

**SUSTAINABILITY OF NHIS: THE ROLE OF SOCIAL CAPITAL AND
SERVICE CARE PROVIDERS IN THE LEDZOKUKU-KROWOR
MUNICIPAL ASSEMBLY (LEKMA)**

BY

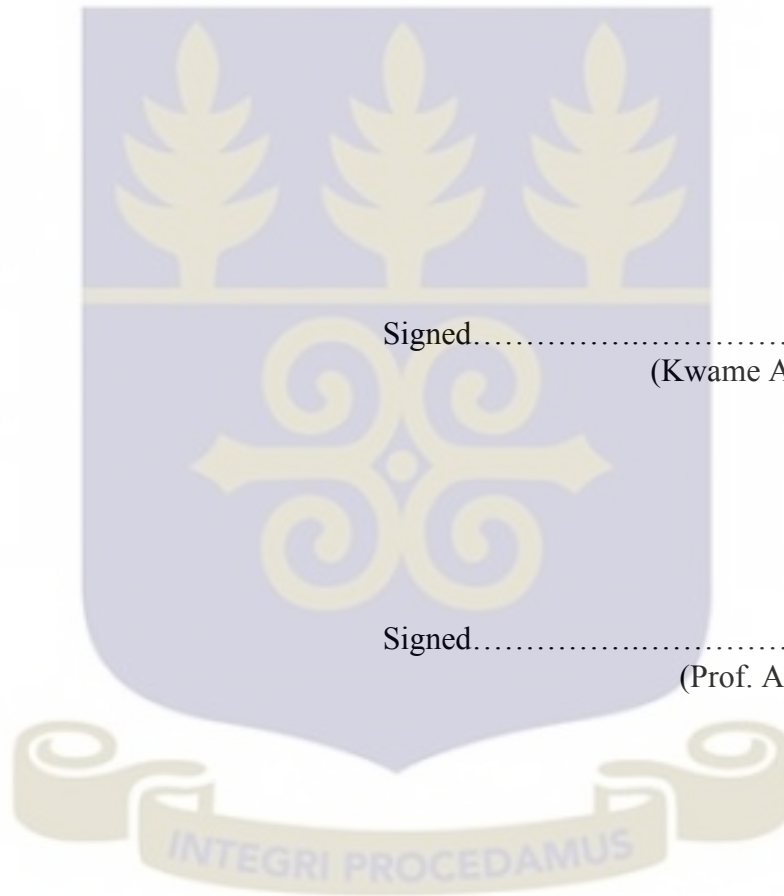
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DECLARATION

I declare that this thesis is my own original and independent work under supervision. All authors and other intellectual materials and sources that have been quoted have been fully acknowledged. I also declare that neither part nor in its entirety has this thesis been published in any form or submitted to another University or Institution for the award of a degree.



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ABSTRACT

Over the years healthcare has been identified as a major area of concern among the general population in Ghana. For that matter various policies have been put in place to respond to health needs, but to no avail. Using an explorative study within the Ledzokuku-Krowor Municipal Assembly of Accra, the study sought to ascertain if any elements of social capital could be relevant in the provision of quality healthcare in conjunction with future policies implemented in Ghana.

Using a qualitative and quantitative methodology framework, the study established that the inclusion of elements comprising social capital, include norms, networks, trust, reciprocity, and resource pooling is necessary to aid in sustaining the National Health Insurance Scheme and their service care providers. The study also yielded that 44.4% of NHIS subscribers on the whole disagreed with the idea that the scheme is not being managed properly. Although the participants feel that the National Health Insurance Scheme is good, the consensus among the participants was that there needs to be a source of alternative funding for the scheme. It was also found that the members of NHIS have inadequate knowledge as to whether the scheme is being managed well or not, indicating a lack of transparency on the part of the National Health Insurance Scheme.

The study therefore suggests several points that contribute to the schemes longevity. A revision in acquisition of funding pertaining specifically to the development of alternative funding methods for the scheme, restructuring the filing and reimbursement of claims, sensitization of the people through mass education, and implementation of monitoring and evaluation strategies. These points unearthed by the study could help the scheme become more efficient and effective in providing quality and sustainable health care for everyone.

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DEFINITION OF TERMS

CHI	Community Health Insurance
DHS	District Health Administration
GHS	Ghana Health Service
FGD	Focus Group Discussion
HMOs	Health Maintenance Organizations
LEKMA	Ledzokuku-Krowor Municipal Assembly
MOH	Ministry of Health
MDG	Millennium Development Goals
MTHS	Medium Term Health Strategies
NHS	National Health Scheme
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
PHR	Public Health Record
SAP	Structural Adjustment Program
UNFPA	United National Population Fund
VAT	Value Added Tax

Chapter One

Introduction

1.1 Introduction / Background

Many countries around the world are now concerned with financing the health care of their people. In North America during the 1990's, the system of Health Maintenance was put into place to tackle the issue of managing and maintaining healthcare (Hendryx, 2002). In Germany there is a system in place more commonly known as sickness funds (Insaadoo, 2007) originally known as *Krankenkassen* (Tulchinsky and Varavikova, 2009). In Canada, parliament saw the need for a more comprehensive health care policy, with this came the birth of Canada Health Act established in 1984 (Nielson, 2009).

Countries in Sub-Saharan Africa also have critical concerns about health care. Various policies and practices have evolved over the years to better enhance the healthcare system in countries in Sub-Saharan Africa (Cassels, 1995; Cassels and Janovsky, 1996). Some of these countries have reformulated previously presented policies. For example, in the late 1990s, Ghana reformed the healthcare sector. One of the reforms that had been implemented was called Medium Term Health Strategy, and its purpose was to improve access and quality of healthcare. Medium Term Health Strategies also worked to improve efficiency of health care (Ghana Health Service website, 2011).

It is evident, from the various healthcare policies that have been passed, that health care systems are an important component of human overall longevity. (Global Health Leadership Institute, 2009) Health care systems are more than just a system of delivering health care; they are an essential part of society (Gilson, 2005).

Healthcare is so important that the Millennium Development Goals number 1 (Eradicate extreme hunger and poverty), Goal 4 (Reduction of Child Mortality), Goal 5 (Improve maternal health), and Goal 6 (Combat Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS), malaria and other diseases) related to it. Thus Ghana as a country has seen the implementation of many health care policies in the past, such as the cash and carry, and Medium Term Health Strategies (MTHS). Presently the country's public healthcare policy is the NHIS, as well the policy of cash and carry. The NHIS was established to reduce the financial burden on the government and on the individual families as well as increase access to healthcare. It is difficult to access healthcare when one does not have the means to pay for the services rendered especially the poor. In addition, if one is in a situation of extreme poverty, the person would not be able to obtain nutritious food in order to stay healthy. According to the Millennium Development Report 2010:

Overall progress in reducing the prevalence of hunger has not been sufficient to reduce the number of undernourished people. In 2005-2007, the last period assessed, 830 million people were still undernourished, an increase from 817 million in 1990-1992 (MDR, 2010:11).

Both lack of financial access to health care and poverty are concerns and questions that need to be addressed with the development of a scheme such as the NHIS.

Achieving good maternal health is one of the eight Millennium Development Goals (MDGs). A passage from the millennium development report 2010 shows that in Ghana:

Between 1990 and 2005, maternal mortality rate reduced from 740 per 100,000 live births to 503 per 100,000 live births, and then to 451 deaths per 100,000 live births in 2008. This trend is also supported by institutional data, which suggests that maternal deaths per 100,000 live births have declined from 224/100,000 in 2007 to 201/100,000 in 2008. This was after an increase from 187/100,000 in 2004 to 197/100,000 in 2006 (MDG Progress in Ghana, 2011).

The current trends in maternal mortality show that there has been a decrease, but not enough of a decrease to reach the target of 185 per 100,000 by 2015. The decrease in rate of maternal mortality expressed in the millennium development report gives rise to the notion that there is some change being made for the better, but not at the rate desired. Less than half of the women in developing countries receive adequate healthcare when giving birth, as opposed to the women who are attended to by skilled health professionals in developed countries (Millennium Development Report, 2010). This may account for the inadequate drop in mortality rate that was stated earlier.

Preventing the spread of HIV/AIDS is also a very important millennium development goal. HIV/AIDS is interwoven with the subject of access to quality healthcare. Access to quality healthcare is only the start of decreasing the spread of HIV/AIDS.

The HIV prevalence rate slowed down after peaking at 3.6% in 2003. It then declined to 3.2% in 2006 and further dropped to 2.2% in 2008 but increased to 2.9% in 2009. Given this trend, Ghana has to sustain the efforts in order to meet the target of halting and reversing the spread of HIV/AIDS by 2015 (MDG Progress in Ghana, 2011).

The rate at which HIV/AIDS is spreading has slowed and this is attributed to the rise in awareness of the disease, as well as increased access to anti-retroviral treatment (Ghana Demographic and Health Survey, 2008). The rationale here is that awareness, and

increased access to these antiviral treatments, go hand in hand with an informed, efficient, and effective healthcare system in place.

Overall, the original focus of the NHIS providing safe and affordable healthcare to all its citizens is one that most people seem to agree with. The issue that many people have with the scheme is whether or not it can be sustained (Nguyen *et al.*, 2011). In the 2007 study conducted by Nguyen *et al.* (2011) in two Ghanaian rural districts concerning the financial protection effect of Ghana's national health insurance scheme, the issue of out-of-pocket payment was discussed. The study makes two very important points pertaining to the sustainability of the NHIS. The first issue deals with the subject of insurance not serving as the sole remedy for out-of-pocket payments made by individuals. This is due to the fact that patients are still required to pay for medicines that should have been covered under the NHIS. The second idea found in the findings from the study conducted has to do with the need for improvement in the quality and access to health care as shown below:

Without proper regulation and incentives for the supply side to improve quality and availability of services, insurance cannot be an attractive product. This in turn will be a hindering factor in coverage expansion and ultimately will affect the prospect of achieving universal coverage (Nguyen *et al.*, 2011:10).

With this said one could see that the insurance scheme does have challenges that need to be addressed, in order for it to be sustainable and efficient.

1.2 Statement of the Problem

The current debate in the literature deals mainly with the feasibility, and sustainability of the NHIS. A feasibility study conducted by Edoh and Brenya (2002) among students on study leave on their willingness to pay a percentage of their income to NHIS showed that more than 74% were willing to contribute to the scheme. 38% and 37% were willing to pay 1% and 2% of their incomes thus highlighting the current debate in the literature of affordable and sustainable healthcare. In the view of Edoh and Brenya:

Financing health has been one of the issues confronting the Ghana government. Most Ghanaians cannot afford medical care as a result of high escalating costs. Health services, whether preventative, curative, or rehabilitative, now demand financial commitment which many people cannot meet from their own resources (Edoh and Brenya, 2002:41).

An article published by Ghana Web Health News on Sunday, 6 February 2011 discusses the trend in the delays in NHIS claims. The article elaborates on the delays in the re-imburement claims having a negative impact on the provision of quality of healthcare (Ghana Web Health News, February 2011). To further substantiate the on-going problem that is affecting the day to day operations of the NHIS, the allocation of funds needs further exploration. Green *et al.*, (2000) expands further on this issue pertaining to the untimely allocation of funds. They noted that:

While timely allocation of funds is crucial for supporting decentralized health systems, regional and district health authorities in Africa often have to endure long delays in funding which further weakens their already precarious financial positions (Green *et al.*, 2000).

This idea of untimely allocation of funds presupposes that NHIS's system of funding is unsustainable. "The majority of funds acquired via the health insurance levy

for the NHIS in 2009 were recorded as 61.49%” (NHIA Annual Report, 2009). The main argument being put across in the literature is that funding for a NHIS should come from alternative sources. The literature questions the long run sustainability of the funding for NHIS, untimely acquisition of funds, coupled with skewed acquisition of funding, could result in the unsustainability of the scheme. According to Asante *et al*, 2006:

If the current bottlenecks in disbursement of funds from the national level are not rectified, this may affect the allocation of subsidies from the Nation Health Insurance Fund to equalize the amount of premium generated across schemes in different parts of the country, thereby perpetuating the existing geographical inequities in funding of health activities (Asante *et al*, 2006: 8).

Another article, published by Ghana Web Health News addressed the issue of 170 patients who were detained due to non-payment of hospital bills at ten regional government hospitals (Dowuona, 2011). The article remarked about how a telecommunication company, Vodafone gave out GHC 60,000 to settle unpaid hospital bills (Dowuona, 2011). People who present their NHIS cards are forced to pay for certain services that are inclusive within the NHIS because of NHIS re-imburement challenges. This raises further questions about sustainability, and whether these healthcare facilities are able to adequately treat those that have registered and will register for the NHIS.

The Ghanaian Journal.com also posted an article on May 20, 2010 stating:

It recommended that the National Health Insurance Authority (NHIA) developed innovative ways of reimbursing claims of service providers timely to facilitate acquisition of medicines and medical equipment for improved service delivery. The findings suggested that the Ministry of Health (MOH) and Ghana Health Service (GHS) should pay serious attention to the development of existing health facilities, improve on human resource situation and re-distribute health personnel to underserved and overburdened areas.

There are numerous issues concerning NHIS funding and stable access to quality healthcare, as noted from quotations above, yet there are few suggestions made to remedy

these recurring problems. This research work plans to address the gaps in the literature by analysing the dynamics with regard to limitations and short comings of re-imbursement of claims, as well as the impact of social capital on the sustainability of NHIS.

This research work focuses on the management practices so as to identify problems related to membership intake, funding, and claims re-imbursement in the NHIS programme. These three issues will be explored further to ascertain their legitimacy as well as their feasibility.

The NHIS is a program that is supposed to rely on the premium that the subscribers pay (before they visit a health facility and these payments are later pooled and used to fund the scheme). One of the short comings identified by the NHIA annual report 2010 dealt mainly with information and computer technology capabilities. The problems that confront the scheme consisted of poor data integrity, limited membership authentication at service provider sites and manual vetting of claims. There is thus the problem of how the scheme would accurately monitor and measure the number of people enrolled, and the number of people receiving services from the NHIS.

Funding is another issue that would impact on the sustainability of the scheme. The plan for funding the NHIS is one that needs attention. Most of the funds used to support the NHIS are coming from the NHIS levy. This brings to the fore the concern about issue of its sustainability. The issue of concern is how effectively is the collection of the levies? And how effectively are the funds that are collected properly appropriated?

Sustainability addresses the issue of claims reimbursement. Hospitals and clinics everywhere give treatment to the registered members of the NHIS as per their stipulations. The concern is that when the claims are made to the NHIA, the time it takes

for a claim to be reviewed and disbursed is often times too long, sometimes over one year (Ghana Web Health News of Sunday, 6 February 2011). The problem is often a breakdown in communication between the health care providers, and those allocating the funds. It is hoped that this study would clarify the necessary challenges in funding sustainability, and claims reimbursement in order to extend the longevity of the NHIS.

1.3 Research objectives

The main purpose of the study is to explore the management practices of the NHIA. Specifically the research seeks to:

1. Examine the management practices of the NHIS.
2. Assess healthcare providers and clients' perceptions about the NHIS's sustainability with regards to funding, issuance of cards, payment of annual premiums and "one time premium".
3. Examine the management practices relating to claims re-imbursement by the NHIA
4. Evaluate the relevance of the concept of social capital to the NHIS operations.

1.4 Definition of Concepts

Sustainability: within the scope of this study, refers to what the Brundtland report describes as "meeting the needs of present generation without compromising the needs of future generations" (WCED, 1987: 43). The report emphasizes the urgency to critically consider the essential 'needs' of the world's poor, and the idea of limitations imposed by the state of technology and social organization on the environment's ability to meet present and future needs. Hence, the main issues of sustainable development include

economic development, social development, and environmental protection (World Summit, 2005). All these three issues have direct bearing on the health sector of any developing country such as Ghana. Another definition that would further focus on the scope of its sustainability is based on CGIAR's mission statement in 1989 about sustainability in agriculture. This definition was stated as "successful management of resources for agriculture to satisfy changing human needs while maintaining or enhancing the quality of the environment and conserving natural resources" (TAC/CGIAR 1989).

Public and Private Service providers: Private health service providers, as termed by Mills *et al* 2002, are described as "comprising all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease." The private sector includes large and small commercial companies, groups of professionals (including doctors, nurses, pharmacists, radiologists, and other staff members). These are the people that would be included under the private service care providers.

Public service providers, as described by Winslow are responsible for:

The prevention of disease, prolonging of life and promoting of health through the organized efforts and informed choices of communities and individuals through society, organizations... for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health (Winslow, 1920:30).

With this definition both private and public service providers are responsible for providing every individual in a community the right to adequate healthcare through early diagnosis and prevention of diseases.

Social Capital: Putnam (1995) defined social capital as “features of social organization such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam, 1995:67). The second definition is one presented by The World Bank. The World Bank interprets social capital as:

Referring to the norms and networks that enable collective action; Encompassing institutions, relationships, and customs that shape [sic] the quality and quantity of a society's social interactions (Grootaert and Basteler, 2002).

These definitions put forward gravitate to the idea that there is a network and that individual members of the network are contributing to a particular goal or ideal. The contributions made to this network by various individuals are geared toward the advancement of a collective group or society.

Management: Contemporary theories of management tend to account for and help interpret the rapidly changing nature of today's organizational environments. The following definition of management presented by Fayol (Fayol, 1949) who saw the task of management as: “To manage is to forecast and plan, to organize, to command, to coordinate and to control” - i.e., making sure people do what they are supposed to do. From the general perspective, management is “the process of designing and maintaining an environment in which individuals, working together in groups, efficiently accomplish selected aims” (Koontz and Weihrich, 1990:4). In contrasting the more specific and broad understanding of management, this study is concerned with the management ideals

concerning problem identification, problem solving, organization effectiveness, and human resource management.

Insurance: Most definitions of insurance vary because of their diverse modes of application such as life insurance, automobile insurance, home insurance, liability insurance, and disability insurance to name a few. However, the numerous definitions of insurance share key elements of risk transfer and risk management. More specifically the term insurance as defined by Outreville is that:

Insurance is a concept, a technique, and an economic institution. It is a major tool of risk management, and plays an important role in the economic, social, and political life of all countries (Outreville, 1998).

This definition provides an understanding of the significance of insurance institutions such as NHIS as well as the rationale for its existence and functions.

The explanations of the concepts above give further clarity to the research work when addressing the various subject matters in question; and helps narrow the focus and the approach of this study.

1.5 Justification and Significance of the study

The significance of this study is an exploration of the operations of the NHIS; its service facilities, service providers and clients as a means of determining best management practices, the role of social capital, funding and claims reimbursement challenges. The research would be useful for governmental and nongovernment organizations interested in policy making and implementation in the health sector and in

particular, the NHIS as a mechanism for serving the people of Ghana, and providing an ultimate reliable, effective and efficient healthcare to the people of Ghana for higher socio-economic productivity, as the saying goes that ‘a healthy mind lies in an healthy body’.

1.6 Methodology of the study

Health is considered as one of the most paramount things that contribute to a person’s wellbeing as well as to a country’s productivity. The study uses a variety of methods for the data collection known as triangulation. This ensures data reliability and integrity. These strategies are useful in studying the issues outlined, including the relevance of social capital within the national health insurance scheme of Ghana.

This explorative study was undertaken within the Ledzokuku-Krowor Municipal Assembly (LEKMA) area. It encompasses all service providers accredited by NHIS, essentially a census of the NHIS facilities in LEKMA. The Kpeshie mutual health centre, the NHIS central office of LEKMA, was one place utilised to acquire qualitative data for the study. The Kpeshie mutual health centre comprises of a general manager, claims manager, accounts manager, and public relations officer. They also utilized the services of 25 agents to serve as a link between the scheme and the community. Beneficiaries are also captured within the study. These people are identified as those with valid health insurance cards that were yet to expire – including men, women, and children.

1.7 Study Population

As indicated in Chapter One, this study encompasses all service providers accredited by the NHIS. LEKMA is comprised of Teshie and Nungua. Within these two towns are Hedzoleman (Teshie), MarteyTsuru (Teshie), North Teshie, South Teshie, Teshie, Teshie Military Zone, Teshie/Nungua Estates, and TeshieWajir Barracks.

With a total land area estimated at 50 square kilometres and an estimated population of 261,571 in 2008, the general population density is calculated as 5,231 persons per square kilometres (Ledzokuku-Krowor Municipal Assembly Demographics, (2010). Ledzokuku-Krowor has been selected for this study for various reasons. One of the reasons being that LEKMA is a new municipal assembly, and with its recent inception different ideological practices could be implemented in order to aid in the sustainability of the NHIS. Another reason why LEKMA has been chosen is its relatively small size with respect to other NHIS providers in the Greater Accra Region. Although it is not as large as its neighbouring municipal assemblies, it could serve as a pilot assembly to test new practices and procedures. Being a small municipal assembly it would be easier to research for work of this dimension. Furthermore, the objectives of a study of this nature warrant a smaller area of research to thoroughly investigate the various ideas being suggested in this research.

Table 1.1: Population Demographics of LEKMA

Locality	Total Population	Percent	Male	Male Percent	Female	Female Percent
Hedzoleman (Teshie-Nungua)	14,726	5.63	7,31600	49.68	7,41000	50.32
MarteyTsuru-Teshie	5,807	2.22	2,808	48.36	2,999	51.16
North Teshie	73,109	27.95	35,706	48.84	37,403	51.16
Nungua	80,721	30.86	39,561	49.01	41,16000	50,99
South Teshie	45,461	17.38	22,185	48.80	23,276	51,20
Teshie	11,431	4.37	5,90600	51.67	5,52400	48.33
Teshie Military Zone	3,217	1.23	1,808	56.20	1,409	43.80
Teshie/Nungua Estates	24,143	9.23	11,854	49.10	12,289	50.90
Teshie-Wajir Barracks	2,956	1.13	1,470	49.72	1,486	50.28
Total	261,571	100.00	128,615	49.17	132,956	50.83

Source: LEKMA Home Page - Demographics 8th April, 2011
<http://lekma.lakesidegh.com/aboutlekma/232/demographics/>

Teshie Old Town is a community in the Teshie Sub-Metro, which has a population of about 35,410. The community is made of mostly Gas and is predominantly comprised of fishermen, drivers, and petty traders amongst others. The community is currently confronted with a very serious water problem. They also lack a waste disposal facility, which leads to the dumping of refuse at the shores of the sea thereby polluting the sea with both solid and liquid waste. The buildings in the area are so clustered that accessibility is often difficult, which could indicate a lack of city planning. The implications for such an environment may be the deterioration of the people's health. Indiscriminate dumping of refuse and congestion may facilitate the spread of disease, and prevent men and women from being productive in society.

The Nungua Sub-Metro is one of the Sub-Metros created by Legislative Instrument 1722 under the Accra Metropolitan Assembly. In central Nungua, the market cannot operate regularly because of the waterlogged ground and poor drainage. Poor maintenance of the earth drains (un-cemented trenches) along the area of the Maritime Academy also causes flooding of the coastal road. (Ghana Districts, 2006)

Table 1.2: Demographic and Housing Characteristics of some selected localities in Accra

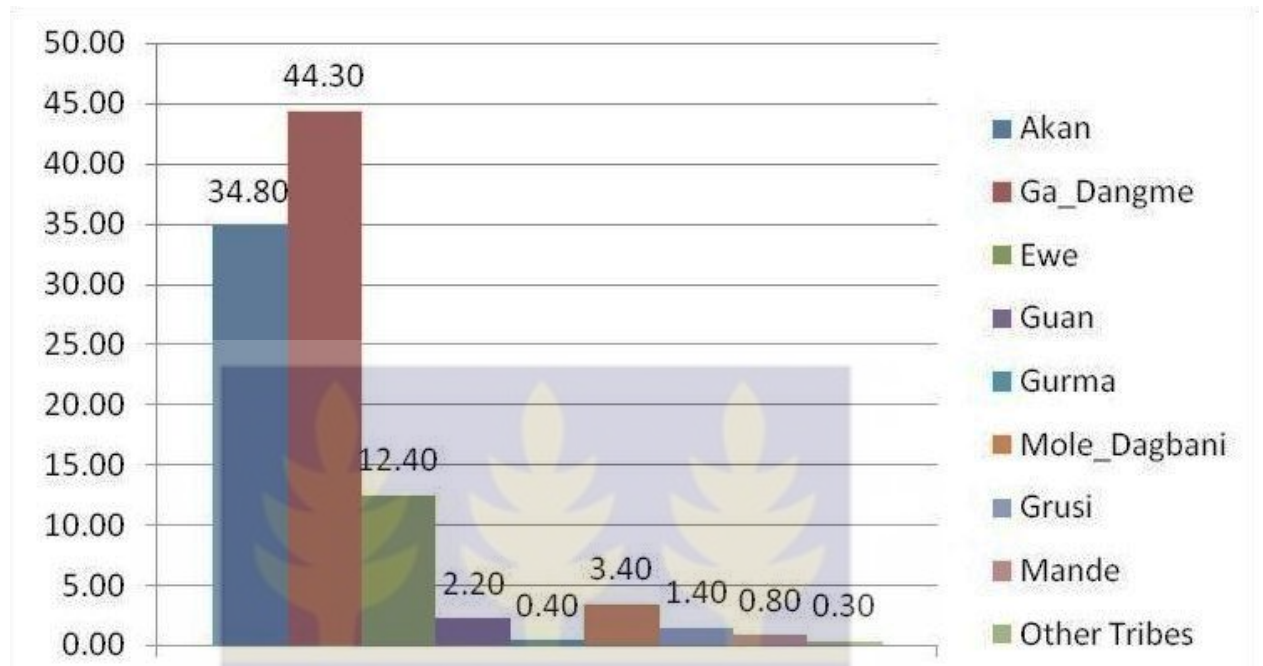
LOCALITY	POPULATION	HOUSES	AV. HH. SIZE
South Teshie	35,410	2226	4.4
Nungua	62,902	5140	4.5
North Teshie	56,949	4862	4.5

Source: Ghana Statistical Service, 2000 Census.

Buildings in low-income areas are made of poor quality material such as mud, untreated timber, and zinc roofing sheets for walling. The housing environment is characterized by haphazard development, inadequate housing infrastructure, poor drainage, erosion and high population concentrations (LEKMA Webpage, 2011).

The census figures for the 2000 population and housing census revealed that the Municipality is ethnically diverse. The indigenous Ga-Adangbe Group makes up a majority and accounts for 44.30%, with the Akans at 34.8% and Ewes following with 12.4%.

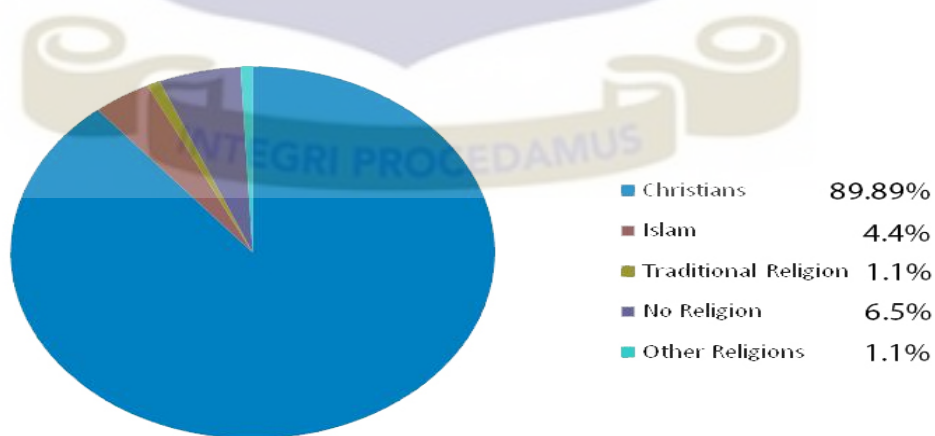
Figure 1: Ethnicity Demographic of LEKMA



Source: LEKMA Home Page – Ethnicity

The Population and Housing Census conducted in 2000 shows that 89.89% of the people in the Municipality are Christians, while only 4.4% and 1.1% are Muslims and traditionalists respectively.

Figure 2: Religious Demographics of LEKMA



Source: LEKMA Home Page - Religion

1.8 Sampling Procedure and Sample Frame

The sampling frame used was a list of accredited service providers of NHIS in the study area. The sampling frame included seven hospitals, seven pharmacies, and one diagnostic centre. It also included a list of managers of the health insurance scheme at the head office in Kpeshie. Survey questionnaires were administered via the accidental sampling method. Powell defines the accidental sampling method as “the researcher simply selecting cases/individuals that are at hand until the sample reaches a desired, designated size with little or no preferential selection of respondents” (Powell, 1997). In all 75 questionnaires (ie sample size) were administered to respondents. These 75 respondents did not include the officials of NHIS.

Any person that possessed a valid NHIS health insurance card was then asked to partake in my study concerning NHIS. If the person consented they were then asked to complete a questionnaire. This collection of data took place in both pharmacies and hospitals, but the bulk of the questionnaires were administered at the hospital than the pharmacies since more respondents were accessible at the hospitals than the pharmacies. The study included the entire population of accredited service providers of the NHIS consisting seven hospitals, seven pharmacies, and one diagnostic centre. It also included managers of the health insurance scheme purposively selected.

The sampling frame consists of all accredited services providers of NHIS in the study area. This includes seven hospitals, seven pharmacies, and one diagnostic centre. It also includes managers of the health insurance scheme. The list of all service providers in LEKMA is shown in the table 1 below.

Table 1.3: Kpeshie Mutual Health Insurance Scheme (Health Providers in LEKMA)

Hospitals: 7	Location
Manna Mission Hospital	TeshieTsui-Bleoo
Christian Medical Hospital	Nungua
Finger of God Maternity Home	Teshie
Family Health Hospital	Teshie
Prima Health Service	Spintex
LEKMA Hospital	Teshie
Teshie Community Clinic	Teshie
Pharmacies: 7	
Health Consult Pharmacy	Teshie Estate
Fabby Chemists	Nungua
Pro-Life Pharmacy	TeshieTsui-Bleoo
Danpong Pharmacy	Nungua
Bright Pharmacy	Teshie Estate
East Airport Pharmacy	Teshie
Camp Road Pharmacy	Teshie
Diagnostic Centre: 1	
Nungua Medical Laboratory	Nungua

Source: Kpeshie Mutual Health Insurance Scheme, (2010)

1.9 Data Collection Procedure

Collection of data was from primary and secondary sources. Primary data was collected through a combination of methods such as questionnaires, focus group discussions and in-depth interview. Information about the reimbursement schedule, cost of premium, and number of health facilities providing health insurance services, was acquired through secondary data. The semi-structured questionnaire used consists of both close and open-ended questions which allowed for some flexibility in responses given by respondents.

The semi-structured questionnaire was used to gather information from the beneficiaries to assess respondents' reasons for joining national health insurance scheme, care given at facilities, the social ties between patrons and the NHIS, the trust between doctors and patrons, among others. The use of the questionnaire was to provide consistency in questions asked avoiding subjectivity while also saving time.

To collect relevant qualitative data, in-depth interviews were conducted among key personnel of the scheme. This included those that manage the NHIS within the municipality. These interviews were carried out to build data; with specific reference to how managers cope with the delay of reimbursement claims made to NHIS. Structured interviewing has some degree of pre-established questions, but still ensures some flexibility in the way questions are asked and answered (Hay, 2010).

The focus group discussion (FGD) conducted in the study was to help identify gender and generational differences in the issues raised, looking primarily at the views and opinions of the individuals' registered under the NHIS as to whether they prefer a

one-time premium over an annual payment plan. This FGD provided the participants a platform to express their opinions and ideas about the questions concerning the NHIS, which gave me valuable information as it provided an additional opportunity to observe the peoples body languages, feelings and emotions concerning the issues being discussed.

1.10 Data Management and Analysis

The data gathered from the field was analysed using the Statistical Package for Social Sciences (SPSS). The use of SPSS facilitated the identification of trends and patterns for interpretation and analysis. Data from the focus group discussion and in-depth interviews were subjected to descriptive analysis. The use of tables and charts were also employed to enhance clear understanding of findings in the research.

All interview guides administered were checked for accuracy and completeness before data was coded and entered. The data obtained from the field was analysed using the Statistical Package for Social Sciences (SPSS) which allowed for easy determination of trends and patterns of the phenomena studied for interpretation and analysis.

Descriptive analysis was undertaken for the various study variables. Tables and charts have been used in summarizing the results.

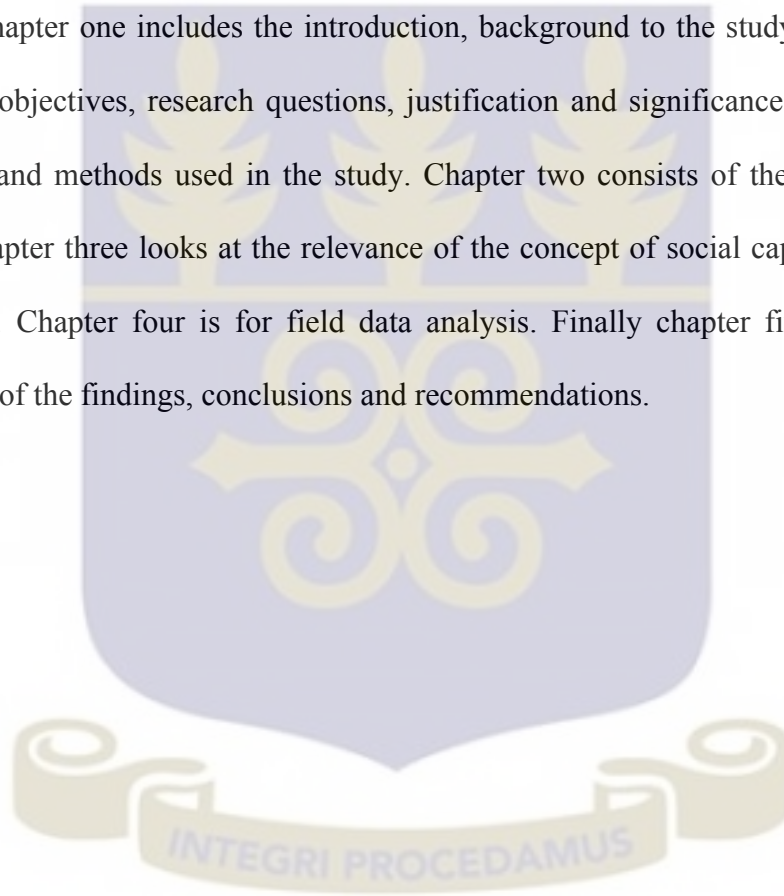
1.11 Pre-Test

The need to ensure validity of the questions asked is very important in helping to elicit the right data for the study. In order to address some of these problems, the questionnaire was first administered on a pilot basis with a smaller proportion of the sample size in the same population before the actual administration of the questionnaire was done. This was to help identify inconsistencies, correct some of the challenges that

were encountered from some of the questions asked, and addressed some of the sensitive questions wrongly written that were ambiguous and could not be understood by the respondents. The overall aim of pretesting was to make sure the questions asked meant exactly the same to all the respondents as they do to the researcher.

1.12 Outline of the Study

Chapter one includes the introduction, background to the study, statement of the problem, objectives, research questions, justification and significance, and definition of concepts and methods used in the study. Chapter two consists of the literature review, while Chapter three looks at the relevance of the concept of social capital to health care insurance. Chapter four is for field data analysis. Finally chapter five consists of the summary of the findings, conclusions and recommendations.



Chapter Two

Literature Review of Healthcare

2.1 Introduction

The literature review looks at the development of health care insurance in Ghana since independence as a means to assessing the current management practices of the National Health Insurance Scheme as a whole and continues to address the impact of the concept of social capital to health care (NHIS) in chapter three. The historical origins of NHIS, and social capital and its relevance are discussed. The sustainability of NHIS is also reviewed by looking at various secondary sources ranging from studies that have been conducted to various reports that have been compiled. Another point that is explored is the structure of the claims made by various health care providers. The reason for looking at the structure of the claims reimbursement is that, the study deems it necessary to critically address the processes and rationale as to why claims that are being presented are delayed. Finally, the issue of financing is discussed in the literature review; focusing on issues like the sustainability of the scheme, feasibility of the one-time payment premium, and the role of social capital in the scheme.

2.2 Health Insurance Schemes in the Discourse

Shortly after the independence of Ghana in 1957, everyone had access to healthcare. In the mid 1990's all Ghanaians were able to acquire medical attention at any local pharmacy with the individuals not obligated to pay any cost (Yale Global Health Leadership Institute, 2009). This free system of healthcare could not be maintained, and

therefore had to be changed. In 1971 the Hospital fee act was established. This act was to curb or reduce the unnecessary use of services as opposed to generating revenue. In 1983 the fees were considerably increased when the new hospital fees act was passed (Nyonator and Kutzin, 1999). “The cost increase is the result of changes in the health care financing scheme, introduced under the Hospital Fees legislation in 1985” (Asenso-Okyere *et al.*, 1998:181). Subsequently, Ghanaians found it very difficult to make payments for medical treatment; which meant that affordable forms of medical relief were sought after including self-medication as well as herbal medication (Asenso-Okyere, *Supra cit.*). With this new behaviour exhibited by Ghanaians resulting from lack of financial access to health care, there was the need for something to be done to alleviate the worries of the people and the burden on the government. The cash and carry system was therefore introduced in 1992. The cash and carry system was and is described as:

The fee per drug item charged to users is related to the procurement cost of the item, marked up with fixed percentages by central and regional medical stores; under this policy the pharmacies and health facilities require that payment is made before drugs are supplied to patients (Nyonator and Kutzin, 1999:4).

The cash and carry system was utilised until people, particularly the very poor, tended to choose alternative health care as opposed to formal healthcare. With the cash and carry system having fallen short of the previous expectations of the government, alternative methods of healthcare was explored in order to lessen the financial burden on those seeking formal healthcare.

The first community health insurance (CHI) scheme in Ghana was the Nkoranza health insurance scheme, championed by the St Theresa’s Catholic Mission Hospital in 1992 (Atim and Madjiguene 2000). The second instance of a community health insurance

scheme was in 1993, by UNICEF. UNICEF funded exploratory research on the feasibility of district-wide community health insurance (CHI) for the non-formal sector in Dangme West (Arhin 1995). These pilot studies that were conducted yielded promising results giving rise to the notion of the NHIS. Although the findings were favourable, there were various concerns such as quality of care in health facilities, availability of technical assistants to manage the scheme, as well as other issues raised prior to the implementation of the NHIS. Preliminary schemes implemented in Dodowa, Okwahuman, and Nkoranza were tested and the results led to the passing of the Health Act 650 in 2003.

The scheme was also instituted to curb the problem of financial losses to the hospital as a result of unpaid bills by poor residents and people who abscond after receiving health services due to their inability to pay for the service fee (Ghana Health Service and Partners for Health Reform plus, 2004:1).

The National Health Insurance Act was passed in 2003 (NHIA Annual Report, 2010). The NHIS scheme was instituted by the National Health Insurance Authority (NHIA) in order to reduce the financial burden on the government and its citizens.

The National Health Insurance Scheme of Ghana was established and implemented with the passing of the Health Insurance Act (Act 650, 2003). The primary objective or mission of the National Health Insurance Scheme is to obtain the goal of securing basic health care services to the people of Ghana (National Health Insurance Scheme Annual Report, 2009). The various issues pertaining to inadequate healthcare that have been put forth by the NHIS have become an issue of great deliberation since its implementation in 2003. The various bodies of literature, such as the recent report

published by Oxfam (2011), implies that constant complaints of funding, continued feasibility, and equal coverage for all registered participants are not being addressed. Every Ghanaian citizen pays for the NHIS through NHIL embedded in the Value added Tax (VAT), but as many as 82% remain excluded (Oxfam Executive Summary Report, 2011:7). On the other hand, the mission statement stated in the national health insurance scheme's annual 2009 report is that the NHIS is to be a model of a sustainable and equitable social health insurance scheme in Africa and beyond (NHIA, 2009).

Even though this research work pertains primarily to Ghana, it is necessary for this work to highlight other instances of health insurance being implemented in other parts of the world such as the United Kingdom. The United Kingdom is comprised of four countries namely: England, Wales, Northern Ireland, and Scotland. These four countries operate a National Health Service (UK's Department of Health Website, 2011) (Robinson & Dixon, 1999).

This Service, introduced by the Labour Government after 1945 with subsequent formulation and execution of the *NHS Act* in 1946, provided the platform for people to have 'free' health care. This National Health Service derived most of its funding from taxes. According to the World Health Organization:

However, to the extent that the overall tax system is broadly progressive, so the NHS finance system may be described as broadly progressive...Collection through general taxation also means that the costs of collection are kept low because funding destined for the NHS is collected as part of the general Inland Revenue, tax collection process (Robinson & Dixon, 1999:111).

Here the issue regarding the collection of funds through taxes is plausible, but the taxation must be broad and progressive in order for it to be sustainable. This would mean that taxation must be effective and efficient in its operation and application. This scheme is quite similar to Ghana's one as both schemes rely on taxes to operate.

In the UK's National Health Service there were various features that were put into place to ensure sustainability. The issue behind the establishment of the NHIS was that there was a backlog of people that had already been ill prior to the implementation of the NHIS and that issue would have to be dealt with by the new service, but later in the 1950's the demand outstripped the funding that was made available (Robinson & Dixon, 1999:111).

One consequence of limited funding was extreme pressure on an under-resourced hospital service. Recognition of this problem led to the 1962 Hospital Plan. This plan promoted sustainability by proposing new capital funding over the next ten years, and introduced the concept of the district general hospital (Robinson & Dixon, 1999).

As a result of untimely distribution of funds, the Merrison Royal Commission was set up in 1976 to consider the best use and management of resources in the NHIS (Taylor, 2010).

2.2.1 Reforms Ensuring Sustainability

There was a funding crisis of the winter of 1987, which prompted the Prime Minister, Margaret Thatcher, to set up a high-profile ministerial review of the NHIS (Robinson & Dixon, 1999). The early decisions of the group were particularly focused on

alternative means of funding NHIS. These deliberations on alternative funding triggered the establishment of further policy and measures that ensured sustainability of NHIS. I believe that in the case of Ghana, alternative sources of funding is equally necessary but prudent management practices are more critical to the success of the NHIS.

2.2.2 Unsustainable Cost of Health Care

Some of the concerns among those that have criticized the national health insurance scheme state that:

Many of its critics are quite aware that universality is indeed 'affordable,' much more so than a system of multiple funding sources. Their argument is rather that health expenditures should be substantially higher than they are that universality leads, not to an overly costly system, but to an 'underfunded' one (Barer and Evans, 1987:851).

The problem is that the willingness to divert funds towards national health is not apparent, thereby driving health care experts to conclude that health is not the priority of the people. Barer and Evan, continues in the formulation on this thought of health care not being a primary concern, by drawing attention to underfunding stating:

The problem of 'underfunding,' therefore, reduces the providers' perceptions that the community priorities expressed through the political process are 'wrong,' or at least unacceptable to themselves, and that they would be better able to further their own professional priorities, which they believe are 'right,' if they could sidestep the political process of allocating resources, and gain access to less closely guarded private funds (Barer and Evans, 1987:852).

Dunn (1994) and Anderson (1997) argue that public policy making is a series of intellectual activities that comprise five main phases consisting of agenda setting, policy formulation, policy adoption, policy implementation, and policy evaluation. Within these five main phases the agenda phase is the phase of concern. Ripley 1985 states that:

The agenda setting refers to the process by which problems come to the attention of government... This stage includes the ability of some individuals/groups to perceive that a problem exists, to decide the government's involvement, definition of the problem, and mobilization of support. The demand for government resolution of some public problems comes from the society (Ripley, 1985).

In my opinion, the creation and implementation phases of any policy, when well formulated can reduce unforeseen problems that occur during its implementation.

The idea being put forth by Ripley would suggest that the concerns of the people may perhaps be reflected with the policy that is being formulated and or implemented. One point derived from the conclusion of Barer and Evans (1987:860) is that people do away with policy, and rather use the community. They further elaborate on this by posing the question of whether it rather has to do with the political priorities that control expenditure in a universal system. Barer and Evans (1987:860) further discuss the issue of universal health system stating that “the community at large, or at least significant segments of it, would be happier with alternative priorities reflected in a continuing escalation of the share of income devoted to health care costs.”

The object of concern is the correlation between the needs of the people and the formulation of the policy. Do the policy makers play a direct role in addressing the health care needs of the people? To explore this notion further I looked at the Health care system in the First Republic of Ghana.

In Sub-Saharan Africa health care is also an area of major concern in which countries have invoked various policies and practices to better enhance healthcare system (Cassels 1995; Cassels and Janovsky 1996).

According to Ametor-Quarmyne, (2010:1):

Under the First Republic, from the late 1950s up to 1966, when Kwame Nkrumah's Convention Peoples' Party government was overthrown, healthcare financing in Ghana was in line with the Socialist philosophy of Dr. Nkrumah's CPP Government, and was virtually free as was education and other social services

From 1966 there was a radical change in the health care system for Ghanaians, and that radical change occurred when the CPP government was overthrown, and the leaders of the February 24, 1966 coup established the new government forming the National Liberation Council (NLC) (US Department of State, 2010). When this coup took place Ghanaians were asked to pay for their health care, which posed a lot of challenges. The main challenge that occurred through this transformation was addressing the people's needs of acquiring affordable health care, as well as the money spent on healthcare by the government (Ametor-Quarmyne, 2010).

In 1978 Alma Ata declaration, many countries at the international conference on primary health care, adopted the ten declarations that were made with the purpose of inciting an urgent course of action to promote the health of all citizens worldwide.

After independence in 1957, Kwame Nkrumah, then Prime Minister, launched a ten-year plan (Böhmig, 2010). Within it were various initiatives, the cash and carry system in particular, was to address many problems pertaining particularly to health care financing (Böhmig, 2010).

Shortly after Ghana's independence in 1957, everyone had access to healthcare. Up to the mid 1960's all Ghanaians were able to acquire free medical attention at any local pharmacy. That changed considerably when attention was directed to developing a

wide range of primary health care facilities across the country. By the early 1970, general tax revenue in Ghana with its stagnating economy could not support a tax based health financing system. This may be a consequence of the SAP (Sender, 1999).

Economic and social crisis in Ghana between 1975 and 1985 led to the collapse of many health facilities. Cash and Carry was an alternative policy that was established in order to describe a method of payment for services rendered at a medical facility, and under Cash and Carry established in 1992 (Asenso-Okyere *et al*, 1998). People went to hospital only when they were very sick and had money to pay for medical expenses after services were rendered. It was pointed out that ‘Cash and Carry’ institutionalized the belief that healthcare was only necessary when one was in very dire need (Ametor-Quarmyne, 2010). One could conclude that ‘Cash and Carry’ may have also given rise to needless deaths.

In the health sector there were shortages of essential medicines, supplies and equipment, and the quality of care was poor. Structural adjustment programs caused many inconsistencies within Ghana as noted by Brugiavini and Noemi:

In 1985 Ghana initiated health sector reforms, i.e. the Hospital Fees legislation in 1985, as part of broader structural adjustment programs aimed mainly at reducing government spending to address budgetary deficits, introducing cost recovery mechanisms through user fees (traditionally known in Ghana as “cash and carry”) and liberalizing health services to allow private sector involvement (Brugiavini and Noemi, 2010:5).

Due to these numerous reforms under the structural adjustment program, Ghanaians found it very difficult to make payments for medical attention. This meant that other affordable forms of medical relief were sought including self-medication and

traditional approaches such as medicinal herbs and herbal practitioners (Asenso-Okyere *et al.*, 1998).

With this new development of cost saving methods that were exhibited by Ghanaians, there was the need for something to be done to rejuvenate the faith of the people in formal healthcare. The “Cash and Carry” system was described as:

The fee per drug item charged to users is related to the procurement cost of the item, marked up with fixed percentages by central and regional medical stores; under this policy pharmacies and health facilities require that payment is made before drugs are supplied to patients (Asenso-Okyere *et al.*, 1998:185).

There were various concerns on quality of care in health facilities, availability of technical assistants to manage the scheme, as well as other issues raised prior to the implementation of the NHIS (Edoh and Brenya, 2002). Preliminary schemes entitled Dodowa, Okwahuman, and Nkoranza were tested and the results led to the passing of the National Health Insurance Act 650 in 2003. The NHIS was instituted by the National Health Insurance Act (NHIA) in order to reduce the financial burden on the government, and on the people (NHIA Annual Report, 2010).

According to Ghana Health Service and PHRplus, (2004:25):

The scheme was also instituted to curb the problem of financial losses to the hospital as a result of unpaid bills by poor residents and people who abscond after receiving health services due to their inability to pay for the service fee.

2.3 Policy and Health

National policies reflect how countries address problems associated with rapid urbanization and urban poverty (Taylor, 2002). In Ghana, for instance, there was a

national policy for health care from 1957 to 1981 such that health care was ‘free’ until the introduction of the Cash and Carry system under the PNDC.

Public policy has implications for the success of future projects and initiatives that are pertinent to a country at any time. “Public policy is the broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem” (Brooks, 1989:16). Brinkerhoff and Crosby (2002) note that if policy is a process then successful policy outcomes depend not only upon designing good policies, but also upon managing their implementation. Brinkerhoff and Crosby also argue that policy implementation is a process that is as much political as it is technical, and is complex and highly interactive. Besides, technical and institutional analysis, it calls for consensus building, participation of key stakeholders, conflict resolution, compromise, contingency planning and adaptation.

In order to build a comprehensive policy the people need to be involved and their contributions taken as compared to the health care needs of the general population. With such a realization there would be the need to institute a practice of consensus building when conceiving policies to clarify any inconsistencies, and take suggestions into account from all parties affected by the policy. If this is done the identification of policy inconsistencies would be minimized, thereby increasing the likelihood of creating an effective and sustainable health care policy. During the 1980s healthcare reforms were implemented in the political context of a military rule. If the politicians of a country do not recognize the link that the people play in creating sustainable policy, the likelihood of sustainable policy is sure to decrease.

In the Directive Principle of State Policy of Ghana's 1992 constitution one of the main principles underlined was that the president of the Republic of Ghana ensures the realization of basic human rights, a healthy economy, the right to education and work, and the right to good health. As a result The Ministry of Health (MoH) was established to uphold and assure good health in Ghana. For example, in the late 1990's Ghana was implementing several reforms for the healthcare sector. One of these reforms that were implemented was called Medium Term Health Strategy (MTHS), and its purpose was to improve access and quality of healthcare. The MTHS also worked to improve efficiency (Ghana Health Service, 2011).

2.4 Conclusion

In conclusion, review of the literature showed how health insurance schemes have evolved in Ghana since independence. The evolution of the insurance schemes since the independence of Ghana proved very useful in shaping today's NHIS. In chapter three I will discuss the methodology of the study.



Chapter Three

The Relevance of Social Capital in Healthcare

3.1 Introduction

This chapter addresses the impact of social capital on NHIS and also looks at the theoretical framework of the study.

Social capital is often thought of as multifaceted, but at the same time ambiguous. This ambiguity associated with social capital has left the term open to creative definition (Portes, 1998). This ambiguity allowed scholars from different disciplines to collaborate and contribute to the construction of their conceptual ideology on social capital. Social capital provides an explanation for the survival and function of neighbourhoods. The subject matter of survival and neighbourhoods provided the rationale for collective collaboration within these communities (Sorheim, 2003).

The definition by The World Bank, cited by Grootaert and Basteler, interpret social capital as:

Social capital refers to the norms and networks that enable collective action. It encompasses institutions, relationships, and customs that shape the quality and quantity of a society's social interactions (Grootaert and Basteler, 2002:20).

In view of this, it is important to discuss the elements of social capital in relation to health care services.

3.2 Description of Reciprocity and Elements of Social Capital

Social capital theory comprises various elements such as trust, norms, networks, as well as coordination and cooperation. The cooperation and correlation of resources enable interaction between individuals and groups of individuals striving to realize and accomplish goals (Coleman, 1990; Putnam, 1993). Each of these elements is discussed with its application to health care.

3.2.1 Norms

There are three different aspects of norms termed as triple obligation. Norms that are established are often in the form of a 'receipt of benefits'. This receipt of a benefit derived from an outside source creates an obligation to repay an equal benefit. "The first being the obligation to make a gift, the second is obligation to receive it, and the last concerning the obligation to repay that gift" (Mauss, 1954). In the case of NHIS, payment of premiums by clients in expectation of health services is purely a contractual arrangement legally binding and must mutually benefit both parties.

The norm contributes to the maintenance of social stability by providing a 'starting mechanism' for the establishment of relationships between two people or two groups of people (Gouldner, 1960: 74).

Gouldner further elaborates that norms that are established are then used to facilitate a relationship between individuals. Although a norm has been established, the concern that has been raised is that people may be hostile toward this norm at first. Alluding to the gift theory propounded by Marcel Mauss in 1954, Gouldner asserts the rule that accepting a benefit would mean an obligation to repay or reciprocate a benefit to the person that bestowed the initial benefit.

Rules and norms are often used to facilitate and enforce a system of continuous and expected reciprocity. The contributions made by Mauss and Gouldner 1954 to the gift theory, reaffirm and clarify the ideology behind norms that are enforced.

The relation between norms and health care can be seen in enforcement of rules and norms. The various health care facilities invoke the norm that when one arrives at a medical facility they would receive medical attention. The application of rules in health care can be seen during the enactment of norms. These rules that aid in regulating the norms that are set by society have a connection with healthcare by helping to sustain and regulate the way in which norms operate. This connection can also be exhibited within the NHIS as well. The norms would be represented in the form of rules and regulations as well as sanctions created and established by the NHIA.

3.2.2 Networks

Social networks refer to the ties between individuals or groups and could be considered the “structural” element of social capital (Baum, 2003). Formal networks and informal networks are essential within the confines of general theory of networks, and are vital to Putnam 1995 conceptualization of social capital. Networks have also been differentiated on the basis of their size, density, and the extent to which they are open and closed (Stone, 2001). Examples of formal networks are voluntary organizations and associations. Examples of informal networks include friendship ties, family connections, neighbourhood or residential ties and work related ties; they each provide resources such as social support. The relationship between networks and healthcare becomes apparent within systems created to spread information more efficiently. The connection between a network and health care is also shown with the community support given through the

network. The community support could aid in the spreading of important medical information to all members of the network, as well as providing moral support to those in need of medical attention that is, maintaining or establishing relationships with people that are part of the network.

3.2.3 Trust

Trust is something that is reflected within, and considered to be, a factor of social capital. Trust is something that can be measured by looking at an individual or institutions willingness to act competently, fairly, openly, and with concern (Gilson, 2003). Trust has been perceived as an interactive occurrence; where trust exists it has the propensity to enhance cooperation. This enhancement in cooperation would further establish and strengthen the belief in mutual dependence. This act of strengthening mutual dependence has been deemed by Putnam (1993) to result in the accumulation of social capital. Trust has also been characterized as having ties combined with norms creating cohesion between individuals, and institutions, whether formal or informal (Rueschemeyer and Evans, 1985). There are many ways in which trust has been defined and elaborated. While these numerous variations in defining trust all contribute to the general wealth of knowledge accrued within social capital, the way that the study has labelled and defined trust can be attributed to the definition put forth by scholars such as Putnam (1993), Lin (2001), and Woollock (1998) to be more of a cognitive factor serving as the ingredients that construct social capital.

More specifically with reference to health it could be that the trust being exhibited within the NHIS scheme, as per the conceptual framework shown in the author's work, is between the facility and claims encompassed within the rules and norms of the NHIS.

This item of trust is something that would need to be upheld by both facility managers and claims officials.

3.2.4 Reciprocity

There are various types of reciprocity (that is general, balanced, negative, among others) that have been researched into detail. Sahlins (1965) discusses three types of reciprocity that include practicing negative, positive, and balanced reciprocity. His idea of reciprocity looks at the characteristics of the gifts and exchanges in order to determine the type of relationship which exists between the individuals or groups. Sahlins's idea of generalized reciprocity hinges on the distribution of valued assets, goods and services. These goods and services tend to flow largely from one person or group of persons to the other. Sahlins states that "there is the expectation of repayment, but the idea being portrayed is the return gifts or services may be far inferior to what has been received or may be deferred for a very considerable time till the gift being returned is more substantial" (Sahlins, 1965: 147).

Sahlins conceptualized balanced reciprocity by asking the question of equivalence and its importance. "A gift made by one party to the other should be repaid promptly by some article of equivalent worth" (Sahlins 1965: 148). They further mention of balanced reciprocity, combined with Sahlins's example of how a 'gift' should be 'repaid promptly', insinuates that something of equal or greater value should be returned as soon as possible. With this assumption one could then say that if you receive something from someone, the driving force that could be attributed to returning of that something is the anticipation of being repaid in a similar fashion. In this instance of returning a gift in the long run to appease a gift that was previously given, Sahlins cites this type of behaviour

as generalized (Sahlins, 1972). Sahlins's assertions fall in line with Mauss's earlier work. Mauss's earlier work determined "when someone gives they gain authority and power over the recipient and this leads to obligatory circulation of wealth" (Mauss, 1954:10).

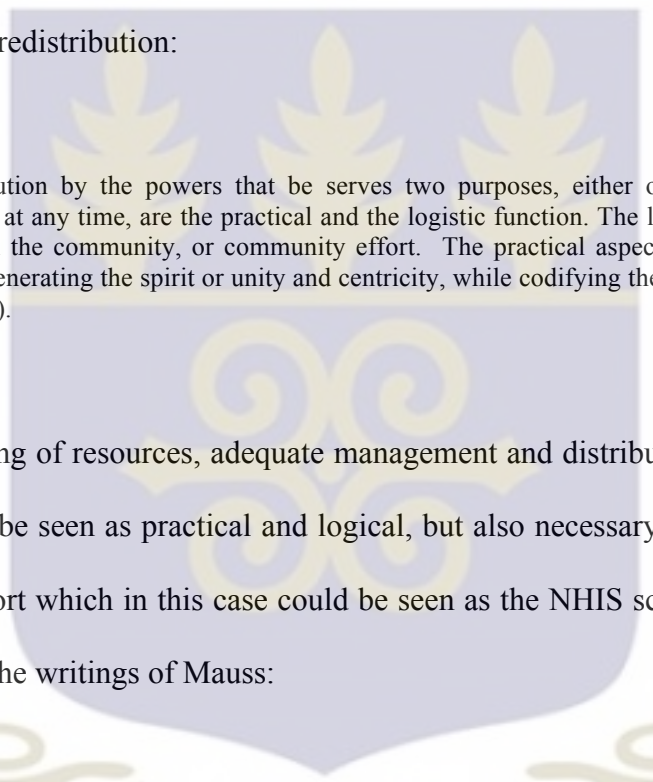
If there is a relationship of negative reciprocity this would be more of a case where each of the involved individuals do not see the need to reciprocate gifts given, but they rather strive to outdo the other and acquire as much profit as they can; examples of negative reciprocity range from instances of bartering to haggling (Sahlins, 1965:149). Reciprocity is evident in healthcare and manifests itself when the knowledge gained by doctors is used to treat registered NHIS recipients, and this treatment is then reciprocated by the patients supporting the scheme that compensates the hospitals. Health seekers only expect health services when they fall sick and then they are in need.

3.2.5 Resource Pooling

Resource pooling in healthcare is defined as "a device which offers individuals protection against risk" (Barr, 1992). This risk pooling, or system of insurance could be seen as a tool used to share a problem among a group of individuals instead of just one or few individuals, effectively reducing the burden or risk on individual(s). Sahlins (1965) also looks at resource pooling in his work *On the Sociology of Primitive Exchange*. Sahlins defines resource pooling as:

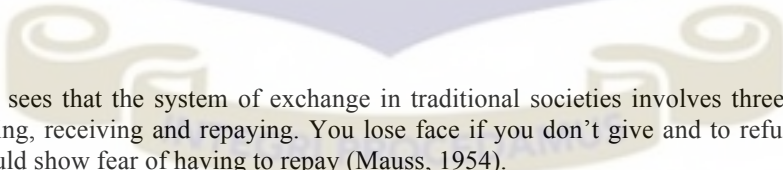
An organization of reciprocities, a system of reciprocities...pooling is the complement of social unity and it stipulates a social centre where goods meet and flow outwards, and a social boundary too within which persons (or subgroups) are cooperatively related (Sahlins, 1965:188).

Risk pooling is seen by researchers, such as Davies and Carrin, 2001 as beneficial because health care costs are generally unpredictable and sometimes high. Due to the disposition of varied health problems among the general population, people cannot reliably predict when they will fall ill and need to make use of health services. With this ideology, there is the need for pooling of resources (Davies and Carrin, 2001). Sahlins also clarifies the idea of resource distribution. He does this by noting two sub descriptions of redistribution:



Redistribution by the powers that be serves two purposes, either of which could be dominant at any time, are the practical and the logistic function. The logistic part is seen to sustain the community, or community effort. The practical aspect also has benefits such as generating the spirit of unity and centricity, while codifying the structure (Sahlins 1965:190).

With this pooling of resources, adequate management and distribution of these resources could not only be seen as practical and logical, but also necessary in order to maintain a community effort which in this case could be seen as the NHIS scheme. The trust aspect can be seen in the writings of Mauss:



He sees that the system of exchange in traditional societies involves three obligations: giving, receiving and repaying. You lose face if you don't give and to refuse to receive would show fear of having to repay (Mauss, 1954).

The idea Mauss is portraying is that once a gift is received it becomes a moral obligation on the one receiving the gift to return the gift in a timely manner.

The link between resource pooling and healthcare is clearly demonstrated when a group or an entity begins to amass resources, ideally contributed by the community, to

accomplish a given task. This pooling of resources can help spread financial as well as social burden.

3.3 Relevance of Social Capital and the Sustainability of the NHIS

The link between social capital and sustainability of the NHIS is evident because NHIS is a scheme that is largely dependent on the health insurance levy (NHIA Annual Report, 2010). Therefore to create the platform of making the NHIS sustainable it is necessary that the ideology of social capital be introduced to ensure collective collaboration and cooperation within communities and districts.

Shiell and Hawe's definition of social capital is relevant to this study. Shiell and Hawe (1996) explain social capital to provide a sense of community competence or community empowerment that contributes to public health. Here healthcare provision as a whole in a community facilitates empowerment of members, both the providers and the users. The idea that is being presented by Shiell and Hawe is that empowering a community would better enable the members of that community to look forward to a collective ideology that would facilitate the longevity of its members. The idea being perpetuated in the literature is that social capital is comprised of the resources that originate from group membership, and the participation in a network of mutually-supportive relationships.

The inclusion of social capital may explore, and perhaps shed more light on factors that could contribute to the sustainability of the NHIS. Putnam (2000:65) gives an example of the Rotary club "where the members of the club contribute to the community and also get important benefits for themselves." This is similar to the goal of

sustainability of NHIS and social capital; where individuals contribute to a larger scheme to reap the benefits of health care thereby reducing financial risk in their own lives.

With the introduction of social capital, and its philosophy of members contributing to a scheme that was created with the idea of helping the people adopt healthy living habits, the idea of the gift theory and reciprocity, could prove to be successful.

3.4 The Ideology of Putnam and Sustainability

Adequate funding is a challenge within the NHIS. “The majority of funds acquired for the NHIS stem from health insurance levy at 61.49%” (NHIA Annual Report, 2010). Untimely allocation of funds, coupled with skewed acquisition of funding could result in un-sustainability of the scheme.

If the current bottlenecks in disbursement of funds from the national level are not rectified, this may affect the allocation of subsidies from the Nation Health Insurance Fund to equalize the amount of premium generated across schemes in different parts of the country, thereby perpetuating the existing geographical inequities in funding of health activities (Asante *et al.*, 2006:8).

Putnam discusses social capital with reference to two factors, which are ‘bonding social capital’, and ‘bridging social capital’. Putnam (2000) describes bonding social capital as intra-community ties among people with similar goals and interests, and bridging social capital refers to ties across social groups, such as ties between communities and public services.

Putnam’s example of bonding social capital is seen to be present in ethnic fraternal organizations such as church based women’s reading clubs and fashionable country clubs. The way in which the term bridging social capital is conceptualized, for

the purpose of this literature review, is cooperation within a group to facilitate solidarity. Bonding social capital is theorized as enabling better access to external resources as well as distribution of information through institutions, relationships and customs.

3.5 Social Capital and its Application

Social capital is a research term that already has a large literature without yet having generated much consensus. Woolcock (1998:155) argues that there are a number of forms or dimensions that are confusingly unified as a single concept “Social capital’s revisionist grounding in different sociological traditions risks trying to explain too much with too little”.

The message that Woolcock is attempting to convey here is that social capital is drawing from so many different backgrounds of expertise that it may be difficult to apply such a concept and an indiscriminate adopting of the term social capital may only result in improper application.

Fiorillo and Sabatini (2011) discussed the application of social capital and health and their thoughts on social groups and the correlation with good health.

Previous literature on the topic generally agrees that social connectedness may in principle be a determinant of good health. However, the lack of data has often forced researchers to measure connectedness by means of indicators of participation in formal organizations – such as voluntary associations, sport clubs, trade unions and political parties (Fiorillo and Sabatini, 2011).

Fiorillo and Sabatini also mentioned how the use of membership in formal associations may or may not provide a substantial correlation with the practice of good health, which may further demonstrate the validation of the social capital definition presented by the World Bank.

Fiorillo and Sabatini (2011) further informs the definition of social capital that was adopted for this study, and provides additional rationale for the definition coined by The World Bank which was more practical for this study. The World Bank's definition was used to construct the conceptual framework for this study.

Some aspects of Putnam's ideas may be portrayed in the NHIS although not all of them are applicable. The definition presented by The World Bank would aid in filling the gaps of Putnam's definition concerning bonding and bridging social capital. The definition of social capital by the World Bank is where the study would be situated.

3.6 Claims Management and Reimbursement

In many service providing facilities that are supposed to be providing NHIS services for free, due to lack of funding, NHIS members are billed to make instant payments. "Three out of six districts visited in Central Region had reverted to charging and the others were close to joining them" (Levin, *Supra cit.*).

Witter and Garshong assert that:

Providers blame the inefficiency of the NHIA while the NHIA places the blame on the providers, citing late submission of claims and fraudulent practices that require vetting. The NHIA faces severe constraints managing claims effectively, 'never mind acting as an active purchaser' to ensure health care is appropriate and effective (Witter and Garshong, 2009:20).

The point being suggested in the literature is that NHIS claims that are received from the various health care providers are not well managed. This mismanagement challenge often manifests itself when claims being processed are delayed.

Another point that has been brought to attention in the Oxfam Report is the lack of skills among the officials who should oversee the scheme:

At the district level health insurance managers frequently lack the medical, management and insurance skills necessary to hold their own in negotiations with providers, including in the verification of claims (Oxfam Executive Summary Report, 2011:31).

This observation by Oxfam presupposes that those in charge of verifying the claims made by various hospitals, clinic and pharmacies do not possess the necessary skills meant to verify and pay claims of reimbursement. An article published in the Daily Guide stated that:

Delays in the reimbursement of the health insurance claims had made the hospital 'a perpetual debtor,' since over 90% of its clients are registered with the scheme... Such delays she noted had made it impossible for the facility to plan ahead and called for an immediate intervention to save the situation (*Daily Guide*, February 9, 2011).

The main issue that needs to be addressed is how the NHIS coordinators plan to address a problem that deals mainly with lack of trained staff, and mismanagement of claims? If claims cannot be managed effectively and securely then its delays would have a profound impact on health care facilities.

Ghana's chief executive of the NHIS, Sylvester A. Mensah, delivered a rebuttal regarding the report that was published by Oxfam (Apoya and Marriott, 2011). He mentioned several issues that Oxfam neglected to take into account while compiling data to publish their report. One of these issues was that "The push by Oxfam for Ghana to implement a free health care policy for all Ghanaians must be analysed within the context of the history of health care financing in Ghana." Mr. Mensah further insisted that the research methodology used by Oxfam was "seriously flawed" and that the study failed to

indicate the type of study being done or the sample size used, as well as using figures that had not been confirmed with the NHIA. With these inconsistencies brought to light it may be difficult to find the report made by Oxfam to be entirely accurate.

3.7 Fraud within the NHIS

A recently published article from the Daily Graphic dealing with the issue of fraudulent claims, dealt with the recovery of GH¢4.9 million from 33 out of the 145 schemes across the country after a forensic audit commissioned by the NHIA (Dapatem, 2010). The article in the newspaper dealt directly with solutions that could aid in reducing fraud within the NHIS:

The audit into the operations of the remaining 112 schemes is on-going to help recover the money allegedly lost through fraudulent means at the scheme level through claims verification and payments submitted by service providers (Dapatem, 2010).

The problem here is that the process in place concerning the verification of claims and time that payments are dispersed is filled with numerous challenges and takes too long to complete making room for instances of fraud.

The misappropriation of funds, with reference to health care efficiency and effectiveness, could be the mark of greed; negative reciprocity and lack of social capital sentiment within the scheme.

3.8 Financial Sustainability of Health Insurance in Africa

In order to achieve a sustainable health care scheme, the scheme has to be viable and sustainable in its given setting, both from an institutional and financial point of view Wiseman and Jutting (2000).

Countries in Africa such as Rwanda, Kenya, and Nigeria have faced challenges with their health insurance schemes especially on the issue of sustainability access to care and adequate funding that would sustain the schemes they have implemented. Ghana's adoption and implementation of a health insurance scheme for its entire population have also had to deal with the challenges of inadequate funding, un-sustainability and inadequate access to care. Other countries that have implemented similar schemes of national health insurance including Rwanda, Kenya, and Nigeria have faced similar issues concerning finance, sustainability, and access to care.

3.8.1 Rwanda Health Insurance

In the case of Rwanda they have also implemented a national health insurance program, and it has been in operation for eleven years with coverage of 92% and premiums of about two dollars a year (McNeil Jr, 2010). A briefing by Caroline Kayonga, at the Brookings Institution regarding her study on the community based health insurance scheme in Rwanda, identified items such as organization and management, financing, and sustainability as essential to the longevity of the scheme (Kayonga, 2007). As explained earlier this study equally considers proper organization and management, financing and sustainability as essential to NHIS operations.

3.8.1.1 Organization and Management

The way that the health insurance scheme was implemented in Rwanda was the formation of a mutuelle or a community based health insurance scheme. Shimeles (2010) describes these mutuelles as community-based health organizations that offer voluntary, non-profit health insurance schemes for the informal sector. They are formed on the basis of mutual aid and the collective pooling of risks at the local sector level for primary care,

delivered at the sector level via clinics, which are run either by government or NGOs. The district level for secondary care, consists of specialized care delivered via district hospitals and specialists. Finally at the national level for tertiary care, care is given via a few specialized, national medical institutions. Kayonga, (2007) commented about the general makeup of the local sector level, district sector level, and national sector level stating:

Each of the sectors must have at least one health centre for primary care. Each sector has a mutuelle that is managed by people who are elected by the community, each district must have one hospital or secondary care facility at the district level, and at the national level tertiary care is given at national-level teaching hospitals (Kayonga, 2007:2).

3.8.1.2 Funding

Kayonga (2007) stated that approximately 50 percent of mutuelle funding is comprised of annual member premiums. Shimeles further breaks down the makeup of the premiums stating that Households pay annual premiums (standardized in January 2007 to the equivalent of US\$1.81) per person per year (Shimeles, 2010). Where citizens cannot pay the individual or family premium up-front, microfinance institutions provide individual loans for the premium, to be paid within a year of disbursement with a 15% rate of interest.

3.8.1.3 Sustainability

Community-orientation, bottom-up architecture, and continual improvement are the main issues underlined in the work done by Kayonga and thought to be of great relevance in the sustainability of the project. Community-orientation was seen to be essential as there is a strong sense of community in Rwanda. Kayonga (2007) note that “In Rwanda, most government programs have roots in the strong community-orientated

culture (e.g., community pooling in agriculture, hygiene, and health)". Bottom-up architecture was also a key component in the sustainability of the Rwanda health insurances as it meant the possibility of more community members joining the program. The aspect of continual improvement was done by the organization of meetings to help analyse and criticize aspects of the program that were beneficial or detrimental to the people.

3.8.2 Kenya's Health Insurance

In the case of Kenya, community based health insurance had started in the nineties (Wiesmann and Jütting, 2000). Since the independence of Kenya their health system has been funded mostly by taxation; but recently the new health-financing policy changes were introduced e.g. 1989's user fees or cost sharing initiative (Carrinet *al.*, 2007:130). Carrinet *al.*, (2007) further noted:

The user fee system was significantly altered in June 2004, when the Ministry of Health stipulated that health care at dispensary and health centre level be free for all citizens, except for a minimal registration fee in government health facilities (Carrinet *al.*, 2007:130).

Carrin *et al.* (2007) also highlights three essential points in the formation and implementation of Kenya's National Social Health Insurance Fund (NSHIF) which are resource generation, optimal use of resources, and financial accessibility of health services for all.

3.8.2.1 Resource Generation

Carrinet *al.* highlights the performance indicator of ratio of prepaid contributions to total costs of the Social Health Insurance benefit package. They remark that this ratio should be close to 100% derived from the member's contributions and government contributions (on behalf of the poor). They added that the government contributions would be maintained because contributions by the government was seen as imperative, given that contributions from the salaried sector would not be fully able to cross-subsidize the poor.

3.8.2.2 Optimal Resource Use

The Fraud and Investigation Department was employed to review the financial records of the National Social Health Insurance Fund in order to promote transparency and accountability. Reviewing budgets in order to control spending and ensure that no one agenda is superseding the others. Implementation of information technology to computerize and improve general operations is another measure that was taken to effectively and efficiently utilize resources. Then finally a definition of benefits was done. This definition of benefits was to ensure each member of the NSHIF would receive an appropriate level of care, as well as an assessment of health service delivery at each of the individual health facilities.

3.8.2.3 Financial Accessibility of Health Services

Pooling of provider payments is thought to be the way forward for increasing financial accessibility. Carrin *et al.* (2007) comments on this saying:

Flat rate remuneration per inpatient per day (daily payment) has been proposed. For outpatient care, a flat fee per visit (case payment) will be paid to providers. These mechanisms were chosen for their ease of administration and resemblance to current practice... Reductions in fee levels may also be considered in the short term if facilities cannot provide the full benefit package while health maintenance organizations (HMOs) will continue to play a role in financing the health system, by providing top-up supplementary health insurance (Carrin *et al.*, 2007:132).

This mechanism may aid in the application of creating a system where a person could be able to afford formal healthcare, while also creating a pool of resources that could aid in the payment of the healthcare the members are receiving.

3.8.3 Nigerian Health Insurance

In the case of Nigeria, they had implemented their national health insurance scheme in 1960 (Omoruan *et al.*, 2009). Initially the health insurance system did not include the informal sector, but recently things have changed. Omoruan *et al.* commented further on this issue stating:

At the 42nd meeting of NCH in 1997, approval was given for the 'repackaging' of the NHIS to ensure full private sector participation, by providing re-insurance coverage to the community base health financing schemes (CBHFs) and Health Maintenance Organizations to form Social Health Insurance (SHI) (Omoruan *et al.*, 2009:2).

Omoruan *et al.*, (2009) also spoke of three components that are necessary to ensure the sustainability of the scheme which are access to care, premium, and financing. Application of these ingredients could promote a longer lasting, and more sustainable health insurance system.

3.8.3.1 Access to Care

One of the suggestions presented in the redesigning of the Social Health Insurance was that exemptions would be necessary for the elderly and the poor or vulnerable groups. Another suggestion was that these groups that are being exempted be provided with transportation to medical facilities. One last suggestion was that government should make an investment in accommodation for health professionals practicing medicine in the rural areas.

3.8.3.2 Premium and Financing

The Nigerian health insurance system was to utilize the services of Health Maintenance Organizations, for the collection of revenue and distribution of health services. The informal sectors should institute a flexible system of payments, as well as implementing a co-payment system for specialist care and cosmetic surgery. The final suggestion that was put on the table was the investing of resources in long term capital gains so that in future services would be self-funded.

3.8.3.3 Solidarity between HMOs

Here, Omoruan *et al.*, addresses two points, the first being that there should be a sense of competition between HMOs while ensuring solidarity, as well as capitation methodology be implemented among medical physicians, and implementing a predetermined billing system. The second point mentioned concerns treatment of population based diseases. Omoruan elaborates further on this stating:

Population based disease management program for chronic disease and high-risk program for sicknesses with complications and comorbidity should be established and funded separately from the funds by government through tax, donation and foreign aid; to reduce excess burden on the scheme (Omoruan *et al.*, 2009).

With these points highlighted in the various countries mentioned above, there are common themes of concern. One may conclude that the idea of health insurance schemes could be viable, with extensive work in financial logistics, and access to care, as well as scheme longevity.

A study by Levin dealing on the costing of maternal health care in South Kwahu district conducted in 1999 found that issues of affordability relative to women's income was not examined (Levin, 1999). With the evidence from Levin's study, the assumption that could be made is the issue of affordability, as per the care women received was circumvented. As per the MDGs proclaiming to improve maternal health care, it is vital to the country's development to look after the health of women especially those that are planning to give birth. This virtual silence on the affordability of healthcare for women could give a further connotation that providing affordable health care may not be one of the main concerns of mission hospitals. This instance of silence could also show that the other health facilities may be more concerned with remedying the sickness of the individual at the cheapest cost to them due to a lack in funding. Actions such as these constitute the need for a comprehensive NHIS that could cater for such issues.

Another point made by Levin was not the dispersion of funds, but lack of guidelines to be followed after fund dispersion. The funds that were dispersed to various health care facilities do not come with suggestions or guidelines as to how the funds should be managed. This means there is no instructions to show how long the funds should last and what priorities should be considered in the budget (Levin, *Supra cit*). The post dispersion of funds in itself can be problematic, especially when there are no budget

guidelines or protocol to follow. The study conducted in 1999 at South Kwahu district mentioned that funding is complex, and with the combination of multiple actors it makes things unclear thereby decreasing the effectiveness of monitoring (Levin, 1999).

One last point about funding of NHIS is that the funding can sometimes be used to facilitate the work being done, but may not be adequate to fund the actual day to day functioning of the scheme itself. In the article *A national policy creating wealth through health* they address the point of inadequate day to day funds:

The increase in funding to the health sector has gone mainly into the payment of personal emoluments rather than to support service delivery. As a result, a major funding gap for the scaling-up of priority public health interventions exists in the sector (Ollennu, 2007: 27).

The idea that can be derived from the literature could be that most of the resources acquired via national insurance health levy are not being allocated correctly. Another point worth mentioning deals directly with the scheme in relation to resource allocation. If the bulk of the money being collected is used on the care of patients, how would effective maintenance of the scheme be catered for without a budget that would make provision for daily operation of the national health insurance scheme.

Is the money that government gives to the NHIS enough is one main question that is on the minds of Ghanaian citizens. This can be seen in the feasibility study conducted by Edoh and Brenya with a finding supporting the notion that Ghanaians would agree to pay more for health services.

In spite of low individual health expenditure in this elite community, respondents were willing to pay premiums to the NHIS. Despite inadequate infrastructure and water supply problems a cumulative of 71% were prepared to contribute 2% or more of their income as based on individual expenditure (Edoh and Brenya, 2002:2).

There are two other questions that come up when dealing with adequate funding. The first question here is whether the funds that are being acquired are adequate for the task of providing free healthcare. If these funds acquired were adequate then the following question would be whether these funds could support a nationwide health insurance scheme. If the majority of the money collected is considered inadequate, misused, or ineffective, auditing of funds may be necessary to ensure effective use of funds. An article from Ghana Web titled *Health Expert Calls on Government to Invest in Care Delivery* further elaborates on the subject of funding and sustainability:

Mr Patrick Apoya, Executive Director of Community Partnerships for Health and Development has called on government to invest in the health of Ghanaians to lay the foundation for a healthy economy...Mr. Apoya explained that free universal health care could be achieved if government was able to increase and sustain its spending to health to a minimum of 14 per cent of total revenue (Ghana News Agency, March, 2011).

Health expert Mr. Patrick Apoya commented on the need for government to invest in the health of Ghanaians. This issue of the need for investment has attracted attention with respect to funding. A project or a scheme that is thought of as sustainable may need additional investment. Here is the case where an increase in funding to 14% of total revenue would enable the government to provide free sustainable health care. Mr. Apoya further commented that "Government must aim at spending at least 45 dollars per capita by 2015 with time bounded plan to reach the World Health Organization recommendation 60 dollars per capita." These two points further substantiate the idea that projects or schemes need a substantial investment in order for them to be sustainable.

3.9 Traditional Activities and the NHIS

There are activities that have been practiced before the implementation of the NHIS. The literature has identified two instances that could indicate that an earlier form of collective support groups was present. The first practice is the Susu, and the second is the cultural work practice called the nnoboa system. The relevance of discussing these systems is to show that pooling of resources for a common good is not a new concept. Systems such as these can be fused with present collective support systems to aid in the application and accommodation of new policies and ideologies concerning collective support groups.

3.9.1 Susu and the NHIS

The concept of the NHIS is not a transplanted one, but rather an assimilation of a new idea with an old idea. If you look at the scheme closely there are characteristics that are also exhibited in other ingenious practices that were present long before the inception of the NHIS. Indigenous practices such as a Susu, popular among the Akan, involved mutual finance assistance (Alabi *et al*, 2007). This practice can be seen as an early form of support group. Arhinful further elaborates on the workings of traditional practice stating:

It is an arrangement by which a limited number of people, friends, or professionals,, contribute money daily, weekly or monthly for the use of one of the group members. Each member of the group is entitled in turn to the entire collection of the week or month. In areas where Susu are popular, someone collects the money every day or weekly, depending on the agreement the members had entered into with the collector. Money was paid out to the members less a day's savings, which was considered an allowance for the person who collects the money daily (Arhinful, 2003:84).

Some of these indigenous practices like Susu have been refined and mixed with other newer ideologies to form newer practices that are more precise for public use. One

idea that has been highlighted by Sahlins (1954) was the theory of the broom stick. The idea is that a single broom bristle alone may not be able to accomplish much, but if the broom bristles are many then the likelihood of accomplishing a given task would be higher. The point of both these practices is that there is strength in unity, and with the pooling of more than one person's resources people created a support system that they could rely on in their time of need.

3.9.2 The Nnoboa System and the NHIS

The nnoboa system that is being practiced in the rural areas can be described as a cultural work practice. Arhinful describes the nnoba system as:

A collective self-help group that may be comprised of age-mates and friends who assisted each other for a number of days in farming activities such as clearing bush, planting or harvesting crops, hunting (referred to as *atwee*), building a house or some marketing venture (Arhinful, 2003:84).

The nnoba system's idea of reciprocity and moral obligation to help one another may have been an early emulation of the ideology behind the NHIS. The earlier practices of resource pooling for collective future benefits within the nnoba system may have also been a second factor that contributed the implementation and creation of the NHIS. This traditional form of support group thrived due to the idea that the individual who had received help reciprocated the help he received from others by offering a similar form of help to a group effort (Arhinful, 2003:84). The ideology behind this was that it helped saved money so that the hiring of labour would not be necessary.

3.10 Conceptual Framework

The World Bank asserts that the norm of good health establishes an avenue for sustainable development. The definition put forward by The World Bank gravitates to the idea that there is a network that individuals are contributing to it. The contributions made to this network by various individuals are geared toward the advancement of a collective group or society.

Figure 3: Conceptual Framework (NHIA)



Source: Author's construct, 2011

3.10.1 Conceptualization

The diagram in figure 3 shown above is the conceptual framework for the study. In the diagram you have a simple Venn-Diagram consisting of the NHIA claims managers, the facilities or services being given to a patient, and the element of social

capital within the overlapping section of the two circles all of which are encased within the NHIS. The concept being illustrated is the gift theory that was mentioned earlier. According to this gift theory by Mauss, (1954) there is the norm that when you accept a gift, you are obligated to equally return that gift received, which in this case are the facilities that are provided to patients. The services and goods used within treatment are compiled, logged, and then submitted to the claims managers. These officials would be obligated, by the gift theory, to reciprocate equally by issuing a return in the form of reimbursement check replenishing the funds of the facility that made the claim in the 30 days permitted by law. This process of reciprocity, mainly norms and rules established by the NHIS, is enforced within the network of NHIS ensuring this perpetuation of balanced reciprocity (Sahlins, 1965) between the facility and the claims managers. Within this conceptual framework I assumed that all things being equal people would get sick at one point, and the idea of reciprocity would be balanced. All things being equal, contributions to the resource pool would ensure that you are taken care of in the event that you get sick. The idea is that the people need a form of security they could rely on, and that this security is that when they get sick they would receive care at the health facilities that take NHIS provided they are making the necessary contributions. Although the NHIS pools resources from various sources such as SSNIT, income investment, value added tax, and insurance premium; the major point where the resources are drawn from is the national health insurance levy.

The NHIS has aided in increasing access to formal healthcare. The logic being applied is pooling resources for a greater good, as per the definitions presented on social capital. If there are delays in the distribution of these pooled resources, the rate of care

given would more than likely decrease due to shortage of supplies and (or) staff. If the delays in distributing these resources continue then the very people who cannot afford formal healthcare, as well as the staff and service providers who administer the services of the NHIS, may bear the burden of this inefficiency.

The untimely release of funding had two major effects on health care delivery. These were the inability to implement planned programs on time, mentioned by all respondents, and the negative impact on staff morale (Asante *et al*, 2006:6).

3.11 Conclusion

In conclusion looking at the literature on social capital and its relevance to healthcare there are common themes present in health insurance schemes in and outside of Africa. Various themes that were present in the literature dealt with optimum use of resources within the scheme, generation of resources for the scheme, regulation of abuse within the scheme. The idea being put forward, as per the literature on health insurance is that the various themes that have been reviewed have been seen to be successful in other countries' health insurance schemes, but would the application of these themes in Ghana be appropriate. Although there are free loaders who can take advantage of any system it could be argued that in principle if the NHIS were properly packaged, a fusion between the traditional cultural practices and more recent practices of support groups, it could reduce cases of abuse while increase the chances of the NHIS being accepted by more people.

Chapter Four

Data Analysis and Findings

4.1 Introduction

This section of the work will discuss the findings of the survey, in-depth interviews, and focus group discussion. Each of the findings from the various instruments is discussed separately. One reason for discussing the results of the instruments separately is to distinguish the issues that were raised within the research so that clear distinctions could be made. The reason why such a distinction would be necessary is to show how the various viewpoints and opinions of those that were involved in the research differed depending on their knowledge of scheme, their education, and involvement. Various kinds of methods and instruments were used to collect data in the research.

To supplement the closed ended questionnaires, which restricted respondents to specific responses, in-depth interview and focus group discussion (FGD) were therefore used to further obtain more information to the questions and answers asked in the survey. In this study fictitious names were used to protect the identity of the FGD participants. The survey questionnaire had been administered using the accidental sampling method. In all 75 questionnaires were administered to respondents (patrons). A representative subset of the hospitals and pharmacies were chosen via simple random sampling methodology. The 75 questionnaires breaks down to 15 distributed at each of the three hospitals chosen totalling 45, and then 10 at each of the three pharmacies chosen totalling 30.

The prevalent themes that were observed throughout the literature were feasibility and sustainability, funding, and transparency of NHIS operation. These three main themes that were noted have been discussed further in section B of chapter four as per the findings from this research.

4.2 Tabular Description of the Study's Participants

This section comprises of the demographics of the participants that took part in the research work. The results have been presented in a tabular form, with a description of what the table is, as well as the particulars of what data is being presented, frequency, and percentage of respondents that participated in the study. Presentation of respondents' ages, ethnicity, level of education, religious affiliation, occupation and marital status are very important as these backgrounds have great potentials in influencing peoples' perceptions about health issues that affect their lives.

Table 4.1: Summary of the age distribution of respondents

<u>Age</u>	<u>Frequency</u>	<u>Percent</u>
18-25	20	26.7
26-35	29	38.7
36-45	15	20.0
45 and Older	11	14.7
	75	100

In table 4.1 the respondents who were involved in the study ages ranged from 18 years to 45 years and above. The respondents that fell within the age of 26-35 constituted 38.7 percent. Those whose ages were above 45 were in the minority with a percentage of 14.7 percent.

Table 4.2: Summary of educational level of respondents

Education Level	Frequency	Percent
None	10	13.3
Primary	6	8.0
J.S.S	7	9.3
S.H.S	24	32.0
Tertiary	28	37.3
	75	100

With regard to educational background as shown in table 4.2, some of the respondents had secondary (31%) and tertiary (37%) education. Only 13% of them did not go to school at all. The rest of the respondents had at least primary and junior secondary education.

Table 4.3: Summary of the Respondent's Ethnicity

Ethnicity	Frequency	Percent
Akan	34	46.3
Ewe	12	16.0
Northerner	12	16.0
Other	17	22.7
	75	100

In terms of ethnicity majority of the people who took part in the study were Akans. The Akan society has the largest population in Ghana and then followed by the Ewe society. Since the study area is part of the Greater Accra region, the nation's capital, the population of this region is largely of a cosmopolitan society with people coming

from different backgrounds even though the Gas are the indigenous people of the region. The ethnic backgrounds of the respondents therefore show a similar trend in table 4.3.

The religious backgrounds of the respondents show that majority of them are Christians who constituted 93%, while 6.7% of them were Muslims as illustrated in table 4.4.

Table 4.4: Summary of respondent's religious affiliation

Religious Affiliation	Frequency	Percent
Christian	70	93.3
Muslim	5	6.7
	75	100

Table 4.5: Summary of occupational distribution of respondents

Occupation	Frequency	Percent
Teacher	7	9.3
Apprentice	4	5.3
Trader	8	10.7
Hair Dresser	2	2.7
Artisan	5	6.7
Other	49	65.3
	75	100

Basically the respondents are engaged in a variety of occupations including teaching, and some in the informal sector such as trading, hairdressing, artisans and apprenticeship. The majority of the respondents are engaging in other forms of trade other than those indicated in table 4.5.

In terms of respondents marital status, majority of them (45.9%) were single. While (45.5%) were married. Those who were either divorced or separated were very few as shown table 4.6.

Table 4.6: Summary of respondent's marital status

Marital Status	Frequency	Percent
Single	37	49.3
Married	34	45.3
Divorced	2	2.7
Widowed	2	2.7
	75	100

One of the objectives of the study was to find out the about quality of management practices of the NHIS in health care delivery facilities. To address this question, both service providers and beneficiaries were asked to present their views about the management of NHIS whether they were doing well or not. The responses obtained are presented in table 4.7 below:

Table 4.7: There is poor management of the NHIS in health care facilities (patron views)

Response	Frequency	Percent
Strongly Disagree	2	2.7
Disagree	5	6.7
Neutral	43	57.3
Agree	16	21.3
Strongly Agree	9	12.0
	75	100

It could be seen from table 4.7 that 21.3% of the respondents agreed to the statement whereas 12.0% strongly agreed to the statement. In contrast, only 2.7% and 6.7% of the respondents reportedly “Strongly disagreed” and “Disagreed” respectively to the statement. Comparing the percentage of respondents who agreed and the percentage of those who disagreed with the statement, it can be concluded that 33.3 % respondents (making specific reference to the 21.3% and 12.0% who “strongly agreed” and “agreed”) agree that the NHIS is poorly managed in health care facilities. In general however, it can be concluded that majority of respondents did not really know whether the scheme is being managed well or not.

The respondents that agreed that the NHIS is being poorly managed explained that there are many things that the scheme could be doing better such as the reduction of the long queues and distribution of quality medicine for example. Some of the respondents also suggested that the scheme is being poorly managed due to the lack of medical supplies and drugs at the facilities. Logistical issues such as obtaining photocopies of their health insurance cards at the facility of treatment is one of the many reasons why people think that the NHIS is not working well. Another reason why some respondents feel that the scheme is being poorly managed is due to the lack of personnel, which also makes the queues go slower and time spent at the hospital longer.

A participant in the *focus group discussion* commented on the question about the queues in the hospital and the respondent from the NHIS subscribers replied: “there is always a queue” (Mark, 21, SSS, unemployed). A follow up question dealing with whether there was an increase in queues was asked to the same respondent; he noted that: there was no increase in the size of the queues. Miss X a FGD participant commented on

the idea concerning whether or not people understood the scheme enough to make an assessment of the schemes performance. She indicated:

You know the way to quality health care, we the professionals have to identify the community as partners, to me that is what we have to do. You tailor whatever information you have to their level so they help you on that level in the communities.

The question of whether there was poor management of the NHIS in health care facilities was directed to the managers of facilities. The purpose of this question was to find out if the facility managers thought that the scheme was being managed well.

Table 4.8

Response	Frequency	Percent
Strongly Disagree	17	22.2
Disagree	17	22.2
Neutral	25	33.3
Agree	17	22.2
	75	100

In table 4.8 from the service providers view point, 22.2% of the respondents reported “strongly disagree” to the statement. Again, 22.2% reported “disagree” to the statement, and 22.2% reported “agree” to the statement. However if both of those who “strongly disagree” and “disagree” are to be considered at one end, it could be said that 44.4% on a whole disagreed with the statement. Hence in conclusion, it can be said that among the service providers, majority disagree that the NHIS is poorly managed.

The following issue concerns whether the general public believes that the NHIS patrons are provided with good services in health care facilities.

Table 4.9

Response	Frequency	Percent
Disagree	8	13.7
Neutral	13	17.3
Agree	24	38.7
Strongly Agree	25	30.3
	75	100

Table 4.9 shows that 38.7% and 30.3% of the respondents reported “agree” and “strongly agree” to the statement. In contrast, only 13.7% reported “disagree” to the statement. This means that the general public believes that the NHIS members are provided with good services in health care facilities.

The managers’ views and opinions as pertaining to the question “Are NHIS members provided with good services in health care facilities.” This question was directed to the managers to find out whether the scheme managers felt they were providing good services to their patrons.

Table 4.10

Response	Frequency	Percent
Disagree	12	16.7
Neutral	12	16.7
Agree	32	41.7
Strongly Agree	19	25.0
	75	100

Table 4.10 depicts that 41.7% and 25.0% of the services providers reported “agree” and “strongly agree” respectively to the statement. On the contrary, 16.7% reportedly “disagree with the statement, and 16.7% reported “neutral” to the statement. This means that the service providers generally believed that the NHIS members are provided with good care in health facilities.

The query regarding the viewpoint of facility managers relating to “In your view how effective is a one-time premium for sustaining the NHIS” was asked. The rationale behind asking this question was to ascertain the views and opinions on the sustainability of a one-time premium.

Table 4.11

Response	Frequency	Percent
Effective	6	8.3
Alternative Sources of funding*	38	50.0
Not effective	31	41.7
	75	100

*Depending if alternative sources of funding are available a one-time premium would be effective.

Table 4.11 above shows that 50.0% of the respondents reported that the effectiveness of the one-time premium depends on obtaining other available sources of funding such as grants and loans, internal generation of funds via fundraisers and benefits, and acquisition of medical supplies at reduced prices are all ways of generating alternative sources of funding to sustain the scheme. In addition, 8.3% of the respondents reported that the one-time premium is sustainable. However, 41.7% of the respondents reported that the one-time premium would not be effective in sustaining the scheme. In

conclusion, the majority of the respondents contended that the sustainability of the one-time premium depends on other available sources of funding for the scheme.

The service providers and their thoughts on delays of reimbursement were addressed, with particular reference to “How do managers cope with the delays of reimbursement”.

Table 4.12

Response	Frequency	Percent
Rely on loans*	38	50.0
Suspend the rendering of services	25	33.3
Resort to cash and carry	12	16.7
	75	100.0

* Loans from banks, close friends, and lines of credit

Table 4.12 revealed that 50% of the service providers rely on loans from the bank to sustain them in their time of need. They also rely on loans from friends to remedy emergency situations such as shortage of medical supplies and drugs. Lines of credit are also extended whereby facilities are given drugs on credit from the facilities they purchase their drugs from. This is used as a method of coping with delays of reimbursement of claims. 33.3% of the service providers reported suspending their services to NHIS until they receive claims/ reimbursement. Finally 16.7% reported that as a way of coping with delays in reimbursement, they resort to cash and carry.

The question “If you could change one or two things about the way that NHIS system operate, what would you change” was posed to both managers and beneficiaries. The results of this question are shown below:

Table 4.13

Response	Frequency	Percent
Scheme should cover all drugs	28	35.7
Scheme should make immediate payment of claims	22	28.6
Scheme should reduce renewal date to six months	5	7.1
Categorize clients according to socioeconomic status	5	7.1
Establish scheme pharmaceutical stores	5	7.1
Monitoring and evaluation	10	14.3
	75	100

35.7% of the respondents recommend that the NHIS should cover all drugs. Also, 28.6% reported that the scheme should make immediate payment of claims so that the clients can receive good/uninterrupted treatment. 7.1% recommend that the scheme should reduce its renewal date to six months. Furthermore, 7.1% recommended that the scheme should categorize clients according to their socioeconomic status, so that the premium would differ based on this. 7.1% also recommend that the scheme should establish its own pharmaceutical stores so that clients can purchase their drugs at a reasonable price as opposed to buying at the market price. Finally, 14.3% recommended that there should be proper monitoring and evaluation of the activities of the scheme. This, they said, can help solve many problems such as lack of consistent stock of drugs, availability of funding to manage the scheme, and streamline the process of treatment and processing of NHIS patrons.

4.3 Section B

This section of the work is broken down into three themes. These three themes are feasibility and sustainability, funding, and transparency. Throughout this section these

three themes are discussed as per the findings from this research based on the FGD, in-depth interviews, and the survey.

4.4 Feasibility and Sustainability

From the service providers' view point, 33.3% as indicated in table 4.1.2 below reported being neutral on the statement "There is poor management of the NHIS in health care facilities". It could also be said that 44.4% on a whole disagreed with the statement.

Hence in conclusion, from table 4.8 it can be said that among the service providers, the majority of respondents disagree that the NHIS is poorly managed. These findings can be an indication of a perception that the management of the NHIS is being properly managed. With this perception you could also insinuate two additional assertions. The first point being that if the facility managers believe that the scheme is being managed properly, then the issue is not that the scheme is being poorly managed; it is rather that its implementation that is being called into question. The second point that could be noted from this particular finding is that the idea that the scheme can be perceived as feasible.

Table 4.9 shows the statistics of whether members of the NHIS are provided with 'good services' at health care facilities.

If the general public believes that the goods and services are being provided at health care facilities, then one could draw the conclusion that the NHIS is performing necessary services that people saw as essential.

4.5 Claims Dispersion, and Acquisition of Funds

Table 4.11, as a result of the data gathered, depicted that 50.0% of the respondents reported that the effectiveness of a one-time premium would depend on other available sources of funding to sustain that one-time premium.

However, 41.7% of the respondents reported that the one-time premium will not be effective in sustaining the scheme. In conclusion the general consensus of the respondents pointed to the fact that sustainability of a one-time premium would depend on availability of other sources of funding for the scheme. With this finding one could see that the majority of the respondents advocating for the one-time premium are concerned with alternative sources of funding. This meant that people are in favour of the one-time premium, but they also think it is unsustainable if the bulk of the funds being acquired by NHIS are mostly from the national health insurance levy. The point being stressed here is that the people think that a proposal such as the one-time premium plan is feasible, but without diversified funding a one-time premium alone may not be able to sustain the NHIS.

50% of the service providers stated that their facilities rely mostly on loans, which was portrayed on Table 4.12.

Such a response from service providers would suggest that the NHIS method of claims repayment is not as efficient as it should be. Another point that could be derived from this finding is that if the claims are not being paid in a timely manner then the burden of care falls squarely on the service providers and not on the scheme, as it should

be. One last issue that can be seen from the finding presented in table 4.7 is that the NHIS services are at times withheld due to late reimbursement of claims.

Table 4.8 indicated 35.7% of the respondents recommend that the NHIS should cover all drugs.

Here the finding is that all drugs should be covered by the NHIS. This is a very interesting finding that also pertains to the pharmacies as well. Some of the information gathered by conversing with the pharmacists shows that the acquisition of prescription drugs is not the issue; the issue is the price they acquired it. The price that the drugs are being purchased always fluctuates. For instance, the drugs that are considered under the NHIS are covered at a specific price, but the point is that when the claims are not reimbursed on time there needs to be an alternative/solution to the problem of inadequate drugs and supplies. A lack of constant drugs and other medical supplies ends up costing them money. The reason why drugs are not constantly available is that when the drugs that are covered under the NHIS are sold out, the patients do not wait for you to receive your reimbursement from the NHIS and restock the drugs that are sold out. The patients keep coming, and since they keep coming drugs need to be available for them otherwise the people will go to another place for treatment. In order not to be found wanting, the health facilities end up purchasing drugs at a high prices from the open market, which ends up costing these facilities more in the long run since the price of the drugs they are purchasing are constantly going up. Essentially one conclusion you could draw from this notion is that facilities are losing money dealing with the inconsistencies in claim reimbursement. 28.6% reported that the scheme should make immediate payment of claims so that the clients can receive uninterrupted treatment. The finding being

presented here shows that immediate payment of claims is something that is essential to the efficient and effective operation of the NHIS. 7.1% recommend that the scheme should reduce its renewal date to six months. One rationale behind this finding could be that the renewal date that is in place now may not provide a platform for members to renew their subscription. Furthermore, 7.1% recommended that the scheme should categorize clients according to their socioeconomic status, so that the premium would differ based on ability to pay. The point exhibited by this finding is that if clients were classified by their socioeconomic status it would aid in the provision of quality health care. This meant that the disadvantage segment of clients would be identified, and with that realisation they would be given more attention than those who are better able to care for themselves. 7.1% also recommend that the scheme should establish its own pharmaceutical stores so that clients can purchase their drugs at a reasonable price as opposed to buying at the market price. The provision of pharmacies established by the NHIS would help in reducing the burden on facilities that operate under the NHIS. Finally, 14.3% recommended that there should be proper monitoring and evaluation of the activities of the scheme. This finding asserts that enhanced monitoring and evaluation is necessary in order to effectively manage the NHIS. It would aid in effectively utilising resources of the NHIS, and it would also help in identifying any inconsistencies within the scheme as well as bringing about improvements and modifications.

4.6 Transparency

Comparing the percentage of respondents who agreed with the percentage who disagreed against the idea of poor management of the NHIS in health care facilities in the view of the patrons, it can be concluded that relatively more respondents (making specific

reference to the 21.3% and 12.0% (see table 4.7) who “strongly agreed” and “agreed”) agree that the NHIS has been poorly managed by health care facilities. In general however, it can be concluded that the respondents did not really know whether the scheme is being managed well or not. If the beneficiaries have no knowledge of whether the scheme is being managed well or not then it could be that the beneficiaries feel that they do not know enough about the scheme to say if it is managed well or not. The notion that people feel that they are not knowledgeable enough to comment on the good services being provided at health care facilities, coupled with the finding that the people receiving these “good services”, can translate to the lack of transparency within the NHIS.

4.7 In-depth Interview Findings

A woman involved in the day to day dealings of the NHIS, who will be referred to as Miss Y, was consulted for an in-depth interview. She thought that “the NHIA has taken on more than they could handle”; it should have not been so ambitious, but ought to rather implement the scheme in bits, and that realistically those who have cards that they can use, are about 40%. In addition these 40% have registered and have not renewed.

She then commented on the need for a change in mentality. The mentality of the people has yet to change, since some people feel that if they are not visibly sick they should not register for the NHIS. If however it were made mandatory, such as car insurance for example, the likelihood of success for the NHIS would be higher. The main ideology that needs to be introduced is a behavioural change. Changing the behaviour of a person is essential and it is not easy to change. If the behaviour of the people is modified then there can be an enabling environment for people to be more inclined to adopt the program of NHIS.

Next the idea of sensitization came into the discussion. She noted that sensitization needs to be done in order to give the people a sense of ownership. She always saw that financing of the NHIA is something that can be thought of as problematic for both her and her staff, as well as the NHIA itself. The main concern was rather where the money that is present is to be channelled and how to spend it. Concerning MDG 4 and 5, Miss Y has the strong belief that if women do not get pregnant they are not at risk for maternal health, meanwhile NHIA gives free services to mothers when they are pregnant. Items such as family planning are not on the list of treatment for NHIA. From this assessment one could presuppose that the NHIA rather deals with the symptoms of problems, instead of the root causes of the problem.

Suggestions for funding on her part also were a topic of discussion. Her view was that the NHIA portrays them as not being constrained by finances, so her thoughts are more concerned about where to channel the funds. The issue of the one-time premium for her was that “it was a mirage”. She considered the one-time premium to be a mirage because variables such as inflation for example, were not considered when drafting the policy.

The next topic that was brought to her attention was issues of whether if implementing co-payments would be effective. Her response was that the patient should be able to “have a say” on what type of drugs or treatment they would receive, but as it stands now if you come with any particular illness there is a set of treatment procedure that the patient goes through. At the end of this treatment there are key drugs that the doctor is to prescribe for that illness. If a patient is making a co-payment then the idea is that they should also be able to make their wants, needs, and concerns known at the

treatment facility. The idea is that there is the need to make the system more transparent. Patients should be made aware of what the scheme is responsible for, in terms of provision of medicines, so that the patient would then become empowered to make a choice as to whether they would make that commitment or not.

Another point that was brought up was the idea of the medication being free. Miss Y made a statement that when patrons come for treatment, and we give them drugs for free, at times they do not value them. The consensus being gathered from the discussion was that the more potent drugs that were being used were discontinued because they were being 'abused'. Patients that were prescribed drugs discontinued their usage thereby curing the symptoms of the sickness but not the sickness itself. If a patient were made to make co-payments for drugs they will also be inclined to take the drug as directed. Co-payments would also be a mechanism to reduce the abuse of drugs that are prescribed; because patients have the perception that if they do not take the drugs they will not get well. A general conclusion that could be drawn is that people prefer to take their drugs as prescribed than to be forced to co-pay for the same drug again.

The idea behind whether making claims is the best way to operate a health insurance scheme, as opposed to dispersal of funds with accountability was discussed. Subsequently the response that was given was that dispersal of funds with accountability would be a better option for the facilities. The reimbursement of claims in her thoughts was preferred over pre-dispersion, and it has improved overtime. Over time the reimbursement of claims has gone from eight weeks to a maximum of three months, but the issue here is that during that time period financial planning has been more than a burden in her eyes. If one was to plan their financial budget, according to the constantly

fluctuating reimbursement payment schedule, it may be quite difficult to sustain a facility that accommodates NHIS patients. If the NHIA is able to study the claims being submitted by a given facility, and make 40% of the money being claimed available to the facilities upfront they could possibly alleviate any shortage of drugs or supplies. With measures of accountability in place dispersal of funds with accountability would be a viable idea to help make the NHIS a viable alternative to cash and carry.

If one or two changes could be made to the NHIS her first suggestion noted was the production of the NHIS card. The production of the NHIS card takes so long; if three or four centres were established to produce the card it would relieve this long wait endured by the NHIS member. Patients are frustrated and in this case they do not have a voice. The lack of a voice coupled with patient frustration, force individuals to do something outside the rules and regulations put down by NHIS. In this particular instance this frustration has caused people to arrive at facilities without their NHIS card and rather pay for services rendered than depend on the NHIS. If the production of the NHIS card were decentralized into maybe three facilities, the time in producing the NHIS cards would decrease.

How hospital managers cope with the delays in reimbursement of claims is becoming less of a problem. The private facilities' problem deals with the quantum of money provided for services rendered. The public facilities do not have to pay for accommodation, salaries, and other things, but the private facilities have to factor these things in. The money that is allocated is not adequate and has forced some to start charging patients. One of the reasons given for charging patients is that the private facilities provide more services than the public facilities. If the tariffs could be reviewed

upward for them it would reduce the instance of patients being charged. It would make more money available to the facilities reducing the burden on the private and public facilities.

When the issue of complaints by the beneficiaries are brought to the attention of the scheme how are the complaints addressed? Miss Y stated that she can only do so much, and that when the complaints of the community are brought to her attention she tells those who matter. She rather goes to the source to identify the problem and then she addresses the problem within her power as best as she could.

The next topic of discussion that was on the table was about the way forward to effective health care delivery in Ghana. 'Healthcare is manufactured in the homes you cannot do without the community'. The health care professionals should identify the community as partners by tailoring information to chemists, for example, for local specifications. This is one approach that can be utilized in order to achieve potent health care.

There was a point in the discussion that talked about the role that pharmacies play in providing health care. The issue that was discussed was that the health care facilities are usually a one stop shop for treatment and prescription of drugs. If the quality of care increases at the facility, says Miss Y, then naturally you as a person, who receives all the necessary lab tests and is seen to in a timely manner, would be inclined to acquire all of their services at that facility than any other place. Most people prefer places that are thought of as "a one stop shop" a place that can accommodate all of their needs, which can unintentionally displace other drug providers.

4.8 Interview with Kpeshie Scheme Managers

The first question that was discussed is whether the NHIS is an appropriate tool to address the health care needs of the nation. The response that was given was that it is because it bridges the financial gap between those seeking quality healthcare and those that are able to afford that health care; implying that the NHIS is a good tool to address the health care needs of Ghanaians. The main point regarding the inception of the scheme was that the government decided to address the health needs of Ghanaians by implementing this scheme. The NHIS was for those who could not access quality health care due to their financial situation. With this scheme it was envisaged that those who could not afford quality health care would be able to do so through the NHIS.

The topic of availability of resources as per the health care needs of Ghanaians was brought up. The responses received from the scheme managers were that regarding human resource capacity they have enough resources. Funding was seen to be an issue that was of concern. The reason for such a statement was because, though the number of patients receiving health care is greater than the funding of the NHIS; It would be wise on the part of NHIA to consider alternative sources of funding to provide uninterrupted care for patients and sustainability of the scheme.

The perception among the scheme managers was that the NHIS is effective for now, as per the MDGs as discussed in chapter one, and they are doing their part to contribute their quota of keeping citizens healthy. The NHIS has aided in the realisation of development by addressing the MDG by improving maternal health via implementation of free maternal health care services. It has also aided in the fight against diseases such as malaria and other diseases. Healthy citizens are productive citizens, and

productive citizens are more likely to do work to contribute to the socioeconomic development of Ghana.

The scheme managers see the one-time premium as having both positive and negative impacts. In this instance the idea of having a one-time premium or nothing at all has changed. Now, in the opinion of the scheme managers at Kpeshie, an optional one-time premium payment would be the better direction to move on. The rationale behind this statement is that some people will not be able to afford the one-time premium; therefore with this change the patient is presented with a situation where he or she can choose what is best for him / her. Patients should be empowered and better informed so that whether rich or poor one can receive quality health care at an affordable price. If this is effectively implemented then this would constitute an additional avenue to acquire revenue for the NHIS. If there is additional revenue for the NHIS then they could channel that revenue to places in the scheme that need it.

The conclusion on implementing a co-payment system was positive and the scheme managers thought that it should be implemented. The system of co-payments being made by patients is one that they agree with. The point about the abuse of the NHIS had been brought up and discussed within the interview between the scheme managers. The main comment on abuse dealt with the behaviour of people not taking the drugs as prescribed, and returning for more drugs since they have not paid for the drugs out of their own pocket.

Changes that could be made to the scheme were also discussed. Examples of some things, which could be changed within the NHIS, were implementing compulsory

annual tariff review. The effect of tariff revision would present a more current picture on the actual prices of drugs so that private facilities do not incur financial losses when treating patrons of the NHIS. The other thing that could be changed is the institution of a co-payment system, a development of a policy as it were. If this institution were put into effect the likelihood of a patron abusing the scheme would reduce.

One more thing that should be changed is the institution of centralised facilities owned by the NHIS to supply drugs at a steady and subsidised price. The rationale for the point that was made about centralized drug facilities is that the private service providers are always thought to be out for profit. With the delays in claims forcing them to purchase drugs at market value, as well as the idea of a private facility to make a profit, the reality of the situation is that prices for the same drugs differ from facility to facility increasing the apprehension of private facilities treating NHIS patrons. If such a central facility that warehoused the drugs covered under the NHIS were to exist it would relieve the burden of late reimbursement of claims. These warehouses that are maintained exclusively by the scheme could extend drugs to these facilities on credit when their claims are not refunded on time. This would end up solving the problem of private facilities incurring financial loss, and relieve the apprehension of treating NHIS patrons.

With regards to whether complaints of the patients are met the NHIS subscribes to the notion that the complaints of the patients are met. There are contact numbers and agents that are around all the facilities that can be contacted and if they cannot solve your problem it is then passed on to the scheme level for further deliberation. If your problem cannot be solved there and then, it is sent to the regional office, and if that fails the

national level is then consulted to deal with the problem. If the problem remains unsolved it is then forwarded to the secretariat level.

Subsequently, the question involving the effectiveness of making claims, as compared to the distribution of funds with accountability was made. The system that is in place now is a diagnostic formatting system; where by the treatment for malaria for example has been broken down and priced. Each treatment has been itemised and given a predetermined price that would be covered under by the NHIS. The issue that comes up here is when the facility goes beyond using more than the medical materials listed to treat a sickness it becomes the burden of the facility. The point being made here is that when prices for treatment start to climb over the rate that they are entitled to claim per individual and their sickness a facility may find it hard to treat scheme members. Diagnostic pricing as compared to the ideology of distribution of a lump sum of money to be accounted for, in the opinion of the scheme managers is best. The reason why they respond this way is due to increased corruption. The managers further elaborated on the subject, stating that distribution of funds with accountability of these funds provide negative consequences such as a decrease in the quality of care, and corruption. This decrease in the quality of care can be contextualized in the treatment given to patients. For example, this decrease in the quality of care can occur if a facility claims a malaria treatment at 10 Ghana Cedis per person, while quoting a price of 15 Ghana Cedis per person. This left over 5 Ghana Cedis would be lost and may be misappropriated leaving room for corruption and laundering of funds. Such inconsistencies this could translate to a decrease in care because they are spending less money than they are claiming. The

diagnostic pricing being practiced by the NHIS is seen to be far more effective than distribution of funds with accountability.

Another point that was unearthed during the interview was that if the supplies that are covered under the NHIS are exhausted, one facility could end up giving substandard treatment due to depletion of funds or drugs that are covered by the NHIS.

The issue of changing attitude also came up. The managers commented that it does not matter which health insurance scheme is being operated so long as clients continue to harbour the negative attitudes toward the health insurance scheme it would be difficult to make people gravitate towards a wholehearted adoption of NHIS.

Furthermore if patients do not change unhealthy behaviours, such as not having regular medical check-ups to prevent the incidence of ill-health and disease, those seeking medical attention will continue to increase putting undue pressure on health facilities which could cause a collapse of the NHIS.

The NHIA has also stated that when a health facility is affiliating to the NHIS they should give explicit notice to their suppliers that they would not always be able to pay on time; and that they should be extended some line of credit for about 90 days. The scheme also in turn adheres to the promise that they would be able to reimburse their money claim within 90 day at maximum.

Subsequently, the issue of claims being refunded as per the policy was brought up. The ideal situation is that a facility's claim is supposed to be vetted and refunded within 30 days, but the reality of the situation is that the claims that are being filed often contain errors and some of them have to be rejected outright. The ones that are filed

correctly are usually not filed on time. This coupled with the complicated process of vetting and refunding a claim, often run over the time allotted for claims to be refunded. This can also be a reason why healthcare is often disrupted.

The way forward in this case is the model of NHIS as suggested by the scheme managers, as opposed to the implementation of the cash and carry. The NHIS has saved a lot of lives. The NHIS has also been successful in diagnosing patients with early symptoms of future medical problems early thereby avoiding severe medical challenges and undue death. Even for those that are detained due to unpaid bills the NHIS has helped in alleviating burden of some of these.

4.9 Analysis of Focus Group Discussion

The focus group discussion was essential to this research work. The reason why this research work required a focus group discussion was due to its descriptive nature. The focus group discussion would offer different perspectives on the questions presented within the discussion. The respondents would be able to give a range of responses that also creates room for further probing and clarification of issues that would enrich the research, while examining the responses given as compared to the objectives of the research.

The question presented to FGD participants was, “What they thought was the relevance of National Health Insurance? Why did the government introduce the Scheme?” This question brought about responses as well as suggestions. The general consensus among the focus group participants (FGP) was that the NHIS was created to help them pay for treatment in order for them to maintain good health. Another rationale given for the creation of the health insurance scheme was that it came to help them so

that if their children are sick they could access health care, as well as, ‘I see that it came to help sick children’. These responses suggest that women and men have different reasons as to why they appreciate the inception of the NHIS; but their thoughts on why it was created are conclusive.

While discussing the issue concerning the creation of NHIS a suggestion came up. This suggestion dealt with the scheme looking after those that are on pension. This was an issue one woman brought up, and if this suggestion were included in the original implementation it could also stand to benefit the elderly.

Subsequently, the FGP discussed how they thought the NHIS works, and how they understood the scheme to operate. The responses that were given were based more on the positive outcomes that resulted as per the implementation of the scheme. One of the overall responses of how they see the scheme to operate is stated below:

It helps when you visit the clinic that your folder is created for you and you don’t pay for anything. Just this month I visited the hospital, they created a folder for me, I went to see the doctor, I went for the lab test I wasn’t charged (Mercy, 40 years old, SSS, Trader).

Another respondent noted that two years ago one of their sisters gave birth, and it was free because she was enrolled in the NHIS. The last account made in reference to this subject made reference to a preference to having the NHIS as opposed to not having the NHIS:

For me it is good because I am suffering from typhoid. I also go to Iran clinic and all the lab tests and drugs I receive free of charge. The last time I went to the hospital my NHIS had expired. I spent almost 50 cedis on lab tests and medication (John, 25, Tertiary, Trader).

These responses show that members of the NHIS have started to understand what the scheme is doing to help in the provision of affordable health care.

The issue of long queues at facilities was discussed. All of the participants unequivocally agreed that the queues are just too long; although the queues are not getting any longer they are not getting any shorter either.

One point brought up in the FGD dealt with the perception that some prescription drugs were not being covered under the scheme. One experience that was shared by a female member of the FGD was that:

I cannot be sure if the drugs are free. I remember that when my father was ill and surgery was performed on him 4 years ago at Korle-bu. We had NHIS but we were made to pay for the drugs we needed and the drugs were expensive (Agnes, 45, Seamstress).

Another experience narrated by Diana a female participant:

First when the scheme was in place, treatment was free, but now it seems that they take half the cost. It's not like before. If your child is sick and you visit the hospitals they would dispense paracetamol for you, but will tell you the rest of the drugs are not available so go out and buy the drugs elsewhere (Diana, 33, SSS, Trader).

One more experience that was recounted in this regard is shown in the response below:

Some hospitals when you visit them you enjoy full services, but at a polyclinic even something as small as cotton to dress a wound you would have to purchase it. I gave birth and fell sick I was treated for free. The medicines in bulk were free but in Accra here I do not know how things are done (Emmanuel, 28, Tertiary).

One suggestion that could be of great help, as suggested by one of the participants, was that it would help if a list of a hospital's drugs and services that are covered by NHIS were put on display at all the facilities treating NHIS patrons; so that people can prepare and know exactly what they are entitled to, and what instances would require additional payment.

These three occurrences have shown first hand that most of the drugs are not always available when they are needed, and that some of the people undergoing treatment at an accredited NHIS facility are not always aware of the particulars that go into the treatment, thereby making them powerless to complain if they feel that they are not receiving the best of care.

Issues of surgical operations within the NHIS were also discussed. When members go for care they are to have photocopies of their identification cards. The question on most minds of the NHIS members is why they should pay for a service that is supposed to be free under the scheme. Some of the health facilities take money for the photocopies, others do not and one reason why this is happening is shown in one of the responses made by the FGP:

At times the machine does not work and they would not tell you. I make copies before I go, because you might have queue and you will have to leave and cross the street to make a photocopy. So I do mine for 20 Ghana pesewas before I go (Efua, 34, Hair Dresser, SSS).

Participants complained that losing your place in the queue when leaving to make photocopies is frustrating. The same individual also proposed an alternative that if there are photocopy machines in each hospital it would solve the problem. Providing every NHIS accredited facility with a photocopy machine would relieve some of the burden of cost on the patient seeking healthcare.

Another significant aspect of the discussion centred on what the NHIS is responsible for covering. The people wish that the NHIS coverage protocol would be stated explicitly at each of the facilities. One account that was made by a participant

showed that this confusion over coverage responsibility was a glaring issue that needed a resolution:

All I was saying is that first operations differed. Some were covered some were not, but now even the free ones you will still pay something. A sibling went in for an operation and was not charged anything. So I agree with her that a list of service that is covered would be good so that if you are to undergo operation you will know which one covered what (Mark, 21, SSS, unemployed).

In such instances the people feel, as per the FGD, that the hospitals themselves are the ones that dictate what they would pay and would not pay.

It was also pertinent to discuss the services that were being provided and whether they were adequate or not. So far the general consensus is that the NHIS has done well, but has not gotten there yet. There is still work to be done. Theoretically once you have the card you should be assured of a basic level of treatment, and that the NHIS is doing a great job, but the faults seem to be from the hospitals. This comment means that the people acknowledge that the scheme itself is trying to do something good for the people. On the other hand the comment also suggests that the hospitals are not doing enough to support the scheme in its efforts. One also deduces that the hospitals are contributing to the problem unknowingly.

Another significant point that was addressed in the discussion was the policy of cash and carry and whether it should continue to be practiced or abolished. The response that was received was that yes cash and carry should be out. The NHIS is good because there could be a time that you would fall sick and not have money to treat yourself. With the NHIS you can still be treated. Other participants have the impression that the private

facilities benefit more from cash and carry patients than they do from the NHIS patients.

One respondent indicated:

Looking at cash and carry the private clinics are opened to make profit, but if you look at the government sector they are supposed to provide certain essential services. So a mixture of cash and carry won't be bad, and people can access care. For private facilities you cannot blame them much because they have to pay workers and bills (Kwame, 24, Trader, SSS).

The people stressed that the private facilities are in the business of making money as opposed to providing quality health care. This opinion is due to previous obligations that the private facilities had to their employees and the maintenance of their facility. One comment made by a male participant affirms this statement:

I do not condemn private clinics because they also help. When we go to the government clinics and they charge us we know they are cheating us. They might not be able to wait for payments from NHIS. This accounts for most of them not tending to NHIS patrons (Maame, 30, unemployed).

Another topic that was unearthed in the FGD was whether the NHIS had come to stay, and if it was sustainable. One person said that yes if it stops then it is because the government stopped it. The general consensus among the FGD participants was that the obligation was rather on the government to maintain the scheme.

This could be an isolated incident, but there have been other instances where the service providers abused the scheme. This account given by a female participant affirms such an allegation:

Hospital authorities should check their workers some are corrupt and charge certain menial amounts even though you are enrolled in the NHIS. At a certain facility, there was a gentle man taking one cedi per patient, and the reason given was that this is the first time they are visiting this clinic. The same incident happened at another local polyclinic. I do not understand (Regina, 37, SSS, Seamstress).

There would need to be some type of mechanism to combat such abuses in order to provide longevity for the scheme. One point that was given was that such instances of ‘corruption’ on both sides of the scheme make the scheme inept in the eyes of the patients. They believe that the money that has been ‘extorted’ from the scheme may never be recovered. One account that was made during the FGD also substantiates people’s thoughts on whether monies that are ‘stolen’ are ever recovered:

They take the monies for their own pockets, and we do not think it gets to the authorities... Some even charge two cedis for lab test even though it is covered by NHIS. What are we doing about it? (Solomon, 20, Tertiary, Trader)

The general thought on the effectiveness of the NHIS was the next topic on the agenda. One of the responses that were given in reference to the topic of effectiveness was that it has now made access to the medical services easy. In addition one does not have to be on their death bed before visiting the hospital. One suggestion that was made dealt with adjustments in payments for treatment/premiums based on the income level and the age. One response that shed light on this issue, made by a male respondent, was that he thought each age group should be made to pay different premiums. An example could be the working class could pay different prices than children and dependents. That response is also linked to the thoughts and opinions on the one-time premium. A point that was made in the discussion was about the feasibility of the one-time premium:

That won’t be possible because people cannot afford it. This yearly method has its challenges. For example how can a grandparent in the village, who has not set eyes on one hundred Ghana cedis before pay that one time premium (Solomon, 20, Tertiary, Trader)?

Such a response suggests that the idea of a one-time premium would not be plausible; such an idea would need to be revised to better suit the people. When we asked what suggestions they could make to help the scheme better there were many different types of responses. One response was that all hospitals should be able to provide general types of treatment across board, so that all hospitals can provide the same services for all NHIS patrons. Another suggestion that was made earlier within the discussion was about age being a factor in what kinds of payments people should be obligated to pay as per the treatment one undergoes. This point was contextualized by one of the male participants as payment being aggregated according to age. For example, those 18 and above should pay a different price, while those students below the age of 18 be obligated to pay a lower amount. The recommendation being put across is that there should be concession for certain ages. In particular those above the age of 65 should be exempt from paying for medical attention, and those that have not reached 18 years of age should be entitled or exempted from any medical expenses. Another suggestion that was given was about where citizens can report problems and injustices that have occurred. If there was a hot telephone line it would make medical staff think twice, as they know they can be easily reported. One more very important suggestion that was brought up pertained to the issue of ‘corruption’ within the scheme:

I agree with you; village health workers do not manipulate the system. Usually people from the villages might not even have one Ghana cedi to pay for much of anything, but in the cities the health workers are taking “kickbacks” and spoiling the system. So in the city, the health workers are not helping us with sustaining the scheme. So I suggest the hospital authorities should check their workers and put them to order. Now after this discussion if any health worker charges me I would report them (Kwabena, 38, Trader).

These suggestions that were made showed that the people do enjoy the benefits of the scheme, but they wish that improvements were made to make the scheme better. These ideas also bring about some necessary changes that need to be addressed within the scheme. If there was a way that community members could contribute to the welfare of the scheme in a positive way, it could provide the push that the NHIS needs to solve some of the many inconsistencies present within the scheme.

The research problem and questions were contrasted against the findings of the focus group discussion, the in-depth interview, and survey. The outcome of this contrasting resulted in three major findings. The research work dealt with various research questions and problems namely:

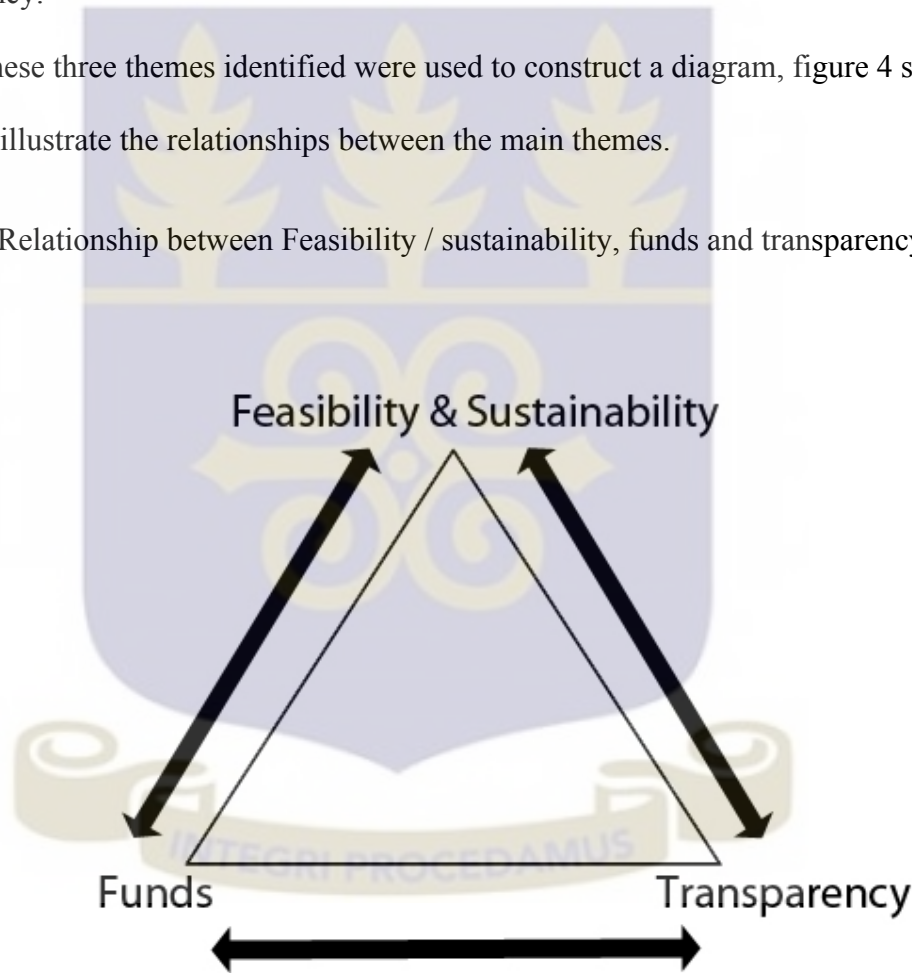
- Financing health has been one of the issues confronting the Ghana government. Health services, whether preventative, curative, or rehabilitative, now demand financial commitment that many people cannot meet from their own resources. (Edoh and Brenya, 2002:41).
- Problems that have confronted the scheme consisted of poor data integrity, limited membership authentication at service provider sites, and manual vetting of claims.
- The various issues pertaining to inadequate healthcare that have been put forth by the NHIS have become an issue of great deliberation since its implementation in 2003.

4.10 Relationship between Reoccurring Themes

There was a diversity of responses to many questions posed to the respondents in the study. Their responses were analyzed for common trends, themes, and anomalies. The data yielded three main themes, which provided the basis for an in-depth analysis of their relationships. These themes were categorized as feasibility and sustainability/funds/transparency.

These three themes identified were used to construct a diagram, figure 4 shown below, to illustrate the relationships between the main themes.

Figure 4: Relationship between Feasibility / sustainability, funds and transparency



Source: Field Survey, 2011

The interrelationships between these themes have been identified in various responses given by the participants. The first theme, feasibility & sustainability, relate to

transparency in different ways. The first way the theme related to transparency is seen in a variety of conceptual explanations derived from the responses of the participants. The earlier conceptual response shows a link between transparency, feasibility and sustainability: Medical emergencies have caused people to arrive at facilities without their NHIS card, and pay for services rendered outright. If the production of the NHIS card were decentralized into three facilities, the time in producing the NHIS cards would decrease.

This link can be shown by the relationship between the theme feasibility, sustainability and the theme transparency by examining logistics. Looking at logistics, if the NHIS card distribution process is making people frustrated it means people would decide not to register with the scheme at all. This frustration can be attributed to lack of transparency on the part of the NHIS. People who do not register for the NHIS because of unwanted frustration would decrease the sustainability of the scheme.

The link shown between the two themes is the idea of people's frustrations not being acknowledged thereby forcing them to behave contrary to the rules of treatment provided by the scheme. The pertinence of this link is that the members of the NHIS should be obligated to serve the people more diligently. This shows that the service the NHIS is providing could be better.

The second mode of relationship between feasibility and sustainability has to do with the understanding of how the scheme operates. First, it is apparently obvious that lack of transparency in the operation of the system frustrates the subscribers.

This can be observed in the responses made earlier referring to posting of services and medication covered under the NHIS. Also drawing on the three occurrences noted earlier in the FGD, mention was made in the lack of shortage of drugs when they are needed most. Some of the people undergoing treatment at an accredited NHIS facility are not always aware of the particular issues that go into the treatment, thereby making them powerless to assert themselves if they feel they are not receiving the best of care.

The relationship between these two themes constitute the idea that when they visit the facilities the items and treatment procedures should be made visible in a form that is readily accessible and easily understandable. Such an idea would make the operations of the NHIS more transparent to the user. The higher the degree of transparency the more the people would be able to understand how the scheme works, so that they can plan their treatment according to their wants and needs.

One more connection that can be made between the two themes is the idea of members making relevant suggestions that could better the NHIS. If there was a way that community members could contribute to the welfare of the scheme in a positive way, it could provide the little push the NHIS needs to solve some of the many inconsistencies present within the scheme.

Referring to the point made during the FGD “that the NHIS has tried, but have not gotten there yet, and that there is still work to be done” shows that the relationship between the two themes make people feel like they are a part of the program. If such a protocol is implemented people would feel like they played a role in making the scheme what it is, while providing them with a sense of ownership.

The next relationship this analysis addresses is between feasibility, and sustainability and funding. The first connection that can be made between these two topics is seen in the responses concerning alternative sources of funding and effectiveness of the scheme. The first comment referring to alternative sources of funding was about the implementation of a one-time premium. The issue of the one-time premium is a mirage, according to some of the scheme managers. This ideology also raised the question as to whether a one-time premium was sustainable. The second point noted in table 4.4 pertaining to the general public's thoughts on the scheme's effectiveness was:

If the general public believes that the good services are being provided at health care facilities; one could draw the conclusion that the NHIS is performing a necessary service that people see to be good.

These points that were made could be seen as more or less positive. This is due to the nature of the responses given by the respondents. The people do not seem to have a problem with the idea of a one-time premium, but it seems to be unsustainable. This negative feelings pertaining to the sustainability of the one-time premium could be attributed to variables, such as inflation, that were not incorporated in the formulation of the one-time premium policy. Variables that were not considered may cause the early dismissal of the one-time premium ideology. The relationship between the two themes show there is not enough funding being channelled toward this ideology of a successful implementation of a one-time premium. Furthermore, for the scheme to be effective factors such as alternative sources of funding would need to be taken into account to

further stabilize the NHIS. A respondent made the suggestion of alternative funding during the FGD:

That won't be possible because people cannot afford it; further emphasising the challenges of the yearly one time premium. For example, a grandparent in the village who has not set eyes on one hundred Ghana cedis before. How can they pay the one time premium (Kojo, Teacher, 27, Tertiary).

Such a response suggests that the idea of a one-time premium would not be plausible; such an idea would need to be pursued further so it would better suit the people. Application of a one-time premium may be possible, but it would constitute major changes for it to become a reality.

Another point ascertained through the relationship between the two themes was that timely allocation of funds is very critical and shows how effective a scheme can be. The results from table 4.7 indicate that if claims were not reimbursed in a timely fashion, the scheme would not operate as effectively compared to claims reimbursed on time. Scheme managers at Kpeshie also commented on the issue stating:

They have also stated that when a facility is coming on board with the NHIS, they would instruct the facilities to let their suppliers know that they would not always be able to make their payments on time. In addition they also requested that there should be a line of credit good for 90 days. The scheme would also adhere to the promise that they would be able to reimburse their claims within a 90 day period.

The idea being portrayed here still remains the same, even though the NHIS in her opinion has done much better by timely reimbursing claims, the system of reimbursing claims needs to be streamlined and adhered to from both the recipients and the providers.

The next and final correlation is the relationship between transparency and funding. The point unearthed by this research is that funding of different projects,

whether for educational or for project purposes, is something that can provide solutions to many financial problems the scheme may be facing. Funding can be channelled into projects that could aid in the cultivation of new attitudes and habits, which will enhance both the clarity and understanding of the program. Funding can be used to inform and sensitize people about the benefits of NHIS via television programs, advertisements, radio programs, newspaper articles, etc.

The first linkage between funding and transparency is seen within the in-depth interview of Miss X who stated that:

She can only do so much, and that when the complaints of the community are brought to her attention she tells those who matter. She prefers to go to the source to identify the source of a problem and then deal with it as best as she can.

The opinion of Miss X is that if there is a problem she is unable to solve then she would go to the source and find out a solution; but this would not be necessary if the scheme itself were able to effectively communicate its methods of service to those who want to know. This idea of translating a clearer message to the people as to what / how the scheme is operating can be seen in the in-depth interview with Miss X. She explored the issue of sensitization by making this comment:

Sensitization needs to be done in order to give the people a sense of ownership. I believe that financing the NHIA would be problematic as far as compensating Miss Acheampong's staff, as well as financing the NHIA as a whole.

These two comments could be conceptualized by concluding that if the people were subjected to intensive sensitization it is likely that complaints will decrease due to new knowledge and skills acquired through the sensitization.

The procedure used to voice complaints about the NHIS by the scheme's patrons was discussed within the in-depth interview with the Kpeshie Scheme managers, as noted here:

The complaints of the patients are met, and there are contact numbers and agents located at all of the facilities that can be contacted in case of any issue. If they cannot solve your problem it is then passed along to the higher authority in the scheme for further deliberation. If your problem cannot be solved there, then it is then set to the regional office. If your problem is not resolved there then it is sent to the national level. If your problem remains unsolved it is then forwarded through to the secretariat level till your problem is addressed.

The issue about complaints being passed up through the hierarchy can be seen here. The scheme managers are suggesting that the NHIS patron should have a contact number of the scheme representative in order to deal with the issues people have. One point made by the members is that they have no idea where such a number can be located, and they have no clue as to whether they would be victimised after lodging such a complaint.

The other linkage between funds and transparency is the corruption that some of the members are experiencing. People from the FGD complained that people who experience injustices or problems within the scheme have no idea where or how to report their grievances:

One more very important suggestion that was brought up dealt more with the issue of 'corruption' within the scheme: I agree with you, village health workers do not manipulate the system. Usually people from the village do not even have one Ghana cedi

to pay for anything, but in the cities the health workers are taking “kickbacks” and spoiling the system (Kwabena, 38, Trader).

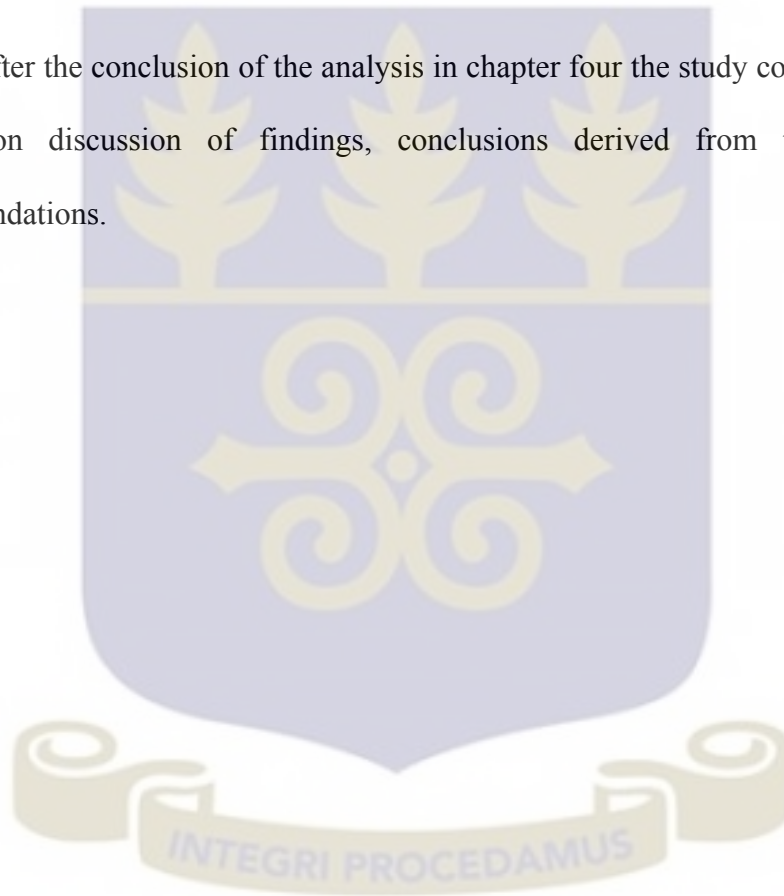
The common problem pertains to how complaints about corruption and related problems within the scheme are handled; and that people have no mechanism to voice their concerns. There also needs to be a well-publicized method that one can use to report injustices, strange happenings, or inconsistencies that have taken place regarding things that are contrary to NHIS procedures. If such a number were readily available instances of corruption and inadequate service could be reduced. The method of reporting injustices or concerns should be discreet and effective so it can incite the necessary change.

The last link discussed is between transparency and funding. The link is about how the complaints are handled after they are received, and the abuse of the scheme by subscribers. How the complaints of people are addressed is also very critical in maintaining the scheme’s transparency. Within the FGD the respondents discussed the abuse of the NHIS on both ends of the system. On the part of the NHIS patrons an episode of abuse was described by one of the participants as an “abuse of the physician’s time”. It would warrant a policy to outline the regulations regarding the responsibilities of the NHIS patrons. On the other hand abuse on the part of health care providers is seen below:

Hospital authorities should check their workers; some of them are corrupt and take bribes even if you are using NHIS. At a particular facility, there was a gentle man taking one cedi per patient. The reason given for this was that it was their first time of visiting this clinic. The same incident happened at another local Polyclinic. When things like this happen I do not understand (Regina, 37, SSS, Seamstress).

The linkage being drawn out from these two accounts is that there is no visible mechanism that is readily available to both the service providers and the members to report injustices. From this finding it appears that a more suitable system is needed to report injustices that take place and inconsistencies in order to limit abuse of the scheme by all stakeholders.

After the conclusion of the analysis in chapter four the study continues to the next chapter on discussion of findings, conclusions derived from the findings and recommendations.



Chapter Five

Findings, Conclusions and Recommendations

5.1 Introduction

The NHIS is a policy initiative that is supposed to aid in the provision of quality health care. The results acquired from conducting this research aid in the improvement of the NHIS, as well as explore the rationale behind its implementation and execution. Factors such as affordability, feasibility, and sustainability were explored and this chapter will provide the discussion, conclusion and the recommendation of the study.

5.2 Summary of the Findings

Contrasting the various points from the people interviewed in the research work, the research discovered several findings.

1. The respondents that agreed that the NHIS is being poorly managed explained that there are many things that the scheme could be doing better, such as the reduction of the long queues and distribution of quality medicine. Some of the respondents who suggested that the scheme is being poorly managed suggested this might be due to the lack of medical supplies and drugs at the facilities. Difficulties in obtaining logistics including photocopies of health insurance cards at the facility of treatment is one of the many reasons why people think that the NHIS is not working well. Another reason why some respondents feel that the scheme is being poorly managed is due to the lack of personnel, which also makes the queues go slower and time spent at the hospital longer.

2. Health services differ from place to place and looking at the responses from the clients it was clear that the services they are being rendered were not as good as they should have been. On the other hand less than half of the facility managers believed that they were providing good health services. This indicates that the majority of both the facility managers and clients believed that the health services NHIS are providing are inadequate.
3. Hospitals and pharmacies also rely on loans from friends to remedy emergency situations such as shortage of medical supplies and drugs. Lines of credit are also extended whereby facilities are given drugs on credit from the facilities they purchase their drugs from. This is used as a method of coping with delays of reimbursement of claims. 33.3% of the service providers reported suspending their services to NHIS until they receive claims/ reimbursement. Finally 16.7% reported that as a way of coping with delays in reimbursement, they resort to cash and carry.

The findings as compared to the research questions put forward unearthed other issues such as Information computer technology (ICT), inconsistency of care, availability of drugs, and general education.

ICT and other logistical issues: ICT is one of the issues that the study sighted as a shortcoming and if some of these problems are addressed the schemes daily operations would realize growth and sustainability.

Inconsistency of Care: There is a growing disparity between what the NHIS actually covers and the care that people are receiving. If procedures for diagnosis are made known or available to patrons they would know exactly what the NHIS covers and what it does not.

Availability of Drugs: Lack of medicine at smaller clinics as opposed to government hospitals. Supplies do not last long and they are not also restocked in a timely manner due to the late reimbursements of claims. If these claims are reimbursed on time one could make the conclusion that their reimbursement checks could come back on time for them to restock their supplies.

General Education: Instances of corruption and different prices at each facility need to be explicitly shown or explained to each patron. Patrons of clinics and hospitals must have prices of the facility made separate from any charges resulting from the NHIS.

The study is an explorative one, which also tried to assess the importance of social capital to NHIS. There were many issues about social capital that the study looked at, however concentrated on the World Bank and Putnam's notions about social capital. The World Bank's definition of social capital was adopted and used to construct the conceptual framework of the study because according to Fiorillo and Sabatini (2011) the use of membership in formal associations can provide a substantial correlation with the practice of good health, which further demonstrates the validation of social capital as an important concept. In addition, the study sought to achieve three other main objectives. One, whether the management style of the NHIS facilities was good or bad? What health care providers thought about NHIS; and how managers cope with delays of reimbursement in view of the pre-dispersion of funds versus subsequent treatment claims?

The study also assessed three successful national health scheme practices in Africa: Rwanda, Kenya, and Nigeria to provide examples of NHIS effectiveness in similar African countries. In the case of Rwanda three problems were identified as having made the scheme successful; these had to do with funding, organisation and management

and sustainability, while that of Kenya it was resource generation, optimum use of resources and financial accessibility of health services. In Nigeria the problems with the health care system was access to healthcare, premium and financing and solidarity between HMO. In Rwanda, the national health scheme was organised into three tiers; that is local, district and national. The local tier offered service that did not warrant admission or hospitalisation; the district was for those that had very severe illness and injuries, whilst at the national tier level specialised services are given. In the case of funding there was an annual membership premium and where individuals could not pay for it up front a micro financial institution was made to provide loans that were to be paid within one year at 15% interest rate. For sustainability, the bottom up architecture was used to facilitate a sense of ownership.

In Kenya, resources for the national health scheme were generated through the taxation of salary workers and government contributions. To sustain this resource generation, systematic tracking of resources ensured optimal use; combat fraud in order to minimise misappropriation of funds; budget reviews to make sure that money was going where it was needed; implementation of information technology to further streamline complex processes and increase accuracy and efficiency within the scheme; as well as the definition of benefits to clearly define goals and targets of the scheme. To ensure financial accessibility, there was the adoption of pooling of providers payment and putting the resources into a long term investment plan.

To tackle access to care in Nigeria, the elderly, the poor and vulnerable groups were exempted from contributing to social health insurance, and whilst in the rural area

provisions were made for health professionals to have accommodation in order to keep health professionals within reach if an emergency occurred. The Nigerian health system utilised the services of HMO for the collection of revenue and distribution of health services. The issue of premium and financing was done through the flexible payment system. A co-payment system was adopted for specialist care and cosmetic surgery. The investment of pooled resources in long-term investments was also utilised.

Ghana's adoption and implementation of a health insurance scheme for its entire population faces the challenges of adequate funding, sustainability and access to care, hence the study found out how social capital impacted NHIS. A total of 75 questionnaires were administered. The distribution was broken down; 15 questionnaires were administered at each of the three hospitals chosen making 45, and then 10 at each of the three pharmacies chosen making 30. The data collected from the interviews, focus group discussions and semi-structured questionnaires were analysed both qualitatively and quantitatively.

The key findings of the study indicated that 57.3% of the client and 33.3 % of the facility managers were neutral as to whether the scheme was being poorly managed or not. Additionally, on a five (5) point Likert scale, 30.3% and 41.7% of the client and managers of the facility agreed they are provided with good health services in healthcare facilities. In the situation of the delay of reimbursement majority of the facility managers rely on loans from friends, banks and lines of credit. Concerning the findings on the one time payment policy, half of the facility managers interviewed indicated that if other sources of funding were available to support the scheme one time premium would be possible.

From the in-depth interview with some of the scheme managers, it was realised that there was a need for a change in mentality as some people felt that if they were not visibly sick they should not register for the NHIS. Others also argued for the need for sensitization to give the people a sense of ownership.

On the implementation of co-payment, the in-depth interview revealed that patients should be able to “have a say” in what type of drugs or treatment they receive. If a patient is making a co-payment then the idea is that they should also be able to make their wants, needs, and concerns known at the treatment facility.

Is social capital relevant at all? Is its inclusion warranted in healthcare? After looking at this research and its findings the conclusion that can be drawn is that elements of social capital are relevant in sustaining the NHIS. The role of social capital, as per the definitions cited from Putnam and the World Bank, play an essential part within the NHIS. Factors that were included in the composition of social capital were trust, norms, networks, and reciprocity.

5.3 Social Capital and its Relevance to Healthcare

The relevance of social capital, which was examined and found in the literature review, shows that elements of social capital are important in sustaining the NHIS. The inputs known as trust, enforcement of norms, and reciprocity were identified as crucial elements which must be established among all stakeholders of the NHIS for it to be successful. These include claims facility and the healthcare facilities, and the clients or patients. The element of trust often manifests itself in the reimbursement of claims. Trust

on the part of healthcare facilities to believe that their claims will be reimbursed in a timely fashion, and trust for the claims facilities would be shown by their ability to live up to the norm of repaying claims within the allotted time of 30 days as stipulated by their rules and regulations.

Enforcement of norms is also something that can be seen as a necessary component in the sustainability of the NHIS. If a more rigorous enforcement of norms were put into place, such as monitoring and evaluation mechanisms for example, would provide more accountability while aiding in the decrease of instances of fraud and abuse.

Factors such as reciprocity should also be taken into account when addressing the sustainability of the NHIS. Reciprocity often manifests itself within the scheme in a number of ways. This reciprocity occurs, as per the gift theory propounded by Mauss and Gouldner stated earlier in chapter two, between the members and the health care providers. The members that sign up for the scheme, and contribute to the scheme's longevity financially, expect to receive quality healthcare treatment from the various facilities accredited by the NHIS. Another way that reciprocity is present within the scheme is the provision of quality treatment. Facilities would be obligated, by the gift theory, to reciprocate equally by issuing quality health care to all NHIS members.

It may enhance the operations of the NHIS in a positive manner. It would also help provide a solid basis for enforcing the already present protocols within the scheme.

5.4 Recommendations for the NHIS

After collecting and analysing the data gathered from this study there are recommendations that are important to state. The application of these suggestions provide alternative means of addressing different problems the scheme may be incurring.

5.4.1 Monitoring & Evaluation

The first suggestion that could be made based on the findings of this research is the need for increased monitoring and evaluation mechanisms. In Table 4.13, shown in the findings, 14.3% recommended that there should be proper monitoring and evaluation of the activities of the scheme. A recommendation regarding this particular finding therefore cannot be taken for granted to sustain and improve the performance of the scheme.

It was also found that the NHIS has plans to enrol all Ghanaian residents (NHIA Annual report, 2010). It would be prudent to use registration / renewal as a means of generating adequate funds and resources for operations.

5.4.2 Reporting Problems

Another suggestion that was seen to be necessary was that there should be a practical way that both health care providers and members of the NHIS can use to report injustices and inconsistencies. If such an avenue were made available most of the things that occur unnoticed would be brought to the attention of the scheme operators. With the problems being brought to their attention, plausible solutions could be formulated to deal with problems.

5.4.3 Issue of Late Claims and Re-imbursement

The idea of claims being reimbursed on time is something that needs to be addressed as soon as possible in order to bring about efficient and timely allocation of funds to where the funds are most needed. Claims that are not being put in on time and claims that are not being reimbursed on time can cause numerous problems for the scheme and those that participate in it. The suggestion here is that the protocol for filing claims should be streamlined. Streamlining of claims could be simplified, training on how to properly complete claims forms can be conducted, introduction of information and communication technology equipment such as intra-networks, reliable internet connections, cell phones, and portable landlines that are ‘immune’ to the utility challenges experienced here in Ghana could be used to remedy the problem of late claims.

5.4.4 Alternative Funding

Alternative methods of funding are also needed in order to bring about change in the way the scheme operates, to provide more revenue for the scheme. Sources of alternative funding reduce unnecessary financial stress that is being incurred by the scheme. Alternative funding will also provide the necessary resources to the scheme to institute the needed changes. Alternative funding may also be one avenue to provide sensitization and education for the people to have a better understanding about their health needs.

Other avenues need to be explored to generate funding to help finance the scheme. Reliance on funds acquired through taxation alone may not be a viable means of

survival for a scheme that was targeted to meet the needs of all Ghanaians seeking healthcare.

5.4.5 Reviewing Tariffs Upward

A revision in tariffs upward yearly is something that is also seen to be a necessary adjustment tool. The increase in tariffs will change how much the scheme anticipates the cost of particular treatments that are covered under the scheme. The idea of the yearly tariff revisions would also keep up with prevailing market prices for treatments that the scheme is willing to cover. If such a suggestion is implemented it may help ease the burden of what some would call “unrealistic” treatment pricing instituted by the NHIS.

5.4.6 Sensitization and Education

The idea of sensitization and education is very necessary for something like the NHIS. Some people see things that they do not understand; mass education and sensitization of the people would help in people participating in the scheme. People do not understand some of the procedures that the NHIS is implementing. If they are properly sensitized and educated about particulars of the scheme they could have a different outlook about health and how the scheme contributes in maintaining good health.

5.4.7 Pharmacies Operated by the Scheme

One last suggestion that is worth making is the idea of the scheme operating a scheme-owned set of centralized pharmacies. The idea is to relieve the burden of filing for credit lines to other outside facilities where their prices for prescription drugs are

higher than the scheme is able to afford. This is aimed at stopping the purchasing of drugs outside the schemes price range to cease, and transfer the distribution of drugs to the scheme exclusively.

5.5 Conclusion

The NHIS has put in place new principles and objectives for improving the various healthcare inconsistencies present in Ghana. The general conclusion being drawn from this research is that the building blocks of social capital and the argument inherent in the concept are relevant in the NHIS. Secondly, the scheme is sustainable if substantial changes are made to ensure its longevity. Thirdly, the scheme should not be considered a foreign policy that has been transplanted within the health care system of Ghana; it should rather be considered as one that derives from cultural notions of shared responsibility and reciprocity.

5.6 Suggestions for Further Research

With these conclusions being made the general consensus that can be gathered is that the NHIS can be sustainable as well as effective. Although the research did not go into detailed accounts of the scheme dealing with issues such as membership intake or in-depth statistics dealing with impact of ICT, other studies may be able to take up such topics and expand on this research.

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APPENDICES

Appendix 1.Observation Report

In this document the nonparticipant observations that have taken place in the various hospitals, clinics, pharmacies, and laboratories. The different types of reflective and descriptive notes that were taken include problems, impressions, physical setting, portrait of participants, account of events or activities, and hunches.

From April 20th to April 24th nonparticipant observations were undertaken in the Ledzokuku-Krowor Municipal Assembly. These facilities that were included in the observation are listed below.

Hospitals:

1. Manna Mission Hospital
2. Christian Medical Hospital
3. Finger of God Maternity Home
4. Family Health Hospital
5. Prima Health Services
6. LEKMA Hospital
7. Teshie Community Clinic

Pharmacies:

8. Health Consult Pharmacy
9. Fabby Chemists
10. Pro-Life Pharmacy
11. Danpong Pharmacy
12. Bright Pharmacy
13. East Airport Pharmacy
14. Camp Road Pharmacy

Diagnostic Center

15. Nungua Medical Laboratory

The facilities listed above were subjected to non-participant observation, and there were trends as well as general notes that were recorded. Some of the common trends that were present in these facilities dealt with the cleanliness of the facilities. There was also a sense of dichotomy that appeared to be present between the pharmacies and the hospitals concerning the staff present, and the cues present in the pharmacies relative to the hospitals. Other comments recorded that were prevalent to the observation pertained to ideas, perceptions, suggestions, and biases.

General Observations

Some of the general observations that were made pertained mainly to the location of the facilities. Most of the facilities visited did not have sign boards to direct you to their location. If you do not ask someone in the area where the hospital or pharmacy is located, chances are you may find it difficult locating the facility in question. Another general point that was noted was that the majority of the hospitals didn't have anyone to greet you, that onus was rather on the patient to look for staff members to direct them to the appropriate office that would be able to address the problem of the patient. One more thing that I took notice of was the amount of people loitering around the compound. At one hospital people that were waiting to visit patients were made to wait outside the building. Some were made to stand others sat where ever they felt comfortable be it the floor, steps, or against the wall of the building itself.

Conventional & Unconventional Trends

The common trend that dealt with cleanliness was related to the tidiness of the facilities. Most of the facilities were fairly neat, with the exception of the surrounding neighbourhood outside or next to the establishment. The compounds of the health facilities were neat, clean. The facilities were well kept, making specific reference to atmosphere, wash room facilities, and offices used in the serving of the public. The conditions of the structures were well painted, although there was minor structural degradation, the majority of the facilities were in good condition.

Descriptive Notes

I felt that there were two dichotomies present between the pharmacies and hospitals; the first of which dealt with location of the pharmacies. The pharmacies that were independent of hospitals were not as crowded as the pharmacies that were located within or around the grounds of the hospitals. The second dichotomy that was observed was the cue at hospitals. The hospital cues seemed to be over crowded with less staff members; as opposed to clinics and pharmacies that had more than adequate staffing.

I had an experience when first entering the Danpong pharmacy dealing with the access to information. One of impediments that I was faced with was access to information. People were very suspicious, or apprehensive of outsiders. With this understanding, in my candid opinion, these may be due to a fear of outsiders and the potentially destructive reports that could be made about the facility as others have done in the past.

Reflective notes

Other issues that were unearthed by observation were problems of storage and record keeping. One main problem is that if efficient and copious records are not kept one could argue that the efficiency and effectiveness of a hospital/scheme dependent on these records may decrease.

After visiting all of the facilities my intuition tells me that if you are using NHIS the likelihood of you receiving quick service at a hospital, unless you are in a state of emergency, is very unlikely. One of my biases was that I was accustomed to a different type of healthcare system originating from outside of the country. This bias may have had an influence on the way in which I speculated on some of the procedures and protocol of NHIS that took place. Some of the ideas that I put down for possible improvement is the introduction of ICT into the scheme to help aid in recording, counting, and record keeping.

Another thing that was common among many of the pharmacies was the presence of plasma televisions and tables with magazines and other amenities to keep one occupied during their wait.



Appendix 2.Observation Guide:

April, 20th -24th 2011

Wednesday	Thursday	Friday	Saturday	Sunday
20	21	22	23	24
8 :00 – 11 :00 Observation of Facilityat LEKMA Hospital. (Teshie) 12 :00 – 1 :30 Observation of FacilityatManna Mission Hospital (Teshie-Tsui-Bleoo) 2:00 – 3:30 Family Health Hospital(Teshie)	9:00 – 11:00 Observation of Diagnostic Center at Nunguna Medical Laboratory (Nungua) 1:00 – 2:00 Observation of Fabby Chemists (Nungua) 2:00 – 3:00 Danpong Pharmacy (Nungua)	9:00 –11:00 Christian Medical Hospital(Nungua) 11:00 – 12:00 Camp Road Pharmacy (Teshie) 1:00 – 3:00 Bright Pharmacy (Teshie Est.)	9:00 – 12.00 Finger of God Maternity Home (Teshie) 12:00 – 1:00 East Airport Pharmacy(Teshie) 1.00 – 3.00 Health Consult Pharmacy (Teshie Est.)	9:00 – 12.00 Teshie Community Clinic (Teshie) 1:00 – 3.00 Prima Health Services (Spintex) 3.00 – 5.00 Pro-Life Pharmacy (TeshieTsui-Bleoo)



Appendix 3. In-depth Interview Questions for Scheme Managers

IN-DEPTH INTERVIEW QUESTIONS FOR MANAGERS

1. Why is the NHIS a tool to be considered in providing quality healthcare?
2. What is your opinion on NHIS's resources as compared to health care needs of Ghana?
3. What are your thoughts on the NHIS's effectiveness?
4. If you were to suggest an avenue for funding the NHIS what would it be and why?
5. How effective is a one-time premium for sustaining the NHIS? What are the alternatives to a one-time premium?
6. What are your thoughts on co-payments made by patients, and are they effectively utilized in your opinion?
7. Do you think the NHIS should use both one-time premium and the annual payment, or one of the two?
8. How do you handle the complaints of card holders?
9. If you could change one or two things about the way the system operates, what would you change?
10. How effective is the making of claims as a way to operate a health insurance scheme. To what extent would dispersal of funds with accountability be a better option and why?
11. How do you think hospital managers cope with the delay of re-imbursement of claims?

Appendix 4. Questions for the Focus Group Discussion

FOCUS GROUP DISCUSSION QUESTIONS

1. What do you think is the purpose of NHIS?
2. How does the NHIS work?
3. Do you think the NHIS provides adequate healthcare to all registered members under NHIS?
4. What categories of Ghanaians benefit from the NHIS most and which less so?
5. What are your thoughts on the one-time premium? Do you think it would be expensive?
6. Have your experiences with NHIS been positive or negative and why?
7. Do you believe that the scheme is sustainable?
8. If you compare the NHIS to the former scheme, do you think the NHIS is good or bad idea and why? What do you think can be done to improve it?
9. Which system of healthcare do you prefer NHIS or cash and carry?
10. What aspects of the Cash and Carry scheme do you think are worth keeping?
11. Has the NHIS changed your thoughts and opinions of living a “healthy lifestyle”?
12. Do you have any suggestions for improving NHIS?



Appendix 5. Questionnaire for NHIS Card Holders

Semi-Structured Questionnaire

My name is Kwame Afadzi Insaiddoo Jr, Master of Philosophy aspirant with The Kwame Nkrumah Institute of African Studies, at University of Ghana Legon. I am conducting a research titled **Sustainability of NHIS: The role of social capital and service care providers in the Ledzokuku-Krowor Municipal Assembly (LEKMA)** for the completion of my thesis. The information acquired during this research will be kept strictly confidential and anonymous.

Questionnaire No _____

Date _____

INTERVIEWERS NAME _____

(A) SOCIO-DEMOGRAPHIC DATA

1. Age []

2. Sex? Male [] Female []

3. Educational Level None [] Primary [] JSS [] SSS [] Tertiary [] Pre-University [] University

4. Ethnicity Akan [] Brong [] Ewe [] Northerner [] Fante [] other (specify): _____

5. Religious affiliation a) Christian [] b) Muslim [] c) Traditionalist []

d) Others (specify): _____

6. Occupation a) Farmer [] b) Teacher [] c) Apprentice [] d) Trader [] e) Hairdresser [] f) Seamstress [] g) Artisan [] h) Other (specify) _____

7. Marital status a) Single [] b) Married [] c) Divorced [] d) Living with a Partner [] e) widowed []

8. Did you register with the scheme last year (2010 1st and 2nd batch)? Yes [] No []

9. Did you benefit from insurance by being a member of the scheme last year? Yes [] No []

If yes specify the type of benefits: a. OPD ☐ b. admission medical ☐ c. admission d. surgical

☐ Other specify: _____

10. Have other members of your household registered? Yes ☐ No ☐

If yes specify: Children under 18 ☐ Wife/husband

☐ other, specify _____

11. Have you registered with the scheme this year (2001 1st and 2nd batch)? Yes ☐

No ☐

If yes why?

If no why have you not renewed your membership?

Service Providers' related factors (Please tick one)

12) Insured clients are not given good medicine at the health facility

Strongly Agree (☐) Agree (☐) Neutral (☐) Disagree (☐) Strongly Disagree (☐)

13) Insured clients delay when they visit a health facility

Strongly Agree (☐) Agree (☐) Neutral (☐) Disagree (☐) Strongly Disagree (☐)

14) Insured clients are not treated with respect at the health facility

Strongly Agree (☐) Agree (☐) Neutral (☐) Disagree (☐) Strongly Disagree (☐)

15) Health workers are not patient with insured clients

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

16) Drugs are not available at the health facilities for clients

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

17) Insured clients are given substandard drugs than cash and carry clients

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

18) Health workers are not always available to attend to you when sick & waiting

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

19) I have to pay more to access to quality medicine

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

Scheme Management related factors (Please tick one)

20) I did not know I have to renew my registration every year

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

21) I don't know where to go and renew membership

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

22) Insurance ID takes so long to be processed

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

23) Cannot afford the premium and registration

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

24) If I am extremely sick, or deathly ill, I still have to pay in advance before treatment

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

25) Scheme staff is not patient with us

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

26) Our complaints are not settled adequately

Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree ()

27) Do you understand what the NHIS is, and how it works?

28) How is the NHIS, in your opinion, working to give you the best of care?

29) What are your thoughts on the quality of care that you have or will receive under NHIS?

30) Do you think the NHIS is able to empower health care providers to provide quality health care? If so how? If not why?

Appendix 6. Questionnaire for Facility Managers

Semi-Structured Questionnaire
(Facility Managers)

My name is Kwame Afadzi Insaiddoo Jr., Master of Philosophy aspirant with The Kwame Nkrumah Institute of African Studies, at University of Ghana Legon. I am conducting a research titled **Sustainability of NHIS: The role of social capital and service care providers in the Ledzokuku-Krowor Municipal Assembly (LEKMA)** for the completion of my thesis. The information acquired during this research will be kept strictly confidential and anonymous.

Questionnaire No _____

Date _____

INTERVIEWER'S NAME _____

(A) DEMOGRAPHIC FACILITY DATA

1. Years of establishment? []
2. Years of operation within the NHIS? []
3. The number of staff members working at the facility? []
4. Can you please disaggregate the staff by gender?
Men _____ Women _____
5. What are the different types of care provided at the facility?

6. What are the different types of care covered under the NHIS?

7. What is your opinion on NHIS's resources as compared to health care needs of Ghana?

8. Did your facility benefit from being accredited by the NHIS?

A) Yes [☐]

B) No [☐]

If yes please explain

9. What are the challenges attributed to the daily operation of NHIS?

10. The assumption is that you are expected to use your own materials to treat patients and then later make claims. What are the most challenging aspects about maintaining materials for adequate health care?

11. How effective is the making of claims as a way to operate a health insurance scheme.

12. When filing a claim do you receive your reimbursement in a timely fashion?

A) Yes [☐]

B) No [☐]

If no how long does it normally take for a claim to be reimbursed?

13. How do you cope with the delay of re-imbursement of claims?

14. To what extent would dispersal of funds with accountability be a better option as opposed to the submission of claims?

15. In your view how effective is a one-time premium for sustaining the NHIS?

16. In its current form, in your opinion, is the NHIS sustainable. Please explain?

17. If you could change one or two things about the way the system operates, what would you change?

(B) Service Providers' related factors (Please tick one)

18) Insured clients are not given good medicine at the health facility

() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

19) Insured clients delay when they visit a health facility

() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

20) How would you reduce the delay of a patient seeking health care under NHIS?

21) Drugs are not available at the health facilities for clients

() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

22) Insured clients are given fewer drugs than non-insured clients

() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

23) Health workers are not always available to attend to those that are sick
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

24) Patients have to pay more to access to quality medicine
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

(C) Scheme Management related factors (Please tick one)

25) Do clients know where to register for NHIS?
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

26) NHIS members don't know where to go and renew membership
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

27) Insurance ID takes so long to be processed
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

28) Is the registration process is simple and easy for all to follow
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

29) Should extremely sick, or deathly ill patients receive immediate attention regardless of their NHIS status.
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

30) The staff works together to accomplish goals
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

31) Complaints of patients are dealt with in a satisfactory manner
() Strongly Agree () Agree () Neutral () Disagree () Strongly Disagree

32) Is the NHIS, in your opinion, working to the best of its ability?

33) What are your thoughts on the quality of care that you provide to those under NHIS?

