UNIVERSITY OF GHANA

IMPLEMENTATION OF THE DISTRICT- WIDE MUTUAL HEALTH INSURANCE SCHEME IN GA WEST MUNICIPALITY

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL PUBLIC ADMINISTRATION DEGREE

JUNE, 2014

DECLARATION

I do hereby declare that this work is the result of my own research and has not been presented by anyone for any academic award in this or any other university. All references used in the work have been fully acknowledged.

I bear sole responsibility for the shortcomings.

…….....… ……..

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(STUDENT)

CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University.

……... ……..

DR. KWAME ASAMOAH DATE

(SUPERVISOR)

DEDICATION

This thesis is dedicated to three important people who contributed so much in my upbringing but have all been called to glory: Mr. J. D. Amoni (my dad and 'teacher'), Rev. Fr. Bolek Gielata (SVD) and Rev. Sis. Genevieve Siesegh (SMI). May they have eternal rest.

ACKNOWLEDGEMENT

The successful completion of this thesis depended on the goodwill and assistance of a number of people to whom I owe a debt of gratitude.

My sincere gratitude goes to my supervisor Dr. Kwame Asamoah for his academic guidance, support and tolerance. His patience, advice and critical insights from the proposal stage through to drafts and finally the completed work deserve much commendation.

I am equally indebted to the management and staff of Ga District Mutual Health Insurance Scheme (GDMHIS) for all the data they gave for this work and their assistance and cooperation during the period of study. I am equally grateful to the Administration and staff of Amasaman government hospital, Francogina Laboratory Services in Amasaman and St. Moses Clinic in Pokuase for providing me with information on the Health Insurance in their respective facilities. Great thanks also to the numerous subscribers of the Ga Scheme who made themselves available and provided information for the purpose of this study. I also want to say thank you to my colleagues and friends especially Police Superintendent Sylvester Boyuo, Michael Ansong Diawuo and Lawrence Offei Asare for their support and encouragement.

I also want to appreciate the care and concern from my mother Madam Alice Amanki Attah who supported in diverse ways especially in the upkeep of my children whiles I undertook this study. I cannot also forget my siblings Ken, Sister Laadi, Theresa and Flora for their moral and spiritual support.

Finally my heartfelt gratitude goes to my husband Dr. Samuel Aniegye Ntewusu and my children Kingsley and Sammy Junior. They have been a source of support and exhibited a lot of understanding as I pursued this course.

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Ghana's NHIS is unique in the sense that it is a hybrid of Social Health Insurance and Community Based Health Insurance schemes. This study is about the implementation of the District-wide Mutual Health Insurance Scheme (DMHIS) in Ga West Municipality. The study is necessitated by the perceived success of the scheme such as increase in enrolment, and utilization of health facilities. Furthermore, there are gaps and challenges which include inadequate medical facilities, escalating cost, and difficulty in reimbursement of providers, which have not only emerged in the process of the implementation of the scheme but have also threatened its sustainability. The study used a mixed methods approach to gather data from a sample of subscribers in Ga West (the seat of the Ga District Scheme), Management and Staff of the Ga scheme and health providers to discuss the implementation process of the scheme. In all, information was gathered from 100 subscribers, 30 healthcare providers, and 30 staff members and management of the Ga scheme. It was found out that community participation, intensive education and special registration exercises, among others were paramount in bringing about the successes chalked by the Ga West scheme whiles inadequate office space, human resources and funding, as well as illiteracy and corruption accounted for the failures of the scheme in Ga West Municipality.

The study recommends the development of a comprehensive computerization system that will help in an effective processing of claims to minimize the fraud and corruption associated with the manual system. It is also strongly recommended that more and well trained permanent staff be recruited to ensure a smooth operation of the Ga West Scheme.

ABSTRACT

The National Health Insurance Scheme (NHIS) was introduced in Ghana in 2003. Its main goal was and still is to ensure healthcare access and bridge the inequality gaps in healthcare.

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CHAPTER ONE

GENERAL INTRODUCTION TO THE STUDY

1.0 Background to the Study

The socio-economic development of a nation to a very large extent depends on a healthy population. A healthy people with the requisite skills and knowledge become the backbone through which the development agenda of any society is implemented. Quality human resource base is therefore cardinal to the attainment of development goals of countries (Kwarteng, 2011). Health is often considered as a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. More importantly, health is a resource for everyday life, not the object of living. The attainment of the highest possible level of health is very important worldwide for social and economic sectors in addition to the health sector. This is because health preserves human capital, which is the major resource for economic development in all of the social and economic sectors.

It is in this light that all countries in the world place much premium on ensuring an improved health condition for their citizens. The significance of health issues relating to people is further epitomized by the existence of global institutions dedicated to the promotion of human health. For example, the World Health Organisation (WHO) is one of such global institutions dedicated to the promotion of the health of people.

Most countries in the world have developed some form of health care system aimed at ensuring that sick people are catered for efficiently and speedily without any inhibitions.

Ghana is no exception to this phenomenon. Healthcare facilities in the form of hospitals, polyclinics, clinics and healthcare centres have been provided in the country for delivering quality healthcare to people. Many of these facilities are operated by the state with a few operated by private individuals and institutions either for profit or as social service. Until the recent emergence of the private sector in the provision of healthcare, the state has always played a dominant and pioneering role in ensuring that people access affordable healthcare. It has therefore become the state's responsibility to provide healthcare to the people of Ghana and this responsibility comes with financial challenges in view of the difficult economic issues that confront the country (Kwarteng, 2011).

Financing an efficient and effective healthcare system is of a major concern to countries all over the world. This is even more critical in developing countries where there are several developmental challenges of which limited resources and poverty are dominant. Healthcare financing is a general term which refers to the resources used in providing healthcare. These include money, and other resources such as labour, equipment and supplies (Goodman and Waddington, 1994).

In Ghana, healthcare financing has gone through several phases. After independence in 1957, Ghana adopted a socialist centralist development approach with the state taking absolute control over the provision of social services including health. The provision of healthcare was financed by the state through tax revenue. However, it became obvious that this method of financing healthcare was not sustainable following the economic difficulties the country experienced from the beginning of the 1960s (Osei-Akoto, 2004).

As part of efforts to revamp the Ghanaian economy, the state began to reduce expenditure on the provision of social services and the health sector witnessed considerable reduction in state funding. The erstwhile Provisional National Defence Council (PNDC) government in 1985 passed a legislative instrument, popularly referred to as L. I. 1313 which introduced user fees for all medical conditions except certain specified communicable diseases. The main aim of L. I. 1313 was to enable hospitals to totally recover all costs involved in their operation. This system where people who access public health facilities pay user fees became known as "cash and carry" and resulted in several operational challenges (Asenso-Okyere et al., 1998).

The introduction of the user fees and the full cost recovery for drugs as a way of generating revenue led to a remarkable decline in the utilization of health service in the country. Poor people in the country who required healthcare were not able to access it because they could not afford the user fees. Self-medication and the use of herbal medicine became common in the country. It was estimated that only 20% of people who require healthcare were able to access it (Mensah et al., 2010).

In order to ameliorate the problems associated with the "cash and carry" system the then New Patriotic Party (NPP) government introduced the National Health Insurance Law, Act 650 in 2003.The Act sought to provide basic healthcare services to persons resident in Ghana through mutual and private health insurance schemes, and to establish a National Health Insurance Fund that will provide subsidy to licensed District Mutual Health Insurance Schemes. Health Insurance is an alternative healthcare financing system which involves resource pooling and risk sharing among members (MOH, 2003). It is important to indicate however, that prior to this, the National Democratic Congress

(NDC) government started to pilot the Mutual Health Insurance Scheme in some selected districts in Ghana towards a National Health Insurance Scheme (NHIS). Examples of such districts are, Dangbe West in the Greater Accra region, Kwahu South in the Eastern region and Nkoranza in the Brong Ahafo region.

As previously indicated, the District Mutual Health Insurance schemes cover the entire geographical area of one or more administrative districts. The private Mutual Health Insurance schemes are those that are not based on administrative district boundaries. For example, these could be workplace based, faith based and community based schemes. The private commercial schemes are those operated for purpose of profit. Section 31 of the Act grants every individual or group of individuals the right to belong to any of the three schemes identified above. The state supports the development of the District Mutual Health Insurance Scheme (DMHIS) as a strategy for delivering its pro-poor policy to the under-privileged segment of the society, from both the formal and informal sectors. The implementation of the National Health Insurance Scheme has achieved several successes but also encountered some challenges.

1.1 Statement of the Problem

Health insurance schemes are increasingly recognized as a tool to finance healthcare provision in developing countries and have the potential to increase utilization and better protect people against health expenses and address issues of equity (WHO, 2000). Ghana's National Health Insurance Scheme, introduced in 2003, aims to remove financial barriers to healthcare access and bridge the inequality gaps in healthcare. The scheme has been praised for its coverage, associated legal reforms and clinical audit

mechanisms and for serving as a hub for knowledge sharing and learning within the context of South-South Cooperation (Fusheini et al, 2012).

Since its inception, several studies have been conducted on the NHIS. Some of these cover financial aspects (Agyepong and Adjei, 2008; Abekah-Nkrumah et al., 2009), others focus on, coverage levels (Witter and Garshonog, 2009). Again, some of the studies concentrated on the effects of NHIS on out-of-pocket expenditures, healthcare demand, health status and labour productivity, assessment as to whether NHIS is providing an affordable healthcare financing arrangement (NDPC, 2008).

As the scheme is being extended to cover a number of communities in the country, there is the need for evaluating its implementation at both the local and national level. However, little research has been conducted on the implementation of the scheme at the district level and more specifically the Ga West Municipality. What is readily known about the scheme and its implementation at the district level is often based on newspaper reports and anecdotal evidence. This leaves us with little empirical evidence about the implementation of the scheme at the local level. Yet, a deeper appreciation of the implementation of the scheme is crucial in understanding the extent to which the scheme has been successful in Ga West Municipality. This thesis therefore sets to fill this gap and provide empirical evidence about the implementation of NHIS at the local level by using the Ga West Municipality as a case.

1.2 Objectives of the Study

The general objective of this study is to find out the factors that facilitate or constrain the implementation of NHIS in Ga West Municipal Assembly. Specifically, the study seeks to:

1. Find out the factors that facilitate the implementation of NHIS in Ga West Municipal Assembly.
2. Find out the factors that constrain the implementation of NHIS in Ga West Municipal Assembly.
3. Find out the roles played by different actors such as healthcare providers, subscribers and staff of the insurance scheme in the implementation of NHIS in Ga West Municipality.

1.3 Research Questions

The research questions emanating from the problem statement are as follows:

1. What factors facilitate the implementation of NHIS in Ga West Municipal Assembly?
2. What are the factors that constrain the implementation of NHIS in Ga West Municipal Assembly?
3. What are the roles played by different actors in the implementation of NHIS in the Ga West Municipality?

1.4 Scope and Limitations of the Study

The geographical scope of this study covers the Ga West Municipal Assembly. Institutionally, the study covers the management, subscribers and healthcare providers of NHIS under the Ga West municipality. Issues of implementation of NHIS in the Ga West

Municipality were also part of this study. The focus is on the process through which policies are transformed into action. It focuses on four issues that influence processes of policy implementation: the actors involved and their beliefs, service delivery arrangements, management practices, and citizen participation.

The study is not, however, concerned with the actual content of the policy or their effects on health outcomes. The study is also limited to the Ga District Mutual Health Insurance Scheme (GDMHIS) in the Greater Accra Region. It does not seek to discuss in details the economic and political implications of the scheme. The study does not seek to draw relationships nor does it seek to compare schemes. It is only concerned with describing the views and the experiences of the stakeholders within GDMHIS. The study is limited to the implementation, challenges and experiences of stakeholders about the scheme in the Ga West Municipality.

1.5 Significance of the Study

This study discussed the constraining factors of the implementation of NHIS in the Ga West Municipal Assembly. Hence the results will help the concerned parties to re-examine the constrains and find better ways of addressing them based on empirical evidence. It will also give some highlights to governmental and non-governmental organizations working in this area to focus on the challenges and be involved in efforts to improve the situation.

The study has both policy and scholarly implications: At the macro-level, the study is relevant to policy makers as it will help in the designing of appropriate programmes and policies to tackle implementation challenges of NHIS. It will also offer both politicians

and service providers a guide for future policy and decision making. Academically, the study will contribute to existing knowledge on the management of NHIS in Ghana. This study will provide insightful empirical data that will enhance understanding of the issues related to scheme, thereby contributing to the design and implementation of universal health insurance in Ghana. Finally, the study will act as a basis for further research on healthcare financing in various metropolis, municipalities and districts in Ghana. The researcher also stands to gain considerable knowledge and skills in both research and health financing issues.

1.6 Organisation of the Study

This thesis is divided into six chapters. Chapter One provides the background to the study. In this chapter, a general introduction is given as well as the problem statement, objectives, research questions, scope and limitations of the study, and significance of the study. Chapter Two reviews relevant literature on the concept of policy implementation, top down and bottom up approaches to policy implementation, and a synthesis of the two models, successful and failed implementation, factors that affect policy implementation, barriers to policy implementation as well as the conceptual framework for the study.

The focus of Chapter Three is the implementation of the National Health Insurance in Ghana. Issues discussed in this chapter include historical context of the health insurance in Ghana, the National Health Insurance Scheme and its implementation and the actors in the implementation of NHIS. Chapter Four discusses methodological issues and the profile of the study area. Chapter Five presents the study's results, data analysis and discussions of the findings of the study. Finally, Chapter Six gives a summary of the key findings, recommendations and conclusion of the study.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

2.0 Introduction

The purpose of this chapter is to provide literature on the concept of implementation. Other important themes discussed include top down and bottom up approaches to implementation as well as success and failures of implementation. Additional issues discussed in this chapter include factors that affect implementation and various definitions of implementation. Discussing such literature is important as it helps address the research questions and at the same time form the basis for empirical studies relating to the topics and sub-themes discussed in subsequent chapters.

2.1 Concept of Implementation

Implementation inevitably takes different shapes and forms in different cultures and institutional settings. Implementation literally means carrying out, accomplishing, fulfilling, producing or completing a given task. Pressman and Wildavsky (1973) define implementation in terms of its relationship to policy as laid down in official documents. According to them, policy implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieve them. Policy implementation encompasses those actions by public and private individuals or groups that are directed at the achievement of objectives set forth in policy decisions. This includes both one-time efforts to transform decisions into operational terms and continuing efforts to achieve the large and small changes mandated by policy decisions (Van Meter and Van Horn, 1975).

According to Mazmanian and Sabatier (1983), policy implementation is the carrying out of a basic policy decision, usually incorporated in a statute, but which can also take the form of important executive orders or court decisions. It implies centrally located actors, such as politicians, top-level bureaucrats and others, who are seen as most relevant to producing the desired effects. O'Toole (2003) defines policy implementation as what develops between the establishment of an apparent intention on the part of government to do something or stop doing something and the ultimate impact of world of actions. More concisely, he remarks that policy implementation refers to the connection between the expression of governmental intention and actual result. As part of policy cycle, policy implementation concerns how governments put policies into effect (Howlett and Ramesh, 2003).

From the above discussion, implementation can be conceptualized as a process, output and outcome. It is a process of a series of decisions and actions directed towards putting a prior authoritative decision into effect. The essential characteristic of implementation process is the timely and satisfactory performance of certain necessary tasks related to carrying out of the intent of the law. Implementation can also be defined in terms of output or extent to which programmatic goals have been satisfied. Finally, at highest level of abstraction, implementation outcome implies that there has been some measurable change in the larger problem that was addressed by the programme, public law or judicial decisions (Lester et al., 1995).

2.2 Policy Implementation: Top-Down and Bottom-Up Approaches

A review of literature on policy implementation reveals that two schools of thought have evolved. Different scholars view them differently. Some talk about "forward and

backward mapping" models (Elmore, 1980); while others refer to them as "top-down" and "bottom-up" models (Fataar, 1999). The top-down and bottom up schools of thought are seen as providing the most effective methods for studying and describing implementation (Gornitzka et al., 2005; Sabatier, 2005; Sehoole, 2002). Top-down theorists see policy makers as the central actors and concentrate on factors that can be controlled at a central level. Bottom-up theorists emphasise a focus on participants and service providers, arguing that policy is made at the local level (Gornitzka, et. al., 2005; Matland, 1995).

2.2.1 Top-down Model

The essential features of a top-down approach were developed by Pressman and Wildavsky (1973). This model assumes that policy implementation is a linear process that is characterised by a hierarchically ordered set of events, which can be centrally controlled (Cerych and Sabatier, 1986; Mazmanian and Sabatier, 1981; 1983; 1989; Pressman and Widavsky, 1973; Sabatier, 1986). In this model, policy process is divided into sequential steps, each of which is treated as functionally distinct (Christie, 2008; Sehoole, 2002; Sabatier, 2005). Policy implementation viewed through the lens of this perspective is regarded as the "rational administrative activity of a political neutral bureaucracy whose actions are directed at the achievement of the policy objectives or directives of the politicians" (De Clercq, 1997: 146). This view separates implementation from formulation, suggesting a separation between theory and practice (Badat, 1991; Fataar, 1999; Mazmanian and Sabatier, 1981; 1983; 1989; Sabatier, 1986).

Supporters of this linear view describe implementation as the execution of policy objectives. One example of this interpretation can be found in Hayes' (2001) description

of policy implementation. Hayes describes implementation as a composition of organised activities by government, directed towards the achievement of goals and objectives stipulated in the policy. Similar descriptions can be found in Sabatier and Mazmanian. These theorists define implementation as "the carrying out of a basic policy decision, usually made in statute" (Sabatier and Mazmanian, 1980: 153). With regard to methods of policy analysis, this framework provides a hierarchical model of policy analysis as well as the analytical tools for actors to use to regulate, measure, and control the policy processes.

The policy implementation that is planned in line with this model follows sequential steps such as: Establishing implementation structures; Designing a programme that incorporates task sequences and clear statements of objectives; Developing performance standards; Building in monitoring and control devices to ensure that the programme proceeds as intended.

Implementation analysis that is located in this model tends to focus on factors that appear to centralise control and that are easily manipulated by policy makers. These factors include funding formulae, organisational structures, authority relationships among administrative units and administrative control (Elmore, 1980). An earlier study by Van Meter and Van Horn (1975) provides an example of top-down thinking. In their model of how to analyse the implementation process, variables such as policy standards and objectives and policy resources are regarded as critical. Pressman and Wildavksy (1973) were the first implementation analysts to indicate that the outcomes of even the best supported policy initiatives depend eventually on what happens when the individual implementers throughout the policy system interpret the policy (McLaughlin, 1987).

There are several criticisms that are directed at top-down models. Firstly, top down models take policy decisions as their starting point in the analysis and thus fail to consider the significance of actions taken during other stages of the implementation process (Matland, 1995). Bowe, Ball and Gold (1992) contend that this linear conception of policy in which theory and practice are separated, distorts the policy process. They argue further that this top down model is not the best start for research into the practical effects of policy, as the policy process is not simply a matter of implementers following a fixed text and putting the policy into practice. Rather, policy is contested.

A similar argument was made by Elmore (1980: 603) when he contends that "the notion that policy makers exercise – ought to exercise –some kind of direct and determinant control over policy implementation might be called a noble lie of conventional public administration and policy analysis." Lowry (1992: 50) argues that "Policies are not simply created by national officials and then routinely implemented by state and local governments as if they were unquestioning automations in some Weberian machine."

Proponents of the top-down approach have been accused of seeing implementation as a purely administrative process, either ignoring political aspects or trying to eliminate them (Matland, 1995; Saetren, 1986). These authors argue that the call for clear, explicit and consistent goals distorts the reality of how legislation is passed. Finally, the top down model has been criticised for its emphasis on policy makers as key actors. It is argued that this approach has a tendency to neglect local implementing officials' initiatives and to underestimate the strategies used by implementing actors to divert central policy for their own purposes.

2.2.2 Bottom-up Model

In contrast to the top-down approach, those emphasizing a bottom-up approach such as Berman (1980), Hjern and Porter (1981), Hjern (1982), Hjern and Hull (1982) , Hull and Hjern (1987), Elmore (1980), and Lipsky (1978), suggest a model that starts from the bottom of implementation. The bottom-up approach of Hanf, Hjern and Porter (1978) starts by mapping the network of actors in the actual field where implementation is to take place and asks them about their goals, strategies, activities, and contact persons. This, according to Sabatier (2005), provides a vehicle for moving from the actors at the bottom to policy makers at the top.

One of the key proponents of this approach is Elmore (1980). He argues for "backward mapping" approach as an alternative to "forward mapping". Elmore challenges the assumptions of the top-down approach on the grounds that they are an inappropriate way of describing real life policy implementation.

They argue that a more realistic understanding of implementation can be gained by looking at the policy from the view of the target implementers and the service providers. These theorists argue that successful implementation depends more on the skills of local implementers than upon efforts of central government officials. Matland (1995: 148) notes: "At the macro-implementation level, centrally located actors devise a government programme, at the micro-implementation level; local organisations react to the macro-level plans, develop their own programs and implement them." While a bottom-up approach is regarded as a useful starting point for identifying actors involved in a policy arena, Sabatier (2005: 24) argues that "it needs to be related via an explicit theory to

social, economic and legal factors which structure the perceptions, resources and participation of those actors."

Criticism has been levelled against the bottom-up approach for underestimating the role of the policy objectives (Gornitzka, 2005; Matland, 1995; Sabatier, 2005). It is argued that in a democratic system, policy control should be exercised by central actors whose mandates come from their accountability to their voters (Matland, 1995). The bottom-up approach views policy implementation as an integral part of the policy making process and regards policy formulation and implementation as iterative processes (Barrett and Fudge, 1981; Bowe and Ball, 1992; Dyer, 1999; Elmore, 1980; Fataar, 2006; Lowry, 1992; McLaughlin, 1998). Policy implementation is thus defined as all the activities and interactions that are directly related to the achievement of the envisaged policy intentions.

2.2.3 Synthesis of bottom-up and top-down approaches

In an effort to reconcile the two major schools of thought on policy implementation, different groups of researchers such as Matland (1995), Goggin, Bowman, Lester and O'Toole (1990), Sabatier (2005 ; 1998; 1991; 1988; 1986) and Elmore (1985; 1982), have proposed different ways of combining the two approaches. Elmore's concept of "forward" and "backward mapping" was an early attempt to combine top-down and bottom-up perspectives.

Elmore argues that policy makers need to consider both the policy instruments and other sources at their disposal (forward mapping), as well as the incentive structure of target groups (backward mapping) because success in implementation depends on combining

the two (Matland, 1995; Sabatier, 2005). The second attempt at synthesis was made by Goggin et al. (1990). They developed a communication model of intergovernmental implementation in the United States of America. They view states as the critical actors. They claim that messages are received from the top (government) and from the bottom (local actors).

In 1995, Matland sought a combination of top-down and bottom-up approaches that would identify the conditions under which policy recommendations would be effective (Matland, 1995). Matland proposes that these approaches should be used when appropriate, and not simultaneously. He argues that they are applicable in the following four different situations:

in situations of low-policy conflict and low-policy ambiguity, "administrative implementation" is the appropriate strategy - in other words a rational decision- making process (top-down perspective) is more appropriate; in situations of high-policy conflict and low-policy ambiguity, where actors have clearly defined objectives (top-down perspective) but they cannot agree on appropriate objectives, a top-down approach is appropriate, Matland terms this "political implementation";in situations of high-policy ambiguity and low policy conflict, the emphasis should be on learning (bottom-up perspective); Matland terms this "experimental implementation";in situations of low-policy conflict and high- policy ambiguity, letting local actors find local solutions, "symbolic implementation" is the appropriate strategy; this suggests a bottom up perspective. This comprehensive implementation model is captured in Figure 2.1

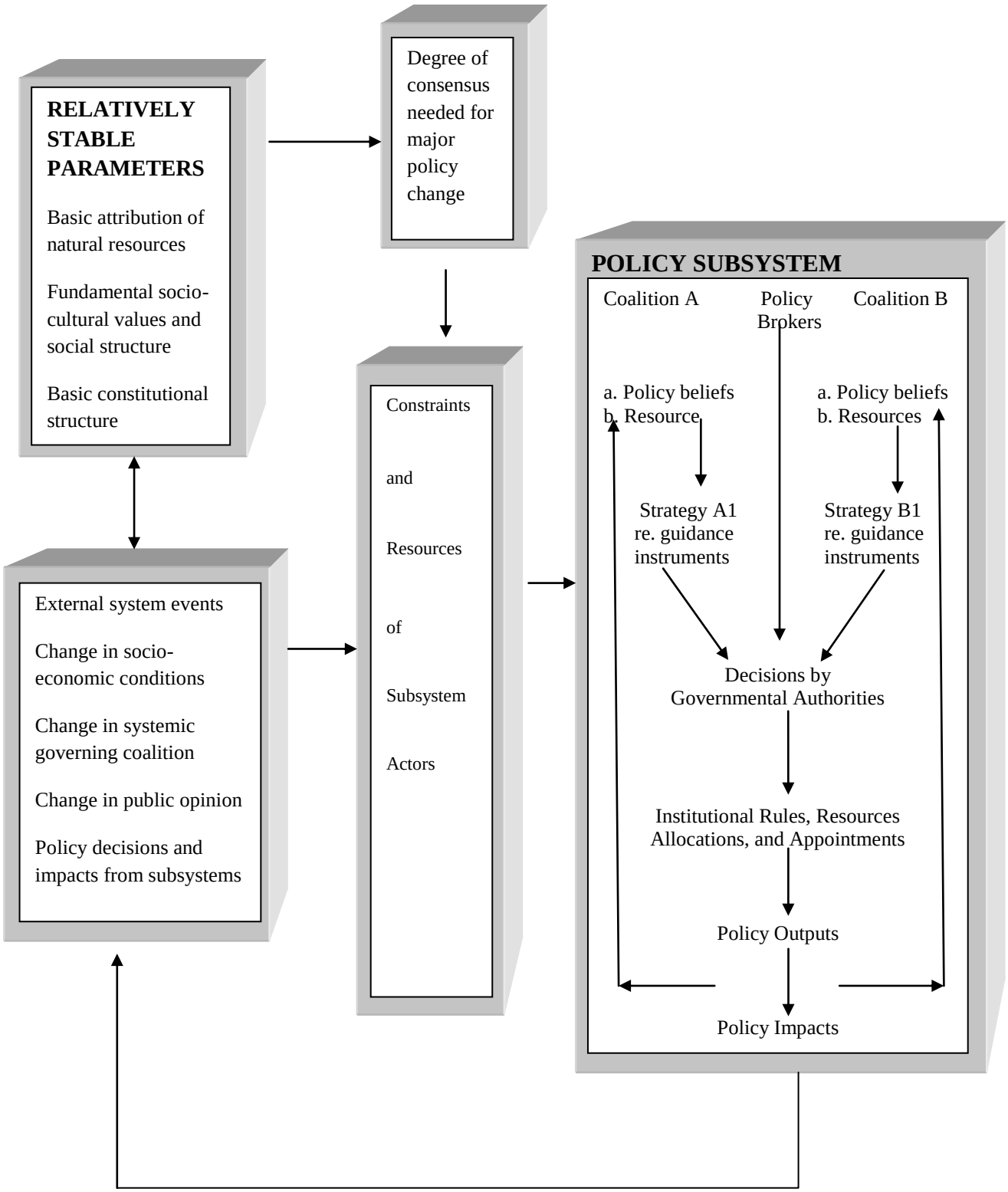
Figure 2.1 Ambiguity-Conflict Matrix: Policy Implementation processes.

		Conflict	
		Low	**High**
Ambiguity	**Low**	Administrative Implementation Resources	Political Implementation Power
	High	Experimental implementation Contextual conditions	Symbolic implementation Coalition strength

Source: Matland (1995: 160)

A fifth model was proposed by Colebatch (2002). This model also combines top down and bottom-up approaches. Colebatch suggests that a policy process should be perceived as a product of two intersecting dimensions: vertical (top-down) and horizontal (bottom-up) sets of activities (Christie, 2008). The vertical dimension in this model covers authorised decision-makers and their decisions. The horizontal dimension covers the activities of many actors in the policy process, both inside government and in non-governmental organisations. This dimension emphasises the importance of negotiations and consensus. Colebatch's model, unlike Matland's Ambiguity-Conflict Model, involves both approaches simultaneously. This model is captured in Figure 2.2.

Figure 2.2 Advocacy Coalition Framework

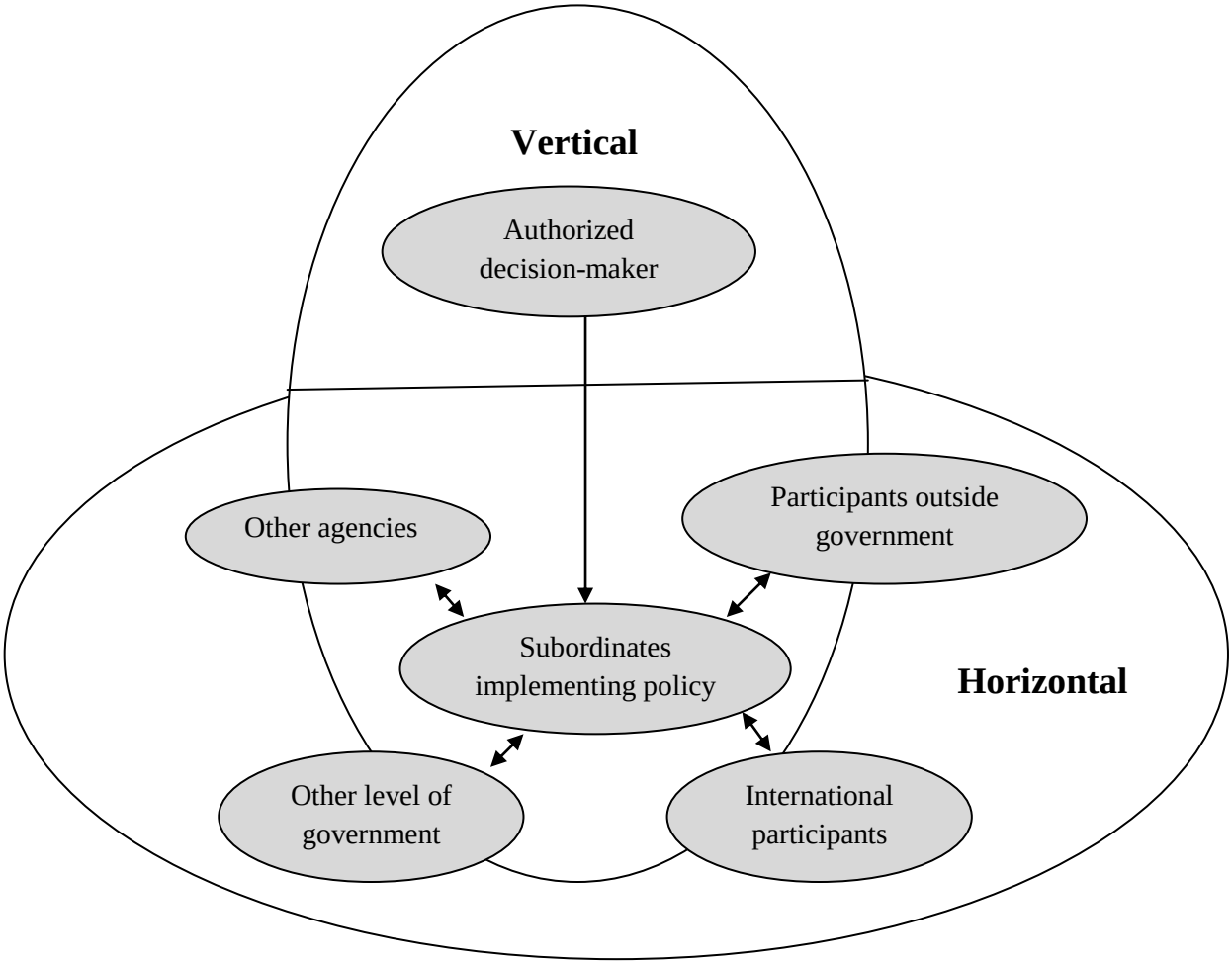


Source: Sabatier, (2005:27)

A sixth approach, the Advocacy Coalition Framework (Sabatier, 1998), was developed as an attempt to combine the best features of top-down and bottom-up approaches to implementation (Sabatier, 1998; 2005). This framework draws from both top-down and bottom-up models. It starts from the premise that the most useful unit of analysis for understanding policy change is a policy subsystem - those actors from a variety of public and private organisations who are involved with the policy (Sabatier, 2005). This framework assumes that these subsystems can be grouped into a number of coalitions, which consists of interest groups, politicians, agency officials and intellectuals who share common beliefs. It argues that "actors perceive the world through a set of beliefs that filters information consistent with pre-existing beliefs" (Sabatier, 2005: 28). In an attempt to implement policy, these coalitions might use conflicting strategies which could create tensions. These tensions are then mediated by "policy brokers" to find compromise. The end product of this process would be policy outputs.

The Advocacy Coalition Framework (ACF) also assumes that there are stable and dynamic variables which affect the constraints and resources of subsystem actors. The stable variables include basic distribution of natural resources, the basic socio-cultural values and social structure (Sabatier, 2005). There are also dynamic factors, including changes in socio-economic conditions and systems which provide principal sources (funding and resources) for change. This is typical of a top-down model. Figure 2.3 presents an overview of an Advocacy Coalition Framework.

Figure 2.3: The vertical and horizontal dimensions of policy



Source: Colebatch (2002:24)

2.3 Brief insights into Successful and failed implementation policy

Policy, by its nature, is not value neutral but it is "a matter of authoritative allocation of values" (Ball, 1990: 2). Ball argues that policies cannot be divorced from interests, from conflict and from domination or justice. Policies are contested, negotiated and fought over by different interest groups or policy communities. Therefore, how one judges the implementation outcomes is subjective and depends on whose values are validated in policy. Implementation failure, like implementation success, is therefore a highly

contested concept. Its description depends on the intentions, expectations and values of those involved in policy implementation.

The majority of donor-funded programmes are evaluated in order to determine the success or failure of the programme. In most cases failure or success is measured against the agreed upon indicators for success or the target objectives. This approach to determining success is mainly used by those who perceive policy implementation as a simple and linear process that entails compliance with stipulated goals. Researchers like Pressman and Wildavsky (1973) who adopt a top-down approach, desire to measure success in relation to the expected outcomes tied to stipulated policy goals. One such example can be found in Ingram and Schneider's (1990**)** definition of successful implementation. These authors define successful implementation in terms of compliance with statutory guidelines, indicators of success and achievement of policy goals.

If one sees implementation as a complex process, then one is likely to consider outcomes resulting from a negotiated process as well as unintended positive gain. Researchers who prefer this bottom-up approach start by looking at how local actors solve societal problems in different areas, and examine the role that the government plays in that (Gornitzka, 2005). The criteria for successful or failed implementation are then not focused on the degree of match or mismatch between formal intentions of the policy and actions of the implementers, or on the deviant behaviour of implementers. Instead, they measure the programme in terms of the positive gains. These gains might be due to intended or unintended outcomes. Jansen (2001) argues that policy itself can affect implementation negatively. For example, policies that are launched during election

campaigns and policies that are announced to appease donors are not always meant to be implemented.

Jansen (2001) uses a theory of policy symbolism as explanation for non-implementation of policies. He terms these policies "symbolic policies" and argues that they were never meant to be implemented in the first place. He argues that policy implementation failures are due to over-investment of the state in the political symbolism of policy rather than its practical implementation. This includes lack of attention to policy implementation strategies and poorly managed policy decisions. Christie (2008: 152) shares the same view. She argues that government "has favoured structural changes with high symbolic value."

2.4 Factors that affect policy implementation

Policy implementation analysis requires understanding of all stages which interact and influence each other. It should be recognised, however, that not all implementation problems can be identified during the stages that precede it. Many of the problems can only be discovered during the implementation stage, which is the primary interface between policy and practice. It should be noted that this study confines its scope to the implementation stage. The choice of this focus does not dispute the fact that some of the complexities that manifest during the implementation stage are as a result of events that occurred in other stages.

This study has adopted a combination of top-down and bottom-up approaches to policy implementation in analysing reasons for success and failure in the implementation of the mutual health insurance scheme in Ga West Municipality. These approaches informed

the selection of literature to be reviewed, and the factors to be extracted. While it is acknowledged that the context in which policy implementation takes place is unique, factors that affect the implementation in different contexts were synthesized in this study. These factors emerged from different scholars adhering to different perspectives, working with different policies, in different countries. Those who utilize a top-down approach emphasise central control as a means to secure successful implementation while a bottom-up approach focuses more on the discretion of the actors in the implementation context.

The central characteristic of both top-down and bottom-up studies is the assumption that if implementation processes can be controlled by relevant variables, implementation will be successful. For example, Sabatier (1986:23) proposed five requirements necessary to maximise successful implementation. Sabatier argues that efforts must be made to ensure that: the programme of action is based on sound theory, which relates changes in target group behaviour to the achievement of desired and stated objectives; The statute or other basic decision is composed of unambiguous policy directives of the implementation process; The leaders of implementing bodies possess the necessary managerial and political skills, and are committed to statutory objectives; The programme being implemented is actively supported by organized constituency groups and by a few legislators or chief executives throughout the implementation process, with the courts being neutral or supportive; The relative priority of objectives of the programme is not significantly undermined over time by the emergence of conflicting policies or changes in relevant social conditions that undermine the technical theory or political support of the programme.

These factors are also cited in a study on policy implementation in higher education conducted by Cerych and Sabatier (1986). In analysing reasons for the success or failure of the higher education reforms, these two researchers (Cerych and Sabatier, in Gornitzka, 2005:39-40) provided a list of factors affecting policy implementation: Legal (official) objectives: (a) Clarity and consistency (b) Degree of system change envisaged; Adequacy of the causal theory underlying the reform; Adequacy of financial resources provided to implementing institutions; The degree of commitment to various program objectives among those charged with its implementation within the education ministry and the affected institutions of higher education; Degree of commitment to various programme objectives among legislative and executive officials and affected groups outside the implementing agencies; Changes in social and economic conditions affecting goal priorities or the program's causal assumptions.

Similar variables are cited by Sabatier (2005: 19):Clear and consistent objectives; Adequate causal theory; Implementation process legally structured to enhance compliance by implementing officials and target groups; Committed and skilful implementing officials; Support of interest groups and sovereigns over time; Changes in socio-economic conditions which do not substantially undermine political support or causal theory.

The variables suggested by Sabatier (1986), and Cerych and Sabatier (1986) can be categorised under five variables, namely, policy content, commitment, context of implementation, support of clients and coalitions, and capacity to implement policy. These variables are also cited by other proponents of top-down and bottom-up

approaches to policy implementation. Table 2.1 shows these critical variables and the scholars who proposed them.

Table 2.1 Critical variables for the success of policy implementation

Variable	Scholars who propose variable
Policy content	Van Meter and Van Horn (1975), Barret and Fudge (1981), Mazmanian and Sabatier (1983), Sabatier (1986; 2005)
Context	Warwick (1982), Berman (1978), O'Toole (1986), Van Meter and Van Horn (1975)
Commitment	Pressman and Wildavsky (1973), Goggin et. al. (1990), Berman (1978), Van Meter and Van Horn (1975)
Support of clients and coalitions	Pressman and Wildavsky (1973), Berman (1978), Elmore (1980), Sabatier (1986; 2005), Barret and Fudge (1981)
Capacity	McLaughlin (1987, 1998), Mazmanian and Sabatier (1981), O'Toole (1986)

In addition to the above analysis, contributions from various social science disciplines on improving the effectiveness of implementation were explored. Hogwood and Gunn (1984) use four approaches to explain variables that affect implementation. These are: structural, managerial, behavioural and political approaches. The structural approach emphasises the need to establish organisational structures in the "planning of change" and "planning for change" (Hogwood and Gunn, 1984). These structures are regarded as crucial for the success of implementation.

The managerial approach, on the other hand, views implementation as a managerial problem. This approach emphasises the development of appropriate processes and managerial procedures (Hogwood and Gunn, 1984). These procedures and processes

include clear statements of objectives, performance standards, funding and resources, and monitoring and control devices to ensure that the programme proceeds as intended. Lazarus (2001) has also pointed out the importance of legislative pressure, control and ownership, finances and sustainability, clear vision, principles and procedure, and intentional forward planning in the process of change.

The structural and managerial approaches resonate with the top-down approach to implementation. The behavioural approach starts from the recognition that there is often resistance to change, and argues that "human behaviour and attitudes must be influenced if policies are to be implemented" (Hogwood and Gunn 1984:212). In support of this view, Lazarus (2001) regards successful experiences and readiness to change as some of the crucial variables in the change process. McLaughlin (1987; 1998) asserts that the implementers' "will" or "motivation" is the most crucial variable for successful implementation. She argues that "local choices about how (or whether) to put a policy into practice have more significance for policy outcomes than do such policy features as technology, program design, funding levels, or government requirements". McLaughlin asserts that the "will" or "motivation" to embrace policy objectives is a necessary condition for effective implementation.

The political approach takes into account the realities of power. Implementation success in this approach is linked to the "willingness and ability of some dominant group or coalitions of groups to impose its will" (Hogwood and Gunn, 1984:216). To support this view, some researchers emphasise the importance of negotiations and the bargaining process during implementation (Christie, 2008; Fataar, 2006; Lowry, 1992; Maharaj, 2005; Sehoole, 2002). They argue that policy implementation is not about transmission

but about bargaining and negotiation. Lazarus (2001) supports the importance of involving strategic people in the process of change. Both the behavioural and political approaches mirror the bottom-up approach to policy implementation.

In conclusion, it is important to note that there is convergence on the critical variables relating to policy implementation identified by the scholars referred to above. Factors that are found to facilitate or constrain policy implementation in the literature are summarised as follows: The content of the policy itself; The context through which the policy must be implemented; The commitment of implementers to the policy; The capacity of implementers to implement the policy; The attitudes of implementers towards the policy; The support of clients and coalitions whose interests are affected by the policy.

2.5 Barriers to policy implementation in developing countries

The problem of policy implementation in developing countries could be likened to the assertion of Honadle (1979) who argued that poor implementation or the existence of an implementation gap can be viewed as social carpenters and masons who fail to build to specifications and thus distort the beautiful blue print. Egonmwan (1971) noted that there is often a gap between policy designers and the powerful forces of politics and administration and implementers. The gaps weaken the process. Any implementation gap results in the widening of the distance between stated policy goals and actual goals realized.

Any implementation gap may be attributed to the policy itself, the policymakers or the environment within which the policy is made and implemented (Makinde, 2005). Thus,

in the case of the top-down approach the problem emanates from the top and not the other stakeholders in the policy implementation process. This is the case in Ga West Municipality where the beneficiaries of the insurance policy such as the subscribers of the insurance scheme are not included in the policy formulation process.

Another problem that may face implementation in developing countries is the issue of bribery and corruption. This may arise where huge amounts earmarked for projects get diverted by officers in charge of implementation for their personal use (Makinde 2005). Corruption has been the bane of most African government's policy implementation processes and has greatly affected the implementation of policies in developing countries especially. The abandonment of projects referred to as planned indiscipline according to Egonmwan (1991) also results in implementation deficits. The abandonment of projects may result from political regime changes, personal interests and the adoption of sophisticated techniques that are not well understood by local agencies and implementers.

Other factors identified as causing implementation problems in developing countries include the problem of not taking into consideration the socio-cultural context of the policy on policy beneficiaries. Any policy that goes against the socio-cultural beliefs and practices of intended beneficiaries may not be successful and therefore results in a gap. Inadequate or lack of funds may also result in implementation gap. Egonmwan (1984) identifies some problems that affect policy implementation in developing countries as inadequate definition of goals (lack of clarity and internal consistency), over-ambitious goals; and the choice of an inappropriate organisational structure in the implementation of policies.

Grindle (1980) and Grindle and Thomas (1990) appear to have a lot of reasons why implementation in developing countries fail. Some of the factors identified to be responsible for implementation failures include: lack of capacity (Palmer, 2000; Larbi, 1998; Mills et al, 2001); bureaucratic inertia (Brinkerhoff and Crosby, 2002); lack of political and bureaucratic commitment (Grindle and Thomas, 1990; Grindle, 1997; Cleaves, 1980; McCourt, 2001; Ayee, 1997); unclear policy objectives (Ayee, 1995; Grindle and Thomas, 1991); policy characteristics (Quick, 1980; Grindle, 1980; Grindle and Thomas, 1991); politicisation of implementing agency and its leadership (Quick, 1980) and institutional and resource constraints (Batley and Larbi, 2004; Brinkerhoff and Crosby, 2002; McCourt and Sola, 1999).

Malama (2003) identified five key conditions for ensuring effective implementation of public policy: (1) political support; (2) sufficient funding; (3) appropriate institutional arrangements; (4) building of sufficient consensus to have enough broad based support for the policy; and (5) proper monitoring of the reform process. Yet another factor that affects implementation is the nature of the implementing agency. With particular reference to decentralisation of implementation, Cheema and Rondinelli (1983) argue that effective implementation of reform policy in developing countries is closely related to four sets of factors, namely: Environmental conditions; Inter-organisational relationships; Resources for programme and policy execution; Characteristics of implementing agencies.

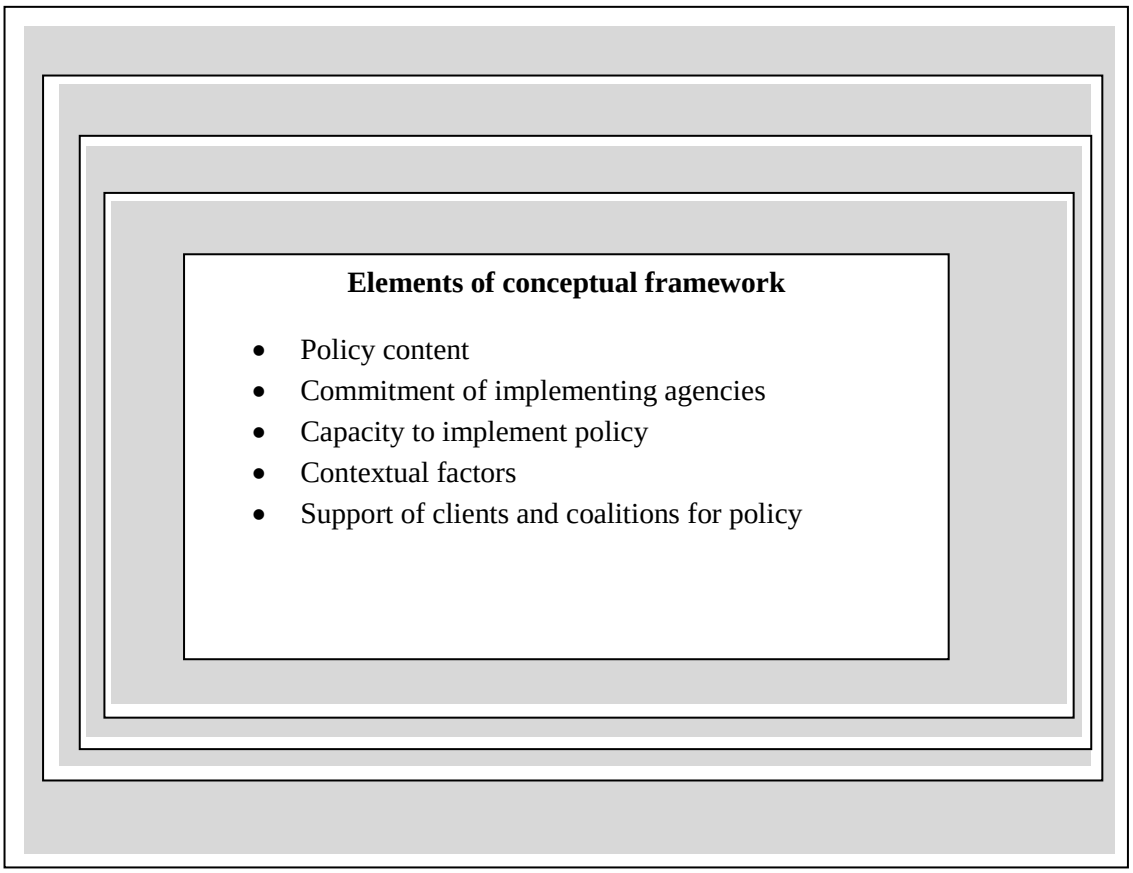
The factors that affect implementation agencies according to Cheema and Rondilli (1983) include technical, managerial, policy implementation skills of the agency's staff,

the agency's capacity to apply all the principles of management to the implementation; the ingenuity of personnel involved in integrating the decisions of all sections/departments plus the benefits gained from both political and bureaucratic leadership and making good use of the strength of bureau-professional and other clientele groups. These are very important organisational features that come into play for policy implementation success. The tactical approach that the agency adopts in dealing with its clients, stakeholders, beneficiaries, the private sector and opinion leaders and allied civil society groups are equally very important. The quality of leadership within the implementing organisation, the acceptance, cooperation and commitment to the policy objectives among the organisation's staff and, often the location of the organisation in the bureaucratic hierarchy also exert a critical impact on the implementation of a policy.

2.6 Conceptual Framework

This section presents a synthesis of variables that affect policy implementation based on the literature review provided above. The systems approach is regarded as the most valuable tool for the conceptualisation of these variables. This approach is specifically helpful in exploring the variables at different levels of the health system, namely, national, regional, district and hospital. This framework was developed to guide the investigation of the factors that affected the implementation of the mutual health insurance scheme in Ga West Municipality. This framework consists of five elements which will be discussed below. These elements include: policy content, context, commitment, capacity, support of clients and coalitions. A diagram of the conceptual framework is depicted in Figure 2.4

Figure 2.4: Conceptual Framework



Source: Researcher (2013)

2.6.1 Policy Content

Policy content is one of the critical pillars on which policy implementation is based. It is generally regarded as a crucial factor in establishing the parameters and directives for implementation, although it does not determine the exact course of implementation (Brynard and De Coning, 2006). The content of policy includes: what it sets out to do, that is the objectives, how it relates to the problem to be solved which is the causal theory, and how it aims to solve the problem, that is, methods (Brynard and De Coning, 2006). In top-down approaches to policy implementation, goal clarity is seen as an important variable that directly affects policy implementation. Matland (1995: 157) states that "goal ambiguity" is seen as leading to misunderstanding and uncertainty and

often is culpable of implementing failure. Supporting this view, Gornitzka et al. (2005) note that clear and unambiguous policy goals are easier to implement than a set of complex and contradictory goals.

Cerych and Sabatier (1986) begin from the premise that success or failure of policy is dependent on the extent of the changes required, and the clarity and consistency of policy goals. These authors argue that the more complex the changes required by policy are, the lower the degree of success of policy implementation. Also, there is more chance of success if the policy is clear and consistent. The emphasis on consistent policy objectives as a condition for effective implementation was criticised by scholars such as Elmore (1980) and McLaughlin (1998) who support a bottom-up approach to policy implementation. These scholars do not focus on policy objectives as prescribed by the government, but rather focus on policy objectives as constructed by local implementers through the bargaining and negotiation process, as well as the initiatives from these actors.

With regard to causal theory, several researchers argue that policies are sometimes ineffective, not because they are badly implemented, but because they may be based upon an inadequate understanding of the problem, its causes and the possible solutions (Cerych and Sabatier, 1986; Hogwood and Gunn, 1984; Pressman and Wildavsky, 1973; Sabatier, 1986; 2005). In other words, if the theory underpinning the policy is fundamentally incorrect, the policy implementation will fail.

2.6.2 Commitment of implementers to the policy

It is generally assumed that the most important factor in individual success is commitment. Commitment means pledging oneself to a certain purpose or line of action. Commitment, like all other abstract things, is subjective and very difficult to measure. However, there are indicators that show the level of commitment of an individual to a particular task. One indicator is fulfilling obligations and promises, especially when one knows what one's role and responsibilities are. Scholars who support both the top-down and bottom-up approaches to policy implementation consider commitment to be critical to effective implementation. These scholars argue that policy may be good, but if the implementers are unwilling to carry it out, implementation will not occur (Brynard and De Coning, 2006; Mazmanian and Sabatier, 1981; McLaughlin, 1987; 1998; Van Meter and Van Horn, 1974, Warwick, 1982). UNESCO's Global Monitoring Report (2005) also notes that government commitment and leadership is crucial for policy success.

Brynard and De Coning (2006: 199) reinforce the importance of the commitment factor in policy implementation and make two propositions:

First, commitment is important not only at the "street level" but at all levels through which policy passes – in cases of international commitments, this includes the regime level, the state level, the street level, and all levels in between.

Second, in keeping with a web-like conception of inter-linkages between the five variables, indicated figure 2.1 commitments will influence and be influenced by all the four variables: content, capacity, context and clients and coalitions. Those interested in effective implementation cannot afford to ignore any of these linkages and are best

advised to identify the ones most appropriate to "fix" particular implementation processes.

As stated earlier, commitment is difficult to measure but can be seen through a person's actions. There are critical questions that one can ask to determine whether there is commitment to the policy. For example, what resources do implementation parties have, and how much are they willing to engage in the implementation? What is the duration of their commitment? To what extent are officials at national, regional, district and hospital levels willing to implement the mutual health insurance policy? Is mutual health insurance policy part of the national / regional / district / hospital development plans?

2.6.3 Support of clients and coalitions for implementation

As stated earlier in this chapter, the research highlights the importance of having coalitions of interest groups, leaders, and other actors outside the government, who support implementation. Elmore (1980), in particular, considers the formation of local coalitions of those affected by the policy to be one of the most crucial elements during implementation. The success or failure of policy depends on the support the policy generates among those who are affected (Brynard and De Coning, 2006; Maharaj, 2005). Christie (2008: 149) states that though policy makers may prefer to emphasise structural changes, they cannot sidestep human agency and its influence on policy outcomes. To investigate the support of different coalitions in the study the following questions could be asked: Who are the potential clients? What parties (inside and outside government) are likely to support the policy? What support do they give to the implementation process?

2.6.4 Capacity to Implement Policy

Policy implementation studies have shown that the success of any public policy rests on the capacity to implement it (Fukuda-Parr, Lopez and Malik, 2002; Makoa, 2004; McLaughlin 1987). In the Ghanaian context, capacity is regarded as a strategic entry point to the development and implementation of policies. It is generally known that many development efforts have failed in many countries because they lack institutions with the ability to implement and sustain policies, and Ghana is no exception. One of the commonly cited reasons is lack of capacity to sustain development.

Capacity is generally defined as the ability to perform functions, solve problems and set and achieve objectives (Fukuda-Parr, Lopez and Malik, 2002; McLaughlin, 1987; 1998). This concept is vague and means different things to different people. Some people assume a narrower approach that does not go beyond individuals' abilities to perform certain functions, while others assume a broader and systemic approach. This systemic approach looks at the capacity of other subsystems as they interact with each other to produce outcomes. One such example is found in Brynard and De Coning (2006) who view capacity in terms of the general system's (structural, functional and cultural) ability to implement the policy objectives. Honadle (1981) views capacity as the ability to perform six tasks, namely: to anticipate and influence change, make informed decision about policy, develop programmes, attract and absorb resources, manage resources and evaluate activities.

Willems and Baumert (2003), on the other hand, pay attention to all the dimensions of institutional capacity. These dimensions include: empowerment, social capital, an enabling environment, culture, values, and the way individuals and organisation interact

in the public sector and within society as a whole. Willems and Baumert's capacity assessment framework distinguishes between three levels of institutional capacity: micro level (individual); meso level (organisation) and macro level (broader context). The macro level is further divided into three distinct levels. These levels include: network of organisation, public governance and society, norms, values and practices.

2.6.5 Attitudes of implementers towards the policy

Lessons from policy implementation research show that the health sector can provide good policy, support, and resources and build the capacity of participants to implement the policy, but if attitudes have not changed, the implementation will fail (McLaughlin, 1987; 1998). McLaughlin argues that success of any policy implementation depends on two broad factors: local capacity and willingness. She further argues that training can be offered, consultants can be hired and funds can be made available, but if there is no willingness on the part of the implementers, implementation will not be successful. Therefore the success of mutual health insurance is dependent on the attitudes of the actors involved.

Praisner (2003:3) contends that leaders demonstrate their beliefs and priorities in the following way: How they make and honour commitments; What they say in formal and informal settings; What they express interest in and what questions they ask; Where they choose to go and with whom they spend time; How they organise their staff and their physical surrounding. The question is: How can one determine whether role players' attitudes are positive or not? It is generally accepted that the concept "attitude" is a very complex phenomenon. It is complex in the sense that it is difficult to observe directly. One can only infer people's attitudes from their expressed viewpoints and from what

they do. Attitudes are generally divided into three components: affective, cognitive and conative components. An attitude is therefore a combination of three conceptually distinguishable reactions to a certain object (Avramidis, Bayliss and Burden, 2000).

2.6.6 Context of Implementation

Researchers are in general agreement that policy implementation is affected by the context in which policies are implemented (Brynard and De Coning, 2006; Maharaj, 2005; O'Toole, 1986; Van Meter & Van Horn, 1975; Warwick, 1982). Policies that work in one context may fail in another. Gornitzka et al. (2005) also state that the socio-cultural, socio-economic and socio-political conditions of the implementing agency shape the outcomes of policy implementation. To investigate the socio-economic, socio-cultural and socio-political factors that affect the inclusive nature of implementation, several questions could be asked. These are: How are decisions made in the national, regional and district hospitals about mutual health insurance scheme? What structures influence policy implementation at national, regional and district hospital levels? Are finances available to provide the services needed in the implementation of the mutual health insurance scheme? How do cultural practices influence the implementation of the mutual health insurance scheme?

2.7 Summary and Conclusion

In an attempt to understand factors that impinge on the implementation of policy, two dominant approaches that are used in explaining and analysing policy processes were explored, namely, top-down and bottom-up. In addition, different frameworks that seek to synthesise these approaches were examined. A top-down approach begins with the objectives and goals of the policy, and measures implementation success or failure in

terms of the original objectives. This approach assumes that clear objectives and control by policymakers will lead to a more effective implementation. The bottom-up approach, on the other hand, places value on the role of local implementers and on the organisation that is trying to solve the problem. This approach acknowledges that policy is not the only determinant affecting the implementation, but that local conditions influence implementation.

Theories that combine top-down and bottom-up approaches acknowledge the role of policy objectives, as well as the discretion of local implementers and the effects of local conditions. The conclusion that can be drawn is that policy implementation is a complex process and there are many factors that contribute or hinder effective implementation. These factors can be best captured by using a combination of these approaches. A simplified combination model has been constructed in order to organise the data collected in this study.

CHAPTER THREE

IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN GHANA

3.0 Introduction

This chapter adopts a broad perspective on the context of the study. It narrates the history of the implementation of the mutual health insurance scheme through the National Health Insurance Authority. The chapter first outlines the historical context of the health insurance in Ghana, the national health insurance in Ghana, the implementation of the health insurance scheme and the actors involved in the implementation. The health insurance scheme is implemented in the whole nation, but this chapter limits its focus to the Ga West Municipality context.

3.1 Historical context of the health insurance in Ghana

Under colonial rule, Ghana, as many other African countries, organized its health system primarily to benefit a small elite group of colonisers and their workers (Arhin-Tenkorang, 2001). Health care provision occurred mainly through hospitals in urban areas, with direct payment at the point of use. The rest of the population relied on services from a range of providers such as traditional healers and missionary health centres. After independence, the government of Ghana provided medical care free of charge to their population at public health facilities. Health care was financed by general taxes and external donor support, user fees were removed and attention was directed to developing a wide range of primary health care facilities across the country.

By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax based health financing system. In the health sector there were shortages of essential medicines and equipment, leading to poor quality of care. In 1985, Ghana initiated health sector reforms as part of broader structural adjustment programs aimed mainly at reducing government spending. Cutting down on spending was to address budgetary deficits. In the health sector, cost recovery mechanisms through user fees were introduced (traditionally known in Ghana as "cash and carry"). Furthermore, health services were liberalized which allowed more private sector involvement. The financial aims of the reform were achieved and shortages of essential medicines and some supplies improved. However, these achievements were accompanied by inequities in financial access to basic and essential clinical services (Waddington and Enyimayew, 1990).

During the 1990s several community health insurance schemes, popularly called Mutual Health Organizations (MHO) emerged in Ghana with some external funding and technical support. Most of them focused on providing financial protection against the potentially catastrophic costs of a limited range of inpatient services (Fusheini et al., 2012).

In 2000, as part of their campaign, the New Patriotic Party, promised to abolish the "cash and carry" system and to remove financial barriers to utilization of health care (Fusheini et al 2012). In line with this objective, the National Health Insurance Scheme (NHIS) was launched and the National Health Insurance Act (Act 650), passed into law in 2003. The scheme was aimed at replacing out-of-pocket fees at point of service use and of making health care affordable, improving access and health outcomes. The implementation of NHIS in terms of access to benefits began in 2005.

3.2 The National Health Insurance Scheme

The National Health Insurance Act (650, 2003) established a National Health Insurance Authority, governed by a Council, to regulate the health care system, including the accreditation of providers, agreeing on contribution rates with the schemes, managing the National Health Insurance Fund and approving cards for membership. The National Health Insurance Act also stated that three types of health insurance schemes may be established and operated in the country: (a) district mutual health insurance scheme (DMHIS), one for each district, with a minimum of 2000 members; (b) private commercial health insurance schemes and (c) private mutual health insurance schemes. With the exception of the first insurance scheme, the last two are not eligible for subsidies from the government since they are privately operated.

The Council, which includes representatives of main stakeholder groups, establishes formula for allocation of funds to pay for subsidies to schemes, cost of enrolling the indigent and supporting access to health care. The funding sources come mainly from the National Health Insurance Levy (2.5% of V.A.T.): secondary sources are pay roll deductions (2.5% of income) for formal sector employees and premium for informal sector members. Other funds come from donations or loans.

In terms of membership of the NHIS, the Act establishes that it is mandatory for all Ghanaian citizens, unless alternative private health insurance can be demonstrated. However, in practice, membership is optional for non-formal sector workers who represent the bulk of the population. For formal sector workers, a payroll deduction of 2.5% is transferred to the NHIS fund as part of their contribution to the Social Security

and National Insurance Trust (SSNIT) fund. Informal sector workers are charged premium that should be income related. Contributions by those outside the formal sector are supposed to be defined according to income such that the lowest-income group pays a premium of 7.20 Ghanaian cedi (GH¢) or US$ 8 while those in the highest income group pay a premium of GH¢ 48.00 or US$ 53.2. In reality, a flat premium payment of GH¢ 7.20 per annum is charged due to the difficulty of categorizing people into different socio-economic groups. There is a six-month gap between joining and being eligible for benefits.

All providers must offer a minimum package of services that is quite comprehensive, covering general outpatient and inpatient services at accredited facilities, oral health, eye care, emergencies and maternity care, such as prenatal care, normal delivery and some complicated deliveries (HIV retroviral drugs, assisted reproduction and cancer treatment are not included). Diseases covered include malaria, diarrhoea, some respiratory infections, skin diseases, hypertension, asthma, diabetics etc. The benefit package is the same for all districts that pay providers on a fee-for-service basis. According to the legislative Instrument which accompanied Act 650, about 95% of all common health problems in Ghana are covered (Ghana Ministry of Health, 2004a and 2004b). However, it is difficult to establish how this estimate was obtained. The drugs provided are listed in the National Health Insurance Drug List (See Appendix).

3.3 Implementing health insurance in Ghana

In discussing the implementation of health insurance in Ghana, Witter and Garshong (2009) indicated that the NHIS is heavily reliant on tax funding since about 70-75% of revenue accruing to the programme derives from tax. Indeed, the revelation that much of

the contribution comes from taxation itself is an indication that insurance is not too distinct from the traditional funding- since earlier governments still provided some budgetary support in addition to donor funding to the health sector.

The authors also discussed membership to the scheme. They indicate that in principle NHIS is legally mandatory (unless alternative private health insurance can be demonstrated) however membership is optional for non-formal sector workers who incidentally comprise the bulk of the population. Their research revealed that there was growth of membership as the number of card holders rose from 6.6% of the population in 2005 to 45% three years later in 2009. The increase compares very favourably with earlier discussions of other states in Africa particularly, Tanzania. The authors concluded that even though the NHIS extends towards full coverage there were some equity concerns. For example, there were issues regarding regional membership patterns. There was also a high level of registration in the Brong Ahafo Region and the North of Ghana and less so in Greater Accra (Witter and Garshong, 2009).

Since this study is about the implementation of the scheme in one of the municipal areas within a region which has low registration, the argument of Witter and Garshong is useful for this study in discussions on registrations in the area. It must however be indicated that the authors have not provided sufficient reasons why the Greater Accra had low enrolment.

Catherine et al., (2008) explored community based health insurance from the perspective of the supply of medicines in low income countries, including Ghana. Their findings highlight the paucity of evidence about medicines coverage and medicines utilisation in

community based health insurance programmes as well as the need for better understanding of the role of medicines in the overall health care financing of low income countries.

It was established that in Ghana, several factors make systematic analysis of data about the structure and process of community health insurance plans challenging. These factors include: small size, diversity of communities, where they function and lack of infrastructure or technical capacity. They also indicated that the focus of the community health insurance since 2005 to date has been on strategic and political acceptance of community health insurance rather than on community health performance. Overall, their findings suggest that voluntary insurance which includes Community Health Insurance has a very small penetration in low income countries where private payment represented over half of health care expenditures (Catherine et al., 2008).

The conclusion drawn by the authors on low income levels vis-a-vis registration are not without flaws. Because it has been observed already that, enrolment to health insurance is low in the Greater Accra region and high in areas such as the Brong Ahafo and Northern regions (Witter and Garshong, 2009). The Ghana Statistical Service (2007) report places the upper poverty line of the Brong Ahafo and the whole of the north higher than the Greater Accra Region, but the Greater Accra registered low enrolment. With this, one would not but agree to the fact that it is not only poverty which can affect registration. As precisely indicated low access to health care in the Greater Accra is not due to poverty but due to a comfortable level of income realised by some of its residents. Despite the criticism, the research provided an important framework for this study. For

example, using their study as a guide, this study considered implementation vis-a-vis access to medicines in the various health facilities in the study area.

Gobah et al., (2011) in their study of NHIS in the Akatsi District conclude that, NHIS has improved access to healthcare services, to different categories of people by removing significant financial barriers to access. The findings suggest that NHIS positively affected health seeking behaviour, access to modern health care services and likelihood of delivery at a health facility and being assisted by trained health personnel. Gobah et al., (2011) further indicate that NHIS also had positive effect on postnatal care but found no evidence of it on usage of antenatal care.

Mensah et al., (2010) evaluateed Ghana's NHIS within the context of the Millennium Development Goals (MDGs) 4 and 5 which deal with the health of women and children. Their findings suggest that with NHIS, women are more likely to receive prenatal care, deliver at a hospital, have their deliveries attended by trained health professionals, and experience less birth complications. They conclude that NHIS is an effective tool for improving health outcomes among those who are covered, which should encourage the Ghanaian government to promote further enrolment, in particular among the poor. Indeed the NHIS has been seen as an effective tool to reach the three health MDGs, namely: reducing infant mortality; improving maternal health; and, fighting malaria and HIV/ AIDS (goals 4, 5, and 6).

However, attributing increased utilization of maternal health care services solely to NHIS is inconclusive because the study should have taken the impact of the free maternal health care policy into consideration. The policy was rolled out in 2004 and

according to Witter et al (2009), the exemption policy was cost effective in that it increased utilization significantly and made modest equity gains. More so the impact of NHIS coverage on the utilization of maternal healthcare services may vary significantly across the country.

USAID (2009) also investigated the impact of NHIS on maternal health in Ghana. They found that there were no significant changes in the proportion of women who received any prenatal care, or in the average number of reported prenatal care visits between baseline and end-line, indicating that the NHIS did not increase utilization of prenatal care. In Nkoranza, where the study was conducted, it indicated that the proportion of women with delivery in the past 12 months who were insured at time of delivery increased from 30% in 2004 to 45% in 2007. Women of reproductive age (15-49 years) from wealthier households enrolled in the NHIS at higher rates, compared to women from poorer households.

Osei-Akoto (2003) also studied the social inclusion aspects of community based health insurance schemes by investigating the demand for the schemes by the poor and exploring design features that could enhance better coverage and improve financial protection for health care services. The results from this study show that the schemes perform quite well in terms of paying hospitalization bills for beneficiaries. However the findings portray a remarkable exclusion of the poorest of the poor, even from other forms of risk-sharing arrangements in the informal sector.

Apart from poverty, the analysis also reveals that high-risk households are less likely to participate fully in the insurance schemes. These findings expose one of the

implementation challenges of NHIS in that the poorest of the poor and the indigent are exempted from the payment of premiums as the Act stipulates categorically. However in practice this provision is becoming illusive with the excuse that identifying the poor is a difficult task.

From what has been discussed so far it is evident that health insurance in Ghana has several dimensions and also includes a number of actors. The next component is a brief discussion of some of the actors in the implementation of the health insurance in Ghana.

3.4 Actors in the implementation of health insurance

The implementation of the National Health Insurance Scheme involves a variety of actors in the process. All these actors have certain roles that they are supposed to play for the smooth implementation and realization of the goal of the scheme. This section provides a brief literature on the role of the various actors in the implementation process of the scheme.

3.4.1 Role of Government in the implementation of health insurance

The government is the major policy actor in the implementation of the national health insurance scheme. Government exercises oversight responsibility in the implementation of all health policies. Again government sets policy agenda and introduces bills to change policies, design policies with the aid of bureaucrats in the ministry as well as engage development partners and other stakeholders on issues in the health sector. Government also seeks to reduce health expenditure by getting the public to contribute to the scheme. As we have already observed above, government ensures that VAT is levied

and deductions made on SSNIT contributions and gives mandate to the DMHIS to collect contributions through premiums.

3.4.2 The National Health Insurance Authority

The National Health Insurance Authority (NHIA) is the statutory body mandated to secure the implementation of the NHIS. It is responsible for the registration, licensing and regulation of all health insurance schemes in Ghana. The NHIA also oversees the operations of DMHISs, grants accreditation to healthcare providers and monitors their performance for efficient and quality service delivery, manage the NHI fund and devises mechanisms to ensure that indigents are properly catered for by the DMHIS (NHIA Annual Report, 2010).

3.4.3 Service providers

Since independence, the Ghana Health Services has always implemented government healthcare policies together with partners. The Municipal Health Directorate in conjunction with the Ministry of Health also plays an important role in the implementation of the insurance scheme. In terms of implementation, they govern and provide oversight responsibilities of the scheme in addition to providing or supplying services. The health directorate assists government in developing and shaping policies in the country, charged with the responsibility of providing quality health care services based on international standards.

3.4.4 Staff of the Scheme

To ensure accountability NHIS is decentralized to regional and district levels. The office of the DMHIS in Amasaman was established in 2005 to assist the implementation of the

health insurance programme at the district level. Staffs in Amasaman are the implementing officials and management body of the Ga District Scheme. Their core functions are the registration of subscribers, issuing of ID cards to registered members, renewal of membership, collecting premium from members in the informal sector, vetting and processing claims submitted by healthcare providers. They are also responsible for generating enough funds to ensure sustainability. Usually the District manager of the scheme takes decisions in consultation with the Board. The operational office in Amasaman is semi-autonomous; in part some of their decisions are tied to the decisions taken by the CEO and management in consultation with the Health Insurance Authority.

3.4.5 Subscribers

In theory the subscribers are mainly consumers of services offered by government, health providers and managers of the scheme. In practice however the subscribers play a very important role in the implementation of the programme. As we shall realise soon the increase in numbers of subscribers to the scheme is not mainly due to the efforts of the staff or managers of the scheme but also due to individual subscribers who took it upon themselves to educate members of the community to subscribe to the scheme. Again it is the subscribers who provide information to the scheme managers about the nationality of subscribers so as to reduce the number of non-Ghanaians who are cheating the system by getting registered as resident Ghanaians. If one considers these roles played by the subscribers' one will not but agree that they indeed play an important role in the implementation.

3.5 Summary and Conclusion

This chapter dealt with the review of related literature on the implementation of the NHIS in Ghana. The review includes the historical context of the health insurance in Ghana, the national health insurance scheme and the various actors and their role in the implementation of the scheme.

CHAPTER FOUR

METHODS OF DATA COLLECTION AND ANALYSIS

4.0 Introduction

This chapter focuses on the methods used in conducting this study. The issues discussed in this chapter include the research design, the population of the study, sample size, sample technique and procedure, sources of data, data collection instrument and data analysis. The chapter also entails the types of data collected from the management of the scheme, varied healthcare service providers, and subscribers of the scheme who were contacted.

4.1 The Research Design

A research design specifies the methods and procedures for acquiring the information needed to structure and solve the research problem and stipulates what information is to be collected, from what sources, and by what procedures. A good research design ensures that the information obtained is relevant to the research problem, and that it is collected by objective procedures. There is no single best research design. Instead, different designs offer an array of choices, each with certain advantages and disadvantages.

A survey research design was used to undertake the study on implementation of NHIS in the Ga West Municipality. This research design was considered appropriate because it is the best method to describe the characteristics, perceptions and preferences of the Scheme under study (Saunders et al., 2009). This design was also chosen because it has

the advantage of producing a good amount of responses from a wide range of respondents. It also provides a clear picture of events and people's behaviour on the basis of data gathered at a point in time. The study however adopted a mix method approach where both quantitative and qualitative techniques were used to analyse the data.

4.2 Population and Sample Size of the Study

The population for this study is all registered health insurance clients, management or staff of the scheme, and staff of healthcare providers in the Ga West Municipal Assembly. Therefore, the units of analysis in this study are three, that is: the registered health insurance clients; management or staff of the scheme; staff of healthcare providers in the Ga West Municipality.

Respondents were randomly, as well as, purposively drawn from the appropriate sections of the study. In the end, one hundred and forty subscribers, thirty healthcare providers, and thirty staff and management of the scheme were sampled. Bringing the total number of questionnaires distributed to two hundred. However, out of two hundred questionnaires distributed, one hundred and sixty questionnaires, representing 80.0% were retrieved. This was made up of one hundred respondents from the subscribers, thirty from the management of the scheme and thirty from the healthcare providers in Ga West Municipality in the Greater Accra Region. These samples were used based on the assumption that all the subscribers, management and healthcare providers are exposed to the same working environment. Thus, all things being equal, the answers provided by any of them at any time were unlikely to vary from those of the others.

4.3 Sampling and Sampling Technique

The simple random and purposive sampling techniques were used to select the respondents for the study. The simple random sampling technique was used to select the subscribers to the scheme. In using this technique, subscribers at the schemes' office were administered questionnaires while at the health providers end, patients at the out-patient and in-patient departments were given questionnaires to answer. A purposive sampling technique was also used to select the staff and management of the scheme. In spite of the purposive sampling technique, a careful attempt was made to ensure that top officials of the scheme were purposively sampled as they are the right people to answer such questions relating to the implementation of the scheme. Therefore, key staffs like the scheme manager, the claims manager and MIS manager were part of the respondents. With respect to the healthcare providers, a simple random sampling technique was used to first select the health facility and then the respondents.

4.4 Sample Size

The total population of this study is large considering the fact that it involves all subscribers of the scheme in the Ga West Municipal Assembly, the management of the scheme and healthcare providers. But due to time and difficulty in data collection, few respondents were selected for the study. A total of one hundred and forty (140) subscribers, thirty (30) members of the management of the scheme and thirty (30) healthcare providers' were sampled for the survey. In all, two hundred (200) respondents were used for the study.

4.5 Types and Sources of Data

Both secondary and primary data were used for the study.

4.5.1 Secondary Data

Secondary data is processed information that is readily available to be utilized. Some of the secondary data used include Statistical figures on implementation, utilization, claims and quality of service from NHIS, as well as annual reports of GDMHIS in the Ga West Municipality**.** Literature was also reviewed. The literature reviewed covered relevant issues, which were considered important to the research topic. Examples include the history of health care in Ghana, as well as, literature on implementation and the general application of the NHIS in Ghana.

4.5.2 Primary Data

Primary data provides first hand information on any subject under study. The primary data was collected from respondents through the use of a questionnaire which was administered to three sets of respondents; subscribers, healthcare providers and management of the scheme at the Ga West Municipal Assembly.

4.6 Data Collection Instruments

The main data collection instrument for the study was questionnaire. This was considered the best instrument as it enabled individuals to stay quietly alone at their own free will to answer the questions. Questionnaires were thus used to gather primary data from the three sets of the respondents. Questionnaire was used because of the large number of the sample size and also its convenience. Generally, the questions in the questionnaire were carefully framed, since answers given to questions depend on how the questions are asked. In designing the questionnaire adequate attention was paid to ensuring that the objectives of the research were covered. The questionnaire was developed mainly through a review of relevant documentary materials. The questions

were mostly close-ended with few open-ended ones. While the open-ended questions enable the respondents to give elaborate responses and express themselves better, the close-ended questions enabled the researcher to guide the respondents to answer the questions appropriately.

There were three sets of questionnaire for the staff of the scheme, the subscribers and healthcare providers. The questionnaires were divided into four sections; section "A" was made of demographic information of the respondents; section "B" contained questions on the factors that facilitate implementation of the scheme, section "C" dwelt on the factors that constrain the implementation of the scheme, "D" had questions on the roles played by the various actors in implementation, while section "E" solicited recommendations and suggestions for improvement in the implementation of the scheme. Please check appendices A, B and C for details.

4.7 Ethical Considerations

Respondents were assured of confidentiality, as their consent was appropriately sought with respect to all information they provided. Respondents were also informed that the work was purely for academic purposes and not for reasons other than that. The privacy and confidentiality of all participants was assured. All documents used and sites visited have also been properly acknowledged and documented to avoid issues of plagiarism.

4.8 Analysis of the Data

The questionnaires were analyzed using the Statistical Package for Social Sciences (SPSS) version 16.0 software and were supported by the application of frequency tables. The interpretation of the frequency tables has been thoroughly given.

4.9 Summary and Conclusion

This chapter discussed the methods of data collection for this study. It concentrated on the research design, sampling and the sample procedure, sample size as well as the data collection instrument which was basically a questionnaire. The next chapter will therefore analyze the data that was obtained from the field.

CHAPTER FIVE

DATA PRESENTATION, ANALYSIS AND DISSCUSION ON THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME

5.0 Introduction

This chapter analyses data collected from the actors in the implementation of the National Health Insurance Scheme in Ga West Municipality. In all, a total of 160, people made up of 100 subscribers, 30 people responsible for the implementation of the scheme and 30 respondents of the health facilities. To be able to draw meaningful, valid and reliable conclusions from the data gathered as well as make relevant conclusions and recommendations, descriptive and quantitative analysis in the form of frequency tables were constructed showing the frequency as well as the percentage for each item on the questionnaire. The data was analyzed by using the Statistical Package for Social Sciences (SPSS) version 16.0 software and was supported by the application of frequency tables.

5.1 Demographic information of respondents

This section gives brief demographic background of the respondents. The demographic information here comprised those of the subscribers, management of the scheme and the healthcare facilities which is displayed in Table 5.1. The responses of the subscribers show that majority of the respondents fall within the ages of 26-35 (40.0%) while a minority of them were over 65 years (3.0%). With respect to the management of the scheme, 56.7% of the respondents fell within the ages of 18-25 and 6.7% were also in the ages of 51-55. The details are shown in Table 5.1 below. With respect to the respondents

of the healthcare facilities, majority of the respondents were within the ages of 36-50 (43.3%) while the minority were within the ages of 18-25 (10.0%).

Table 5.1: The age distribution of respondents

Subscribers			Management of NHIS		
Age (years)	Frequency	Percentage	Age (years)	Frequency	Percentage
under 18	6	6.0%	18-25	17	56.7%
18-25	24	24.0%	26-35	7	23.3%
26-35	40	40.0%	36-50	4	13.3%
36-50	17	17.0%	51-55	2	6.7%
51-65	10	10.0%	56-65	0	0.0%
Over 65	3	3.0%	Over 65	0	0.0%
Total	100	100.0%	Total	30	100.0%

Health providers		
Age (years)	Frequency	Percentage
under 18	0	0.0%
18-25	3	10.0%
26-35	10	33.3%
36-50	13	43.3%
51-55	4	13.3%
55- 60	0	0.0%
Total	30	100.0%

In relation to the gender of the respondents, 53.3% of the subscribers were males while 47.0% were females. In the category of the management of the scheme, 54.8% of them were males while 45.2% were females. Similarly, 66.7% of the respondents were males while 33.3% were females in the category of the healthcare providers. In all the categories male respondents dominated.

The educational background of the respondents is presented in Table 5.2. It shows that only 12.0% of the subscribers do not have formal education with the remaining 96.0% having all forms of formal education. In the category of the healthcare providers, only

6.7% of the respondents do not have formal education while the remaining 93.3% have all forms of formal education. The educational level of the management of the scheme indicates that 54.8% of them had a diploma, 29.0% had first degree while 9.7% had masters degree.

Table 5.2: The educational background of respondents

Subscribers			Healthcare Providers		
Education	Frequency	Percent	Education	Frequency	Percent
No education	12	12.0%	No education	2	6.7%
Elementary	11	11.0%	SHS	1	3.3%
SHS	9	9.0%	Nursing	5	16.7%
Teacher's Cert A	6	6.0%	Diploma	7	23.3%
Diploma	13	13.0%	Degree	6	20.7%
Degree	26	26.0%	Masters	8	26.7%
Masters	18	18.0%	Secretarial	1	3.3%
PhD	1	1.0%	Total	30	100.0%
Technical	2	2.0%	Management		
DBS	1	1.0%	Diploma	17	56.7
Secretarial	1	1.0%	Degree	8	26.7
			Masters	3	10.0
			PhD	2	6.7
Total	100	100.0%	Total	30	100.0%

5.1.1 Occupational background of respondents

With the exception of the subscribers, the other two categories of respondents (the scheme managers and the service providers) had similar background and related job experiences. The scheme management team was working with the scheme while the service providers also were working in a health or health related facility. Unlike the scheme managers and the providers, the subscribers to the scheme indicated a wide range of jobs. The occupational backgrounds indicated by the respondents included:

pensioners, students, assembly members, private business men and women, civil servants, driving, mining, teaching and farming.

It was found that the three most common occupations among the subscribers were private business (33%), farming (18%) and civil/public servants (14%). Farming and trading constituted 42% of the respondents as compared to the civil /public servants who formed only 14%, while unemployment accounted for 7% of the subscribers. It could be said that this finding reflected the low educational background of the subscribers in the district. As a result, civil and public services which invariably required higher educational qualification were not very common in the district (14%) compared to trading which registered 24 percent.

5.2 Factors that facilitate the implementation of NHIS in Ga West Municipality

This section presents data collected, descriptive analysis of data and discussion of the findings in the study, concerning the factors that facilitate implementation of NHIS in Ga West Municipality. The analysis here is based on the three categories of actors in the scheme: management of the scheme, healthcare providers and subscribers.

5.2.1 Management's perception of the factors that facilitate the implementation of NHIS in Ga West Municipality

The management of NHIS at the MMDAs is one of the major actors in the implementation of NHIS. They are in charge of registration, collecting premiums, issuing cards, processing claims and the overall management of the scheme. The factors that facilitate implementation of the scheme are partially attributed to how the management of the scheme acts. In a question as whether the implementation of the

scheme has been successful or not, 86.0% of the management are of the view that the implementation of the scheme was successful while 14.0% of them think the implementation was not successful. Clearly majority of the management are of the view that the implementation was successful. It is therefore important to find out the factors that facilitate implementation.

Public acceptability of the health insurance scheme

The acceptability of a policy by members of the public is a very good starting point for the implementation of that policy. The data from the field shows that 87.0% of the management of NHIS in Ga West Municipality agrees that its acceptability and cooperation by the public contribute greatly in facilitating implementation. Another 10.0% strongly agrees while 3.0% strongly disagrees with this. Indeed health is wealth and a major concern to the Ghanaian populace, therefore any effort or intervention to make Ghanaians healthy will be warmly welcomed.

Thus from the research, 87.6% of the management of NHIS in Ga West Municipality agrees that its acceptability and cooperation by the public facilitates implementation greatly. This is consistent with other findings in the implementation literature. For instance, Sabatier (1986) concluded that when a programme being implemented is actively supported by organized constituency groups it is highly and more likely to be successfully implemented. Indeed one would expect the general public to respond naturally to a policy that promotes good health issues, especially if such policy has the tendency to alleviate or minimise financial difficulties and challenges. The fact therefore, remains that the support and the willingness of the general public to participate and

accept a policy and cooperate with both the management and healthcare providers is essential to facilitate implementation.

Increasing political commitment

Commitment on the part of administrators and politicians goes a long way to facilitate the implementation of a policy. This commitment will let people put in all their efforts for a successful project. From the table below, 76.7% of the management of the scheme agrees that political commitment has facilitated implementation of NHIS while 20.0% strongly agrees with this. Also 3.3% remained neutral as to whether political commitment facilitates implementation of the scheme or not. It is no wonder that political commitment was rated higher because NHIS has been a political message and has won votes for politicians. This has made them to be committed to the policy as it can change their political fortunes.

The willingness and commitment of both implementers and politicians is very important if a policy is to succeed. This was one of the critical issues that were raised by the respondents in this study. Indeed subscribers also mentioned that political will and commitment facilitated implementation of the scheme. In fact, NHIS has become a major political issue in Ghana and politicians are really throwing their weight behind it to make it successful. McLaughlin (1987) asserts that the "will" or "motivation" to embrace policy objectives is a necessary condition for effective implementation. As some authors put it, political aspect plays a significant role in policy implementation.

Supportive legal and regulatory framework

A legal framework is very important for the implementation of any policy in several ways, such as making it legal and enforceable among others. Against this background, 70.0% of the management of the scheme agrees that a supportive and regulatory legal framework facilitated implementation of the scheme while 26.7% strongly agrees. However, 3.3% of the respondents remained neutral, therefore deciding neither to agree nor disagree. The obvious issue here is that a supportive legal framework is important for the success of a policy. For example, according to management, this framework has made it possible for some taxes to be levied to finance the scheme and some monies to be deducted at source from the salaries of government workers to finance the scheme.

Proper coordination among the various actors

The actors involved in the implementation of NHIS at the local level are the management of the scheme, healthcare providers and subscribers. Therefore it is important that they cooperate and coordinate with one another to facilitate implementation. For instance, a section of management of the scheme in Ga West Municipality indicated that uncooperative healthcare providers will not facilitate implementation of NHIS. Data from management of the scheme shows that 46.7% disagrees corporation among the actors has facilitated the implementation of the scheme. On the other hand, 33.3% of them agrees the proper coordination among the actors has facilitated implementation. The data also shows that 20.0% of the respondents remained neutral as to whether this facilitated implementation or not.

Adequate health facilities

One of the most important factors in the implementation of the NHIS is the availability of healthcare facilities. Clearly, health facilities are important for the subscribers to benefit from being part of the scheme. The data collected from the management of the scheme as presented in the table below shows that 46.7% disagreed that the availability of health facilities facilitates implementation of the scheme. On the other hand, 33.3% agreed while 20.0% remained neutral as to whether the availability of health facilities facilitates implementation of the scheme. Clearly, this data shows that there is no connection between the availability of health facilities and the success of the implementation of NHIS. This may be due to the fact that, the subscribers are only concerned and comfortable with the fact that they have insured their health and whether the facilities are there or not they will go ahead to insure their health.

Managerial ability

Human resources and particularly managerial ability are very important for implementing any public policy. Without sufficient managerial ability it means that laws will not be enforced, services will not be provided and reasonable regulations will not be developed. Admittedly, 13.3% of the respondents strongly agree that managerial ability of the management of the scheme of Ga West Municipality has so much facilitated implementation of the scheme while 36.7% agreed. A total of 30.0% remained neutral while 16.7% and 3.3% disagreed and strongly disagreed respectively that managerial ability has facilitated implementation of NHIS in Ga West Municipality. This data has demonstrated to us the importance of managerial ability in the implementation of NHIS policy. Indeed the availability of the adequate managerial abilities has the potential to influence the successful policy implementation.

Training and capacity building programmes for staff

The availability of managerial ability could also be made possible by frequent training and capacity building programmes for the implementers of the policy. Therefore 50.0% of the respondents agree that frequent training and capacity building programmes have facilitated implementation of NHIS in Ga West Municipality. However, 3.3% strongly disagreed while 23.3% disagreed and another 23.4% remained neutral. The importance of training and capacity building is vital in the implementation of public policies and therefore should be incorporated as part of the policy implementation itself to be able to cope with the challenges as the implementation process unfolds.

Efficient supervision of District Health Insurance

Efficient supervision is a very important component of policy implementation. However, most of the management of the scheme (53.3%) tends to disagree that this has facilitated implementation of NHIS in Ga West Municipality. Again, 26.7% remained neutral on this issue as they could not decide whether efficient supervision of District Health Insurance has facilitated implementation of the scheme or not. In spite of this disagreement, 20.0% of the respondents agree that efficient supervision of District Health Insurance has facilitated implementation.

Adequate technology and accessories

Technology has now been incorporated into every aspect of life and as such has become a significant component of managerial work and decision making in this 21st century. With respect to NHIS, technology and its accessories are used to capture records of subscribers, pay claims to healthcare providers among others. In spite of the major role that technology plays in the scheme, 60.1% strongly disagree while another 33.3%

disagree that technology and its accessories has contributed to the success of the scheme in Ga West Municipality. The implication could be that either they have little technology and its accessories there or even with the technology you still need committed management, finance and human resources to carry out the task of implementation. Yet another 3.3% remained neutral on this issue. But 3.3% of the respondents strongly agree that technology has facilitated greatly, the implementation process of the scheme in Ga West Municipality.

Adequate financial sources

Finance is the life blood of policy implementation and its availability or otherwise cannot be over emphasised in any implementation process. Admittedly, 53.0% of the respondents strongly agreed that adequate finance has contributed so much in facilitating the implementation of NHIS in Ga West Municipality. Another 30.0% of the respondents agreed that finance is a major facilitating factor while 10.0% remained neutral. However, 6.7% disagreed that finance has facilitated implementation while 0.3% of them strongly disagreed.

Table 5.3 Factors that facilitate implementation of NHIS in GWMA by Management of the scheme

Public acceptability of the health insurance scheme

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	1	3.3
Neutral	0	0.0
Agree	26	86.7
Strongly agree	3	10.0
Total	**30**	**100.0**

Increasing political commitment

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	0	0.0
Neutral	1	3.3
Agree	23	76.7
Strongly agree	6	20.0
Total	**30**	**100.0**

Supportive legal and regulatory frameworks

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	0	0.0
Neutral	1	3.3
Agree	21	70.0
Strongly agree	8	26.7
Total	**30**	**100.0**

Proper coordination among the various actors

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	14	46.7
Neutral	6	20.0
Agree	10	33.3
Strongly agree	0	0.0
Total	**30**	**100.0**

Adequate health facilities

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	14	46.7
Neutral	6	20.0
Agree	10	33.3
Strongly agree	0	0.0
Total	**30**	**100.0**

Managerial ability

Response	Frequency	Percentage
Strongly disagree	1	3.3
Disagree	5	16.7
Neutral	9	30.0
Agree	11	36.7
Strongly agree	4	13.3
Total	**30**	**100.0**

Training and capacity building programmes for staff

Response	Frequency	Percentage
Strongly disagree	1	3.3
Disagree	7	23.3
Neutral	7	23.4
Agree	15	50.0
Strongly agree	0	0.0
Total	**30**	**100.0**

Efficient supervision of District Health Insurance

Response	Frequency	Percentage
Strongly disagree	0	0.0
Disagree	16	53.3
Neutral	8	26.7
Agree	6	20.0
Strongly agree	0	0.0
Total	**30**	**100.0**

Adequate technology and accessories

Response	Frequency	Percentage
Strongly disagree	18	60.1
Disagree	10	33.3
Neutral	1	3.3
Agree	0	0.0
Strongly agree	1	3.3
Total	**30**	**100.0**

Adequate financial resource

Response	Frequency	Percentage
Strongly disagree	0	0.3
Disagree	2	6.7
Neutral	3	10.0
Agree	9	30.0
Strongly agree	16	53.0
Total	**30**	**100.0**

5.2.2 Subscribers' perception of factors that facilitate implementation of NHIS in Ga West Municipality

Subscribers are one of the major actors of the NHIS and indeed they are the essence for which the scheme is in place. Therefore it is important to look at their perception of the success and what factors that facilitate implementation of the scheme. Clearly, the data shows that 97.0% of the subscribers are of the view that the implementation of NHIS in Ga West Municipality has been a success. On the other hand, a small proportion made up of 3.0% indicated that the implementation of the scheme has not been successful. From this it shows that majority has seen it as a success and it is important to find out the factors that facilitate implementation.

Finance has been one of the major issues in the implementation of any policy including the NHIS. The data as presented in Table 5.4 shows that 18.0% who represent majority of the respondents are of the view that the successful implementation of the scheme is due to its affordability. This issue is very important as NHIS came into existence for financial reasons. Therefore if they could still not pay, it will be unsuccessful. The implication here is that premiums must be affordable and most importantly within the means of the subscribers. The fact is that, apart from the premiums being affordable they also remove the heavy burden of paying upfront for treatment services which has been the greatest barrier for the poor to access healthcare.

Accessibility of healthcare has been a major issue in the Ghanaian healthcare system for long. In fact, apart from the fact that most people cannot pay to enjoy quality health services, the issue of accessibility is also threatening. From Table 5.4, 16.0% of the

subscribers are of the view that the successful implementation of NHIS is partly due to the accessibility of the scheme and healthcare facilities. This may be due to the fact that, private healthcare facilities have been accredited to take part in the provision of healthcare to the subscribers. For instance in the Ga West Municipality about one hundred and eight private healthcare facilities have been accredited to provide services under NHIS. This is coupled with the fact that, with NHIS card, subscribers can access healthcare from any NHIS accredited health facility throughout the nation. Again, the registration of NHIS in the Ga West Municipality has been so decentralized and flexible that subscribers can easily have access to register without travelling for long distances.

Another important factor that has facilitated implementation of NHIS is the availability of skilled and qualified personnel. Resources in terms of human are very crucial in the implementation of any policy. From this angle 13.0% of the subscribers are of the view that the successful implementation of NHIS in Ga West Municipality is due to the availability of qualified and trained personnel. This is clear from the educational background of the management of the scheme in Ga West Municipality as 43.3% of them have a higher degree and to the extent that 16.7% have higher than a first degree. The secondary data collected from the Municipality also shows that there has been consistent training for these staff. Several workshops and training sessions have been organized for them to be handled to manage the scheme successfully. It is therefore no wonder that the subscribers have attributed the success of the implementation of NHIS to availability of qualified and trained personnel.

Massive education of the general public has been listed by the subscribers as one of the factors that facilitate the implementation of NHIS in Ga West Municipality. From Table

5.4, it can be realized that 12.0% of the subscribers attributed its successful implementation to the massive public education. The popularity of NHIS can be attributed to the political nature and slogan under which NHIS was introduced. Therefore political parties were trying to use that to score political points and this to some extent made it popular. For instance in 2008, whereas NPP was campaigning that they should be voted for because they introduced NHIS, NDC was also promising one time premium under NHIS. There is no doubt this went to a large extent to make it popular. It was also made popular by others who have benefited from the scheme and preached its importance to their colleagues. The Municipal Assembly also made significant effort in this direction as the Municipal Information Services Department has been to all the communities in the Municipality to educate people about the benefits of the scheme. Education was also done through both Assembly and Unit Committee members.

Closely related to the massive education of the public is its acceptance. NHIS received a massive endorsement by the Ghanaian populace. Indeed this should not be a surprise as health is wealth and the fact that healthcare has become expensive to most Ghanaians. Thus, the data presented in Table 5.4 indicates that 10.0% of the subscribers attributed the successful implementation of NHIS to the acceptance and participation of the general public. Indeed NHIS is among one of Ghana's most popular policies as a result of its political association and necessity as a basic right and need of any individual.

Issues of adequate technology and logistics, effective management and supervision, financial contribution by the state and subscribers as well as legal backing and Act of parliament were also listed as factors that facilitate implementation of NHIS in Ga West Municipality. Thus, the data shows that 8.0% of the subscribers attributed its successful

implementation to adequate technology and logistics. Another 7.0% were of the view that its success was due to effective management and supervision while 9.0% attributed this to the financial contribution by both the state and subscribers. Also, 2.0% lean the success of the scheme on the fact that the scheme is backed by law and an Act of parliament.

In another category made up of 5.0% of the subscribers, they attributed the successful implementation of the scheme to the commitment of healthcare facilities staff, political will and commitment, support from foreign donors, cooperation of the general public and ease of entry into the scheme. Indeed political commitment is a necessary ingredient in policy implementation as the commitment of the politicians serve as the energy to drive the policy to a successful end. Similarly, the commitment of the implementers (including healthcare facilities staff) is key as they are the end point and their commitment is much needed. The ease of entry into the scheme has been much appreciated by the subscribers and to them this has contributed to its successful implementation. Information from the subscribers shows that entry into the scheme has been made flexible to them, where they can pay by installments to the local representatives of the scheme. This does not strain them to pay upfront and therefore they are able to afford. All the details are shown in Table 5.4 below.

Table 5.4 Factors that facilitate implementation of NHIS in Ga West Municipality by subscribers

Response	Frequency	Percentage
Scheme backed by law and act of parliament	2	2.0
Commitment of healthcare facilities staff	1	1.0
Acceptance and participation by the general public	10	10.0
Political will and commitment	1	1.0
Support from foreign donors	1	1.0
Cooperation of the general public	1	1.0
Ease of entry into the scheme	1	1.0
Financial contribution by both government and subscribers	9	9.0
Availability of qualified and trained personnel	13	13.0
Massive education of the public	12	12.0
Technology and adequate logistics	8	8.0
Effective management and supervision	7	7.0
Affordability of the scheme	18	18.0
Accessibility	16	16.0
Total	**100**	**100.0**

5.2.3 Healthcare providers' perception of the factors that facilitate implementation of NHIS in Ga West Municipality

The healthcare providers have a critical role to play in ensuring the successful implementation of NHIS. Indeed they are the final and consumption point of NHI service and that is where subscribers actually feel the service. Therefore, the quality of healthcare that subscribers will enjoy is largely dependent on the health providers who work in collaboration with all stakeholders. As a critical stakeholder in the implementation of NHIS, they were asked as to whether the implementation of the scheme has been successful or not, 91.7% of them are of the view that the implementation of the scheme has been successful. On the other hand, 5.0% of the healthcare providers indicated that the implementation of the scheme has not been successful while 3.3% remained neutral as they could not tell whether the implementation of the scheme has been successful or not.

On the issues of the factors that facilitate implementation of the scheme, a number of factors were enumerated. Among them were, increase in the number of subscribers, accessibility of the scheme, cooperation between the management and healthcare providers, adequate equipment and logistics, finance, effective management of the scheme and acceptance by the general public. As can be seen from Table 5.4, majority of the healthcare providers representing 29.7% indicated that financial support was crucial in facilitating implementation of NHIS while 13.3% are of the view that the general acceptance of the scheme by the public has facilitated implementation of NHIS in Ga West Municipality.

The respondents also attributed the successful implementation of the scheme to the effective management of the scheme. In this case, 16.7% of them indicated this factor. Indeed managerial skills have been noted in the implementation literature as critical for success. Therefore, it is not surprising that the healthcare providers are also re-emphasizing this variable in NHIS and particularly in the Ga West Municipality. The data also shows that 13.3% of the healthcare providers mentioned that the successful implementation of the scheme is due to the fact that it has made healthcare accessible to all. Indeed that is the essence of NHIS and once they are able to access healthcare, they will definitely enroll, pay the premiums and therefore success is likely to follow.

Increasing subscribers representing 10.0% was mentioned by the healthcare providers as contributing to the successful implementation. Subscribers are major stakeholders in this exercise of NHIS and once they have become increasingly involved, it means it is well accepted by them and most likely to contribute to the success of the implementation. Cooperation between the management and healthcare providers is critical and 10.0% of

the healthcare providers indicated that this has contributed to the successful implementation of NHIS in Ga West Municipality. Indeed, these factors have been enumerated in the implementation literature as being some of the critical factors that contribute to the successful implementation of public policies.

Table 5.5 Factors that facilitate implementation of NHIS in GWMA by healthcare providers

Reasons	Frequency	Percent
Increase number of subscribers	3	10.0
Make healthcare accessible	4	13.3
Cooperation between management and healthcare providers	3	10.0
Adequate equipment and logistics	3	10.0
Finance	8	29.7
Effective management of the scheme	5	16.7
Acceptance by the general public	4	13.3
Total	**30**	**100.0**

From the above discussions, it was concluded that, the NHIS has enabled Ghana to make significant advances in moving away from direct payment at point of service to the use of insurance cards to access health.

A careful analysis of the data shows that one of the major factors that facilitated the implementation of NHIS in Ga West Municipality is support and acceptance of the scheme by the general public. Thus from the research 87.6% of the management of NHIS in Ga West Municipality agree that its acceptability and cooperation by the public contribute greatly to its success. This is consistent with other findings in the implementation literature. For instance, Sabatier (1986) concluded that when a programme being implemented is actively supported by organized constituency groups it is highly and more likely to be successfully implemented. Indeed one would expect the general public to respond naturally to policy that promote good health issues, especially

if such policy has the tendency to alleviate or minimise financial difficulties and challenges. But the fact remains that, the support and the willingness of the general public to participate and accept a policy and cooperate with both the management and healthcare providers is essential to its successful implementation.

Another significant factor that facilitates implementation of NHIS in Ga West Municipality is resources. These resources include finance, human and technology. In relation to funding, the scheme had funding from subscribers' premium and from government coffers. Finance is very important in policy implementation. This is testified by a 53.0% of the management of the scheme who strongly agreed to the notion of finance as a factor in implementation while most of the subscribers too related the successful implementation to financial contribution by both government and subscribers. The findings also show that about 30.0% of the healthcare providers support the view that finance has contributed very much to the implementation of NHIS in Ga West Municipality. On the part of the human resources, 13.0% of the subscribers indicated that the adequacy of the human resources serves as a critical factor in the implementation process. Also 50.0% of the management of the scheme agreed to this.

Technological resources also contributed to the successful implementation of NHIS in the Ga West Municipality. Technology is used in processing ID cards for subscribers, processing claims, sending information to regional and national headquarters (National Health Insurance Authority). From the findings, all the actors which include management, healthcare providers and subscribers strongly agreed to the fact that technology has counted partly for the successful implementation of the scheme. These

findings are consistent with the literature of implementation. For instance, Edward (1980) noted long ago that resources are a critical factor in implementing public policies.

Managerial capacity and ability has also contributed to the successful implementation of NHIS in the Ga West Municipality. Thus from the findings, 50.0% of the management of the scheme in Ga West Municipality are of the view that managerial ability has been a facilitating factor. On the part of the subscribers, out of the available factors that contribute to the success of the scheme, 7.0% of the respondents attributed success to managerial ability and skills. Also among all the factors, 16.3% of healthcare providers attributed success to management. Clearly management of the scheme is important and has gone a long way to facilitate implementation.

From the literature, it has been noted by various writers that managerial skills and capacity is a critical factor if a policy is to succeed. Thus to Edward (1980), an organization's human resources can be regarded as the most important factor in implementing policies. It includes staff of sufficient size and with proper skills to carry out assignments and information, exercise authority, and properly supervise and take care of facilities including buildings, equipments, land and supplies necessary to translate proposals on paper into functioning services. Sabatier (1986) also supported this view when he made the point that the leaders of implementing bodies must possess the necessary managerial and political skills to bring to light the objectives of a public policy.

The willingness and commitment of both implementers and politicians is very important if a policy is to succeed. This was one of the critical issues that were raised by the

respondents in this study. Indeed subscribers mentioned that political will and commitment had contributed to the successful implementation of the scheme. Similarly, 96.7% of the management of the scheme agree to this. In fact, NHIS has become a major political issue in Ghana and politicians are really throwing their weight behind it to make it successful. McLaughlin (1987) asserts that the "will" or "motivation" to embrace policy objectives is a necessary condition for effective implementation. As some authors put it, political aspect plays a significant role in policy implementation.

Other authors and scholars such as Brynard and De Coning (2006), Mazmanian and Sabatier (1981), and Warwick (1982) argue that policy may be good, but if the implementers are unwilling to carry it out, implementation will not occur. Therefore commitment from politicians or administrators is very important for the successful implementation of any policy. One of the interesting things in relation to the commitment of the politicians is the key involvement of the Municipal Chief Executive in the implementation of NHIS to make it a success.

Other factors that also facilitate implementation of NHIS in the Ga West Municipality include legal backing which instilled confidence in the subscribers as well as affordability of the scheme. As indicated already, a key initiative taken very early in the development of NHIS in the Ga West Municipality was the decision to set premium contributions at a very low level. In other words it was recognized from the beginning that participation of the self-employed and low-income population would have to be heavily subsidized, while high premiums would be a major barrier to participation.

In spite of the few personnel and their challenges, the management is efficient and this has contributed to the successful implementation of NHIS in the Ga West Municipality. In fact good management is often cited as one of the key factors for ensuring successful policy implementation in the new public management literature (Kaul 1997; McLaughlin et al. 2001). Thus, the enthusiastic and optimistic behavior of management and their ability to adapt to the prevailing challenges and circumstances has contributed to the successful implementation.

5.3 Factors that constrain the implementation of the National Health Insurance Scheme in the Ga West Municipality

Implementation problems occur when the desired results on the target beneficiaries is not achieved. This occurs when the crucial factors necessary for effective implementation are not present. The factors do not act in isolation but complement each other. The interaction of these factors is the cause of implementation success or failure as the case may be. This section will therefore look at the factors that constrain implementation of NHIS in the Ga West Municipality. This will be based on the views of the management of the scheme, the subscribers as well as healthcare providers under the scheme.

5.3.1 Management's perception of the factors that constrain the implementation of NHIS in Ga West Municipality

This section looks at the factors that constrain implementation of NHIS in the Ga West Municipality from the perspective of the management of the scheme. Management of the scheme were asked about the factors that constrain their implementation of the scheme. The following are some of the factors mentioned by the management of the scheme. The first factor mentioned by the management was inadequate logistics. This has been the

major challenge as 16.7% of them indicated this. Indeed the implementation of the NHIS involves the use of several logistics such as computers, cameras, vehicles, scanning machines, batteries, among others. The availability or otherwise of these equipment can go a long way to affect the implementation of the NHIS in the Ga West Municipality.

Another factor that was recorded by the management of the scheme was finance as 13.3% of the respondents agreed to this. Finance has been recorded in the implementation literature over and over again as a challenge to implementation and therefore not surprising to repeat itself in Ga West Municipality. Of course, no administrative work and particularly a huge exercise like the implementation of the NHIS can do without adequate financial support. Other major challenges to the implementation of the NHIS in the Ga West Municipality are unnecessary delays and lack of skilled and actuarial insurance staff.

In this case, 16.3% of the management indicated that unnecessary delay is a challenge. Delays in whatever form and type, such as delays in submitting claims, processing and payment, they take have been an enemy to implementation for quite a long time and it is high time implementers took this into serious consideration. There is no doubt and this does not deviate from what is known in the implementation literature, that lack of skilled and adequate human resources is a challenge of policy implementation. This has recorded 16.7% of the challenges that confront the implementation of the NHIS in the Ga West Municipality. Clearly, policies remain on the tables of administrators and on papers if there is no skilled personnel to put it into action and this is a source of worry as it should be dealt with appropriately even before implementation begins.

Fraud and corruption also registered its presence here as a constraining factor to the implementation of NHIS in the Ga West Municipality. This recorded a percentage of 3.3%. Whereas management is yearning for more finances to be able to implement the scheme, the small finances in the schemes coffers are being siphoned away by some of the management for their personal gains. This comes in the form of over inflated receipts, claims, among others. This is adding to the already existing financial problems constraining the implementation of the scheme. This is very unfortunate and must be tackled seriously if the success of the scheme is to be achieved. Unprofessional attitude of management towards clients has been a challenge and 3.3% of the respondents agreed to this and it should be attended to as these clients are major stakeholders who need to be treated with care.

The issue of foreigners enrolling onto the scheme is a challenge as 6.7% of the respondents indicated this. This may be due to issues of improper record system in Ghana and the fact that most management of the scheme are compromising on the rules of the scheme. Long processes have been noted in the literature as one of the critical issue in implementation. As a result 3.3% of the management are of the view that bureaucracy and long processes of the NHIS is serving as a constraint to the implementation of the scheme in the Ga West Municipality.

Table 5.6 Factors that constrain the implementation of NHIS in Ga West Municipality by management

Factors	Frequency	Percent
Inadequate education	1	3.3
Foreigners enrolling in the scheme	2	6.7
Unprofessional attitude towards clients	2	6.7
Unnecessary delays	3	16.3
Lack of skilled and actuarial insurance staff	5	16.7
Extortion from the subscribers	2	6.7
Difficulty in data processing	2	6.7
Inadequate logistics	5	16.7
Financial challenges	4	13.3
Bureaucracy	2	6.7
Embezzlement and fraud	2	6.7
Total	**30**	**100.0**

5.3.2 Subscribers' perception of factors that constrain the implementation of NHIS in Ga West Municipality

The subscribers also have their own version of the factors that constrain implementation of NHIS in the Ga West Municipality. This section of the study then takes a critical look at these factors. From table 5.7, majority of the subscribers representing 26.7% are of the view that their major challenge with the implementation of the scheme is the fact that most of the drugs are not in the NHIS medicine prescribed list. This means that they end up paying for most of the drugs prescribed to them at the healthcare facility. This renders the essence of the insurance meaningless as they have to pay for drugs which they were trying to avoid by enrolling to be members of the insurance scheme.

Another challenge which was high on the list of the subscribers was the bureaucracy that characterizes the system and this recorded 30.0% of the respondents. This bureaucratic procedure comes in the form of delays in card renewal, delay of management to respond to their needs, delays at the various healthcare centers, among others. This bureaucracy and the undue delays end up making the subscribers slow in accessing healthcare.

Corruption and bribery could not escape on the list of the subscribers as a challenge to the implementation of NHIS in the Ga West Municipality. This factor registered 13.3%. This is very disturbing as it really reduces the monies that will be used for the implementation of the scheme. This could be in the form of demanding from clients before services are provided, embezzlement and misapplication of the funds.

Delays in reimbursement are also a challenge to the implementation of the scheme in the Ga West Municipality. The data as presented in table 5.7 shows that 10.0% of the subscribers mentioned delay in reimbursement as a challenge. One will wonder why subscribers should mention delay in reimbursement. Could they have heard it from healthcare providers or some other channels? The extent to which the NHIS has been politicized and often debated in the media could have accounted for this knowledge of delays in reimbursement. Similarly, 10.0% talk about inadequate personnel as a challenge. This is obvious as subscribers can encounter this challenge from the end of the management of the scheme and that of the healthcare providers. This could result to the delays in the processing of documents and accessing healthcare.

Financial and poor data entry was also listed as challenges. Thus, financial challenge constituted 6.7% while poor data entry was 3.3%. Finance is critical for policy implementation and once it is a challenge the implementation will definitely be affected and coupled with the fact that some of the funds are also being siphoned away by management. In terms of poor data entry, this is likely to affect implementation as the beginning point is accurate because it enables proper forecasting and planning. Subscribers often encounter this through the issue of wrong identity cards and related documents. Details of the above discussion are presented in table 5.7 below.

Table 5.7 Factors that constrain implementation of NHIS in Ga West Municipality by subscribers

Constraints	Frequency	Percentage
Financial constraints	2	6.7
Bureaucracy	9	30.0
Poor data entry	1	3.3
Most medicines out of the prescribed list	8	26.7
Inadequate personnel	3	10.0
Corruption and bribery	4	13.3
Delays in the reimbursement	3	10.0
Total	**30**	**100.0**

5.3.3 Healthcare providers' perception of factors that constrain implementation of NHIS in Ga West Municipality

This section of the chapter is also to seek the views of the healthcare providers about some of the factors that constrain the implementation of NHIS in the West Municipality. The healthcare providers listed a number of factors which are not so different from those of the management and subscribers. Top among the list is corruption and limited drugs on the NHI drug list. To this end, 16.7% of the healthcare providers indicated that the drugs which are often prescribed by the doctors are mostly not on the NHI drug list. It means that subscribers have to buy these drugs themselves and this defeats the purpose of the insurance that they hold. To them the scheme covers mostly basic drugs and most expensive drugs are not covered here. But the fact is that most subscribers can pay for this basic drugs, it is the expensive ones that they cannot afford.

On the list is also corruption and 16.7% of the healthcare providers stated this. To them there have been massive corruption and fraud cases both on the part of the management of the scheme and healthcare providers. Management embezzle the monies of the scheme while most healthcare providers inflate the charges and even add some unnecessary drugs to the list just to make money. Thus, where there have been several complains of

inadequate funds to run the scheme, the few monies in the coffers of the scheme are being taking away by both management and healthcare providers. This situation ought to be corrected and dealt with seriously if the scheme is to be sustainable. Closely related to corruption is the constraint of finance and 13.3% of the respondents mentioned this. This is very ironic because whereas there is a cry that there are no funds, the limited ones are being siphoned. Therefore there is the need to check this to save the system.

Delays has been one of the major constrains to the implementation of NHIS in the Ga West Municipality. That has run through as a constraining factor, from management to subscribers and finally to the healthcare providers. In this case 10.0% of the respondents mentioned this as a constraining factor. However there are differences in these delays. The concern of the healthcare providers here has to do with the delay in processing claims and reimbursing them. Healthcare providers need to be reimbursed within the shortest possible time to help them to continue to provide services to the subscribers of the scheme. Besides delays, there have been concerns about inadequate personnel and 10.0% of the respondents are of this view. The management of the NHIS needs adequate personnel to handle all the workload and this inadequacy may lead to delay and slow processing of documents and claims.

Related to the issue of inadequate personnel is lack of training for personnel. Thus, 6.7% of the respondents indicated that the personnel do not have the necessary training and skills to handle the management of the scheme. The healthcare providers might have noticed this from their dealings with them in terms of processing of claims and other related activities. Managing health insurance means that the personnel have to be

knowledgeable in actuarial and financial management as well as human relations. The only way to get these is through training which is often lacking in the schemes office.

Political interference is also a constraining factor, as well as improper coordination and lack of proper data. All these factors together were rated 26.7% of the challenges to the implementation of the NHIS in the Ga West Municipality from the perspectives of healthcare providers. Indeed data is very important as this helps in projections and forecast. It is also important for the healthcare providers and management to coordinate well with each other because the healthcare providers are also implementing a major component of the scheme. Political interference has been part of this scheme since its inception. Indeed the birth of the NHIS is the result of politics and has continued to follow it till today and will continue. Details of the above presentation and discussions are presented in table 5.8 below.

Table 5.8 Factors that constrain the implementation of NHIS in Ga West Municipality by healthcare providers

Constrains	Frequency	Percentage
Lack of proper data	2	6.7
Corruption	5	16.7
Improper coordination	3	10.0
Delay and slow process	3	10.0
Inadequate facilities	2	6.7
Lack of finance	4	13.3
Inadequate personnel	3	10.0
Lack of training for staff	2	6.7
Political interference	3	10.0
Most prescribed drugs are not on NHIS drug list	5	16.7
Total	**30**	**100.0**

The implementation of NHIS in Ghana and particularly in the Ga West Municipality has so many constraining factors as clearly indicated above. The findings indicate that the most dominant constraining factors included ineffective claims management and control,

lack of effective mechanism for tracking claims, inconsistent billing system and undue delay of payment of claims due healthcare providers.

Other challenges and factors that constrained the implementation of the NHIS in the Ga West Municipality as mentioned by the management of the scheme included the following: inadequate logistical support for running the office, unattractive remuneration and incentive packages for staff. In spite of the successes, there were still some human resource challenges. For example, some claims managers do not have basic medical background and it is often difficult for them to challenge the medical professionals about prescriptions and billing of the schemes.

Healthcare providers on their part mentioned undue delay of payment of claims, exclusion of some drugs from approved list and low tariff. The dominant problem mentioned by the providers was the delay in the payment of claims by the scheme.

Further worrying challenges to the implementation of the NHIS in the Ga West Municipality are fraud and malpractice by the management of the scheme and healthcare providers. There are a lot of incidences of malpractice by some accredited healthcare providers and this is as a result of lack of an efficient monitoring and evaluation mechanism.

Fraud is affecting the scheme seriously in terms finances. From the data presented in chapter five, 6.6% of the management indicated embezzlement and corruption as a challenge to the implementation of the NHIS in the Ga West Municipality. Again, 13.3% of the subscribers mentioned that corruption and bribery is a challenge to the

implementation of the NHIS in the Ga West Municipality. Similarly, 16.6% of the healthcare providers indicated corruption and financial malpractices as challenges to the implementation of the NHIS in the Ga West Municipality. From the above it is clear that incidences of corruption act as an impediment in the implementation of the insurance policy.

To add to the challenges to the implementation of the NHIS in the Ga West Municipality is the fact that most of the drugs are not listed in the NHIS prescribed drug list. This means that most of the subscribers end up paying for the drugs at the health centers. The data presented above shows that 16.7% of the subscribers indicated that some prescribed drugs are not on NHIS drug list. The non-inclusion of some of the drugs defeats the purpose of the insurance, a situation which has made some of the subscribers to consider even withdrawing from the scheme. A study conducted by Witter et al., (2009) found that most subscribers are complaining about the issue of inadequacy of drugs in the NHIS drug list. Hath et al., (2007) came to a similar conclusion in Nkoranza when they found out that instituting insurance by itself is not adequate to remove fully the out-of-packet payments for health care. Insured patients are still required to pay for items that should be covered by insurance and for informal care. This in turn is a hindering factor in coverage and expansion and thus ultimately affecting the prospects of achieving universal coverage.

5.4 The roles played by the various actors in the implementation of NHIS in the Ga West Municipality

The above discussion has concentrated on a myriad of factors that constrain or facilitate the implementation of NHIS in the Ga West Municipality. This section will look at the roles played by the three actors, in the form of their actions and inactions in the

implementation process. This is important because these actors both constrain and facilitate the implementation of NHIS by the roles they play in the Ga West Municipality. The behaviour of the healthcare providers, in the view of the subscribers, plays both positive and negative roles in the implementation of NHIS the Ga West Municipality.

On the positive side of the role of subscribers, their financial contribution, in the form of premiums, has helped in facilitating implementation of the scheme. Even though, these premiums are small they have a significant impact on the implementation of the scheme. Finance is the lifeblood and engine of providing healthcare and if subscribers do not contribute in the form of finance it would put more stress on the government. In this way, 40.0% of the subscribers indicated this as a significant positive contribution to the implementation of the scheme. Again, 50.0% of the subscribers are of the view that their commitment to the scheme has impacted positively on the implementation of the NHIS in the Ga West Municipality. Thus, in spite of the unprofessional attitude of both management and healthcare providers, subscribers still remain committed to the scheme and this has brought it far.

Also 10.0% of them stated that their role in the dissemination of information to people in their community has impacted positively on the implementation of the scheme. Subscribers play an important role in the dissemination of information about the NHIS to other members in their various communities. By preaching “good” about the scheme, they get their colleagues to register with the scheme.

On the negative role, three main issues were raised. Firstly, 60.0% indicated that most of the subscribers do not finish their medication after visiting the hospital. Because they know they are enjoying healthcare for free, they don't finish the medication given them and therefore tend to visit hospital regularly thereby putting pressure on health facilities as well as causing financial loss to the scheme. Also, 23.0% of the subscribers cited inconsistent behaviour as a role that has a negative impact on the implementation of the scheme. In this way, subscribers argue that, most of them change healthcare facilities making it difficult for Doctors to have their correct medical history.

Finally, 17.0% of them are of the view that the low rate at which subscribers renew their cards is serving as a negative role in the implementation of the scheme. Thus, in spite of the fact that most of the subscribers are registering to join the scheme, others are also not renewing their cards. The role of subscribers in the implementation of NHIS in the Ga West Municipality is presented in Table 5.9 below.

Table 5.9 Role played by subscribers in the implementation of NHIS in Ga West Municipality

Positive Roles			Negative Roles		
Role	**Frequency**	**Percentage**	**Role**	**Frequency**	**Percentage**
Financial	40	40.0	Unfinished	60	60.0
Commitment	50	50.0	Inconsistent	23	23.0
Dissemination	10	10.0	Non renewed	17	17.0
Total	**30**	**100.0**	**Total**	**30**	**100.0**

From the perspective of the healthcare providers, a number of issues were also raised concerning the role of healthcare providers in the implementation of NHIS in the Ga West Municipality. From the positive side, 46.7% of the respondents are of the view that the provision of healthcare by the providers has gone a long way to ensure a positive

impact on the implementation of the scheme in Ga West Municipality. Also, 53.3% of them indicated the fact that the healthcare providers are committed and this has played a positive role on the implementation of the scheme. The availability of the healthcare facilities and the commitment of the workers to the provision of healthcare have no doubt contributed positively to the implementation of the scheme in the Ga West Municipality. On the negative roles, a number of issues were also raised and among them is corruption, rude attitude towards patients and the small number of Doctors in the various healthcare centres.

To this effect, 35.0% of respondents mentioned corruption, 43.0% cited rude attitude towards patients and 20.0% indicated corruption. The issue here is that most holders of NHIS cards are often not responded to as quickly as those who pay upfront at the hospital. This often makes subscribers to lose interest in the scheme and sometimes they have to grease the palms of healthcare officials to receive treatment when they visit the hospital. Healthcare providers often inflating the cost of drugs, taking some sought of monies from subscribers at the health centres and not attending to the needs of NHIS card holders. The role of healthcare providers in the implementation of NHIS in Ga West Municipality is shown in Table 5.10.

Table 5.10 Role played by healthcare providers in the implementation of the NHIS in Ga West Municipality

Positive Roles			Negative Roles		
Role	**Frequency**	**Percentage**	**Role**	**Frequency**	**Percentage**
Provision	14	46.7	Corruption	11	36.7
Commitment	16	53.3	Rude	13	43.3
			Few Doctors	6	20.0
Total	**30**	**100.0**	**Total**	**30**	**100.0**

On the part of the management of the scheme, human resources have been cited as playing a positive role in the implementation of the scheme. Thus a total of 53.3% of the respondents mentioned this. This is very important as the needed human resources are a pre-requisite for the implementation of public policies not only the NHIS. This has gone a long way to help in processing NHIS cards for subscribers, processing claims and reimbursing healthcare providers and mobilizing subscribers for the scheme. Commitment on the part of the management has also contributed towards a positive implementation of the scheme and 46.7% of the management stated this. On the negative side, issues of corruption and rude towards subscriber reappeared here and the fact that management of the scheme lack basic education in insurance and medicine. Thus, 46.6% mentioned corruption while 36.7% indicated rude behaviour towards subscribers and 16.7% stated lack of basic education in insurance and medicine. This is presented in Table 5.11 here.

Table 5.11 Role played by management in the implementation of NHIS in Ga West Municipality

Positive Roles			Negative Roles		
Role	**Frequency**	**Percentage**	**Role**	**Frequency**	**Percentage**
HR	16	53.3	Corruption	14	46.6
Commitment	14	46.7	Rude attitude	11	36.7
			No education	5	16.7
Total	**30**	**100.0**	**Total**	**30**	**100.0**

From the above discussions, the study concluded that the roles played by the various actors in the implementation of the NHIS in the Ga West Municipality are both positive and negative. On the positive side, subscribers have contributed financially to the successful implementation of the scheme. Another set of the subscribers are of the view that their commitment to the scheme has impacted positively on the implementation of the NHIS in the Ga West Municipality while some stated that their role in the

dissemination of information to people in their community has impacted positively on the implementation of the scheme. From the perspective of the healthcare providers, provision of healthcare by the providers has gone a long way to ensure a positive impact on the implementation of the scheme in Ga West Municipality. Some of them indicated the fact that the healthcare providers are committed and this has impacted positively on the implementation of the scheme. On the part of the management of the scheme, human resources have been cited as a positive role in the implementation of the scheme. Commitment on the part of the management has also contributed towards a positive implementation of the scheme.

On the negative role of the actors to the implementation of the scheme in the Ga West Municipality, it came up that most of the subscribers do not finish their medication after visiting the hospital. Some of the subscribers also cited inconsistent behaviour as a negative impact on the implementation of the scheme. Finally, 17.0% of respondents are of the view that subscribers and the low rate at which they renew their cards is having a negative impact on the implementation of the scheme. From the perspective of healthcare providers, a number of issues were also raised and among them are corruption, rude attitude towards patients and the small number of Doctors in the various healthcare centres. Finally from the management of the scheme on the negative side, issues of corruption and rude attitude towards subscribers reappeared here and the fact that management of the scheme lack basic education in insurance and medicine.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSION AND RECOMENDATIONS

6.0 Introduction

It has been observed in the public administration literature that policy implementation is one of the major challenges confronting developing nations. According to policy implementation experts, such as Wildavsky, Pressman, Mazmanian, O'Toole and Sabatier implementation challenges occur when the desired result on the target beneficiaries is not achieved. Wherever and whenever the basic critical factors that are very crucial to implementing public policy are missing, there is bound to be implementation challenges and NHIS in the Ga West Municipality is no exception.

The previous chapter discussed the findings of the study. The purpose of this chapter is to summarise the main findings of the study, draw a conclusion and provide recommendations for redressing the identified challenges.

6.1 Summary of Key Findings

Policy implementation is the significant stage of policy making, between the establishment of a policy and the consequences of the policy for the people whom it affects. Policy implementation is a complex course of action (Van Meter and Van Horn (1975). A good policy if poorly implemented may fail to achieve the goals of its designers. Implementing a public policy may include a wide variety of actions, including factors like financing, personnel, planning, collecting data and disseminating information. Policy implementation requires a complex effort to accomplish it. The

reason is that people who originally determine public policies are usually not the ones who implement them. Moreover, at the national level, policy implementation has had a low priority among most of the elected officials. The problems are due to the lack of expertise and experience in administration. Besides, executives are extremely busy, and little incentive is emphasized to the implementation of policies. The summary of the key findings of this study are grouped into three based on the objectives of the study.

One of the most important findings was the increase in patronage of health facilities by subscribers in the Ga West Municipality. It is important to indicate that until the onset of health insurance there was a decline in the consumption of health care in most of the health facilities in the area. The lack of patronage also had consequential effect on maternal, infant and general mortality. As one of the nurses in the Amasaman Hospital indicated:

'Death was the unavoidable choice of patients' especially pregnant women, until health insurance was introduced. It was a sad situation; pregnant women could simply not pay. Now because of the scheme antenatal care and deliveries- both normal and assisted are free'

Another important finding in the course of the research was improvement in the infrastructure of most health facilities in the Ga West Municipality especially the privately owned health facilities that had the opportunity to be part of the scheme. Initially high operational cost had driven some of the health facilities to the point of closure. But with claims from the scheme such facilities have not only become vibrant but have also expanded their infrastructure.

Finally the implementation of the scheme has also led to some negative practices. Informants have indicated frequent and various forms of abuse of the scheme. While some of the abuses have already been discussed in the general findings one that has received much criticism and which is considered key is the issue of false claims. Majority of the informants indicated that some of the health providers in some instances in connivance with staff of the scheme submit claim forms covering treatments which were not given or even drugs that were not administered. Also some of the staff of the scheme submit claim forms for certain expenditure which in reality were not incurred.

6.2 Recommendations

This section makes three concrete recommendations to strengthen the implementation of the scheme and also to overcome those that constrain its successful implementation.

It was emphasized in previous discussion that the greatest challenge facing the implementation of the NHIS in the Ga is in the area of claim administration. After five years of implementation of the NHIS in Ghana, there has not been any comprehensive development of any computer software or mechanism for the administration of claims. The process has always adopted the manual approach where Claims Managers have to subject every single claim to a thorough manual vetting alongside thousands of prescriptions submitted by the numerous health care providers. One would not but agree that such a process is really cumbersome, time consuming and evidently prone to fraud. It has also been the major cause of undue delays in the release of funds for reimbursement from the Secretariat of the National Health Insurance Fund to the various schemes. It is therefore important to develop a comprehensive computerization system

that will help process claims fast and minimize the fraud and corruption associated with the manual system.

In terms of staff strength, the Ga West Municipal Scheme has about fifteen recognised staff members on the pay-roll of the National Health Insurance Authority. The Scheme relies heavily on the National Service Personnel and students on internship who are given some allowances from the scheme's internally generated funds. This tends to place a heavy burden on the finances of the scheme. These people also do not stay long enough to gather any meaningful experience which could be helpful to the scheme in the long term. It is hereby proposed that more and well trained permanent staff be recruited so as to ensure smooth operations of the scheme.

Corruption has been a great enemy to the implementation of the NHIS in Ghana. It is therefore important that stringent measures be put in place to control the corruption. The internal auditing unit must be strengthened to detect all the fraud and corrupt practices. Corrupt officials should be punished seriously without fear or favour in addition to a refund of all the money that has been embezzled and with interest. This will serve as a deterrent to other officials.

6.3 Conclusion

Ghana's social health insurance scheme remains one of the biggest assets for the country's socio-economic development. The scheme symbolizes the political commitment to improve health status and reduce the major health problems that have confronted the country for several decades. There are widespread public comments that NHIS is comparatively better than the cash-and-carry (user fees) system. The cash-and-

carry system is discriminatory as it favours only the rich in society. Additionally the system made access to healthcare more difficult on emergency situations.

This study showed that there were a lot of people using the health facilities now as compared to the era where cash-and-carry was in vogue, a factor which attests to the success of implementation of the scheme. The study also showed that additional factors that contributed to the successful implementation of NHIS include staff or managers of the scheme, political commitment from government, financial contribution by both the state and subscribers among others. It was also noted that there were constraining factors that frustrated efforts towards the successful implementation of NHIS. These challenges include corruption and fraud, delay in the processing of documents and claim forms as well as the limited number of drugs on NHIS prescribe drug list.

It appears that a major priority of the NHIS is to make healthcare affordable and accessible to all. Although a noble objective, it is important to state that health status and health outcomes cannot be improved if the scheme continues to face myriad problems. The introduction of any health plan, such as that of NHIS, should be followed with an improvement in human resource. Human resource constitutes the most valuable asset for effective delivery of care and without them the intention of NHIS, which is to improve healthcare delivery will lack a solid ground.

6.4 Further Research

The findings in this study show that financial management in terms claims processing and corruption are the major constraining factors in the implementation of the National Health Insurance in the Ga West Municipality. As stated earlier delays in processing of

claims, improper preparing of claims forms by healthcare providers, over billing and corruption are major challenges to the successful implementation of the NHIS in the Ga West Municipality. However the nature of the relationship between financial management and the successful implementation of the NHIS in the Ga West Municipality is complex and an accurate assessment of this is lacking. It is therefore suggested that further qualitative and quantitative research be conducted to investigate how the NHIA can ensure good financial management as a way of ensuring an excellent implementation of NHIS.

Because the focus of this study was limited to the factors that facilitate and constrained the implementation of the NHIS in the Ga West Municipality as well as the impact of the relations between the actors on the implementation of the scheme. Therefore the dynamics of how these affect implementation could not be adequately probed in this study. Quantitative and qualitative research should also be conducted to concretely understand the dynamics of these factors on the implementation of the NHIS in Ghana.

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APPENDIX

QUESTIONNAIRE FOR HEALTHCARE PROVIDERS

UNIVERSITY OF GHANA BUSINESS SCHOOL

I am an MPhil student at the University of Ghana Business School under the supervision of Dr. Kwame Asamoah. The focus of my thesis is the implementation of the National Health Insurance Scheme in the Ga West Municipal Assembly. The aim of the research is: To investigate factors that facilitate or constrain the implementation of the National Health Insurance Scheme and to examine how these factors affect implementation. Please read the following questions carefully and answer according to your own experiences. Please note that answers to these questions will be treated as confidential.

SECTION A: DEMOGRAPHIC DATA

1. How old are you?
Under 18 [ ] 18-25 [ ] 25-35 [ ] 36-50 [ ] 51-65 [ ] Over 65 [ ]

2. Are you
Male [ ] Female [ ]

3. Educational level
No education [ ] Elementary [ ] SHS [ ] Nursing [ ] Diploma [ ]
Degree [ ] Masters [ ] PhD [ ] Others (specify)……

4. In terms of religion, are you?
Christian [ ] Moslem [ ] Traditional [ ] Others (specify)……

5. Marital Status
Single [ ] Married [ ], Divorced [ ], widowed [ ], Cohabitation [ ]

6. Position_____

7. How many years have you work here?_____

SECTION B: FACTORS THAT FACILITATE IMPLEMENTATION OF HEALTH INSURANCE

How do you see the implementation of the National Health Insurance so far in terms of the successes in the implementation?

_____

_____

How can you contribute to the successful implementation of the National Health Insurance Scheme?

_____

_____

SECTION C: FACTORS THAT CONSTRAIN IMPLEMENTATION OF HEALTH INSURANCE

Do you think the implementation of the National Health Insurance Scheme encounters some challenges? Yes [ ] No [ ]

What are some of the main factors that constrain the implementation of the National Health Insurance Scheme?

1._____

2._____

3._____

4._____

5._____

What can be done to mitigate some of the challenges?

_____

_____

SECTION D: ROLES PLAYED BY DIFFERENT ACTORS IN THE IIMPLEMENTATION OF THE SCHEME

What are your roles as health providers in the implementation of the scheme?

_____

_____

_____

SECTION E: SUGGESTIONS FOR IMPROVEMENT IN NHIS

Please kindly provide suggestions or recommendations that will help to improve the implementation of the National Health Insurance Scheme.

_____

_____

_____

QUESTIONNAIRE FOR STAFF OF THE SCHEME

UNIVERSITY OF GHANA BUSINESS SCHOOL

I am an MPhil student at the University of Ghana Business School under the supervision of Dr. Kwame Asamoah. The focus of my thesis is the implementation of the National Health Insurance Scheme in the Ga West Municipal Assembly. The aim of the research is: To investigate factors that facilitate or constrain the implementation of the National Health Insurance Scheme and to examine how these factors affect implementation. Please read the following questions carefully and answer according to your own experiences. Please note that answers to these questions will be treated as confidential.

SECTION A: DEMOGRAPHIC DATA

1. **Age:** Under 18 [ ] 18-25 [ ] 25-35 [ ] 36-50 [ ] 51-65 [ ] Over 65 [ ]

2. **Gender:** Male [ ] Female [ ]

3. **Educational Level:** No education [ ] Elementary [ ] SHS [ ] Teachers Cert A [ ] Diploma [ ] Degree [ ] Masters [ ] PhD [ ] Others (specify)……

4. **Religion:** Christian [ ] Moslem [ ] Traditional [ ] Others (specify)……

5. **Marital Status:** Single [ ] Married [ ] Divorced [ ] widowed [ ] Cohabitation [ ]

6. **Your position?**_____

7. **How many years have you work here?**_____

SECTION B: FACTORS THAT FACILITATE IMPLEMENTATION OF HEALTH INSURANCE

The following statements relate to the factors that facilitate implementation of the National Health Insurance Scheme in Ga West Municipal Assembly. Please indicate your level of agreement or disagreement with each of the following statements by circling the appropriate number.

Strongly agree [5] Agree [4], Neutral [3], Disagree [2], Strongly disagree [1].

Public acceptability of the health insurance scheme	1	2	3	4	5
Increasing acceptance of people to use health insurance					
Partners and actors have similar expectations and conflicting motivations					
Technical and individualistic focus of policy interventions					
Non-participatory focus of the scheme					
Consistent with other health policies					
Increasing political commitment					
Supportive legal and regulatory frameworks					
Proper coordination among the various actors					
Efficient and counterproductive roles and procedures					
Proper cooperation among the various actors					
Adequate health facilities					
Poor state of health facilities					
Managerial ability					
Training and capacity building programmes for staff					
Efficient supervision of District Health Insurance					
Motivational packages for staff					
Attractive remuneration and incentives					
Adequate personnel at the various offices					
Adequate technology and accessories					
Adequate computers and equipment for the work					
Appropriate recording keeping					
Adequate financial resource					
Proper accounting records					
Clients willing to pay the premium					

SECTION C: FACTORS THAT CONSTRAIN IMPLEMENTATION OF HEALTH INSURANCE

The following statements relate to the factors that constrain the implementation of the National Health Insurance Scheme in Ga West Municipal Assembly. Please indicate your level of agreement or disagreement with each of the following statements by circling the appropriate number**.**

Strongly agree [5] Agree [4], Neutral [3], Disagree [2], Strongly disagree [1].

CULTURAL AND SOCIAL CHALLENGES	**1**	**2**	**3**	**4**	**5**
Lack of public acceptability					
Increasing reluctance of people to use health insurance					
Partners and actors have different expectations and conflicting motivations					

POLITICAL AND LEGAL CHALLENGES	**1**	**2**	**3**	**4**	**5**
Technical and individualistic focus of policy interventions					
Non-participatory focus of the scheme					
Conflicts with other policies					
Wavering political commitment					
Unsupportive legal and regulatory frameworks					
ORGANISATIONAL/ INSTITUTIONAL CHALLENGES	**1**	**2**	**3**	**4**	**5**
Lack of coordination among the various actors					
Inefficient and counterproductive roles and procedures					
Application of general standards					
Lack of cooperation among the various actors					
Inadequate health facilities					
Poor state of health facilities					
HUMAN RESOURCE CHALLENGES	**1**	**2**	**3**	**4**	**5**
Managerial inability					
Lack of capacity building programmes					
Poor supervision of District Health Insurance					
Lack of motivation					
Inequitable distribution of health professionals					
Unattractive remuneration and incentives					
Inadequate personnel					
TECHNOLOGICAL AND INFORMATION BARRIERS	**1**	**2**	**3**	**4**	**5**
Poor data quality and quantity					
Inadequate equipments					
Engineering design of the information system					
Inadequate maintenance of equipment					
FISCAL/FINANCIAL CHALLENGES	**1**	**2**	**3**	**4**	**5**
Ineffective claims management and control					
Inconsistent billing system					
Delay of payment of claims					
Inappropriate recording keeping					
Inadequate financial resource					
Weaknesses in the pricing and fiscal frameworks					
Fraud and corruption					
Delay in re-imbursement					
Ineffective mechanism for tracking claims					

SECTION D: ROLES PLAYED BY VARIOUS ACTORS IN THE IMPLEMENTATION OF THE SCHEME

What specific roles do you play as managers of the scheme in the implementation process?

_____
_____
_____

SECTION E: SUGGESTIONS FOR IMPROVEMENT IN MANAGING NHIS

What do you think should be done to improve the management of National Health Insurance Scheme?

_____
_____
_____

What are some of the challenges of the National Health Insurance Scheme?

_____
_____
_____

Thank you for completing the questionnaire

QUESTIONNAIRE FOR SUBSCRIBERS (BENEFICIARY)

UNIVERSITY OF GHANA BUSINESS SCHOOL

I am an MPhil student at the University of Ghana Business School under the supervision of Dr. Kwame Asamoah. The focus of my thesis is the implementation of the National Health Insurance Scheme in the Ga West Municipal Assembly. The aim of the research is: To investigate factors that facilitate or constrain the implementation of the National Health Insurance Scheme and to examine how these factors affect implementation. Please read the following questions carefully and answer according to your own experiences. Please note that answers to these questions will be treated as confidential.

SECTION A: DEMOGRAPHIC DATA

1. **Age:** Under 18 [ ] 18-25 [ ] 25-35 [ ] 36-50 [ ] 51-65 [ ] Over 65 [ ]

2. **Gender:** Male [ ] Female [ ]

3. **Educational Level:** No education [ ] Elementary [ ] SHS [ ] Teachers Cert A [ ] Diploma [ ] Degree [ ] Masters [ ] PhD [ ] Others (specify)……

4. **Religion:** Christian [ ] Moslem [ ] Traditional [ ] Others (specify)……

5. **Marital Status:** Single [ ] Married [ ] Divorced [ ] widowed [ ] Cohabitation [ ]

6. **Occupation**_____

SECTION B: FACTORS THAT FACILITATE IMPLEMENTATION OF HEALTH INSURANCE

As a beneficiary of the National Health Insurance Scheme, what factors facilitate the successful implementation of the scheme?

_____

_____

_____

SECTION C: FACTORS THAT CONSTRAIN IMPLEMENTATION OF HEALTH INSURANCE

What are the main factors that constrain the implementation of the scheme?

_____

_____

_____

SECTION D: ROLES PLAYED BY THE VARIOUS ACTORS IN THE IMPLEMENTATION OF THE SCHEME

What role do you play as beneficiaries in the implementation of the scheme?

_____

_____

_____

SECTION E: SUGGESTIONS FOR IMPROVEMENT OF THE IMPLEMENTATION OF NHIS

Please kindly provide suggestions or recommendations that will help to improve the implementation of the National Health Insurance Scheme.

_____

_____

_____

Thank you for completing the questionnaire