

**COMPARATIVE STUDY OF THE EXPERIENCES OF NHIS SUBSCRIBER AND  
NON-SUBSCRIBERS IN ACCESSING HEALTH CARE AT THE GA EAST  
MUNICIPALITY**

**BY**

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## DECLARATION

I hereby declare that this Dissertation is the result of an original research conducted by me Edward Nii Nuertey Noi, under the supervision of Mr. Daniel Doh of the Centre for Social Policy Studies (CSPS) of the University of Ghana, and that no part of it has been submitted anywhere else for any other purpose.

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Sign.....

Date.....



## **DEDICATION**

I dedicate this work to God Almighty.



## ACKNOWLEDGEMENTS

I am most grateful to The Lord God Almighty for helping me come to a successful completion of this study. This study could never have been done without the patience, encouragement, promptings, corrections, comments and the scholarly assistance of my supervisor Mr. Daniel Doh. I am really grateful.

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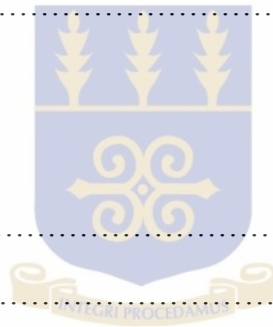
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## ABSTRACT

The main objective of this study is to examine the impact of the NHIS on ensuring accessibility to quality health care in the Ga East Municipality, especially by the poor and under-privileged; and to assess whether comparatively, subscribers or non-subscribers get easier access to health care. To do this, a mixed method approach was adopted in data collection and analyses. Thus, a semi-structured questionnaire and an interview guide were employed for data collection. Quantitative data so collected was analysed using SPSS 18 while the qualitative data was analysed based on the emerging themes through colour coding. In all 208 health respondents were contacted for data- 200 for quantitative and 8 for qualitative.

Findings have it that comparatively; NHIS subscribers have better access to quality formal health care than non-subscribers. Subscribers and their children under 18 years have access to free OPD services, laboratory services, some surgical services, consultation and dispensary services at public and some private health facilities. Non-subscribers would have to pay for all such services when seeking health care.

Subscribers however, have to spend more waiting time, suffer verbal abuses, and at times, frowned at for using NHIS card rather than cash. Subscribers may also pay extra money to cover for extra drugs and services not covered in the scheme. Poverty and negative perceptions were realized as the major barriers to subscription to the NHIS.

In view of the findings, it was recommended that the drug list and surgical operations list be expanded to cover many other common health conditions; health workers who discriminate against NHIS card holders should be sanctioned, and that the NHIA should settle claims by the service providers promptly. Finally, more health workers were to be produced to lessen the burden on the few available.

## CHAPTER ONE

### INTRODUCTION

#### 1.0 Background

The wealth of a nation depends on the health of its citizens and therefore, healthcare provision has been a major developmental issue in many countries. At the global level, health insurance is very well established in many countries (Mavalankar and Bhat, 2000). As a result, health insurance coverage dominates many state and federal health care discussions in the United States of America (Fernandez, 2005). This is particularly based on the growing argument as well as evidence that the introduction of health insurance, especially in poor areas can improve people's access to health care (Berk and Monheit, 2001). A number of countries have adopted and implemented different health insurance schemes to offer affordable health care to their people. For instance, it is reported that Mexico's national health insurance program known as *Seguro Popular* have assisted in reducing substantially the likelihood of extraordinary health expenses amongst insured households, especially the poor (Galárraga et al., 2008).

Funding for health services is often cited as a major constraint for governments to be good stewards of health systems in many countries (Poullier, Hernandez, Kawabata & Savedoff, 2002). Globally, in 1998, Poullier, Hernandez, Kawabata and Savedoff note that the world spent an estimated \$3,1 trillion on health goods and services out of an estimated total world income of \$38.7 trillion. Thus, health spending represented some 7.9% of global GDP. This comes to an average expenditure per person of \$523 on health services. However, this average varies significantly across countries and across regions. It ranged from only \$82 per person in Africa to \$2,078 in the OECD countries. As the data above indicates, the adoption of health insurance in

developing countries such as Ghana is even more critical considering the fact that many governments of these countries have lesser money to finance health care putting untold hardships on the already poor individuals who have to spend large amounts of money to receive good health care (Berk and Monheit, 2001).

The World Health Organisation (2009) in a study found that, in low income countries, out-of-pocket payments constitute almost 85 per cent of the health care expenditure. However, if poor people have to pay for care when they need it, they may avoid seeking care, become heavily indebted and/or become poorer. Again, countries that spend little on health also have poorer health conditions (Poullier, Hernandez, Kawabata and Savedoff, 2002). Buttressing this point, the writers' notes that, the median health adjusted life expectancy in 91 countries that spend less than \$200 per capita on health is only 47.1 years. Health insurance is one way of reducing out-of-pocket payments and improving poor people's access to health care (Berk and Monheit, 2001).

In line with its millennium development agenda, the Government of Ghana, in 2003, established a National Health Insurance Scheme (NHIS), to make health care more affordable and more accessible for Ghanaians. In Ghana, poverty reduction spending is largely targeted at the under-privileged in society. This group of people is usually given the needed support and financial assistance to help equip them for better opportunities in life. Health spending in low income countries is too often driven by this need for improved health care and poverty reduction among others, (Chalkidou et al, 2010). The National Health Insurance Scheme, introduced in Ghana about a decade ago, is a kind of social health insurance that adopts a method of prepayment of

financial contributions for healthcare as contained in the resolution adopted by WHO in May, 2005 (WHO report, 2006). This prepaid mechanism collects funds through taxes and insurance contributions which allows people to access services when in need (ibid.). With this strategy, the poor is protected from financial stress through cross-subsidization and/or reduced out-of pocket spending. Additionally, to boost local sources of funding for the health sector of most countries, the World Health Organization, IMF, and other donor organizations periodically support developing countries financially to help provide quality healthcare to those who need it.

Ghana's national health insurance scheme has received a lot of criticisms from the media, civil society groups as well as ordinary citizens as being discriminatory and being used as a political tool to spend the monies of innocent Ghanaians. It is however also lauded by others as a good policy that has actually relieved a lot of Ghanaians of the stress of having to cough out huge sums of money just to get healthcare. Most studies have actually concentrated on the benefits of the health insurance and seem to ignore the possibility of some truths in the suggestions that there could be some accessibility lapse in the scheme as well as the quality of service delivery, especially in the rural areas.

The savannah regions of Ghana (the Northern, Upper East, Upper West) and part of the coastal localities such as the Volta region, are among the poorest areas of Ghana where many people face the sting of chronic food insecurity, poor healthcare, and disease, (IFAD, 2008). Livelihoods are more vulnerable in those regions and most of the members of the communities suffer as a result of food insecurity during part of the year, leading to low productivity and poor markets of agricultural outputs, (ISSER, 2007). Yet there is a disproportionate distribution of health

personnel nationwide and the inadequate provision of health facilities and equipment in rural areas. As noted by Baafi (2010), "70% of doctors are concentrated in Accra and Kumasi with 4.2% in northern parts of the country; special health care services do not receive enough attention although health receives the second largest portion of government expenditure."

### **1.1 Statement of Problem**

The establishment of the National Health Insurance Scheme (NHIS) was to ensure an improvement in the quality of basic health care services for all citizens, especially the poor and vulnerable with regard to access and utilization. After years of being burdened under the cash and carry system, the introduction of the NHIS received loud applause especially among the poor who now found a social protection system that provided succor for their healthcare expenditure problems.

Five years later, a nationwide Citizen's Assessment of the scheme showed that over 40 percent of Ghanaians have not subscribed to the scheme and about 36 percent others who ever registered failed to renew their cards after expiry of their membership. This trend could be attributed to many factors such as delay in waiting periods at health facilities, verbal abuses of clients, poor quality of health care services and many more (Gobah Freeman FK, Liang Z, 2011).

More often than not, attention of the general public is drawn to the challenges confronting the operation of the National Health Insurance Scheme, challenges as to delay in claims reimbursement, misappropriation of funds by schemes, fraud and irregularities, exponential

increase in utilization of health care facilities by insured clients without its corresponding increase in staff and health facilities (GNA, Arthur, 2009; Abdul-Korah, 2010).

However, there is little or no mention of the experiences of both subscribers and non-subscribers alike in accessing and utilizing health care services. Access to health care services for the past years has seen a fluctuating pattern in health care utilization in Ghana. It is however good to note that, there has been an increased in accessing health care services since 2003 following the introduction of the National Health Insurance Scheme. The behavior of insured and uninsured clients of the National Health Insurance Scheme in accessing health care services could be attributed to either past or present experiences they had at the health facilities in their quest to access health care services.

For people who do not have insurance, they face major challenge of paying very high fees for accessing health care. Many uninsured clients also face the problem of losing their lives as a result of non affordability of health services.

Again, it is also a common place to find out that majority of the insured clients may not access health care due to the delays associated with card bearing members of the scheme at health facilities. Many insured clients prefer to attend private health facilities where they even pay high fees to attain quality health services.

Unfortunately, no attempt is made to understand at a close range the opinion of those who have dropped out of the scheme and those who have refused to register with the scheme or the thrills

of those who are still registrants with the scheme. Information of this sort is important to help pull out both real and out of sight problems that confront the implementation of a publicly-subsidized national programme such as the NHIS.

The study is therefore designed to investigate the various experiences of both NHIS subscribers and non-subscribers in accessing and utilizing health care services in Ghana using the case of the Ga East Municipality.

Thus, based on the problem statement, the study will be guided by the following research questions;

- Is healthcare more easily accessible to NHIS subscribers than non-subscribers?
- Do NHIS subscribers and non-subscribers get different quality healthcare service from providers?
- What are the challenges associated with accessing health care services generally?
- What measures can be put in place to break the barriers if there are any and increase access to health care services by both subscribers and nonsubscribers of the NHIS?

## **1.2 Rationale of the Study**

In view of the unavailability of information with regards to the barriers militating against access and utilization of health care services in the study area, the main rationale for the study is to provide an evidence based material on these barriers as experienced by clients to inform policy makers, the municipal health management team, and management of the Ga East Mutual Health Insurance Scheme (GEMHIS) on the challenges confronting accessibility by both insured and uninsured clients of the National Health Insurance Scheme to health care services. This will

enable proper planning and implementation of mechanisms to deal with the situation for improved health delivery.

More so, it is important to note that removal of the barriers to accessing quality health care services by insured clients is a very crucial tool to increasing the membership drive of the National Health Insurance Scheme. Thus, this study provides proposed recommendations and solutions to dealing with such situations whilst drawing on best practices for improved health service delivery in the Ga East Metropolis. In light of this, the relevance of the study cannot be underestimated if the scheme is to achieve its goal of attaining universal coverage in the municipality.

### **1.3.0 Objectives of the Study**

#### **1.3.1 General Objective**

The general objective of the research is to examine the experience of NHIS subscribers and non-subscribers in accessing healthcare in the Ga East Municipality.

#### **1.3.2. Specific Objectives**

The specific objectives of the study include the following:

1. To investigate the role of the national health insurance scheme on healthcare accessibility in Ghana.
2. To conduct comparative study of the accessibility of health care by NHIS subscribers and non-subscribers.

3. To identify the barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality
4. To examine possible disparities in health care accessibility and make suggestions for improvement.

#### **1.4 Theoretical Framework**

This study is situated in the theory of Health Belief Model (HBM). HBM was initially developed in the 1950s in order to explain why medical screening programs offered by the United States Public Health Service, particularly for tuberculosis, were not very successful as envisaged (Hochbaum, 1958).

The major underlying concept of the original HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. Personal perception is influenced by the whole range of intrapersonal factors affecting health behavior. According to this model, there are four perceptions that could shape the behavior of all health seekers. The four perceptions therefore serve as the main constructs of the model; namely, perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers. Each of these perceptions, individually or in combination, can be used to explain health behavior. In more recent years, the HBM had been expanded by adding other constructs. The HBM has been expanded to include, for example, the “cues to action”, “motivating factors”, and “self-efficacy” (Hochbaum, 1958).

Commenting on “perceived seriousness” as the first perception undergirding the model, McCormick-Brown (1999) indicated that an individual’s belief about the seriousness or severity of a disease would usually influence his or her health seeking behaviour. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general.

The second factor that influences health seeking behavior of people is personal risk or susceptibility. According to HBM, individual’s perceptions of susceptibility to health hazards would prompt people to adopt healthier behaviors. The greater the perceived risk, the greater the likelihood that people engage in behaviors that could decrease the risk. It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it from happening. On the other hand, it was also suggested that when people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviors tend to result (Janz and Becker, 1984).

The next factor has to do with the perceived benefits the individual is likely to attain. Thus, while an individual may admit a personal susceptibility to a disease condition and also believes in its seriousness, these identified factors will not produce any defined particular course of action, a force leading to behavior. Perceived benefits are a person’s opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviors when they believe the behaviour will decrease their chances of developing a disease.

Thus, an individual would not be expected to accept the recommended health action unless it was perceived as feasible and efficacious (Janz and Becker, 1984).

The final factor perceived to inform behavior of health seekers in the HBM is “perceived barriers” to attaining the perceived benefits. Janz and Becker (1984) posit that the potential negative aspects of a particular health action may act as impediment to undertaking the recommended behavior. A kind of cost-benefit analysis is thought to occur wherein the individual weighs the action’s effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects, iatrogenic outcomes), unpleasant (e.g., painful, difficult, upsetting), inconvenient, time-consuming, and so forth. This is an individual’s own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change.

Apart from the four traditional beliefs or perceptions underpinning the HBM, recent modifications added some other factors. One of such new additions is that behavior is also influenced by “cues to action”. According to this view, cues to action are events, people, or things that move people to change their behaviour. Examples include illness of a family member, media reports, mass media campaigns, advice from others, reminder postcards from a health care provider or health warning labels on a product (Hanson & Benedict, 2002). These authors also posit that apart from the cue to action, perceptions are modified by other variables, such as culture, education level, past experiences, skill and motivation.

In 1988, another determinant of health seeking behavior among health seekers was introduced in the debate. Self-efficacy was added to the original four beliefs of the HBM. Self-efficacy is the belief in one's own ability to do something about the health condition. This view holds that people generally do not try to do anything new unless they think they can do it. If someone believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried (Rosenstock, Strecher, & Becker, 1988).

This model is not without its criticisms. A number of scholars and experts in the field of health services while praising the model also criticised some aspects of it. For example, the ETR Associate, a non-governmental agency listed a number of criticisms against the HBM. The Association argued that the HBM focuses on beliefs and attitudes and, as such, may be less appropriate for dealing with habitual behaviors such as smoking, dieting, or other emotionally motivated health behaviors. These behaviors should be addressed separately. In addition, economic and environmental factors are not addressed with the Health Belief Model since these may be out of an individual's control.

It was also pointed out that the HBM is much more effective for a multiple layer intervention. The combination of multiple interventions (e.g., a school health event, classroom instruction, and an educational ad campaign) is more effective than any single intervention. Again, the Association opined that the HBM is best used for a relatively short intervention to achieve a specific change. It may be less effective in achieving long-term change.

This study is believed to fit into this model for a number of reasons. First of all, the idea that a “perceived seriousness” of a health condition will cause a change in health seeking behavior of an individual is synonymous with health seeking behavior of some Ghanaians in general. People normally will wait, take no action or try other unorthodox methods of healing themselves until the situation gets out of hand. Perceiving the seriousness of the condition, the victims are rushed to the health centres, clinics or hospitals for attention.

Another fact is the HBM view that individual’s perceptions of susceptibility health hazards would prompt people to adopt healthier behaviors. In Ghana, people are usually careful when they sense danger. On the other hand, people turn to become careless if there is no immediate danger that could harm them.

Again, many health seekers are at times skeptical and would usually rationalize their choice of health providers. Health seekers in Ghana would for example want to be sure that they would gain rather than lose in their health seeking behaviour. An individual subscribing to the NHIS, for example, would want to analyze the cost and the benefits before subscribing. One may join when the gains out-weigh the cost.

Incidentally, the HBM’s “perceived barriers” happen to be some of the very experiences that affect the health seeking behaviours of majority of Ghanaians. Some of the barriers include expensive cost involve in seeking health care, dangerous outcomes (e.g., side effects, iatrogenic outcomes), unpleasant situations (e.g., painful, difficult, upsetting), inconveniences, time-consuming, insufficient health workers, poor diagnoses and so forth.

The other contributing factors such as level of education, cue to action, self-efficacy are all ripped in analyzing health seeking behavior of Ghanaians.

### **1.5 Limitations of the Study**

The limitations of this study include inadequate finance and the time available for the study. More important is the fact that literature in the area of study is scanty because the scheme is still young. There was also difficulty in administering the questionnaire: Low response rate and unwillingness of respondents to offer accurate information were some of the problems that militated against accuracy and speed.

Notwithstanding these limitations to the study, funds were solicited to carry out the work. A work plan was strictly adhered to as a guide to the study. The study also made adequate use of any available literature of importance. Services of research assistants were engaged to help collect and analyze data.

### **1.6 Organization of the Study**

The study comprises five chapters. Chapter one comprises an introduction, giving an overview of the study which serves as the introductory chapter to the entire research. This chapter also discusses the background of the study, the problem investigated, the aims and significance of the study, and the scope and limitations of the study.

Chapter Two covers a review of relevant literature which is intended to serve as a foundation to the rest of the research. It explores literature that is pertinent to this research. This is to ensure

familiarity with the existing body of knowledge and the position of this study, and therefore provides the conceptual framework for this study.

Chapter Three, explains the research methodology and discusses the data collection methods and justification of selected research techniques. The contribution of primary, secondary, qualitative and quantitative methods of data collection is demonstrated here.

Chapter Four presents an evaluation, analysis, and interpretation of collected data. The chapter focuses on the actual analysis of data collected by establishing the extent to which theories reviewed differ from what pertains in practice. Statistical and descriptive analyses are used.

The report ends with chapter five which comprises a summary of major findings, conclusions, and recommendations. This final chapter draws information from the previous chapters to provide conclusions and recommendations which are organized in accordance with the research objectives.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

In this chapter, the researcher reviews existing literature on pertinent issues surrounding the health insurance scheme in Ghana and other countries, especially with regards to accessibility to quality healthcare of subscribers and non-subscribers under the NHIS in the country. The literature is reviewed under the following themes: The National Health Insurance Scheme; Benefits of the NHIS; Challenges encountered by the NHIS; accessibility of healthcare by insured and uninsured; health seeking behaviours of subscribers and non-subscribers to health insurance, among others. Also, other related studies were reviewed. This review forms the basis for discussion of the results of the study.

#### **2.1 The Concept of National Health Insurance (NHI)**

In low-income countries health insurance is increasingly recognized as a promising tool for financing equitable health care. By pooling risks and resources, it promises to ensure better access and provide risk protection to poor households against the cost of illness (Bennett et al. 1998; Dror and Jacquier 1999; Preker et al. 2002; Ekman 2004; Carrin et al. 2005). Other alternatives such as cost-recovery strategies have been criticized on equity grounds of affecting access to health care (Gilson et al. 2000). Many of these alternatives have not worked to the satisfaction of many of these countries and this has led to several debates as to the best option of financing health care delivery to the poor and vulnerable in these countries. This arguments stem from the realization that the health of the citizens of a country is critical if the country is to make strides towards development.

The provision of health care needs of the people is therefore taken seriously by many governments. As a result of this, Ghana for instance, over the years prioritised universal coverage for universal health care (Osei-Akoto, 2003). Osei-Akoto argues that even though success has been achieved in different areas of the health sector, health care delivery remained inadequate especially for poor people and other disadvantage groups. For instance, life expectancy remains low, morbidity of preventable diseases remained high, malaria, diarrhoea and other preventable diseases accounted for about 40% of child mortality, and maternal mortality was still high (240 per 100,000 births). Osei-Akoto identifies many reasons for inadequate health care delivery. He particularly identifies finance as a major factor for the slow pace of improvement in the health sector in general. In particular, the reduction of public spending on health care and the introduction of user fees created problems of inaccessibility and inequity in health care (Asenso-Okyere et al., 1998).

The success of any NHIS, according to Shaw and Ainsworth (1995) is analyzed based on who are the beneficiaries, its efficiency effects, equity of financing, level of administrative costs and political acceptability. Equally, the choice of a health insurance plan and the extent of involvement by households are driven by two sets of determinants. These are the characteristics of the plan itself, and the personal, household and community characteristics of the individual making the choice (Shaw and Ainsworth, 1995). Characteristics of plans identified by Zweifel and Breyer (1997) are the type of medical services offered, the degree of freedom to choose providers and the extent of compensation given. Other characteristics identified include quality

of care given by the chosen provider and perceived credibility of the insurer (Wiesmann & Jütting, 2001).

## **2.2 The Ghana National Health Insurance Scheme**

Ghana's National Health Insurance Scheme (NHIS) was created by the National Health Insurance Act of August 2003, and is one of very few attempts by a sub-Saharan African country to implement a national-level, universal health insurance program.

A newly-created National Health Insurance Authority (NHIA) was commissioned "to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents." The NHIA licenses and regulates district-level mutual health insurance schemes (DMHISs) as well as other schemes allowed under the Act, accredits providers, determines—in consultation with DMHISs—premium levels, and generally oversees and reports on NHIS operations. There are currently 145 district schemes, including ten that operated in the Greater Accra area during the study period.

The NHIS is financed from four main sources: a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums, and miscellaneous other funds from investment returns, Parliament, or donors. The 2.5 per cent tax on goods and services, called the National Health Insurance Levy (NHIL), is by far the largest source, comprising about 70 per cent of revenues. Social security taxes account for an additional 23 per cent, premiums for about 5 per cent, and other funds for the remaining two per cent.

The NHIS (including all DMHISs) has a single benefit package that is set by Legislative Instrument 1809 and described by the NHIA as covering “95% of disease conditions” that afflict Ghanaians. The NHIS covers outpatient services, including diagnostic testing and operations such as hernia repair; most in-patient services, including specialist care, most surgeries, and hospital accommodation (general ward); oral health treatments; all maternity care services, including Caesarean deliveries; emergency care; and, finally, all drugs on the centrally-established NHIA Medicines List.

The NHIS package excludes some very expensive procedures such as certain surgeries, cancer treatments (other than breast and cervical cancer), organ transplants, and dialysis; non-vital services such as cosmetic surgery; and some high profile items such as HIV antiretroviral drugs (which are heavily subsidized by the separate National AIDS Control Program). Other than the excluded services, there are few formal limits placed on NHIS members’ consumption of benefits — there is no cost-sharing beyond premiums (i.e., no co-payments, coinsurance, or deductibles), no annual or lifetime limits and little effective gate-keeping. Benefits were intended to be “portable” from district to district, but actual portability has been mixed and is one reason for the recent introduction of a single, national NHIS identification card to replace district-level cards.

Official statistics on NHIS registration provided by the National Health Insurance Authority show the increase in enrolment since operations began in late 2005. For example, the total number of active members reportedly increased from 2.4 million in 2006 to 11.1 million in 2009, suggesting that close to 50% of the population was covered by the insurance by 2009. More

recently, however, the NHIA changed its methodology for calculating active members and estimated in its 2010 annual report that about 34% of Ghanaians were active enrollees at the end of 2010.

### **2.3 Administration of the Ghana NHIS**

Ghana's NHIS is regulated by the National Health Insurance Council (NHIC), headquartered in Accra. Regional and District offices of the NHIC are being set up to decentralize the operations of the Scheme. The Council manages the National Health Insurance Fund (NHIF) through the collection, investment, disbursement, and administration of the Scheme. The Council also undertakes the licensing, regulation, and accreditation of healthcare providers. By the end of 2007, the NHIS had accredited 800 private healthcare providers in addition to government health facilities (Ghana Ministry of Health, 2008). It is expected that this system of accreditation will eventually raise standards and quality of care throughout the country for both insured and uninsured citizens. At the District level, there are Health Insurance Assemblies which comprise all members of the respective District Schemes in good standing. The District Schemes are governed by Board of Trustees and Scheme Managers. The management teams at the various Districts usually include an Administrator, Accountant, Publicity and Marketing Manager, Claims Managers, Data Control Manager, and Data Entry Clerk (Ghana Ministry of Health, 2004b; Sabi, 2005).

### **2.4 Health Financing in Africa**

There were two major contributory factors to the rapid growth in explicit policies of charging user fees for government health services in African countries. Firstly, various international

organizations vociferously advocated for the introduction of user fees (Akin et al., 1987). The World Bank and International Monetary Fund were in a particularly strong position to influence policy in African countries as user fees and other cost recovery mechanisms were often an integral part of these institutions' loan conditionality and associated Structural Adjustment Programmes (SAPs).

Secondly, macro-economic difficulties in many countries (related to low or negative economic growth and increasing indebtedness) limited the resources available to government for financing and providing health services and led to financing strategies that increasingly placed the burden on service users (Bennett, 1992).

From the perspective of national governments, two objectives were most frequently cited when introducing or increasing user fees. These were revenue generation and improvement in quality of public sector health services, particularly through availability of medicines at facilities (Nolan and Turbat, 1995). It was anticipated that user fees would generate significant revenue to cover the health care financing gap facing government health services in African countries.

Another objective that was set in some countries was to enhance community involvement in the management and 'taking ownership' of local facilities. International organizations which favoured user fees as a cost-recovery mechanism suggested there were a host of other 'benefits' of fees. These included the idea that user fees prevent unnecessary or frivolous health service utilization and send 'price signals' to patients about the cost of services at different levels of care and thereby promote appropriate use and adherence to referral mechanisms (Akin et al., 1987).

They also argued that providers are more likely to be responsive to patients' needs and concerns and to provide good quality care when patients are paying for services.

## **2.5 Healthcare Financing in Ghana**

Access to effective and affordable health services is a rarity in most developing countries. The problem as the GTZ (2005: 4) points out is not only due to the poor health care services often found in rural areas, or the inadequate quality of care across most of these countries, but also to the high cost of obtaining these services.

Invariably, the very poor are the most vulnerable as they are less capable of recovering from the financial consequences of illness and tend to have higher health risk. More so, they usually have poor working and living conditions with limited access to healthy food, clean water, and adequate sanitation (ILO, GTZ, WHO, 2006).

In the immediate post-independence era, Ghana had a healthcare system that provided 'free' medical services in public health institutions to all citizens. However, during the 1970s and the early 1980s, persistent budgetary constraints, deteriorating health infrastructure, falling standards of healthcare, coupled with massive emigration of healthcare practitioners, compelled the government to implement a cost recovery regime, or "*cash-and carry*" system of payment, as part of its IMF- and World Bank-sponsored Structural Adjustment Programs (SPAs), (Mensah et al , 2006).

There are indications that the *cash-and-carry* system has undermined access to, and utilization of, health services in the country. For instance, research shows that under the system, many low-income households in the country regularly postpone medical treatment, resort to self-treatment, or use traditional medicine provided by unregulated healers, spiritualist, and itinerant drug vendors (Oppong, 2001). It is against the background of these problems that, in 2003, the Government of Ghana established a National Health Insurance Scheme (NHIS), with the hope of making healthcare readily available and more affordable to Ghanaians. It is envisaged that the NHIS will eventually replace the *cash-and-carry* system throughout the country.

Despite the financial protection offered by social health insurance schemes against the uncertainties of illness, some Ghanaians are hesitant to enroll in the incipient NHIS. Without empirical data, it is difficult to determine reasons for nonparticipation or whether the NHIS is actually accomplishing its purpose of making health care available and affordable to all. The rest of the literature review looks at the Health Insurance Scheme and its benefits and challenges. This is to help identify the research gap and position of the current study.

### **2.5.1 Premiums and Benefits**

NHIS premiums are generally based on clients' ability to pay. District Health Insurance Committees identify and categorize residents into four main social groups—viz., the *core poor or the indigent*; *the poor and very poor*; *the middle class*; and *the rich and very rich*—and vary their respective contributions accordingly. The *core poor* (or the indigent) together with people who are 70 or more years of age or former Social Security and National Insurance Trust (SSNIT) contributors who already are in retirement are exempted from paying any premiums. While

premiums vary slightly from District to District, generally members pay no less than GH¢7.2 per annum. For members in the formal sector, 2.5% of their contribution to SSNIT is deducted monthly as their health insurance premium.

Workers in the formal sector are automatic members of the NHIS, but they still have to register with their respective District Mutual Health Insurance Schemes. Those in the informal sector, as well as the self-employed, pay between GH¢7.2 and GH¢48.0 yearly, depending on their income. All contributors' premiums cover their children and dependents below age 18. Thus, NHIS registrations of children were linked to those of parents. Some schemes insist that both parents must be registered (except in single-parent households) before a child can be registered, while others only require the mother to be registered.

Following intense public outcry, this coupling of parents' coverage with their children officially ended in September 2008 (Sulzbach, 2008). In 2004, the government introduced a 2.5% sales tax (i.e., Health Insurance Levy) on selected goods and services to fund the NHIS. Other notable sources of funding for the Scheme include money from the government's budget and donor contributions (Sabi, 2005).

### **2.5.2 Health Insurance Claims**

The reimbursement made to healthcare providers is known as claims. Therefore, a health insurance claim is a bill for health care services that health care providers turn in to the insurance company for payment. Claims payment is crucial considering its strategic role in the sustainability of healthcare provision under health insurance. Ankomah (2009) notes that

sustainability of NHI is dependent on a well designed provider payment mechanism. This is because it will allow for attaining reasonable income for providers, guarantee quality healthcare, and eliminate wastage and/or unnecessary service provision.

Claims payment constitutes a form of reimbursement of service providers by Health Insurance Schemes for services rendered to clients of the schemes. The District Mutual Health Insurance Scheme (DMHIS) Operational Manual (2008) indicates that the purpose of this procedure is to vet and pay claims submitted by accredited health service providers under the NHIS for services rendered to members of a DMHIS.

The system adopted for paying claims under the NHIS is critical especially when dealing with social health insurance. This is because it has profound effect on quality of service, cost containment, and administration (Ankomah, 2009). The methods used for claims payment under health insurance include inter alia: fee for service or itemized per case costing, daily (per diem) payment, capitation, and case payment (e.g. Diagnostic Related Grouping). These systems of payment have unrelated correlations with health service delivery.

Ankomah (2009) indicated that the NHIS in Ghana began with the itemized case costing system of claims payment. This system made payments for each service or procedure undertaken. Therefore services such as patient consultation, accommodation, non-drug consumables, x-ray, laboratory investigations, and feeding were each paid a fee. This system brought its own challenges in view of the volume of information requested on each service, and the non-uniformity in the cost structure for the various health facilities. Problems catalogued out of these

developments included prolonged vetting of claims and delay in reimbursement, variability of the cost of treatment for the same illness episodes in related facilities arising from the proliferation of tariffs among schemes, and the disincentive for some providers to enroll unto the system wholly due to unattractive tariffs. This phenomenon discouraged provider participation and thus, increased congestion in the few NHIS accredited facilities (Ankomah, 2009).

Clearly this situation demanded a reform in the provider tariff structure because the delay in reimbursement coupled with the increasing diversity of prices charged for similar treatment or services was an indication of the gradual collapse of the NHIS. Of course one cannot overlook other possible variables such as multiple utilization and poly-pharmacy at the provider sites and attribute the threat of collapse of the NHI to the fee-for-service system alone. Otherwise there is the possibility of recurrence of similar problems including abuse of the system that can affect the sustainability of the NHIS.

Having seen the adverse effects and implications for sustaining NHI using the fee-for-service system, the NHI adopted a new system based on the Ghana Diagnostic Related Groupings (G-DRG) concept. The G-DRGs are standard groups of diseases related clinically and have comparable treatments under similar healthcare resources (ibid.). This allows for service providers to be paid for patient's treatment according to his or her diagnostic group irrespective of the cost. This is known as the inclusive flat payment. Although this payment mechanism reduces the cost burden for schemes of having to bear huge claims submission by providers, it brings to the fore the issue of unattractive rates which discourage provider participation. This is a concern when considering sustainability and access because limited facilities cannot achieve the

object of promoting primary healthcare which is an important object under NHI. Increased waiting time at NHI accredited health facilities not only discourages potential subscribers, it can also compromise delivery of quality healthcare.

Ankomah (2009) argues that the G-DRG payment regime “covers the full cost of estimated direct consumables for direct patient care, anaesthesia and investigations, and about 80% of the estimated overhead cost for the public health facilities”. Thus, it has the potential of bridging the funding gap for public health facilities. But the crux of the matter is that the health facilities privately owned are unfavoured by this development. By this, it stands to reason that there is no universal applicability of incentive packages that would encourage more provider participation. This critically would affect the sustainability of NHI if more providers are unwilling to enroll unto the NHI.

The G-DRG payment regime is regulated by a tariff structure set by multi-disciplinary team or stakeholders within the health sector. They comprise the National Health Insurance Authority (NHIA), Ghana Medical Association, Association of Pharmaceutical Companies and Ghana Registered Midwives. The rest are Society of Private Medical and Dental practitioners, Christian Health Association of Ghana (CHAG), and District Schemes et al.

The tariff structure varies for different levels of healthcare classified by the NHIA. The broad categories include Government facilities, Quasi-government or religious health institutions, and private facilities. The Government facilities are sub-divided into CHIPS compounds, District level clinics and hospitals, Regional hospitals, and Tertiary or Teaching level hospitals. The

private facilities on the other hand comprise district level clinics and hospitals, maternity homes, community pharmacies, and diagnostic centres.

## **2.6 Accessibility and utilization of health services**

Distance decay: In developing countries, distance is only one variable that may interact more or less strongly with others to influence utilization. Most people will not travel further than 5 kilometres to basic preventive and curative care (Muller et al., 1998). In a study of the effect of distance from home on attendance at a small rural health centre in Papua New Guinea, he found that attendance decreased markedly with distance. There was a 50% decrease of the number of patients at a 3.5 kilometre distance.

In evaluating health service equity at a primary care clinic in Chilimarca, Bolivia, Kinman (1999) also discovered that, within the targeted service area, visitors of the clinic were concentrated in a few blocks of the community, with diminishing numbers with increasing distance from the clinic.

In Nigeria, Stock (1987) found that at a distance of 5 kilometres from a dispensary, per capita utilization fell to less than one-third of the 0-km rate. An Indian study showed that the proportion of a community attending a dispensary decreased by 50% for every additional half-mile between the community and the facility (Frederiksen, 1964).

Wilson et al. (1997) also gathered from their study of the maternity home waiting concept at Nsawam in Ghana that distance from the hospital was, among others, one of the reasons for poor utilization. It has also been pointed out that in the Jasikan district in Ghana, distance decay

played a major role in health service utilization (Institute of Development Studies, 1978). About 3/4 of all registered patients come from within 4 miles and that most people (over 90%) living within 4 miles do, in fact, register at a health unit. However, registration drops off quite sharply for those living further away, and only about 1/10 of the population living more than 6 miles from a health facility appear to be registered at all in Jasikan.

Some factors interfere with distance-decay. These include socio-economic status (Bailey and Phillips, 1990), quality of care provided, and the nature of the illness. In rural Nigeria for instance, people are willing to travel farther for more specialized services, or better quality care (Stock, 1983).

The quality of care provided and the type of services offered, like specialist services can alter distance decay (Smith, 1977). Distance decay may also be altered by the urgency of the service. In a study on male bias in health care utilization for under-fives in a rural community in Western India, Ganatra and Hirve, (1994) found that parents were willing to travel greater distance to seek medical treatment for their sons, but would not for their daughters. This has a cultural cause.

**Time accessibility:** The influence of time on utilization can be examined in three perspectives, namely travel time, waiting time at the hospital, and waiting time with respect to appointments. In developing countries, travel time and waiting time at the facility are more important in examining utilization. Waiting time for appointments is not a regular feature of the health system in developing countries.

**Financial accessibility:** In a study of user satisfaction with health services in government health facilities in the Eastern Region of Ghana, code-named "What does the public want from us?", Delanyo, et al. (1990) identified high cost of services, among others, as a major cause of user dissatisfaction. In the Republic of Congo, the introduction of user charges led to a steep drop in the utilization of health services (Turshen, 1999). In Ghana, the introduction of the Hospital Fee Regulation of 1985, under the Structural Adjustment Programme (SAP), has led to a decline in hospital use in the country as a whole (Kwabia, 1996).

**Social accessibility:** Social accessibility refers to situations in which patients in a community consulted the doctor or General Practitioner with whom they feel comfortable. In a survey on spatial patterns of attendance at general practitioner services in New Zealand Hays et al. (1990) found that the Maori were less spatially bounded than other members of the sample and patients attended doctors who had been recommended by family and relations.

Apart from accessibility variables, socio-economic and demographic, and political factors influence the use of health services. These factors are income, education, health insurance, demography, government policy, and ethnicity, place of residence, quality management and affective behaviour.

**Income:** Habib and Vaughan (1986) in a household survey in rural Iraq, found that the use of higher level government health services and private clinics did increase substantially with increasing income.

In Accessibility and utilization of health services in Indonesia, Chernichovsky and Meesook (1986) in a household survey found low income to be a strong barrier to the utilization of modern primary medical facilities, even when publicly provided. Pickett and Hanlon (1990); and Ensor and Pham-Bich-San (1996) conclude in separate studies on access to health services that, in the developing countries, the poor have less realized access to health services.

Employment is also an important determinant, since it is a determinant of income, hence an enabling factor. The status one has acquired in his workplace is also a factor of income status. There is very little literature on the relationship between employment status, type of employment, and professional status, and utilization in developing countries. Such areas need research.

**Education:** One important predictor of utilization of health services is education. Education and demand for health care are in general positively related (Grossman 1972; 1975). The educated are more cautious and conscious of their health, and tend to use health services more. Illiterate persons with high income are likely to use health facilities less than the educated in the same income category. Of greater impact in determining the use of health facilities is the education of mothers (Caldwell, 1983; Caldwell, 1986; Caldwell, 1989; Swenson, et al.1993; Mensch, et al. 1985; Raghupathy, 1996; Wong, et al. 1987).

Educated women tend to use health facilities more than the uneducated and the level of education of a woman and the number of living children also determine her use of pre-natal and antenatal services. The educational levels of mothers are generally strongly related to levels of

infant mortality, effective feeding, and good use of health services. In studies in the Philippines, Wong, et al., (1987) discovered that improved education of women is associated with increased use of modern pre-natal care. An ILO study carried out in Bolivia, Egypt and Kenya showed that access of women to maternal and child health services were strongly influenced by their level of education and rural-urban status (ILO, 2000).

The education of mothers in Ghana is a determinant of child immunization. Whereas 42.2 per cent of mothers without formal education immunized their children against BCG, DPT, polio, and measles between 1989 and 1993, 86.7 per cent of mothers with secondary education and above did (GSS, 1994:101).

In Ghana, there is also a direct relationship between the level of mother's education and tetanus toxoid vaccinations (GSS, 1999, p.95), a factor that influences maternal and child health. The education of mothers and its influence on their use of health services have positive effects on their children's health outcomes through better nutrition and effective use of health services (Hobcraft, 1993). In a study of the differential effect of mother's education on mortality of boys and girls in India, Bourne and Walker (1991) found that improved mother's education reduced mortality at all ages below five years for both sexes.

**Health insurance:** Health insurance, which is very important in utilization, is least developed in most developing countries. Utilization is higher for insured patients in developing countries where health insurance exists. In a study of the Bwamanda hospital insurance scheme in Zaire (Democratic Republic of the Congo), Criel, et. al (1999) found that utilization increased among

insured patients. Supakankunti (2000), in a study of the future prospects of voluntary health insurance in Thailand, concluded that greater use of health services was the result of the introduction of the Health Card program. There was an improvement in accessibility to health care and a high level of satisfaction among Cardholders. Chen, et al., (2001) also conclude in a study of the impact of national health insurance on the utilization of health care services by pregnant women in Taiwan that the utilization of prenatal and intrapartum care services, especially for the more expensive services, substantially increased in Taiwan since the implementation of the national health insurance plan.

**Demographic factors:** The demographic factors of age and sex show some correlation with the use of health services. In rural India, rural Nigeria, and rural Ethiopia, Kroeger (1983) discovered that children are important clients of Traditional Medical Practitioners (TMPs), whilst Good (1987) found that in India, women consulted TMPs most. They accounted for 55 to 60 per cent of consultations. The two situations could stem from poverty, ignorance, and cultural practices. Ethno medicine is intrinsically embedded in the rural economies of developing countries where poor access to and less knowledge of scientific medicine exist.

Taylor et al. (1983) found in an empirical study that, in rural India, there were no significant differences within the 15-49 year married women age group in the use of women's health services. The study does not show how socio-economic variables and place of residence would affect utilization. In a developed economy, social security services make it easier for the aged to have easier financial access to health services. This is unlike developing countries such as the

study area where there is a weak social security system; making most of the aged rely on the humanitarian goodwill of family members, and sometimes friends.

In an empirical research on accessibility and utilization of health services in a rural district in Ghana, Abugri (1995) found that the youth made use of health services more than the aged. The ages below 20 had more visits to the clinic than those above that age. The elderly above 50 used the clinic very seldomly. The explanation is that the elderly are generally dependent on the middle age group for support; hence, their decisions to visit clinics were constrained by either lack of financial or physical support.

Generally women use health facilities more than men, which relates to higher morbidity and a lower threshold to consult a physician (Kohn and White 1976; Verbrugge 1979). Gender disparities also impact negatively on the use of health services. Ojanuga and Gilbert (1992) in a work on women's access to health care in developing countries established the premise that myriad socio-cultural factors negatively impinge upon the physical well-being and accessibility of appropriate health care facilities of women. In developing nations, women's roles affect their use of health services, since men who monopolize family decisions are strong determinants of health care utilization (Santow, 1995).

**Political factors:** Political, economic and social structures internationally and nationally determine who is going to get what, where and how (Smith, 1979). This finds expression in the impact of the Structural Adjustment Programme (SAP), which is having serious repercussions on the socio-economic life of a section of the population of countries adopting them. Some of the

features of the SAP are the devaluation of the local currencies, removal of subsidies from social services, trade liberalization, and labor retrenchment. The cost of health services is therefore unbearable for the masses.

The SAP has not been able to eliminate poverty, which seriously affects utilization. Moderated levels of poverty are not consistent with SAP basic prescriptions. The growing poverty has led to a remarkable decline in hospital use. In two empirical studies, Kambarin (1996) and Abugri (1995:34) confirm the negative impact the SAP has had on health services utilization in mainly rural Ghana.

According to Kambarin the introduction of the SAP has seriously affected the utilization of health facilities of the rural people. It has also led to the reduction of medical staff, with its negative effects on the quality of services. Abugri also discovered that, in the Volta Region of Ghana, there were significant cuts in outpatient attendance, with the introduction of hospital fees (user charges), which was a by-product of the SAP.

**Ethnicity:** The issue of ethnicity in accessibility and utilization is very important. Certain ethnic groups show a bias to the utilization of certain types of healers or medical providers. In the developing nations, Ramesh and Hyma (1981) have found that preferences for health facilities may be based on a common language or religion that leads to the utilization of certain types of healers or medical providers. In developing countries, the traditional sector has health beliefs in which disorders are seen not to require the intervention of scientific medicine (Joseph and Phillips, 1984). The modern sector thus tends to patronize health services the more.

**Quality of care:** Finally, the application of Total Quality Management (TQM) has been found to enhance accessibility (Dhungel and Dias, 1988). The supplier-inducement model has been used to explain utilization. The objective of patients is to get better, so they seek quality service that can help them achieve this goal. This is, however, limited by enabling and predisposing factors of education, finance, attitudes and physical access.

## **2.7 Implementation Outputs under the Ghana NHIS**

According to the CEO of NHIA, by the end of 2009, a total number of 13,840,198 Ghanaians were registered. This represented 67% of the population according to the 2004 population estimates. Out of this number, 309,110 were indignant while 721,163 were women under free maternal care. A total of 12,146,526 identity cards have been issued, representing 87% of registered members (Health Summit Report: GIMPA, 2009).

In practice, government is to reimburse health service providers for services rendered to insured clients under the NHIS through the premiums contributed by clients, taxes collected (NHIS levy), returns from investment, and parliamentary approvals from the consolidated fund (National Health Insurance Act, 2003 [Act 650]). According to the Chief Executive Officer of the NHIA, 4,000 service providers have accredited so far (Daily Graphic, 2009). The AMHIS had a total of 54 accredited service providers in 2009.

## **2.8 Challenges Associated with Health Insurance Schemes**

A number of literatures have revealed that health insurance schemes everywhere in the world are confronted with several challenges. These challenges in the long run go on to determine the

viability as well as sustainability of health insurance schemes. One of the challenges is moral hazard. Moral hazard is the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have been insured (Weber, 2005).

Weber further classifies moral hazard into two. These are supply side (for instance, when the doctor provides unnecessary care because the patient is insured) moral hazard and demand side hazard (for instance, when the patient demand unnecessary care because he is insured). This classification is also used in a similar study by a government of India's study dubbed 'Framework for Health Insurance' (2005). Such unnecessary use results in over consumption and imperils the financial viability of the insurance system (Atim, 1998). Moral hazard behaviour of insured persons presents a permanent threat to the financial sustainability of schemes. Insurance lowers the price of care at the point of use and barriers to access reduce. This results in increased in the utilization of health facilities which can result in jeopardizing the finances of health insurance schemes (Jutting, 2000).

It is important to emphasize that moral hazard is different from fraudulent use. According to Atim (1998), moral hazard relates mainly to the fact that, for those insured, the price of using the service is often much lower than the actual price of the service especially in the absence of co-payments and deductibles. Furthermore, payment mechanisms like fee-for-service reimbursement give room for the provision of unnecessary and expensive treatment to insured patients implying that moral hazards could also emanate from the provider side. Fraudulent use on the other hand is much more deliberate and intentional.

Literature on NHIS is silent on the processes of claims payments and the challenges these processes pose on the entire scheme. However, Jayapradha (2008) asserts that, claims managements system is an inevitable part of any insurance institution.

Delay in reimbursement of claims has been attributed to the inadequacy of staffing or human resource and the high volumes of claims schemes receive within a period. Approximately 30,000 claims are received each month for processing (AMHIS Report, 2009). The report also suggests that there is little effort towards the processing of claims and reimbursement. The NHIA is also blamed for the untimely release of funds to pay claims. There have since not been any policy formulated by the NHIA to guard against fraud, over billing and the like which delay the processing of claims.

The National Health Insurance Authority has arrears amounting roughly to Gh  $\phi$ 120 million as of June 2009, mainly in the form of unpaid claims by management (Public Agenda, October 23, 2009). What further compounds this problem is the shortfalls in the flow of funds into the NHIS reserves. This is attributable to the fact that half of the user population is exempted from contributing (ibid). Clearly, this shows that the amount of money in the pool is not sufficient. The Ghana Medical Association (GMA) also indicated that, the National Health Insurance Scheme is collapsing due to outstanding insurance claims owed to service providers (Brocke, 2010).

Notwithstanding the inherent challenges that confront management, it is clear that service providers are a factor in the delay of processing claims. The AMHIS Annual Report, 2009, came

out with several problems caused by providers that further delayed the processing of claims. With the new computerized system of processing claims not all service providers complete filling of mandatory fields of claims forms. Not all diagnosis is written hence the inability of some service providers to justify the dispensation of certain medicines. In a relation to the just mentioned is the fact that some facilities were culprits of wrong billing of unit prices of some medicines. Other claim forms also showed some discrepancies of quantities of medicines as compared to prescriptions. The claims department is also troubled with claims forms showing multiple filling of some patient for the same day by the same facility. Service providers do not also adhere to standard treatment protocol. Service providers have also delayed with the submissions of claims (Ordoi-Larbi, 2009).

## **2.9 Health Seeking Behaviour of the Insured and Non-Insured**

MacKian (2003) discussing people's health seeking behaviours indicated that researchers have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to their health. Health seeking behaviours can simplistically be divided into two types. Firstly there are studies which emphasise the 'end point' (utilisation of the formal system, or health care seeking behaviour); secondly, there are those which emphasise the 'process' (illness response, or health seeking behaviour).

Citing the work of Tipping and Segall (1995), MacKian (2003) posits that studies demonstrate that the decision to choose a particular medical channel is influenced by a variety of socio-economic variables, namely; sex, age, the social status of women, the type of illness, access to services and perceived quality of the service. In mapping out the factors behind such patterns,

MacKian asserted certain broad trends. According to MacKian (2003), firstly there are studies which categorise the types of *barriers* or *determinants* which lie between patients and services. These barriers generally fall under the divisions of geographical, social, economic, cultural and organisational factors. Secondly, there is the view that in some cases, the desired health care seeking behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained doctor, in a formally recognised health care setting. However, other studies also consistently made findings suggesting that, for some illnesses, people will chose traditional healers, village homeopaths, or untrained doctors above formally trained practitioners or government health facilities (Ahmed et al, 2001).

According to MacKian (2003), the second trench of work, rooted especially in psychology, looks at health seeking behaviours in more a general perspective paying attention to the various factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviours or their use of medical care and treatment. These factors are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality. The underlying assumption is that behaviour is best understood in terms of an individual's perception of their social environment.

In their recent survey on assessing the effect of the NHIS on access to and utilization of healthcare services in the Akatsi District of the Volta region of Ghana, Cobah and Liang (2011) found out that higher proportion of the insured (70.8%) than the non-insured (6.0%) sought formal care during ill-health. Some of the services received the insured normally ranged from consultation and treatment (54.7%), medicines/drugs (18.6%), laboratory services (9.8%),

delivery (8.8%) and hospitalization (8.1%). Again, it was realized that Government health facilities were the first point of call for most respondents especially the Government Hospital at the District capital for both the urban and rural dwellers. This was followed by private health facilities all located at the District capital (22.0%). The proportion insured that used health centres located close to the communities accounts for 6.6%. None reported using the CHPS compounds. Various reasons were adduced for the choice these facilities. Prominent among them were competence and friendly staffs (30.1%), reputation of provider (19.5%), availability of medicines (17.2%), prompt attention (16.3%). About 17% of the responses were related to cost and proximity to a health facility respectively.

Another interesting revelation was that higher proportions (63%) of the female insured respondents who gave birth during the last 12 month preceding the survey as compare with the non-insured (4.7%) gave birth in a health facility and were assisted by a trained health personnel (75.0%). Use of postnatal care services is also higher among the insured (67.2%) than the non-insured (7.8%) (Cobah and Liang, 2011).

Interrogating the health seeking behavior of the un-insured, it was understood that lack of insurance (42.3%) is the single most important reason for not seeking formal care among the non-insured. A higher proportion of the non-insured who did not seek care (48.1%) either delays or postpones treatment. The result revealed that health insurance is a key determinant in seeking healthcare and using modern health facilities. Care-seeking, choice of health facility, place of last birth, professional attendance at delivery and use of postnatal care services are all statistically significant (Cobah and Liang, *ibid*).

Majority of the insured (67%) indicated receiving good quality of service with 33.0% stating otherwise. Unavailability of essential drugs (39.0%) and long waiting time (31.4%) respectively were the major reasons stated for the low quality of service received. From the perspective of the non-insured, quality of healthcare delivery in the district is rated as low. Waiting time, cost of treatment, quality of drugs, availability of drugs at the facility were rated as 'worse than before' while privacy during examination and treatment and availability of laboratory services at the facility were rated as 'same as before' (Cobah and Liang, *ibid*).

This study seeks to compare the behaviours and experiences of the NHIS subscribers and non-subscribers in accessing health care in the Ga East Municipality taking into consideration, particularly, the various factors that influence health seeking behaviours of people in the municipality and the views of MacKian (2003), and Cobah and Liang (2011).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This chapter covers the methods used for the study and explains in detail the various techniques, procedures and processes used to gather information from the sampled population. The information so gathered was all in the view to highlight some important aspects of the NHIS especially on the issue of the experiences of both subscribers and non-subscribers of the national health insurance scheme in accessing health care services in the Ga East Municipality. The chapter also entails the types of data collected on the subjects from the many and varied service providers plus subscribers of the scheme that were contacted. It further explains the kind of sampling procedures employed and offers information on how the collected data were analyzed.

According to Daly (2003), methodology may be looked at as a set of rules and procedures that may guide the conduct of research and also provide the tool for evaluating and understanding its findings and claims. For other scholars, such as Silverman (2005), methodology explains the choices researchers make about cases they wish to study, how data is collated, the types of data analysis, among others in planning and executing a research in order to achieve the set goals.

#### **3.1 Research Design**

This study adopted mixed method approach using a combination of qualitative and quantitative methods of research to collate and analyse its data. According to Creswell and Clark (2010), mixed methods in research may be viewed as research design that has both philosophical assumptions as well as methods of inquiry undergirding its operations. As a methodology, it

involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. Similarly, as a method, it focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies. In this view, the mixed method's central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone (Creswell and Clark, 2010).

In order to better understand the behaviours and experiences of both subscribers and non-subscribers of the NHIS in accessing health care services in the Ga East Municipality, this study adopted the mixed methods approach. This is to enable the study have a more comprehensive approach to answering its research questions and also to use the different approaches to supplement, and offset the weaknesses of each other.

### **3.2.0 Study Area**

#### **3.2.1 Location and Population**

The Ga East Municipal Assembly is located at the northern part of Greater Accra Region. It is one of the ten (10) districts in the Greater Accra Region and covers a Land Area of 166 sq km. It is boarded on the west by the Ga West Municipal Assembly (GWMA), on the east by the Adenta Municipal Assembly (AdMA), the south by the Accra Metropolitan Assembly (AMA) and on the north by the Akwapim South District Assembly. The Municipality has a total population of 259,668 people of which there are 127,258 males and 132,410 females (GSS, 2010 National Population and Housing Census). The major towns in the district include: Abokobi (the capital),

Dome, Madina, Taifa, and the villages in the district include: Ashongman, Ayi Mensa, Bansa, Haatso, Kwabenya, Oyarifa and Pantang.

### **2.2.2 Economic activities**

The Ga East Municipal Assembly has a great deal of opportunities for both private investment and for public-private partnership ventures. This is due to the enabling factors for development coupled with the infrastructure set-up and the municipality's proximity to the nation's capital, Accra. There are four main economic activities in the municipality which are industry, service, commerce and agriculture.

Farming is the major economic activity for about 55% of the economically active population. About 70% of the rural population depends on agriculture as their main source of livelihood with about 95% of them being small farm holders. The major agricultural activities are: Crop production and Livestock production. Petty trading, stone cracking and artisanary are some of the non-agricultural activities carried out in the rural areas of the municipality. Stone cracking is undertaken in areas such as Sesemi, Boi, Kwabenya and Otinibi. (Ga East Municipal Composite Budget for the 2012 fiscal Year).

### **3.2.3 Health Sector**

The municipal is divided into 4 sub municipalities for the organization of primary health care services namely: Madina, Danfa, Taifa and Dome. A sub-municipal health management team is responsible for the delivery of health services to defined areas and population and has at least a health centre with either one or two community clinics. Curative and preventive health services

are provided in these facilities and at outreach centres. There are trained TBAs and other care providers such as chemical shop dealers, maternity homes, traditional healers etc in the municipality. The doctor population and nurse population ratios are given as follows:

Population to Doctor Ratio is 49,020:1. Population to Nurse Ratio is 2,254:1.

There are thirty-nine (39) health facilities in the municipality. Out of the 39 facilities, 2 are government polyclinics, 2 health centres and a Community Based Health Planning Compound (CHPS). The polyclinics are Madina Polyclinic at Kekele and another Polyclinic near the Rawlings circle, Madina. The health centers are at Abokobi and Danfa whilst the CHPS compound is located at Taifa. There is no public municipal hospital to care for cases referred from the polyclinics and health centre.

It is worth noting that the polyclinics which were health centres were elevated to the present status in 2008 without any infrastructural expansion. These structures can no longer cope with the ever increasing population who access services from them. There is a specialized hospital at Pantang which has become a general hospital for only OPD cases. The communities are yet to recognize it as such. There is also a quasi government facility at Atomic which serves the workers of Atomic Energy Commission and the community at Kwabenya and its environs. Alpha Medical Centre is a mission facility at Madina. It is a 40 bed hospital. Currently, it serves the as the municipal hospital. The remaining 32 facilities are of small capacity. Most of them are in Madina and Danfa sub municipalities.

Dome and Taifa sub municipalities do not have any government facilities and are also challenges with insignificant number of private facilities. The community members therefore access services from neighboring municipalities. The OPD per capita for the municipality which talks about the facility utilization has increased from 0.43 in 2006 to 0.61 in 2009. The disease burden is not different from the rest of the country. However, Ga East is endemic in Lymphatic Filariasis (Elephantiasis). Mass distribution campaign against this dreadful disease is organized every year. Other top diseases include; malaria, diarrhea, hypertension and diabetes mellitus.

### **3.3 Sources of Data**

Data for this study were drawn from both primary and secondary sources. Secondary data was sourced from some existing books, magazines, journals, other published and unpublished papers, working papers and internet sources.

Primary data were also collected through the administration of questionnaires and in-depth interviews which were conducted with relevant stakeholders whose work directly or indirectly impact on the work of NHIS and its operations. Respondents in this area included subscribers and non-subscribers to NHIS; health workers, officers from the Ministry of Health, officers from the District Health Directorate and other relevant bodies in the Ga East Municipality. This was intended to get the public's perspective on the system of healthcare.

### **3.4 Method of Data Collection**

Primary data for this study were collected by administering questionnaire and an in-depth interview guide. The questionnaires were administered with the help of two well trained field assistants who assisted the researcher to collect data relevant to the topic and meet the objectives of the research. The field assistants also helped in conducting in-depth interviews with some stakeholders of the health industry in Ghana who provided very detailed information relevant to the study.

The questionnaire and the interview guide were structured with the following objectives:

- a) To investigate the role of the national health insurance scheme on healthcare accessibility in Ghana.
- b) To conduct comparative study of the accessibility of health care by NHIS subscribers and non-subscribers.
- c) Identify the barriers to accessing and utilizing health care services by both insured and non-insured clients in the municipality
- d) To examine possible disparities in health care accessibility and make suggestions for improvement.

With a number of provisional questions generated, the questionnaire and the interview guides were segmented into six sections comprising:

- The demography of the respondents,
- Respondents' awareness of the NHIS and its operations;
- The role of the NHIS on healthcare accessibility in Ghana,
- An analyses of the accessibility of health care by NHIS subscribers and non-subscribers;

- The major barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality; and
- Exploring possible disparities in health care accessibility.

The questionnaires were then piloted to ensure the suitability of the questions to the research population and to ensure that it captured all relevant questions needed for answering the research questions. Also, three pilot interviews were also carried out to ensure the questions asked during the interview were appropriate for covering all stated objectives.

Secondary data were mainly collected from some existing books, magazines, journals, other published and unpublished papers; working papers and internet sources. These materials were sourced from various libraries including the Balme Library, the Centre for Social Policy Studies Library, the Ministry of Health, the offices of the NHIS and some hospitals and health centres. The approach of desk-based research was to help review existing literature on the subject across the globe and zeroing in on what has been documented on Ghana' NHIS. The desk study also helped in analyzing existing theories, concepts and assumptions underpinning the universal understanding of health insurance, its access and health seeking behaviours.

The core of the research rests on the experiences of subscribers and non-subscribers of NHIS in accessing health care services in the Ga East Municipality. These categories of respondents are the integral part of the study. First, subscribers of NHIS were selected as a way of allowing the researcher the opportunity to identify whether being insured with the scheme (NHIS) allows one

the opportunity to access quality health care services or it makes it very difficult to access quality health care services from facilities. This serves as the basis for the comparison.

The selection of non-subscribers of the NHIS is prudent in that, they represent the uncontrolled group of respondents who have the choice of accessing any kind of services from any health facility (whether the facility is a National Health Insurance accredited service provider or not). Thus, their experiences with these facilities will help us to make an informed decision and conclusion on the situation.

### **3.5 Sample size**

In selecting the sample for the study, a number of factors were considered. According to Tsumasi (2001), the size of sample is contingent on the homogeneity or heterogeneity of the population. Kumekpor (2002) also indicated that, a sample size for a particular investigation is normally fixed, but when there are units which occur more than once, it is necessary to select more units than the actual size of the sample to enable elimination of repetitions in order to obtain effective sample size. The effective sample is the actual sample size used for the investigation and it is void of repeated units.

This study used the average daily attendance of health seekers at the five selected health facilities to determine the study population and sample population. It was ascertained that the average daily attendance to the various facilities were as follows: Abokobi Health Centre (350 patients), Alpha Medical Centre (250 patients), Danfa Health Centre (300 patients), Madina Health Centre

(350 patients) and the Ghana Atomic Energy Commission health centre (200 patients). Thus, the cumulative average daily attendance to these facilities was 1, 450 patients.

Out of the study population of 1,450 patients per day, a total number of two hundred (200) respondents were sampled for the study. The choice of this sample size was purely due to financial and time constraints faced by the researcher. Another factor informing the choice was the homogeneity in the characteristics of the health seekers at all the five health facilities. Forty (40) patients were engaged from each of the health facilities comprising twenty (20) insured and (20) non-insured NHIS health seekers to these facilities. In addition, eight (8) other officials were also purposive selected for in-depth interviews for a more detailed and expert views on the NHIS's operations.

### **3.6 Sampling procedure**

The study employed both purposive and simple random sampling techniques to identify the facilities and the respondents. First, the researcher adopted a purposive sampling technique to identify the health facilities in which the respondents were interviewed. Thus, the facilities so selected were Abokobi Health Centre, Alpha Medical Centre, Danfa Health Centre, Madina Health Centre and Ghana Atomic Energy Commission. These health facilities were purposively selected due to their proximity to the researcher. In addition to the advantage of proximity, the researcher was also financially constrained from adding any other facility. Again, time constraints limited the study to the choice of these five facilities out of a total of 39 facilities.

However, at the facility level, a random sampling technique was adopted. In order to make a meaningful comparison between the behaviours of the NHIS insured and the non-insured health seekers, twenty insured and twenty non-insured health seekers were sampled from each of the five selected health facilities. At the Abokobi Health Centre and Madina Health Centre where daily average attendance was 350 patients each, every fourth NHIS insured and every fourth non-insured health seekers were sampled to fill a questionnaire each until the sample was achieved. Similarly, at rest of the health facilities: Alpha Medical Centre, Danfa Health Centre, and the Ghana Atomic Energy Commission health centre, every third NHIS insured and every third non-insured patients were sampled to fill in a questionnaire each.

In addition to the 200 respondents sampled for quantitative data collection, eight other respondents were sampled for in-depth interviews for qualitative data collection. These respondents were two (2) members of the management staff of the NHIS, one (1) official each from the five selected health facilities and a pharmacist from a private dispensary. The choice of adding the qualitative dimension to the quantitative data was to get a more detailed and expert views on the operations of the NHIS and the behaviours of the NHIS subscribers and non-subscribers in the Ga East Municipality.

The study adopted an exit polling system to sample respondents from among out-patients. However, a number of in-patients who were able to answer questionnaires or their caretakers were also allowed to fill questionnaires. The researcher and his two well trained field assistants met respondents at the entrance of the health facilities when they were exiting after they had

undergone diagnoses or received treatment at the health facilities. With permission from health facilities' authorities, the teams entered some wards to engage in-patients.

### **3.7 Community Entry**

First of all, the researcher took an introductory letter from the Centre for Social Policy Studies (CSPS), University of Ghana, Legon which was presented to the respondents on demand. The researcher then went to the managements of the five selected health facilities to explain his mission and also to obtain permission to carry out the research in their premises. Having obtained their consent, the researcher proceeded to conduct the interviews and administer the questionnaires. Letters were also sent to the District Health Directorate, the offices of the NHIS and some private dispensaries that accept NHIS prescriptions to seek their permission to engage health seekers around their facilities.

### **3.8 Ethical Considerations**

Adhering to the highest ethics in research conduct, the researcher was regulated by the necessary international ethical considerations associated with the conduct of research and data collection in communities, especially at health facilities. Respondents were well educated on the purpose of the study and were never coerced to respond to any question and were free to end the interview when they so wished. The researcher and his team, first of all, thoroughly explained to the respondents what the study was about, assured them of absolute confidentiality and sought for their consent. Respondents' consent was granted by signing or thumb-printing a consent form attached to the questionnaires. For the sake of sanity and morality, interviews with women and

girls were held in the open in the full glare of all people; however, confidentiality was not compromised at any moment.

### **3.9 Data Management and Quality Assurance**

Before engaging in the actual data collection, a pre-testing of the instruments was carried out. This was done in order to ensure the suitability of the questions to the respondents. Necessary corrections: additions and subtractions were duly carried out as the instruments were appropriately reworked.

In order to avoid the common errors associated with data collection, the researcher carefully trained his field assistants on how to administer the questionnaires and to conduct the in-depth interviews. The team made every effort to explain the questions in both the English language and the respondents' own native language when necessary. Also, the in-depth interviews were carefully carried out to make sure all questions were appropriately asked, well answered and that all necessary follow up promptings were duly made.

The administered questionnaires were systematically coded and serialized for easy data entering. The Data collected with the questionnaire were entered into the Statistical Package for Social Sciences (SPSS). Before the actual data analyses were done, a test run of the data for analysis was done for the necessary clean-ups to be carried out. Similarly, data from the interviews were transcribed, labelled and carefully edited for analysis.

### **3.10 Data Analysis**

Data for this study was analyzed using both quantitative and qualitative data analyses methods. For example, the data collected with the questionnaires were analyzed by using the SPSS. In these analyses, descriptive and inferential analyses were made leading to generation of statistical tables. Certain variables were also cross-tabulated and frequencies were calculated for easier understanding of behaviour of the respondents. Again, under the quantitative data analyses, some graphs, charts and other innovative graphical data display and interpretations were presented.

On the other hand, qualitative data analysis which has to do with a classification system, taken from patterns, themes, or other kinds of groups of data was carried out on the data collected from the in-depth interviews. The data generated from the in-depth interviews were transcribed and analyzed based on certain emerging themes resulting from the data. In general, colour coding and axial coding were employed to enable the researcher easily identify and synthesize similar themes for easy analyses. Having done several readings thoroughly through the texts, the qualitative analyses were done based mainly on the main identified emerging themes.

## CHAPTER FOUR

### DATA ANALYSIS AND PRESENTATION OF FINDINGS

#### 4.1 Introduction

This chapter presents analyses of both the quantitative and the qualitative data and puts forward the findings of the study. The study made use of both the qualitative and quantitative methods in analysing its data. Data used for the study were sourced from both primary and secondary sources. In general, primary qualitative data for the study were collected through in-depth interviews with various stakeholders connected to the operations of the National Health Insurance Scheme (NHIS). On the other hand, quantitative data were collected through the administration of questionnaires to both male and female adult health seekers at five health facilities, namely; Abokobi Health Centre, Alpha Medical Centre, Danfa Health Centre, Madina Health Centre and Ghana Atomic Energy Commission Health Centre. Also, secondary data comprising some scholarly books, magazines, journals, published and unpublished papers as well as working papers were sourced from some renowned libraries such as the Balm Library and the Centre for Social Policy (CSPS) Library all at the University of Ghana among others.

In order to comprehensively answer the questions raised in this study, a number of variables were set forth and interrogated. Major among them were issues regarding the demographical profile, respondents' awareness of the NHIS and its operations; the role the NHIS on healthcare accessibility in Ghana, an analyses of the accessibility of health care by NHIS subscribers and non-subscribers; the major barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality; and exploring possible disparities in health care accessibility.

## 4.2 Data Analyses and Presentation of Findings

### 4.2.1 Demographic Background of the Respondents

In all, 200 respondents were engaged for quantitative data for this study. In terms of gender distribution, 48.0% of the respondents were males with the rest 52.0% were females. Table 1 below shows the details of a further distribution of the gender for the two streams of the respondents- NHIS subscribers and non-subscribers.

**Table 1: Gender Distribution of Respondents**

Status of Respondents	Gender	Frequency	Percent
NHIS Subscribers	Males	45	22.5
	Females	55	27.5
NHIS Non-Subscribers	Males	51	25.5
	Females	49	24.5
<b>Total</b>		<b>200</b>	<b>100</b>

*Source: Field survey, 2012*

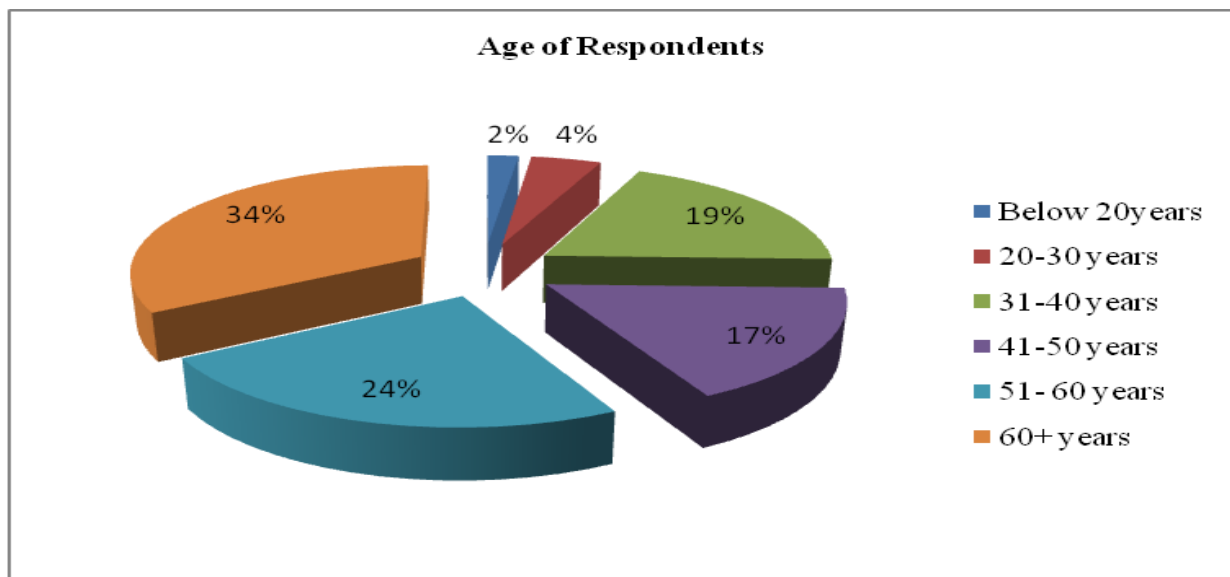
Similarly, the eight (8) other respondents who were interviewed were four males and four females.

The nature of gender distribution of the respondents in the quantitative data category severally confirms the views of many authors regarding gender and health seeking behaviours of people. It is the view of some researchers that in general terms, women use health facilities more than men (Kohn and White 1976; Verbrugge 1979). However, Ojanuga and Gilbert (1992) in a work on women's access to health care in developing countries established the premise that myriad of socio-cultural factors negatively impinge upon the physical well-being and accessibility of appropriate health care facilities of women. For example, in developing nations, women's roles affect their use of health services, since men who monopolize family decisions are strong determinants of health care utilization (Santow, 1995). In general, this study seems to agree

more with the position of Kohn and White (1976) and Verbrugge (1979) than that of Ojanuga and Gilbert (1992) since no such variables were tested in this study.

The age of the respondents were generally between 18 years and 74 years. While 25.0% of the respondents (health seekers) were below 40 years, the majority (75.0%) of the health seekers were 41 years and above. Interestingly, 58.0% of the respondents were 51 years and above. This may be an indication that majority of health seekers are older people. This may be as a result of the fact that old age is usually associated with illnesses. Figure 1 below throws more light on the age distribution of the respondents.

**Figure 1: Age of the Respondents**



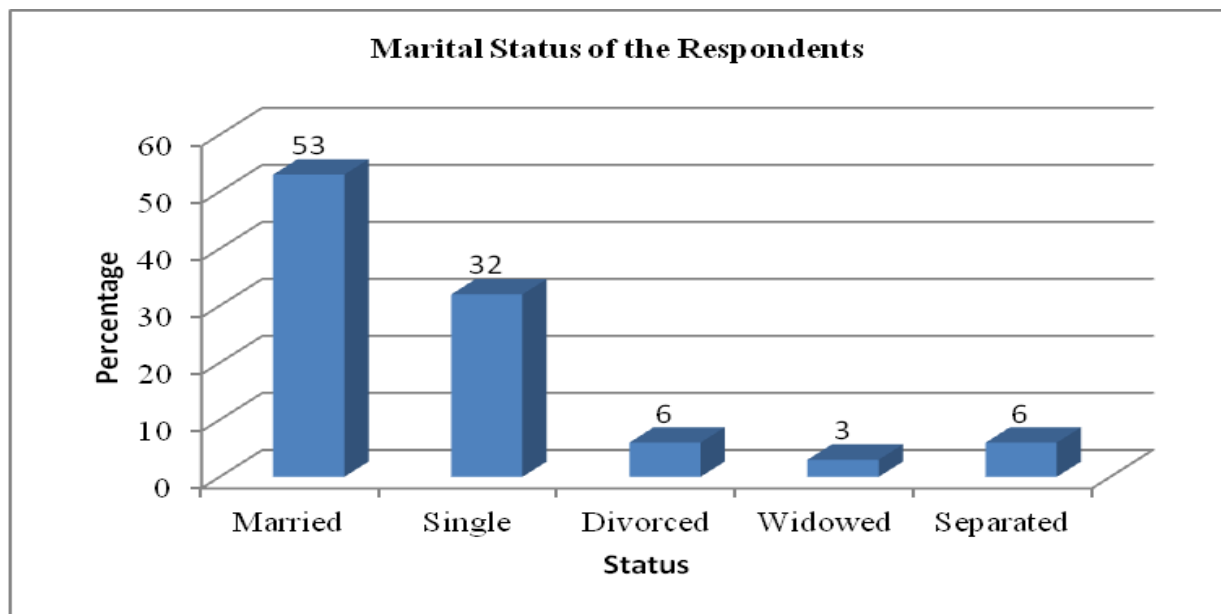
*Source: Field survey, 2012*

The findings of this study on age of health seekers and health seeking behaviours seem to contradict the findings of Abugri (1995) who found out that more younger people seek health care at the health facilities than the aged. In an empirical research on accessibility and utilization

of health services in a rural district in Ghana, Abugri (1995) found that the youth made use of health services more than the aged. The ages below 20 had more visits to the clinic than those above that age. The elderly above 50 used the clinic very seldomly. The author's explanation is that the elderly are generally dependent on the middle age group for support; hence, their decisions to visit clinics were constrained by either lack of financial or physical support.

With respect to marital status of respondents, majority of the respondents were married. While it was observed that majority of the respondents (53.0%) were married, 32.0% were single. 6.0% each were either divorced or separated from their spouses with the rest 3.0% being widows. Figure 2 below vividly displays the distribution of marital status of the respondents graphically.

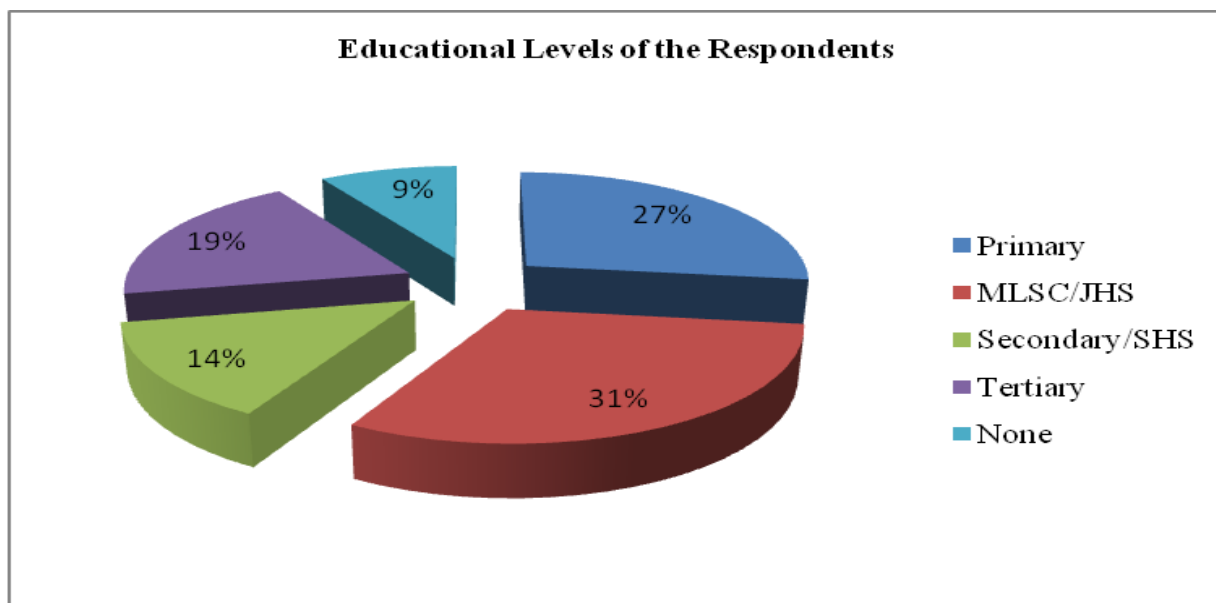
**Figure 2: Marital Status of the Respondents**



*Source: Field survey, 2012*

With regard to the educational status of the respondents, it was realised that a greater proportion of the health seekers (31%) had JSS/MSLC education, 27% also had primary education, whilst 19% had tertiary education. Again, 14% had SHS education while 9% had no education. The findings of this study indicate that as much as 72% of these health seekers (respondents) only had educational status up to only SHS. Again, as much as 9% did not have any formal education at all. Only 19% of the health seekers attained any form of tertiary education. The full distribution of the educational statuses of all respondents could be seen on Figure 3 below.

**Figure 3: Educational Status of the Respondents**



*Source: Field survey, 2012*

With this kind of educational pattern and health seeking behaviour in mind, the obvious question to ask here is “is there any relationship between educational status of health seekers and their health seeking behaviour?” This study suggests that there is, and that respondents with low levels

of educations are more likely to seek orthodox health care than respondents with higher levels of education.

These findings, however, contradict the findings of earlier studies. First of all, Grossman (1972; 1975) confirmed the view that education and demand for health care are in general, positively related. The educated are more cautious and conscious of their health, and tend to use health services more. Illiterate persons with high income are likely to use health facilities less than the educated in the same income category. Of greater impact in determining the use of health facilities is the education of mothers (Caldwell, 1983; Caldwell, 1986; Caldwell, 1989; Swenson, et al.1993; Mensch, et al. 1985; Raghupathy, 1996; Wong, et al. 1987). The findings of this study which suggest that people from low educational backgrounds seek health care at the health facilities more than the highly educated could have many implications. This could be as a result of the fact that most educated people are cautious of their health and take good care of themselves therefore, do not get sick often. It could also be that highly educated people tend to earn higher wages and therefore are capable of seeking health care at expensive private clinics where they are given special attention, which most of the times, is lacking in the public health facilities.

#### **4.3 Respondents' awareness of the NHIS and its operations**

In order to ascertain respondents' views on the operations of the NHIS and the health seeking behaviour of NHIS subscribers and their non-subscriber counterparts, respondents were first and foremost asked if they had ever heard of the NHIS. In response, all the respondents (100%) from both the NHIS subscribers and their non-subscribers responded in the affirmative.

When respondents were tasked to mention their sources of getting this knowledge, mention was made of various sources. Major among them were the television, radio and from health facilities.

Table 2 below displays all the other sources on a multiple response table.

**Table 2: Sources of Information on the NHIS**

Sources of Information	Frequency	Percent (x/200)
On the Radio	178	89.0
On the Television	187	93.5
NCCE Van	23	11.5
At a health facility	156	78.0
From a friend/family	89	44.5

*Source: Field survey, 2012*

Asked further to say what they know about the NHIS, many interesting views were expressed by the respondents. Views ranging from the NHIS as a social insurance health scheme to a scheme for accessing free health care were expressed. The multiple response table, Table 3 below shows all the responses and their distributions.

**Table 3: Respondents' Knowledge of the NHIS**

<b>Views on the MHIS</b>	<b>Frequency</b>	<b>Percent (x/200)</b>
It is a social insurance scheme on health	175	87.5
It was established by government to help the poor and the vulnerable people in society	155	77.5
Sick people can go to hospital without paying money ( <i>cash-and-carry</i> )	190	95.0
Pregnant women can attend hospital without paying	162	81.0
Pregnant women can attend anti-natal and deliver at the hospital for free	164	82.0
Children under 18 years whose parents are subscribers do not pay at the hospital	134	67.0

*Source: Field survey, 2012*

Responses as displayed on the Table 3 above indicate that the top most perception of respondents on the NHIS is that sick people can go to hospital without paying money (*cash-and-carry*). Thus, as much 95% of the respondents saw the NHIS as a means of seeking health care without having to pay money instantly. In separate view, 87.5% of the respondents again believe that NHIS is a social insurance scheme on health where resources are pooled together from which every contributor can seek health care in times of illness. Other interesting views have to do with their perceptions on pregnant women's free access to pre-natal, delivery and post-natal health care.

The themes that emerged from the qualitative data analyses regarding respondents' knowledge on the NHIS was no different from the thoughts expressed in the quantitative data. Mention was made of the attempt to gradually fade off the *cash-and-carry* system, provide affordable health care for the poor and the vulnerable people in society, provision of a social insurance on health

care delivery and free medical care for the pregnant women. One of the managers of the scheme was of the view that:

*“...the intention of the health insurance scheme is to provide a safety net for the poor and the vulnerable people in society. The very poor, the core poor and the aged for example are exempted from premium payment. ...People now do not need to carry money in their hands to be able to access health care...expecting mothers can now, upon paying a token premium, attain free anti-natal, delivery and even post-natal health care...” [A scheme manager, Accra, 12<sup>th</sup> March, 2012].*

These perceptions in many ways confirm the main objective of the NHIS as it was established in 2003. Thus, the newly-created National Health Insurance Authority (NHIA) was commissioned “to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents.” (NHIA, 2003). Also, many other authors hold the view that in many low-income countries, health insurance is increasingly recognized as a promising tool for financing equitable health care. By pooling risks and resources, it promises to ensure better access and provide risk protection to poor households against the cost of illness (Bennett et al. 1998; Dror and Jacquier 1999; Preker et al. 2002; Ekman 2004; Carrin et al. 2005).

When respondents who subscribed to the NHIS were identified, they were asked to state why they did so. In their responses, it was realised that the respondents’ major reason for subscribing to the NHIS was to enable them seek and attain health care delivery without having to pay on the spot (as in *cash-and-carry*). As many as 95% of the NHIS subscribers said they did so because they wanted be able to seek medical attention at any time they fall sick whether they had money at the time or not. Another prominent reason offered by the respondents (88%) is that the NHIS

is a scheme for the poor and the vulnerable in society. They were of the view that the poor and the vulnerable in society may not always have money for them to engage in any *cash and carry* activity but would be able to pay their premiums once a year and then benefit from this payment all year long. Other reasons offered are tabled below on a multiple response table, Table 4.

**Table 4: Reasons for Subscribing to the NHIS**

<b>Reasons for Subscribing to the NHIS</b>	<b>Frequency</b>	<b>Percent (x/100)</b>
It is a social insurance scheme on health	77	77
I subscribed because I can seek health care without paying on the spot	95	95
This scheme is help us the poor and the vulnerable people in society	88	88
When I am/my wife is pregnant I/she can attend hospital without paying	34	34
I/my wife can attend anti-natal and deliver at the hospital for free	37	37
My children under 18 years can seek health care for free	73	73
I am not working so I cannot pay all the times I attend hospital	27	27
I can receive essential drugs for free	22	22

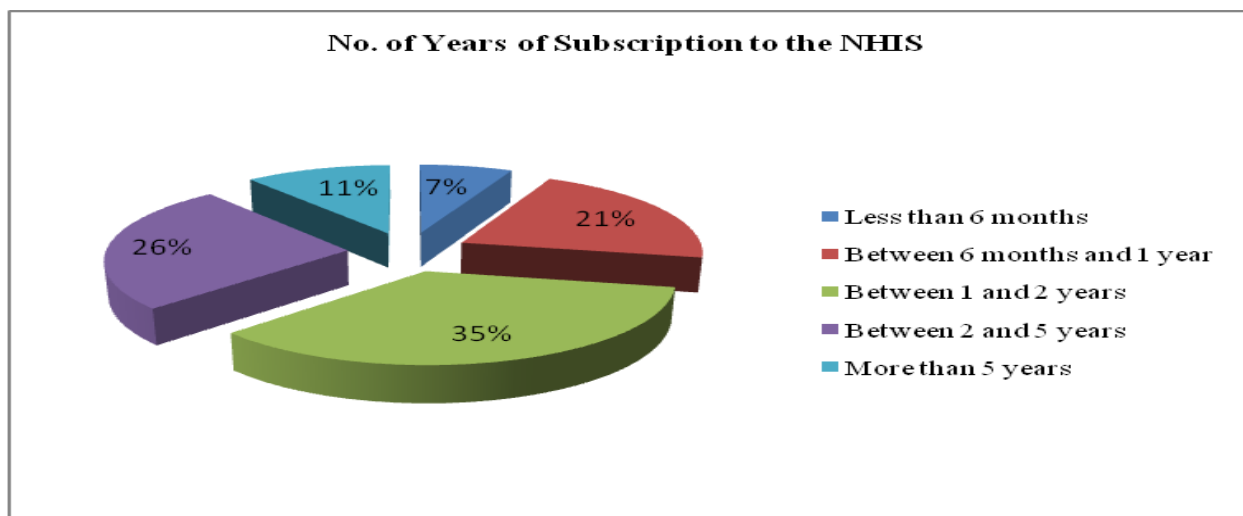
*Source: Field survey, 2012*

Responses on the question as to why people may subscribe to the NHIS with regards to respondents from the qualitative data category identified some salient themes. The major themes that emerged are that the NHIS is a social insurance health scheme, free health care could be accessed, free drugs could be accessed, poor and vulnerable people could now access free health care upon paying a token premium.

These reasons in many ways corroborated the plans of the NHIA on premium payment for the various groups including the poor and the vulnerable in society. It could be recalled that the NHIS premiums are generally based on clients' ability to pay. For example, District Health Insurance Committees identify and categorize residents into four main social groups—viz., the *core poor or the indigent*; *the poor and very poor*; *the middle class*; and *the rich and very rich*—and vary their respective contributions accordingly. The *core poor* (or the indigent) together with people who are 70 or more years of age or former Social Security and National Insurance Trust (SSNIT) contributors who already are in retirement are exempted from paying any premiums.

In attempting to find out how long these NHIS subscribers have actually registered, it was realized that 35% of the users had been users between 1 and 2 years. Similarly, 26% had been subscribers between 2 and 5 years. In all, every respondent had been member of the scheme for at least six months. The full distribution of the number of years members of the scheme had subscribed to it is displayed on Figure 4 below.

**Figure 4: Number of Years Respondents have Subscribed to the NHIS**



*Source: Field survey, 2012*

When the NHIS non-subscribers were asked to give reasons why they were not members of the health insurance scheme, many interesting reasons were given. For example, an overwhelming majority (87%) were of the view that health attendants/staff at various health facilities- both public and private- prefer cash rather than the NHIS card. Similarly, 71% of the respondents pointed out that these health attendants intentionally ignore NHIS card holders to attend to non-subscribers who hold money for the payment of their services. While some respondents (78%) thought the premiums charged were too expensive for them to pay, others (68%) claim they do not often fall sick. The multiple response table, Table 5 below shows all other reasons offered.

**Table 5: Reasons for not subscribing to NHIS**

<b>Reasons for not subscribing to NHIS</b>	<b>Frequency</b>	<b>Percent (n/100)</b>
<b>The premiums are too expensive</b>	78	78
I do not fall sick often	68	68
I do not have any dependents	12	12
There are health facilities in my community	22	22
The distance between my community and a health facility is too far	34	34
I prefer traditional health care	11	11
The scheme gives only cheap drugs	67	67
NHIS subscribers often pay extra money at health facilities	56	56
Health attendants prefer cash and carry rather than the NHIS card	87	87
Health attendants intentionally delay NHIS card holders	71	71

*Source: Field survey, 2012*

These views in many ways confirm various conclusions drawn by various authors. For example, regarding distance between the health seekers community and the health facility, Muller et al., (1998) posit that in developing countries, distance is only one variable that may interact more or less strongly with others to influence utilization. Most people will not travel further than 5 kilometres to basic preventive and curative care. In a study of the effect of distance from home on attendance at a small rural health centre in Papua New Guinea, he found that attendance decreased markedly with distance. There was a 50% decrease of the number of patients at a 3.5 kilometre distance. Similarly, Wilson et al. (1997) also gathered from their study of the maternity home waiting concept at Nsawam in Ghana that distance from the hospital was, among others, one of the reasons for poor utilization of health facility. It has also been pointed out that in the Jasikan district in Ghana, distance decay played a major role in health service utilization (Institute of Development Studies, 1978). The implication for these kinds of view is that if one will not get access to a health facility, why waste scarce resources subscribing to the NHIS which could not be used.

Again, the view that expensive premium payments were reasons for non-subscription seems to agree with some early findings. For example, in a study on user satisfaction with health services in government health facilities in the Eastern Region of Ghana, code-named "What does the public want from us?", Delanyo, et al. (1990) identified high cost of services, among others, as a major cause of user dissatisfaction. Similarly, in the Democratic Republic of Congo, Turshen (1999) found out that the introduction of user fee charges in to their health care delivery led to a steep drop in the utilization of health services. Here also, the issue is that when user fees or

premiums are perceived to be expensive and therefore affordable, health seekers tend to seek alternative health care methods such as unorthodox means.

All of these points strengthen and lend credence to the choice of the theory of Health Belief Model (HBM) for understanding this study. Janz and Becker (1984) in explaining the final point of the theory, posit that a kind of cost-benefit analysis is thought to occur wherein the individual weighs the action's effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects, iatrogenic outcomes), unpleasant (e.g., painful, difficult, upsetting), inconvenient, time-consuming, and so forth. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change.

#### **4.4 The role the NHIS on healthcare accessibility in Ghana**

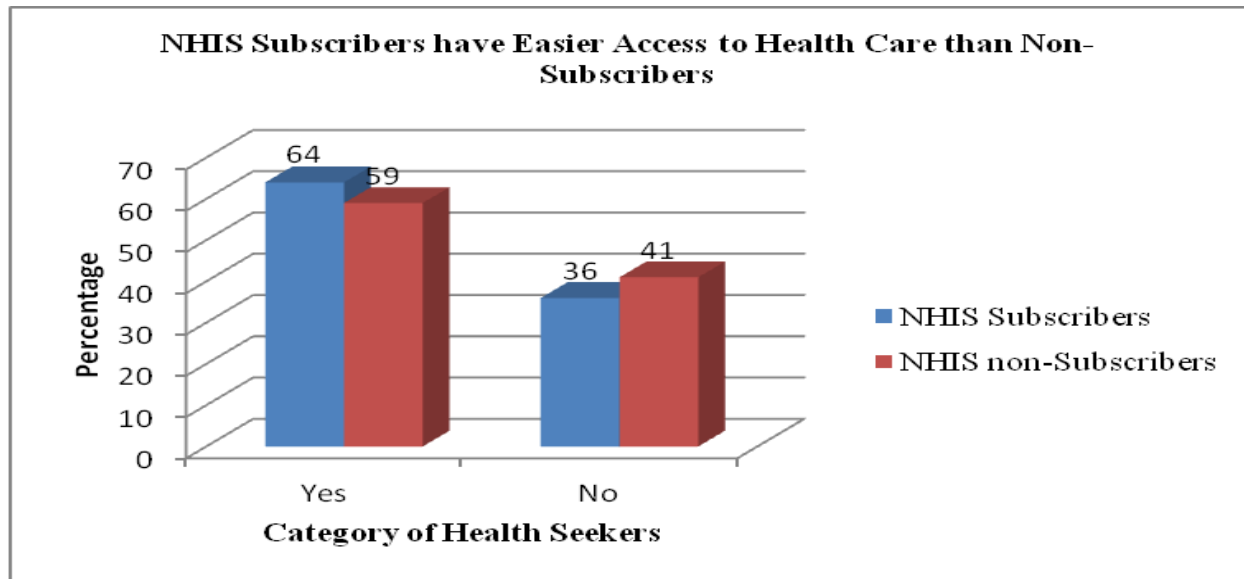
In an attempt to examine the various roles the NHIS plays in accessing health care in Ghana, respondents were first of all tasked to state any benefits subscribers to the NHIS may get. Overwhelming majority of the respondents (97%) stated that NHIS subscribers can seek health care even if they do not have money. Another benefit mentioned was that children (under 18 years) of subscribing parents could access health care for free. The other benefits stated are displayed below on a multiple response table, Table 6.

**Table 6: Benefits for subscribing to the NHIS**

<b>Benefits for subscribing to the NHIS</b>	<b>Frequency</b>	<b>Percent (n/100)</b>
They could seek health care even if they do not have money	194	97.0
Subscribers' children under 18 years could seek health care free of charge	156	78.0
They could have access to essential drugs even the don not have money	133	66.5
Pregnant women can attend hospital without paying	141	70.5
Pregnant women can attend anti-natal and deliver at the hospital for free	137	68.5
They basically insure their health against ill-health	121	60.5

*Source: Field survey, 2012*

Asked further if the NHIS subscribers have easier access to health care than their counterpart non-subscribers, the responses were mixed. Majority of the subscribers (64%) responded in affirmation with the rest 36% responded in negation. Similarly, while 59% of the non-subscribers believed the NHIS subscribers have easier access to health care the rest 41% thought otherwise. In all, 61.5% of all the respondents responded positively to the question whereas the rest 38.5% responded in the negative. These responses are displayed on Figure 5 below.

**Figure 5: NHIS subscribers have easier access to health care than non-subscribers**

*Source: Field survey, 2012*

When those who responded in the affirmative were tasked to say why they reasoned in that direction, some interesting revelations were made. Their responses were that even without having money at the point of illness, one is able to seek health care. Other reasons include access to basic essential drugs without paying for them on the spot, and the opportunity for expectant mothers to have access to pre-natal, delivery and post-natal services without having to pay at the time accessing these health care services.

Responding why they answered in the negative, respondents who claimed that NHIS subscribers have no easy access to health care than non-subscribers also made certain assertions. For example, it was said that health attendants usually would prefer cash to NHIS card. These attendants sometimes frustrate the card bearers to the point that they could get angry and leave the health facilities in search for alternative means of treatment and cure. Some other

respondents, in this category, were of the view that due to the high premium charges, some subscribers are not able to renew their membership therefore becoming inactive members at the turn of a new year when they are supposed to do so. This last view seem to confirm the findings of the NHIA 2010 report which indicated that the official statistics on NHIS registration provided by the National Health Insurance Authority show the increase in enrolment since operations began in late 2005. For example, the total number of active members reportedly increased from 2.4 million in 2006 to 11.1 million in 2009, suggesting that close to 50% of the population was covered by the insurance by 2009. More recently, however, the NHIA changed its methodology for calculating active members and estimated in its 2010 annual report that about 34% of Ghanaians were active enrollees at the end of 2010.

Measuring these responses with those from the qualitative data, it was realised that the managers and the officials of the NHIS were more positive than negative. These respondents were of the view that NHIS subscribers have better access to health care than their counterpart non-subscribers. The reasons stated were not any different from those already stated in the quantitative data. An excerpt from one of the transcripts stated that

*“...to me, in every way, I can confidently say that the NHIS subscribers have better access to health care than their counterpart non-subscribers. The reasons are not far-fetched. Upon payment of a onetime yearly premium, the NHIS subscriber is free to seek health care at any time, in any NHIS operating health facility. This is irrespective of whether the health facility is public or private in nature, whether the health seeker has money at the point of the illness or not, whether their children under eighteen are many or few... Look, my brother, the benefits are innumerable...These benefits cannot accrue to a non-subscriber. No, to*

*them, no money at the point of illness means the non-subscriber cannot seek health care at the health facilities since he/she would need to pay for everything, no free drugs, no access to health care...” [An officer, Ga East Municipal DHIS, Greater Accra, 14<sup>th</sup> March, 2012].*

The generality of the views expressed on whether NHIS subscribers have a better access to health care than their counterpart non-subscriber or not tend to confirm some conclusions drawn by some writers. Scholars such as Bennett et al. (1998) and Dror and Jacquier (1999) among others believe that by trying to pool risks and resources towards creation of a health insurance scheme, such as the NHIS, nations are able to ensure better access and provide risk protection to poor households against the cost of illness. However, it must be made clear that there are many challenges associated with the operation of the health scheme that is why as many as 38.5% could say the NHIS subscribers have no better access than non-subscribers.

Interestingly, when the respondents were asked if access to health care would have been very difficult if there were no NHIS, majority of all the respondents (89%) said “yes” with the rest 11% seeing no such difficulties. 59% of those who answered yes alluded to the fact that many people would not be able to pay for health care delivery since they are poor. 24% of the respondents were of the view that majority of the people cannot buy drugs when they are sick and the rest 17% said people would rather turn to unorthodox methods such as traditional means of cure and treatment or self medication as alternative health care delivery. These views expressed agree with the findings of some scholars such as Cobah and Liang (2011). In their recent survey on assessing the effect of the NHIS on access to and utilization of healthcare services in the Akatsi District of the Volta region of Ghana, Cobah and Liang (2011) found out

that higher proportion of the insured (70.8%) than the non-insured (6.0%) sought formal care during ill-health. In interrogating the health seeking behaviour of the non-insured, it was understood that lack of insurance (42.3%) is the single most important reason for not seeking formal care among the non-insured. A higher proportion of the non-insured who did not seek care (48.1%) either delays or postpones treatment. Their result revealed that health insurance is a key determinant in seeking healthcare and using modern health facilities (Cobah and Liang, 2011).

Those who did not perceive any such difficulties simply state that when the scheme was not introduced, people, no matter how poor they were, were able patronized orthodox health care. Others thought that there are many non-subscribers today who seek health care at health facilities and pay for. What actually could have informed these kinds of reasoning among this later group of respondents (those who envisage no difficulties if the NHIS were absent) could form a ground for a further research. Were they very rich such that they could do without the scheme? Could it be that they may be viewing other alternative means of seeking health care? Do they have organizations paying for their health care? These questions could be just few of the interrogations that could be made.

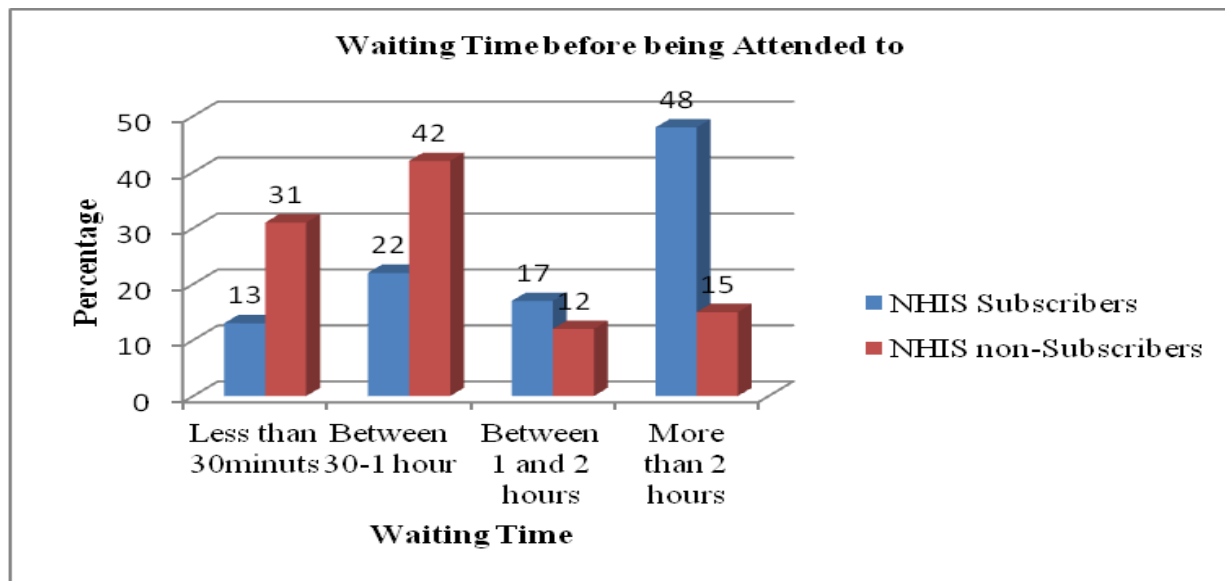
#### **4.5 An analysis of the accessibility of health care by NHIS subscribers and non-subscribers**

##### ***Waiting Time***

In an attempt to analyse the accessibility of health care by NHIS subscribers and non-subscribers in to some details, the researcher wanted to know how long each category of these health seekers

have to wait at the health facilities before being attended to. As such, respondents were tasked to state on the average how long they usually wait to be seen by a medical attendant. The responses were somehow mixed. However, one thing that stood out clearly was that majority of NHIS subscribers (65%) claimed that they usually would have to wait for more than an hour before they are attended to. Only 35% were attended to within one hour. On the other hand, 67% of the non-subscribers claimed they were usually attended to within one hour with the rest 27% affirming that they usually spent more than an hour to be seen.

This information established that most respondents who are not registered members of the scheme spent less time in health facilities when seeking health care services as compared to registered members. This statistics confirms a study conducted by Tabor in 2005. According Tabor (2005), most subscribers of the national health insurance scheme had to wait for longer times before finally being attended to. He opines that subscribers had to go through certain unnecessary procedures before their cards are accepted and they are attended to. The procedures NHIS subscribers go through make the whole process not “health friendly”. Figure 6 below shows the differences in waiting time for the various groups of health seekers.

**Figure 6: Waiting at Health Facilities**

*Source: Field survey, 2012*

Themes emanating from the qualitative data also confirm the views that NHIS subscriber spent much more time at the health facilities than their counterpart non-subscribers. Issues of unnecessary time wasting procedures featured strongly in their views. For example one of the managers of the NHIS puts it this way:

*“...well, we hear many funny stories about how some health attendants treat the NHIS card bearers at their facilities. Some ask for photocopies, extra identity cards, extra money and many other things which all turn to delay the card holder at the hospital... We also heard of how some OPD staff also attempt to separate card holders from those holding cash with the intention of seeing the cash holders first after which they will see to the card holders...These are all illegal but because supervision is poor, they engage in some of these illegalities with impunity...” [A manager, NHIA office, Accra, 15<sup>th</sup> February, 2012].*

Interrogating further the claim that NHIS subscribers spend much more time at the health facility than the non-subscribers, the respondents were categorically asked to say –between a NHIS subscriber and a counterpart non-subscriber- who is likely to wait longer at the health facility when both are seeking health care. In response, majority of the respondents (87%) claimed that the NHIS card holder was likely to wait longer. The rest 13% thought the non-subscriber would stay longer. Asked why such views were upheld by the respondents, those who said subscribers would spend longer time at the health facilities than non-subscribers simply indicated that most health staffs at the OPD, laboratories and dispensaries intentionally delay card holders. Others also mentioned that the lengthy unnecessary procedures subscribers have to pass through before they are attended to tend to delay them at the facilities. Those who said non-subscribers rather spend much more time than the subscribers just said they have no such evidence that people are intentionally delayed at health facilities because they were holding cards rather than cash.

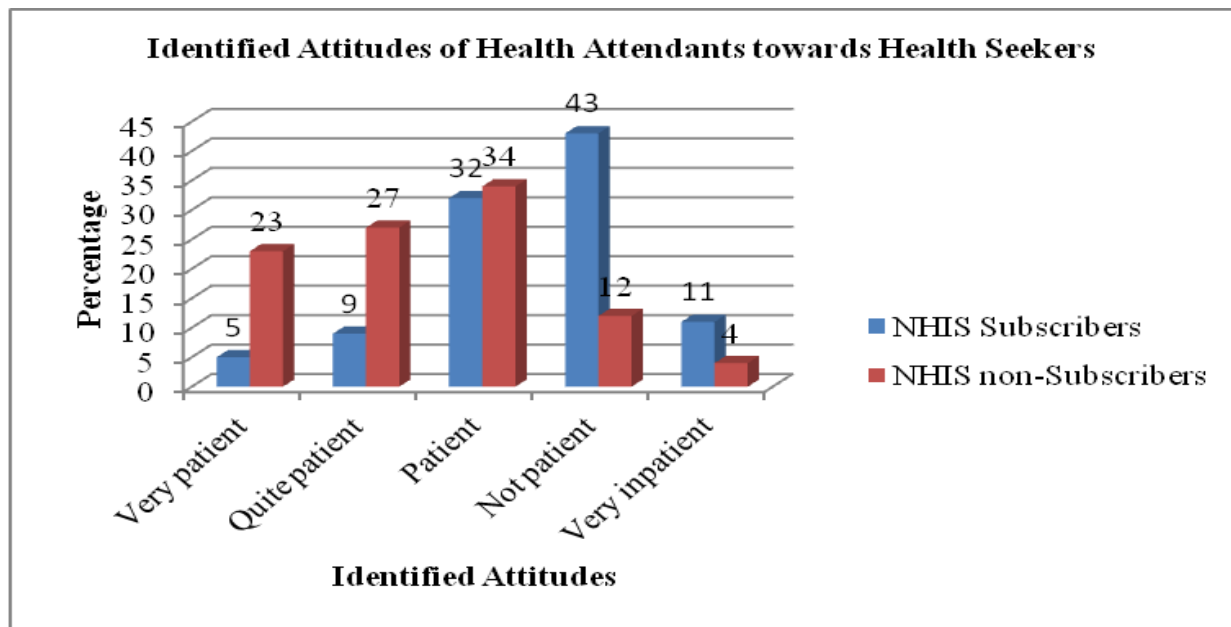
#### ***Attitude of Health Attendants towards Health Seekers***

In order to further analyse the level of accessibility of NHIS subscribers and non-subscribers to health care, the study sought to interrogate the attitude of health attendants at the health facilities towards these two categories of health seekers when they seek health care at these facilities. As such, the respondents were made to state how patient the attendants have been with them- at the OPD, laboratory, consulting room and the dispensary. Again, here also, it was realised that the health staff were seemed to be more patient and tolerant towards non-subscribers than towards card the holders. For example, 46% of NHIS subscribers claimed that the health attendants were at least patient with them but the rest 54% said the health staff were either impatient or very

impatient towards them. However, for the non-subscribers, while as much as 84% praised the attendants for at least being patient, only 16% said they were either impatient or very impatient.

The detailed breakdowns of these views are presented on Figure 6 below.

**Figure 6: Attitude of Health Attendants towards the Health Seekers.**



*Source: Field survey, 2012*

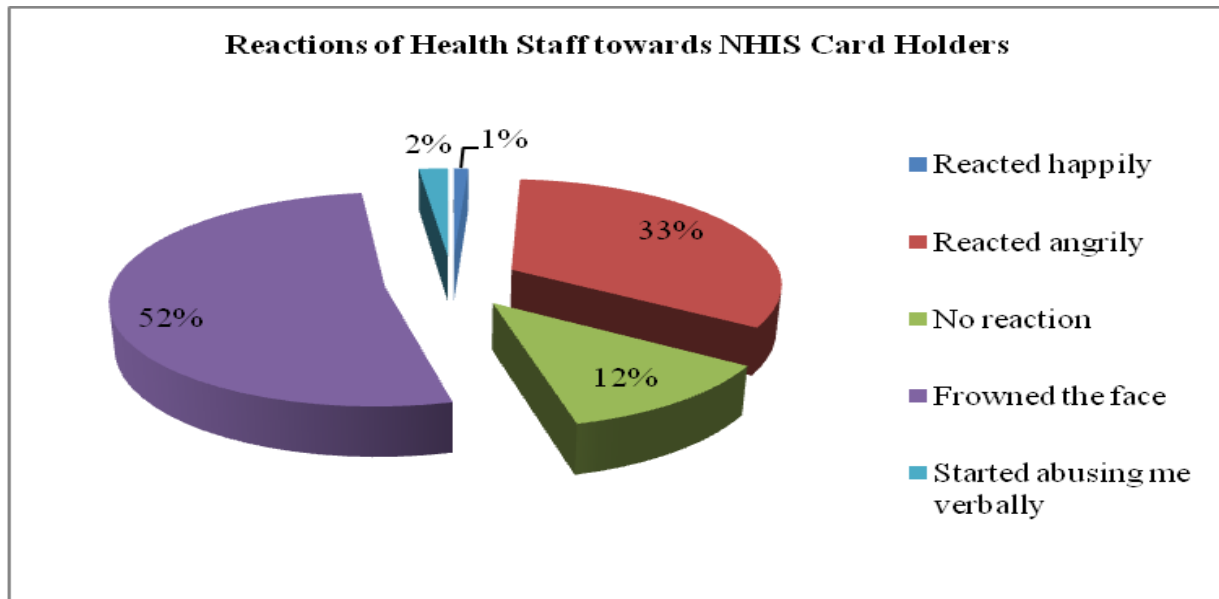
Themes emerging from the qualitative data also made some revelations. All respondents in this category admitted hearing about the discriminated attitudes put by some health institutions in attending to card holders and cash holders. They were of the view that “it is somehow natural” for a rational being, as the health attendants are, to seek to attend to those who came with money and could pay for services rendered to them immediately than card holders whose money may come after months. One of such officials bluntly stated that:

*“...it is a difficult situation we find ourselves in. I think it is somehow natural for every rational being to attend to those who bring money to*

*them quicker than those who are coming “virtually to borrow services” which may be paid after many months... naturally, one may be tempted to discriminate... If we were able to reimburse these service providers in time and they are sure that at a set time they could get their money, all of these could be avoided... Most of the times, paying them delays and this turns to throw them out of gear... We know, but what can we do?...” [A manager, NHIS, Accra, 24<sup>th</sup> February, 2012].*

Apart from the stated reasons why health staff may be hostile towards some health seekers, one other reason could be the nature and the intensity of the illness for which a health seeker is seeking attention. It could be thought of that these differentials on the level of friendliness and hostility may be a result of the fact that, because of the introduction of the scheme, many insured clients are seeking health services on illnesses that health staff may consider minor in which case did not demand their visit to the facility. Un-insured clients because they are not insured will only seek medical attention on serious medical conditions. This may accounts for the differential on the level of attitudes of the health staff attitudes towards the two categories of health seekers.

In seeking to further understand the nature of attitudes of the health staff and the experiences of the NHIS subscribers in the attempt to receive health care, the respondents (in this view, NHIS subscribers) were requested to point out their experiences at the health facilities they visited. Asked whether they experience any verbal abuse, were frowned at or encounter any other uncomfortable situation, many issues were stated. While some card bearers were verbally abused, others were frowned at. Some health staff were also said to have expressed anger upon realising that the patients were NHIS card bearers. Figure 7 below shows the distribution of the responses.

**Figure 7: Reaction of Health Staff towards NHIS Card Holders**

*Source: Field survey, 2012*

From the figure 7 above, it could be deduced that majority of the NHIS card bearers were at least frowned at by the health staff when it was realised that the client was a NHIS beneficiary. Closely followed was expression of anger by the health attendants against the card holders. Reasons for these attitudes have been expressed already.

Again, subscribers were requested to indicate if they were asked by the health staff to pay any extra cash at the health facilities even though they were carrying their NHIS cards. In response to this question, 23% of the NHIS card holders indicated that they were made to pay extra cash with the rest 77% paying no extra money. When those who paid extra money were asked to say what the money they paid was meant for, majority of the respondents (82.6%) said the money was meant to cover the cost of extra medicines that were not covered by the NHIA approved drug

list. The rest of these respondents pointed out that such money was to cover some extra laboratory services they requested for.

Asked further if the respondents were able to access all the drugs prescribed for them at the health facilities, with regard to the NHIS subscribers, 71% of the respondents responded in the affirmative with the rest 29% responding in the negative. Those who could not receive all their prescribed drugs were also made to state the reason why. 65.5% of these respondents stated that the drugs they did not get were drugs that were not covered by the NHIS drug list, as such they were made to pay for only those drugs. The rest said the dispensaries they contacted did not have such drugs in store. For the non-subscribers, 81% of the respondents reported to have all their prescribed drugs purchased at the dispensaries. The rest 19% who could not get all their drugs stated that such drugs were absent from the dispensary. It is however not clear if the disparity between the number of the NHIS card holders and cash holders was as a result of dispensary attendants' preference for cash to accepting cards.

#### **4.6 The major barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality**

It is understood from the findings of this study and many other studies that in many ways, subscription to the NHIS is more beneficial to the many people in the low income countries due to poverty. However, many people in these poor countries have not been able to subscribe to the mutual health schemes. Seeking to find out the various barriers that could be preventing people from joining these schemes, the respondents were tasked to state what they thought could be the hindrances to non-subscribers. Many reasons were mentioned. It was, for example, stated that the

major reason people could not join the schemes was poverty. Thus, while people may genuinely desire to be members of such schemes, their inability to pay premiums due to poverty would prevent them. Other major reasons stated have to do with perception that NHIS card holders are usually left attended to for longer hours at health facilities and that the scheme covers only cheap drugs that could be bought easily even without subscription to the NHIS. The rest of the perceived hindrances are presented on a multiple response table, Table 7 below.

**Table 7: Barriers to Accessing and Using the NHIS**

<b>Barriers to Accessing and Using the NHIS</b>	<b>Frequency</b>	<b>Percent (x/200)</b>
It is because of poverty	192	96.0
It is too expensive for the ordinary health seeker	178	89.0
The scheme covers only cheap drugs	177	88.5
The scheme covers only simple surgical problems (operations)	122	61.0
Health facilities prefer cash and carry to NHIS	170	85.0
NHIS card holders are usually left attended to for longer hours	187	93.5
Some people do not get sick often	137	68.5
People prefer to use traditional systems rather than orthodox method for cure	88	44.0
Unavailability of health facilities in their communities	43	21.5
Health facilities are too far from them (Time wasting to travel to one)	49	24.5

*Source: Field survey, 2012*

Critically considering the views expressed on the Table 7 above, it could be seen that poverty is the major reason why many people are not members of the NHIS. While some people may not be able to pay the initial registration fees to join the scheme, many others may not be able to renew

their membership when their membership expires. The perceptions that only cheap drugs and minor surgical operations are covered under the health insurance scheme are also factors that turn some people away from joining the scheme. Worth mentioning is also the perception that health staffs prefer attending first to cash holders to NHIS card holders and that this tends to make waiting time longer for card holders than their counterpart cash holders.

The findings of this study confirm a number of findings of many studies. For example, in a household survey on the accessibility and utilization of health services in Indonesia, Chernichovsky and Meesook (1986) identified low income to be a strong barrier to the utilization of modern primary medical facilities, even when publicly provided. Similarly, in their studies, Pickett and Hanlon (1990) as well as Ensor and Pham-Bich-San (1996) concluded in separate studies on access to health services that, in the developing countries, the poor have less access to health services.

The findings also confirm and point to the limited services provided under the NHIS. For example, it confirms the fact that the NHIS covers outpatient services, including diagnostic testing and operations such as hernia repairs; some in-patient services, including specialist care, most surgeries, and hospital accommodation (general ward); oral health treatments; all maternity care services, including Caesarean deliveries; emergency care; and, finally, all drugs on the centrally-established NHIA Medicines List. However, the NHIS package excludes some very expensive procedures such as certain surgeries, cancer treatments (other than breast and cervical cancer), organ transplants, and dialysis; non-vital services such as cosmetic surgery; and some high profile items such as HIV antiretroviral drugs.

Interrogating further, the non-subscriber respondents were asked to say exactly why they did not subscribe to the NHIS. The reasons offered were very much as ones already mentioned on Table 7 above. In their personal experiences, poverty and inadequate funds for registration and renewal of premiums top the list. Again, was the perception of intentional delay and time wasting long procedures card holders had to go through to be able to access health care.

Similarly, the various themes emanating from the qualitative data were just the very views expressed in the quantitative data. However, some other themes emerged that have to do with management and the administration of the health insurance scheme which were considered as contributing to the inaccessibility and usage of health seekers to the scheme. Mention was made of inability of the scheme managers to reimburse the service providers in time, insufficient supervision, overcharging invoices, poor record keeping and poor filling of forms for claims, and insufficient supply of essential drugs to the public health facilities. All of these factors were considered as coming together to create more barriers to the smooth running of the health insurance scheme. These factors in many ways tend to turn potential subscribers and disgruntled subscribers away from the accessing and using the scheme. Invariably, these views seem to agree with the view of Zweifel and Breyer (1997) when they postulate that factors such as the type of medical services offered, the degree of freedom to choose providers and the extent of compensation given all may tend to be barriers to health care providers and health seekers. Other characteristics identified include quality of care given by the chosen provider and perceived credibility of the insurer may all tend to be barriers to health seekers joining health insurance schemes (Wiesmann & Jütting, 2001).

The AMHIS Report (2009) explains that delay in reimbursement of claims has been attributed to the inadequacy of staffing or human resource and the high volumes of claims schemes receive within a period. Approximately 30,000 claims are received each month for processing. The report also suggests that there is little effort towards the processing of claims and reimbursement. The NHIA is also blamed for the untimely release of funds to pay claims. There have since not been any policy formulated by the NHIA to guard against fraud, over billing and the like which delay the processing of claims.

#### **4.7 Exploring possible disparities in health care accessibility**

Various factors combine to influence access to and usage of health insurance schemes in various countries. These factors tend to inform the health seeking behaviours of people seeking health care. The kind of behaviours these factors induce in the health seeker also invariably determines the success or otherwise of the health insurance schemes. According to Shaw and Ainsworth (1995), for example, the success of any NHIS is analyzed based on who are the beneficiaries, its efficiency effects, equity of financing, level of administrative costs and political acceptability. Equally, the choice of a health insurance plan and the extent of involvement by households are driven by two sets of determinants. These are the characteristics of the plan itself, and the personal, household and community characteristics of the individual making the choice.

Similarly, according to the theory of Health Belief Model (HBM) in which this study is situated, perceived barriers to health care accessibility seriously influence a health seeker's behaviour. According to the HBM, the final factor (of the original four factors) perceived to inform

behaviour of health seekers in the HBM is “perceived barriers” to attaining the perceived benefits. Janz and Becker (1984) pointed out that the potential negative aspects of a particular health action may act as impediment to undertaking the recommended behaviour-to seek health care. According to the authors, usually, a kind of cost-benefit analysis is thought to occur wherein the individual weighs the action’s effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects, iatrogenic outcomes), unpleasant (e.g., painful, difficult, upsetting), inconvenient, time-consuming, and so forth. This is an individual’s own evaluation of the obstacles in the way of him or her adopting a new behaviour. Of all the constructs, perceived barriers are the most significant in determining behaviour change (Janz and Becker, 1984).

In an attempt to explore the various factors that may influence the health seeking behaviour of the NHIS subscribers and non-subscribers, a number of statements were made for which respondents (the health seekers) were to affirm or deny. These statements include issues on easy access to health care, waiting hours at the health facilities, cost of seeking health care and access to orthodox essential drugs. Responses to the various statements are presented on a multiple response table, Table 8 below.

**Table 8: Possible disparities in health care accessibility**

No	Issues	Yes Frequency	Percent	No Frequency	Percent
1	NHIS subscribers have easier access to health care than non-subscribers	168	84.0	32	16.0
2	NHIS subscribers spend longer time at the health facilities than non-subscribers	155	77.5	45	22.5
3	NHIS subscribers have to pay extra money for health care	88	44.0	112	56.0
4	Non-subscribers to the NHIS find it difficult to access health care	153	76.5	47	23.5
5	NHIS subscribers end up paying more money than non-subscribers accessing health care	67	33.5	133	66.5
6	NHIS non-subscribers who pay money instantly are given much more attention at health facilities than subscribers	163	81.5	37	18.5
7	NHIS non-subscribers may not be able to access orthodox health care when they have no money at the time of the illness	147	73.5	53	26.5
8	NHIS subscribers do not need to pay even in times of complex birth related complications but non-subscribers would have to pay for	187	93.5	13	6.5
9	NHIS subscribers have free access to essential drugs but non-subscribers would have to pay for	189	94.5	11	5.5

*Source: Field survey, 2012*

From the table 8 above, it could be understood that in many ways, subscribers to the NHIS have many benefits and advantages that their counterpart non-subscribers do not have. It was also found out that with regard to speed of service delivery to both categories of the health seekers,

cash holder NHIS non-subscribers receive quicker services than their counterpart NHIS subscribers.

The emerging themes from the transcriptions of the in-depth interviews follow similar patterns adduced in the in the quantitative data. Subscribers to the NHIS were said, for example, to have better and easier access to health care than their counterpart non-subscribers with the simple reason that subscribers could access health irrespective of whether they have at the moment of ill-health or not. However, it was reported that non-subscribers receive quicker services.

Finally, when respondents were asked to suggest ways in which access to and usage of the NHIS could be improved, many views were held. It was for example, suggested that the high registration fees and premiums charged by the scheme should be reduced and made more affordable to potential NHIS subscribers. Respondents were also of the view that the NHIA should expand the drug list covering only essential drugs to include some expensive drugs also and also that supply of the essential medicine/drugs to health facilities be increased to prevent the situations where there are shortages of drugs. The other recommendations and the manner of their distributions are presented on a multiple response table, Table 9 below.

**Table 9: Suggestions for improving access to and the utilisation of the NHIS**

<b>Recommendations</b>	<b>Frequency</b>	<b>Percent (x/200)</b>
NHIA should expand the drug list to include some expensive drugs	155	77.5
NHIA should include some expensive surgical operations in NHIS	127	63.5
Health facilities that discriminate against NHIS card holders should be sanctioned	178	89.0
Re-imburement of service providers should be prompt and regular	121	60.5
Premiums should be made more affordable	168	84.0
NHIA should increase supply of medicine/drugs to health facilities	157	78.5
Health staffs should be given re-orientation training in manners and etiquette	147	73.5
Dispensing staff should always take their time to explain how to use the medicine so prescribed to clients	119	59.5
More doctors and nurses should be trained and posted to the health facilities	133	66.5

*Source: Field survey, 2012*

It was the view of the respondents that if all of these suggestions are taken into consideration and are actually implemented, the Ghana's NHIS would be one of the best in the world.

## CHAPTER FIVE

### SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

#### 5.0 Introduction

This chapter presents a summary of the findings of the study, draws some salient conclusions and puts forward some recommendation for improving access to and the utilization of the National Health Insurance Scheme (NHIS).

#### 5.1 Summary of Findings

The general objective of the research was to examine the experience of NHIS subscribers and non-subscribers in accessing healthcare in the Ga East Municipality. In order to carry out this task, a mixed method approach was adopted for data collection and analyses. A number of interesting findings have been made. First and foremost, it was realized that more women seek formal health care than men in formal health facilities in the Ga East Municipality. However, it was found out that contrary to findings and conclusions drawn by some authors in their studies, more of low educated people in the Ga East Municipality seek formal health care than their counterpart highly educated people. Again, it was realized that contrary to conclusions drawn by some other writers that younger people seek formal health care; this study found out that older people rather seek formal health care than their younger counterparts.

Regarding health seekers understanding of the operations of the NHIS, it was revealed that health seekers in the Ga East Municipality have an appreciable knowledge on the NHIS and its operations. It was clear that the health seekers understood the NHIS to be a social health insurance scheme aimed at pooling risks and resources together so that members could access

affordable health care. It was also understood that the scheme was designed to provide a safety net for the poor and the vulnerable people in society against health challenges. Health seekers upon payment of a yearly premium could access health care anytime they are indisposed without having to pay cash at the health facilities. In this wise, able bodied and physically fit members are made to pay premiums while very old pensioners, the core poor and other vulnerable members pay no such premiums yet fully benefitting from the scheme.

The role of the NHIS in accessing health care have been, in view of the health seekers, to able to access formal health care at both public and some private health facilities without having to pay cash at the time of receiving the health care services. Thus, it was realized that majority of health seekers in the Ga East Municipality view the scheme as an opportunity to seek formal health care free of charge. It was also viewed as a means of getting access to free essential drugs. Also, it was understood that the NHIS was seen as a tool for medically caring for expectant mothers from the time of conception through to all post-natal cares without having to pay any money. Similarly, mention was made of children less than 18 years whose parents are members of the scheme that they could seek formal health care for free.

In view of all of this knowledge about the benefits of the NHIS, it is thought that all health seekers would subscribe to it. However, findings have it that this is not the case with some health seekers in the Ga East Municipality. Various reasons were adduced as to why these health seekers were not members of the scheme. It was unearthed that the major reason why majority of the people have not subscribed to the scheme is poverty. Because these people are poor but do not qualify to be among the core poor, they could not join the scheme. Many other people, who

initially registered, could also not renew their membership. Apart from poverty, certain negative perceptions such as the fact that the NHIS is bedeviled with longer waiting time, cheap drugs and abusive tendencies from health staffs prevent some people from acceding to the scheme.

Comparing the accessibility and usage of formal health care between the NHIS subscribers and their non-subscriber counterparts, many findings were made. Findings were that NHIS subscribers in general, have an easier access to and usage of formal health care than their non-subscriber counterparts. Members of the scheme could seek formal health care irrespective of whether they have money at the time of the illness or not. They are also able to access essential drugs, have their wards less than 18 years and pregnant women access free health care. Non-subscribers would have to pay for each service they receive. Again, no money at hand in time of illness means an inability to access formal health care.

However, despite the beautiful benefits enumerated above, NHIS subscribers were found to suffer many ill-treatment from the hands of health attendants. It was realized that NHIS card holders spend more waiting time before being attended to at the OPD, at the laboratory, the dispensary and even at times in consulting a medical officer. This is as a result of the fact that health facilities prefer ready cash to NHIS card transaction which in many ways result in delayed re-imburement. Again, the NHIS subscribers are sometimes made to pay extra money in order to cover for diagnoses, laboratory tests and drugs not covered by the scheme. Some cards holders are frowned at, verbally abused and at time rudely spoken to because they are holding card instead to cash while seeking health care. Simply put, health facilities prefer cash to NHIS card.

## 5.2 Conclusions

In view of the findings made in this study, some conclusions have been drawn. With regards to demography of health seekers in the Ga East Municipality, it could be concluded that gender wise, majority of health seekers were women. Again, more of older people seek formal health care at health facilities than younger people. Education wise, health seekers with low educational background tend to seek formal health care than people with high educational background.

It is also concluded that there is a high level of knowledge on the nature and the operations of the NHIS among health seekers in the municipality. The people were aware of the NHIS as a social health insurance scheme created to provide cushioning for the poor and the vulnerable people in society. They had a good understanding on issues of membership, premiums and benefits of the scheme.

It is also concluded that members of the health insurance scheme have a better and easier access to and usage of formal health care than their counterpart non-subscribers. Members of the scheme upon onetime yearly payment could access health care at both public and some private health facilities without having to pay any money. On the other hand, non-subscribers would have to pay at every stage of accessing health care services. Members of the NHIS have access to free essential drugs, minor surgical operations, laboratory services, OPD charges and consultation fees. Their counterpart non-subscriber health seekers would have to pay for all of these services.

In spite all of these privileges enjoyed by the NHIS subscribers, there are still majority of health seekers who have not subscribed to the scheme. Many reasons were alluded to as barriers to

people who might want to join the scheme. Critically looking at the reasons offered, it is concluded that the major reasons why some health seekers in the Ga East Municipality did not subscribe to the scheme were poverty and negative perception about the attitudes of the health staffs of the various health facilities towards NHIS card bearers. Some of the health seekers were very poor such that they could not afford to register to join the scheme. Similarly, those who initially registered to join the scheme could not maintain their membership due to the excuse that they could not renew their members for lack of funds. Negative perceptions such as the possibility of NHIS card holders to be intentionally delayed, frowned at and even verbally abused by health staff also strongly serve as barriers to many health seekers who may want to join the scheme.

Also, apart from suffering longer waiting time before being attended to, verbal abuses and frowned faces, the NHIS card holders also at times had to pay extra cash. The extra cash paid was usually to cover for drugs and other services a health seeker required which were covered under the benefits of the scheme.

### **5.3 Recommendations**

Majority of health seekers who could not join the NHIS were not able to do so due to poverty or inadequate funds. In order for these health seekers to be able to make some money for them to join the health scheme, it is suggested that government in collaboration with the Ga East Municipal Assembly create enough jobs, both white colored and menial, to enable able bodied but unemployed people to get work so as to make money. Again, it is suggested that about ten government-assisted micro finance schemes should also be created across the length and breadth

of the municipality. These financial schemes should be made to provide mini-credit facilities for the poor people to enable them start some trade. When these poor health seekers are able to generate some cash, they will willingly join the scheme and then enjoy all the benefits associated with it. Also, as a complementary effort towards assisting the poor, the NHIA should reduce the registration fees and the premium to make it more affordable for such poor health seekers.

A number of countries around the world are tilting towards free health care delivery to their citizens in order to improve the citizens' wellbeing. This they do by setting aside part of their gross domestic product (GDP) and part of their tax revenues. Ghana's NHIS's aim is to gradually attain this feat in the near future. In order to accelerate this desire, it is suggested that government takes bold steps by setting aside an extra eight percent (8%) of GDP to pump into delivery of free health care to its largely poor citizens. In addition, very good fundraisers should be recruited to contact all the international health care non-governmental agencies that support health care delivery to raise funds to support Ghana's NHIS. Similarly, health donor agencies could be contacted to assist in this direction. With enough money available, government and the NHIA could achieve their aim of providing free health care.

One strong factor that served as a barrier to many potential subscribers to the NHIS was the perception that the NHIS covers only cheap drugs and guarantees the conduct of only inexpensive surgical operations. However, looking critically at the drug list and the surgical operations covered under the scheme, it appears their concerns are strongly premised. This is because about 90% of all health conditions were covered. Also, most basic surgical operations including cervical and breast cancer treatments are all included with exception of cosmetic

surgery and other very expensive and luxurious operations. This rumour could be as a result of miscommunication and inadequate education of the health seekers on the full benefits of the NHIS. It is therefore recommended that better education be made on these benefits. More education should be carried out on televisions, radios, in leaflets and moving vans trumpeting the full benefits of the NHIS. This well done, the negative perceptions would have been a thing of the past.

As intense education goes on, government and scheme managers must also work hard to expand the coverage of the drug list and the surgical operations lists to cover all the common health conditions that are common with Ghanaians no matter how expensive they may be. In this wise, the NHIS would be advancing towards its idea of providing free health care to all Ghanaians.

One other potent rumour that tends to prevent potential subscribers to the NHIS was the perception that health facilities prefer cash to card. Thus, health staff would want to attend to health seekers carrying cash before attending to NHIS card holders. Inherent in this rumour is the fear that card holders may spend more waiting time, suffer abuse from health staff and be made to undergo unnecessary and time wasting procedures for their cards to be accepted. This perception, in many instances, was confirmed to be true. In order to curb this situation, it is recommended that a more effective supervision of health facilities and health staffs be carried out. A well trained task force should be established and be made to disguise themselves to move from one health to another checking this canker. Culprits should be sanctioned to serve as deterrent to other health staffs and facilities. When this ill is cured, many more health seekers would be willing subscribe to the NHIS.

Health facilities and health staffs that discriminate against NHIS card holders do so, at times, due to the fact that re-imburement of such claims to them could take very long time. In this study, the managers of the scheme confirmed delays in re-imburement of claims to the service providers. So long as health service providers have this believe that their claims will take very long time to mature, they will continue to discriminate against card holder while giving special attention to cash holders. To eliminate this practice, it is recommended that the NHIA works very hard, employ more competent staff and adopt easier but more effective means of receiving, processing and paying claims within the scheme's stipulated 90 days period. Electronic devices that could transmit claims from the point of service delivery to the NHIA for onward processing could be provided to all service providers. This could be followed later with photocopies just for auditing purposes. When service providers are paid in time they would be happy to accept the NHIS cards and attend to their holders as they would cash holders.

Finally, with regard to the high doctor-patient ratio as well as low numbers of nurses and other health workers in comparison to the teaming health seekers visiting health facilities daily, it is seen that there is too much pressure on health workers. This may be as a result of their bad attitudes towards health seekers. To reduce this burden on the health workers, it is recommended that government trains enough doctors, nurse, dispensary staff, laboratory technicians and the other health workers who will complement the efforts of the existing overburdened health workers. More medical schools and nurses training colleges could be built to help in this direction. The already existing health workers should also be made to go on refresher courses to

help sharpen their skills. When all of these recommendations are put in place, access to and the utilization of the NHIS would greatly improve with new enrollees coming on board.

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# University of Ghana

## Centre for Social Policy Studies

### Questionnaire

Serial Number.....

### **Introduction**

Hello, good morning/afternoon/evening, my name is .....I am student of the Centre for Social Policy Studies, University of Ghana. As part of my course requirements, I am undertaking a research doing comparative study of the experiences of NHIS subscribers and non-subscribers in accessing health care in Ga East municipality. The findings of this study will be used solely for academic purposes and confidentiality of respondents is guaranteed. Your participation in this study is highly important but optional. Your decision to participate or not will not affect you in any way. Thank you.

### **Consent Note:**

**Having explained the purpose of this study to me and assuring me of absolute confidentiality, I hereby give my consent to take part in this survey. You can go ahead and interview me:**

.....Signature

### **Interview details**

Date of interview:..... Start Time:.....End Time:.....

Location:.....



**Q7c.** If Yes to Q7a, for how long have you subscribed to the NHIS?

- |                          |     |                                |     |
|--------------------------|-----|--------------------------------|-----|
| 1. Less than 6 months    | [ ] | 2. Between 6 months and 1 year | [ ] |
| 3. Between 1 and 2 years | [ ] | 4. Between 2 and 5 years       | [ ] |
| 5. More than 5 years     | [ ] |                                |     |

**Q7d.** If No to Q7a, please give reasons why not.

- a.....
- b.....
- c.....

### Section C: The role the NHIS on healthcare accessibility in Ghana

**Q8.** What benefits are there for a person who subscribes to the NHIS? (**Multiple Response Possible**)

- |   |     |
|---|-----|
| 1. They could seek health care even if they do not have money                 | [ ] |
| 2. Subscribers' children under 18 years could seek health care free of charge | [ ] |
| 3. They could have access to essential drugs even the don not have money      | [ ] |
| 4. Pregnant women can attend hospital without paying                          | [ ] |
| 5. Pregnant women can attend anti-natal and deliver at the hospital for free  | [ ] |
| 6. They basically insure their health against ill-health                      |     |
| 7. Other (specify)...../.../.../...   |     |

**Q9a.** Do you think an NHIS subscriber has an easy access to health care than a non-subscriber?

- |        |     |       |     |
|--------|-----|-------|-----|
| 1. Yes | [ ] | 2. No | [ ] |
|--------|-----|-------|-----|

**Q9b.** If Yes to Q9a, please give reasons why.

- a.....
- b.....
- c.....

**Q9c.** If No to Q9a, please give reasons why not.

- a.....
- b.....
- c.....

**Q10a.** In your opinion, do you think without the NHIS access to health care to people will be difficult?

- |        |     |       |     |
|--------|-----|-------|-----|
| 1. Yes | [ ] | 2. No | [ ] |
|--------|-----|-------|-----|

**Q10b.** If Yes to Q10a, please give reasons why.

- a.....
- b.....
- c.....

**Q10c.** If No to Q10a, please give reasons why not.

- a.....  
 b.....  
 c.....

**Section D: An analysis of the accessibility of health care by NHIS subscribers and non-subscribers**

**Q11a.** On the average what was your waiting time before being attended to?

1. Less than 30minuts [ ]      2. Between 30-1 hour [ ]  
 3. Between 1 and 2 hours [ ]      4. More than 2 hours [ ]

**Q11b.** In your opinion between an NHIS subscriber and a non-subscriber, who do you think will have a longer waiting time at a health facility?

1. Subscriber [ ]      2. Non-subscriber [ ]

**Q11c.** Is an NHIS subscriber, why do you think so?

- a.....  
 b.....  
 c.....

**Q11d.** If non-subscriber, why do you think so?

- a.....  
 b.....  
 c.....

**Q12.** How did you perceive the health official attitudes towards you?

1. Very patient [ ]      2. Quite patient [ ]      3. Patient [ ]  
 4. Not patient [ ]      5. Very inpatient [ ]

**Q13a.** Between an NHIS subscriber and a non-subscriber, who do you think will have easier access to health care?

1. Subscriber [ ]      2. Non-subscriber [ ]

**Q13b.** Is an NHIS subscriber, why do you think so?

- a.....  
 b.....

**Q13c.** If non-subscriber, why do you think so?

- a.....
- b.....
- c.....

**Q14. (For NHIS Subscribers only).** When the health attendant got to know that you were using NHIS, what was his/her initial reaction?

- 1. Reacted happily [ ]
- 2. Reacted angrily [ ]
- 3. No reaction [ ]
- 4. Frowned the face [ ]
- 5. Started abusing me verbally [ ]

**Q15a.** If you are a registered member of NHIS did you pay any extra money at the health facility?

- 1. Yes [ ]
- 2. No [ ]

**Q15b.** If Yes to Q15a, what the payment for?

- a.....
- b.....
- c.....

**Q15c.** Were you given all the medicine you needed?

- 1. Yes [ ]
- 2. No [ ]

**Q15d.** If Yes to Q15c, why not?

- a.....
- b.....
- c.....

**Section E: The major barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality**

**Q15.** What are the major reasons why some people are not able to subscribe to the NHIS? (**Multiple Response Possible**)

1. It is because of poverty [ ]
2. It is too expensive for the ordinary health seeker [ ]
3. The scheme covers only cheap drugs [ ]
4. The scheme covers only simple surgical problems (operations) [ ]
5. Health facilities prefer cash and carry to NHIS [ ]
6. NHIS card holders are usually left attended to for longer hours [ ]
7. Some people do not get sick often [ ]
8. People prefer to use traditional systems rather than orthodox method for cure [ ]
9. Unavailability of health facilities in their communities [ ]
10. Health facilities are too far from them (Time wasting to travel to one) [ ]
7. Other (specify)...../...../...../.....

**Q16. (For non-subscribers only).** Why have you not personally subscribed to the NHIS?

- a.....
- b.....

#### **Section F: Exploring possible disparities in health care accessibility**

**Q17.** Please respond “Yes” or “No” to the following statements on the table below:

No	Issues	Yes	No
1	NHIS subscribers have easier access to health care than non-subscribers		
2	NHIS subscribers spend longer time at the health facilities than non-subscribers		
3	NHIS subscribers have to pay extra money for health care		
4	Non-subscribers to the NHIS find it difficult to access health care		
5	NHIS subscribers end up paying more money than non-subscribers accessing health care		
6	NHIS non-subscribers who pay money instantly are given much more attention at health facilities than subscribers		
7	NHIS non-subscribers may not be able to access orthodox health care when they have no money at the time of the illness		
8	NHIS subscribers do not need to pay even in times of complex birth related complications but non-subscribers would have to pay for		
9	NHIS subscribers have free access to essential drugs but non-subscribers would have to pay for		

**Q18.** What recommendations do have to make that will help better the NHIS?

- a.....
- b.....
- c.....

**Thank you for taking part in this Survey**

# University of Ghana

## Centre for Social Policy Studies

### Interview Guide

#### Introduction

Hello, good morning/afternoon/evening, my name is .....I am student of the Centre for Social Policy Studies, University of Ghana. As part of my course requirements, I am undertaking a research doing comparative study of the experiences of NHIS subscribers and non-subscribers in accessing health care in Ga East municipality. The findings of this study will be used solely for academic purposes and confidentiality of respondents is guaranteed. Your participation in this study is highly important but optional. Your decision to participate or not will not affect you in any way. Thank you.

#### **Consent Note:**

**Having explained the purpose of this study to me and assuring me of absolute confidentiality, I hereby give my consent to take part in this survey. You can go ahead and interview me:**

.....Signature

#### Interview details

Date of interview:..... Start Time:.....End Time:.....

Location:.....

**Section A. Demographical Profile:**

- Gender of respondent of respondent: Male or Female
- Age of respondent: How old is the respondent?
- Highest level of education attained: Secondary/SHS? Tertiary? Post-graduate?
- Marital status: Married? Single? Divorced? Widowed? Separated?

**Section B: Respondents' awareness of the NHIS and its operations**

- Have you ever heard of the NHIS?
- If Yes, where have you heard about it? Was it on the Radio? Was it on Television? From NCCE Van? At a health facility? From a friend/family? Any other source?
- What do you know about the NHIS?:
  - Is it a social insurance scheme on health?
  - Was it established by government to help the poor and the vulnerable in society?
  - Can sick people go to hospital without paying money (cash and carry)?
  - Can pregnant women attend hospital without paying?
  - Can pregnant women attend anti-natal and deliver at the hospital for free?
  - Can children less than 18 years of parents who subscribe to the NHIS seek free health care?
  - Any other idea?
- Have you personally subscribed to the NHIS?
- If Yes to Q7a, please give reasons why.
- If Yes to Q7a, for how long have you subscribed to the NHIS?
- Less than 6 months? Between 6 months and 1 year? Between 1 and 2 years? Between 2 and 5 years? More than 5 years?
- If No to Q7a, please give reasons why not.

**Section C: The role the NHIS on healthcare accessibility in Ghana**

- What benefits are there for a person who subscribes to the NHIS? Please respond to the following statements:
  - They could seek health care even if they do not have money
  - Subscribers' children under 18 years could seek health care free of charge
  - They could have access to essential drugs even the don not have money

- Pregnant women can attend hospital without paying
  - Pregnant women can attend anti-natal and deliver at the hospital for free
  - They basically insure their health against ill-health
  - Any other idea?
- Do you think an NHIS subscriber has an easy access to health care than a non-subscriber?
  - If Yes to Q9a, please give reasons why.
  - If No to Q9a, please give reasons why not.
  - In your opinion, do you think without the NHIS access to health care to people will be difficult?
  - If Yes to Q10a, please give reasons why.
  - If No to Q10a, please give reasons why not.

#### **Section D: An analysis of the accessibility of health care by NHIS subscribers and non-subscribers**

- On the average what is the normal waiting time before being attended to?
- Less than 30minuts? Between 30-1 hour? Between 1 and 2 hours? More than 2 hours?
- Why do you think so?
- Have you ever heard from health seekers that NHIS card holders spend more waiting time than those who carry cash? Why does it happen like that? What can you do about it?
- In your opinion between an NHIS subscriber and a non-subscriber, who do you think will have a longer waiting time at a health facility?
- Subscriber?                      Non-subscriber?
- Is an NHIS subscriber, why do you think so?
- If non-subscriber, why do you think so?
- How did you perceive the health official attitudes towards you?
- Very patient? Quite patient? Patient? Not patient? Very inpatient?
- Between an NHIS subscriber and a non-subscriber, who do you think will have easier access to health care?
- Subscriber                      Non-subscriber?

- Is an NHIS subscriber, why do you think so?
- If non-subscriber, why do you think so?
- When the health attendant got to know that you were using NHIS, what was his/her initial reaction?
  - Reacted happily? Reacted angrily? No reaction? Frowned the face?
  - Started verbally abusing you?
- If you are a registered member of NHIS did you pay any extra money at the health facility?
- If Yes to Q15a, what the payment for?
- Were you given all the medicine you needed? If no, why not?

**Section E: The major barriers in accessing and utilizing health care services by both insured and non-insured clients in the municipality**

- What are the major reasons why some people are not able to subscribe to the NHIS?
  - Is it because of poverty?
  - Is it too expensive for the ordinary health seeker?
  - Is it that the scheme covers only cheap drugs?
  - Does the scheme cover only simple surgical problems (operations)?
  - Is it the case that health facilities prefer cash and carry to NHIS?
  - Are NHIS card holders usually left attended to for longer hours?
  - Is it the case that some people do not get sick often?
  - Do people prefer to use traditional systems rather than orthodox method for cure?
  - It is the case that there are no health facilities in their communities?
  - Is it that health facilities are too far from them (Time wasting to travel to one)?
  - Any other reason?

**Section F: Exploring possible disparities in health care accessibility**

**Q17.** Please respond “Yes” or “No” to the following statements on the table below and say why you think so:

No	Issues	Yes	No
1	NHIS subscribers have easier access to health care than non-subscribers		
2	NHIS subscribers spend longer time at the health facilities than non-subscribers		

3	NHIS subscribers have to pay extra money for health care		
4	Non-subscribers to the NHIS find it difficult to access health care		
5	NHIS subscribers end up paying more money than non-subscribers accessing health care		
6	NHIS non-subscribers who pay money instantly are given much more attention at health facilities than subscribers		
7	NHIS non-subscribers may not be able to access orthodox health care when they have no money at the time of the illness		
8	NHIS subscribers do not need to pay even in times of complex birth related complications but non-subscribers would have to pay for		
9	NHIS subscribers have free access to essential drugs but non-subscribers would have to pay for		

- What recommendations do have to make that will help better the NHIS?

**Thank you for taking part in this Survey**