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DISSERTATION

TOPIC

**COMMUNITY HEALTH FINANCING:
THE WAY FORWARD IN AGOGO SUB DISTRICT**

**BY
DR FRANCIS BOAKYE TAKYI**


**SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC
HEALTH DEGREE**

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DECLARATION

This dissertation is the result of independent investigation. Where my work is indebted to the work of others, I had made the necessary acknowledgement.

I declare that, the same work has not been submitted anywhere for the same purpose.

Signed 

DR. FRANCIS BOAKYE TAKYI

ACADEMIC SUPERVISORS:

1. Signed 

MR. A. A. D. OBUOBI

(Lecturer, GSPH, University of Ghana)

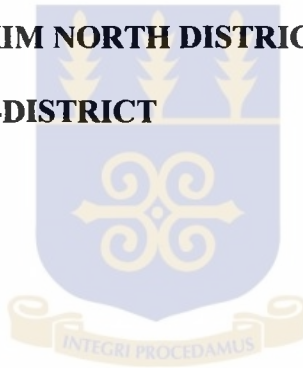
2. Signed 

DR. IRENE AGYEPONG

(Lecturer, GSPH, District Director of Health Services, Dangbe-West District)

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DEDICATION

This piece of work is dedicated to the memory of my Beloved Father and to my Mother.

With God all things are possible.

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ABBREVIATIONS

A	-	AGOGO
AH	-	AGOGO HEMAA
AIDS	-	ACQUIRED IMMUNO DEFICIENCY SYNDROME
AK	-	ANANEKROM
BM	-	BEBOME MIDWIFE
CWC	-	CHILD WELFARE CLINIC
DA	-	DISTRICT ASSEMBLY
DCD	-	DISTRICT COORDINATING DIRECTOR
DDHS	-	DISTRICT DIRECTOR OF HEALTH SERVICES
DHMT		DISTRICT HEALTH MANAGEMENT TEAM
ENT	-	EAR NOSE AND THROAT
F.M	-	FREQUENCY MODULATION
FE		FINANCIAL ENCUMBERANCE
FGD	-	FOCUS GROUP DISCUSSION
GM		GENERAL MANAGER
GOG	-	GOVERNMENT OF GHANA
GPRTU	-	GHANA PRIVATE ROAD TRANSPORT UNION
H	-	HWIDIEM
ID		IDENTITY CARD
IMT	-	INSURANCE MANAGEMENT TEAM
M	-	MAGYIDA

MOH	-	MINISTRY OF HEALTH
MS	-	MEDICAL SUPERINTENDENT
NGO		NON GOVERNMENTAL ORGANIZATION
ORD	-	OUTPATIENT DEPARTMENT
PHC	-	PRIMARY HEALTH CARE
PHC	-	PRIMARY HEALTH CARE COORDINATOR
RCH	-	REDUCTIVE AND CHILD HEALTH
RTI		RESPIRATORY TRACT INFECTION
SPH	-	SCHOOL OF PUBLIC HEALTH
STCA	-	SECRETARY TRADITIONAL COUNCIL AGOGO
UCC	-	UNIT COMMUNITY CHAIRMAN
USB	-	UNIDAD DE SAUDE DE BASE
WHO	-	WORLD HEALTH ORGANIZATION

ABSTRACT

The cost of providing basic health care in Ghana is escalating and it is beyond the ability of the government alone to finance health care. The introduction of the cash and carry system although had advantages, however for the majority of the people in the rural areas the system has not been of much help as money was not always available to pay for the cost of health care.

Therefore, there has been the need to find alternative method of financing health care in Ghana. Mutual health insurance has been suggested as one form of financing health care.

The DHMT intends to start a Mutual Health Insurance Scheme in Agogo sub-district. Since health insurance is a new thing to the area, this exploratory study was designed to examine the knowledge and attitude of the people on community health financing. Data was collected using qualitative methods of in-depth interviews and FGDs. In all 83 participants took part in the study. Six FGDs, six key informant interviews and six in-depth interviews were conducted.

The key result of the study indicates that the knowledge of health insurance was very low. People are willing to join the scheme but they should be educated about the scheme and the premium should be affordable. The premium should be collected in cash and each individual should pay a fixed rate. Divergent views expressed about the scope of services as the community wanted all service covered under the scheme while the key

informants wanted out-patient services or admissions covered under the scheme only.

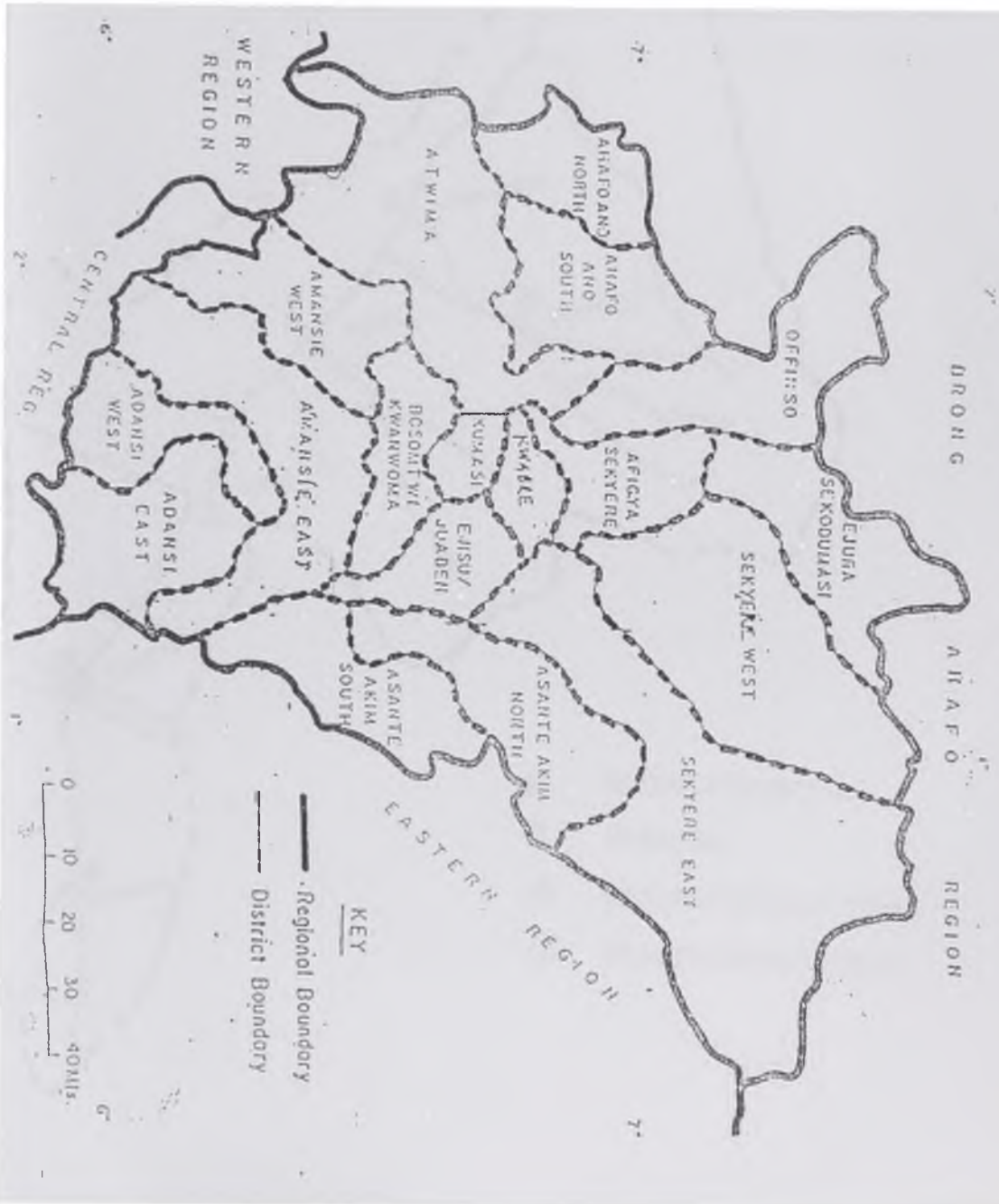
They wanted exemption policy to be maintained and then government to give seed money to start the scheme.

The study concluded that community health insurance is feasible in Agogo Sub district;

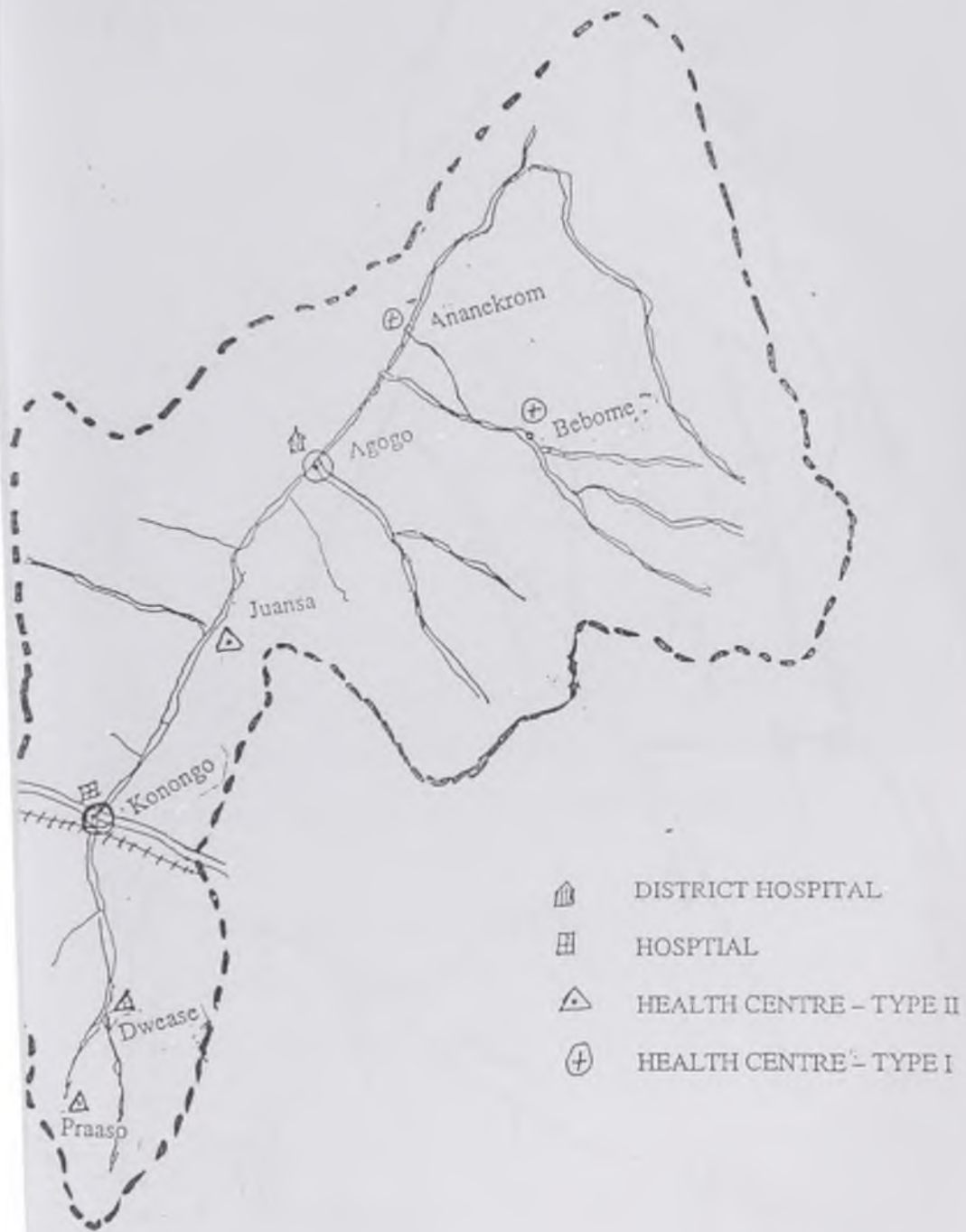
The following recommendations were made following the study

- Both the cash and carry system and Health Insurance should be operated side by side.
- Intensive education on the concept of Health Insurance should be carried out in the Sub-district.
- The scheme should start with OPD Services
- Ananekrom and Bebome health centres should be up graded and
- The Government should continue with the exemption policy and give seed money for the start of the scheme.

MAP OF ASHANTI REGION



MAP OF ASHANTI AKIM NORTH DISTRICT
SHOWING HOSPITALS AND HEALTH CENTRES



CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Health care financing in Ghana has been a problem not only for government, but also for the private health sector as well. Consideration of a National Health Insurance arose out of the difficulties to finance health care both at the national and at individual/household levels.

Health services are still not the best and there exist inequality in the rural and urban areas. Efforts to improve financial access to health would require strategies that provide alternative forms of payment for health care. To address these problems the MOH set up the national health insurance scheme secretariat. The health insurance scheme is being developed in Ghana to, among other things improve the financial accessibility of Ghanaians to modern health care.

The national health insurance scheme is an arrangement through which the citizens of Ghana are to share the cost of their health care to ensure that every citizen stays healthy and is able to afford health care services at the time of sickness.

1.2 DEFINITION OF HEALTH INSURANCE

Health insurance is defined as a method of financing (paying for) Health Services, which involve spreading the risk of incurring healthcare costs over a group of individuals. Individuals who belong to a Health Insurance Plan or Fund contribute money regularly to the fund regardless of whether they are sick or not. This contribution is known as premium. Any time they are sick, money from the fund which they have contributed is

used to take care of their health care costs. Health insurance does not mean that people no longer pay for services. There is nothing in reality such as a 'free service'.

There are several possible options for financing health care or ways in which people pay for health care in any given country. They are classified as:

Government financing from tax revenue

Direct out of pocket payment at the point of service by users

Risk pooling insurance payment mechanism

Social health insurance plans (not for profit)

Mutual health organization type plans (not for profit)

Private for profit health insurance

Personal health accounts and other individualized prepayment schemes that do not involve risk pooling.

1.3 THE PROPOSED GHANA HEALTH INSURANCE SCHEME

According to the MOH Policy Framework for establishing of Health Insurance Scheme (January 2002), the Ghana health insurance scheme will be made up of the following:

Social Health Insurance plan

Mutual Health Organization plan

Commercial Health Insurance plan

Social Health Insurance plan

Social health insurance typically refers to insurance in which contributions are based on ability to pay and access to services depends on need. It is non profit making. The most common basis for contributions to social health insurance plans are the payroll with

contributions from both employer and employee. Government may also make contributions to the fund.

Mutual Health Organization plan

“A Mutual Health Organization is the generic name for an autonomous, not-for-profit organization based on solidarity between members that is democratically accountable to them. Its objective is to improve members’ access to good quality health care through risk sharing based on their own financial contributions. It also aims at improving the lives of members and all citizens and promotes democratic decision making” (Atim C. 2000)

The principles of Mutual Health Organizations are similar to those of Social Health Insurance organizations in several respects. Mutual Health Organization is not for profit organizations, and premiums are usually community rated so that risk is shared across the pool of individuals. However Mutual Health Organizations tend to have a strong community focus and ownership as contrasted to the workplace focus of social health insurance plans.

For our purposes, Mutual Health Organization and Social Health insurance schemes represent a continuum of a kind of insurance plan that is focused on:

- Individuals contributing to the pool according to ability and benefiting according to need.
- The insurance plan being publicly accountable to its members.
- The plan being not for profit.

The major difference would appear to be the traditional focus of social health insurance on those in formal employment as compared with the focus of the Mutual Health

Organization on covering the non-formal sector. It may not prove very equitable in the long run to gather all those in formal employment under the umbrella of the social health insurance plans and leave those in non-formal employment to the Mutual Health Organization. What is encouraged rather is that both kinds of plans make efforts to attract people in formal as well as non-formal employment by providing coverage using geographic based rather than employment based health plans.

Private Health Insurance

Private Health Insurance refers to health insurance that is operated for profit based on market principles. Premiums are based on the calculated risks of particular individuals incurring health care costs. Thus those with higher risks pay more. Commonly the ownership of the health insurance plan resides with a company and shareholders and stocks of the company can be traded on the market just like the stocks of the producers of any other goods and services.

The relationships that bind these partners together and sustain the viability and success of the insurance arrangement are given form and substance through a number of legal and contractual documents

1.3.1 POLICY GOALS AND OBJECTIVE

The vision of Ghana government in instituting a national health insurance health scheme is to assure equitable universal access for all resident of Ghana to an acceptable quality of a package of essential health services without out of pocket payment being required at a point of service use. Health insurance will completely replace out of pocket payment at the point of service use (the cash and carry system) in future.

The long - term policy goal

Every resident of Ghana shall belong to an insurance plan that adequately covers him or her against the need to pay out of pocket at the point of service use to obtain access to a defined package of acceptable quality needed health services.

Medium term policy goal

Within the next 5 to 10 years, at least 50% - 60% of residents of Ghana will belong to a health insurance plan that adequately covers them against the need to pay out pocket at point of service use to obtain access to a defined package of adequate quality needed health services.

Short term policy goal

Within the next five years, the necessary bodies will be created, awareness raising and consensus building carried out, needed legislation passed and the enabling climate developed to ensure the realization of the medium and long –term policy goals of government. At the same time efforts will be made to achieve at least 40% nationwide insurance coverage.

1.4 STUDY AREA

INTRODUCTION: The Ashanti Akim North District is one of the 18 districts in the Ashanti Region. It is made up of 5 Sub-Districts, the largest of which is the Agogo Sub-District. The Agogo Sub-District is situated in the northern part of the District and shares boundaries to the North with Sekyere East District, South with Ashanti Akim South, West with Juansa Sub-District and in the East with Kwahu South District. The Sub-

district is divided into 12 electoral areas with Agogo as the Sub-District capital. It is made up of 64 communities and covers about 650sq.Km. The population of the Sub-District is 40,472 (Projected from 2000 Census) which is 35.6% of the district population.

ETHNIC GROUPS: Majority of the people in the District belong to the Akan tribe. Minority ethnic groups include Ewes, Gas, Sissalas, Nzemas, Dagombas and Kussasis. The predominant language spoken is Twi.

VEGETATION: The vegetation is mainly Tropical Rainforest and Savannah Grassland. Frequent bush fires have destroyed some of the forest vegetation and are threatening to turn the district into grassland. Due to logging activities of the timber industry, legal and illegal, the virgin forest is being depleted.

RAINFALL: There are two main rainy seasons in the sub-district between mid-March and late June and between September and November. The first dry season is from December to February with North Easterly Winds (The harmattan dry winds from the Sahara Desert) and the second and shorter dry season from the end of June until August.

RELIGIONS: The religions in the district include Christianity, Islam and Fetish Priests. Majority of the people are Christians and belong to the Presbyterian Church.

ELECTRICITY AND WATER: Agogo Township and Hwidiem has electricity and pipe borne water. There are 4 hand-dug wells and 15 boreholes, which supply the other communities with water.

TRANSPORTATION AND COMMUNICATION: The main forms of commercial transportation are passenger buses and taxis. Tractors, motorbikes, and bicycles are the main forms of transport in the Afram Plains. A tarred road of about 30km connects

Konongo the district capital to Agogo. The remaining roads are feeder road and tracks created by vehicles. The feeder roads can be found in the Afram Plains. The Afram Plains is virtually inaccessible during the rainy season.

Telephones Services, private and commercial are available at Agogo.

BANKING SERVICES: The Agogo sub-district has 2 Banks, The Ghana Commercial Bank and the Ashanti Akim Rural Bank.

MAIN ECONOMIC ACTIVITIES: The main occupation of the people is farming and fishing. Majority of the people (70%) depend on small-scale farming and fishing with very little disposable income. Crops produced include tomatoes, cassava, plantain, maize, cocoyam, groundnut and yam. Appropriate period for farming during the year is between March and September.

Sand winning, galamsey (small-scale mining) and timber logging are practiced. Commercial farming is practiced on a small scale and crops planted include cocoa and oil palm. Fishing on a small-scale is practiced in the Afram Plains.

TRADITIONAL AUTHORITIES: Traditionally Chiefs and Queen mothers rule the town and villages. The Agogo Traditional Council is made up of the Paramount chief and his divisional chiefs. Hwidiem does not fall under Agogo Traditional Council.

TABLE 1: EDUCATIONAL INSTITUTIONS IN THE SUB DISTRICT

INSTITUTION	NUMBER
NURSE TRAINING COLLEGE	1
TEACHER TRAINING COLLEGE	1
SENIOR SECONDARY SCHOOL	2
JUNIOR SECONDARY SCHOOL	15
PRIMARY SCHOOL	31
KINDERGARTEN	12
DAY CARE CENTER	1

However there is a high drop out rate at secondary school level. Literacy rate is quite low.

SUB DISTRICT HEALTH SYSTEM: The Presbyterian Church adopted the Agogo Sub-district in 1999, they fund 80% of the health activities in the sub-district, and the rest of the funds are from the district health administration in the form of financial encumbrance from the Government of Ghana.

GOVERNMENT HEALTH FACILITIES

LEVEL	FACILITY	LOCATION
C	Agogo Hospital	Agogo
B	Bebome Health Centre	Bebome
B	Ananekrom Health Centre	Ananekrom

PRIVATE HEALTH FACILITIES

Daasebre Clinic

Dr. Frempong Clinic

Ntiamoah's Clinic

MATERNITY HOME

Daasebre Maternity Home – Agogo

Nyamebikyere Maternity Home-Hwidien

AGOGO HOSPITAL: Agogo hospital has infrastructure for 250 beds. This admission facility caters for medical, paediatrics, surgical, ophthalmologic, gynaecological and obstetrics cases. In all there are 300 staff working at the Agogo Presbyterian Hospital. Other facilities include the out patient department that houses the laboratory, consulting rooms and records departments. The other infrastructures are administrative block, guesthouse, eye and chest clinics, two theatres and recovery wards. Others are a meeting hall and a hostel for mothers whose children are on admission. Residential accommodation is available on the hospital premises for senior staff. Junior health workers are accommodated in housing units just outside the hospital. It has a newly constructed mortuary. An emergency room is sited in one of the blocks containing wards.

BEBOME AND ANANEKROM HEALTH CENTERS: These are small health centers with single block structures, Facilities for consulting rooms, maternity units, dispensaries, lying in wards and RCH office. There is a residential accommodation for the head of the Health Centre. The centers under take the treatment of minor ailments and mainly OPD cases.

AUXILIARY FACILITY: There are five village Health committees and five drug-stores.

UNORTHODOX HEALTH PROVIDERS: There are herbalists and spiritualists in the sub-district who also provide healthcare. They have not been organized into an association. They address Conditions like ulcers, pregnancy-related diseases, boils, breast abscesses and mental disorders..

BUDGET AND FINANCE: Finance for health activities in Government health institutions come from three sources. They are the financial encumbrances (FE) i.e. GOG funds, NGO funds, and internally generated funds of health institutions.

Budgets for various activities are prepared, as part of operational plan for the subsequent year. The budget is prepared for Fe's (District and Sub-Districts) and internally generated funds of Government health institutions.

Agogo Hospital depends on internally generated funds and NGO funds, which are budgeted for and spent as such.

PUBLIC HEALTH INTERVENTIONS: Public health interventions, which take place at are promotion of iodated salt, exclusive breastfeeding, immunization and health education..

COMMUNITY INVOLVEMENT: There are 5 functioning Village Health Committees in the Sub district. Each Village Health Committee is made up of 7 persons selected by the community. The sub district team members trained them all. The sub-district monitors the activities of the Village Health Committees by visiting the

communities on a quarterly basis. Outcomes of the visits are reported in the minutes of sub district monthly meetings to the DHMT.

NGO's CONTRIBUTING TO SUB DISTRICT HEALTH PROGRAMME

Netherlands Reformed Church – funds for miscellaneous activities. E.g. Buruli Ulcer.

Swiss Red Cross – provided funds for building for, Ananekrom and Bebome health centres. They also provided 4 wheel drive pick-ups and 12 motorbikes.

Danida

1.5 PROBLEM STATEMENT

The burden of ensuring the good health status of a nation's citizens especially in the developing countries can no longer be shouldered by the government even with the most efficient use of available scarce government resources. Following the introduction of the cash and carry system, in the Ghana health sector in the late 1980's many patients began to experience difficulties in paying for their health care (especially admission) cost. As a result, many do not go to the hospital until it was too late or their illness had advance to a more complicated phase (Atim et al, 2000). Many absconded without paying for their treatment. Many individuals with low economic status could not afford to pay for their health cares (Dery Lucio, 1999)

Most of the people in the catchment area of Agogo hospital are subsistence farmers with very little disposable income. They can therefore hardly afford the cost of medical care. Many people who seek medical care are unable to pay for the services provided and are declared poor and sick by the hospital, in which case the cost of their treatment is borne by the hospital (Agogo Hospital Annual Report, 2001). It is estimated that for every

patient is declared poor and sick, there are two or more sick persons at home who are not able to access health care due to unavailability of money at the time of illness.

Attempts to solve the problem have included the following:

Creation of a Poor and Sick Fund: Under this fund The Presbyterian Church provides health care to all manner of persons irrespective of ability to pay for health services. In the year 2000, the Hospital absorbed a total bill of 52,657,200.00 cedis in respect of 100 patients declared poor and sick. Additionally, bills approximating 12 million cedis in respect of absconders were absorbed.

Government's Exemption Policy for the aged above 70 years, pregnant women and children under five as well as Buruli ulcer and other exempted patients. For the period January-September, 2001, a total amount of 88,497,650.00 cedis was spent on these exempted cases.

Despite all these efforts, a good many people are still unable to access health care on account of poverty and must be provided for without overburdening the hospital. Community financing scheme is known to improve access to health care, however this is new to Agogo Sub district. Therefore **the following research questions** need to be answered:

What do they know about health insurance?

What means can information reach community members?

Are they willing to join such a scheme?

What should be the mode and time of paying premium?

These questions must be answered in order to put in place, a scheme that will provide for the people of Agogo Sub district, an increased financial access to health care in order to reduce preventable morbidity and mortality

Since community health care financing scheme is something new to the sub district, there is a need to do a baseline exploratory study to find out their knowledge and attitude towards community health financing scheme as a stepping stone for finding ways and means of making health care accessible to the people of the sub district.

1.6 AIM OF THE STUDY

The study aims at generating baseline information on the knowledge and attitude of the people of Agogo Sub district on mutual health care financing. The data can be used for further research into how mutual health care financing scheme can be started in the Sub district.

1.7 RATIONALE FOR THE RESEARCH STUDY

In finding ways for making health care financially accessible to the people of Agogo Sub-district, there is the need to carry out this study to generate the necessary baseline information. This information will help the scheme planners to come out with a scheme that is sustainable and acceptable to join people of the sub-district.

Furthermore, no such study has been done in the district. The annual report of the Presbyterian Hospital confirms that many people do not seek health care just because they cannot to pay for the services all the time and the church through the poor and needy fund, the exemption package has absorbed millions of cedis.

Currently, community-financing scheme are being practiced in some parts of the country with varying degrees of success so why not in Agogo Sub District.

1.8 STUDY OBJECTIVES

1.8.1 General Objective

To determine knowledge and attitude of the people of Agogo Sub-District to community health financing.

1.8.2 Specific Objectives

- To determine the level of awareness of health insurance among the people of Agogo Sub-District.
- To determine their willingness to participate in the scheme.
- To determine their perception on the scope of services that the scheme should cover.
- To determine the willingness of the services provider to provide services under the scheme.
- To determine ways through which information can reach community members

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 RURAL HEALTH INSURANCE SCHEMES

In developing countries that have health insurance arrangements, community-based health insurance schemes are less common than formal social security systems. In 1982, a review of 100 community-financing schemes throughout the developing world found that 31 involved some form of prepayment. The organization of some of these schemes depended on the production and sale of primary products such as coffee and rice. In Africa many existing and planned community financing schemes combined prepayment with a fee at the time of receiving the service.

It is only within the last 10 years that a number of African countries have experimented with rural health insurance schemes that cater for rural communities; these countries include Burundi, Guinea Bissau, Ghana and Zaire. The schemes they have adopted have taken a variety of forms. In some cases benefits are provided at a central facility, such as a district hospital, or at scattered lower level facilities, such as health centers and health posts. In other schemes the benefits consist of comprehensive care at all levels of the health system. The administration of these schemes is also varied; some are managed by central government organization together with local officials, while others have been implemented solely by autonomous community solidarity groups.

Three examples, a) La Carte D'Assurance Maladie (CAM) in Burundi, b) the hospital health insurance in Nkoranza District Ghana and c) the Abota village insurance scheme

in Guinea Bissau, illustrate the diversity of the benefits and administration arrangements.

The main features of these schemes are summarized below

a) Carte d'Assurance Maladie (CAM)

This is a national health card insurance scheme introduced by the government of Burundi in 1984. Purchase of a CAM card by a household entitles its members (restricted to two adults and children below 18 years of age) to free health care at all public health facilities. The card is sold at a fixed price irrespective of the household size (in June 1992, the price of the card was 500 Fbu (1.85 US \$)). Persons without cards are required to pay user charges for government health care. All health services provided by the government are covered by the CAM scheme and therefore, in theory, CAM card holders who seek health care at government facilities should not incur out of pocket expenses. However, due to the shortage of drugs and other inputs, CAM holders, like fee-paying patients, are sometimes given prescriptions to purchase drugs on the market.

The names of household members entitled to use a card are written on the card at the time of purchase, making it difficult for it to be used by individuals from other households. The card is valid for one year and may be purchased from a community representative at any time of the year. This makes it possible for non-CAM patient to pay a user card at a health centre and, on referral to a hospital, to purchase a CAM card in order to obtain free hospital care. The cards are not accepted by non-government health facilities, such as mission and for-profit clinics and hospitals.

The revenues from CAM card sales and user charges are retained by the "commune" committees (the "commune" is lowest level of local administration in the country). These committees have some financial responsibilities for the health centres in their localities

and are expected to fund recurrent expenditures, such as stationary, fuel for refrigerators and linen, and in some cases capital projects, such as construction of new health centres. However, revenues from CAM and user charges are not designated to be used in the provision of health. In 1990, 8% of the revenues of communes in Muyinga Province came from the sale of CAM cards, whereas an average of only 1% of commune revenues was used to finance health care. Health worker salaries and drugs costs are funded by the government through the Ministry of Health's budget.

b) Nkoranza Health Insurance Scheme:

The scheme started in 1992 to cover the cost of inpatient care at St Theresa hospital Nkoranza District in Ghana. The benefits are full costs of admission in the medical, surgical and maternity wards. Admissions for normal deliveries are excluded. Insured persons who are referred to other health institutions may claim refunds equal to the cost of an average admission at Nkoranza. The scheme is available only to families living in the Nkoranza district and all members of a family must register. The premiums are calculated per person and so vary with the size of the family. Registration is renewable annually, during the last two month of the year only.

The scheme is administrated by a three-tier structure made up of The Insurance Management Team (IMT) in the hospital, Insurance Advisory Board and Zonal coordinators.

A District Insurance Coordinator, who is a salaried officer and a member of IMT and the Insurance Advisory Board, is responsible for coordinating registration at the district level, evaluating record sheets and accounts, and coordinating refunds, zonal coordinators and field workers.

c)The Abota Village Insurance Scheme:

The Abota system entails prepayment for essential drugs and the provision of primary health care at the village level by the community. The system comprises many hundreds of autonomous Abota schemes at village level. Health care is provided voluntarily by members of the village, village health workers known as Agents de Saude De Base, and by birth attendants at the village health posts (Unidad De Saude de Base, USB). The USBs were constructed from local building materials by the villagers and furnished with basic equipment (such as metal storage cupboard, obstetric stethoscope, lantern and a kit of teaching aids) by the Ministry of Health. Administration of the Abota system in each village is the responsibility of the village committee, the lowest level of the country's decentralized political system.

The earliest Abota schemes began in 1980 in a few villages as part of a general village health care programme. Villages in the programme adopted and modified an indigenous payment mechanism, originally used to collectively finance ceremonies, in order to fund inputs for primary health care. Chabot et al (1991) describe the process of trial and error used by these villages over a three to four year period to determine the frequency and level of prepayments that would ensure the availability of drugs throughout the year.

The Abota system is now widespread, totaling 462 villages in 1991, and is an integral part of the country's health system. Since 1983, patients referred by village health workers to the public health facilities have been exempt from payment of consultation fees on showing evidence, usually a receipt, of having

contributed to Abota. Furthermore the Government of Guinea Bissau's ten year health plan (1984-1993) emphasized the role of village-based primary health care, thus making the efficient functioning of the Abota system critical to the country's health strategy.

The Abota revenue is used to purchase essential drugs and bandages from nearby government health centres or sectoral hospitals. The ultimate supplier is the Central Medical Store situated in the capital. In each village, the village committee decides the procedures for collecting contributions, purchasing drugs and overall monitoring of the system. As a consequence of this autonomy, prepayment terms vary substantially from one village to the other. In 1988 the annual contributions per adult male varied from P.G. 20-500, in 2 of 18 villages surveyed by Eklund and Stavem only men paid and in another two villages contributions were on a household basis. Other villages accepted kind contributions of agricultural produce.

d) Fandene MHO, Thies, Senegal

The Fandene system in Thies, Senegal has the following key features;

The scheme covers a population of 250,000 people, mainly Christians and of Sereer ethnic group. It is served by a Catholic hospital and a regional public hospital. The MHO serves 2500 people. The executive committee is made up of educated people living in villages as farmers or running other local enterprises. Services offered are only hospital admission and emergency evacuation (surgery excluded). Hospital agreed to offer 50% reduction on prices to MHO members including services not covered by MHO. Dues charged were 700 cedis per person per month for all family members. MHO pays

patient's entire bill to hospital, and then recovers member's portion afterwards directly from member.

e) The Bokoro Insurance Plan, Zaire

The Bokoro Insurance Plan in Zaire where the provider is Bokoro rural health zone. The scheme started because of the following:

1. Financial accessibility to health care too limited for majority of the population.
2. A referral to hospital was a severe financial burden and
3. Revenues were not able to cover most recurrent cost.

Premium is based on utilization rate, average length of episode of illness and the quality of drugs and materials consume. Only employees enrolled. The employer pays premium for employed person and their dependant. Benefits cover only out patient care. The scheme covers ambulatory curative care episode of illness at St. Alphonse health centre. The plan entitled members to pay a fixed fee for each episode of illness up to five days. Enrollment is voluntary and it's open to residence in the catchment area of the health centre. The insurance plan is offered directly by the provider. Membership cards are issued and verification is done by comparing with personal national ID card.

2.2 OPERATIONAL DEFINITION OF TERMS

For the purpose of this study, the following terms are defined:

Knowledge of Health Insurance: Having heard of Health Insurance and explaining with any key words like contribution of money or farm products, risk-sharing, not for free, regular contribution whether sick or not and no upfront payment at point of service.

Rising cost of Health Service: The fact that cost for the same services keeps increasing at different time of the year.

Perceived Benefit: What one expects to get from the scheme.

Premium: Money dues to be paid.

Mode of payment: Whether contribution should be cash or products like cocoa etc.

Health Care Services: treatment obtained.

Awareness campaign: any campaign on Health Insurance

Physical disabled: A disabled person not working.

Scope of Services: services that will be offered under the scheme.

Age – Last completed birthday

Ethnicity - People of the same race and speak the same language

Number of children: Children that one is caring for.

Language spoken: Base on ethnicity

Occupation: main source of income

Educational background: Highest Level of education achieved.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

The study was exploratory in nature, using qualitative methods in collecting data

The study was conducted in Agogo Sub district. Six communities (Agogo, Bebome, Hwidiem, Ananekrom, Magyeda, and Pataban) were chosen for the study.

3.2 Sampling

The scheme will be hospital based and services will be rendered from Agogo hospital mainly, with Ananekrom and Bebome health centers acting as supporting centers. Agogo, Ananekrom and Bebome communities were purposively selected for the study. The other three communities (Magyeda, Pataban and Hwidiem) were randomly selected using the lottery system. All the remaining communities were listed and placed in a bowl. Three communities were randomly selected.

3.3 Study Population

Data was collected at both District and community level.

At the district level, key informant interviews were carried with the DCD and the DDHS.

At the community level key informant interviews were carried out with the GM, the SMO in charge and the PHC coordinator of Agogo Presbyterian hospital, and the Midwife in charge of Bebome health center. The Midwife in charge of Ananekrom health center could not be interviewed as she was on leave. In depth interviews were carried out with opinion leaders and the FGD with the community members.

In all eighty four respondents and participants were interviewed of the eighty five target set, representing 99.0% success.

Both females and males subject, were selected from different social, educational, and economic background for the focus group discussions and the in depth interviews.

SUMMARY

- Agogo Sub district selected as the study Sub district
- Six communities were selected as study areas
Agogo, Bebome, Hwidiem, Ananekrom, Magyeda, and Pataban
- Six FGD sessions were held
Agogo-2, and 1- each in Hwidiem, Ananekrom, Magyeda and Pataban.
- Six Key informant interviews were held
DCD, DDHS, GM, the SMO in charge, PHC coordinator, and a Midwife in charge.
- Six In depth interviews were held
Three Chiefs, Two Queen mothers, and one unit committee chairman.

3.4 Data collection techniques

- **Structured questionnaire** was used to collect socio-demographic background information on the participants of focus group discussion and the in-depth interviews.
- **Focus group discussion guide** was used to collect information on the knowledge and awareness of health insurance, willingness to participate, mode and time of payment, and the scope of services that the scheme should cover.

- **In-depth interview guide** was administered to six opinion leaders, DDHS, GM and SMO in charge of Agogo Hospital and the Midwife in charge of Bebome health center to find their knowledge and commitment to starting the scheme.

3.5 Data collection tools

- The data collecting tools were Structured and non-structured questionnaires, stationery, Record Cassette player, Dry cell batteries and Blank audio cassette.

4.6 Pre-testing and training

The researcher, who is the principal investigator trained 4 research assistants in community entry skills, how to recruit participants, the interpretation of questionnaire into the local language, how to conduct an FGD, how to record and transcribe interviews, and assurance of confidentiality of respondent. Pre-testing was done in Nyamebkyere community which was not selected for the study.

4.7 Ethical consideration

The Regional health administration, The Agogo traditional council, the District coordinating director, the DDHS, and the GM of Agogo Presbyterian were informed of the study.

Verbal consent was sought from the chiefs, the community leaders, and the participants of the chosen communities after the objectives and purpose of the study were clearly discussed with them. The participants had the right to opt out of the study.

4.8 Data Collection

Collection of data was done by the principal investigator and the research assistants.

The PI conducted all the interviews. Data collection took one month. The research team

was made up of 1 Public health nurse, 1 Environmental officer, 1 Senior disease control officer, and 1 field technician.

For the data collection, FGD guide, in depth interview guide, semi structure questionnaire and a tape record were used.

The data collecting tools were tested in Nyamebekyere community. The necessary modifications were made before being administered in the study community.

All the interviews were recorded by the note taker and also by using the tape recorder.

All the FGD's were done in Twi except one that was done in English. All the key informant interviews were done in English and all the in depth interviews were done in Twi. All the Twi interviews were translated into English and transcribed with the help of the note taker. The English interviews were also transcribed. At the end of each interview or discussion, the tapes were played and transcribed together with the notes to prepare a report.

3.9 DATA PROCESSING AND ANALYSIS

The FGDs, the in depth, and the key informant interviews were analyzed manually while the background characteristics of the participants were analyzed using Epi 6 info.

3.10 LIMITATIONS

Due to the rains and the poor road network, most of the communities in the Afram plains were not included in the sampling, as it would be impossible to reach those communities should they have been picked.

Bebome community was chosen for the study but the research team could not go there as the river we had to cross had over flown its banks. The midwife was carried across to come for her interview.

3.10 VARIABLES**TABLE 2: The Variables, their indicators and the data collecting tool**

VARIABLES	INDICATOR	DATA COLLECTING TOOL
Knowledge about health Insurance	Type of insurance Risk sharing Regular contribution Not free	FGD/IDI
Source of information	Mass media Churches Gong-gong	FGD/IDI
Willingness to participate	Willing to join Not willing to join	FGD/IDI
Scope of services	All services OPD services Admissions only	FGD/IDI
Motivation to service providers	Increase salary Better Accommodation Transportation	FGD/IDI

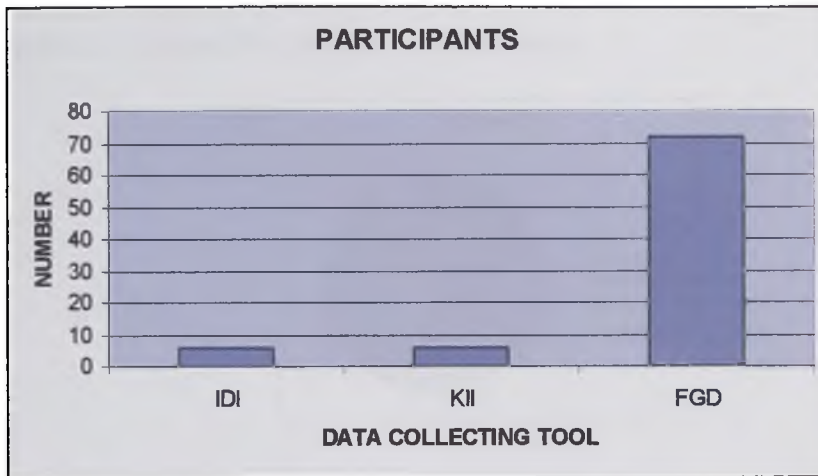
CHAPTER FOUR

4.0 RESULTS AND ANALYSIS

4.1 BASIC CHARACTERISTICS OF PARTICIPANTS

In all 83 participants took part in the study as shown below

FIGURE 1: DISTRIBUTION OF PARTICIPANTS



For the FGD, out of the 72 invited, 71 participants reported representing 98.8%. The distribution is as shown

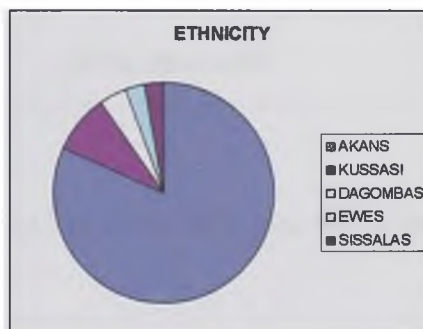
TABLE 3: DISTRIBUTION OF FGD PARTICIPANTS

COMMUNITY	NUMBER
AGOGO 1&2	23
ANANEKROM	12
HWIDIEM	12
MAGYEIDA	12
PATABAN	12

One person from Agogo failed to turn up as promised. There were two FGDs in Agogo because the weather and the terrain did not allow the research team to go to Bebome. Of the 71 participants 53 (74.6%) were males and 18 (25.4%) were females. This goes to show that whenever matters are to be discussed it is the men that are called. Although we told them that at least 40% of the participants should be females.

The participants were aged between 22 years and 85 years. Majority of them 23 (32.4%) are between 30 years and 39 years.

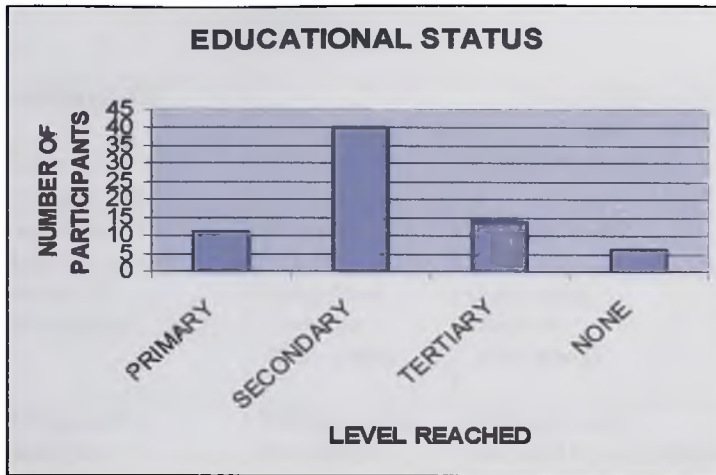
FIGURE 2: ETHNICITY OF FGD PARTICIPANTS



Ethnically 58 (81.7%) were Akans, the dominant ethnic group. The language spoken also followed the same pattern as the ethnicity, however all except one were conducted in Twi as all the participants could speak that language. The only discussion not conducted in Twi was done in English and it was at Agogo.

60 (84.5%) of the participants were married, 6 (8.5%) were not married, 4 (4.2%) were divorced, and 2 (2.8%) were widowers. Out of the participants 3(4.2%) had no children, while 2 (2.8%) had 17 children each. Majority of them 11 (15.5%) had 6 children each.

FIGURE 3: EDUCATIONAL STATUS OF FGD PARTICIPANTS



Most of the people in the Sub district stop schooling at the secondary level to start farming or learn a trade.

34 (47.9%) of the participants are engaged in farming and fishing, 22 (31%) are engaged in trading, dressmaking, hairdressing, 13 (18.3%) were civil servants, 1 pastor and 1 lotto operator.

Out of the participants 57 (80%) are Christians, 6 (8.5%) are Moslems and 8 (11.3%) are Traditionalist. The overall number of the Moslems in the sub district is more than the traditionalist but the higher percentage here is due to the sampling.

There were six key informants interviewed. They are DCD, GM, DDHS, PHC, MS, and BM. They are all Akans, Christians and are married with children. They have studied at the tertiary level.

Seven opinion leaders were interviewed. They are all Akans.

TABLE 4: SUMMARY OF RESULTS

VARIABLES	PARTICIPANTS		
	FGD	IDI	KII
Views about cash and carry system	Should be abolished	Should be abolished	Should be maintained
Knowledge about health Insurance	Very low	Knowledgeable	Very knowledgeable
Source of information	Gong-gong Churches Mass media	Gong-gong Churches Mass media	Mass Media (80%) Churches Gong-gong
Willingness to participate	Willing to join But need to understand and should be affordability	Willing to join But need to understand and should be affordability	Willing to join But need to understand and should be affordability
Mode and time of payment	Cash Annually	Cash Annually	Cash Annually
Scope of services	All services	All services	OPD services Admissions only
Motivation to service providers	Increase salary Better accommodation Transportation	Increase salary Better accommodation Transportation	Increase salary Better accommodation Further studies

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RESULT OF THE COMMUNITY FGD'S

VIEWS ABOUT CASH AND CARRY

When asked about their views on the cash and carry system, the participants said the system is not good. They said health had been free and there was no need to borrow money before going to seek health services. People who do not have money are left to die. People live longer in the olden days because they easily go to hospital. Participants

came out to say that cash and carry is not good because many people lost their lives under that system. A cocoa farmer at Pataban said

- *Cash and carry system is not good as our grandfathers enjoy free treatment and they live longer but because you have to pay and you do not have the money we are dying.*

And a trader in Hwidiem had this to say

- *Cash and Carry is not good because many people die under that system as people do not have money always on them to go to hospital.*

But one person said cash and carry is good because you only pay for services only when you are sick. A teacher in Magyeda said

- *Cash and carry is good in some way and bad in some ways. In the good ways it is only when you are sick that you pay not like the insurance even if you are not sick you have to pay and it is bad because you need to have money before you can go to the hospital.*

VIEWS ABOUT RISING COST OF HEALTH SERVICE

They saw rising cost of health services as normal. Drugs are imported which is tied to foreign money, if the rate goes up then prices will go up. A health worker at Agogo said

- *It all depends on the way the cedis is going up, when we import our drugs we used foreign money so when the changing rate goes up then prices will also go up.*

KNOWLEDGE OF HEALTH INSURANCE

When questioned about health insurance, majority of respondent do not know about Health Insurance and wanted us to explain it to them at the end of the interview. A market woman at Ananekrom said

- *It is only today that I am hearing about health insurance so try and explain it to us before you go.*

And a farmer at Pataban said

- *I have not even heard about Health Insurance before.*

Some had heard about it but do not understand it. A trader at Hwidiem said

- *I have heard about Health Insurance but I do not understand.*

A few could however explain as by a teacher at Agogo who said

- *Health insurance is contribution you make by paying small money to the organization so that when your children and your wife including yourself are sick can go to the hospital.*

An assemblyman at Magyeda explained Health Insurance as

- *Something you use to protect your health whenever you are sick. Pay something now then you can enjoy later, whenever you join the health insurance you do not have to pay any money when you go to the hospital.*

However in the two FGD held in Agogo majority of them understood the term health insurance as Banker explained Health Insurance as

- *An advance contribution towards our health services care in terms of money, contributions in a group where one takes advantage of the other that is when one in the group gets sick he can get services for free and your family also can get free.*

SOURCE OF INFORMATION

They heard about health insurance from Nkoranza, radio (F.M station mainly Fox fm). Their source of information is through the F.M station, announcement van, and churches, beating of the gong- gong by the elders and through community volunteers. A farmer at Hwidiem said information should spread

- *Through the chief linguist by the beating of gong-gong.*

And a driver from Agogo said

- *I think the public van goes around every morning, the news papers, and the FM stations.*

PERCEIVED BENEFITS

They think Health Insurance will be helpful because it will remove upfront payment, the poor can go to hospital anytime, and it will eliminate bribes at the hospital as you do not have to pay money to anyone. A farmer from Magyeda said

- *It will help because here we are farmers and are exposing too many risks. I remember when a member of this community got sick; we all had to contribute small money before they could send him to the hospital so it will be very helpful when it comes.*

Another farmer from Agogo said

- *Health insurance will help us because we are farmers and we do not always have money so when we get sick and we are members of the health insurance we can go to hospital free.*

WILLINGNESS TO JOIN THE SCHEME

The participants said majority of the people in the community will be willing to join because they can go to hospital whenever they are sick. However they need to understand the policy very well and it will also depend on the premium being charged – if it is affordable. A teacher from Agogo said

- *Yes, I think they will join very well but people will have to be made to understand the health insurance well.*

However an assembly man from Magyeda said

- *I do not think everybody will join because many here do not understand the scheme and not everybody here can afford to contribute.*

People will be willing to join but some may like to wait and see what happens as it is a new scheme. A trader from Agogo said

- *Since it is something new here some people will wait and see if others are benefiting before they join, may be they will take your money and run away.*

PREMIUM DETERMINATION, MODE AND TIME OF PAYMENT

They said the premium should be charged individually. All above 18years and below 18 but married should pay and those below 18years should be paid for by their parents. The family head should be responsible to pay for all family members. A farmer from Anankrom said

- *I think single person should be given a particular amount to pay. I think the head of the family should take care of the family but any body above 18 years should be insured by himself but those below 18 years should be cater by their parents.*

The mode of payment all agreed should be cash. A trader from Hwidiem said

- *I beg, please collect money even if the person is a farmer he should go and sell his tomatoes or cocoa and bring the money.*

But at Magyeda they thought to get the poor farmers to join products like cocoa, maize, plantain should to be accepted. A farmer said

- *For the poor farmers to join please collect cocoa, maize, and tomatoes. It will be easier for us to get these things.*

Depending on one's occupation, the payment should be monthly, annually and best at the time of harvest of major crops. A teacher from Anankrom said

- *The cocoa farmers should pay yearly but the other workers should pay monthly.*

There should be an office in town, or at Omanhene's palace or even at the hospital where monies can be paid, or trusted people should come at appointed time to collect money. A health worker from Agogo said

- *I think an office should be set up in town and there should be a kind of company managing it for the few people, but the location I am not very sure whether within the hospital or the Omanhene's palace.*

EXEMPTION POLICY

In all FGD conducted it came out Government should continue with the exception policy.

A Market woman at Hwidiem said the

- *The exemption policy is good and the government should continue with it.*

COMMON ILLNESS AND SCOPE OF SERVICES

The common illness in the Sub district is malaria. However, they think the scheme should cover all illness. A chemical storeowner said

- *I think everybody may have different illness so I think since everybody is contributing it should cover all the illness.*

SERVICE PROVIDERS

The community members seek health services at Agogo hospital except those at Ananekrom and Bebome. Some agreed that the services are good but the charges are expensive. A farmer at Hwidiem said

- *Their service is very fantastic*

But a teacher at Pataban had this to say.

- *The services at Agogo hospital are good but the charges are too expensive because whenever you go, you have to pay money.*

However some thought the nurses are not caring, do not have patience, shout at their elders at times, sometimes collect monies without issuing receipt and after 2.00pm they charge emergency fees. A farmer at Magyeda said

- *Another bad thing is that after two o'clock they will charge something called emergency fee, which is not good.*

A Hairdresser at Hwidiem had this to say about the nurses.

- *The nurses do not have patience at all when they call you and you do not respond the next time they call you, they will shout on you but they should know that we are sick that is why we are there, the doctors are good.*

To provide better services they say service provider's salary should be increased, be given better accommodation, and should go for in service training. The hospital should get ultrasound and more laboratory equipment. Some thought the staff strength is enough while others felt, the number of doctors; nurse and paramedics should be increased.

A teacher at Pataban said

- *There should be more diagnostic machines to help the doctors to diagnose better and give treatment better and we need more doctors. Increase the salary of the staff.*

At Ananekrom, the center should be given better salary, ambulance to transport patients, motorbike for Health Centre staff and more staff to make the work easier. An assemblyman at Ananekrom said

- *Ambulance should be provided to the center to help transport emergency cases to Agogo and more staff should be brought to the health center.*

There should be legislative law backing Health Insurance so that subsequent government can not change it. It should be made compulsory and those who do not take part should be taken to court. The Hwidiem Hema said

- *There should be a legislative instrument backing this insurance that is parliament any approval so that if there is a change of government the Health Insurance Scheme should be maintained.*

RESULTS OF OPINION LEADERS

VIEWS ON CASH AND CARRY

All the opinion leaders view the cash and carry system to be bad because people suffered under that system as people do not have money on them always, and it is not easy to find money to borrow in the community. If you are lucky to be seen to, your relatives have to go and look for money to pay your bills otherwise you will be detained at the hospital. Removing cash and carry help them and this was made clear by the Agogo Hema who said

- *Cash and carry is not good because most of us do not have money and when you go to hospital you do not know how much they are going to charge you if it is big you have to leave your child and go and look for money. It is not easy to get money because of that sometimes we do not go to hospital.*

VIEWS ABOUT RISING COST OF HEALTH SERVICE

The respondents felt that the rising cost of health services in general is in line, with the rising cost of living in the country. The Unit Committee Chairman said

- *These days' prices are going up and it is not the fault of anybody and most of the things we use in the country are imported including drugs.*

KNOWLEDGE OF HEALTH INSURANCE

They all understand health insurance. Nana Kontihene of Agogo explained it as

- *Health Insurance is for your own health let's say, when you pay money as contribution and later when you are sick you can benefit from the contribution.*
- *Pay with money now that one is not sick and in future go to hospital and enjoy free medical care. Contribute for free care. (The Pataban Chief explained)*

SOURCE OF INFORMATION

Their source of information is similar to the FGD participants but includes the following places like what The Kontihene of Hwidiem said

- *I heard it on FM station and Otumfuos' palace.*

The means by which information can reach them is through the beating of gong-gong, the fm stations, in Agogo there is a public van that goes around making announcements and through the church leaders. The Hema of Agogo said

- *Information can reach everybody, through Nana. Nana has a lot of elders and people who work for him so they can send message to all part of the district, where gong-gong will be beaten and people will be gathered and listen to Nana's message or messenger.*

PERCEIVED BENEFIT

They perceive health insurance will benefit the people and will be very helpful as they can go hospital anytime, in case of emergency they can readily go to hospital. The number of people who die in the community will reduce. The Hema of Agogo said

- *Health Insurance will be helpful because we are poor people and we do not have money to always pay so when the cash and carry is removed we can go to hospital to seek treatment.*

WILLINGNESS TO JOIN THE SCHEME

The community member will be willing to join as it is a good policy and it will improve access, but they need to let the people understand the scheme. However some will wait and see if it is good.

The Unit Committee Chairman said

- *In the initial stages I know all workers will not join but as time goes on and the community sees that it is good, I am sure all the people including the farmers will join and if they understand. We have to educate the elders who will then pass the message onto the farmers because most of the farmers have not been to school, so they will wait to let certain people start and if they see the benefit they will all join.*

PREMIUM DETERMINATION MODE AND TIME OF PAYMENT

They all agreed that to the views expressed by the FGD participants. The Hema of Hwidiem said

- *The head of the family should pay for the rest and the children above 18 years should pay for themselves. If you are less than 18 years and you have a baby pay yourself.*

All payments should be in cash and the time of payment should be base on one's occupation. The payment should be made monthly, quarterly and annually. If one default for three months, he is no longer a member of the scheme. The Chief Pataban said

- *The mode of payment should be cash and the farmers should pay annually especially cocoa farmers should pay annually but tomato farmers and maize farmers should pay monthly.*

EXEMPTION POLICY

All agreed that the exemption policy must continue. The Hema of Hwidiem said

- *Government should take care of the under five and old age pay so they should not contribute under the scheme.*

COMMON ILLNESS AND SCOPE OF SERVICES

The commonest illness was Malaria but they want the scheme to cover all illness and the chief of Pataban made this clear.

- *Since I have paid my insurance it should cover all disease. I cannot God to predict what will happen tomorrow so it should cover all illness.*

SERVICE PROVIDERS

They all go to Agogo hospital for health care and they think the service there are very good but expensive as The Chief of Pataban Community said

- *The services are very good but the charges are much for us.*

The service providers should have their salaries increase, good housing and better transportation to take them to and from work. Nana kontihene of Agogo said

- *The workers should have bus that will transport them to and from their house to work this will motivate them. Increasing salary without improvement in working conditions like housing and transportation will lead to nothing.*

They said the hospital would need ultrasound, more doctors and nurses, ENT specialist and chest machines.

RESULTS OF KEY INFORMANTS INTERVIEWS

VIEWS ON CASH AND CARRY

The key informants interviewed had a different view. All said cash and carry system has both advantages and disadvantages. The advantage is that cost recovery is excellent,

drugs are always available, and those with money are getting the best of services but the bad side is that one has to pay before being seen and those who did not have money on them at the of illness was denied health care. The General Manager explained that

- *In fact it has both good and bad sides. The good side is that it helps the institution to recover its cost and with the cash and carry at least we are able to recover. Drug account is going up and we are able to buy enough drug to store the hospital for three months so since the cash and carry started we have never run short of drugs and other medical items and the bad side is that in terms of the patients ability to pay for the services is a problem.*

VIEW ABOUT RISING COST OF HEALTH SERVICE

They also agreed with the other participant that rising cost of health service is due to inflation and the importation of the drug we use, which is also tied to the dollar, so as the dollar goes up then the prices will go up. The District Coordinating Director said

- *The rising cost of health is in line with the rising price since we import most of the drugs and the cost of living goes up then naturally the prices have to go up.*

UNDERSTANDING OF HEALTH INSURANCE

All were able to explain health insurance with keywords, like pooling of resources, cost sharing, risk taking, regular contributing, and enjoying medical care throughout the period they are members. The Primary Health Care Coordinator said

- *Health Insurance to me personally is a process where people contribute money and when they are sick they use part of the money to that care of themselves. People contribute to their health needs whether sick or not sick.*

SOURCE OF INFORMATION

The source of their information is as the other participants except that, they have attended seminar, workshops, and conferences. They say information can reach people through the mass media (especially the FM radio station), gong-gong beating, and health volunteers and through the church elders. The District Coordinating Director said

- *The source of information in this district differ from where you are so it is a combination depending upon where you are, in Konongo area for example is effective through the media especially the FM radio but in the communities and the Plains it is effective when you send letters to the elders, chief, assembly man where they will beat gong-gong for public gathering and sending message to the grass root.)*

PERCEIVED BENEFITS

They all agreed that it would be helpful and beneficial to community members, as it will easily increase access to health. People can seek care promptly thus avoiding complications like death. Health insurance will improve their quality of life. This will enable them to work harder and that will also lead to improvement in their community.

The Behome Midwife said

- *It will be very helpful to the community because they can easily access health care when they are sick so they can work harder to develop their community and themselves.*

WILLINGNESS TO JOIN THE SCHEME

They feel many people will be willing to join the scheme but a few may adopt lets wait and see attitude. The second year will have an increase in membership. The District Coordinating Director said

- *Definitely the people in the sub district will be willing to join, I am very sure about that although we have not created any awareness campaign in the district when we talk to the assembly men and the unit committee the signs are good and the people are waiting for the scheme to come so that they will join. These people are the representatives of the people and they express their views.*

PREMIUM DETERMINATION, MODE AND TIME OF PAYMENT

They also said premium should be determined individually. Each person must pay a fixed rate. The District Director of Health Service said

- *Each one in the family should pay a fixed price.*

They all agreed that the mode of payment should be in cash. Anybody who has any farm produce should sell and bring cash. The Behome Midwife said

- *I think we should pay cash if the person has tomatoes he can sell and bring cash. I think it should be paid monthly.*

On the time of payment, it came out that depending on one's occupation the contribution could be monthly, half yearly and annually. The District Director of Health Services said

- *The time of payment depends on the type of work. Salary workers should be deducted from their monthly salaries. Farmers, half yearly or annually and should be by cash.*

There should be a place in town outside the hospital where people can go and pay, contributions from the hinterland can be collected by appointed persons on a fixed day. All monies at the end of the day should be taken to the bank.

THE EXEMPTION POLICY

They all agreed that the government should continue with the exemption policy. The Primary Health Care Coordinator said

- *I hope and think that the government should continue paying for the under fives, antenatal patients and the aged.*

But the General Manager said

- *The Government should take care of the physically disabled that cannot work, but those who are working should contribute.*

COMMON ILLNESS AND SCOPE OF SERVICES

They said commonest illness in the community is malaria. On the scope of services, the scheme should cover, their views varied, some wanted OPD services. The District Coordinating Director said

- *I think for me our interest is for OPD services because if you want it to cover so many services, then the cost will be too much and the poor people cannot afford.*

While some wanted only admission and the District Director of Health Services said

- *It should start with admissions only.*

SERVICE PROVIDERS

They said service provider should be motivated by increasing their salary, the staff in the hospital should be increase, and they should be given good accommodation. The Medical Superintendent had this to say

- *I think they should be motivated with incentives like monetary and other conditions of services so that the work will go on successful.*

They think the hospital has almost all the staff and equipment to provide services but the Bebome and Ananekrom health centers should be upgraded to be able to provide good service, with the option of referring cases to Agogo Hospital. They said the centers be given ambulance. The general manager said

- *I think we have enough staff and equipment to provide services.*

CHAPTER FIVE

5.0 DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 DISCUSSIONS

VIEWS ABOUT CASH AND CARRY

From the interview with the key informants it came out that cash and carry had some advantages and has met the purpose for which it was started. Participants said cash and carry made it possible for health institution to recover cost especially on drugs; this has enabled the health authorities' stock hospitals with essential drugs and consumables. Those that had money are getting good services. The cost recovery program has helped reduce drug shortage but it brought problems, hardships and lack of access to many patients with great toll in the rural majority (Waddington and Enyimayew, 1990; Gertler and Vander Baag, 1988)

During the in depth interviews and the FGDs it came out that the system had many disadvantages as one has to pay upfront before accessing health services. For the community members, majority of who are mainly farmers and traders, money is not always available. They may have to go around borrowing with repayment problems or have to wait at home until the illness becomes serious before going for health services. In fact, majority of them shared the view of The President of Ghana in his state of the nation address when he said the government is committed to abolishing the cash and carry system. Majority of the people in the sub-district wanted the cash and carry system abolished. However, abolishing it completely may not be possible, as not everyone will be willing to join the insurance scheme.

VIEWS ABOUT RISING COST OF HEALTH SERVICE

Basically in developing countries the economy is not stable and inflation keeps going up. Most of the drugs, consumables, diagnostic machines and materials are all imported into the country, to be used by the health institutions. From the study, the participants felt that since these items are imported with foreign currency, if the exchange rate goes up, then prices have to go up. Since this health services delivery is part of services being delivered in the country, should prices of goods and services go up, then the prices of health services should also go up.

One of the participants rightly put it; it is no body's faults as prices go up, the cost of health services will also go up.

KNOWLEDGE OF HEALTH INSURANCE

Majority of the people in the key informant interviews and the opinion leaders had knowledge about Health Insurance. Most of them had been to meetings, seminars, and workshops so could explain the term health insurance.

Participants of the FGDs especially those outside Agogo had little or no knowledge about health insurance. A participant from Pataban said

- *If you have not come here today, I will have never heard about health insurance, so try and explain it to us before you go.*

However the teachers and some opinion leaders could explain health insurance.

SOURCE OF INFORMATION

Those who said they had heard about Health Insurance heard it from many places and depending on where one is, the source of information are newspapers, radio, television,

and meetings. Health Insurance awareness and education can be undertaken by passing the messages through the F.M. stations especially for Fox F.M., newspapers, the announcement vans in Agogo and by beating of gong-gong in the communities. When messages get to the Traditional Council, all the Odikro's in the sub-district will be informed; they will in turn beat gong-gong for public gathering. The churches can be used, as majority of them are Christians, and they listen to the elders of the church.

PERCEIVED BENEFIT

All the participants in the discussions and interviews viewed Health Insurance as a helpful and a beneficial intervention. They want the government to facilitate it's early implementation. They perceived it would increase access to health care, as there will no longer be the need for upfront payment. People will seek health care promptly as they have already contributed. Emergency can easily be taken to the hospital thus avoiding avoidable deaths. From the Nkoranza scheme member of the scheme can afford to go to hospital because, the fear of admission bills is cover by the scheme.

In Thies, Senegal, about 90% of the beneficiaries come from the village and the scheme has made quality health care affordable to the people.

WILLINGNESS TO JOIN THE SCHEME

From the interviews and the FGDs, majority of participants felt that, people in the sub-district will be willing to join the scheme. However, their willingness is based on the fact that they are made to understand the scheme very well and if the premium is affordable.

In the Nkoranza scheme one of the factors that come out from the review of the scheme by PHR plus was that most of the people in the community did not understand Health Insurance and this has accounted for the low enrollment.

In most of the scheme like the Nkoranza, the Dangme West scheme, the people involved keeps increasing year by as it was clear in the study that, people will be willing to join but will wait and see if, the scheme is sustainable and if people are getting some benefit. The medical superintendent said,

"I think most of them like everything initially they have reservation but when they see the system is working they will join".

PREMIUM DETERMINATION MODE AND TIME OF PAYMENT

All agreed that the premium should be determined individually. Each person is charged a fixed rate. The family head pays. All family members should register. This will avoid adverse selection. In Nkoranza scheme beneficiary must be living in Nkoranza district, all family members must register. The premium calculated per person and so varies with the size of the family.

Majority agreed that the payment should be in cash as in many other schemes like the Nkoranza, the Abota, the CAM scheme and the Dangme West scheme except in one of the FGD at Agogo a participant said to get the farmers to join the scheme organizers should accept cocoa, maize, tomato etc which was seen in some Abota scheme.

Depending on people's occupation the premiums should be paid annually or half yearly for farmers like in the Nkoranza scheme and in some Abota schemes. It should be monthly for salary workers as in the Ashanti civil servants scheme. They all however, agreed that there should be two periods where people can register. That is half yearly and annually.

All agreed that if one default for three month from the day of schedule payment, the person is no more a member of the scheme.

EXEMPTION POLICY

All agreed that the exemption policy of the government should continue. It will help the scheme financially and also take some burden of parents. They wanted the government to care for the disabled person.

COMMON ILLNESS AND SCOPE OF SERVICES

There are many illnesses but the commonest is malaria, the number one cause of morbidity in the country. (MOH Annual Report, 2001) However, majority of the people in the FGD and the in depth interview wanted all services covered under the scheme.

This is obvious from the fact that most of them do not understand the concept of Health Insurance. From the key informant interview, majority wanted to start the scheme with OPD services like the Dangme West Scheme. Few wanted to start with admission only like in the Nkoranza and the Okwawuman schemes.

SERVICE PROVIDER

All agreed that service providers should be motivated by cash incentives and improved condition of services as proposed by Atim et al (March, 2000) in their external evaluation of the Nkoranza Community Financing Health Insurance Scheme.

5.2 CONCLUSIONS

Based on the study the following conclusions can be drawn.

- The key informants wanted the cash and carry system and the insurance scheme to operate side by side while the community members wanted the cash and carry systems to be abolished completely.
- The rising cost of health services is normal as inflation keeps going up.
- The knowledge of health insurance among the community members is very low.

- Their source of information is through the mass media, by beating of gong-gong and through the church.
- Participants perceive Health insurance will be very beneficial and helpful to the people in the Sub district.
- Participants think community Members will be willing to join if they are made to understand the scheme and if the premium is affordable.
- Participants wanted all services to be covered by the insurance scheme while the key informants wanted limited services like OPD or Admissions only.
- Participants say premium should be paid in cash and each individual should pay a fixed amount depending on the person's occupation, payment should be made monthly, half yearly, and annually.
- All said that government should maintain the exemption policy.
- They wanted services to be provided from Agogo hospital, Behome and Ananekrom health centers.
- All said that service providers should be motivated by increasing their salary, better accommodation and transportation and the staff strength should be increased.

5.3 RECOMMENDATIONS

Based on the findings and conclusions the following recommendations are made

- Both the cash and carry and the health insurance scheme should be operated side by side, thus giving people the option to use any, as some community member will not join the scheme.

- Intensive education should be undertaken by the DHMT with the help of the District Assembly on health insurance in the communities through the mass media especially Fox FM, the churches, and the traditional council.
- The scheme should start with OPD services, this will allow people to seek health services early and they can easily see the benefits of health insurance.
- The staff strength at Agogo should be increased; the hospital should get ultra sound and more laboratory equipment. The nurses have to be given in service training and lectures on good behavior.
- Anankrom and Behome health centers should be upgraded; more equipment and staff should be posted there to enable the centers deliver quality services under the scheme.
- The roads in the sub-district should be improved to allow easy access to the health facilities.
- Government should maintain the exemption policy, should provide seed money to start the scheme, get an office in Agogo where the scheme will be operated from and should help in the awareness campaign in the sub-district.

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APPENDIX A**STRUCTURED QUESTIONNAIRE FOR PARTICIPANTS**

Questionnaire ID: _____

Interviewers Name: _____

Date: _____

Name of Community _____

Socio-demographic Information

1. Gender.....
2. Age (complete years)
3. Ethnic group
4. Language spoken at home.....
5. Educational background (select highest obtained)
6. Marital status.....
7. Number of any children (own and others) living in the household
.....
8. Occupation (Main source of income)
.....
9. Religion

APPENDIX B

FOCUS GROUP DISCUSSION GUIDE FOR BOTH COMMUNITY MEMBERS AND OPINION LEADERS

INTRODUCTION

The moderator introduces himself and the rest of the research team consisting of, the principal researcher, the research assistant, the note taker, and the recorder. He will explain the role of each member of the team and where the team has come from.

PURPOSE

The moderator will then explain to the discussant that the team is there to discuss Health Care Financing with them, to find out what they know about Health Insurance, from where they heard about Health Insurance, their willingness to participate and the scope of services they want the scheme to cover. At the end of the discussions, the information gathered will be used to prepare the grounds for the commencement of a scheme that will be acceptable to the people in their community.

As this is a discussion, every participant should speak freely and express their view. No answers are wrong.

WARM-UP QUESTION

- Q1 What are your views about the “cash and carry system”?
- Q2 What do you think about the rising cost of health care services?

KNOWLEDGE

- Q3 What do you understand by the term Health Insurance?

Probe for

- The types of Health Insurance.
- The fact that it is not free.
- The fact that people contribute regularly whether sick or not.
- The fact that people need not pay at the point of service.

SOURCE OF INFORMATION

- Q4. From where did you hear about Health Insurance?
- Q5. What is the source of information in this community?

Q6. How helpful do you think Health Insurance will be to the people in your community?

WILLINGNESS TO PARTICIPATE

Q7. Will people be willing to join the Health Insurance Scheme in your community?

Q8. What benefit do you think the people in this community will get by joining such a scheme?

Q9. How should the premiums be determined?

Q10. What should be the mode of payment and how often should they contribute?

Q13. How should the under fives, the antenatal patients, and the aged be catered for under the scheme?

Q14. How will the physically disabled be covered under the scheme?

SCOPE OF SERVICES

Q11. What are the common illnesses in your community?

Q12. Which of these illnesses do you want the scheme to cover?

Q13. Where do you go health care services when you are ill?

Q14. What do you think about their services?

MOTIVATION TO SERVICE PROVIDERS

Q15. What will motivate the service providers to provide service under the scheme?

Q16. What resources both material and human will need to provide the services under the scheme?

Q18. What are the problems that you envisage in the implementations of the scheme?

Q19. How do you think these problems should be managed?

APPENDIX C

KEY INFORMANT INTERVIEW GUIDE

DISTRICT DIRECTOR OF HEALTH SERVICES

Interviewer introduces himself and the purpose of the interview. Ask for permission to record the interview.

Q1 What are your views about the “cash and carry system”?

Q2 What do you think about the rising cost of health care services?

Q3 What do you understand by the term Health Insurance?

Probe for

- The types of Health Insurance.
- The fact that it is not free.
- The fact that people contribute regularly whether sick or not.
- The fact that people need not pay at the point of service.

Q4. From where did you hear about Health Insurance?

Q5. What is the source of information in this community?

Q6. How helpful do you think Health Insurance will be to the people in your community?

Q7 What type of insurance scheme do you want start in Agogo Sub-district?

Q8 What type of awareness campaign on health insurance had been under taken in the Sub-district?

Q9 What type of benefit will the people of Agogo Sub-district get from such a scheme?

Q10 Why will the people of Agogo be willing to join an insurance scheme?

Q11 How should the under fives, the antenatal patients, and the aged be catered for under the scheme?

Q12 How will the physically disabled be covered under the scheme?

- Q13 How should the premiums be determined?
- Q14 What should be the mode of payment and how often should they contribute?
- Q17 What will motivate the service providers to provide service under the scheme?
- Q18 What resources both material and human will be needed to provide the services under the scheme?
- Q19 What type of services do you want the scheme to cover?
- Q20 What are the problems that you envisage in the implementations of the scheme?
- Q21 How do you plan to manage these problems?

THANK YOU

APPENDIX D**KEY INFORMANT INTERVIEW GUIDE****THE DISTRICT CHIEF EXECUTIVE**

To find out, The District Assembly's commitment in starting an insurance scheme in Agogo Sub-district.

INTRODUCTION

The interviewer introduces himself.

PURPOSE OF THE INTERVIEW

The interviewer states the purpose of the interview asks for permission to record the interview and starts the interview.

Q1 What are your views about the "cash and carry system"?

Q2 What do you think about the rising cost of health care services?

Q3 What do you understand by the term Health Insurance?

Probe for

- The types of Health Insurance.
- The fact that it is not free.
- The fact that people contribute regularly whether sick or not.
- The fact that people need not pay at the point of service.

Q4. From where did you hear about Health Insurance?

Q5. What is the source of information in this community?

- Q6. How helpful do you think Health Insurance will be to the people in your community?
- Q7 Why do you want to start an insurance scheme in Agogo Sub-district?
- Q8 What type of awareness campaign on health insurance had been under taken in the Sub-district?
- Q9 Why will the people of Agogo be willing to join an insurance scheme?
- Q10 What do you think should be the scope of services under the scheme?
- Q11 What part will the Assembly play in the implementation of the scheme?
- Q12 How should the under fives, the antenatal patients, and the aged be catered for under the scheme?
- Q13 How the physically disabled should be covered under the scheme?
- Q14 What motivate can the assembly give to the service providers to provide service under the scheme?
- Q15 How should the premiums be determined?
- Q16 What should be the mode of payment and how often should they contribute?
- Q17 What are the risks sharing organizations in the Sub-district you know about?
- Q18 What problems do you envisage in the implementation of the scheme?
- Q19 What suggestions do you for making the implementation a success?

THANK YOU

APPENDIX E

KEY INFORMANT INTERVIEW GUIDE

C- THE HOSPITAL ADMINISTRATOR

Interviewer introduces himself and the purpose of the interview. Ask for permission to record the interview.

- Q1 What are your views about the “cash and carry system”?
- Q2 What do you think about the rising cost of health care services?
- Q3 What are the main sources of revenue for the hospital?
- Q4 What happens to patients who do not readily and promptly pay their bills?
- Q5 What do you understand by the term Health Insurance?
Probe for
- The types of Health Insurance.
 - The fact that it is not free.
 - The fact that people contribute regularly whether sick or not.
 - The fact that people need not pay at the point of service.
- Q6. From where did you hear about Health Insurance?
- Q7 What services is the hospital ready to offer under the scheme?
- Q8 Why do you think the people in the sub –district will be willing to join the scheme?
- Q9 How should the premiums be determined?
- Q10 What should be the mode of payment and how often should they contribute?
- Q11 How should the under fives, the antenatal patients, and the aged be catered for under the scheme?

- Q12 How the physically disabled should be covered under the scheme?
- Q13 What will motivate the service providers to provide service under the scheme?
- Q14 What resources both material and human will need to provide the services under the scheme?
- Q18 What problem do you envisage in the implementation of the scheme?
- Q19 What suggestions can you give to the District Health Management Team to make the scheme a success?

THANK YOU

APPENDIX F**KEY INFORMANT INTERVIEW GUIDE****D- THE SENIOR MEDICAL OFFICER IN-CHARGE OF THE HOSPITAL**

The interviewer introduces himself and the purpose of the interview. He then asks for permission to record and then starts the interview.

Q1 What are your views about the “cash and carry system”?

Q2 What do you think about the rising cost of health care services?

Q3 What are the main sources of revenue for the hospital?

Q4 What happens to patients who do not readily and promptly pay their bills?

Q5 What do you understand by the term Health Insurance?

Probe for

- The types of Health Insurance.
- The fact that it is not free.
- The fact that people contribute regularly whether sick or not.
- The fact that people need not pay at the point of service.

Q6. From where did you hear about Health Insurance?

Q7. What is the source of information in this community?

Q9 Will the people of Agogo Sub-district benefit from health insurance?

Q10 Why do you think the people of Agogo Sub-district be willing to join the scheme?

Q12 What type of services should the scheme cover?

Q13 How should the under fives, the antenatal patients, and the aged be catered for under the scheme?

Q14 How the physically disabled should be covered under the scheme?

- Q15 What will motivate the service providers to provide service under the scheme?
- Q16 What resources both material and human will need to provide the services under the scheme?
- Q17 What problems do you envisage in the running of the scheme?
- Q18 What suggestions do have to make the scheme viable?

THANK YOU