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UNIVERSITY OF GHANA BUSINESS SCHOOL

**SUBSCRIBER PERCEPTION OF QUALITY OF HEALTH CARE
SERVICES UNDER THE NEW JUABENG AND KETU DISTRICT
MUTUAL HEALTH INSURANCE SCHEMES IN GHANA.**

BY

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DECLARATION

I declare that except for references to other people's works which have been duly acknowledged, this work is the result of my own research undertaken under supervision and has not been presented in part or in whole for the award of any degree anywhere.



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DEDICATION

This thesis is dedicated to my family and friends with love and gratitude for the immeasurable support I received from them in coming this far.



ACKNOWLEDGEMENT

This work owes its form and content to the diverse contributions of several people. I would therefore like to extend to these people in a special way, an unquantifiable big word of gratitude.

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ABSTRACT

The perception that an individual forms about a thing affects that individual's behaviour and attitude towards that thing. The District Mutual Health Insurance Schemes in Ghana are a new way of financing health care in the country. The need to sustain these newly introduced schemes by improving and sustaining quality of health care services under them is extremely important. However, there is a dearth of knowledge on subscribers' perception of the quality of health care services under these schemes. Bridging this knowledge gap is a necessary first step in determining the improvement and subsequent sustainability of the quality of health services provided under the schemes.

A convenient sample of 400 respondents each from the New Juabeng and Ketu District Mutual Health Insurance schemes participated in the study. The empirical research was conducted using questionnaire and interviews to assess subscribers' perception of service quality under the two schemes. Respondents' perception of service quality was measured along the following quality dimensions the level of communication, the demeanour of staff and availability of essential drugs using a likert scale. The scale was anchored 1 and 5 with one being "very good" and 5, "very poor".

The findings of the study indicate that subscribers in New Juabeng rated the overall level of communication and the attitude of staff as good on the likert scale, whilst those in Ketu rated the same quality dimensions as fair. On the issue of availability of essential drugs, 63% of the respondents in New Juabeng said

prescribed drugs were available at the health care facilities and 44% of the respondents in Ketu said prescribed drugs were available at health care facilities in the locality.

Respondents on the two schemes appeared to agree that an explanation on medical tests to be taken by them was important in determining the level of communication, while the courtesy of the nursing staff was a major determinant of the attitude of staffs in the health care facilities.

Respondents recommended that nursing staffs of the various health facilities be courteous and helpful, National Health Insurance Drugs should be in constant supply at the health care facilities and health care facilities be expanded to accommodate the increases in hospital attendance following the introduction of the health insurance scheme.

TABLE OF CONTENTS

Declaration	I
Dedication	II
Acknowledgement.....	III
Abstract	IV
Table of Contents.....	VI
List of Tables	XI
Figure.....	XII
List of Acronyms and Abbreviations.....	XIII
Chapter One.....	1
Introduction.....	1
1.0 Background.....	1
1.1 Problem Statement.....	6
1.2 Objectives of the Study	7
1.3 The Research Questions.....	8
1.4 Significance and Justification for The Study.....	9
1.5 Structure of the Study	10
1.6 Conclusion	11

Chapter Two	12
Conceptions, Determinants and Importance of Quality in Health Care	12
2.0 Introduction.....	12
2.1 The Concept of Quality.....	12
2.2 Determinants of Services Quality	13
2.3 Quality as an Issue in Health Care.....	18
2.3.1 DIFFERENT PERSPECTIVES IN HEALTH CARE QUALITY.....	20
2.4 Importance of Quality and its Measurement.....	22
2.5 The Context of Quality Assurance in Ghana.....	23
2.6 Conclusion	26
Chapter Three	27
Measuring Health Care Quality: The Context of the Study	27
3.0 Introduction	27
3.1 Measuring Health Care Quality	27
3.2 Models for Measuring Quality of Health Care Service	31
3.3 Conceptual Framework for the Study.....	33
3.3.1 LEVEL OF COMMUNICATION	33
3.3.3 AVAILABILITY OF DRUGS	36
3.4 Operational Definitions of Terms	41

3.5 Conclusion	41
Chapter Four	43
Health Reforms and Financing Strategies	43
4.0 Introduction	43
4.1 Sources of Funds for the Health Sector in Ghana	44
4.2 Health Reforms and Financing In Ghana.....	44
4.2.1 THE NATIONAL HEALTH INSURANCE SCHEME.....	48
4.3 District Mutual Health Insurance Schemes In Ghana	51
4.3.1 CASE STUDY 1 - THE NEW JUABENG MUNICIPAL HEALTH INSURANCE SCHEME	52
4.3.2 CASE STUDY 2 - THE KETU DISTRICT MUTUAL HEALTH INSURANCE SCHEME	54
4.4 Conclusion	55
Chapter Five	57
Methods and Techniques of Data Collection	57
5.0 Introduction	57
5.1 Research Design.....	57
5.2.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.....	59
5.3 Sampling Design and Procedures.....	60
5.4 Questionnaires and Indicators.....	62
5.4.1 PRE-TESTING OF QUESTIONNAIRE.....	63

5.4.2 ADMINISTRATION OF QUESTIONNAIRES AND INTERVIEWS	63
5.5 Data Processing and Analysis	64
5.6 Ethical Considerations.....	65
5.8 Conclusion	65
Chapter Six	66
Presentation of Findings.....	66
6.0 Introduction	66
6.1 Demographic Characteristic of Respondents.....	66
6.2 Average Perceptual Judgments.....	70
6.2.1 LEVEL OF COMMUNICATION	70
6.2.2 ATTITUDE OF STAFFS.....	71
6.2.3 AVAILABILITY OF DRUGS	73
6.2.4 GENERAL QUALITY RATINGS	74
6.2.5 RECOMMENDATION OF SCHEME BASED ON QUALITY RATING	75
6.3 Comparative Analyses of the DMHI Schemes.....	76
6.3.1 LEVEL OF COMMUNICATION	77
6.3.2 ATTITUDE OF STAFF	78
6.4 Other Related Issues Emerging from the Study.....	81
6.3.3 COMPLAINTS AND THE HANDLING OF COMPLAINTS	81
6.4.1 UNEXPECTED EXPERIENCES OF RESPONDENTS	82
6.4.2 BEST THING ABOUT NHIS AT THE HEALTH FACILITY	82
6.4.3 WORSE THING ABOUT NHIS IN THE HEALTH FACILITY	83

6.4.4 RECOMMENDATIONS FOR MEETING NEEDS OF SUBSCRIBERS	83
6.5 Quality Before the Introduction of the Schemes	84
6.7 Conclusion	84
Chapter Seven	86
Summary, Conclusions and Policy Implications	86
7.1 Introduction	86
7.2 Discussions	86
7.3 Restatement of Objectives	92
7.4 Summary of Key Findings	93
7.5 Conclusions	95
7.6 Policy Implications of the Study	96
7.6.1 IMPLICATIONS FOR FURTHER RESEARCH	98
7.7 Conclusions	99
References	100
Appendix I	112
Appendix II	116
Appendix III	117
Appendix IV	119
Appendix V	120
Appendix VI	121

LIST OF TABLES

Table 6.1: Gender Distribution of Respondents	67
Table 6.2: Age Distribution of Respondents	68
Table 6.3: Level of Education of Respondents	68
Table 6.4: Occupation of Respondents	69
Table 6.5: Type of Health Facility Used	70
Table 6.6: Rating of Quality Based on Level of Communication	71
Table 6.7: Rating of Quality Based on Attitude of Staffs	72
Table 6.8: Availability and Effectiveness of Drugs under DMHI schemes	73
Table 6.9: General Quality Rating	75
Table 6.10: Rating of Quality and Recommendation of schemes	76
Table 6.11: Comparison on Level of Communication	78
Table 6.12: Comparison on Attitude of Staffs	80
Table 6.13: Complaints on Handling of Complaints	81

FIGURE

Figure 3.1: A Diagram Conceptualising the Variables Used to Assess Subscribers' Perception of Health Care Quality39

LIST OF ACRONYMS AND ABBREVIATIONS

ANA	-	American Nurses Association
BSI	-	British Standards Institute
CBHI		Community Based Health Insurance
CHPS	-	Community Based Health Planning and Services
DMHI	-	District Mutual Health Insurance
GHS	-	Ghana Health Service
GNP		Gross National Product
IGF		Internally Generated Funds
IMF		International Monetary Fund
IOM		Institute of Medicine (American)
L.I	-	Legislative Instrument
MHI		Mutual Health Insurance
MOH	-	Ministry of Health
N. Juabeng		New Juabeng
NHIC		National Health Insurance Council
NHIS		National Health Insurance Scheme
NLCD		National Liberation Council Decree
PHC		Primary Health Care
POW	-	Programme of Work
QA	-	Quality Assurance
RCH		Reproductive and Child Health
SAP	-	Structural Adjustment Programme
SSNIT	-	Social Security and National Insurance Trust

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND

The newly introduced District Mutual Health Insurance (DMHI) schemes in Ghana are a source of financing the ever-increasing cost of medical care. The object of these schemes according to the Policy Framework (establishing the scheme) (MOH, 2004) is to assure equitable and universal access to an acceptable quality package of essential health care for everyone resident in Ghana. The issues of accessibility and affordability are closely linked to that of quality of health care services provided. When users of health care services perceive such services provided as being of good quality and hence valuable, their propensity to pay (financial accessibility) for and utilise these services increases. Understanding the way subscribers perceive the quality of health care services under these schemes may be considered a first step in assessing the sustainability of the schemes in the country.

The cost of health and medical care has increased in the past decade due to expensive medical equipment, buildings, medical malpractice and increasing labour cost of hospitals. The economics of health care systems are however not configured to limit these costs of health care provision (Dorfman, 1987). Health insurance, having been identified as an efficient way of financing health care is also plagued by the problem of increasing health care cost, which in turn threatens the sustainability of health insurance schemes. These threats of sustainability could lead to the insolvency (bankruptcy) of these schemes. Insolvency is a function of several factors including poor quality of services provided by the schemes.

Quality in health care provision has different perspectives to its meaning depending on the person defining it. Generally however, there are two common ways of measuring health care quality: the technical quality and the functional quality measures (Gronroos, 1984; Baker, 1995; Zineldine, 2006). Asubonteng, McCleary and Swan (1996) described technical quality as concerning the competence (professional expertise and qualification) of the service provider and patient outcomes (rate of cure, mortality and disability rates) and Donabedian (1980) describes functional quality as involving the process in health care delivery, such as the quality of nurse-patient interaction, the level of communication and in Africa in particular, the availability of drugs (Baltussen, Haddad, & Sauerborn, 2002). It is thought by many involved in health evaluation that the technical aspect of health care quality exceeds the full understanding of most patients (Baker, 1995; Asubonteng *et al.*, 1996). The functional quality however, is what forms the perception and subsequent behaviour of consumers of health care services as this quality is easily accessible by users of health care services.

In the Ghanaian Times of October 17, 2006 (Abdul-Majeed, 2006) it was reported that members of the Nanumba District Mutual Health Insurance Scheme in the Northern Region of Ghana accused hospital staffs of sabotaging the scheme in the district. By sabotage, the members meant that nurses shouted at them unnecessarily upon presenting of insurance cards; doctors prescribed drugs to be purchased from the open market; and subscribers were asked to wait for long hours before being attended to.

In another development, the Ghanaian Times of October 20, 2006 (Abdul-Majeed, 2006) carried a report that, the Board of Directors of Mfantseman Mutual Health

Insurance Scheme appealed to government to increase the premium from 72,000.00 to 100,000.00 so the scheme could be sustained. On October 25, 2006, the same paper reported that at a conference organised by the Association of Certified Chartered Accountants (ACCA) a participant argued that if more Ghanaians did not join the National Health Insurance Scheme, it would collapse (Atagra, 2006).

The concerns raised in the preceding paragraphs indicate that the DMHI schemes could be at risk in terms of quality of the delivery process as expressed in the Nanumba report, collapse because of low premiums and non-enrolment in the second and third reports. The issues of low-premiums and non-enrolment may be a consequence of poor quality, as a high quality of health services may justify increase in premiums and increase enrolment rates for the sustainability of the scheme.

According to Wiesmann and Jutting (2000), low and unstable tax revenue and cutbacks in public budgets including health care have led to deterioration in the quality of health care services, poorly paid and less motivated staffs as well as shortage of drugs and medical equipment in public health care facilities. These difficulties have led to the introduction of DMHI schemes, based on the concept of Community Based Health Insurance (CBHI) schemes.

CBHI schemes or Mutual Health Insurance (MHI) schemes (Atim, Diop, & Bennet, 2005) emerged as a means of financing health care at the community level made up of people usually not covered by national schemes because of their informal nature¹. The

¹ Informal nature relates to people working in the informal sector, from whom collection of premiums for a national health insurance scheme is usually difficult because of the difficulty in defining the people in this sector.

Nkoranza Mutual Health Insurance scheme in the Brong Ahafo region is an example of such a scheme.

Health insurance as a health financing mechanism has many benefits. Bennet, Gamble, Brant, Raj and Salamat (2004) assert that CBHI schemes are very important because they provide benefits such as improving quality of care through mobilization of additional financial resources. The additional revenues generated for the health care facilities may be used to purchase essential pharmaceuticals, pay supplementary staff, or enhance supplies all of which improve quality of care. The CBHI schemes also provide the health facilities with more reliable cash flow to facilitate planning.

In addition to the above, the CBHI schemes improve quality by strengthening lines of accountability and providing avenue for open dialogues between providers and community members. Perhaps this form of quality assurance is more important than sheer financial resources in terms of improving quality of care. The CBHI schemes offer a forum for discussing quality and providing feedback to health care providers and also for creating more formal health care consumers. It must however be said that this happens when CBHI schemes and providers share common vision and platform.

In spite of all these benefits from health insurance schemes, in some African countries where it has been operational, there have been frequent complaints raised about shortage of drugs and other supplies, rude personnel, dirty hospitals and poor security (Batusa, 1999). The complaints can lead to unwillingness to pay premiums by community members, as the feeling of absence of value for money becomes apparent.

Wiesmann and Jutting (2000) argue that, quality, as an issue in health care provided by health insurance schemes would have to be addressed first and not be an outcome of resource mobilization via insurance. It should also be considered as a necessary pre-condition for a successful implementation of CBHI schemes. An important aspect of quality of care that they advocate is a positive attitude of hospital staff towards insured patients.

The introduction of the DMHI schemes in Ghana has brought about concerns about the quality of service provided. One of the principles underlying the design of the National Health Insurance Scheme is quality care (Ministry of Health, 2004). Under this, the designers of the scheme believe that subscribers to the scheme would utilize the scheme if they perceived providers of service under the scheme to be providing quality service and that subscribers are having value for their money. There is therefore the need to determine the perceived quality of care under the scheme as one of the pre-conditions to findings explanations for the low subscription rate of about 35% of the total Ghanaian population of about 21 million (GBC² telecast, December 15, 2006).

The quality in health care services especially under a health insurance scheme is particularly important because, it could affect its sustainability through renewal as well as new subscription rates. Six times more people hear about a negative customer service experience than hear about a positive one. A positive statement can be a very powerful tool for attracting new customers and negative statement can have a devastating impact on the credibility and effectiveness of organizations to attract new

² Ghana Broadcasting Corporation

customers (Kim, Kim, Im, & Shin, 2003). The sustainability of these schemes may thus be threatened in one way or another.

1.1 PROBLEM STATEMENT

Consumers of a product or service of an organisation hold the key to the survival and success of such an organisation. The issue is in no way different where health care services are concerned. When users of health care services perceive such services provided as being of good quality and hence valuable, their propensity to pay for and utilise these services increase. This was reiterated by Wiesmann and Jutting (2000) when they argued that the issue of quality in health care affects the implementation of health insurance schemes if not addressed.

Sixma, Keressens, Campen, and Peters (1998) assert that patient satisfaction with health care services plays an important role in maintaining relationships between patients and health care providers, compliance with medical regimens, and continued use of medical services. Compliance with medical regimes brings about favourable health outcomes, which is then translated into increased productivity and reduction of poverty.

Mutual Health Organisations have been operating in various communities in the country before the introduction of the DMHI schemes. The MHO are organised by Non-Governmental Organisations (NGO) in collaboration with the communities in which they are established. Subsequent evaluations of these schemes however concentrated on issues such as contributions of the schemes to the creation of access, equity, mobilisation of resources, level of community participation and potential financial viability other than quality (Atim et al, 2000; Atim et al, 2001; Baku, et al,

2006; Agyepong, 1999). Where there is an assessment of quality, it only forms a relatively small portion of evaluation of these schemes.

A dearth of knowledge on subscriber perception of quality under health insurance schemes in the country is evident in these evaluations conducted in the country. The introduction of the DMHI schemes has necessitated the need to do an in-depth study into subscribers' perception of the quality of the services provided. This study therefore is a modest attempt to bridge this knowledge gap by assessing subscriber perception of quality of service under the DMHI schemes in Ghana using the New Juabeng and Ketu districts as case studies.

1.2 OBJECTIVES OF THE STUDY

The main aim of this research was to determine the perception of subscribers on the quality of health care services under the New Juabeng and Ketu District Mutual Health Insurance Schemes in Ghana. To achieve this general objective, the following specific objectives were examined:

1. Subscribers' current perception of the quality of health care services under the New Juabeng and Ketu DMHI schemes in Ghana in relation to;
 - a) the level of communication at health care facilities
 - b) the attitude of staffs towards subscribers and
 - c) the availability of drugs.
2. The relevant service quality dimension(s) used by beneficiaries to evaluate service quality.
3. The particular areas of health care services under the DMHI schemes subscribers consider as most important at the health care facility.

1.3 THE RESEARCH QUESTIONS

Following from the research objectives, the research assumption was that the successful implementation and sustainability of the DMHI schemes in Ghana was threatened by a perceived poor quality of services provided by the schemes. To determine whether this assumption was true, research sought to answer a major question.

What are subscribers' perceptions of the quality of service under the New Juabeng and Ketu DMHI schemes?

In answering this question, some minor questions were answered. These are,

1. What is subscribers' perception of the level of communication with medical staff?
2. How do subscribers perceive the attitude of the staffs of the health facilities they attend?
3. What is subscribers' perception of availability of the essential drugs promised under the schemes?

In operational terms,

The following indicators were considered under the quality dimensions chosen:

1. Level of communication considered;
 - a) the thoroughness with which patients conditions were explained to them
 - b) the level of explanations on medical tests before they were taken
 - c) whether doctors insisted on follow-up from patients and

- d) the level of explanations on the side-effects of prescribed medications.
2. Attitude of staff considered;
- a) the level of help given to subscribers
 - b) the courtesy of the nursing staff towards subscribers
 - c) the level of interest expressed by doctors in patients
 - d) the courtesy of the dispensary staff and
 - e) the difference in treatment if any as experienced by subscribers
3. The availability of essential drugs considered;
- a) whether prescribed drugs were available in the health care facility
 - b) whether prescribed drugs were considered effective

A likert scale of 1 to 5 anchored 'very good' and 'very poor' with 1 being 'very good' and 5 'very poor' was used to measure the quality dimensions. The quality dimensions, which the research questions sought to answer, were further elaborated upon in chapter three of the study.

1.4 SIGNIFICANCE AND JUSTIFICATION FOR THE STUDY

One of the principles underlying the design of the National Health Insurance Scheme is quality care (Ministry of Health, 2004). Health insurance, so far the best form of financing health care, must be sustained and one of the ways in which it could be sustained is when subscribers have a positive perception of the quality of health care services provided under the scheme.

The study would contribute to existing knowledge on patients' perception of health care quality and would form the basis for further research with respect to the national health insurance scheme.

The study would also help the providers of health care services, which were used in the study to know their status regarding consumers' perception of their service. Knowledge of this would help them take any corrective measures necessary.

Since government spends huge amounts money every year on quality assurance in public health care facilities, this study is especially important to public health care providers under the scheme in determining whether the efforts being put into assuring quality are indeed improving quality.

1.5 STRUCTURE OF THE STUDY

This study was divided into seven chapters. The first chapter gave an overall picture of the treatise, discussed the study problem, the objectives of the study and the significance of the study. Chapters two and three gave a theoretical and empirical review of literature on the issue and provided a basis of a working conceptual model which informed the data collected. Chapter four reviewed the development of the DMHI schemes by looking at health policies and the modes of financing them since independence in 1957. Chapter five concentrated on the methods and techniques of data collection. Chapter six presented the findings of the research. The last chapter discusses the findings and the policy implications of these findings on the DMHI schemes.

1.6 CONCLUSION

This chapter provided the overall outline of the study and discussed the rationale for the research, with concentration on the problem to be studied, objectives and research questions to be answered in arriving at the objectives. This work was however limited by the fact that only evidence from two districts was gathered. The two districts used for the study were chosen because they had been in operation for a year when the research was initiated. The relatively younger status of the other schemes as well as time and resource constraints did not permit a wider coverage. This limitation does not however invalidate the findings of this study.

CHAPTER TWO

CONCEPTIONS, DETERMINANTS AND IMPORTANCE OF QUALITY IN HEALTH CARE

2.0 INTRODUCTION

This chapter presents a review of the concept of quality and its relation to health care, its determinants and the importance of measuring it. The aim of the chapter is to provide a theoretical framework within which the study was conducted.

2.1 THE CONCEPT OF QUALITY

Various definitions of the concept of quality can be deduced from literature. Amongst them is the British Standards Institute's (BSI) definition which views quality as the totality of features and a characteristic of a product or service that bears on its ability to satisfy stated or implied needs. Additionally, the Institute recommends that any usage of the term quality should involve a degree of excellence, reflect on the measurement of a product in terms of departure from an ideal and demonstrate fitness for purpose relating to the ability to meet stated needs (La Monica, 1994).

This definition of quality is looking at the ability of a product to perform the function for which it was produced. In health care parlance, this is known as the outcome of health care or technical quality, which is restoring the individual to a healthy position. The definition of quality has however evolved to include the processes involved in the delivery of the product and more importantly, processes involved in service delivery. This process involved in service delivery is best assessed by the consumer of the service and is believed to be a major determinant of the survival of service

organisations such as health insurance schemes (Wiesmann and Jutting, 2000). The focus of this study is the quality of the process involved in health care delivery, as the consumer of the service perceives it.

Quality according to Peter and Donnelly (1998) is the degree of excellence or superiority that an organizations' product possesses. It encompasses both the tangible and intangible aspects of a firm's product or services and could refer to such traits as features, performance, reliability, durability, aesthetics, serviceability and conformance to specifications. They further assert that although quality can be evaluated from different perspectives, the customer is the key perceiver of quality as it is his/her purchase decision that determines the success of an organizations product or service and even the fate of the organisation itself. This definition of quality appears to encompass the delivery process in addition to the features and performance of a product. The consumer, who appears to lack the technical knowledge involved in assess the quality of services relies on the aspects that are experienced such as quality associated with personal contact.

2.2 DETERMINANTS OF SERVICES QUALITY

It would be impossible to define or even ensure service quality without first determining the salient aspects that are incorporated under the term. Ghobadian, Speller and Jones (1994) argue that quality is a multidimensional phenomenon and service or product quality cannot be ensured without determining its salient aspects. This observation is reflective of both previous and current thought on the subject matter as can be inferred from the empirical works, which are discussed in the succeeding sections.

Sasser, Olsen, and Wyckoff (1978) cited seven service attributes, which they believe satisfactorily embraces the concept of service quality. These attributes are: security, consistency, attitude, completeness, condition of the facility, availability of the service and training on the use of the service. Security is an assurance of confidence in and physical safety of the service or product being offered. When consumers perceive that there is a high level of security in a service that is being sold or purchased, quality would be inferably rated high or very good. Consistency has to do with receiving the same service in the same form each time. This means that irrespective of the time or circumstance of the purchase or use of a service, the consumer is assured of the same service in the same form. Attitude is in respect of the interaction between the provider and recipient of a service and is often perceived in a subjective manner. Examples include courtesy shown to the customer and the amount of explanation provided in terms of what needs to be done amongst other things.

The rest includes completeness of the services as the provision of ancillary services is also used as a determinant of service quality. Condition of the facility in which the service is being provided is also considered a determinant of the quality of services provided. The condition is viewed in terms of physical circumstance of the reception area, its neatness, user friendliness and appearance of the site amongst others. Availability of the service in terms of access, location and frequency is another determinant of quality. The service must be easily accessible financially and geographically and must be available at anytime for consumers. Training on the use of the service is the seventh determinant of quality according to Sasser *et al.* (1978).

Gronroos (1983) identified three dimensions of service quality. These are the functional quality of the service encounter, the corporate image and the technical quality of outcome. The functional quality is the same as the attitude and interactive quality discussed earlier. Lehtinen and Lehtinen (1992) also contend that service quality has three dimensions, physical quality, corporate quality and interactive quality. A close look at the works of Gronroos (1983) and Lehtinen and Lehtinen (1992), appears to suggest a consensus on corporate image and interactive quality as fundamental aspects of determining service quality in principle but a question of terminology in their explanations. The technical quality of outcome is the actual outcome of the service encounter. This has to do with whether what the consumer sets out to get was actually gotten, that is, healing from ailment.

Parasuraman, Zeithaml, and Berry (1985) in extending the preceding works, provided a criterion for determining quality of a service. According to them, reliability, responsiveness, credibility, competence, access, security, courtesy, communication, tangible and understanding form the criterion that customers of a service use in determining its quality.

Reliability means that the firm performs the service right the first time. It also means keeping it words concerning what it has promised to provide. Reliability also involves accurate billing, accurate record keeping and performance of services at the designated time.

Responsiveness concerns the willingness or readiness of employees to provide the service. It involves, for example, the immediate mailing of transaction slip to

consumers, calling the customer back quickly, dealing effectively with complaints and giving prompt service.

Credibility involves trustworthiness, believability and honesty, having the customers' best interest at heart. The service providers' name and reputation and the personal traits of the frontline staff all contribute to credibility.

Competence means the staff must possess the necessary skills, knowledge and information to perform the service effectively. This involves knowledge and skills of the contact personnel, operational support personnel and the research capability of the organization.

Access, used in determining quality of services provided, involves approachability and contact that is, the convenience of opening hours, telephone accessibility and the convenient location of the service facility.

Courtesy in determining quality according to Parasuraman *et al* (1984) means the politeness, respect, consideration and friendliness shown to customers by the contact personnel.

Security, as a determinant of service quality, means freedom from danger, risk and doubt. It involves personal safety, financial security and confidence in the service being rendered.

Communication involves keeping customers informed about the service in a language that can be understood by them and listening to them as well. It may mean that the company has to adjust its language for different customers – increasing the level of sophistication with a well-educated customer and speaking simply and plainly to a novice. It involves explaining the service itself, explaining how much the service would cost, explaining the trade-offs between service and cost and assuring the customer that a problem will be handled.

Tangibles involve the state of the facilities, goods, physical condition of the buildings and the environment, appearance of the personnel as well as the conditions of the equipments.

Understanding the customer involves making the effort to understand the customers' needs and specific requirements, providing individualized attention and recognizing the regular customer.

The various factors explained above are used in determining the criteria to be used in determining and measuring health care quality. The definition of quality at any time would therefore be dependent on the criteria that the person wanting to measure it uses. Philip & Hazlett (1996) advised that in examining the determinants of service quality, it is necessary to differentiate between quality associated with the process of service delivery and quality associated with the outcome of service judged by the consumer after the service is performed.

It can be observed from the literature on the determinants of service quality that, the authors seem to have a consensus on what factors determine service quality. However, it is the terminologies that are different. What has been observed is that communication with providers of the services rings out as a dominant determinant and so also does the physical condition of the facility.

2.3 QUALITY AS AN ISSUE IN HEALTH CARE

In the previous section, the concept of quality and the determinants of service quality were discussed. This subsection explores the quality issue further. It attempts to look at quality in health care in general as well as the definition of quality by the different groups involved in the provision and delivery of health care. The definition, measurement and improvement in health care quality have been important issues with no definite definitions. Health care is the diagnosis, treatment or rehabilitation of a patient under care, accomplished on a one-on-one basis (Gordon, 1993). Health care services are therefore those activities that involve the diagnosis, treatment or rehabilitation of a patient under care.

The Institute of Medicine (IOM)³ (1994) defines quality of care as the degree to which health services, individuals and populations increase the likelihood of desired health outcomes that are consistent with current professional knowledge. An explanation of the definition would give a better understanding of the terms used in the definition.

³ IOM is a component of the American National Association of Sciences in Washington DC

'Health services' refers to services that affect physical and mental illness, prevention of diseases and promoting health and well-being as well as acute, long-term rehabilitative and palliative care.

"Individual and population" refer to how specific episodes of care are provided to the individuals and how this is reflected in the health status of the population as a whole.

"Desired health outcomes" refer to health outcomes that the patient desires and highlights the link between how care is provided and its effect on health, alternative medicines and consideration of patients and family satisfaction with health care services.

The phrase "increase the likelihood" means that quality is not identical to positive outcomes. Individual difference can bring about poor outcomes even when best care is provided. Good outcomes could also result when poor care is provided. This means that both the process and outcome of health care are important in assessing quality in health care.

The expression, "current professional knowledge" as used in the literature, emphasises the point that health care professionals must be abreast with current developments in their various fields and use such knowledge appropriately to achieve better health outcomes.

The IOM's definition is very comprehensive and includes technical as well as functional measurements of health care quality. The phrase "desired health outcome"

refers to how patients' desire health care (that is the process involved in the delivery of the service) and it is a very important aspect of the definition of health care quality as it determines the satisfaction of patients with health care services.

A patient satisfied with the delivery process according to Sixma *et al.* (1998) is more likely to comply with medical regimes and continue using health services. The assessment of quality from the patients' perspective, therefore, can be effectively done by looking at the delivery process involved. This delivery process is mainly concerned with the interpersonal relationship between patient and the health professional encountered in the process of acquiring health care.

Apart from the IOM's definition, parties interested in health care also have their own definitions of health care quality. Camilleri and O'Callaghan (1998) and Øvretveit (1992) identified three parties interested in health care quality. The parties identified are the providers of the service (that is, the health care professionals); the users of the service (that is, the patients); and those who manage the services (that is, the health service managers). A fourth party made up of purchasers of the service and policy makers has been identified (Morgan and Everett, 1990).

2.3.1 Different Perspectives in Health Care Quality

The providers of health care are the professionals such as medical doctors, nurses, pharmacists, and other health care professionals who provide health care services. Historically, quality has meant to the health care provider, clinical quality of care offering technically competent, effective, safe care that contributes to an individual's

well being. Health care professionals tend to define quality in terms of the attributes and results of care provided and received by patients.

The perspective of the health care professional emphasizes the technical excellence with which care is provided (Blumenthal, 1996). Bannerman, Tweneboa Offei, and Acquah (1992) provide the following as specific concerns of quality for health care providers: outcome of treatment like speedy recovery, mortality rate, and low reattendance rates and motivation factors such as transport, accommodation, sick benefits, good salaries as well as training and development. Although the perspective of the health care professional is important in defining quality in health care, other perspectives are also important.

According to Blumenthal (1996), health care plans and organizations include both private and public health insurance plans and public programmes that purchase health care for the poor and aged in the society. This group of parties interested in quality of health care concentrate on the health of enrolled members and on attributes of care that reflect the functioning of organisational systems. This includes accessibility, measured by how long patients wait for an appointment or whether specialists services are available within a given health care organization.

The clients are those who go to providers for cures to various ailments that afflict them. According to Kols and Sherman (1998), clients' quality depends largely on their interactions with providers and attributes such as waiting time, level of privacy and access to care. Quality from the clients' perspective is being redefined as the way clients are treated by the system (Bannerman *et al.* 2002). When health care systems put clients first, they offer services that do not only meet technical standards of quality

but also satisfy the client's need for other aspects of quality such as respect, relevant information, access and fairness. The concerns of clients include good staff attitude, maintaining clients' dignity, respecting clients, comprehensive information about services and fees and a follow-up with clear instructions amongst others (Bannerman *et al.* 2002).

The different perceptives of these groups of people on the quality of health care would reflect how it is measured. Whilst health care plans and organizations are interested in quality from attributes such as accessibility and availability of specialist services, health care providers are interested in the technical excellence of the service provided. Though concentration on the technical excellence of the service provided is important, the consumer does not have the technical knowledge to be able to assess it. The attributes that the consumer can effectively assess are the interactive attributes in the hospital. Quality measures in this dimension although subjective are the focus of this study.

2.4 IMPORTANCE OF QUALITY AND ITS MEASUREMENT

Health care services also have the attribute of services in general – inseparability - as being produced and consumed at the same time (Gabbot & Hogg, 1999). It is therefore very important to know how users perceive it all the time. Assurance of good quality in health care service delivery is an ethical obligation of health care providers, as well as organisers of health plans (Koenig, Hossain, & Whittaker, 1997). The importance of having such knowledge all the time is discussed in the succeeding paragraphs.

Sweeney, Brooks and Leahy (2003) identifies three relevance of measuring patients' perceptions of health care quality, it serves as a structured mechanism for patient feedback and communication. It also serves as an important performance indicator of subsequent health related behaviour and overall organizational effectiveness.

Evaluation of health care provision is essential in the ongoing assessment and consequent quality improvements of medical services (Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002). Service quality affects the repurchase intentions of both existing and potential customers. Research (Tschol, 1994) has shown that customers dissatisfied with a service will divulge their experiences to more than three other people. In another research, it was established that, six times more people hear about a negative customer service experience than those that hear about a positive one. Positive statements about a product or service can be a very powerful tool for attracting new customers. Negative statements can also have devastating impact on the credibility and effectiveness of the organizations efforts to attract new customers (Ghobadian, Speller, & Jones, 1994).

2.5 THE CONTEXT OF QUALITY ASSURANCE IN GHANA

Assuring quality is important in ensuring continuous use of health care and compliance with medical regimes amongst others. A fall in the quality of health services can result in patients waiting for ailments to aggravate before seeking health care. When this happens, the results include increase in treatment costs and complications that patients suffer as a result of late treatment. Compliance with medical regimes reduces the probability of diseases becoming resistant to drugs. Compliance prevents the situation where resistance leads to the production of more

drugs at extra cost to health care delivery. The problems associated with poor service delivery have led to the introduction of the concept of quality assurance.

Quality Assurance (QA) in health care is a planned, systematic approach for continuously monitoring, measuring and improving quality of health services with the available resources, to meet the expectations of both providers and users (Bannerman *et al*, 2002,). St. Martin (1986), in the American Nurses Association (ANA, 1986), defines QA as activities to estimate and increase the level of excellence in the alteration of the health status of consumers, attained through review of providers' performance of diagnostic, therapeutic, prognostic or other health care activities. Quality Assurance is cyclic, intermittent and retrospective (St. Martin, 1996).

A management concept, developed by Juran (1992) for assuring quality in health care is in the form of a triangle. Each of the three points of the triangle represents quality design, quality control or quality improvement. These points are essential and interrelated and mutually reinforcing components of quality assurance.

Quality design is the planning process in quality assurance. It defines the organization's mission, clients and services. It allocates resources and sets the standards for service delivery. **Quality control** consists of monitoring, supervision and evaluation that ensure that every worker and unit meets those standards and consistently deliver good quality services. **Quality improvement** aims to increase quality and raise standards by continually solving problems and improving processes.

Concerned with the low utilization levels and poor quality of health services in government and mission health facilities in Ghana, the Eastern Regional Health Administration in 1992 investigated the quality of health care issue in two districts in the Eastern Region of Ghana. It was found out that the quality concerns of the people included:

1. Poor quality care to the public.
2. Delay in attending to emergency cases.
3. Shortage of vital drugs.
4. Lack of maintenance of hospital facilities.

In the Ghanaian Quality Assurance Manual (2002), the effects of poor health care quality were listed as including loss of customers, loss of lives, loss of revenue, loss of material resources, loss of time, loss of morale, loss of staff, loss of trust, loss of respect and loss of recognition.

In 1994, therefore, a set of quality indicators were developed and tested in some health care facilities. These indicators were found to be valid, reliable, sensitive to variations in the different socio-cultural practices of Ghanaians and feasible for health staffs to measure. A Quality Assurance document was therefore developed in April 2002, and it is currently being used to monitor the level of health care quality in the country.

In the Ghanaian Quality Assurance Manual, the dimensions of quality listed are: access, equity, amenities, technical competence, efficiency, effectiveness, safety, continuity of service and interpersonal relations in health care. In substance, the

Ghanaian model has been fashioned along the lines of propositions of the researchers discussed earlier.

However, it can be observed from the quality dimensions in the Ghana Quality Assurance Manual that factors that measure both technical and functional qualities are part of the quality indicators established. This can be seen as an attempt to measure service quality in its totality. Whilst this document was made to assess health care quality in the various health care establishments in the country, it could be used to assess quality of care provided under the health insurance scheme operational in the country. However, since the focus of this study is quality from the user perspective.

2.6 CONCLUSION

This chapter has reviewed thoroughly quality in health care, the different perspectives of quality in health care and its importance as well as the importance of measuring it. The development of quality assurance in Ghana has also been discussed. This has formed the basis for the theoretical review on health care quality measurement and a further development of a conceptual framework in the succeeding chapter.

CHAPTER THREE

MEASURING HEALTH CARE QUALITY: THE CONTEXT OF THE STUDY

3.0 INTRODUCTION

Some theoretical and operational definitions of health, quality in health care and ways of measuring quality in health care are critically examined. In the context of the definitions, a framework is then formulated within which this research is cited.

3.1 MEASURING HEALTH CARE QUALITY

The measurement of health care quality is an elusive but achievable goal. This is because health care is not a single product but it entails several components and different professionals are involved in its provision (Bodenheimer, 1999). While some measures use the process involved in its delivery, others focus on the outcome to the client of the service. Whichever measure is used, however, the ultimate aim is to determine the quality or otherwise of the health care provided.

Donabedian (1966) proposed a triad perspective for assessing health care services. These are: structure, process and outcome. Studying the settings in which health care takes place and the instrumentalities used in the provision of care is the assessment of structure. This assessment of structure is concerned with such things as the adequacy of facilities and equipment, qualification of the medical staff and their organization, the administrative structure and operations of programmes. Here the assumption is that, given the proper settings and instrumentalities, good medical care will follow. According to Bannerman *et al.* (2002) structure quality refers to the availability and

quality of inputs needed to carry out an activity or deliver a service, the numbers and types of personnel, how well-trained they are and what systems there are to motivate, develop and retain them.

Examination of the process itself rather than the outcome is another measure of quality of health care services. This is justified by the assumption that one is interested not in the power of medical technology to achieve results but in whether what is now known to be 'good' medical care has been applied. Judgments are based on considerations such as appropriateness, completeness and redundancy and information obtained through clinical history, physical examination, diagnosis and tests, justification of diagnosis and therapy, continuity of care, acceptability of care to the recipient amongst others. The estimates of quality one obtains using this method is less stable and less final than those that are derived from the measurement of outcomes. They may however, be relevant to the research question at hand, how consumers perceive the quality of health care provided.

Process quality is the manner in which services are actually rendered to meet expectations. Examples of process issues in delivery of care are: waiting time, information flow and rapport with patients, receiving patients, privacy, adherence to professional standards and guidelines (Bannerman *et al.*, 2002). Widtfeldt and Widtfeldt (1992) explained process in health care parlance as connoting examining what must happen, when, by whom and in what sequence. It is the interaction amongst staff and clients (individual, family and the community). It takes place in both the administrative and clinical areas (in the community health centre).

The outcome of medical care, which includes recovery, restoration of function and survival, is frequently used as an indicator of quality of health care. Examples are studies on prenatal mortality, surgical fatality rates and social restoration of patients discharged from psychiatric hospital. The advantage of using outcome, as a measure of health care is that the validity of outcome is seldom questioned. Outcomes also tend to be fairly concrete and as such seemingly amenable to more precise measurement. Bannerman *et al.* (2002) express outcome quality as being measured by the results of care which are, satisfaction of patients with services, recovery of patients, utilization, re-attendance, and re-admissions complications and deaths.

The relationship between structure and process and structure and outcome is often not well established (Brook, McGlynn, & Cleary 1996; Flynn & Ray, 1987). According to Brook *et al.* (1996), if quality of care criteria based on structural or process data is to be credible, it must be demonstrated that variations in the attribute they measure lead to differences in outcome, and if outcome criteria are to be credible, it must be demonstrated that differences in outcome will result if the processes of care under the control of the health professional are altered. The concepts of structure, outcome and process are interactive and they all influence the overall quality of health care services.

Other literatures cite two ways of measuring health care quality. These two methods relate closely to Donabedian's structure and process measures of health care. They are Technical and Functional Quality (Gronroos, 1984; Baker, 1995; Zineldine, 2006) respectively.

Technical quality also known as Clinical Performance Measures (Zineldine, 2006) or Physical Quality (Asubonteng *et al.*, 1996), in the health care environment is defined

on the basis of the technical accuracy of the diagnosis and procedures, the application of science and technology of medicine to the management of the personal health care problem (Donabedian, 1980).

Even when outcome is specific, the consumer does not know if the health care service has been delivered in the most effective or efficient way. For example, the patient would know his/her symptoms have been relieved but not that he/she has been cured. Technical quality of care is said to have two dimensions, the appropriateness of the service provided and the skill with which appropriate care is performed (Palmer, 1991; Blumenthal, 1996). Various techniques for measuring technical quality have been proposed and are currently in use in health care organizations. Because this information is not generally available to the consuming public, knowledge of the technical quality of health care services remains within the purview of health care professionals and administrators (Bopp, 1990). This measure of health care quality, because of its technical nature, and the fact that the health care consumer has little information on what criteria to use in assessing it is not the actual focus of this study

Functional quality also referred to as “Consumer Ratings” (customer satisfaction) in some literature is the manner in which health care service is delivered to the patient. This involves interpersonal relationships – that is the social and psychological interaction between the client and the practitioner (Donabedian 1980). Functional quality also refers to the facilitating goods that enable service to be performed, the relationship aspects, the willingness to help, the knowledge and courtesy of staff and the individualized attention to customers (Gabbot & Hogg, 1999). Since patients are often unable to accurately assess the technical quality of a health care service,

functional quality is usually the primary determinant of patients' quality perceptions (Donabedian, 1980; 1982; Kovner & Smits, 1978; La Monica, 1994).

There is growing evidence to suggest that this perceived quality is the single most important variable influencing consumers' value perceptions. These value perceptions, in turn, affect consumers' intentions to purchase products or services (Bolton & Drew 1988; Zeithaml, 1988; Blumenthal, 1996).

3.2 MODELS FOR MEASURING QUALITY OF HEALTH CARE SERVICE

The determinants of service quality established by Parasuraman *et al.* (1985) were further developed by them in 1988, into a five dimensional construct of perceived service quality known as SERVQUAL. Its purpose was to provide an instrument for measuring service quality that would apply across a broad range of services with minor modifications in the scale to suit a particular service industry. The five dimensions are: (1) tangible – physical facilities, equipment, and appearance of personnel; (2) reliability – ability to perform the promised service dependably and accurately; (3) responsiveness – willingness to help customers and provide prompt service; (4) assurance – knowledge and courtesy of employees and their ability to inspire trust and confidence; and (5) empathy - caring, the individualized attention the service provider offers its customers.

The scale contains 22 pairs of items. Half of these items are intended to measure consumers' expected level of service for a particular industry (expectations). The other 22 matching items are intended to measure consumer perceptions of the present level of service provided by a particular organization (perceptions). Both sets of items are presented in seven-point Likert response format, with the anchors "strongly agree" and

"strongly disagree." Service quality is measured on the basis of the difference scores by subtracting expectation scores from the corresponding perception scores.

The premise of SERVQUAL is the assumption that the difference (gap) between a patient's expectation and a patient's perception reflects the quality performance of a given service (Camilleri & O'Callaghan, 1998).

The main critics of this model have been Cronin and Taylor (1992) who argues that, little if any theoretical or empirical evidence supports the relevance of the expectation-performance gap, as the basis for measuring service quality. Expectation, they argue, plays no significant role in the conceptualization of service quality. They therefore came up with a model that measures performance only (perception only).

Cronin and Taylor (1992) proposed an alternative to SERVQUAL, a model for measuring service quality termed "SERVPERF". This is a performance (perception only) based measure of service quality. It is composed of a 22-perception item scale like the SERVQUAL with the same five item construct but excludes any considerations for expectation, which is dominant in the SERVQUAL measure. The perception only measure of service quality appears to have higher convergence and predictive validity (Buttle, 1996). According to Collier and Bienstock (2006) current studies into service quality have started to show more support for the exclusion of expectations in measuring service quality.

The dimensions of service quality attributes on both the "SERVQUAL" and "SERVPERF" measure functional quality. However, constructs such as tangibles and reliability are not of particular importance to the subject matter of this research. The National Health Insurance Scheme is too young for the study to include factors such

as physical facilities, equipment, and appearance of personnel since the old facilities are the ones still in use. However attributes such as responsiveness, assurance and empathy which only need attitudinal change are of major concern to the researcher.

3.3 CONCEPTUAL FRAMEWORK FOR THE STUDY

As the developers of SERVQUAL have pointed out, the model could be adapted or supplemented to fit the characteristics or specific research needs of particular organisations (Parasuraman, Zeithaml, & Berry, 1988). In adherence to this therefore, a framework has been developed within which service quality would be examined in this study.

As discussed in the preceding chapter, attitudinal or interactive quality is very important in determining health care quality. This quality comes in the form of the level of communication and attitude of staffs. This two attributes have been taken from the literature and from empirical evidence of other researches a third attribute has been added which is that availability of drugs. These constructs have been fully discussed in the succeeding paragraphs.

3.3.1 Level of Communication

Communication is the process by which information is transferred from one person to another. According to Eyre (1983) communication is not just the giving of information, but is the giving of understandable information and receiving and understanding the message. It is the transferring of a message to another party so that it can be understood and acted upon. Communication involves actions (sharing of information), reactions (a response to the shared information) and interactions

(exchange of messages between senders and receivers) (James, Ode & Soola, 1999). The communication process is very important in the delivery of health care services because the sender of the message, the health care provider, needs to let the patient, the receiver of the message, know about the processes involved in the treatment and there need to be a reaction from the patient to show understanding so that treatment regimes would be complied with.

Service operations depend on consumers to articulate their needs or provide information. The accuracy of the information and the ability of the service provider to interpret this information correctly have a significant influence on the consumers' perception of service quality.

According to Andeleeb (1998), communications with patients can greatly affect the healing process. He argued that if a patient felt alienated, uninformed, or uncertain about health outcomes he/she could take longer to heal and that communication was vital to delivering service satisfactions in the hospital setting.

Information given to clients enables users (example of a family planning product) to employ the method effectively and to appreciate the methods' potential to create physical changes, healthy or unhealthy feelings and the impact of these experiences on daily activities and the most intimate aspects of partnerships (Bruce, 1990).

Bruce (1990) advises that the client/provider contact should be characterized by two-way communication question-asking and flexible guidance (as opposed to authoritarianism) on the part of the provider should be encouraged. She mentions that

the desired outcome from this interaction from the point of view of the provider may be that the client reports a belief in the competence of the provider, trust of the personal nature and willingness to make contact again them, and even refer others.

Under the rights of the patient in the Patients Charter produced by the Ministry of Health of Ghana in February 2002, a patient is entitled to full information on his/her condition, management and the possible risks involved except in emergency situations when the patient is unable to make such a decision and the need for treatment is urgent. The patient is also entitled to know of alternative treatment(s) and other health care providers within the Service (Ghana Health Service) if these may contribute to improved health outcomes (Ministry of Health, 2002).

3.3.2 Attitude of the staff

The attitude of staff in this study is concerned with the demeanour of the staff towards consumers of health care services. The attitude of staff is in relation to courtesy, respect and their helpfulness. When relating to customers, the general demeanour of the staffs' in the various service settings can have a significant impact on customer satisfaction (Andaleeb & Simmonds, 1997). Again, in the hospital environment, past studies have shown that the manner in which the staff interact with patients and the staff sensitivity to patients' personal experience are most important to customer satisfaction (Andaleeb, 1998; Press & Ganey, 1989).

According to Ghobadian *et al.* (1994), the delivery of service often involves some form of contact between the consumer and service provider. The behaviour of the service provider influences the consumer's perception of quality. It is difficult to

assure consistency and uniformity of behaviour. Moreover, it is not easy to standardize and control this facet of service delivery. In effect what the firm intends to deliver may be entirely different from what the consumer receives.

In a research conducted in a District Hospital in the North-West England under the British National Health Service (NHS) in 1999 on patients and relatives experience and perspective of “good” and “not so good”, it was established that the nature of care provided and the interpersonal aspects of caring emerged as key quality issues for patients. Good quality care was characterized as individualized, patient-focused and related to need; it was provided in a humanistic manner, through the presence of a caring relationship by staff that demonstrated involvement, commitment and concern. “Not so good” care was regarded as routine, not related to need and delivered in an impersonal manner, by distanced staff that did not know or involve patients (Attree, 2001).

In another survey conducted on the Dodowa (Dangme West) Community Health Insurance Scheme, which was a pilot project for the National Health Insurance Scheme, Atim *et al.* (2001) found that non-subscribers, when asked why they had not enrolled explained that there was a problem with the quality of care. The non-subscribers defined the quality of care as health worker discriminating against the insured.

3.3.3 Availability of Drugs

The availability of drugs in any health care facility is very important, as patients go to health care facilities to be diagnosed and treated, mostly with drugs. Assurance of the

availability of drugs in a health care facility could boost confidence in utilising such facilities. The cost of drugs is normally on the increase and with a national health insurance scheme, what subscribers would naturally expect would be the availability of drugs for their illness. In a study conducted in Burkina Faso by Baltussen *et al.* (2002) on quality of primary health care services, it was discovered that the quality and adequacy of resources and services was valued as relatively poor. Respondents were said to have criticized the absence of drugs for all diseases on the spot.

Other studies (Abu-Zaid & Dann 1985; Waddington & Enyimayew, 1989; Parker & Knippenberg, 1991; Litrack & Bodart, 1993; Bitran, 1995) conducted in several African countries, reveal that drug supply is a very important determinant of the utilization of health service. These studies suggests that appropriate drug policies are likely to be amongst the single most important policy actions that could improve quality of health care.

In a study conducted in Ogun State, Nigeria on the cost of health care and its effect on utilization, it was found out that improvement in drug availability elicited large responses. Full availability of drugs in both public and private health care facilities induced patients to move from self-care and the private sector to public care in substantial proportions (Wouters, 1991).

Factors identified as affecting patients' perception of health care quality in Ghana are accessibility to health care facility, distance from the facility, ease of getting to the facility, convenience, costs, humanness, technical competence, information provision to clients, bureaucratic arrangements and efficient, physical facility, continuity of

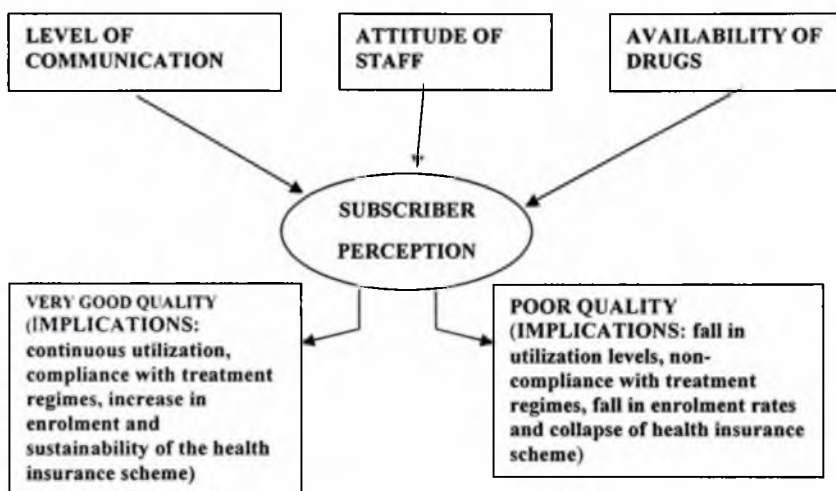
care, outcome of care, availability of drugs, supplies of essential drugs and equipment. Agyepong (1999), reporting on a pilot NHIS in the Dangme District in Ghana, again reiterated that, there was the continuous problem of clients being asked to buy drugs outside the health care institution. This has caused inconvenience and financial strain on people since it may entail travel outside the community. Some patients even suspect that the public sector workers may be in league with private drug sellers, making sure patients buy drugs privately so the public workers can get a percentage of the profit – otherwise, why should hospitals run short of a drug that is readily available on the market?

In another evaluation done on the Nkroranza Mutual Health Insurance Scheme, several perceptions relating to quality were noted particularly by 15 focus groups of non-subscribed members. These perceptions were the cause of respondents not joining the scheme. Six groups out of the fifteen said they experience discrimination against insured members, seven groups said non-insured received better treatment, six groups complained about staff attitude towards insured which they considered discouraging amongst other complaints (Atim & Madjiguene, 2000).

From the discussions in the preceding paragraphs, the dependent variable in this study is the perception of subscribers of the quality of health care services provided under the DMHI schemes in two districts. The independent variables are the level of communication experienced in the health care facilities, the attitude of the staff towards insured clients and the availability of drugs in the various facilities operating under the National Health Insurance Scheme.

A model for easy conceptualization of the variables used in determining the subscriber perception of quality of health care services provided under the DMHI scheme has been provided in figure 3.1.

Figure 3.1 - A diagram conceptualizing the variables used to assess subscribers' perception of health care quality



Level of Communication – is examined in the context of how much information about patients medical conditions are relayed to them. The study seeks to find out whether the patient is allowed to thoroughly explain his condition before prescription is given, information regarding the side-effects of drugs are given, whether reasons for medical examinations are given.

Attitude of Staff – The attitude of the staff according to literature is said to affect utilization rate, compliance with treatment and recommendation of a product or

facility to others. This study attempts to find out if the hospital staffs are responsive and courteous to the needs of patients and whether there is a difference in the way subscribers and non-subscribers are treated.

Availability of drugs – drugs are deemed very important in the treatment of diseases and most people go to the hospital for the right drugs to be prescribed for their condition. The NHIS is said to cover 90% (Ministry of Health, 2004) of all diseases and hence the drugs to treat them. The study is an attempt to find out if drugs prescribed are available in the health facility.

The assumption is that the variables level of communication, attitude of staff and the availability of drugs in a health care facility would shape the perception of users of health services under the DMHI schemes. The perception created could be a good perception which would then be translated into continuous utilization, compliance with treatment regimes, increase in enrolment and ultimately lead to the sustainability of the health insurance scheme (Sixma, *et al.* 1998) or a bad perception.

On the other hand, however, if a poor perception is created based on the variables, the implications are; fall in utilization levels, non-compliance with treatment regimes, fall in enrolment rates and probable collapse of the health insurance scheme. These implications are expressed by Rust, Zahorik and Keiniingham (1996) when they stated, “if we view the organization as a service, then what matters is quality as perceived by the consumer; if the consumer perceives quality as bad, it matters little then that “objective” quality may be good” (p.228).

It is believed that the perception of the three independent variables would lead to the determination of quality of health care being either very good or poor.

3.4 OPERATIONAL DEFINITIONS OF TERMS

District Mutual Health Insurance (DMHI) scheme is a fusion of Social Health Insurance Scheme for the Formal Sector workers and the traditional Mutual Health Insurance Organizations for the Informal sector organized in the various districts of the Ghana. It would thus incorporate members from for the formal and informal sector.

Perception is defined in the study as a positive or negative feeling towards quality care.

Quality health care service in this study refers to the highest grade of excellence of care from the subscribers' point of view. The dimensions used to determine quality of health care service in this study are level of communication between patients and hospital staff, the attitude of the staff as perceived by the patient and availability of essential drugs as provided by the scheme.

Patient/ Subscriber: It refers to recipient of health care services who is enrolled under any of the two DMHI schemes mentioned in the study and who has used a health care facility under the scheme for at least two times.

Essential Drugs: this refers to drugs that have been labelled as such under the scheme.

3.5 CONCLUSION

The measurement of health care quality is very important in determining whether health systems goals are being achieved. Different groups interested in health care

have different perspectives on what they look out for in terms of quality. However, according to Baltussen *et al.* (2002) patients' perception of quality of care is critical to understand the relationship between quality of care and utilization of health services and it is increasingly being treated as an outcome of health care.

In this chapter, different perspectives on measurement of quality and health quality in particular measurement of health care services out of which a framework has been developed within which this research would be conducted. No pre-determined or universal standards exist for the evaluation of the quality of a service – that is services are subject more to social, cultural and national boundaries. Therefore when designing or developing a model that is intended at measuring service quality, these boundaries and many other factors must be taken into account (Philip & Hazlett, 1996). This has been observed in the development of the framework described above. This framework is reflected in the process involved in data collection for this study in the succeeding chapter.

CHAPTER FOUR

HEALTH REFORMS AND FINANCING STRATEGIES

4.0 INTRODUCTION

Health care financing in Ghana has gone through a chequered history. Immediately after independence, health care provided to the people was “free” in public health facilities. However, beginning 1969, to 1985, user fees were introduced successively through legislations. The user fees were as a result of economic difficulties during the period. The World Bank and The International Monetary Fund (IMF) advocated the introduction of the Structural Adjustment Programme (SAP) to restore the economy. The SAP led to the removal of state subsidies for the public sector operations, health care services inclusive. The results were the deterioration of health care facilities and falls in utilisation levels.

In order to improve access to health care services, a law establishing a national health insurance scheme was enacted in October 2003 known as the **National Health Insurance Scheme (NHIS)**. The national scheme was further decentralised into District Mutual Health Insurance Schemes, which are in charges of providing mutual health insurance services at the district level. The ultimate vision of the scheme is to assure **equitable and universal** access to health care for all residents of Ghana. The NHIS is meant to cover the 20% user-fees being charged at the point of service provision. The remaining 80% will continue to be from tax revenues and donor funds (Ministry of Health, 2004).

This chapter traces this history further and provides an understanding of the events leading to the introduction of the DMHI schemes. The history would provide an insight into the need to know perceived quality, a first step in ensuring sustainability of the health insurance scheme.

4.1 SOURCES OF FUNDS FOR THE HEALTH SECTOR IN GHANA

Ghana's health sector is financed through the Government of Ghana, Donor Pooled funds, Donor Earmarked funds and Internally Generated Funds (IGF) (GHS, 2003) and local donations from philanthropists. The Government of Ghana funds is from budgetary allocations of the consolidated vote. Mission hospital gets subventions from the budgetary allocation as well. Donor pooled and earmarked funds are external aid funding for the sector. The pooled funds are from various countries and organisations that are pooled into an account for use by the health sector. The earmarked funds are also contributions by donors that are given for specific projects in the health sector. Sometimes the donations come in the form of vaccines for immunizations. The IGFs come in the form of user charges. The Hospital Fees Regulation L.I. 1313 of 1985 introduced this system into public hospitals and the hospitals keep these internally generated funds to supplement the annual budgetary allocation from the Ministry of Health (Ackon, 2003). The budgetary allocations as well as the donor funds form about 80% of the total financing for the health sector.

4.2 HEALTH REFORMS AND FINANCING IN GHANA

The Ghanaian health care system has been modelled along the lines of its colonial master, the British. The first government health services in Ghana can be traced back to 1880 when the Gold Coast Medical Department was established and concentrated

on providing health care for the European population and government official in particular (Dummett, 1993). The system was focused on curative rather than preventive health services. Funding of health care was the sole prerogative of the colonial government at the time, or the missionaries where they were involved in the provision of health services.

After independence from colonial rule in 1957, the government at the time, embarked on massive development in infrastructure and human resource for health. As a result, by 1963, health centres in the country totalled forty-one and health personnel totalled 3169 and these include 379 doctors, 28 dentists, 954 midwives 1453 nurses and 355 pharmacists (Twumasi, 1975). Health services were in public health facilities free and funding of the health sector was entirely from government budget.

Commoditisation of Health Services in Ghana

However, between the 1970s and early 1980s, the global oil crisis from the sudden hike in oil prices on the international market severely affected the country. This immediately resulted in balance of payment difficulties, heavy debt burden and general economic disequilibrium. As a result, the World Bank⁴ and the International Monetary Fund (IMF⁵) proposed structural changes to improving the economy, which suggested withdrawal of state subsidies. This led to declines in the health budget, putting the health sector under severe economic pressure (World Bank, 1993). According to Bawumia (1998) government budget fell from 18.3% to 10.1% of Gross National Product (GNP) between 1972 and 1982 resulting in a fall in real expenditure

⁴ World Bank is a specialized United Nations (UN) agency that lends money to its members for reconstruction and development.

⁵ Another UN specialized agency, which promotes international economic corporation to facilitate international trade amongst member nations.

in the education and health sectors of the economy. Equipments in health institutions fell into disrepair due to lack of spare parts, basic drugs such as nivaquine and aspirin, as well as consumerables such as bandages, needles and syringes were in desperately short supply and were often unavailable in rural clinics. This led to what can be termed as commoditisation of health services. Commoditisation refers to the forces of demand and supply determining health care provision. The supply was determined by the user fees charged and the demand by the ability of the people to pay.

In spite of the growth in manpower and health facilities between 1957 and 1963, a review of the health sector in 1977 revealed high infant (131 deaths per 1000 live births) and child mortality (40% of children die before school going age) rates and the existence of communicable diseases such as yaws and cholera. The policy adopted for the period was the Primary Health Care (PHC)⁶. The PHC was a concept adopted from the Alma Ata Declaration of WHO in the same year. The adoption of this policy was aimed at bringing health care to the doorsteps of Ghanaians. It was organized at three levels in the country: the Community (Level A), the Local council Areas (Level B) and the Districts (Level C) (MOH, 1978). During this period also, government continued to fund health care services. However, as discussed earlier, expenditure on health by this time had reduced considerably.

In 1985, the government at the time introduced a cost recovery programme known as the **user-fees system**. Laws enabling the charging of fees dates back to 1969 with the

⁶ PHC is concept that encompasses multi-sectoral approach, appropriate technology, focus on preventive and promotive health, community participation in health decision-making and equitable distribution of health services.

introduction of the Hospital Fees Decree, 1969 NLCD⁷ 360; Hospital Fee Decree, 1969 (Amendment) Act, then, the 1970 (Act 325); then again the Hospital Fees Act, 1971 (Act 387). These charges were however token fees charged compared to the 1985 legislation which raised the fees above token levels (Smithson, Asamoah-Baah, & Mills, 1997). There were however, exemptions for antenatal and family planning and communicable diseases (Nanda, 2002). These exemptions were, however, not taken advantages of because there were no guidelines for implementation and consumers were unaware of the existence of the exemptions. Compliance level by health staffs was also poor (MOH, 2004).

The introduction of user fees greatly reduced the utilization of health services because most people could not afford the user fees and the fees were also not matched with improvement in quality of services provided. In spite of the introduction of the user fees, government still bore a considerable proportion of the expenditure in health care.

In 1992, the government, in conformity with the Bamako Initiative⁸ of 1988 introduced the Revolving Drug Fund, which officially introduced the Full Cost Recovery Policy for drugs as a way of generating revenue to address the shortage of drugs. It was envisaged that, the cost recovery process would contribute about 15% of the health sector resources. A review of the process in the First Five Year Programme of Work (1997-2001) of the MOH revealed that the contribution of the cost recovery process to the country's health sector financing was below 10%. The application of the revolving drug fund policy was popularly termed '**cash and carry**' system. The cash

⁷ NLCD is the National Liberation Council Decree – the military government which overthrew the government of Nkrumah.

⁸ World Health Organization Conference in Bamako, where it was decided that people should pay for drugs in public health care facilities.

and carry system caused a decline in the utilization of health care services especially for the very poor who needed the services most, since this represented financial barrier to access Health care (Arhin-Tenkorang, 2000).

In 1997, the 1977 PHC strategy was reviewed and a new one introduced. The new strategy was known as Five Year Programme of Work (POW I) (Ministry of Health, 1996). The aims of this reform were amongst other things to significantly reduce infant child and maternal mortality rates, increase access to health care especially in the rural areas, control risk factors that exposed individuals to major communicable diseases and the strengthening and effective management of health systems. To these ends, the MOH adopted strengthening of inter-sectoral collaboration, strengthening of the hospital management teams, re-orientation of secondary and tertiary health service delivery to support primary health services and several other strategies.

The second Five Year Programme of Work (POW II) (Ministry of Health, 2001) commenced in 2002. The objective of this strategy was to reduce the inequalities in health between the northern and southern parts of Ghana, between urban and rural areas, and gender.

4.2.1 The National Health Insurance Scheme

In order to improve access to health care services, a law (Act 650, 2003) establishing a national health insurance scheme was enacted in October 2003 known as the **National Health Insurance Scheme (NHIS)**. This is with the ultimate vision of assuring *equitable and universal* access to health care for all residents of Ghana (Ministry of

Health, 2004). The types of health insurance schemes that are operational in Ghana are:

1. **Social Health Insurance Schemes**, these are

District Mutual Health Insurance Schemes - are health insurance schemes organised at the district level and managed by members of the district. People in all the towns and villages that form a district and are interested in the scheme join the scheme. Premiums are paid to the schemes and the scheme contracts health care facilities for its members and

Private Mutual Health Insurance Schemes – this is also health insurance by people who have a common interest and therefore come together to have a health insurance. These people choose their own scheme managers to whom premiums are paid. The management is responsible for the contracting of health services for the group. Example could be members of a credit union having a mutual health insurance scheme for themselves.

2. **Private Commercial Health Insurance Schemes**

The private commercial health insurance schemes are insurance schemes or policies usually sold by insurance companies. These policies are either sold to individuals or groups and it is for profit. The profit element differentiates it from the social type health insurance. Example is the health insurance policy for private individuals and corporate entities being offered by Ghana Life Insurance Company (GLICO) in Ghana.

The principles underlying the design of the NHIS include:

Equity – this means every subscriber has access to a minimum benefit package irrespective of ones socio-economic background.

Risk-equalization – this means that allocation of financial resources to geographical areas would be based on disease patterns and burdens.

Cross-Subsidisation – payment of premiums have been put in a hierarchical form with the poor paying less and the rich paying more. The healthy would also cross-subsidise the sick.

Quality of care – this is a principle underlying the scheme. It is believed that if quality of care were perceived to be good, it would lead to increase in utilization of services.

Solidarity – unity in upholding the national health insurance scheme.

Efficiency – this is to be in the collection of premiums from the informal sector and reimbursement to service providers.

Community or subscriber ownership – this means the community must be involved in decision making for the health services delivered in the area.

Partnership – this is with government especially since it would be bridging the gap between expected premium payments and actual premium payments.

Reinsurance – has to do with the setting aside of central funds in times of catastrophic events such as epidemics and natural disasters.

Sustainability – involves management of the scheme in terms of fraud control and risk management.

Health care facilities accredited and providing health services to insured members of the scheme include teaching, regional and district hospitals. Quasi-governmental

hospitals and clinics, mission hospitals as well as pharmacies, shops and drug stores are also included.

Benefit package under the NHIS is a minimum health care benefit that includes outpatient services, in-patient services, oral health services, eye care services, maternity care and all forms of emergencies (MOH, 2004). Please refer to Appendix II for details of the benefit package.

4.3 DISTRICT MUTUAL HEALTH INSURANCE SCHEMES IN GHANA

In the previous sections, the history of health reforms and financing strategies and events leading to the birth to health insurance schemes in Ghana were outlined. This section continues the discussion and looks at the DMHI schemes. The scheme is a fusion of two concepts, social health insurance scheme for formal sector workers and the traditional mutual health insurance organization for the informal sector. It is made up of members from both the formal and informal sectors of the economy.

Each district is divided into Health Insurance Communities, which are responsible for the collection of contributions and managing the affairs of health insurance in the community. Each community consisting of a Chairman, Secretary, Collector, Publicity Officer and a Member constitutes a Health Insurance Committee. These committees would then form the District Health Insurance Assembly. The Assembly is the highest decision making body in the district and it provides policy guidelines for the operation of the scheme for the district. The Assembly also appoints a Board of Directors for the district (Ministry of Health, 2004).

Premium from subscribers to the DMHI schemes would be made up of 2.5% of the 17.5% contribution to Social Security and National Investment Trust (SSNIT) for formal sector workers deducted at source and transferred to a central fund. Non-SSNIT contributors would contribute directly to the scheme of their choice and according to the schedule provided (see appendix III). A fund known as the National Health Insurance Fund has been established into which a 2.5% Value Added Tax (VAT) is contributed. This fund is under the control of the National Health Insurance Council (NHIC) (Refer to appendix IV).

The NHIC was established by the NHIS Act 650, and is headed by an Executive Secretary who is mandated with the object of ensuring that policy decisions taken by the council are duly implemented. The council reports to the president of the country through the ministry of health. The council for the purposes of its functions has four units that aid in its efficient and effective operations. These comprise a Policy, Planning, Monitoring and Evaluation unit; Licensing and Accreditation unit; Administration, Management support and Training unit and Fund Management and Investment unit.

It can be observed from the preceding that the DMHI scheme concept was adopted as the benefits derived from them are in line with some of the health system goals of the country.

4.3.1 Case Study 1 - The New Juabeng Municipal Health Insurance Scheme

The New Juabeng Municipal Health Insurance Scheme is situated in the Eastern Region of Ghana. The municipality is located in the Eastern Regional capital,

Koforidua, which also doubles as the municipal capital. The municipality is bounded to the northwest by East Akyem District, to the east and south by Akuapem North District, northeast by Yilo Krobo District and to the west by Suhum-Kraboia Coalta District (New Juabeng Municipal Health Directorate, 2006).

The municipality covers an area of about 98.8 square Kilometres and has a population of about 146,618 and is demarcated into four sub districts namely Oyoko/Jumapo sub-district, Effiduase/Akwadum sub-district, Koforidua/Zongo and Medical village/Old Estate sub districts with about 150 different communities (Municipal Health Directorate, 2006).

The scheme was officially launched on the 28th of April, 2005, and started operations in May of the same year. It has a total registered number of 54, 000 members as at January 2007. The New Juabeng Scheme has a Board of Directors, a General Assembly and a Management Team. Major challenges cited as facing the scheme include complaints from members about the six months waiting period after registration and the inadequacy of the minimum benefit package (Scheme Manager, 2007).

The municipality has one regional hospital, one mission hospital, two health centres, 11 private clinics, three private maternity homes, ten Reproductive and Child Health (RCH) centres, 80 trained birth attendants six Community Based Health Planning and Services centres and 70 chemical shops. There are also 387 nurses, 38 doctors and 5 pharmacists in the public sector and 6 doctors and 8 pharmacists in the private sector.

All the Reproductive and Child Health centres in the municipality as well as the only mission and regional hospitals, the two health centres have been contracted in the New Juabeng Municipal Health Insurance Scheme. Five of the eleven private clinics, two of the three maternity homes and five of the 70 chemical shops have also been contracted by the Scheme to provide services to its subscribers.

4.3.2 Case Study 2 - The Ketu District Mutual Health Insurance Scheme

The Ketu district on its part is located in the southern eastern part of the Volta Region, in Ghana. It shares common boundaries with the Republic of Togo to the east, Akatsi district to the northwest and to the southwest by the Keta district. On its southern border is the Gulf of Guinea Atlantic Ocean⁹.

The district has a population of about 260,674, a projection from the March 2000 population census with a growth rate of about 1.9 and occupies an area of 962 square kilometres (Ketu District Health Directorate, 2006). The district capital is Denu¹⁰. There are nine towns constituting the Ketu district. These are Afife, Aflao Urban, Aflao Wego, Dzodze, Klikor, Penyi, Some Wego, Some Fugo and Weta sub district.

The scheme was officially launched on the 8th of August, 2005, but started operations in September of the same year. As at January 2007, only 57,854 people were active members (those who had renewed their premiums) out of about 260,674 people living in the district.

⁹ (www.ghanadistricts.com)

¹⁰ (www.ghanadistricts.com)

Like all other schemes, the Ketu scheme also has a Board of Directors, General Assembly, Community Health Insurance Committee, District Complaints Committee to resolve complaints, a Service Providers Committee, Medical Review Committee which is charge with overseeing claims administration and a Quality Assurance Control Committee charged with ensuring that quality is ensured with all contracted health service providers in the district.

Major challenges cited as facing the scheme was the influx of Togolese nationals and Beninois who pay for services at point of usage competing for the same services with members of the scheme, inadequate health professionals to match the upsurge in attendance and inadequate staff strength at the secretariat.

The district has one government hospital, one mission hospital, four private clinics, sixteen health centres, five Reproductive and Child Health centres and four maternity homes (Ketu District Health Directorate, 2006). Of these, the Ketu District Mutual Health Insurance Scheme operates with the district and mission hospitals, all the 16 health centres, one maternity home out of the four, two of the four private clinics, two chemical shops and one pharmacy shop (Ketu Health Insurance Scheme, 2007).

4.4 CONCLUSION

The chapter was concerned with the financing of health care in the country, the various health policies since independence until the current NHIS and a brief history and operations of the two districts, which are the focus of this study. The health policies and the modes of financing them are all aimed at the provision of affordable health care for economic development. The background as provided in the succeeding

paragraphs is aimed at providing understanding on the need to sustain the current scheme by addressing the quality issue.

CHAPTER FIVE

METHODS AND TECHNIQUES OF DATA COLLECTION

5.0 INTRODUCTION

This chapter represents a detailed description of and justification for the methodology adopted in the conduct of the research. In order to draw valid conclusions and make meaningful suggestions in any research work, it is imperative for the researcher to employ appropriate scientific techniques in its conduct. This research therefore follows the scientific methods as much as is applicable with some limitations.

5.1 RESEARCH DESIGN

The research design is multidimensional in nature. Combinations of exploratory and descriptive research designs were used. Exploratory research involves the discovery of ideas and insights. This is to generate possible explanations to a research problem (Saunders, Lewis, & Thornhill, 1997). In the data collection instrument used, there were attempts to discover features of the DMHI schemes at the health care facility level that were of particular concern to subscribers.

Descriptive research on the other hand is concerned with determining the frequency with which something occurs and the relationship between two variables. It describes the characteristics of a particular groups based on information gathered such as income, sex, age, and educational level amongst others; or estimates the proportion of people in a specified population who behave in a certain way (Saunders, *et al.*, 1997). The study made use of this type of design to determine the view of respondents on

quality and determine variables that are likely to determine quality of health care services for respondents.

The survey technique was used in the collection of primary data for this study. Surveys provide a methodology (questionnaires and interviews) for asking people to provide information about themselves, their attitudes and beliefs demographics and facts, past or intended future behaviour (Cozby, 2003). The survey method has proven over time to be very useful in examining a sample from a population. According to Babbie (1973), a survey method ensures among other things population validity, accurate results of subsequent assessment of the attributes of the same sample and generalisation of findings.

One of the features of the survey method involves designing and administering of questionnaires. The administration of the data collection instrument (questionnaire in this study) could be done through the telephone, group administration, mail, Internet or focus group interviews (Cozby, 2003). For the purposes of this research, the self-administration technique was adopted. This option was taken based on the opportunity it created for meeting respondents and persuading them for more and timely responses.

5.2 STUDY POPULATION

The study population of a research applies to the collection of all possible individuals, objects or measurements of interest (Mason, 1999). Identification of the population of the research in question was necessary in narrowing down to the specific objects that were the subject matter of the study.

The DMHI schemes are new schemes in line with the government's policy of making health care accessible to Ghanaians. The study population consisted of only people who had subscribed to the New Juabeng Municipal Health Insurance Scheme and the Ketu District Mutual Health Insurance Schemes, under the NHIS and had used the facility at least two times. An objective assessment of the quality of health services provided was important in arriving at valid conclusions.

5.2.1 Demographic Characteristics of Respondents

In the New Juabeng district, the population sampled for the research was diverse in terms of the ages of the respondents, their gender and occupation. There is a diversity of peoples and cultures in the municipality. The major ethnic group is Akan. Other ethnic groups found in significant numbers in the municipality are the Ga Adangbes, Ewes and people from the northern part of Ghana. The common language spoken in the municipality is Twi. The main occupations of the people in the municipality were commerce, civil or public service, agriculture and wood/timber processing.

The Ketu district also had a diversity of respondents in terms of age, gender and occupation. The diversity of cultures and peoples observed in the New Juabeng municipality is not reflected in the Ketu district. The main ethnics group in the district is the Ewes. The main occupations of the people in the district were commerce, trade in fish and fish products as well as civil and public services works.

5.3 SAMPLING DESIGN AND PROCEDURES

Non-probability sampling design was used in selecting respondents to the survey. Non-probability research design is explained as where the sample frame cannot be defined in definite terms. In the case of this research, subscribers who had used the health facility two or more times could be identified from the secretariat of the schemes; however, locating such subscribers was very difficult as post numbers were used and most streets in Ghana are not named and houses also not numbered for easy identification.

Even though probabilistic sampling technique is theoretically upheld as being superior, non-probabilistic sampling technique is also accepted in the fields of business and social sciences and has its own merits. For example, a non-probabilistic sampling design is most appropriate if a definite sample frame cannot be identified; this study was a classical example. This sampling technique is also convenient, cost efficient and time saving.

Respondents were made up of only subscribers who had used health services under the two DMHI scheme two times or more. This criterion was chosen because subscribers who had used health care services under the scheme two or more times would be able to give a relatively more objective assessment of quality. The selection was in line with one of the attributes of judgmental or convenient sampling, which enables the researcher select cases, which aid in answering research questions and thus meet set objectives (Saunders *et al.*, 1997).

The questionnaires were given to respondents based on the number of times health care facilities had been used since joining the DMHI scheme. The New Juabeng municipality is divided into subdistricts, namely Oyoko/Jumapo sub-district, Effiduase/Akwadum sub-district, Koforidua/Zongo and Medical village/Old Estate sub districts with about 70 different communities. All the 70 communities were visited and information was solicited from at least 6 respondents in each community.

The nine towns Afife, Aflao Urban, Aflao Wego, Dzodze, Klikor, Penyi, Some Wego Some Fugo and Weta that constitute the Ketu district had a minimum of 45 respondents each from them.

The expected sample sizes for the two schemes were 450 and 450 for the New Juabeng and Ketu districts respectively. This made a total of total of 900 respondents. The sample size was informed by statistical methods used in the determination of the minimum size of a sample from a finite population with a 95% level of confidence. The 95% confidence level meant that from the sample chosen from the population, valid statistical inferences could be confidently made to represent the total population with only an error margin of 5%.

According to Krejoie and Morgan (1970) a population size of between 50,000 and 75,000 would need a sample size of about 381 respondents to be able to make inference at a 95% confident level. The New Juabeng scheme had as at the time of collecting the data, 54,000 subscribers to the scheme and Ketu had 57,854 active members between January and March 2007 when the data was collected.

5.4 QUESTIONNAIRES AND INDICATORS

The study primarily made use of questionnaires and interview to collect the data needed. The questionnaire was written in simple clear language devoid of technical terms and enquired from respondents their perception of quality of health services provided by the two selected schemes within the conceptual framework developed.

The questionnaire was divided into two sections, A and B. Section A enquired about respondents demographic characteristics and the B was concerned with the respondents perception of quality of health care services provided with respect to level of communication, attitude of staff, availability of drugs and general information on the National Health Insurance Scheme. The questions on the variables (level of communication, attitude of staff and availability of drugs) were closed ended (Likert Scale type questions) and the open-ended aided in achieving the objective of determining the particular areas of health care quality subscribers considered important at the health care facility under the NHIS. The Likert scale had five points ranging from “very good” to “very poor”. The Likert scale type of questionnaire has been recommended for measuring attitude type questions, which is the type the researcher was involved in (perception).

The interview questions were structured and enquired about quality of health care services (in relation to the variable identified) provided before the introduction of the scheme in the two districts. The interview was conducted after respondents had answered the questionnaires.

5.4.1 Pre-Testing of Questionnaire

The questionnaire was pre-tested at the Out Patients Department (OPD) of the Achimota Hospital. The Achimota Hospital is a district hospital in the Greater Accra Region. Twenty subscribers who had used the scheme at least two times were asked to fill the questionnaires and were interviewed afterwards on quality of health care before the scheme. This took place outside the pharmacy department, which is the last point of service in the hospital before a subscriber leaves the hospital.

Some wordings in the questionnaire were revised and a question was eliminated because it could be implied from an earlier question. Some of the respondents to the questions felt intimidated in the hospital setting. They asked that their names should not be written. This attitude confirmed earlier decision of the researcher not to interview subscribers in the hospital setting for fear of bias as a result of the intimidation some subscribers would feel by the mere fact of being in the hospital at the time of filling the questionnaires. The final questionnaire was then presented to subscribers in the New Juabeng and Ketu Districts.

The pre-testing of the questionnaire enhanced validity. This is because poorly worded and poorly understood questions were identified and restructured or eliminated. To ensure reliability, the same questionnaire, based on the conceptual framework developed was given to the respondents in the two districts.

5.4.2 Administration of Questionnaires and Interviews

The questionnaires and interviews were conducted in the homes, workplaces of the respondents and on the streets of the two districts. According to Zikmund (1996)

door-to-door interviews conducted in respondents' homes or offices increases participation rates. Thus the research was conducted using the door-to-door approach. The hospital setting, which would have been convenient, was avoided as it was noticed at the pre-testing stage that there was the tendency for respondents to be apprehensive.

5.5 DATA PROCESSING AND ANALYSIS

Likert scale responses were coded and the Statistical Package for Social Sciences (SPSS) was used to analyse responses. Descriptive statistics covering measures of central tendencies and relative dispersions are computed based on the likert scale response ratings. Given the approximately normal distribution of the responses, the mean responses along the likert scale of "very good-1", "good-2", "fair-3", "poor-4" and "very poor-5" on an overall basis approximated the consensus views of the respondents. Therefore, the overall average Perceptual Ratings were used to determine how respondents perceived the services provided under the various quality dimensions.

Tables were used for the presentation of the data. The descriptive analysis made use of averages, frequencies and percentage distributions in drawing inferences and related conclusions. Open-ended responses were tabulated and frequencies determined then supportive and/or suggestive views could be elicited. This was considered important so as to provide opportunity and basis for incorporating the subjective views of respondents which are nonetheless vital in their appraisal of the services they receive.

5.6 ETHICAL CONSIDERATIONS

On the questionnaire was a brief introduction of the purpose of the research and the rights of the respondents to participate or not. Very clear instructions on answering the questions were provided in order to avoid ambiguity. Anonymity of participants was guaranteed because the names of respondents were not solicited. Respondents were orally asked if they were interested in participating in the survey. Those not interested were left alone.

5.7 LIMITATIONS OF THE RESEARCH METHOD

The strength of this research finding could be limited by the unwillingness of the respondents to provide truthful and accurate answers. Again, the judgemental sample used for the study may affect representativeness of the views of the entire population as there exist the possibility that objectivity of the assessment may not be based on the number of times subscribers may have used the facility.

5.8 CONCLUSION

In the preceding sections, the methods used in collecting data for the study has been outlined. The research design, the choice and size of the sample as well as the data collection instruments have been thoroughly discussed in the preceding paragraphs. It would thus be observed from the chapter that, this study attempted to use the scientific method in arriving at conclusions drawn. This chapter forms the basis for the presentation of the data and its analysis.

CHAPTER SIX

PRESENTATION OF FINDINGS

6.0 INTRODUCTION

This chapter presents the findings of the study. For a survey, a response rate of at least 50% is adequate for analysis and reporting. A response rate of 60% is good whilst that of 70% is very good and 90% raises no question for analysis and reporting (Babbie, 1989). This research had a response rate of 89%, which could be considered as very good. A larger sample size of 450 instead of the 381 was used for the study to ensure that response rates were high.

6.1 DEMOGRAPHIC CHARACTERISTIC OF RESPONDENTS

Respondents' demographic characteristics in the areas of gender, age, educational level and occupation were carefully examined. These characteristics provide information that helps in assessing whether the social, economic and other circumstances of subjects impact on their behavioural activities and to what extent. This is particularly important because perceptions and attitudes are behavioural qualities that are largely informed by the social constructions surrounding the individual. The results in this category have been analysed both within and across the two districts so that a good comparison could be made.

From Table 6.1, it can be observed that of the 400 respondents interviewed in the Ketu district (197 approximately 49%), were male while in the New Juabeng District, 39.5% of the respondents were male. Approximately 45.6% of the total respondents for the two districts were males. The results reveal a relatively higher female to male respondent's ratio for both districts. Whilst this may not provide conclusive evidence

of the male female enrolment levels, it could give an indication in that direction although the difference may appear insignificant.

Table 6.1: Gender Distributions of Respondents

DISTRICTS	GENDER		
	MALE	FEMALE	TOTAL
N JUABENG	168 (42%)	232 (58%)	400
KETU	197 (49%)	203 (51%)	400
TOTAL	365 (46%)	435 (54%)	800

Of the 365 males out of the 800 respondents to the survey, 357 rated overall quality of health services (question 12 in appendix I). Quality of services was rated as “fair” by 115 respondents, who constituted about 32% of the 357 respondents. About 33% of the total male respondents rated quality as good and only 23 (6%) rated it as very good. In comparison, 409 out of the 435 females responded to question 12. In rating quality, 42% rated it as fair, 25% as good and 14% rated it as very good (appendix VII).

The age distribution of respondents in the Ketu district, as observed from table 6.2 appears to fall between the age categories of 35 and 49 years, the youthful stage. A similar phenomenon was observed in the New Juabeng district. The age group with the lowest number of respondents was the 18 and 24 group. This age group forms the proportions that are usually in school or have just finished school.

Table 6.2: Age Distributions of Respondents

DISTRICT	AGE GROUP OF RESPONDENTS					TOTAL
	18-24	25-34	35-49	50-64	65 ≥	
N JUABENG	46	89	104	93	68	400
KETU	52	70	145	82	51	400
TOTAL	98	159	249	175	119	800

A clear difference could be seen in the level of education of respondents in the two districts (Table 6.3). In the Ketu District, for example, 26.5 % of the respondents have had secondary level education, whilst New Juabeng seems to have a majority of its respondents having the Junior Secondary or Middle School as their highest level in education. In spite of these differences in the levels of education, in both localities, commerce appears to be the dominant occupation of the respondents.

Table 6.3: Level of Education of Respondents

DISTRICTS	LEVEL OF EDUCATION					TOTAL
	NO EDU.	PRIM.	JSS/MIDD	SEC	TERTIARY	
N JUABENG	32 (8%)	92 (23%)	130 (32%)	78 (20%)	68 (17%)	400
KETU	30 (7.5%)	99 (25%)	78 (20%)	106 (27%)	87 (21%)	400
TOTAL	62 (8%)	191(24%)	208 (26%)	184 (23%)	155 (19%)	800

A large proportion of respondents in both localities were employed in one form or the other (Table 6.4). This could mean that unless one was employed, access to the health insurance scheme was impossible because of premiums to be paid. The exemptions to this phenomenon were if one was 70 years or more, or was below 18 years and whose

parents are registered. Most of those employed in the districts were mostly artisans who were informal sector workers. These included carpenters, hairdressers, mechanics, labourers, electricians and seamstresses. Others were bakers and farmers. These respondents constitute approximately 76% (Refer to Table 6.4) of employed respondents in New Juabeng and approximately 84% of employed respondents in Ketu.

Table 6.4: Occupations of Respondents

DISTRICTS	OCCUPATION				
	EMPLOYED	UNEMPLOYED	RETIRED	STUDENT	TOTAL
N JUABENG	306 (76%)	53 (13%)	10 (3%)	31 (8%)	400
KETU	337 (84%)	28 (7%)	4 (1%)	31 (8%)	400
TOTAL	643 (80%)	81 (10%)	14 (2%)	62 (8%)	800

The unemployed constituted 13% and 7% of total respondents in the New Juabeng and Ketu district respectively. Respondents on retirement constituted approximately 3% and 1% and students constituted 8% each for New Juabeng and Ketu. The rest of the respondents were made up of public sector workers (health workers, teachers and civil servants), bankers and housewives.

Table 6.5 provides an indication of the type of health care facilities used in the two localities. It can be observed that, majority of the respondents patronise government health facilities. These health care facilities include regional or district hospitals, health centres, Reproductive and Child Health (RCH) centres, and Community Based Health Planning and Services (CHPS) centres.

The Ketu and New Juabeng districts have approximately 57% and 64% of their respondents using government facilities respectively. New Juabeng seems to have private health facilities as the second highest frequented by respondents. Ketu has a lot more respondents using the only Mission health facility in the area than private health care facilities.

Table 6.5: Type of Health Care Facility Used

DISTRICT	TYPE OF HEALTH CARE FACILITY USED			
	GOV'T	PRIVATE	MISSION	TOTAL
N JUABENG	254 (64%)	75 (19%)	71 (17%)	400
KETU	226 (57%)	60 (15%)	114 (29%)	400
TOTAL	480 (60%)	135 (17%)	185 (23%)	800

The type of health care facility used is important in assessing health care quality as the state and quality of the facility bear directly on the continual use of service by subscribers.

6.2 AVERAGE PERCEPTUAL JUDGMENTS

The means for the variables on which quality of health services is determined are provided and analysed in the succeeding paragraphs.

6.2.1 Level of Communication

Adequate and relevant knowledge on the part of health service beneficiaries plays a central role in ensuring speedy treatment of ailments (Andeleeb, 1998). Administering health service and its related therapeutic prescriptions are quite technical and require

expert knowledge. Therefore, the transfer of this knowledge (communication) to patients goes a long way to improve health service quality.

On average, subscribers in the New Juabeng district appeared to have a consensus that the quality of service was good, as the mean perception rating approximates 2.0 (Table 6.6), which corresponds with good (2) on the likert scale. Subscribers in Ketu however, appeared to have a mean rating of approximately 3.0 (fair on the likert scale). The 2.0 rating in New Juabeng indicated that subscribers perceived the level of communication as good. In Ketu however, the level of communication appeared to be insufficient as it was rated fair by respondents.

Table 6.6: Rate of Quality Based on the Level of Communication

	THOROUGHNESS OF EXAMINATION	EXPLANATIONS ON MED. TESTS	INSISTENCE ON FOLLOW-UP	EXPLANATIONS ON SIDE EFFECTS
N. JUABENG	2.378788	2.377215	2.384416	2.385787
NO OF RESPONSES	396	395	385	394
KETU	3.013514	3.008219	3.013514	3.016349
NO OF RESPONSES	370	365	370	367

6.2.2 Attitude of Staffs

The demeanour of the staffs is very important in determining whether patients continue to utilize a particular health service. Clients want to be treated with respect, friendliness, helped and an interest expressed in their condition. These are interpreted by clients as being treated equal (Kols & Sherman, 1998).

In the New Juabeng municipality, the mean perceptual judgment of subscribers on the attitude of staffs approximates 2.0 (which is good (2) on the likert scale) (Table 6.7). In Ketu however, the average rating is 3.0 (fair on the likert scale). This the ratings means that respondents on the two schemes rate the attitude of the staff towards them as good and fair in the New Juabeng and Ketu respectively.

Table 6.7: Rate of Quality Based on Attitude of Staff

	HELPFULNESS OF NURSES	COURTESY OF NURSES	LEVEL OF INTEREST OF DOC.	COURTESY OF DISPENSER	DIFFERENCE IN TREATMENT		
					YES	NO	N/S
N. JUABENG	2.378788	2.378788	2.409326	2.400517	231	64	79
NO OF RESPONSES	396	396	386	387			
KETU	3.013514	3.05042	3.051282	3.050847	237	143	15
NO OF RESPONSES	370	357	351	354			

However in establishing the specific factors that determine the attitude of staff, respondents in New Juabeng appeared indifferent between the helpfulness and courtesy of the nursing staff (Table 6.7). This means that to the respondents, the courtesy and help shown by the nursing staff are major determinants of the attitude of the staff. In Ketu however, respondents were certain that, the help extended to them by the nursing staff, was a major determinant of the attitude of the staff.

Differences in treatments between the insured and uninsured were not rated on a Likert scale. It was based on yes, no and not sure. This rating was used to test the subjective experiences of respondents. In both districts, the yes response appears to dominate (Table 6.7).

6.2.3 Availability of Drugs

The availability of drugs in a health care facility can greatly affect utilization of health services (Baltussen *et al.*, 2002). Medications are considered as a major element in the recovery process and therefore a determinant of quality in health care services. The ratings on availability of drugs was on a yes, no or not sure bases.

The dominant response was “yes” in the New Juabeng municipality for the availability and effectiveness of drugs (Table 6.8). However, in the Ketu district, 44% of the 400 respondents asserted that drugs prescribed for them were readily obtainable at the dispensary of the health facility.

Table 6.8: Availability and Effectiveness of Drugs under the DMHI Schemes

AVAILABILITY OF DRUGS					
	YES	NO	NOT SURE	MISSING	TOTAL
N. JUABENG	253 (63%)	143 (36%)	3 (0.007%)	1 (0.003%)	400
KETU	177 (44%)	219 (55%)	1 (0.003%)	3 (0.007%)	400
TOTAL	430 (54%)	362 (45%)	4 (0.005%)	4 (0.005%)	800
EFFECTIVENESS OF DRUGS					
N. JUABENG	292 (73%)	84 (21%)	12 (3%)	12 (3%)	400
KETU	278 (70%)	54 (14%)	5 (1%)	63 (16%)	400
TOTAL	570 (71%)	138 (17%)	17 (3%)	75 (9%)	800

Considering that availability of drugs in a health care facility is very important and people go to hospitals to be diagnosed and cured, the views of minority in the case of New Juabeng and majority in Ketu are equally important. Approximately 36% of the respondents in New Juabeng did not have access to all of their prescribed drugs at the dispensary of the health facility they utilised. On the other hand, 219 out of 400 (Table

6.8) respondents in the Ketu district did not have access to most of the prescribed drug in the health care facility.

Overall, approximately 54% of a total of 800 respondents appeared to have access to drugs prescribed for them at the health care facilities. The other respondents numbering 362 (Table 6.8) did not have access to drugs prescribed for them in the health care facilities.

Approximately 71% of the respondents attested to the efficacy of the drugs prescribed for them under the schemes in the two districts irrespective of whether these were given at the hospital or not. While a total of 138 of the 800 (Table 6.8) respondents expressed reservations about the efficacy of the drugs, 3% were not sure about the efficacy of drugs they had used under the schemes and 75 people out of the 800 did not respond to the question.

6.2.4 General Quality Ratings

Table 6.9 sums up the total quality rating of respondents. A total of 82 (approximately 10%) respondents of the two schemes rated quality of health care as very good, approximately 28% of the respondents (226 out of 800) rated the scheme as good whilst 41% (328) respondents rated it as fair. About 13% of the respondents rated it as poor with the majority of these respondents (96 out of 111) in the Ketu district. Approximately 2% of the respondents rated quality as very poor. Interestingly, all of these respondents are from the Ketu districts. Approximately 4% of respondents did not respond to the question on the overall rating of quality.

Table 6.9: General Quality Rating

RATING OF OVERALL QUALITY							
RATE	V. GOOD	GOOD	FAIR	POOR	V. POOR	MISSING	TOTAL
N. JUABENG	76 (19%)	109 (27%)	196 (49%)	15 (4%)		4 (1%)	400
KETU	6 (2%)	117 (29%)	132 (33%)	96 (24%)	19 (4%)	30 (8%)	400
TOTAL	82 (10%)	226 (28%)	328 (41%)	111 (14%)	19 (3%)	34 (4%)	800

6.2.5 Recommendation of Scheme Based On Quality Rating

Recommendation of the scheme was matched with how respondents rated the quality of services provided (Table 6.10). All the 82 (approximately 11%) respondents from both localities who rated the scheme as being “very good” declared they were willing to recommend the scheme to those who had not joined. Of the 223 respondents who rated overall quality of the scheme as being good, 69% of them said they would recommend the scheme. However, 59 out of the 223 respondents said they would not recommend the schemes and 3 of them were not sure about recommending the scheme.

Table 6.10: Rate of Quality and Recommendation of Scheme

RATE OF QUALITY	RECOMMENDATION			
	YES	NO	NOT SURE	TOTAL
VERY GOOD	82 (14%)	-	-	82 (11%)
GOOD	161 (28%)	59 (39%)	3 (19%)	223 (30%)
FAIR	247 (43%)	59 (39%)	13 (81%)	319 (43%)
POOR	71 (12%)	31 (22%)	-	102 (14%)
VERY POOR	17 (3%)	1 (0.006%)	-	18 (2%)
TOTAL	578 (78%)	150 (20%)	16 (2%)	744

A rating of fair was made by about 319 respondents out of a total of 743 who responded to the question. Of this number, 43% of them said they would recommend the scheme and 39% said they would not recommend the scheme at all. However, 4% of them were not sure about recommending the scheme. Of the 102 respondents who rated the scheme as being poor in the two localities 12% of them, in spite of their ratings, reported they would recommend the schemes (Table 6.10).

6.3 COMPARATIVE STUDY OF THE DMHI SCHEMES

A comparative analysis of the findings is the focus of succeeding paragraphs. New Juabeng is a municipality and is located in the Eastern Regional capital, Koforidua; it has a diversity of people living there because of its strategic position. Ketu on the other hand is a district located in the south-eastern part of the country, sharing boundaries with Togo. It is also known to be a stronghold of the opposition to the

6.3.1 Level of Communication

On the level of communication at the various health facilities in the two localities, there appeared to be consensus among respondents that, they were examined adequately (Table 6.11). This forms approximately 92% of 800 respondents, who rated the thoroughness of examination as “very good”, “good” and “fair”. The rest rated the thoroughness of examination as poor. It is interesting to note that none of the respondents rated the communication variable as very poor.

Of the 92% respondents who said they were thoroughly examined before medication was administered, 48% were from the Ketu District and 52% were from the New Juabeng Municipality. Approximately 5% and 11% of respondents in New Juabeng and Ketu rated the variable as poor.

The explanation on medical tests also received a consensual response as “good” in the two localities. These respondents constituted approximately 46% of the total respondents. Explanations on side effects had majority of respondents in both localities (approximately 39%) alluring to it being “fair” and both districts have most of their respondents choosing it as fair. A close look at Table 6.11 indicates that 38 more people in New Juabeng than Ketu appear to agree that their physicians insisted on a follow-up after their visits to the health care facility under the scheme whilst 39 more people in Ketu than New Juabeng appear to be holding an opposing view. There however appear to be a consensus (47% of total respondents) that physicians under the scheme insisted on follow-up.

Table 6.11: Comparison on Level of Communication

THOROUGHNESS OF EXAMINATION							
RATE	V. GOOD	GOOD	FAIR	POOR	V. POOR	MISSING	TOTAL
N. JUABENG	121 (30%)	178 (45%)	82 (21%)	19 (5%)		-	400
KETU	126 (32%)	167 (42%)	63 (15%)	44 (11%)			400
TOTAL	247 (31%)	345 (43%)	145 (18%)	64 (8%)			800
EXPLANATIONS ON MEDICAL TESTS							
N.JUABENG	35 (9%)	200 (50%)	151 (38%)	13 (3%)	0	1 (0.003%)	400
Ketu	23 (6%)	169 (42%)	125 (31%)	74 (19%)	1 (0.003%)	8 (2%)	400
TOTAL	58 (7%)	369 (46%)	276 (35%)	87 (11%)	1 (0.001%)	9 (1%)	800
EXPLANATIONS ON SIDE EFFECTS							
N. JUABENG	33 (8%)	108 (27%)	169 (42%)	86 (22%)	2 (0.005%)	2 (0.005%)	400
KETU	7 (2%)	107 (27%)	144 (36%)	121 (30%)	16 (4%)	5 (1%)	400
TOTAL	40 (5%)	215 (27%)	313 (39%)	207 (26%)	18 (2%)	7 (0.008%)	800
INSISTENCE ON FOLLOW-UP							
	YES	NO	NOT SURE	MISSING	TOTAL		
N. JUABENG	202 (51%)	168 (42%)	19 (5%)	11 (3%)	400		
KETU	164 (41%)	207 (52%)	28 (7%)	1 (0.003%)	400		
TOTAL	366 (46%)	375 (47%)	47 (6%)	12 (1%)	800		

6.3.2 Attitude of Staff

Approximately 35% and 37% of the respondents in Ketu rated the helpfulness and courtesy of nurses as “poor” respectively (Table 6.12). In New Juabeng, 9% and 50% of respondents rated helpfulness and courtesy of the nursing staff as fair respectively. It is apparent in New Juabeng however (Table 6.12), that the nurses are perceived to be more helpful than courteous whilst in Ketu there was not much difference in the ratings of courtesy and helpfulness.

The courtesy of the dispenser was rated as 'fair' in both New Juabeng and Ketu, with the respondents constituting approximately 38% and 40% in the two districts respectively. Whilst 34% of the respondents in Ketu rated the courtesy of the dispenser as poor, approximately 17% of the respondents in New Juabeng rated it as poor. It is apparent that a lot more respondents in Ketu were unsatisfied with how they were treated by dispensers.

On the level of interest expressed by the doctor in them, 57% of the respondents in New Juabeng and 37% of the respondents in Ketu rated it as good whilst approximately 33% in New Juabeng and 51% in Ketu rated the level of interest expressed in them by the doctors as fair (Table 6.12). Whilst approximately 6% of the respondents did not respond to this question in Ketu, only about 3% of the respondents in New Juabeng did not respond it.

Approximately 58% and 59% of respondents in New Juabeng and Ketu respectively answered, "yes" to being treated differently or observing others being treated differently whilst 21% and 36% (approximate) responded no respectively (Table 6.12). About 20% and 4% of the respondents in New Juabeng and Ketu respectively were unsure whether they experienced or noticed any difference in the way insured and uninsured health care users were treated. It could be inferred that respondents in Ketu were more observant of any differences that existed in their health care facilities.

Table 6.12: Comparison on Attitude of Staff

HELPFULNESS OF NURSES							
RATE	V. GOOD	GOOD	FAIR	POOR	V. POOR	MISS'G	TOTAL
N. JUABENG	24 (6%)	136 (34%)	195 (49%)	34 (8%)	11 (3%)	-	400
KETU	35 (9%)	93 (23%)	116 (29%)	138 (35%)	18 (5%)	-	400
TOTAL	59 (7%)	229 (27%)	311 (39%)	172 (22%)	29 (3%)		800
COURTESY OF NURSES							
N. JUABENG	19 (5%)	119 (30%)	201 (50%)	50 (13%)	11 (2%)		400
Ketu	17 (4%)	109 (27%)	85 (21%)	147 (37%)	28 (7%)	14 (4%)	400
TOTAL	36 (5%)	228 (29%)	286 (35%)	197 (24%)	39 (5%)	14 (2%)	800
COURTESY OF DISPENSER							
N. JUABENG	26 (7%)	146 (37%)	153 (38%)	66 (16%)	-	9 (2%)	400
KETU	13 (3%)	46 (12%)	160 (40%)	136 (34%)	19 (5%)	26 (6%)	400
TOTAL	39 (5%)	192 (24%)	313 (39%)	202 (25%)	19 (2%)	35 (4%)	800
LEVEL OF INTEREST DISPLAYED BY DOCTOR							
	V. HIGH	HIGH	FAIR	LOW	V. LOW	MISSING	TOTAL
N. JUABENG	14 (4%)	230 (58%)	130 (32%)	16 (4%)		10 (2%)	400
KETU	4 (1%)	147 (37%)	205 (51%)	18 (5%)	3 (0.007%)	23 (6%)	400
TOTAL	18 (2%)	377 (47%)	335 (42%)	34 (4%)	3 (0.003)	33 (4%)	800
DIFFERENCE IN TREATMENT							
	YES	NO	NOT SURE	MISSING	TOTAL		
N. JUABENG	231 (58%)	84 (21%)	79 (20%)	6 (1%)	400		
KETU	237 (59%)	143 (36%)	15 (4%)	5 (1%)	400		
TOTAL	468 (58%)	227 (28%)	94 (12%)	11 (1%)	800		

6.4 OTHER RELATED ISSUES EMERGING FROM THE STUDY

The variables used in assessing the quality of health care services for this study concentrated on level of communication, attitude of staff and the availability of drugs. However, there were particular concerns of respondents that could not have been covered by the quality dimensions used for the study. Therefore some general questions were asked to help determine which quality aspects respondents considered important under the schemes.

6.3.3 Complaints and the Handling of Complaints

In Table 6.13, there appears to be a low level of complaints in the two localities. Only 37 out of 400 respondents in New Juabeng had ever made complaints to their scheme and of this only 12 of them were satisfied with the way the complaints were handled.

Table 6.13: Complaints and the Handling of Complaints

COMPLAINTS MADE					
	YES	NO	NOT SURE	MISSING	TOTAL
N. JUABENG	37 (9%)	277 (69%)	4 (1%)	82 (21)	400
KETU	69 (17%)	217 (55%)	25 (6%)	89 (22)	400
TOTAL	106 (13%)	494 (62%)	29 (4%)	171 (21%)	800
HANDLING OF COMPLAINTS					
N. JUABENG	12 (3%)	6 (2%)	1 (0.003%)	381 (95%)	400
KETU	53 (13%)	12 (3%)	1 (0.003%)	334 (84%)	400
TOTAL	65 (8%)	18 (2%)	2 (0.003%)	715 (89%)	800

In Ketu only 69 out of the 400 respondents had ever made complaints. Even though this is on the low side, when compared to complaints made in New Juabeng however, it is high. Of the number of respondents who had ever made complaints, 53 of them were happy with the way their complaints were handled and only 12 of the 37 respondents in New Juabeng had been satisfied with the handling of complaints in the municipality (Table 6.13).

6.4.1 Unexpected Experiences of Respondents

Respondent were asked whether anything has happened on any of their visits to the health care facilities that was unexpected. Responses to such unexpected experiences under the scheme were few. However, respondents who responded stated among other things they were surprised when they were directed to specific health care facilities to obtain drug, pay for some services while others did not pay anything at the health facility. These apparently contrast respondents impressions formed following television adverts on the scheme that drugs were obtainable free of charge.

6.4.2 Best Thing about NHIS at the Health Facility

There is the need to know the things subscribers find good about the health insurance scheme in term of quality. A large proportion of respondents to the question on the best thing about the NHIS indicated among other things they enjoyed not paying for any service at the health facility; having prescribed drugs available and for “free”; and the sympathetic attitude of the hospital staff towards their children. Some also asserted that the drug stores in the community were no longer their first point of contact in case of illness.

6.4.3 Worse Thing about NHIS in the Health Facility

Knowledge of the dislikes of consumers of a service is important to ensure continuity of use of that service by consumers. This question gave an indication of the quality dimensions that respondents used in determining the quality of services provided under the schemes.

Generally, respondents were disappointed that not all diseases were covered by the insurance scheme; not all prescribed drugs were covered; and the fact that the schemes were networked to ensure access in to health care in districts other than theirs.

Some stated that doctors, unlike before, did not request laboratory tests as often as they used to and nurses were disrespectful to insured patients. In New Juabeng, in particular the concern was the unfriendly nature of the workers of the records department where patient folders were kept. This sentiment was reiterated by a lot of respondents in the same district. In Ketu, respondents concerns were that Togolese patients continued to be treated better than Ghanaian insured patients.

In general respondents from the two localities stated that there was constant shortage of prescribed drugs at the health facilities, constant delays in being attended to and doctors did not often request or insist on follow-up.

6.4.4 Recommendations for Meeting Needs of Subscribers

Having identified the concerns of respondents about the scheme in the health facilities, it was important to know what they would want done to solve these problems. The recommendations made included expansion of the health facilities to

accommodate the increase in attendance rate as a result of the health insurance, that nurses be patient, respectful and friendly; the desire that the number of doctors be increased and they should insist on follow-up and the wish that prescribed drugs be available at the health facilities and the wish that dispensers be patient with patients. In Ketu, in particular, respondents recommended that Ghanaian patients, especially those insured, be given preferential over or at the least equivalent treatment as Togolese and Beninios patients.

6.5 QUALITY BEFORE THE INTRODUCTION OF THE SCHEMES

An interview was conducted to ascertain the quality of health care services in the two districts, before the introduction of the schemes. The quality dimensions enquired from respondents (also respondents of the questionnaire) revealed that of the quality in terms of level of communication and of the attitude of staff was good. The exception being that some nurses occasionally were unpleasant and impatient towards patients. On the availability of drugs most respondents were of the opinion that drugs were almost always available at the health care facilities and these drugs were bought. This is in contrast to some the statement some respondents made under the DMHI schemes that covered drugs were constantly in short supply at the health facilities. On how they would rate quality of health care services provided before the introduction of the health insurance scheme, respondents were of the view it was fair.

6.7 CONCLUSION

The chapter has presented the data collected. On a likert scale of 1 to 5 with 1 being “very good” and 5 “very poor”, quality of health care under the DMHI schemes appeared to be fair. This quality rating has implications for decisions to be taken at the

various schemes. Ketu in particular appeared to have more respondents not satisfied with the attitude of staffs and having to compete for the attention of the hospital staff with Togolese and Beninios nationals who use Ghanaian health facilities. The succeeding chapter discusses the findings and their implications and provides recommendations.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND POLICY IMPLICATIONS

7.1 INTRODUCTION

This concluding chapter discusses the findings made in the study, relates the findings to the objectives of the study brings out possible policy implications of the findings of the study and outlines areas of further research.

7.2 DISCUSSION

The discussion considers how the demographic characteristics of respondents reflect on their perception of quality along the level of communication, attitude of staff towards insured patients, availability and effectiveness of prescribed drugs, as well as the willingness of respondents to recommend the schemes to others.

Gender of Respondents

The gender of the respondents from the findings shows a higher female to male ratio in the two localities. There appear to be a consensus among the male and female respondents on the overall rating of health care quality (Tables 1 and 2 in Appendix VI). Majority of the two sexes rated quality as fair. Approximately 4% and 3% of male and female respondents respectively in New Juabeng rated quality as poor. In Ketu, approximately 27% of male and 36% of female respondents rated quality as 'poor' and 'very poor'. Thus a lot more male and female respondents in Ketu appeared to be unsatisfied with the quality of health care services received than in New Juabeng.

Age of Respondents

The findings indicate that the NHIS does not cover people 18 and 69 years who are informal workers and have not paid premiums. Tables 3 and 4 in Appendix VII indicates that more than half of the respondents falling within the 25 and 64 age groups rated quality of health care services as being below “good” on the likert scale.

Occupation of Respondents

The employment levels of respondents in the two localities appear to be high. The occupation of respondents gives an indication of the type of people enrolled on the DMHI schemes. The lowest proportion as presented in table 6.4 indicates that unemployed constituted only 6% of the respondents, students ranged between 6% and 8 % in the two districts and those on retirement ranged between 4% and 7% in the two districts. This indicates that, to be a member of the scheme, one had to be employed to be able to pay premiums hence the low percentage of unemployed respondents. Ghanaians between the ages of 61 and 69 years are not covered especially if they are informal sector workers. This could account for the low number of retirees among respondents.

Level of Education of Respondents

The level of education of respondents appeared to have an effect on quality ratings. In New Juabeng for instance, respondents with primary, junior and senior secondary education rated quality of health care below good. Those with tertiary education however rated quality or being good. This difference could be explained by the probing attitude of people with higher education and therefore they have understanding of issues that those with relatively lower education may not have. In

Ketu, respondents of all the educational levels rated quality as being below good. The level of education did not have effect on the rating of quality in the district (see Tables 5 and 6 in Appendix VII).

Number of times Health Services have been Utilised

The number of times a health care facility has been used appeared to have an effect on the quality ratings. In the two districts, respondents who had used health services under the schemes between two and five times has a lower quality rating than those who had used it six and more times. Quality was rated higher with more use. This could have been as a result of the uncertainty of respondents as a result using the services for the first time under the schemes.

Level of Communication

Though rating for the level of communication in the two districts were “good” and “fair” in New Juabeng and Ketu respectively, respondents under the two schemes appeared to have a consensus on explanations to medical test as being a determinant of the level of communication in the health care facilities. It is apparent that subscribers in the two districts value explanations of medical tests to be taken by them as a very important factor in the communication process. These findings reiterates the importance of communication expressed by Bruce (1990) when she asserted that information given to clients enables users to adhere to medical regimes and understand complications associated with certain diseases.

Attitude of Staff towards Insured Patients

The attitude of staff was rated as “fair” in Ketu and “good” in New Juabeng. However in establishing the specific factors that determine the attitude of staff, respondents in New Juabeng appeared indifferent between the helpfulness and courtesy of the nursing staff. This means that to the respondents, the courtesy and help shown them is a major determinant of the attitude of the staff. In Ketu however, respondents were certain on that the help extended to them by the nursing staff, was a major determinant of the attitude of the staff. This appears to be in line with the arguments of Bannerman *et al.* (2002) when they argued that concerns of clients include good staff attitude, maintaining clients’ dignity, respecting clients, comprehensive information about services and fees and a follow-up with clear instructions amongst others

Respondents in response to how they were treated differently from uninsured patients gave the following: in the new Juabeng municipality for instance, the 231 respondents (Table 6.12) who agreed to having been treated differently or observed the treatment of others, gave the following as the form in which the discrimination occurred: long queues at the dispensary, delays in being attended to (in the health care facility), availability of drugs to those paying at the health care facility and the impatience of the nurses towards insured. In Ketu, respondents said Togolese and their Beninios counterparts were treated faster and had access to all their medication at the health facility. Some respondents added that it was because they tipped the hospital staffs, a gesture they could not afford. This finding appears to be in line with the October 17, 2006 news reports of Abdul-Majeed (2006) on the complaints of subscribers of the Nanumba District Mutual Health Insurance scheme in the Northern Region of Ghana.

Some respondents however confessed to positive treatments as a result of being subscribers to the DMHI schemes. Respondents who expressed these views were in the minority. Some of these views were: insured treated faster; nurses admonishing non-subscribers to insure; and much attention was paid to insured patients relative to uninsured.

Availability and Effectiveness of Prescribed Drugs

It appeared that in the two localities, patients had equal chance of having access to prescribed drugs. Respondents who asserted they did not have access to the prescribed drugs at the health facility said amongst other things, they had to buy the drugs. Reasons attributed to the unavailability were that the drugs were either in short supply or not covered by the schemes. Some respondents were told to buy the prescribed drugs at the facility without any explanations on why they had to buy. A few others were referred to particular drug stores to be served. The number of pharmacies and chemical shops, contracted by the schemes to serve their subscribers, confirms this.

Majority of the total respondents attested to the efficacy of prescribed drugs. Respondents, who did not attest to the efficacy of the drugs, by responding either “no” or “not sure” gave several reasons for those responses, these reasons included uncertainty of the drugs’ efficacy; return to the hospital with the same condition; going to drug store for new medication; and the belief that drugs of better quality were not prescribed for them. Some commented that the same drug was given for the different conditions they took to the health facility.

Recommendation of the Schemes to Others

Interestingly respondents (in both localities), who rated overall quality as “very good”, were very sure of recommending the schemes to others and the 17 respondents (Refer to Table 6.10), who rated health services as “very poor”, said they would recommend the scheme to those who had not yet joined.

Those who said they would recommend the scheme gave reasons such as; not paying at the point of service, having an insurance cover prevents aggravation of illness and unnecessary deaths, and in times of financial difficulty health care services could still be accessed.

In spite of the general dissatisfaction with the quality of health care services under the DMHI schemes, majority of the respondents in the two districts said they would recommend the scheme. This is in sharp contrast to Sixma *et al.* (1998) assertion that patients satisfied with a service were more likely to comply with medical regimes and continue using health services.

The euphoria associated with accessing health care services without having to pay at the point of service, the first in Ghana after the period immediately after independence could account for this resounding acclaim of recommendation of the schemes.

However, respondents who said they would not recommend the schemes gave, drugs not being covered and the unavailability of covered drugs at the health facility as reasons for not recommending the schemes. Others considered unfriendly treatments and delays in being attended to as not recommending the schemes to non-subscribers.

Complaints and Handling of Complaints

Making of complaints was very low in the two localities with the lowest being the New Juabeng municipality. Enquiries made on why this was so from the manager of the New Juabeng scheme revealed that complaints were handled as and when they were made. In Ketu however, there was a District Complaint Committee charged with the duty of looking into complaints made. The 53 respondents who said they were satisfied with the way their complaints were handled confirm the existence of committees set up in the Ketu district to handle complaints (Table 6.13). The importance of enabling customers of a service to complain is argued by Kim *et al.* (2003) when they asserted that complaining may increase long-term satisfaction of clients by facilitating the venting of the source of dissatisfaction.

7.3 RESTATEMENT OF OBJECTIVES

The objectives of this study were to determine subscribers' perception of quality of health care services under the New Juabeng and Ketu Mutual Health Insurance Schemes, determine the service quality dimension(s) used by beneficiaries to evaluate service quality and the particular areas of health care services under the NHIS subscribers considered most important at the health care facility. The need to sustain the newly introduced National Health Insurance Scheme, an alternative to financing the ever-increasing cost of health care services in the country necessitated this study.

To achieve the objectives set, the variables used in determining the quality of health care services included: the level of communication between service providers and patients, the attitude of the staff towards insured patients and the availability of essential prescribed drugs at the health care facility. The following questions were therefore numerated as aiding the process.

1. What were subscribers' perceptions of the level of communication with medical staff?
2. How do subscribers perceive the attitude of the staff of the health facilities they attend?
3. What were subscribers' perceptions of availability of the essential drugs promised under the schemes?

7.4 SUMMARY OF KEY FINDINGS

The major findings of the study in respect of the objectives and research questions are discussed in the succeeding paragraphs.

Level of Communication

Using the average perceptual ratings, it was apparent that respondents in New Juabeng rated the level of communication at the health care facility as good (approximately 2.0 on the Likert scale used for the study), those in Ketu rated it as fair (approximately 3.0 on the scale).

Perception on the Attitude of Staff

The ratings for the attitude of staff towards respondents in the New Juabeng were good and (2.0 on the Likert scale) and in Ketu fair (3.0 on the Likert scale).

Perception on the Availability of Drugs

Approximately, 46% of the respondents attested to the availability of prescribed drugs at the health care facilities they attended. About 45% of the respondents said prescribed drugs were unavailability at the health care facilities. The percentages

appeared to present a divided view on the availability of prescribed drugs at the health care facilities. The perception of subscribers on the availability of drugs is that to a large extent prescribed drugs are available at the health facilities.

Others

Subscribers' current perception of quality of health care services is good under the New Juabeng Municipal Health Insurance Scheme (based on the mean perceptual averages of 2.0). In Ketu, subscribers perceive service quality to be fair (based on the mean perceptual average of 3.0). Availability of drugs and its efficacy has been rated high in both districts.

The relevant service quality dimension used by subscribers to rate quality of health care services, under the two schemes, were explanation on medical tests, the help extended to them by the nursing staff and the courtesy of the nursing staff.

The particular areas of health care services under the NHIS considered important to subscribers arising from the study include the length of time spent in the health care facility (considered to be too long) for insured patients, the demeanour of the nursing staff in terms of respect towards insured patients, availability of prescribed drugs (considered to be constantly in short supply) at health facilities, insistence on follow-up (considered to be uncommon) and in Ketu particularly, the seemingly better treatment given to Togolese and Beninois patients than Ghanaian health insured patients.

7.5 CONCLUSIONS

The major conclusions in respect of the quality dimensions used in the study and their implications on the health insurance scheme are discussed in the succeeding paragraphs.

Level of Communication

The rating of good, on the level of communication in the New Juabeng municipality is favourable as it apparent that the hospital staffs communicate effectively with the respondents under the scheme. Careful consideration should however be given to the explanations on medical tests to be taken by respondents as it has been established as a major determinate of the level of communication under the scheme in New Juabeng.

In Ketu, the perceptual rating of fair is unfavourable. Fair implies respondents were not happy about the level of communication from the health care staffs in the facilities they attended. However particular attention should be given to the explanations on medical examinations subscribers are requested to undertake, as respondents appeared to indicate it was a major determinant of the level of communication.

Attitude of Staff

The attitude of staffs of the health care facilities in the New Juabeng municipality was rated as good, implying respondents considered it favourable. However, the courtesies of the nursing staff as well as the help offered by them were considered a major determinant of quality in the municipality.

The perceptual rating in Ketu, for the attitude of the nursing staff was fair. A rating of fair is unfavourable for the scheme as respondents could easily refuse to renew their premiums. This could be attributed to the dwindling enrolment levels in the district compared to the high initial enrolment levels at the inception of the scheme (KDMHIS Annual Report, 2007). The courtesies of the nursing staff towards respondents were considered important in determining the attitude of staff under the scheme.

Availability of Drugs

Prescribed drugs were generally considered to be available at the health care facilities. Where the drugs were not available at the health care facility, respondents were either referred to a contracted drug store for the drugs at no cost or were asked to buy them. Explanations on why the drugs were unavailable at the facility or why they were required to buy them were not given to them. The non-existence of explanations on why prescribed drugs were not available left room for respondents to attribute several reasons as to why the drugs were not available. Some of these reasons included: expensive drugs were not covered; dispensers hoarded and sold NHIS drugs to non-subscribers amongst others.

7.6 POLICY IMPLICATIONS OF THE STUDY

An inter-institutional collaboration between the Ghana Health Service, the National Insurance Commission, the DMHI schemes and health care professionals in establishing provider norms, training, job description, developing clearly defined structures of supervision and rewards, would ensure best practices in terms of ensuring quality of health care services.

Subscribers viewed explanations on medical tests to be taken by them as a major determinant of the level of communication in the two districts, doctors and nurses as well as laboratory technician need to be sensitised through joint training programmes as described in the preceding paragraph on how to communicate effectively with patients the medical tests they are to take and the implications of such tests to them.

The courtesy of the nursing staff was also considered a major determinant of the attitude of the staffs in the two districts. Institutionalisation of reward schemes for nurses considered courteous by patients in health care facilities would motivate nurses to be courteous. In the Ketu district in particular, Ghanaian patients should be considered as important as their Togolese and Beninios counterparts in the provision of health care services.

Adequate supply of essential drugs under the NHIS should be in constant supply at the various health care facilities providing NHIS services. More pharmacists should also be contracted to provide these essential drugs to subscribers. Continuous education of subscribers on the fact that not all drugs are covered by the scheme should be provided.

The low levels of complaints and satisfaction with the handling of such complaints reveal a shortcoming in this area. Institutionalisation of proper reporting and complaint channels in the various schemes would enable complaints to be handled in a good manner and assurance of subscribers that their welfare is of concern to the scheme which are linkages between the subscribers and health care providers. The establishment of special complaints committee as practiced in the Ketu district to

address complaints as soon as practicable would exude confidence in the schemes and ensure quality at the health facilities contracted by the schemes.

These recommendations notwithstanding, a time series analysis of these perceptual ratings in quality of health care services provided under the schemes over considerable periods may be helpful in establishing appropriate patterns and subsequent valid conclusions. This is because this study was conducted a little over a year into the introduction of the DMHI schemes.

7.6.1 Implications for Further Research

This study would not be complete without a recommendation for further studies on issues arising from the study. The following have been suggested as furthering the course of quality in the NHIS, to ensure its sustainability.

The Role of the District Mutual Health Insurance Schemes in Ensuring Quality of Health Care Services in Ghana – the DMHI schemes is the link in the NHIS between subscribers and providers of health services. A discussion of their role in ensuring quality would not only contribute to assuring quality but furthering academic discourse.

A study into the Ghanaian patient's definition of health care quality would elaborate further the quality dimensions considered by Ghanaian subscribers to the scheme as of importance thus needing particular attention.

7.7 CONCLUSIONS

Ghana's development strategy is on alleviating poverty. Poverty is believed to be both a cause and consequence of poor health. The National Health Insurance Scheme was thus introduced to increase financial access to affordable and quality health care services. The financial access is reflected in the low premium levels charged annually (Appendix IV). Quality of health care services can be assessed from various perspectives however, the consumer of the service's perspective is gaining importance, as it is a major determinant of the survival of organisations that provide services.

The study thus set out to determine quality of health care services under the DMHI scheme in Ghana from subscribers' perspective with particular focus on the New Juabeng and Ketu Districts. The finding revealed that whilst respondents in New Juabeng viewed quality as good, respondents in Ketu perceived quality as fair.

These ratings require measures such as institutionalization of quality measures and reorientation of providers of health care services to see quality from the subscribers' perspective and consider that as an important base for the success of the schemes, which contracted them. When serious considerations are given to the findings of this study, there is no doubt it would contribute to the sustaining of the DMHI schemes in Ghana.

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6. How many times have you used the services under the NHIS? _____

7. What is your occupation? _____

SECTION B

How would you rate the NHIS services provided at the hospital under the following features?

Level of Communication

1. The thoroughness with which the doctor examined you before writing your prescription?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

2. The explanations of the hospital staff gave you about your medical tests.

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

3. Did the doctor or hospital nurse insist on follow-up on your illness?

[a] Yes [b] No [c] Not Sure

4. How well were possible side effects of medications explained to you?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

Attitude of Staff (workers the hospital)

5. The helpfulness of the nurses in the hospital under the NHIS?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

6. The courtesy of the nursing staff under the NHIS?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

7. The level of personal interest expressed by the doctor in your illness?

[a] Very High [b] High [c] Fair [d] Low [e] Very Low

8. The courtesy of the dispenser when you went for your drug?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

9. Would you say there is a difference in the treatment offered you as an insured patient?

[a] Yes [b] No [c] Not Sure

b. If yes, in what way(s)

Access to Drugs

10. Do you often find prescribed drugs under the NHIS available at the dispensary?

[a] Yes [b] No [c] Not Sure

b. If No, what were you asked to do? _____

11. Would you consider the drugs given you under the NHIS the best for your condition?

[a] Yes [b] No [c] Not Sure

b. If No, what why? _____

General Information on NHIS

12. How would you rate the over all quality of service provided under the National Health Insurance Scheme?

[a] Very Good [b] Good [c] Fair [d] Poor [e] Very Poor

13. Have you made any complaints since you started using the hospital under the NHIS?

[a] Yes [b] No [c] Not Sure

14. If yes, were you satisfied with the way the complaint was handled?

[a] Yes [b] No [c] Not Sure

15. Did anything happen during your visit(s) to the hospital under the NHIS that you thought was surprising or unexpected? _____

16. What best thing do you want to say about the NHIS at the hospital? _____

17. What worse thing do you want to say about NHIS at the hospital? _____

18. Is there anything the hospital could do better under the NHIS to meet the needs of the insured patients? _____

19. Based on the quality of services provided under the scheme, would you recommend the scheme to those who have not joined?

[a] Yes

[b] No

[c] Not Sure

Please give a reason _____

Thank You

APPENDIX II**INTERVIEW GUIDE:****UNIVERSITY OF GHANA BUSINESS SCHOOL****UNIVERSITY OF GHANA, LEGON**

1. What was the general level of communication between you and the following hospital staffs before the introduction of the National Health Insurance Scheme:
 - (i) The doctor
 - (ii) The nurses
 - (iii) The drug dispenser
 - (iv) Laboratory technicians
 - (v) Other workers (specify)
2. What was the attitude of the staff towards you whenever you were in the hospital before the Introduction of the NHIS?
3. What would you say about access to the following before the introduction of the NHIS?
 - (i) Access to facility
 - (ii) Access to a doctor
 - (iii) Provision to make complaints
4. What was access to drugs and medication like before the introduction of NHIS?
5. What general information can you give me about quality of health care services from your perspective before the introduction of the NHIS?

APPENDIX III

The Benefit Package

The government has come out with a minimum benefit package of diseases, which every district-wide scheme must cover. The package covers about 95% of diseases in Ghana and these include among others the following; Malaria, Diarrhoea, Upper respiratory tract infection, Skin, diseases, Diabetics, Hypertension, Asthma.

- i. **Out – Patient Services:** Consultations, requested investigations, medication.
 - **Out – patient/** day surgical operations
 - **Out – patient** physiotherapy
- ii. **In –patient services:** General and specialist inpatient care
 - **Requested investigation:** Laboratory, X – rays, ultra sound scanning etc.
 - Medication: prescribed drugs under NHIS
 - Surgical and breast cancer operations
 - Inpatient physiotherapy
 - Accommodation and feeding (where available)

Other Specific services

- Oral health services
- Eye care services
- Maternity care
- Emergencies

Free services

- Immunization
- Family planning
- Mental illnesses
- Tuberculosis
- Confirmatory HIV test on AIDS patient

Exclusion Lists

These services will not be covered under the NHIS. This means health insurance schemes have the freedom to decide whether they will offer them as additional benefit to their members. They include:

- Rehabilitation other than physiotherapy
- Appliances prostheses (optical, hearing and orthopaedic aids, and dentures.
- Cosmetic surgeries and aesthetic treatment
- HIV retroviral drugs
- Assisted reproduction
- Echocardiography
- Photography
- Angiography
- Mortuary services
- Diagnosis and treatment abroad
- Etc

Source: Ministry of Health, 2004

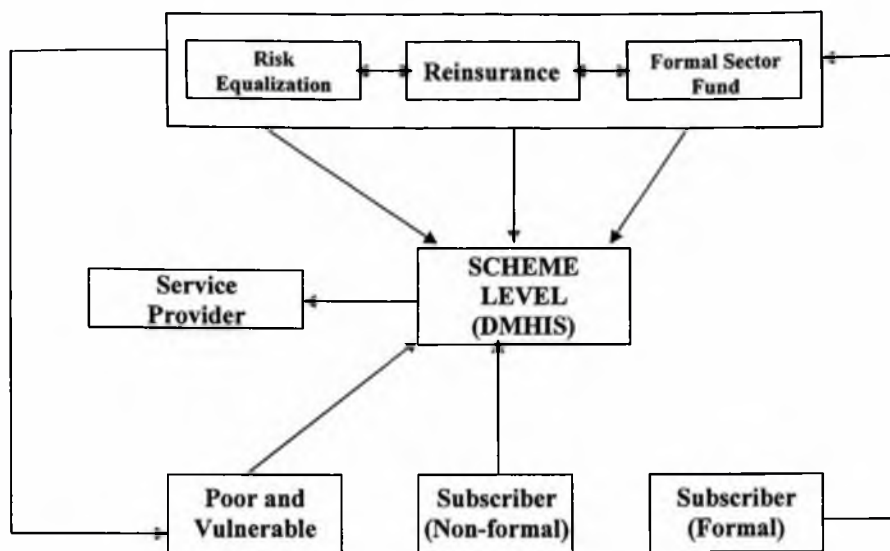
APPENDIX IV

Name of Group	Category	Who they Are	Minimum Contribution p.a.
Core Poor	A	Adults who are unemployed and do not receive any identifiable and constant support elsewhere for survival.	Free
Very Poor	B	Adults who are unemployed but receive identifiable and consistent financial support from sources of low income	¢72,000.00
Poor	C	Adults who are employed but receive low returns for their efforts and are unable to meet their basic needs	¢72,000.00
Middle Income	D	Adults who are employed and able to receive their basic needs	¢180,000.00
Rich	E	Adults who are able to meet their basic needs and some of their wants	¢480,000.00
Very Rich	F	Adults who are basic needs and most of their wants	¢480,000.00

Source: Ministry of Health, 2004

APPENDIX V

NATIONAL HEALTH INSURANCE FUND



A Fund Flow Model

Source: Ministry of Health, (2004), National Health Insurance Policy Framework, p17

APPENDIX VI

Table 1: Gender Rating of Quality in New Juabeng

GENDER	RATE OF QUALITY UNDER NHIS				
	V. GOOD	GOOD	FAIR	POOR	TOTAL
MALE	18	55	87	7	167
FEMALE	58	54	109	8	229
TOTAL	76	109	196	15	396

Table 2: Gender Rating of Quality In Ketu

GENDER	RATE OF QUALITY UNDER NHIS					
	V. GOOD	GOOD	FAIR	POOR	V. POOR	TOTAL
MALE	5	66	68	37	14	190
FEMALE	1	51	64	59	5	180
TOTAL	6	117	132	96	19	370

Table 3: Rating of Quality in Respect of Age in New Juabeng

AGE	RATE OF QUALITY				
	V. GOOD	GOOD	FAIR	POOR	TOTAL
18-24	20	5	21	2	46
25-34	12	33	41	2	88
35-49	26	25	47	5	103
50-64	10	31	43	7	91
65 & ABOVE	8	15	44	1	68
TOTAL	76	109	196	15	396

Table 4 Rating of Quality in Respect of Age in Ketu

AGE	RATE OF QUALITY					
	V. GOOD	GOOD	FAIR	POOR	V.POOR	TOTAL
18-24		11	29	4	3	47
25-34	5	24	23	10	3	65
35-49		44	47	46	3	140
50-64	1	29	15	22	8	75
65& ABOVE		9	18	14	2	43
TOTAL	6	117	132	96	19	370

Table 5: Rating of Quality in respect of Educational Level in New Juabeng

EDUCATIONAL LEVEL	QUALITY RATING				
	V. GOOD	GOOD	FAIR	POOR	TOTAL
NOFORMAL EDU.		18	13	1	32
PRIMARY	15	18	57		90
JSS/MIDDLE SCH.	39	20	64	6	129
SSS/SECON.	20	18	35	5	78
TERTIARY	2	35	27	3	67
TOTAL	76	109	196	15	396

Table 6: Rating of Quality in Respect of Educational Level in Ketu

EDUCATIONAL LEVEL	QUALITY RATING					TOTAL
	V. GOOD	GOOD	FAIR	POOR	V. POOR	
NOFORMAL EDU.		11	3	7	1	22
PRIMARY	1	34	25	28	2	90
JSS/MIDDLE SCH.		17	33	21	2	73
SSS/SECON.	5	39	32	17	10	103
TERTIARY		16	39	23	4	82
TOTAL	6	117	132	96	19	370