0.8	1.4
Other	14.3	8.2	18.8	13.2
Total	100	100	100	100

Source: Study data, 2011

Based on Table 4.11, it can be deduced that availability of NHIS service is not important in people's choice of health facility. The reason is because most of the health facilities have been accredited by the NHIA. Also, only 0.2 percent indicated that the nice attitude of the health workers attracted them to the place. What it presupposes according to the study is that although majority of the health workers' attitude towards patients at the facilities are despicable, people have turned a blind eye to all of them.

During the in-depth interviews, the attitude of some health personnel became a very strong point in all the districts.

We have received complaints about some nurses insulting patients and refusing to attend to them and I have personally followed up at the hospital to ascertain the truth. Not that I doubted these complaints but just to get a first-hand information so that we can apply the necessary sanctions {IDI, District Health Director, Kwaebibirem, 17th May, 2012}.

A medical director also recounted his experience:

In fact I can say without fear of contradiction that some of our workers and their attitude towards patients is very bad. We as management had to even suspend some people for gross misconduct and extorting money from patients with the promise of getting them “better drugs” .{IDI, St. Elizabeth Hospital, Hwiediem, Asutifi, 31st May, 2012}.

On the alleged despicable behaviour of some health workers, all the discussants in the focus groups were unanimous and some recounted their ordeals:

As for the nurses they don't respect at all, one time a nurse yelled at me all because she mentioned my name and I didn't hear it and she started insulting me. I had to apologize because if I insult back they might not give me the needed treatment {FGD, at Savelugu, 15th July, 2012}.

As for me I complained that anytime I come to hospital they ask me to buy drugs and that was my bane. The nurse told me that they don't manufacture drugs and if I can't then I should not come and disturb them {FGD at Dokyi in Kwaebibirem, 10th May, 2012}.

In fact the doctor here is too arrogant and because he is the only person here that is why he behaves like that. At times you will be waiting and he will tell the nurse to inform patients who are suffering that he is going to

eat and he will leave us and go home just to eat. Why can't he bring the food to the office, aren't we also important? {FDG, Donkorkrom in Asutifi, 2nd June, 2012}.

These sentiments resonated throughout the interviews and that should be a matter of concern to authorities because people patronize these health centres for relief and not for their predicaments to be compounded so that they cultivate disaffection for hospitals. The attitude of health personnel towards patients confirms findings by the Ministry of Health (2009), that health workers discriminate among patients and also charge unauthorized fees.

Also, the results presented in Table 4.11, highlights the issue of gate-keeping role being trumpeted by the NHIA and this is because more people reported to the health centres and the CHPS compounds. With regard to gate-keeping, patients do not have direct access to secondary or tertiary care unless it's a referral by a general health practitioner (Brekke, Nuscheler & Straume, 2007). What this means is that treatment should always begin from the health centre and CHPS compounds before they are referred to the secondary and tertiary hospitals and not vice versa as people normally do. Besides, poor gate-keeping in the healthcare systems is a general concern in Ghana because it raises the price of healthcare and this ends up in higher repayment by the regulator (Witter & Garshong, 2009).

4.2.7 Perceived Delay in seeking health care

Although the NHIS has increased access to health care, some people still find it difficult to report ill-health to the various hospitals and clinics (NHIA, 2012). Therefore, respondents were asked what informed their delay in seeking health services. The results presented in Table 4.12, show that majority of the respondent said that their inability to seek healthcare

was because they did not consider their illness to be serious (52%), and the distribution among the aged groups are the same 52 percent for the children and 53 percent for the aged. Also, due to self-medication (25%), respondents delayed in seeking health care and the children recorded the highest of 26 percent and the aged 21 percent. From the results, self-medication has emerged again and it's a problem because though it is a risk to health care, people are still indulging in the practice. The practice is more prevalent in the Asutifi and Kwaebibirem districts. Regarding the lack of funds, the children had 13 percent as compared to 5 percent of the aged.

Table 4.12: Reasons for Perceived Delay

Reasons	0-17 years	Above 70 years	Total
Illness not serious	51.8	52.6	52.0
Lack of funds	13.1	5.3	11.3
Long distance to facility	0.0	1.8	0.4
High cost of health care	0.5	0.0	0.4
Nobody to accompany patient	2.1	7.0	3.2
Self-medication at home	25.7	21.1	24.6
Other	6.8	12.3	8.1
Total	100	100	100

Source: Study data, 2011

Another interesting outcome is the lack of funds (11%) and more respondents in Savelugu saw this as a bane to health care. Due to the high incidence of poverty in this area, the burden of accessing health service would be serious as compared to the other areas; yet, people are paying high fees for healthcare services. This is a woman's account during the FGD:

The cost of care is too high in the sense that any time I go to the hospital I pay for everything including the drugs. Meanwhile, my insurance is still valid, so when the insurance expires, I am thinking not to renew it again.

That one when I go to the hospital and pay then that would be okay, since I can't pay for drugs and everything {FGD, discussant, Depali, Savelugu, 19th July, 2012}

Aside this high cost of care and other challenges, people are generally satisfied with the overall healthcare service they receive and that is a feather in the cup of the healthcare practitioners. This is a man's account during the FGD:

The hospital is doing well and whenever we visit, they take good care of us. My brother was bitten by a snake and I got to the hospital in the night, yet the nurses took good care of him and he is now doing well {FGD discussant at Nkaseim, Asutifi, 5th June, 2012}

4.3 Out of Pocket (OOPs) Payments by the Exempt Group

One of the objectives for the establishment of the NHIS was to reduce out-of-pocket (OOP) payments made by households at the health centres. In fact OOP payments can inflict hardships on households and make them vulnerable to catastrophic health expenditures (Shahrawat & Rao, 2012). The rationale for this section is to find out the extent of OOP payments made by the exempt group whenever they visit the health facilities. Variables studied included, the insurance status of household members, and the total medical expenses at the facilities at the OPD. Also the type of insurance respondents had subscribed to, whether they had valid I.D cards, the last annual premium paid, whether anyone had stopped registering, what was the basis for such action and finally, this section looked at the impact the NHIS had made in the lives of the people.

4.3.1 Insurance Status

The new NHIS Act (852) mandates all Ghanaians to be enrolled into the NHIS yet not all Ghanaians are enrolled. Furthermore, once a person enrolls, the subscriber is also mandated

to renew his /her membership annually before becoming eligible to access health care services. The stipulated premium is therefore paid as a form of renewal except one is exempt where they pay only processing fees according to the in-depth interviews. The results as presented in the Table 4.13 have the currently insured 63 percent with more aged (73%) insured than children (62%). The result indicates that more of the exempt are also eligible which means they have renewed their subscription. Besides, those who were previously insured (28%) had children recording 29 percent and the aged about 22 percent. The results give a paradoxical picture because these groups are supposed to be exempt therefore the expectation is that they should be always insured, yet some are still not insured and this is because they had not renewed their subscription for that year. Even more worrying was the situation where some had withdrawn their membership (0.7%) and these were people who indicated that due to certain unpleasant experiences, they were not going to renew their subscriptions again. Also about 9 percent were registered and waiting for their identity cards.

Table 4.13: NHIS status among the Exempt Group

NHIS status	0-17 years	Above 70 years	Total
Currently insured	61.5	73.2	62.5
Previously insured	29.0	21.5	28.4
Registered without ID	8.9	4.1	8.5
Withdrawn membership	0.6	1.3	0.7
Total	100	100	100

Source: Study data, 2011

The results were disaggregated further across the study districts to ascertain the district dynamics and the results were grouped under insured which comprise (currently insured

and registered without ID cards) and uninsured which is (previously insured and withdrawn membership).

The results according to Table 4.14 indicates that the currently insured were about 61 percent, previously insured (30.5%) and registered without I.D cards (7.7%).

Table 4.14: Insurance Status of the Exempt Group by the Study Districts

District	Currently insured	Previously insured	Registered without ID	Withdrawn membership	Total
Kwaebibirem	63.4	29.5	4.7	2.4	100
Asutifi	67.0	26.2	6.6	0.3	100
Savelugu-Nanton	53.9	35.2	10.9	0.0	100
All	61.1	30.5	7.7	0.7	100

Source: Study data, 2011

The Asutifi district has more insured (67%) than the other districts. These results can be attributed to the fact that this district is located in the Brong Ahafo region where mutual health insurance scheme started and gained prominence, that is, the Nkoranza Scheme initiated by the Catholic Church in 1989, followed by Kwaebibirem (63.4%) and then Savelugu (54%).

Consequently, the previously insured had about 35 percent for Savelugu, 29 percent for Kwaebibirem and Asutifi 26 percent. The NHIS initially achieved a remarkable coverage within the early stages of its inception. However, these figures dwindled as the years went by and this can be ascribed primarily to the cumbersome nature of the process of registration coupled with the delay in even processing identity cards for the subscribers (Quedraogo, 2012). The design of the NHIS means that people without valid or unexpired cards pay the full cost for their healthcare and currently, about 65% of the total population are still uninsured (Arhin, 2013).

Another issue of concern is that some people have also withdrawn their membership from the scheme with Kwaebibirem leading (2%). When one has withdrawn membership from the NHIS, according to this study that person previously registered with the scheme but had not renewed membership for two years prior to the study and had also indicated their unwillingness to renew their subscription. This number may seem insignificant, yet it becomes a dent on the scheme despite its social protection component and the fact that the new NHI Act 852 states that every Ghanaian must belong to the NHIS. Those who have withdrawn their membership have cited a number of reasons. The distribution of responses is shown in Table 4.15. Eliciting from the table, the premium is what has forced some people to exit from the scheme (67%) followed by others (18%) and those who think that they do not often fall sick (12%). The expensive premium as cited by respondents which has caused them to withdraw their membership is contrary to Act 650 (2003) and the Act 852 (2012) which stipulates that these groups should not pay any premium.

The children recorded the highest (67%) as compared to the aged (56%) and the new NHI Act 852 sought to decouple children from their parents. This means that unlike the previous situation where both parents would have to register to ensure the eligibility of their children, this new Act has changed that clause. Therefore it can be adduced that maybe parents who responded for their children were oblivious of this or the schemes are capitalizing on their ignorance to exploit them.

Table 4.15: Reasons for Non-Membership of NHIS among the Exempt Group

Reasons	0-17 years	Above 70 years	Total
Premium too expensive	67.3	56.3	66.8
Do not trust the NHIS	1.3	2.2	1.3
Not a sick person	11.2	17.8	11.5
Poor services to NHIS subscribers	1.2	1.5	1.2
Misconception about the NHIS	0.6	0.7	0.6
Other	18.3	21.5	18.4
Total	100	100	100

Source: Study data, 2011

Analysing the results by the study districts in Table 4.15, Savelugu recorded the highest for those who reported on high premium as the reason for leaving the scheme (75. %), followed by Kwaebibirem (53%) and Asutifi (51%). According to the literature, (Blanchet, Fink & Osei-Akoto, 2012), schemes are not charging according to one's earnings as prescribed by the law. Rather, they are charging a standard fee for everybody, and the poor are those suffering under this kind of regressive arrangements (Asante & Akins, 2008; Jehu-Appiah et al., 2010). Besides, the rich are more likely to enrol and benefit from the scheme as compared to the poor because the poor are confronted with constraints when it comes to enrolling unto the scheme (Chankova, Sulzbach & Diop, 2008).

Table 4.16: Reasons for Non-Membership by the Exempt Group according to the Study

Districts

District	Premium too expensive	Do not trust the NHIS	Not a sick person	Poor services to NHIS Subscribers	Misconception about the NHIS	Other
Asutifi	50.6	1.5	22.8	2.8	0.5	21.8
Kwaebibirem	53.0	4.0	24.4	2.2	1.6	14.9
Savelugu-Nanton	75.2	0.2	8.3	0.8	0.5	15.1
All	63.2	1.5	16.1	1.6	0.7	16.8

Source: Study data, 2011

Regarding Savelugu, their case is special because the annual premium paid by subscribers are flat-rated and also on the high side. This is what the scheme manager had to say during the in-depth interview:

We charge Ghc 18 for renewal and Ghc 21 for new registration and we have arranged it in such a way that our agents can collect the money in bits and in pieces. Generally as a scheme, we are even running at a loss considering the effort we put in to reach out to the people {Scheme Manager, Savelugu, 10th July, 2012}.

In a district where poverty is so rife, charging such rates as premium is exceedingly high and may demotivate people from registering. For instance in the Kwaebibirem and Asutifi districts, the annual premium paid by subscribers is about GHc 10 and GHc 4 as processing fee and this brings the total cost to GHc 14.

As for those who think they do not fall sick and so cannot continue to contribute to something they cannot benefit from, their reason is that the money can be used for more important things. The implication is that they do not see health care as a matter of need and therefore think that they are wasting money when they pay insurance.

In fact the men think that insurance is for women and children because they are considered more vulnerable, but certainly not the men because they consider themselves to be strong and healthy, then the next time they are here with snake bites or motor accidents {IDI, Scheme Manager, Savelugu, 10th July, 2012}.

The other category of the response is also high (16.8%) and delving into those responses; many of them said that the penalty imposed for non-renewal of subscription caused them not to renew their membership again. Also others gave their reasons as the long waiting period before obtaining their I.D cards after paying the registration fee. In fact in one community in the Savelugu district, the people had waited for more than a year to get their cards. The reason was that an agent registered them, collected their moneys and never returned:

Somebody came here with the assemblyman to register many of us in this village and took our moneys and photographs with the promise of getting us our I.D cards. Up till date, the cards have not come and our monies are also gone for one year now. We have asked the assemblyman so many times who said he has reported to the NHIS office but they can't trace that person. People always take us the villagers for granted and we know this cannot happen in any city {FGD at Tampion, 16th July, 2012}.

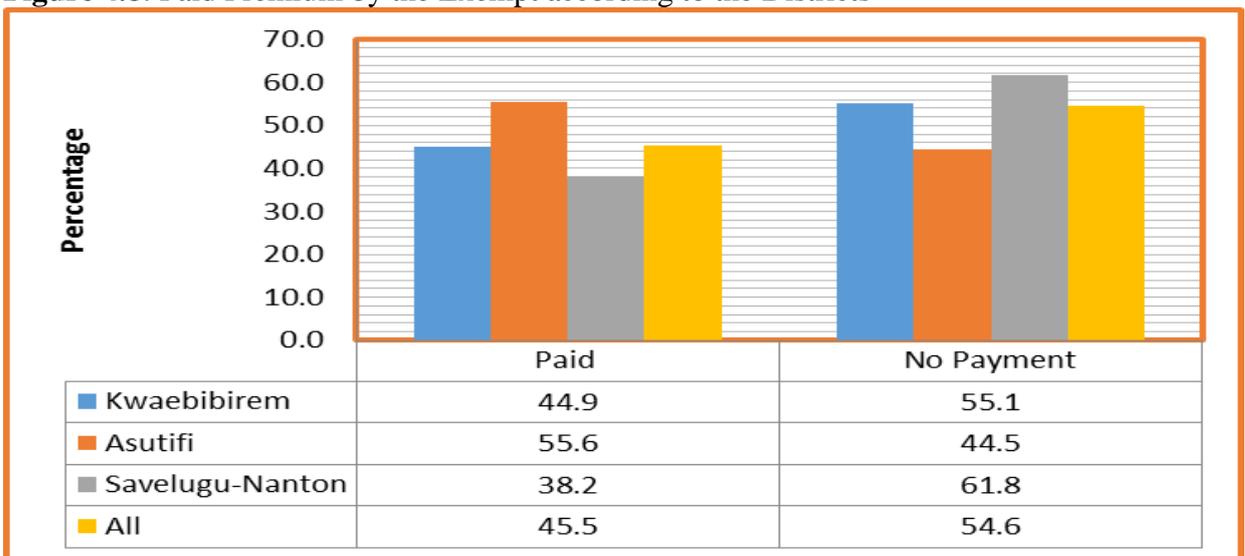
The suggestion was that the NHIA should recruit credible agents with proper identification and if possible pay them something in addition to the commission they get.

4.3.2 Last Premium Paid

The NHIS Act (650) mandates that all schemes must charge an annual levy of GHc 7.20 as minimum and GHc 48 as maximum per adult from the informal sector. These premiums

are based on a person's income and job position. However, schemes are using their own initiatives to charge flat rates regardless of one's income and position and this is an affront to the Act. Moreover, some categories of people have been exempted by the Act and with this background, respondents were asked whether they have paid any premium during the past year.

Figure 4.8: Paid Premium by the Exempt according to the Districts



Source: Study data, 2011

The results indicate that more people did not pay any premium the previous year (55%) as compared to about 46 percent who paid the premium. Savelugu district recorded the highest percentage of those who did not pay any premium (62%), followed by Kwaebibirem (55%) and Asutifi (45%) which recorded the lowest.

However, in terms of those who paid premium the previous years, Asutifi recorded the highest (56%), with Kwaebibirem (47%) and Savelugu (38%) recording lower percentages. The results show serious contradictions because according to the Act, these cohort age groups are exempted from paying any premium; yet, about 46 percent paid. What accounted for the payment by these groups was explained by the scheme manager at Asutifi:

Those who are exempt don't pay any premium, what they pay is processing fee which is about GHc 4, while the premium is more than that amount {IDI, Scheme manager, Asutifi, 28th May, 2012}

This assertion was corroborated by other scheme managers, who said that apart from the indigents who do not pay for anything including processing fee, the others only pay processing fee. However, the claim of payment by the exempt was confirmed by discussants during the FGDs. One revealing issue was that they consider any amount subscribers' pay as "fees". This is an elderly man's assertion during a focus group discussion:

I first registered for the national health five years ago and every year I pay to renew my card.....even last year I paid GHc4 meanwhile they say old people like us don't pay anything and we are paying {FGD, at Pramkese, in Kwaebibirem, 11th May, 2012}.

Two people shared a similar view on this at different locations during the FGDs:

After giving birth, I wanted to register my daughter and I had to pay a fee of GHc10 before she was given a card {a discussant at Senchiem, Asutifi, 31st May, 2012}.

I pay every year to renew my registration and that of all my children.....I paid GHc18 for each of them as well as myself" {a discussant at Savelugu, 15th July, 2012}

Regarding the payment for renewal, there are variations in all the districts; hence, the different amounts. Apart from Kwaebibirem where a male respondent cited above, actually paid for processing and not premium, the others paid premiums. What the scheme has failed to do is to educate the people on the various amounts they pay, so that subscribers can distinguish processing fees from premiums.

4.3.3 Medical Expenses paid at the Facility (OPD) by the Exempt Group

In Ghana, OOP payments account for about 37 percent of the total health expenditure, far above the WHO threshold of adequate financial protection and this is in excess of 15 – 20 percent (Schieber, Cashin, Saleh & Lavado, 2012). Medical expenses incurred by households especially the poor have made them poorer. Table 4.17 provides information about medical expenses incurred at the OPD within the last four weeks prior to the data collection. About 66 percent did not incur any expenditure, 17 percent spent between GHc 1 – GHc10 and 7.4 percent also spent between GHc 11 – GHc 20. More people are not paying for health service in the Asutifi district (74%) compared to people in the Kwaebibirem district (62.1%) and the Savelugu district (48.1%). One interesting outcome is that, as the expenses increases, the number of people also decreases; however, expenses above GHc 50 are only about 3 percent with Savelugu leading the chart (7.6%).

Table 4.17: Medical Expenses at OPD by the Exempt Group according to the Study

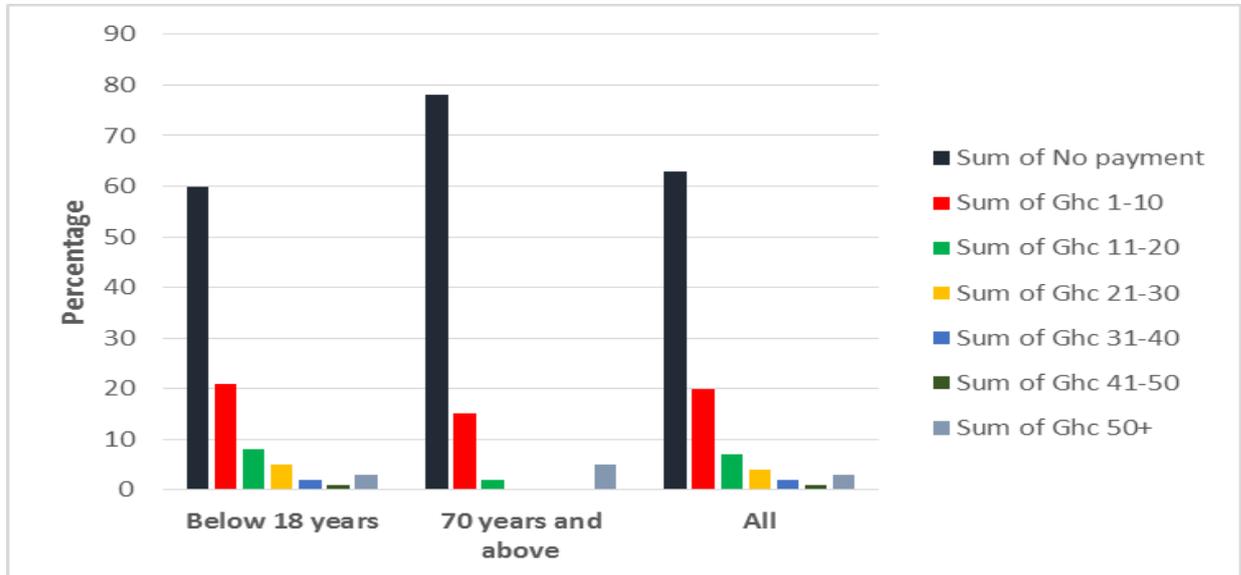
District	No payment	GHc1 – 10	GHc11- 20	GHc21- 30	GHc31- 40	GHc41- 50	GHc50+
Kwaebibirem	62.1	19.0	9.2	5.1	1.0	1.5	2.1
Asutifi	74.0	13.0	5.5	2.4	2.0	0.8	2.4
Savelugu- Nanton	48.1	25.3	8.9	5.1	1.3	3.8	7.6
All	65.7	17.1	7.4	3.8	1.5	1.5	3.0

Source: Study data, 2011

Generally, more people are incurring OPD expenses at Savelugu district than the others (52%) as fewer people in Kwaebibirem (38%) and Asutifi (26%) incurred OPD expenses. In fact this OPD increase has an inverse relationship with the proportion (65%) who have not registered with the NHIS. According to Hendriks (2010), there has been an increase in

OPD attendance since the introduction of the NHIS in 2005. This data was disaggregated among the age categories to find out the trend of OOP payments at the OPDs.

Figure 4.9: Medical Expenses by Age the Exempt Group



Source: Study data, 2011

The results are not different from that of the districts, as many of the respondents are not paying for their healthcare. The benefit package under the NHIS is to cover healthcare services, such as, OPD consultations, essential drugs, in-patient care, maternity care both normal and caesarean, eye care, dental care and emergency care. This is made up of about 95 percent of all treatments in Ghana (Witter et al., 2009). However, other services deemed too expensive have not been included in the treatment list. Besides, the benefit package is heavily skewed towards curative to the detriment of preventive healthcare (Schieber et al., 2012). In terms of the OOP payments, the national average have reduced by at least 4 percent over the last decade, yet that of the household level OOPs remain at about 22-37 percent of the gross spending which is above the WHO financial protection threshold (Arhin, 2014).

4.3.4 Impact of the NHIS

The study tried to find out from respondents the impact the NHIS has made on their lives. Majority of them confirmed that the NHIS had indeed made access to healthcare easier for them. Some respondents emphasized that the burden of thinking about how to get money to attend hospital has reduced to the barest minimum. These successes were recounted by participants during the FGDs:

I don't think of how much I will pay when I go to the hospital; rather, all I have to do is get my transport fare and I am gone. At first I used to think of the monies that I have to pay when I visit the hospital {FGD Nkwantanang, Kwaebibirem, 9th May, 2012}.

An aged woman recounted her experience of how the NHIS helped her when she became sick:

I became sick for about three months and was even admitted to the hospital at Hweddiem and I tell you but for the insurance I would be dead. I did not pay anything. In fact the insurance has really helped those of us in the villages immensely {FGDs Mehame, Asutifi, 1st June, 2012}.

The financial burden that has been reduced for subscribers and the easy access to healthcare and treatment have been some of the successes of the NHIS. However, others had their reservations. Some subscribers complained about the quality of the drugs given to them and the fact that most of the time they had to pay for the drugs that were given to them. A man shared his experience:

“Anytime I go to the hospital and drugs are given to me, I have to pay for it because they tell me that those drugs are not part of those listed under the scheme meanwhile my card is still valid and this is worrying because I know that I don't have to pay for the drugs” {FGDs@ Otumi, 9th May, 2012}.

This confirms what Rosner et al., (2012) said that people in some instances have to pay at the health facilities even when they are subscribers before they are given drugs.

4.4 Conclusion

This chapter started by discussing the objectives that underpinned this study. This discussion was grouped under three headings; the socio-economic factors (Objective one), the health seeking behaviour of the exempt group (Objective two) and the out-of-pocket payments by the exempt group (Objective three). The first part revealed that the very old people (80 years and above) and children under 5 years were those who utilize healthcare services more than the other age groups who were also exempted and according to Andersen's theory age is a key variable under predisposing factors that influences utilization of health services. This calls for better medical services and consumables at the health centres to cater for such a delicate group.

The second objective was tailored around Andersen's model under enabling factors and this comprise of access to health services, income, health insurance, a regular source of care, travel, extent, quality of social relationships and waiting time. The findings were that a lot of the respondents report most of the diseases that affect them to health centres. But what was of paramount interest is the number that patronized drug stores (or engaged in self-medication). Besides, peoples' choices of health facility were found to be largely dependent on the proximity of the facility to their homes. This means that the farther the facility, the lesser the possibility of people patronizing it. Also, these exempt groups have their health insurance valid; however, others too have not renewed their status and this was a matter of concern especially for the aged.

Finally, the last objective on OOP payments which according to the Andersen's model was the need factors and these are catalysts to health care utilization. The study found out that people knew their health status especially the aged, however some of the exempt still

make payments at the facilities, although a greater number of them said they do not pay anything. Also, this group is supposed to be exempted from paying premium, yet some, especially the children, still pay for health insurance renewals.

Generally, the NHIS had positively improved the lives of the people due to the access it gave them to healthcare and also how it insulated them from some amount of direct payment at the health facilities.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The main objective of the study was to investigate the socio-economic challenges that affect the exempt group of the NHIS during healthcare utilization. In order to achieve this, the following specific objectives were considered:

- To investigate the socio-economic factors that affect utilization of healthcare services by the exempt group.
- To examine the health seeking behaviour among the exempt group
- To explore the extent to which the exempt group make OOPs at the point of service delivery.

Andersen's theory of utilization is the main theory underpinning this study. The theory explains the factors that can influence or hinder someone from seeking healthcare and is dependent on three factors: that is the predisposing factor (social structure, the health beliefs and the demography), enabling factors which consider the logistics and other ancillary aspects that may boost or impede healthcare services and finally the need factors that is the immediate cause of seeking healthcare.

The study employed both the quantitative and qualitative approaches with respect to three ecological zones in Ghana namely forest (Kwaebibirem), middle (Asutifi) and savannah (Savelugu-Nanton) belts vis a vis the selected districts. Two sets of data were used, that is a secondary data (quantitative) and primary data (qualitative).

The motivation for this study was to investigate why people who are categorized as exempt may be hindered from accessing healthcare due to some socio-economic issues. The study did not consider all the categories of people under exemptions, but rather

limited it to these two cohort age groups (those below 18 years and those 70 years and above) because they constitute about 56 percent of the gross exemption figures. Besides, one is exempted depending on the condition of such person, such as being pregnant, indigent, below 18 years, above 70 years. Also one's current status such as being a SSNIT contributor or a SSNIT pensioner can cause one to be exempted. The main findings of the study are summarized under the following headings: socio-economic factors, health seeking behaviours and the extent of OOP payments at the point of service delivery.

5.2 Socio-economic Factors

Some of the outcomes of the study under this objective were that children 5 years and below and the aged (above 80 years) utilize medical services more than the others due to their vulnerability. Also educational attainment of these age groups indicates that some children who are enrolled, commute long distances to school on daily basis and encounter various hazards on the road. The implication is that the dangers they are exposed to on the roads can affect their utilization of health care. Another finding from the study is that most of the people in the study group were either pensioners or unemployed and the implication is that any financial burden on these people may affect their health care utilization.

The probit model also revealed some factors are statistically significant such as children under five who may be less likely to utilize healthcare services than the very old (over 80 years). Also, people who are exempted do seek medical services more than those who are not exempted and not insured. Fever/malaria tended to be the highest probable disease to send people to seek medical services compared to other forms of sicknesses which the exempt group reported with at the OPDs. Based on the regression analysis, a Christian was more likely to report to a health centre for treatment than a Muslim or a traditionalist and this was 5% statistically significant. Regarding the districts according to the study, people

in Asutifi were likely to utilize healthcare services than their counterparts from Kwaebibirem and Savelugu districts.

5.2.2 The Health Seeking Behaviour of the Exempt Group

This section of the study summarizes the major findings that emerged from the descriptive statistics and the qualitative interviews on health seeking behaviour among the exempt group under study. One major finding was that respondents generally did not know about their current health conditions. This can be attributed to factors such as illiteracy and poverty and others only get to know their health conditions when they become sick. Malaria/fever was the leading reported disease in the OPDs. Regarding where respondents seek treatment, most of them resorted to drug stores and this resulted in self-medication. The rationale for these choices from the study can be attributed to the attitude of health workers. Another interesting finding was that more respondents started their treatment from the primary sources, that is clinics and health centres and this was basically due to proximity. This confirmed the gate-keeping policy being championed by the NHIA which stresses the need for people to seek medical care from the health centres and CHPS compounds which are considered the primary points of health care. Secondary and tertiary treatment can only be sought from these facilities through referrals and by a medical practitioner.

5.2.3 OOP Payment made by the exempt Group

This objective sought to find out why these cohort age groups, although exempt, also make out-of-pocket payments at the point of service delivery and this was answered using the descriptive statistics and the in-depth and focus groups discussions. The insurance status of the respondents seemed encouraging as most of the people were insured due to

their exemption status. However, one interesting finding is that majority of respondents indicated that they paid premium (which is a violation of the NHIS law) and had caused some to even withdraw their membership from the scheme. . Others also gave their reason as the unnecessary delay in the issuing of NHIS I.D cards which at the time of the study was between three to six months and in the extreme cases even up to a year. These findings were all discussed based on the enabling factors under the Andersen's behavioural theory of utilization that is access to health services, health insurance status, and income, regular sources of care, extent and quality of social relations can all motivate or hinder people from access health care.

5.3 Conclusion

The NHIS, with the mandate of ensuring unequivocal access to health care among the Ghanaian populace, has been able to grant access to health care. Also, as a social protection scheme, the NHIS grants exemptions to some of the vulnerable people in our society such as the core poor, aged, children, pregnant women, etc. to harness the social development of this country. However, lack of knowledge among some members of the exempt group about their exemption status, the collection of high premium and the negative attitude of some health professionals as evident from this study needs to be addressed. Also in terms of financial sustainability of the scheme, the NHIA needs to implement innovative ways in order to attain financial sufficiency for this laudable social protection scheme because health financing is a developmental issue. The conclusion of this study is premised along the three objectives; socio-economic factors, health seeking behaviour and the extent of OOP by the exempt at the point of service delivery.

5.3.1 The Socio-economic factors

The study discusses some of the socio-economic factors that affect the exempt when it comes to utilization under the first objective and concluded that among the exempt group under study, in terms of age, the aged (80 years and above) and the toddlers (under 5 years) utilize health care services more than those between the ages of 6 years to 17 years and between 70 years to 80 years. The reason is attributed to the vulnerability associated with these groups.

The findings from the probit model indicated that more females utilized healthcare services as compared to the males. In fact, this was supported by one of the in-depth interviews where it was alluded that men do not see themselves as being vulnerable to diseases as compared to women and children. Therefore the men were adamant to get enrolled onto the NHIS.

5.3.2 Health seeking behaviour among the Exempt Group

Concerning health seeking behaviour among respondents under the study's second objective, it was concluded that that knowing ones' health status is very encouraging as this ensures that the right medical care can be accessed. Also, the study concludes that malaria/fever is still the leading illness reported at the OPDs in the country; yet, heart related diseases have also gone up, especially among the aged.

One interesting finding of the study is the rate at which people are engaged in self-medication due to the proliferation of drug stores and drug peddlers. People resort to different avenues to seek health and the study concludes that many respondents (the exempt) in recent times resort to the hospitals and clinics which are the ideal places to seek care from.

5.3.3 Out of Pocket Payment by the Exempt Group

The last objective was to explore the OOP payments by the exempt group at the point of service delivery. This stems from the fact that subscribers were charged at the point of service delivery under the pretext of co-payment, an illegal form of cost-sharing according to the NHIA. Therefore, from the study it was concluded that some of the exempt still pay annual premium to renew their subscriptions. This is a contradiction to the law which states that apart from pregnant women and the indigent who are not expected to pay anything, other members of the exempt group are only expected to pay processing fees and not premiums. Furthermore, the study sought to find out the expenses these respondents make at the health facilities and concludes that the exempt group still make OOP payments at the health facilities.

5.4 Policy Recommendations

The NHIS was established to ensure that there is equity in health service delivery, improvement in access and also serve as a form of social and financial protection for the aged, poor and vulnerable. The NHIS has achieved remarkable success since its inception more than ten years ago. This is because access to healthcare has increased considerably and also about 95 percent of the disease burden of this country has been listed and covered by the scheme (NHIA, 2012). The findings from the study also indicate that not all the exempt are insulated from OOP payment at the facilities. The study therefore recommends that the regulator (NHIA) should reinvigorate her monitoring mechanisms to ensure compliance.

The study identified that about 56 percent of the insured were below 18 years and above 70 years. What it means is that a lot of financial burden may be brought unto the scheme which can affect the quality of care and also render the NHIS insolvent. Therefore, it is

recommended that the teenage group be made to pay a token premium and this should be instituted by the regulator to augment the scheme's finances.

Regarding identity cards administration, the NHIA would be commended for instituting the biometric registration as a way of addressing the delay with the issuance of these cards. The study therefore recommends that intensive training be given to the scheme managers and their staff in order not to use this biometric registration to siphon money from the already burdened people from these communities.

The perceived high premium charged by most schemes, from the study, has caused some people to relinquish their status. The problem is that these same people who cannot afford the premium are also vulnerable. The study therefore recommends that people who cannot pay the supposedly expensive premium (mostly farmers and fishermen) can substitute with their produce. For instance in the Savelugu-Nanton district, if a household maintains that they cannot pay the premium, yet they have cattle or guinea fowl or millet or groundnuts, what it means is that these commodities can be quantified into monetary terms as premium.

Another area of concern is the self-medication which emanates as a result of people buying drugs from the drug-stores without doctors' prescription. It is therefore recommended that the Pharmacy Council intensify its monitoring activities to flush out these quack drug sellers.

Finally, the poor attitude of some health workers towards patients' leaves much to be desired because the attendant ramifications were that people were becoming apathetic towards seeking health care from the health facilities. Therefore, it is recommended that the Ghana Medical and Dental Council, the Nursing and Midwifery Council and other

stakeholders provide avenues where clients can lodge complaints when they are mistreated and ensure that offenders are penalized to serve as a deterrent to others. Also, more training sessions should be organised for health personnel to enable them provide more humane services to patients.

5.5 Recommendations for Further Research

The study concentrated on two out of all the exempt categories (those below 18 years and the aged 70 years and above) to ascertain their socio-economic factors on utilization. It is therefore recommended that another study extends the investigations on socio-economic factors that affect all categories of the exempt group in relation to the financial sustainability of the scheme in order to fully inform policy on the exemptions.

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APPENDIX

Socially Inclusive Health Care Financing in Ghana

Interview Guide for In-depth and Focus Group Discussions

- Can you please tell us a little bit about yourself?
- What are the various types of health services that are provided in the community?
(Probe for orthodox, herbal, drugs stores, religious, traditional etc.)
- Are all these facilities accessible to all people? (probe for the distribution of these health facilities among the different socio-economic groups)
- What are the primary obstacles facing the community? In terms of environment, geographic, ethnic tension, poor trade route, water or land right, what are the problems?
- Do any groups of people such as the poor, non-educated, women, children, aged experience greater obstacles in accessing community resources or services?
- What is the history of the community?
- Have there been significant changes in the wellbeing of the community? (probe for prosperity have there been significant changes)
- Are there the existence of social groups in this district? (probe for ethnic, religious or cultural groups in this district)
- How socially heterogeneous or homogeneous is the community?
- What are the primary livelihoods of both men and women? (probe for that of the different ethnic groups)
- Are there new entrants that have entered the community recently? (probe for refugees, internally displaced persons, economic migrants)
- What formal and informal groups of association and networks exist in the community? (probe for how these groups were started)

- What are the main functions and of these association? (probe for their implicit and explicit functions)
- How are the leaders selected or what factors contribute to the selection leadership within such group?
- Who are the poor or indigent when it comes to socially excluded health care financing?
- Generally do these people have access to healthcare services?
- Are there mechanisms available that protects the poor?
- Who are community members likely to trust with issues confronting them? (probe for traditional, religious leaders, ethnic, political etc.)
- Do patterns of mistrust and suspicion exist between household members or among groups in this community?
- What are some of the local or cultural practices that create socially excluded groups? (probe for early marriage, widowhood rites, child betrothal, forced marriages, female genital mutilation, traditional practice of ritual bondage of virgins etc.)
- What do people consider the most pressing problems or issues in the community?
- To what extent do the community members work together to solve these problems?
- What cultural practices affect mutual assistance, cooperation and collective actions?
- Are some groups or neighbourhoods / households more likely than others to work together and if so why?
- What kinds of constraints limits people's ability or willingness to work together?
- Are there any social sanctions for violating expected norms of collective action in the community? (probe for examples)
- What are the sources of access to information in the community?
- What are the preferred local sources and channels of information?

- What informal sources of information exist in the community?
- Which members of the community are included or excluded from such sources of information and why?
- What information is available through the different networks?
- What information is not available to different households or groups and why?
- What groups or individuals or network do people feel morally or socially obligated to assist?
- What events or activities usually bring the people together in this community?
- What are the underlying values that people express or emphasize when they come together as a group to achieve a common objective?
- What factors support cohesion in the community?
- How often do people from different social groups intermarry?
- Are there any recurring conflicts among any groups or networks in this community?
- What community patterns of differentiation or discrimination exist in this community?
- What prevent public services from reaching the poorest and most vulnerable groups?
- What are the patterns of inclusion or exclusion in political participation in this community?

Thank you