UNIVERSITY OF GHANA

THE ROLE OF THE NATIONAL HEALTH INSURANCE SCHEME IN ACCESSING HEALTH CARE IN THE GA WEST MUNICIPALITY

BY

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DECLARATION

I, Joseph Alagwei Alirah, hereby declare that this thesis is my own work and has not been presented for a degree in any other University, and all materials used in this thesis have been duly acknowledged.

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DEDICATION

To Lydia Gameli Kwadzi and my brothers, Humphrey Aniwei and Michael Adalewei Alira.

ABSTRACT

Ensuring access to quality healthcare is deemed a basic necessity and a fundamental driver for economic growth and development. In view of this, there have been several efforts geared toward ensuring universal health coverage, especially in developing countries. Given the barriers cost of payment for health care pose to health care access and utilisation, health policies such as the health insurance play significant roles in mitigating these barriers. However, some studies suggest that the over-arching purpose of Ghana's National Health Insurance Scheme – to provide financial access to quality health care – continue to be constrained by some challenges, and this poses a serious challenge to bridging the health care accessibility and utilisation gap. Against this backdrop and further positioned in the Ga West Municipality of Ghana, this study examined the role of the National Health Insurance Scheme in accessing health care. Specifically, it examined the awareness of households on NHIS in the Ga West Municipality; assessed the role of NHIS in quality healthcare accessibility in Ga West Municipality; examined the relationship between socio-demographic characteristics of respondents and HIS subscription; and lastly, examined the challenges to NHIS implementation in Ga West Municipality. The study relied on the mixed method approach for its data collection. A total of 200 respondents were sampled for the questionnaire survey and various institutional heads and some respondents were selected for the in-depth interview. The study reported high level of NHIS awareness amongst suscribers and non-subscribers of NHIS, and the major source of information on NHIS was friends and family. Also, most of the study population had little knowledge on other insurance schemes aside the NHIS. In terms of access to health facilities, NHIS subscribers indicated that they experience longer waiting time, poor attitude of staffs and personnel, unavailability of prescribed drugs at the facilities as compared to those who pay out-of-pocket. Findings from the study revealed that females were more likely to enrol on NHIS than males, and people with tertiary education were also more likely to subscribe to the NHIS. Finally, the study revealed that barriers to NHIS subscription influence healthcare accessibility in the context of the Ga West Municipality. Given how important the NHIS is in bridging the health care utilisation gap and ensuring inclusivity of every Ghanaian in quality health care delivery, the study recommends that much effort should be directed at resolving the various challenges associated with the scheme.

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LIST OF ABBREVIATIONS

DMHIS	-	District Mutual Health Insurance Scheme
MDGs	-	Millennium Development Goals
NHIA	-	National Health Insurance Authority
NHIS	-	National Health Insurance Scheme
PCHIS	-	Private Commercial Health Insurance
PMHIS		Scheme
SDGs	-	Sustainable Development Goals
SPSS	-	Statistical Package for Social Sciences
UHC	-	Universal Health Coverage
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Background of the Study

A significant proportion of most health policies are geared towards ensuring Universal Health Coverage (UHC) (WHO, 2014). The concept of UHC gives credence to the view that all people, especially the vulnerable, socially excluded and poor, should be able to access quality health care services without any barrier (WHO, 2014; Assan et al., 2018). Nonetheless, while the existing disparities in quality health care accessibility continue to pose as a major barrier to ensuring UHC, cost of payment for health care, especially among the poor, also hinders the attainment of the 2030 health goals in the Sustainable Development Agenda (Tangcharoensathien et al., 2015; Hogan et al., 2018). Globally, it is estimated that 150million people experience financial barriers in accessing health care every year because of out-of-pocket fees for their healthcare demands (Addae-Korankye, 2013; WHO, 2013; Fusheini, 2017). To resolve these barriers, other stakeholders and advocates of universal health care, including the Rockefeller Foundation World Bank, USAID, the Inter-American Development Bank and the Bill and Melinda Gates Foundation among others, have played many different important roles in promoting UHC such as financing and accompanying reforms, supporting programs and research publication, and literature on the subject. (Gideon, Alfonso, & Diaz, 2013).

The United Nation's Millennium Development Goals (MDGs) prioritized Universal Health Coverage (UHC) among poverty eradication, education, and food security and nutrition. As a result, there has been a reduction in HIV, tuberculosis (TB), malaria epidemics, child mortality and maternal mortality around the world. Subsequently, the SDGs aim to expand the scope of

global sustainable development in the areas of economic, social and environmental strategies and policies while maintaining health as a priority (WHO, 2015).

Today, Ghana is among several middle-income nations employing systems that aim to enhance an effective transition to universal health coverage, and many other low- and middle-income nations are initiating similar health programs. (Gideon et al., 2013). To remedy the challenges associated with out-of-pocket payment and bridge the health care utilization gap, the National Health Insurance scheme has been progressively implemented as a medium to achieving UHC (Sakyi et al., 2012). Even at a global level, health insurance is very well established in most developed countries (Mavalankar & Bhat, 2000, Berk & Monheit, 2001), and currently gaining much grounds in developing countries (Galárraga *et al.*, 2008; Lagaomarsino et al., 2012; Odeyemi et al., 2014; Brugiavini & Pace, 2016).

A number of countries, including Ghana, have embraced and implemented different health insurance schemes to offer affordable health care to their people. For instance, it is reported that Mexico's national health insurance program known as *Seguro Popular* has assisted in substantially reducing the likelihood of extraordinary health expenses amongst insured households, especially the poor (Galárraga *et al.*, 2008).

The extant literature on health insurance portends that the adoption of health insurance in developing countries such as Ghana is more critical and useful (Jehu-Appiah et al., 2011; Blanchet et al., 2012; Mensah et al., 2013; Brugiavini & Pace, 2016). This is because many governments of the developing countries have less money to finance health care (Mills et al., 2012). This puts countless hardships on the already poor individuals who spend significant portions of their income to receive quality health care (Berk and Monheit, 2001; Dixon et al., 2011; Akazili et al., 2014). The government of Ghana's national vision was for Ghana to

achieve middle-income status by 2015. (ACCA, 2013). Ghana's health care policy is in sync with this vision and to the attainment of the Millennium Development Goals amongst a series of Health Sector Medium Term Development Plans (HSMTDPs). (ACCA, 2013)

The NHIS, introduced in Ghana about a decade ago, is a kind of social health insurance that adopts a method of prepayment of financial contributions for health care as contained in the resolution adopted by WHO in May 2005 (Blanchet *et al*.., 2012; Fenny et al., 2016). Ever since the formation of Ghana National Health Insurance Scheme in 2003, the Ghanaian Government has made extensive development towards its overarching goal of ensuring access to quality health care. (Wang, Otoo, & Selby, 2017). In 2014, about 10.5 million people had enrolled on the NHIS representing 40 per cent of Ghana's populace. Also, the average number of inpatient and outpatient attendance increased from 0.5 OPD per capita in 2005 to nearly 3.0 OPD per capita in 2014. (Wang, Otoo, & Selby, 2017). In all, Ghana's NHIS covers 95% of health conditions including inpatient and outpatient services for general and specialist care, surgical operations, hospital accommodation, prescription drugs, blood products, dental care, maternity care and emergency treatment. Exclusions currently include cancer services–other than cervical and breast cancer–dialysis, organ transplants and appliances, comprising optical and hearing aids (Alhassan et al., 2016; Awoonor-Williams et al., 2016; Williams et al., 2017; Van Der Wielen et al., 2018). Recently, the government announced that it plans to extend the NHIS to cover cancer services.

Over the past years, Ghana's NHIS received a lot of criticisms from the media, civil society groups as well as citizens as being discriminatory and used as a political tool to spend the monies of Ghanaians. However, it is lauded by others as a good policy that has relieved a lot of financial burden of Ghanaians when they access health care. Even though the NHIS has

improved general access to health care (Blanchet et al., 2012), it is yet to meet its goal of providing the healthcare demands of the poorest people in society. A survey by the NDPC of Ghana showed that 30% of Ghanaians within the socio-economic quintile had enrolled on the NHIS relative to 60% of the wealthiest (ACCA, 2013).

Moreover, some studies have identified factors that affect NHIS enrolment in the Ghanaian context (Jehu-Appiah et al., 2011; Boateng & Awunyor-Vitor, 2013; Parmar et al., 2014; Kusi et al., 2015; Kotoh & Van der Geest, 2016). These factors include: inaccessibility of health facilities, cost of travelling to health care facilities, perceived quality of service, cost of travelling to NHIS registration centres and socio-cultural factors. Additionally, NHIS subscribers indicated that there is poor quality of health care services provided at the various accredited healthcare facilities. These include longer waiting times, bad attitude by health facility staff, and unavailability of medicine (Teye et al., 2014; Kotoh & Van der Geest, 2016).

In Ghana for instance, studies show that populace residing in Upper West, Northern and Upper East regions have very limited access to secondary health care services relative to those in the southern zone of the country. As an indication of the existing disparity in the distribution of health facilities, the northern regions are also poorly served in the number of clinical staff. For example, just 90 medical officers cover the whole region. (ACCA, 2013). These incidents influenced the decision of the Government of Ghana to pave the way for other schemes to work alongside the NHIS with the aim of improving health delivery in the country. These insurance schemes include the DMHIS, Private Commercial Health Insurance Scheme (PCHIS), and Private Mutual Health Insurance Scheme (PMHIS) (ACCA, 2013). These schemes have shown some level of benefits as well as challenges. Although these insurance schemes are geared towards bridging the financial barriers to health care accessibility and ensuring access to quality

health care, the impact of the scheme as an enabling factor and choice of health care remains key to most health care utilisation discourse.

1.2 Problem Statement

Evidence on the relevance of NHIS in health care accessibility shows that the scheme has made some improvements in its spatial coverage and has also contributed significantly to the utilisation of healthcare services since its inception (Nsiah-Boateng et al., 2019). Nonetheless, a nationwide citizens' assessment of NHIS scheme in 2011 showed that 40 per cent of Ghanaians were non-subscribers and about 36 per cent of subscribers were inactive (Teye et al., 2015). Cobah and Liang (2011) indicated that this trend could be attributed to many factors including delay in waiting periods at health facilities, verbal abuse of clients, poor quality of health care services, and change in government, among others. Additionally, Kodom et al. (2019) also revealed that subscriber's dissatisfaction is likely to be linked to long waiting hours, the poor attitude of nurses and the demand for payment of additional money as client's preferred private facility based on the quality of customer service delivery in the absence of NHIS scheme. The qualitative study further revealed that NHIS subscribers do not receive the quality of healthcare as the scheme is guaranteed, and this has insinuations of premium renewals and health-seeking behaviour. (Kodom et al., 2019).

To achieve the SDGs agenda of ensuring healthy lives and promoting well-being for all (WHO, 2015), there is enough evidence to suggest that an effective implementation of the NHIS would help guarantee access to basic healthcare services for all residents of Ghana (Blanchet et al., 2012; Nsiah-Boateng et al., 2019). According to ACCA, (2013), the NHIS was aimed at bridging the disparities in health service provision amongst the rich and the poor. Irrespective of the successes chalked by the NHIS in terms of health coverage and health service utilisation,

some studies report that it's overarching objective has still not been achieved (Brugiavini, & Pace, 2016; Fusheini et al., 2017; Nsiah-Boateng et al., 2019). In a study by Schieber et al. (2013) which examined access to health care delivery for citizens from diverse socio-economic groups, the poorest members of society were found to be more likely to self-treat than to visit a hospital. This shows that though the NHIS presents some benefits to most subscribers, its role in enhancing access to quality health care has been questioned.

The Ga West Municipality, like other Municipalities in Ghana, continue to be a beneficiary of the NHIS. While the NHIS is intended to enhance access to quality health care and further bridge other inequalities in health care distribution, albeit in varying forms, there is a dearth in studies on how the NHIS influences health care accessibility in the Ga West Municipality. Even though some studies have been conducted on the NHIS in various municipalities and districts in Ghana (Nsiah-Boateng et al., 2016; Fusheini et al., 2017; Kumi-Kyereme et al. 2017), there are little studies specifically examining the role NHIS plays in influencing healthcare accessibility in the Ga West Municipality. For example, the study by Yin et al. (2019) focused only on the influence of politics on the outcomes of the implementation of the NHIS in the Ga West District. Additionally, considering that there could be variations in how the NHIS influences health care utilisation across the various municipalities and districts in Ghana, this study positions itself, specifically, within the context of the Ga West Municipality to examine how NHIS influences use of health care services. For example, what has been the rate of enrolment overtime; which kinds of health facilities are NHIS users more likely to use; and which specific groups of people are more likely to enrol on the NHIS? Also, what is the quality of services rendered to NHIS users when they access healthcare services in the Ga West Municipality? Additionally, this study attempts to add to existing knowledge on the role of NHIS as an enabling factor to healthcare accessibility in Ghana's health system. Against this background,

this study examined the role of NHIS in accessing health care in the Ga West Municipality of the Greater Accra Region of Ghana.

1.3 Research Objectives

The general objective of the study was to examine the role of NHIS in accessing health care in the Ga West Municipality. The specific objective of the study are;

i. To examine the awareness of Households on NHIS in the Ga West Municipality
ii. To examine the role of NHIS in quality healthcare accessibility in the Ga West Municipality
iii. To examine the relationship between socio-demographic characteristics of respondents and NHIS enrolment in the Ga West Municipality
iv. To assess factors affecting NHIS utilisation and healthcare accessibility in the Ga West Municipality.

1.4 Research Questions

Based on the research objectives, the study sought to provide detailed answers to the following research questions;

i. What are the awareness levels of Households on NHIS and its benefits to its subscribers in the Ga West Municipality?
ii. What is role of NHIS in quality healthcare accessibility in Ga West Municipal?
iii. Do socio-demographic variables such as sex, age, level of income, level of education and marital status have and influence on NHIS enrolment in the Ga West Municipality?
iv. What are the challenges to NHIS implementation in Ga West Municipality?

1.4 Research Hypotheses

Null Hypothesis: Level of education has no significant relationship with NHIS subscription in the Ga West Municipality.

Alternate Hypothesis: Level of education has a significant relationship with NHIS subscription in the Ga West Municipality.

Null Hypothesis: Marital status has no significant relationship with NHIS subscription in the Ga West Municipality.

Alternate Hypothesis: Marital status has a significant relationship with NHIS subscription in the Ga West Municipality.

Null Hypothesis: Age has no significant relationship with NHIS subscription in the Ga West Municipality.

Alternate Hypothesis: Age has a significant relationship with NHIS subscription in the Ga West Municipality.

Null Hypothesis: There is no significant relationship between sex of respondents and NHIS enrolment in the Ga West Municipality

Alternate Hypothesis: There is a significant relationship between sex of respondents and NHIS enrolment in the Ga West Municipality

1.6 Significance of the Study

The main rationale for the study is to provide evidence-based material on the experience of members and non-members of NHIS on the role NHIS plays in quality of care in the context of Ga West. This is expected to inform policy makers, the municipal health directorate, and management of the Ga West Mutual Health Insurance Scheme (GWMHIS),

on the challenges confronting both subscribers and non-subscribers of health insurance schemes in accessing health care services. This will enable proper planning and implementation of mechanisms to deal with the situation for improved health care delivery.

Moreover, it is important to note that removal of the barriers to accessing quality health care services by insured clients is a very crucial tool to encouraging the community members to sign on to health insurance schemes. This study further proposes recommendations and draws on best practices for improved health service access and delivery in the Ga West Municipality. In theory, the findings of this study would add to an existing body of knowledge and also provide a broader contextual municipal perspective of how NHIS, given its financial and cost benefits, serves as an enabler to health care accessibility and ensuring universal health coverage.

1.6 Study Limitations

One of the major limitations of this study was inadequate finance and the time available for the study. More important is the fact that getting updated data related to accountability of NHIS and claims reimbursement was difficult to access. Also, there was difficulty in administering the questionnaire: low response rate and unwillingness by respondents to offer accurate information were some problems that militated against accuracy and speed. Notwithstanding this, funds were solicited to carry out the work. The work plan was strictly adhered to as a guide to the study. The study also adequately used any available literature of importance. Services of research assistants were engaged to help collect and analyse data.

1.7 Organization of the Study

The study comprises six chapters. Chapter one comprises an introduction, which summarizes the study -an introductory chapter to the entire research. This chapter also discusses the

background of the study, the problem investigated, the aims and significance of the study, and the scope and limitations of the study.

Chapter two covers a review of relevant literature which served as a foundation for the rest of the research. It explored literature pertaining to the various objectives of the study. This helped in gaining a thorough understanding of existing knowledge and how to fill the gaps identified by the study. Additionally, the conceptual issues identified were taken into consideration and aided in the constructing the conceptual framework for this study. Chapter three explains the research methods adopted by this study. This include how respondents were sampled, how the data were collected and analysed.

Chapters four and five present the results and discussions of the study based on the objectives. These include an analysis of both qualitative and quantitative data collected. The last chapter, chapter six, presents the summary of key findings from the study and draws conclusions based on the findings, conceptual and theoretical framework of the study. Lastly, the study makes recommendations in the sixth chapter.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

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

2.1 Health and Quality of care

According to WHO, health is defined as "a state of complete physical, mental and social well-being and not the absence of diseases or infirmity" (WHO, 2002). The foremost goal for every sustainable development is the health of its populace (Akhtar, 2005). Research has shown that good health and longevity is a foundation for the progress of modern economy and a catalyst for economic development, and not merely the quality of life of the individual (Bryne, 2004). According to Asher (2004), health is considered a human right that is preserved through the economic, social and cultural rights. It is also acknowledged across the global human rights medium as in domestic legislation in numerous countries. The health of the citizen is significant to the well-being of the community and the individual happiness. Good health is also considered a significant determinant of people's earning capacity (Olujimi, 2007). The Government plays a key role in ensuring that the populace enjoy their right to good health with no disparities among the poor and the rich in the society (Asher, 2004).

WHO (2002) stated that the right to health can be explained as the right to access a variety of good facilities, services and significant conditions. The World Health Organization (WHO) has indicated that determinants of health should consist of social and economic environment, the physical environment, the individual characteristics and the behaviours. It is known that the setting in which a person lives is of significance to his quality of life and health status. Other studies have shown that socio-economic characteristics are important determinants in deciding the health status of persons considering that higher educational levels are often correlate with good standard of life and higher income (WHO, 2006).

According to Anderson (2004), people deprived of good health are likely to experience sicknesses and short life span. It is fairly easy to achieve good health, but it involves certain changes in life style that are sometimes difficult. Nepal Institute of Medicine defines quality health care as 'the degree to which health services for populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Institute of Medicine, 2001). According to Mosadeghrad (2012), quality healthcare is "the provision of the right healthcare services in a right way in the right place at the right time by the right provider to the right individual for the right price to get the right results". The important aspect of it is about satisfying the patient by improving the quality of healthcare beneficial to their life.

In a study by Fenny et al. (2014) where the Donabedian model was adopted to study the quality of service NHIS clients receive in three districts in Ghana, specifically covering the three ecological zones (coastal, forest and savannah), the model highlighted and conceptualized healthcare quality features such as "structures, processes and outcomes. Further logistic regression analysis redefined quality healthcare as embodying waiting time, friendliness of staff and satisfaction with the consultation process". Data gathered from 250 NHIS clients, revealed

four significant dimensions of quality healthcare; namely, interaction with service providers, provider demeanour, physical infrastructure/facilities and waiting time (Atinga, 2012).

Ministry of Health's (2004) standpoint is that quality health care should focus on the perspectives of clients, enlightening the capabilities and skills of providers and refining the working setting by better management, delivery of medical equipment and supplies, and motivating staff by improving their conditions of service.

2.1 The Concept of Health Insurance

Health protection coverage is a necessity for every person and to the economy as well since labour productivity demands a healthy labour force (Social Protection Department, 2014). Literature has shown that quality health care is a precondition for sustainable development and economic growth. By extension, for a labour force to be fully productive, it is based on an active workforce. It is significant that the working population is able to make enough from their income.

Also, literature has shown that good health protection is significant for the quality healthcare of the population and for boosting the economy. Certifying the population have access to quality health care is essential for sustainable development on the basis of equity and inclusiveness. Universal health coverage must comprise even access to quality healthcare for all population within all geographical locations. It however demands comprehensive policies addressing inequities emanating from barriers within and beyond the health sector (Social Protection Department, 2014)

There have been a historical change in global implementation of health insurance. (Anita, 2015). Health service delivery, particularly within the developed countries, is no more restricted

to the responsibilities of primary healthcare medical doctor. With the availability of advance technology, acute and critical healthcare can now handle many calamitous, intricate, chronic, and solemn conditions and injuries which were hitherto considered deadly or disabling. While the advancement of innovative therapies that can restore functioning and/or extend life is hospitable, the expenses for these interventions and additional hospital admission can be excessively high for several people (Anita, 2015). According to (WHO, 2013), it is estimated that 150 million people globally undergo financial devastation every year because of out-of-pocket fees for their healthcare demands.

Many countries have been exploring several models of insurance and health financing schemes based on their corresponding socioeconomic status and cultural settings. Depending on the kind of insurance plan and service being covered, it's based on whether public or private have diverse components and payment requirements. Many insurance plans compel members to pay premium price for registering in the program and have several stages of out-of-pocket payments such as deductibles, co-payments, or coinsurance. They may also demand preceding endorsement from insurance companies to stimulate reportage for particular processes or may impose coverage limits for subscribers. Many insurance companies may also exploit payment fee for healthcare providers to control price by inspiring providers to state only needed services and within the lowest price setting. Universally, there are three noticeable classifications of health insurance. However, disparities thrive for each category, and in some countries, there are variations. China, for example, has manifold insurance programs even for basic healthcare. (Anita, 2015).

2.2 Health Care Financing in Africa

African countries were noted to put in more investment and amendments to improve healthcare system and quicken progress to meet the Millennium Development Goals (MDGs). The moves by political leaders to prioritise health in the development of the nations have been restated at the continental level through actions such as "the Abuja Declaration in 2001 on government increasing funds for health", "the Addis-Ababa Declaration in 2006 on community health in African Countries" and the "Ouagadougou Declaration in 2008 on primary healthcare and health system in Africa". Health system financing is considered one of the significant areas that offer imperative opportunities to explain these responsibilities and political will into results. (WHO, , 2013)

The common objectives of these initiatives are to develop strong health financing system, even with the richest countries. With the rise in the cost of healthcare, countries are finding it challenging to keep up with the healthcare financing and with the current economic decline adding more burden on healthcare expenditure. (WHO, 2013)

According to research, majority of the African countries are ranked within low or middle income countries where scarcity of funds for quality healthcare is considered a challenge. Averagely, the total healthcare expenditure amongst African countries was around US$135 per capita in 2010, which is only a little fraction of the total expenditure on healthcare in an average high-income country. (World Health Organization, 2010)

According to the extant literature, these limitations, rising from shortages in African countries, are the policies and systems that strengthen healthcare financing. Statistically, in about 50 percent of African countries, 40 percent or more of the total healthcare expenses come from household's out-of-pocket payments. The dependence on this payment method poses financial

hindrances to access to quality healthcare and, ultimately, puts people at the risk of privation (Series Steering Group, 2006)

Moreover, the present financial flows in the healthcare systems are generating and aggravating inadequacies and inequalities, for example, through biased distribution of funds to urban regions and specialized care. (WHO, 2013). According to WHO (2013), many African countries have lately implemented effective health financing reforms that have improved access to quality healthcare services and financial risk protection, moving them closer to meeting the objective of universal health coverage (UHC).

2.3 Health Care Financing in Ghana

The Ghanaian health system has gone through many transformations. After Ghana attained independence in 1957, it was dedicated to delivering "free for all" health service delivery at all levels. In view of this, Ghana established a policy which thrived till the economic crisis in 1970s and 1980s which occasioned the Economic Recovery Programme (ERP), which further resulted in a reduction in government expenditure on health care service. It also caused shortage of supplies, disheartened working population and caused a standstill on investment in infrastructure. (ACCA, 2013). The literature has suggested that Ghana, at independence, run a free health care for its populations (Durairaj, et al. 2010; Mensah, et al. 2010).

According to Blanchet, Fink, & Akoto (2012), succeeding the implementation of structural adjustment reforms in the year 1983, the then governing administration led by ex-president Rawlings elevated and extended user fees for public health care services which was termed as "cash and carry." The Ghanaian government after receiving support from the World Bank agreed to enact a charge for health services provision, amounting to 15% of recurring

expenditure. The ‘cash and carry’ has impacted the system and caused a rapid decline in health care service utilisation greater than 50% nation-wide and of over 70% in rural areas. The findings of most studies have since discovered that occupants shifted away from modern medicine and turned to traditional medicine or self-medication for treatment. (ACCA, 2013)

Within the year 1980s, the government introduced payment exemptions for restricted number of health service which covers children under five years of age, adult above the age of 70 and the poor. However Submission of these exemptions was irregular. Complexities includes: access to exemption by health providers, obtaining patients proof of demographic information such as age, validation of the poor and non-uniform application of exemption.

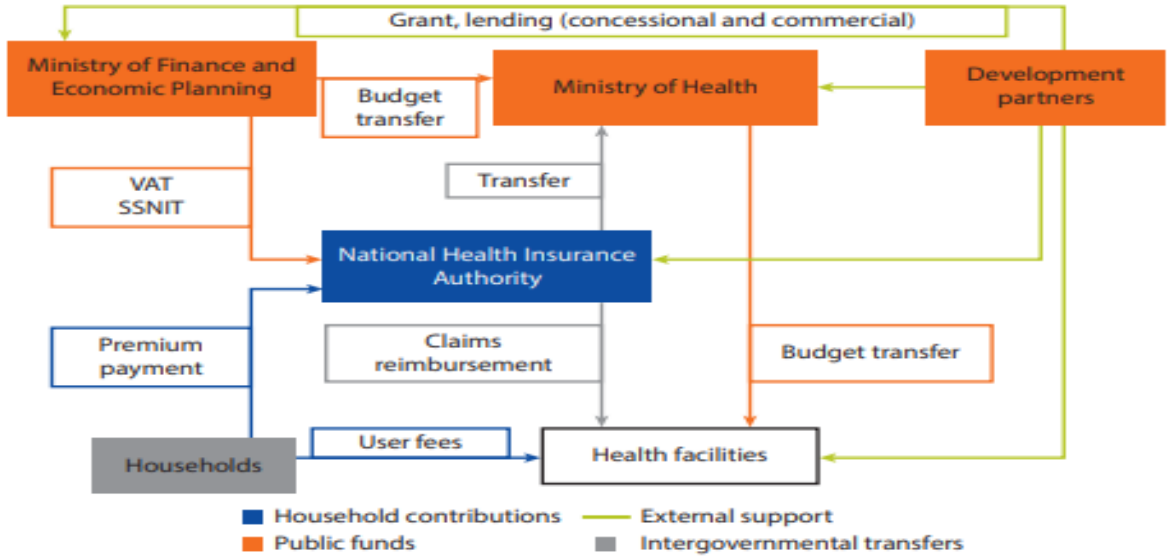
About the year 2000, a selection of health providers tried to introduce health insurance schemes that is meant at resolving the worries patients go through in accessing and paying for care. Mutual health organizations were established as the subject progressed overtime. A nationwide recognition of such schemes became popular before the year 2003: the country recorded 258 total number of functional schemes. Meanwhile the population indicator coverage was just 2%.

In the year 2003 and 2004, the government pass a legislation permitting healthcare financing reform which aimed at building on the success of prior insurance schemes leading to the enactment of National Health Insurance Scheme in 2005. The objective of the NHIS was to make free health care obtainable to all, but exceptionally to the poor and the deprived. In all, there is enough literature on the evolution of Ghana health system. The literature is replete with studies on the evolution of Ghana’s health system − from free health care delivery to a “cash and carry” payment system and, now, the inception of NHIS system − has been well documented.

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

The Ghanaian health sector is largely funded by the government, its elaboration partners, and Ghanaian citizens. Allocation of Public resources to the Ministry of Health (MoH) and health facilities was carried out through monetary transfers. The National Health Insurance Authority is funded by the national health insurance (NHI) levy and deductions form Social Security and National Insurance Trust (SSNIT). Other supports were from Ghana's development partners to MoH, NHIA, and individual health facilities through provision of grants, concessional and commercial loans and technical assistance. Citizenship contributions include NHIS premium payments and out-of-pocket spending at the point of care delivery (Wang, Otoo, & Selby, 2017)

Figure 2.1: The flow of funds in the Ghanaian Health sector



(Wang, Otoo, & Selby, 2017)

2.4 The Ghana National Health Insurance Scheme Law (Act 650) enacted in 2003

The National Health Insurance Scheme (NHIS) was established by an act of parliament in 2003 (Act 650) as a remedy to the existing "cash and carry system". Ghana was among the very few countries within the sub-Saharan African countries to establish such a universal health insurance program nationwide. This was aimed at providing a broad range of health care services to Ghanaians through various district mutual and private health insurance schemes. Additionally the NHIS was established as panacea to the negative consequences user fees was having on health care accessibility and utilisation. Consequently, Ghana's NHIS primarily aimed at increasing the utilisation of health care services and making drugs affordable to the general populace. Per the Act 650 that established the NHIS, all district-level mutual health insurance including licenses and regulations are done by the NHIA. The NHIA is mandated to accredit

providers, determine premium levels in agreement with the district mutual health insurance schemes and oversee all NHIS activities.

Also, per the Act 650, every Ghanaian is required to enrol on the NHIS. Nonetheless, enrolment is *de facto* voluntary because there is no penalty for failing to enrol, and individuals or households are not enrolled automatically. The Section 31 of the Act 650, which states categorically that every Ghanaian ought to enrol, is as follows: (1) A person resident in Ghana other than a member of the Armed Forces of Ghana and the Police Service shall belong to a health insurance scheme licensed under this Act. (2) A person resident in a district, who is not a member of a private health insurance scheme or any other district scheme registered under this Act, shall apply to be enrolled as a member of the district mutual health insurance scheme in the relevant district.

The NHIS is financed from four main sources: a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums, and miscellaneous other funds from investment returns, Parliament, or donors. The 2.5 per cent tax on goods and services, called the National Health Insurance Levy (NHIL), is by far the largest source, comprising about 70 per cent of revenues. Social security taxes account for an additional 23 per cent, premiums for about 5 per cent, and other funds for the remaining two per cent. Although portions of the funding for the scheme comes from SSNIT, SSNIT contributors are expected to subscribe personally and pay registration fees in order to obtain the insurance cards. Others who are exempted from paying premiums include people over age 70, children under 18 years whose parents both enrol, the "core poor" defined as being unemployed with no visible source of income, no fixed residence, and not living with someone employed and with a fixed residence, and all pregnant women – since July 2008. The Act 650 makes provision for three types of schemes, viz. district (public) mutual health insurance, private mutual health

insurance, and lastly, private commercial health insurance. Put differently, the three legitimate classifications of health insurance were certified and include;

- District Mutual Health Insurance Schemes (DMHIS);

The DMHIS presents the public insurance schemes which is available for every Ghanaian resident to enrol. This insurance scheme is funded by the central government's national health insurance levy and complemented by annual member contributions. The NHIA was mandated to ensure accountability in normalizing the insurance scheme, making sure accredited health care providers are paid and managing the funds.

- Commercial Health Insurance Schemes (CHIS);

The CHIS presents the schemes which is funded solely from member contributions. And lastly,

- Private Mutual Insurance Schemes (PMIS);

PMIS presents the schemes which manages the contributions of individuals, perchance members of a church or social club, to cater for group health needs. To be funded solely from member contributions.

The NHIS covers outpatient services, including diagnostic testing and operations such as hernia repair; most in-patient services, including specialist care, most surgeries, and hospital accommodation (general ward); oral health treatments; all maternity care services, including Caesarean deliveries; emergency care; and, finally, all drugs on the centrally-established NHIA Medicines List. The NHIS package *excludes* some very expensive procedures such as certain surgeries, cancer treatments (other than breast and cervical cancer), organ transplants, and dialysis; non-vital services such as cosmetic surgery; and some high profile items such as HIV antiretroviral drugs (which are heavily subsidized by the separate National AIDS Program).

Other than the excluded services, there are few formal limits placed on NHIS members' consumption of benefits—there is no cost-sharing beyond premiums (i.e., no co-payments, coinsurance, or deductibles), no annual or lifetime limits and little effective gate-keeping. Benefits were intended to be "portable" from district to district, but actual portability has been mixed and is one reason for the recent introduction of a single, national NHIS identification card to replace district-level cards

2.4.1 The Ghana National Health Insurance Scheme

Recently, a structured National Health Insurance Authority (NHIA) was instituted "to secure the usage of a national medical coverage approach that guarantees access to fundamental social insurance administrations to all inhabitants" (MoH, 2008). The NHIA licenses and manages area-level common medical coverage plans such as the District Mutual Health Insurance Schemes (DMHISs) and, in addition, different policies permitted under the Act, certifies suppliers, and decides — in discussion with DMHISs — premium levels, and by and large regulates and reports on NHIS operations. Currently, there are 145 locale plans, incorporating ten that worked in the Greater Accra Region amid the review time frame.

The NHIS (counting all DMHISs) has a solitary advantage bundle that is set by Legislative Instrument, LI 1809 and described by the NHIA as covering "95% of sickness conditions" that plague Ghanaians. The NHIS covers outpatient administrations, including symptomatic testing and operations, for example, hernia repair; most in-patient administrations, including expert care, most surgeries, and clinic settlement (general ward); oral health medications; all maternity mind administrations, including Caesarean conveyances; crisis mind; and, at last, all medications on the halfway settled NHIA Medicines List. (MoH, 2008).

The NHIS bundle rejects some exceptionally costly methods. For example, certain surgeries, tumor medications (other than bosom and cervical disease), organ transplants, and dialysis; non-imperative administrations, for example, corrective surgery; and some prominent diseases, for example, HIV antiretroviral drugs (which are intensely sponsored by the different National AIDS Control Programs). Other than the avoided administrations, there are couple of formal points of confinement set on NHIS individuals' utilisation of benefits — there is no cost-sharing past premiums (i.e., no co-instalments, coinsurance, or deductibles), no yearly or lifetime breaking points and minimal viable door-keeping.

Official measurements on NHIS enlistment provided by the National Health Insurance Authority demonstrate the expansion in enrolment since operations started in late 2005. For instance, the aggregate number of dynamic individuals purportedly expanded from 2.4 million in 2006 to 11.1 million in 2009, recommending that near half of the populace were secured by the protection by 2009. Be that as it may, the NHIA changed its technique for figuring dynamic individuals and assessed in its 2010 yearly report that around 34% of Ghanaians were dynamic enrolees toward the finish of 2010. (MoH, 2008).

Ghana's NHIS is supervised by the National Health Insurance Council (NHIC) in Accra. Regional and district workplaces of the NHIC are being set up to decentralize the operations of the scheme. The council deals with the National Health Insurance Fund (NHIF) through the gathering, payment, and organization of the Scheme. The council, additionally, embraces the permitting, control, and accreditation of social insurance suppliers. At the end of 2007, the NHIS had licensed 800 private medicinal services suppliers notwithstanding government health offices (Ministry of Health, 2008). It is normal that this arrangement of accreditation will, in the long run, raise models and nature of care throughout the nation for both guaranteed and

uninsured nationals. At the district level, there are Health Insurance Assemblies which include all individuals from the separate district schemes on favourable terms. The district schemes are represented by Board of Trustees and Scheme Managers. The administration groups at the different districts incorporate an Administrator, Accountant, Publicity and Marketing Manager, Claims Managers, Data Control Manager, and Data Entry Clerk (Ministry of Health, 2004; Sabi, 2005).

2.4.2 Premiums and Benefits

NHIS premiums are meant to facilitate customers' capacity to pay. Regional Health Insurance Committees recognize and sort inhabitants into four principal social gatherings—viz., the pro-poor or the impoverished; poor people and exceptionally poor; the white collar class; and the rich and extremely rich—and fluctuate their separate commitments in like manner (Sulzbach, 2008). The pro-poor (or the impoverished) together with individuals who are at least 70 years old or previous Social Security and National Insurance Trust (SSNIT) patrons already on retirement are exempted from paying any premiums (Sulzbach, 2008). While premiums shift somewhat from district to district, individuals pay nothing less than GH¢7.2 per annum. For individuals in the formal sector, 2.5% of their commitment to SSNIT is deducted monthly as their medical coverage premium (Sulzbach, 2008).

Even though labourers in the formal sectors are listed as individuals on the NHIS, they also need to enlist with their separate District Mutual Health Insurance Schemes. The casual workers and independently employed pay between GH¢7.2 and GH¢48.0 yearly, depending on their wage (MoH, 2008). All supporters' premiums cover their kids and wards under the age of 18 years. In this manner, NHIS enlistments of kids were connected to those of guardians. A few policies demand that both guardians must be enrolled (with the exception of in single-parent family units) before a youngster can be enlisted, while others just require the mother to be

enrolled. In 2004, the administration presented a 2.5% deals charge (i.e., Health Insurance Levy) on chosen merchandise and ventures to support the NHIS. Other remarkable sources of subsidizing for the scheme incorporate cash from the administration's financial plan and benefactor commitments (Sabi, 2005).

2.4.2 Health Insurance Claims

The reimbursement made to health care providers is known as claims. Therefore, a health insurance claim is a bill for health care services that health care providers turn in to the insurance company for payment. Claims payment is crucial considering its strategic role in the sustainability of health care provision under health insurance. Ankomah (2009) notes that the sustainability of NHIS is dependent on a well-designed provider-payment mechanism. This is because it will allow for attaining reasonable income for providers, guarantee quality health care, and eliminate wastage and/or unnecessary service provision. Claims payment constitutes a form of reimbursement of service providers by Health Insurance Schemes for services rendered to clients of the schemes. The District Mutual Health Insurance Scheme (DMHIS) Operational Manual (2008) indicates that the purpose of this procedure is to vet and pay claims submitted by accredited health service providers under the NHIS for services rendered to members of a DMHIS.

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

indicated that the NHIS in Ghana began with the itemized case costing system of claims payment. This system made payments for each service or procedure undertaken.

Therefore, services such as patient consultation, accommodation, non-drug consumables, X-ray, laboratory investigations, and feeding were each paid a fee. This system brought its own challenges in view of the volume of information requested on each service, and the no uniformity in the cost structure for the various health facilities (Ankomah, 2009). Problems catalogued out of these developments included prolonged vetting of claims and delay in reimbursement, variability of the cost of treatment for the same disease episodes in related facilities arising from the proliferation of tariffs among schemes, and the disincentive for some providers to enrol unto the system wholly due to unattractive tariffs (Ankomah, 2009). This phenomenon discouraged provider participation and thus, increased congestion in the few NHIS accredited facilities (Ankomah, 2009).

Clearly, this situation demanded a reform in the provider tariff structure because the delay in reimbursement coupled with the increasing diversity of prices charged for similar treatment or services was an indication of the gradual collapse of the NHIS (Ankomah, 2009). Of course one cannot overlook other possible variables such as multiple utilisation and poly-pharmacy at the provider sites and attribute the threat of collapse of the NHI to the fee-for-service system alone. Otherwise, there is the possibility of recurrence of similar problems including abuse of the system that can affect the sustainability of the NHIS.

Having seen the adverse effects and implications for sustaining National Health Insurance (NHI) using the fee-for-service system, the NHI adopted a new system based on the Ghana Diagnostic Related Groupings (GDRG) concept. The G-DRGs are standard groups of diseases related clinically and have comparable treatments under similar health care resources

(Ankomah, 2009.). This allows for service providers to be paid for patient's treatment according to his or her diagnostic group irrespective of the cost. This is known as the inclusive flat payment. Although this payment mechanism reduces the cost burden for schemes of having to bear huge claims submission by providers, it brings to the fore the issue of unattractive rates which discourage provider participation. This is a concern when considering sustainability and access because limited facilities cannot achieve the object of promoting primary health care which is an important object under the NHI. Increased waiting time at NHI accredited health facilities not only discourages potential subscribers, it can also compromise delivery of quality health care. (Ankomah, 2009.).

Ankomah (2009) argues that the G-DRG payment regime "covers the full cost of estimated direct consumables for direct patient care, anaesthesia and investigations, and about 80% of the estimated overhead cost for the public health facilities". Thus, it has the potential of bridging the funding gap for public health facilities. But the bottom line of the matter is that the private-health facilities are not favoured by this development. By this, it stands to reason that there is no universal applicability of incentive packages that would encourage more provider participation. This critically would affect the sustainability of NHI if more providers are unwilling to enrol unto the NHI.

The G-DRG payment regime is regulated by a tariff structure set by multi-disciplinary team or stakeholders within the health sector. They comprise the National Health Insurance Authority (NHIA), Ghana Medical Association, Association of Pharmaceutical Companies and Ghana Registered Midwives. The rest are Society of Private Medical and Dental practitioners, Christian Health Association of Ghana (CHAG), and District Schemes among others. (Ankomah, 2009)

The tariff structure varies for different levels of health care classified by the NHIA. The broad categories include Government facilities, Quasi-government or religious health institutions, and private facilities. The Government facilities are sub-divided into CHIPS compounds, District level clinics and hospitals, Regional hospitals, and Tertiary or Teaching level hospitals. The private facilities on the other hand comprise district level clinics and hospitals, maternity homes, community pharmacies, and diagnostic centres. (Ankomah, 2009)

2.5 Accessibility and Utilisation of Health Services

Ghana is amongst the first sub-Saharan Africa countries to initiate the implementation of a National Health Insurance Scheme (NHIS). According to Agyepong & Adjei (2008), Ghana initiated the implementation of the NHIS as a policy with the objective of minimizing out-of-pocket spending at the point of healthcare delivery, thus reducing the financial barrier to health service utilisation.

In recent times, studies have also explored in the area of healthcare accessibility in relation to national insurance utilisation across the globe. Many studies have shown that poor quality of healthcare service plays a significant role in healthcare accessibility and utilisation in many context. Alhassan, Amponsah, & Arthinful (2016) are of the view that poor quality of care in most of the NHIS accreditated health facilities potentially affect NHIS subscriptions and utilisation. According to Opoku, Amposah, & Janssens (2018), being a subscriber to NHIS was associated with a significant lower perception of health quality amongst households. They further indicated that once people are insured they tend to percieve quality of health care as poor as compared to the non-insured. According to Odame (2014), most hospitals, especially public health facilities were found to be sub-standard with regards to how they interact with their patients which influence client's perceptions on healthcare accessibility and utilisation. Unavailabiltiy of medicine and percieved poor quality of care was is a challenge to subscribers

during healthcare service provision (Emmanuel , Julius, & Gbolo, 2018). Atinga, (2011) established in his study that dimension of service quality such as staff attitude were perceived by subscribers to be good in the context of Ghana. A research by Aryeetey, Nonvignon, Amissah , Buckle, & Aikins (2016) disclosed that the implementation of NHIS was accompanied by increased access and use of health care services in the context of Ghana.

2.6 Health Insurance

Health insurance, which is very important in utilisation, is least developed in most developing countries. Utilisation is higher for insured patients in developing countries where health insurance exists. Supakankunti (2000), in a study of the future prospects of voluntary health insurance in Thailand, concluded that greater use of health services was the result of the introduction of the Health Card program. There was an improvement in accessibility to health care and a high level of satisfaction among cardholders. Chen *et al.* (2009) also conclude that the utilisation of prenatal and intrapartum care services, especially for the more expensive services, substantially increased in Taiwan since the implementation of the national health insurance plan.

The relationship between gender and health insurance enrolment has received a lot of attention in the academia with varied outcomes. For instance, Owusu *et al.* (2014) found that more males are likely to enrol on NHIS compared to the female. On their part, Kusi *et al.* (2015) in their study of refusal to enrol in Ghana's national health insurance scheme observed that females were more likely to subscribe to NHIS. According to Owusu *et al.* (2014) the tendency for higher male enrolment on NHIS was that the patriarchal nature of most Ghanaian societies have placed enormous burden on men ranging from providing for accommodation, education and

health care needs of his household. Consequent to that and in order not to be caught unprepared have led to more men enrolling on NHIS as a safety net for the health needs.

2.7 Challenges Associated with Health Insurance Schemes

A number of literature have revealed that health insurance schemes everywhere in the world are confronted with several challenges. In the long run, these challenges go on to determine the viability as well as sustainability of health insurance schemes. The introduction of NHIS was to make free health care obtainable to all, but mainly the poor and deprived. Current data have shown that, the scheme is yet to achieve this goal; only 29% of the poorest members of society were subscribed compared with over 64% of the wealthiest (ACCA, 2013)

One of the challenges is moral hazard. Moral hazard is the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have been insured (Weber, 2005). Weber further classifies moral hazard into two. These are supply side (for instance, when the doctor provides unnecessary care because the patient is insured) moral hazard and supply side hazard (for instance, when the patient demand unnecessary care because he is insured). This classification is also used in a similar study by a government of India's study dubbed 'Framework for Health Insurance' (2005). Moral hazard behaviour of insured persons presents a permanent threat to the financial sustainability of schemes. Insurance lowers the price of care at the point of use and barriers to access reduce. This increases the utilisation of health facilities which can jeopardize the finances of health insurance schemes (Jutting, 2000).

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

of claims has been attributed to the inadequacy of staffing or human resource and the high volumes of claims schemes received within a period. Approximately 30,000 claims are received each month for processing (AMHIS Report, 2009). The report also suggests that there is little effort towards the processing of claims and reimbursement. The NHIA is also blamed for the untimely release of funds to pay claims. There has since not been any policy formulated by the NHIA to guard against fraud, over billing and the like which delay the processing of claims. Study in the Northern Region of Ghana observed that majority of claims subjected for payment were partially or totally rejected for reasons such as suspicion of fraud, lack of evidence for claims and use of expired card by members (Sodzi-Tettey,2017)

The total revenue generated during the year 2012, was of GH¢773.83 million against total expenditure of GH¢788.32 million resulting in net operating deficit of ¢14.49 million. The cost of claims for the period was GH¢616.47 million, signifying 78.2% of the total expenditure. (NHIA, 2012). What further compounds this problem is the shortfalls in the flow of funds into the NHIS reserves. This is attributable to the fact that half of the user population is exempted from contributing (Public Agenda, October 23, 2009)**.** Clearly, this shows that the amount of money in the pool is not sufficient.

The Ghana Medical Association (GMA) also indicated that, the National Health Insurance Scheme is collapsing due to outstanding insurance claims owed to service providers (Brocke, 2010). Notwithstanding the inherent challenges that confront management, it is clear that service providers are a factor in the delay of processing claims. The AMHIS Annual Report for 2009, highlighted several problems caused by providers that further delayed the processing of claims. The delay in payment of insurance claims is consistent with studies such as Fusheini *et al.* (2012).

With the new computerized system of processing claims, not all service providers complete filling of mandatory fields of claims forms. Not all diagnoses are written hence the inability of some service providers to justify the dispensation of certain medicines. In relation to the just mentioned, is the fact that some facilities were culprits of wrong billing of unit prices of some medicines. Other claim forms also showed some discrepancies of quantities of medicines as compared to prescriptions. The claims department is also troubled with claims forms showing multiple filling of some patients for the same day by the same facility. Service providers also do not adhere to standard treatment protocol. Service providers have also delayed with the submissions of claims (Ordoi-Larbi, 2009). Emmanuel , Julius, & Gbolo, (2018) also noted that unavailabiltiy of medicine and percieved poor quality of care was is a challenge to subscribers.

2.7.2 Health Seeking Behaviour of the Insured and Non-Insured

MacKian (2003), discussing people's health seeking behaviours indicated that there have been growing interests in factors amplifying the use of specific health services, and what spurs people to act differently relative to their health. Health seeking behaviours can be categorized into two types. Firstly, there are studies which emphasise the 'end point' (utilisation of the formal system, or health care seeking behaviour); secondly, there are those which emphasise the 'process' (disease response, or health seeking behaviour).

MacKian (2003) posits that the choice of a specific medical channel is influenced by a variety of socioeconomic variables such as sex, age, the social status of women, the type of disease, access to services and perceived quality of the service.

In mapping out the factors behind such patterns, MacKian (2003) asserted certain broad trends. According to MacKian (2003), firstly, there are studies which categorise the types of *barriers* or *determinants* which lie between patients and services. These barriers generally fall under the

divisions of geographical, social, economic, cultural and organisational factors. Secondly, there is the view that in some cases, the wanted health care seeking behaviour is for an individual to respond accordingly to a disease episode by seeking, first and foremost, help from a trained doctor, in a formally recognised health care setting. According to MacKian (2003), the second trench of work, rooted especially in psychology, looks at health seeking behaviours regarding to the various factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviours or their use of medical care and treatment. These factors are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality. The underlying assumption is that behaviour is best understood in terms of an individual's perception of their social environment.

In their recent survey on assessing the effect of the NHIS on access to and utilisation of health care services in the Akatsi District of the Volta Region of Ghana, Gobah and Liang (2011) found out that higher proportion of the insured (70.8%) than the non-insured (6.0%) sought formal care during ill-health. Some of the services received by the insured normally ranged from consultation and treatment (54.7%), medicines/drugs (18.6%), laboratory services (9.8%), delivery (8.8%) and hospitalization (8.1%). Again, it was realized that government health facilities were the first point of call for most respondents especially the government hospital at the district capital for both the urban and rural dwellers. This was followed by private health facilities all located at the district capital (22.0%).

The proportion of the insured that used health centres located close to the communities accounts for 6.6%. None reported using the CHPS compounds. Various reasons were given for the choice of these facilities. Prominent among them were competence and friendly staffs (30.1%), reputation of provider (19.5%), availability of medicines (17.2%), prompt attention

(16.3%). About 17% of the responses were related to cost and proximity to a health facility. Most hospitals especially public health facilities were found to be sub-standard with regards to how they interact with their patients (Odame, 2014). Health workers are all times anticipated to be friendly and hospitable towards their patients (Muriithi, 2013).

Another interesting revelation was that higher proportions (63%) of the female insured respondents who gave birth during the last 12 month preceding the survey as compared with the non-insured (4.7%) gave birth in a health facility and were assisted by trained health personnel (75.0%). Use of postnatal care services is also higher among the insured (67.2%) than the non-insured (7.8%) (Cobah and Liang, 2011). It was understood that lack of insurance (42.3%) is the single most important reason for not seeking formal health care among the non-insured.

A higher proportion of the non-insured who did not seek care (48.1%) either delayed or postponed treatment. The result revealed that health insurance is a key determinant in seeking health care and using modern health facilties. Care-seeking, choice of health facility, place of last birth, professional attendance at delivery and use of postnatal care services are all statistically significant (Cobah and Liang, 2011).

Majority of the insured (67%) indicated receiving good quality of service with 33.0% stating otherwise. Unavailability of essential drugs (39.0%) and long waiting time (31.4%), respectively, were the major reasons stated for the low quality of service received. From the perspective of the non-insured, quality of health care delivery in the district is rated as low. Waiting time, cost of treatment, quality of drugs, availability of drugs at the facility were rated as ‘worse than before’ while privacy during examination and treatment and availability of laboratory services at the facility were rated as ‘same as before’ (Cobah and Liang, 2011).

Waiting time was seen to be too long amongs subscribers of NHIS in the context of Ghana. (Atinga, 2011)

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

2.8 The Importance of Health Financing to Economic Development

The significance of health as an essential facet of development and economic comfort of individuals and nations is progressively being documented in the globe. (Piabuo & Tieguhong, 2017). This can be understood from a series of reforms undertaken by African countries to increase investments in healthcare delivery in order to meet the health Millennium Development Goals (MDGs). African leaders have voiced this conviction through proceedings such as the 2001 Abuja Declaration on an increase in government funding for health by allocating 15% of the government budget to the health sector, the 2006 Addis Ababa Declaration on community health in the African Region and the 2008 Ouagadougou Declaration on primary health care and health systems in Africa.

2.8.1 Importance of Health to Labour Productivity

Health is a reason for employment profitability. Great health has a positive, sizable, and measurably huge impact on total yield. Labourers' profitability is being improved by expanding not only their physical limits, for example, quality and perseverance, but expanding their mental capacities as well, for example, intellectual working and thinking capacity (Bloom and Canning, 2005). More beneficial labourers are more gainful and win higher wages. They are additionally more averse to be missing from work in light of ailments. Disease and incapacity lessen time-

based compensations considerably, with the impact particularly solid in developing nations, where a higher extent of the work force is occupied with physical work than in developed nations (Bloom *et al.* 2004). Health is an imperatively vital type of human capital and merits an abnormal state of consideration in the improvement procedures of Cardio-vascular Diseases (CVDs). A superior health improves work efficiency which thus leads to enhanced wages.

2.8.2 Importance of Health to Savings

Weakness influences both the capacity to spare and the catalyst to spare (Bloom and Canning, 2008). A key component in East Asia's monetary achievement was the area's high rate of capital amassing, driven by a financial high reserve funds rate of around 30% of pay (Alsan, *et al.*, 2006). A more drawn out life expectancy evokes more noteworthy funds for retirement. The reserve funds could be transmuted into interests in resources that directly influence profitability, for example, property, hardware, and so on. Then again, irresistible ailment can bring down efficiency and prevent speculations. Likewise, health influences remote direct venture (FDI). Outside speculators have a tendency to keep away from regions where disease is wild and with constrained access to human services. Blossom and Canning (2008), gave a case of the development of the Panama Canal to back the observational aftereffect of health on reserve funds (venture). Yellow fever and transmittable ailments killed 10,000 to 20,000 specialists in the period of 1882 and 1888, compelling Ferdinand de Lesseps and the French to surrender the development extend.

2.8.3 NHIS and Demography

According to (ACCA, 2013), Ghana there has long been a north south division with citizen in the Northern, Upper East and Upper West regions (an area covering about 17 per cent of the total population and presenting about 40 per cent of Ghana’s land mass) enclosing significantly

less than those in the south. Less than 50 per cent of the citizen in the northern regions have access to electric power supplies, for instance, likened with 72 per cent nationwide. When matched with citizens in the southern part, the resident in the Northern, Upper East and Upper West regions have very restricted access to secondary healthcare facilities but are to some extent better served by community health services, possibly as an indication of the inequitable distribution of facilities, the northern regions.

2.8.4 NHIS and Socio-economic Characteristics

The overview of the NHIS was proposed to eradicate inequalities of health service provision amongst the rich and poor (ACCA, 2013). However, it has not attained this goal. In a survey undertaken by Schieber, Cashin, Saleh, & Lavado (2013) to evaluate admittance to health care for individuals from different socio-economic groups, the poorest citizen of the society were discovered to be more likely to self-treat than to visit a hospital.

Literature has shown a significant disparities amongst the poorest and wealthiest citizen mutually with the rate of under-five mortality and the figure of births attended by skilled health practitioner. The under-five mortality rate amongst the poorest population of the society, for instance, was 102 deaths per 1,000 live births matched with just 60 per 1,000 live births for the wealthiest population. (WHO, 2012).

2.9 Health Insurance Awareness

Data have shown that NHIS subscribers have limited knowledge of the benefits to which they are entitled. Approximately half of NHIS subscribers are aware that members under the age of 18 are exempt from paying premiums; around 70% were aware pregnant women are exempt; and 60% were aware that NHIS members are not required to make out-of-pocket payments. Nevertheless, merely 29% of NHIS members are aware of all three features. Alike examples is

spotted for benefit packages: though 60% to 70% of members were aware of each individual service (antenatal care, postnatal care, childbirth and cash transfers), barely 39 % were aware of all five (Wang, Otoo, & Selby, 2017)

According to a study by Indumathi, Saba, Gopi, & Subramanian (2016), 75.7% of a study population were aware of health insurance. A study by Okaro, Ohagwu, & Njoku (2010) also disclosed that there is a high level of awareness of NHIS amongsts a specific group of population in Nigeria. Okaro, Ohagwu, & Njoku, (2010) in their study revealed that, knowledge on other various aspect of the scheme was not encouraging. A study by Choudhary, et al.,(2013) revealed that 57.25% of it study population were aware of health insurance. The results of the study further showed that there socio-demographic characterisitics such as sex, education and occupation have a significant relationship with respondents awareness of health insurance. They concluded that awareness of health insurance is poor and thus, there is the need for creating awareness. According to Singh, Rudrapal, & Sangma (2016), about 62.7% of the respondents were aware about national insurance and the major source of information about Health Insurance were from friends and relatives.

2.10 Theoretical Framework

The theoretical framework employed to guide this study is social constructivism. This theory studies individuals' understanding, experiences, and meanings of the world around them (Creswell , 2013). Patton (2002) in his study indicated that the critical subjects a societal constructivist seeks to respond to are "how people in a given setting perceive and explain truth? And, how that perception has shaped their behaviour as well as those they interact with?" He further stated that Social Constructivists consider that people's life-world experiences produce multiple realisms (Creswell, 2013), and henceforward, the reason they are concerned in

uncovering these manifold realisms together with their insinuations for the way of their living and people they interrelate with (Patton, 2002). Persons attribute diverse connotations to the issues they confront in their life. The study adopting the "social constructivist paradigm" is interested in discovering these intricacies in the views and implications people embrace about a social phenomenon 'rather than to narrow the implications into a few categories or ideas within a period of time' (Creswell, 2007). The current study consider that people's experiences in accessing healthcare under the Ghanaian NHIS are varied, and, given the same indicators for quality healthcare delivery, individual experiences may differ. The focus is therefore to explore these complexities within a period of time.

2.11 Andersen and Newman's Health Utilisation Theory

Given that this study sought to examine NHIS as an enabling factor to health care utilisation, this study adopted the Andersen and Newman theory (1973) on health care accessibility and utilisation as the theoretical framework for the study. The Andersen and Newman (1973) theory was initially developed in the late 1960's to explain why families use health services, and to further define and measure equitable access to health care. Generally, the theory was developed to help in developing policies geared towards enhancing equitable access and utilisation of health care services. (Andersen, 1995).

According to the key tenets of the theory, an individual's use of health services is as a result of his or her predisposition to use the services, factors that enhance or impede the use of such services, and the why there is the need for such health care. Initially when the theory was developed, the household was basically used as the unit of analysis. However, given the heterogeneity of household members, Andersen (1995), in the subsequently revised model, adopted the individual as the unit of analysis. According to Andersen & Newman (1973), the purpose of the theory was mainly developed to predict levels of health care utilisation and

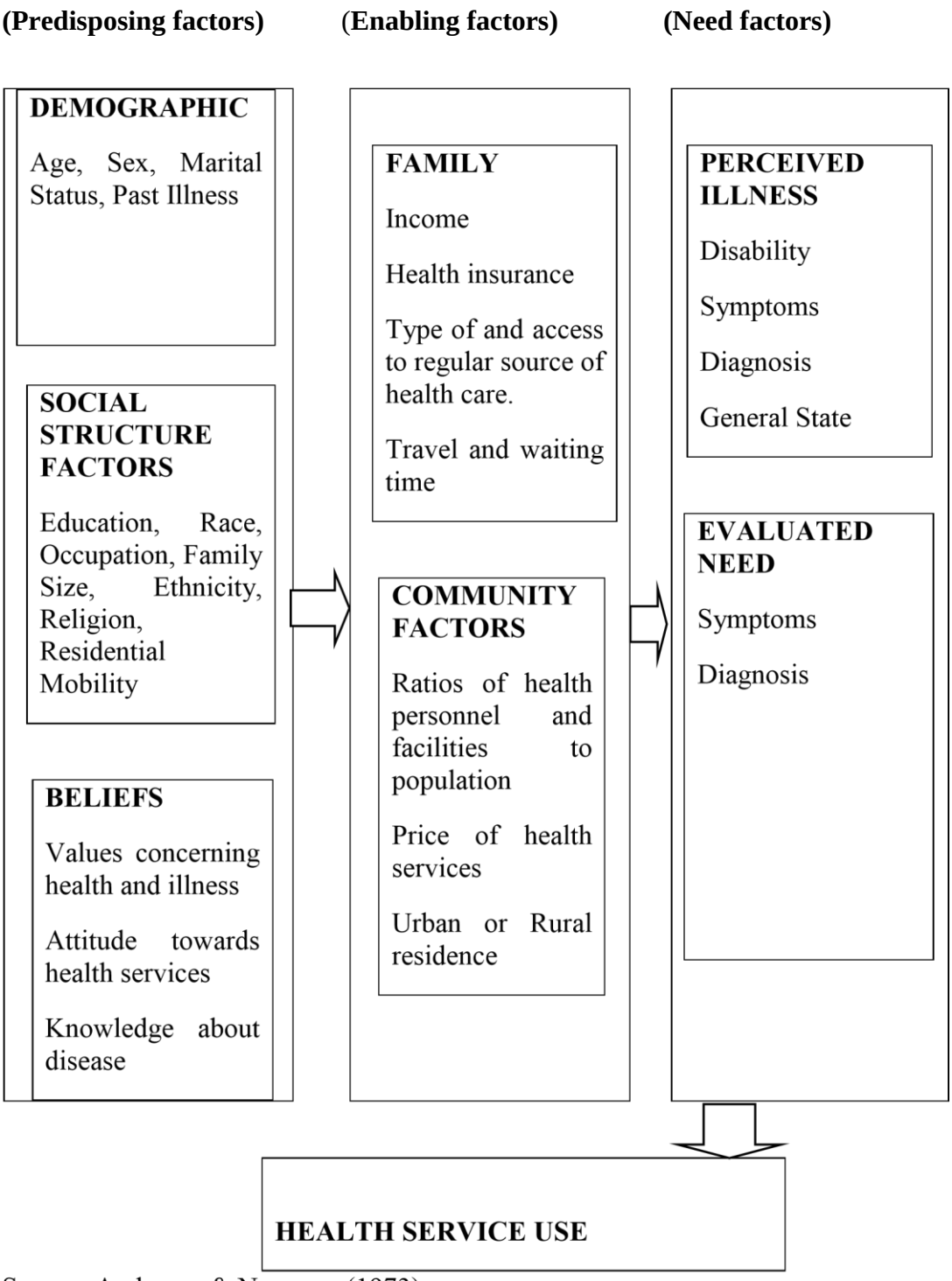
describe various patterns and also account for the use of health services. It mainly centres on treatment selection.

This model was formed around three main tenets, namely, predisposing factors, enabling factors and need factors. The predisposing factors include socio-demographic factors like age, sex, marital status, past illness; social structure factors like education, race, occupation, family size, ethnicity, religion, residential mobility; and beliefs like values concerning health and illness, attitude toward health services and knowledge about disease. These factors, they noted, influence an individual in the use of health services and help predict the pattern and level of utilisation.

Andersen & Newman (1973) further indicated that the enabling factors include factors that make it possible for people to utilise a particular health service. They also noted that these factors could also act as barriers to prevent an individual from utilising a particular health facility. These include family related factors like income, health insurance, type and access to regular source of health care; and community factors like ratios of health personnel and facilities to population, affordability of health services, urban/rural residence, travel and waiting time. Predisposing and enabling factors have being reported in several studies in developing countries to have a greater effect on health care utilisation than need as reported by Andersen (1995) (Buor, 2004). For instance, people are noted to seek for remedy to their morbid status irrespective of the kind of health care they opt for. This suggests that the enabling factors, especially the mode of payment for health care, would play a major role in influencing the type of health care sought when an individual is ill. Admittedly, this further accounts for the poor health seeking behaviour of people. To a large extent, as rightly opined by Buor (2004), the enabling factors play a major role in influencing health care accessibility and utilisation in the Ghanaian context.

Lastly, Andersen & Newman (1973) reported that the need for health care, also termed as illness level factors in their model, is a significant factor that influences the use of health care. Andersen (1995) for instance notes that the need for health care was a social construct, thus, the need to distinguish between perceived need based on the client or patient's experience and evaluated need, the professionally established need. This characterisation was as a result of criticisms levelled against him over his emphasis on need as a major significant factor in health care utilisation.

Figure 2.1: Schematic Representation of Andersen and Newman's Health Utilisation Model



Source: Andersen & Newman (1973)

Despite the usefulness of the model in explaining health care utilisation, it has been criticised for a lack of attention to social relationships and cultural aspects given that health care interactions are similar to social interactions. For instance, unfriendly attitude of nurses and health workers has been reported in several studies in developing countries to be a determinant of under-utilisation of health services (Majaj et al., 2013). This, to a larger extent, highlights the relevance of social relationships in the use of health care. Andersen (1995), in his revised model, emphasised that such relationships were captured under the social structure factors among the predisposing factors.

Additionally, some studies have criticized the theory for overly emphasizing on the need factors as a major determining factor in the use of health (Buor, 2004; Stekelenburg, 2004). This could be the case given that the theory was initially modelled around the health care system of developed countries, where there are limited or no barriers to stymie health service utilisation. There is sharp contrast within developing countries like Ghana where enabling and predisposing factors are pivotal in predicting health care utilisation. In Ghana for example, mode of payment for health play a major role in influencing health care accessibility and utilisation. Additionally, enabling factors and restrictive factors like distance, poor nature of the roads and unavailable transport facilities tend to have a greater effect on utilisation than need (Buor 2004).

In view of the fact that the Andersen and Newman (1973) theory considers all the predisposing, enabling and need factors that influence use of health care, this study adopted this health care utilisation theory. While controlling for all the other predisposing, need and enabling factors, the study places much emphasis on health insurance as a major enabling factor that influences health care utilisation. It further draws on the various predisposing factors such as sex, age,

income, education and marital status to explain similarities and variations in health care utilisation when assessing health care services with NHIS.

CHAPTER THREE

PROFILE OF STUDY AREA AND RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the profile of the study area and the methodology adopted. The first section describes the location and size of the Municipality, demographic characteristics and migration trends, and the health features of the Municipality. The second section focuses on the research design and strategy, the sources of data and processes of garnering the data, the research instruments used and how the data were analysed.

3.1 Background of Research Area

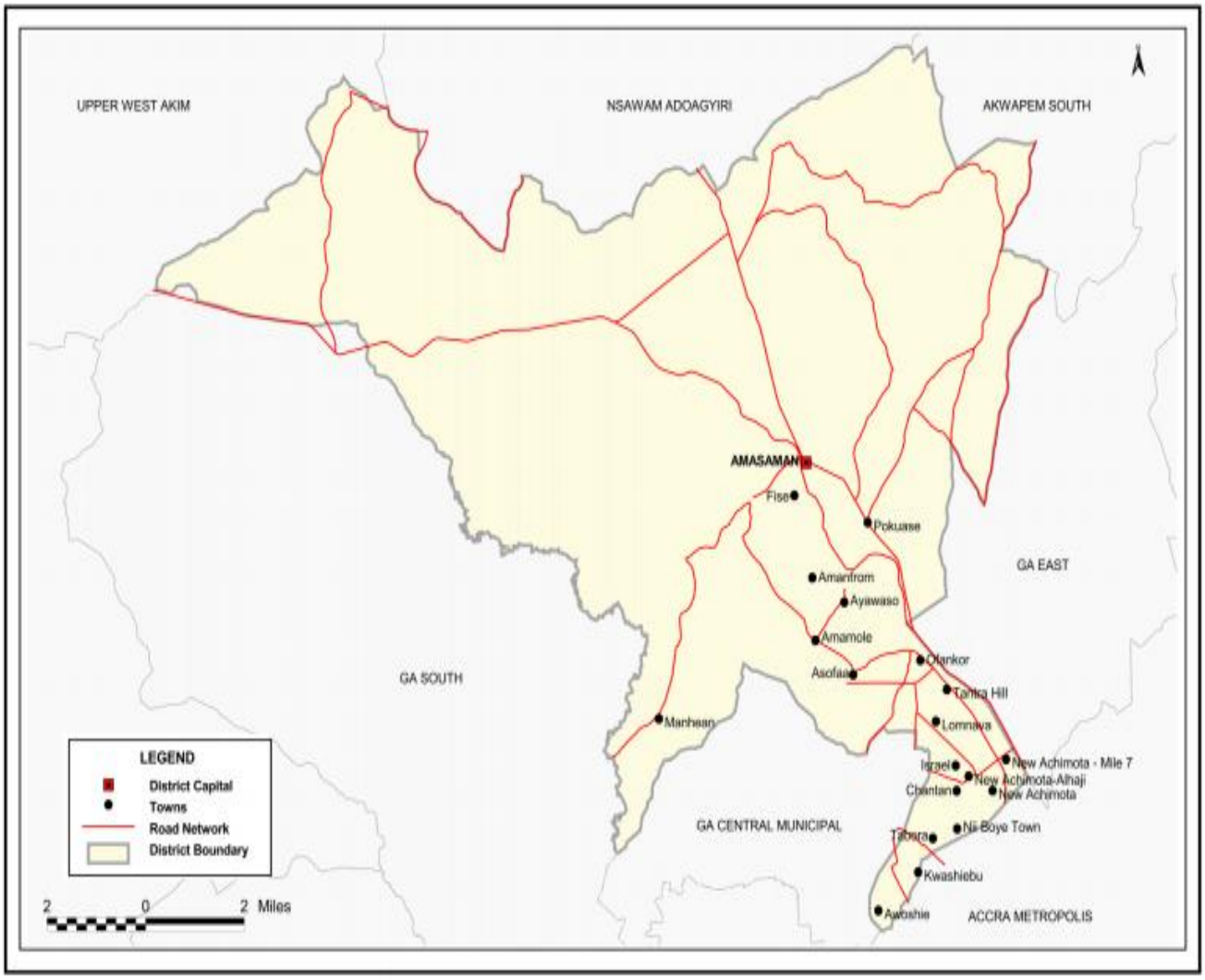
The Ga West Municipal Assembly has a number of unique demographic and social characteristics that makes access to health and health financing very important for the growth of the municipality in particular and Ghana as a whole. As a result, the study profiles the study area in terms of location and size, demographic characteristics, population size and density, age and sex composition, migration trends, as well as the health care delivery in Ga West Municipality.

3.1.1 Location and Size

The Ga West Municipality was established by Legislative Instrument 1858 in 2007. It is located on 5 ° north latitude 35 °, 5 ° 29 'north and longitude 0 ° 10' and 0 ° 24 west. The municipality has its capital at Amasaman and it is bounded by Ga East and Accra Metropolitan

Assembly, East, North and South Akwapem, Ga South and Central. The municipality occupies an area of approximately 284.08 square kilometers with about 412 communities as shown in Figure 3.1 below.

Figure 3.1: Ga West Municipality in the Greater Accra Region



Source: Ghana Statistical Service, 2010

The location of the municipality shows that residents could access health facilities from neighbouring districts with relative ease, and at the same time suggests that the residents of the

municipality could also be vulnerable to other health challenges such as disease outbreaks from any of the surrounding districts.

3.2 Demographic Characteristics of the Study Area

The demographic characteristics have been profiled under population size and density, age composition and household characteristics. According to the 2010 population and housing census, the total population of the municipality was about 219,788 and represents 5.48% of the total population in the Greater Accra Region. This statistic includes 107,742 men and 112,046 women (GSS, 2013). The population density based on the surface area of 299.6 km² is approximately 7325.7 people per square kilometer in 2010. This puts pressure on socioeconomic facilities and land for both housing and other economic development activities. Approximately 102 houses are built on each square kilometer. The implication of the population size and density is that the high population densities make the study area more susceptible to communicable diseases such as cholera and Ebola. However, the high population size suggests that the NHIS when well packaged can attract and maintain new customers which ultimately will improve health care delivery within the municipality.

The 2010 census of population and housing also reveal that females constituted majority of the population of Ga West. Comparatively, the female dominance is an indication that adequate health financing system through the NHIS can lead to reduced maternal and infant mortality due to the free maternal health care under the NHIS. The average household size is 3.9. The number of households in the Ga West municipality stands at 55,913. The municipality has a total household population to be 215,101. It is an indication that majority of the people in the

municipality are compound house dwellers. The composition and structure of household in the municipality are a reflection of the social structure of the Ghanaian society. The extended family system is the predominant family set up in the municipality.

3.3 Migration Trends

The urban nature of the municipality and with industries related to mining, including trade, continued to attract people from all over the country. The GSS 2010 statatistics reports that 146,520 (66.7%) of the total population of 219,788 in the municipality, are migrants. It is observed that persons born outside the Greater Accra Region but are resident in the municipality are mostly from the Eastern (31.9%), Ashanti (20.8%), Volta (16.3%) and Central (12.5%) regions while those from the Upper West region are the least (0.8 %) GSS. (2013). The migration dynamics reveal that it is possible for migrants from other parts of the country to carry along with them other disease contracted outside the municipality.

3.4 Health

The municipal health system follows a service delivery system offered at three levels of the community (community clinic) by sub communal and municipal level. There are twenty-two health centers in the municipality that includes seven hospitals, two (2) health centers, eight maternity clinics, four homes and a CHPS center. This shows a considerable increase in the number of health centers in the municipality from twelve years in 2005 to twenty-two in 2009. This increase can be attributed to private participation in the provision of health services.

Despite this increase, some of the people, particularly the communities on the outskirts of the municipality complained about the relatively long distance they must travel to access health services. This is due to the fact that most of these facilities are situated in the center of the municipality. This coupling with a relatively low road network at points in the municipality makes access to health care quite difficult, especially for rural communities.

Malaria remains at the top of the list of top ten diseases in the municipality despite the program against AGA/OMA malaria underway. Other important diseases include hypertension, rheumatism and so on. There was a slight reduction in the HIV/AIDS prevalence rate by 0.3%. In Ghana, common diseases include malaria, HIV/AIDS, diarrheal diseases, lower respiratory tract infections and perinatal conditions. According to the World Resources Institute (2008), these are the five most common diseases, accounting for 50% of all deaths and 68% of deaths in children under 14 years of age in Ghana.

The municipality is endowed with sufficient medical health specialists (GWMHD, 2008). The current population requires twelve (12) medical, in relation to standard medical/population ratio of 1:20000, but there are twenty (21) with a medical doctor/population ratio of 1:10 796. In effect, these doctors are complemented by one hundred and sixty-five (165) nurses and two hundred and twenty-three (223) paramedics.

3.5 Research Methods

This section presents the various methods and procedures that were used in collecting, analysing, presenting, and discussing the data for the study. It focuses on the research design, target population, sources of data and collection processes, sample size, sampling procedures, and techniques of the data analysis

3.5.1. Research Design

Kothari (2004), observes that research design serves as the framework from which activities of research are undertaken. The research design consequently guides the entire research process such as data collection, measurements, and analysis. The current study is a cross sectional study and was not carried out over a period of time but rather at one point in time. This was adopted

to obtain information regarding the objectives of the study from various sources. According to Levin (2006), a cross-section study is adopted when the purpose of the study is descriptive, often in the form of a survey. Usually there is no hypothesis as such, but the aim is to describe a population or a subgroup within the population with respect to an outcome and a set of risk factors.

In addition to the cross-sectional design, the study employed the mixed method approach. This implies that both qualitative and quantitative data were collected. Both quantitative and qualitative approaches have been adopted in this study. Mixed method strategy was adopted because it provides the opportunity for interpreting complex social phenomena (Teye, 2012). Assessing health financing is complex and hence, requires the use of mixed method approach. Again, Teye (2012) is of the view that mixed methods help to harness the inherent strengths of both qualitative and quantitative methods, while limiting their respective deficiencies. The triangulation on both methods, quantitative and qualitative, helps in providing deeper understanding of the phenomenon because of its inherent complementarity.

3.6 Data Sources

The sources of data for the study were both primary and secondary data. The primary data were data collected for the first time by the researcher, and the secondary data entailed data from existing documents or empirical studies that was deemed relevant to the study.

3.6.1 Primary Data

The primary data for the study were collected using interview guides, questionnaires, and focus group discussions (FGDs). This tools were very useful in garnering data for achieving the objectives of the study.

3.6.1.1 Questionnaire Survey

The questionnaires were structured into both open and close ended questions, and were administered at the individual and household levels. The questionnaires were structured into six sections. The first section focused on the background characteristics of respondents. The second section identified respondents' awareness of the Health Insurance and its operations, and the third section focused on the role of the NHIS to health care accessibility. The fourth section also sought to assess the accessibility of health care by NHIS subscribers and non-subscribers. The fifth section focused on the factors which prevent NHIS users from effectively accessing health care services in the Ga West municipality. Lastly, the last section explored possible disparities in health care accessibility

3.6.1.1.1 Sampling Procedure

The study adopted the multi-stage sampling process since it allowed for extensive research units to study under least cost (Kothari, 2004). The current study sample was derived from a selected households in selected communities within the Ga West Municipal. The next stage after the stratification process involved the purposive selection of five communities to form the study localities. The study further selected five communities; Ofankor, Chatan, New Achimota, Tantra Hill and Amasaman for the questionnaire survey. After the selection of five study communities, the next phase of the sampling process involved the use of systematic sampling to select households as determined by the sample size. A total population of 400 household's individuals were considered as a coverage for this study.

3.6.1.1.2 Simple Size

The study adopted Yamane & Taro, (1967) formula to calculate determine sample sizes for finite population correction for proportions was used to derive a sample size of – 367 students at the age of 7-14 in the Ahanka Municipality. A 95% confidence level and P = 0.5 was exploited;

Sample formula (**n**) = $\frac{N}{1+N(e)^2}$

n = sample size

N= population size

e= level of precision (or margin of error) is (0.05)

Where total students population (N) is 400

$$\frac{400}{1+400(0.05)^2}$$

n = 200

Therein

Adjusting for 10% non-response rate,

n = 1.1 * 200 = 220

Total sample size = 220

The sample size adopted for the quantitative study was 220, however after data screaming, 20 sample questionnaire were rejected. The data screaming identified that some questionnaires recorded inconsistencies with outliers. Finally 200 sample questionnaire was used for data analysis under the quantitative analysis.

3.6.1.1.3 Data Collection Process

The survey was done within a four-week period. The in-depth interviews were also conducted within a two-week period after the questionnaire survey. Thus, in all, the data collection was done in six weeks. Two field assistants were trained and used for the data collection. They were

taken through the questionnaire and given an orientation on how to seek responses from the respondents and the appropriate were of asking the questions. The two field assistants were familiar with three languages, viz. English, Twi and Ga. Given the heterogeneous nature of the Ga west municipality, it was important to select field assistants who could speak these languages. Additionally, to test the efficacy of the research instrument and make corrections, a pre-test was carried out at the La-Nkwantanang municipality. 10 questionnaire were given out for the pre-test but only 8 were returned. The responses given and the suggestions provided by the respondents aided in shaping some questions. Thereafter, with the help of the field assistants, the field work began in the selected communities in the Ga West municipality.

3.6.1.1.4 Quantitative Data Analysis

According to Cooper and Schindler (2003), raw data obtained from a research are useless unless it is transformed for the purpose of decision-making. Data analysis usually involves reducing the raw data into a manageable size, developing summaries and applying statistical inferences. Consequently, the following steps were taken to analyse the data for the study. Analysis of data varies as to the purpose and objective of the study. For the purpose of this study, the researcher agrees with Yin (1994) revealing that analyses of data is a constituent of examining, categorizing, tabulating or perhaps recombining evidence to address the initial proposition of a study.

Quantitative analysis, as captured in this study, includes the use of frequency tables, chi square test of independence, employing the use of Statistical Package for Social Service (SPSS V.20) and logistic analysis using STATA V.15. These tools facilitated the generation of statistical tables for proper and significant statistical analysis with infinitesimal error occurrence.

3.6.1.2 Qualitative method

The semi-structured interviews aided in seeking expert views through key informants and stakeholders such as NHIS managers, claim managers, hospital administrators, doctors as well as other stakeholders within the health financing and health care delivery chain. The key informants included the Municipal Health Director, the Municipal Health Insurance Manager among others. Field observations and FGDs were also conducted as part of the primary data collection processes. Non-participant field observations were used to monitor the core activities of health financing and health care delivery within the GA West Municipality. The non-participant field observation was preferred to the participant field observation because Kothari (2004) observed that it helps in the collection of requisite data without coming into direct contact or the knowledge of the people under study.

Grosh and Glewwe (2000), observe that FGDs help to generate genuine responses from respondents. Participants for the FGDs at the community level were drawn from the study locations in order to unravel their lived experiences. Subsequently, four FGDs with eight discussants each were conducted during the period of the fieldwork. Eight discussants per FGD is justifiable by Elliot et al. (2016) assertion that it facilitates hearing and getting the best out of ideas as well as satisfying group participants.

3.6 .1.2.1 Qualitative Sample Size

In all 10 respondents were selected for the in-depth interviews. The criteria for selection was based on the type of information respondent could provide, their willingness to participate in the interview and their sex. Six males and four females were selected for the interviews. Additionally, various forms of interviews were held with some officials of the NHIA regional and district offices, hospital administrators and other health service administrators as well as

other stakeholders within the health financing and health care delivery chain. Also, an interview was conducted with the Municipal Health Director and the Municipal Health Insurance Manager of the Ga West district.

3.6.1.2.2 Qualitative Data Analysis

With regards to qualitative analysis, they are those analyses that are not numerical in nature. They are mostly descriptive in nature. To derive the results from the interview, the study adopted an in-depth content analysis of the transcripts. Major themes were teased out and subjected to further analysis.

3.6.2 Secondary Data Sources

Information from published and unpublished sources including journals, textbooks, periodicals, government publications, the internet as well as reports served as secondary sources of data for the study. The secondary source of data was employed as a guide to the development of our survey question. Some of the documents such as NHIS enrolment were accessed from the NHIA website.

3.6.3 Ethical Considerations and Validity of Data

Given the nature of the study, the anonymity of respondents were given much priority. To avoid any attempt to trace a questionnaire to the name of a particular respondent, or to identify and aligned an answered questionnaire to a particular respondent, respondents were asked not to indicate their names on the questionnaire. For easy data entry and analysis, however, each questionnaire had a unique code number for referencing purposes. The study made sure to keep the views of respondents fully confidential and made them anonymous to the best of its ability. A consent form was given for them to fill before answering the questionnaire. In a situation where a respondents doesn't fill the consent form they are not given the questionnaire to

answer. Thus, respondent were always given the opportunity to withdraw from the study at their own will.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS AND NHIS AWARENESS AMONGST HOUSEHOLDS

4.0 Introduction

This chapter presents findings on the socio-demographic characteristics of respondents and NHIS awareness among households in the Ga West Municipality. The first section discusses the background characteristics of respondents. These include sex, age, level of education, marital status and level of income. The second section discusses NHIS awareness and the sources of information on NHIS in the Ga West Municipality. Lastly, it examined the relationship between socio-demographic characteristics of respondents and NHIS enrolment in the Ga West Municipality.

4.2 Socio-Demographic Characteristics

Table 4.1 presents the results on the socio-demographic characteristics of respondents. Out of the 200 respondents, 64.5% were males and 35.5% were females. A higher percentage of respondent were within the ages of 36-40 years (32%). followed by those with the ages of 20-25 years (22.5%) and 26-30 years (22.5%). The mean age of the respondents was 32 years, even though 23 percent were above 40 years. This shows that a higher percentage of respondents were in the active working age group and could make decisions regarding their health seeking behaviour. In terms level of education, the results in Table 4.1 further show that a relatively higher percentage of respondents had attained tertiary education (36%) and about 23 percent had received some form of SHS education Additionally, about 49 percent of respondent were married whiles 23 percent indicated that they were single. Respondents who were either divorced (1.5%) or Widowed (7.5%) represented the least group in terms of marital status of respondents. The results also show that about 51 percent indicated that they earn between 1000

cedis and 2000 cedis whereas only 6.5 percent earn above 5000 cedis. This suggests that a higher percentage of respondents earn below GH₵ 500. In view of this, one can suggest that there is a higher likelihood of respondents enrolling on the NHIS given the benefits respondents would gain when they access health care.

Table 4.1: Socio-demographic characteristics of respondents

Variable	Frequency	%
Sex		
Male	129	64.5
Female	71	35.5
Total	200	100%
Age Group		
20 – 25 years	45	22.5
26 – 30 years	45	22.5
36 – 40 years	64	32.0
Above 40 years	46	23
Level of Education		
None	35	17.5
Primary	31	15.5
SHS	45	22.5
Tertiary	72	36.0
Postgraduate	17	8.5
Marital Status		
Married	97	48.5
Single	85	42.5
Divorced	3	1.5
Widowed	15	7.5
Level of Income		
Less than GH₵ 100	28	14.0
Between GH₵ 100 and 200	101	50.5
Between GH₵ 201 and 500	58	29.0
Above GH₵ 500	13	6.5

Source: Fieldwork, 2017

Literature have shown that income level - particularly with the poor - plays a significant role as a socio-economic variable that is associated with the adoption and implementation of Ghanaian

NHIS (ACCA, 2013). This study, in the context of Ga West Municipal, has revealed that more than 90% of the respondents earn less than GH¢500.00 per month. Considering the low income level recorded, it becomes ideal to examine the level of respondents' NHIS enrolment, the perceptions and experiences of respondents on their awareness, enrolment and use of the NHIS in accessing health care in the Ga west Municipality (Blanchet, Fink, & Akoto, 2012).

4.3 Respondents Awareness of Health Insurance.

Given that the main aim of the study is to examine the role NHIS plays in health care accessibility and utilisation in the Ga west Municipality, this section begins with an analysis of the awareness of insurance among respondents. The results of the analysis is presented in Table 4.2. The household head was used as a proxy to represent the entire household considering the fact that awareness of a phenomenon by a household head would reflect the entire household. Also, this is because they play a major role in decision-making for the entire household. The results in Table 4.2 show that all the respondents (100%) were aware of NHIS. This is unsurprising because of the popularity and attention the scheme has received in the media and also because it is one of the major achievement by the NPP government.

Also, 24.5 percent of respondent were aware of PCHIS. Of the number of respondents who were aware of PCHIS, there were relatively more females (26.8%) than males (23.3%), Also, a higher percentage of respondents within the ages of 36-40 years (40%) were aware than those below 36 years or above 40 years (see Table 4.2). Apart from a majority of respondents with postgraduate education (76.5) who were aware of the PCHIS, there were no major significant percentage differences in terms of respondents' level of education, even though only 2 percent of respondents with no formal education were aware of PCHIS.

Table 4.2 Level of Awareness on Insurance Schemes (Multiple Responses)

Variables	Awareness of Insurance Schemes			
	NHIS (N=200) (% = 100%)	**DMHIS (N=1) (% = 0.05%)**	**PMHIS (N=1) (% =0.05%)**	**PCHIS (N=49) (% = 24.5%)**
Sex				
Male (n= 129)	129 (100%)	1 (0.7%)	1 (0.7%)	30 (23.3%)
Female (n= 71)	71 (100%)	0 (0.0%)	0 (0.0%)	19 (26.8%)
Age Group				
20–25 years (n= 45)	45 (100%)	1 (100%)	1 (100%)	5 (11.1%)
26–30 years (n= 45)	45 (100%)	0 (0.0%)	0 (0.0%)	11 (24.4%)
36–40 years (n= 64)	64 (100%)	0 (0.0%)	0 (0.0%)	23 (40.0%)
Above 40 yrs (n=46)	46 (100%)	0 (0.0%)	0 (0.0%)	10 (21.7%)
Level of Education				
No formal (n= 35)	35 (100%)	0 (0.0%)	0 (0.0%)	2 (5.7%)
Primary (n= 31)	31 ((100%)	0 (0.0%)	0 (0.0%)	6 (19.4%)
SHS (n= 45)	45 (100%)	0 (0.0%)	0 (0.0%)	10 (22.2%)
Tertiary (n= 72)	72 (100%)	1 (100%)	1 (100%)	18 (25%)
Postgraduate (n= 17)	17 (100%)	0 (0.0%)	0 (0.0%)	13 (76.5%)
Marital Status				
Married (n= 97)	97 (100%)	1 (100%)	1 (100%)	22 (22.7%)
Single (n= 85)	85 (100%)	0 (0.0%)	0 (0.0%)	18 (21.2%)
Divorced (n= 3)	3 (100%)	0 (0.0%)	0 (0.0%)	1 (33.3%)
Widowed (n= 15)	15 (100%)	0 (0.0%)	0 (0.0%)	8 (44.4%)
Level of Income				
Less than GH₵ 100 (n= 28)	28 (100%)	0 (0.0%)	0 (0.0%)	5 (17.9%)
Between GH₵ 100 and 200 (n= 101)	101 (100%)	0 (0.0%)	0 (0.0%)	29 (28.7%)
Between GH₵ 201 and 500 (n= 58)	58 (100%)	0 (0.0%)	0 (0.0%)	9 (15.5%)
Above GH₵ 500 (n= 13)	13 (100%)	1 (100%)	1 (100%)	6 (46.2%)

Source: Fieldwork, 2017

While about 19 percent of respondents with primary or basic education were aware of the scheme, about 22 percent of those with SHS educational background were aware of the scheme. Additionally, a higher percentage of respondents who were married (44.9%) indicated that they

were of PCHIS as compared to those who were single (36.7%), divorced (2.0%) or widowed (16.3%). Moreover, the results in Table 4.2 show that a higher percent of respondents who earn above 5000 cedis (46.2%) were aware of the scheme relative to those that earn below 5000 cedis.

With respect to insurance schemes such as DMHIS and PMHIS, 99.5 percent of respondents indicated that they were not aware of these insurance schemes in the Municipality. The only person who was aware of these insurance schemes was a male within the 20-25 age group, with a tertiary education, married and was earning above 500 cedis monthly. In views of these findings, one can conclude that NHIS and PCHIS are the two most popular insurance schemes in the Ga West Municipality. Given that majority of respondents are aware of NHIS, it can also be deduced that there is greater likelihood of higher enrolment on the NHIS than the other insurance schemes. This study mirrors the study by Indumathi et al. (2016), where 75.7% of the study population were aware of health insurance.

Additionally, the findings of this study is in consonance with the study by Okaro et al. (2010) which reported a high level of awareness of NHIS amongsts a specific group of population in Nigeria, while awareness of other insurance scheme was not encouraging. Certainly, this gives much room to deduce that the awareness and popularity of an insurance are mostly contingent on its purpose, usefulness and achievement. In the case of the NHIS, the bane that was associated with "cash and carry" system on the poor and vulnerable presented the NHIS as a better alternative to bridging the health care utilisation gap and affording the poor and vulnerable access to better quality health care. As indicated earlier on, NHIS was given much prominence by the NHIS as a major achievement and became one of the major issues often debated and discussed in the media space by the two major political parties in the country – NPP and NDC. These might have contributed to the higher level of NHIS awareness among the

respondents of the Ga West Municipality. And this could be reflective of the situation at the regional and national level.

The qualitative study also brought to the fore various views on respondents' awareness of NHIS. The study revealed that the various households were very aware of the existence of health insurance. Some were of the view that the NHIS is one of the major issues often discussed in the country. Angela, 33 year-old teacher interviewed was of the view that:

> "…….Is there anyone in this country who has not heard of NHIS? They are always talking about it; either the benefits, non-payment of claims, other problems or renewal. I would be very surprised if there is anyone in this country (Ghana) who can deny that they have not heard of NHIS (33 year-old, female, individual interview).

Mr. Mantey, a 46 year-old man also reported that;

> "……I don't know about any other insurance schemes apart from the NHIS. There could be other private insurance schemes but I know that NHIS is the only government insurance scheme. The NPP government brought it and it has been the major card they play when they want to win over electorates. It has really helped them and us the people. We are able to access health for free (46 year-old, male, individual interview)

These two excerpts from Angela and Mantey further highlight the reasons why NHIS is very popular among respondents and why they are aware of it. Moreover, the findings from the qualitative facet of the study supports the results in Table 4.2. Furthermore, Mr. Agyei indicated that;

> "I have only and always heard about NHIS and nothing else, I didn't know we have other types of insurance scheme in Ghana" (39 year-old, male, individual interview)

This suggests that in the context of Ga West Municipality, there is little knowledge on other insurance schemes relative to the NHIS. This could be as a result of its popularity in the media and the politics often associated with it. The NHIS gained much popularity as a social intervention and health policy introduced by the NPP government. One would clearly underscore the fact that there is a higher likelihood it would be popular among the Ghanaian populace.

Even though the results presented thus far show that majority of respondents are aware of the scheme, during the interviews, most of the respondents could not tell the full benefits they are entitled as a subscriber of the NHIS. Most of the participants indicated that they were not aware of the full benefits apart from the general benefits of not paying for the cost of health care when they access and utilise a health facility. For example, Kwaku, a mechanic reported that:

> '' …….. I know when I have the card and I go to any health facility, I am not supposed to pay for anything. Someone said some services are not included but I don't know the kinds of services they refer to. However, I have been asked to pay for laboratory services before even though I used a card. (28 year-old male, individual interview)"

Generally, some reported on some of the reported barriers associated with the scheme and assumed ignorance of not knowing they were entitled to the full benefits of being an NHIS subscriber. In the case of Mantey, he noted that:

> "I don't explicitly differentiate what or not I pay for when I visit the hospital. I'm only asked to drop my insurance card and sit down. However, I pay when I'm going to do my laboratory test and medicine. (46 year-old, male, individual interview)"

The views of Kwaku and Mantey show that most of the issues are associated with the reported barriers associated with the use of the NHIS. More significantly, according to some participants, they acknowledged the introduction of health insurance but further indicated that

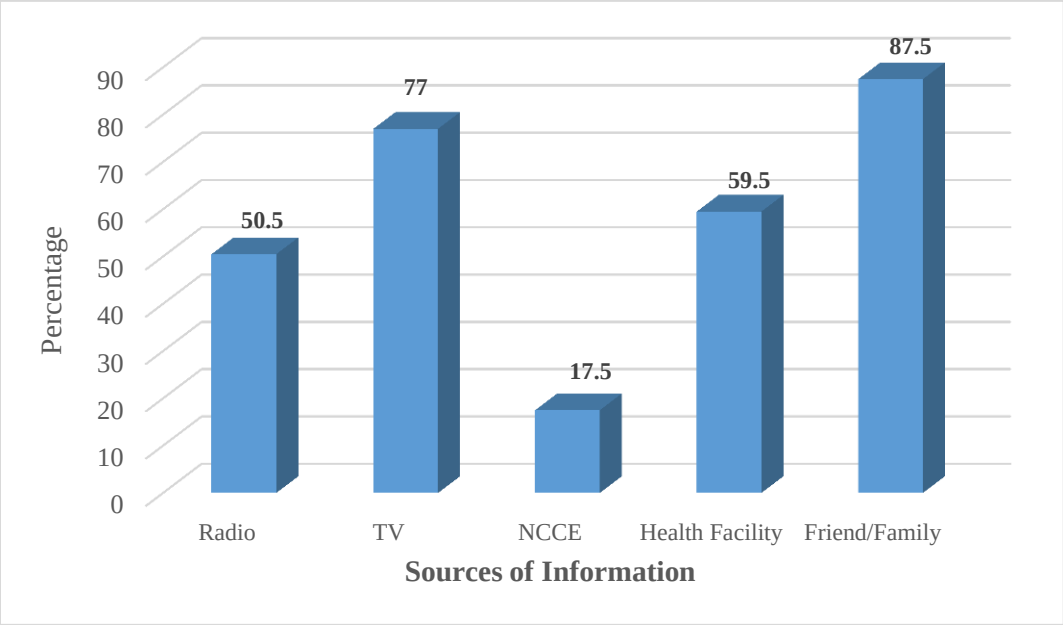
the usefulness and purpose of the insurance does not reflect during their visit to the health facilities.

4.3.2 Sources of Information on NHIS

This section sought to identify respondents' sources of information on NHIS in the Ga West Municipality. Undoubtedly, awareness and perception are underpinned either by information or experience. In view of this, the study sought to identify the various sources through which respondents became aware of NHIS. Given the fact that there could be multiple sources of information, the study allowed for multiple responses from the respondents. The results of this analysis are presented in Figure 4.1. Figure 4.1 shows that majority of respondents indicated that they became aware of NHIS via family and friends, followed by television (77%) and health facilities (59.5%).

Considering the important role radio plays in the dissemination of information, it was surprising that comparatively, it was not the highest mode through which respondents became aware of NHIS. Arguably, the communal nature of Ghana's socio-cultural set-up makes it easy for people to receive information via family and friends than via television or radio. Similarly, this finding is in line with the study by Adele et al (2016) in Nigeria where family and friends were the most important sources of information on NHIS. The role of family and friends in the desimmination of information and the shaping of thoughts of people cannot be understimated. They play key roles in informing and influencing the decisions of others. Even though radio and television are key elements in the dessimination of information in the Ghanaian context, they might not necessarily be essential in influencing decision making vis-à-vis family and friends.

Figure 4.1: Sources of Information (Multiple responses)



In relation to how respondents became aware of the insurance scheme and the usefulness of enrolling on it, the results from the qualitative study revealed that some people heard of the scheme from family relations and were motivated by them to subscribe because of the benefit of it and the ease with which they could access health care. One respondent interviewed indicated that;

> ”My cousin asked me in 2009 if I had an NHIS card and I said no. He spent about 40 minutes educating me on it and why I should enrol and enjoy the benefits. Luckily for me, I am a SSNIT contributor so I didn’t have to pay much to subscribe (34 year old male respondent, individual interview)

Another female participant who is a trader indicated that she was introduced by another trader and later advised to subscribe to the scheme by friends and what she witnessed. She remarked:

> "My friend has spoken about it several times but I didn't believe it till she had to undergo a surgery and all her bills were catered for. I was amazed. I quickly enrolled the next week.

The views of the two respondents lend support to the quantitative findings which revealed that family and friends are the major source of creating awareness on insurance schemes. According to Singh et al. (2016), majority of information acquisition on health insurance are through the friends and relative. Apart from the role of information sharing, the results presented thus far suggest that family and friends play a dual role – the dissemination of information and influencing others to subscribe to the NHIS. Suffice to point out that, in the dessimination and executuon of any relevant health policy, family and friends should be considered as key stakeholders.

The results from the quantitative study also revealed that television plays a significant role in promoting awareness on health insurance. During the interview, it was also revealed that TV is an important medium for the dissemination of health policy or other health interventions. For instance, a 33 year old artisan remarked that;

> "My family and I do watch television and we aquire most of the information on NHIS through the television" (33 year old, male, individual interview)

Another female participant also indicated that most of these health related issues and insurance related matters are normally communicated via advertisement on television and sometimes, radio. She indicated that

> "Yes I do get most of the information through advertisiement and news on the television, and in most cases, have been the source of information on national programs including NHIS". (28 year-old, male, individual interview)

Again, health facilities were reported as a major source of information on insurance scheme. It can be argued without any equivocation that because these health facilities are the service providers of health services, there is a higher likelihood respondents are given some education or sensitization about the benefits of having an insurance when accessing health care at these facilities. This could partly account for why health facilities serve as a major source of information on health insurance in the Ga West Municipality. In an interview with some respondents, they indicated that they were informed on the availability and utilisation of national insurance during their visit to the health facilities. Mr Mantey reported this during the interview

> "…….some of the health professionals are the ones mostly informing this people about NHIS and why they should enroll. I went to the hospital for general check-up and there was this woman who had not enrolled on the NHIS. A nurse was the one who asked her to go and subscribe on the scheme because it would her access health care and not pay anything"(46 year-old, male, individual interview)

The views expressed by Mr. Mantey show that the health care providers play some role in influencing people to enrol on the scheme. This suggests that health care provoiders are key stakeholders in influencing NHIS enrolment and the use of the card in accessing health services in the Ga west Municipality. In some circumstances, people do not enroll on the scheme because of ignorance. Most people are not fully aware of the benefits associated with the scheme. For example, one of the personnel at the NHIA noted that, in some circumstances, clients were not aware of the benefits of enrolling on the NHIS. He stated that:

> "In some occasions, our clients were not able to subscribe to the NHIS because they have some misconceptions that the NHIS does not cover most of their medications and services, some complianed that they are only given paracetamol during their vistit to the health facility. It was then important to

> educate our clients on the benefits they are expected to enjoy as a subscriber to the NHIS".

In addition, it was also noted that in some situation where the client has to pay for all his bills but happened to be more expensive, he or she is further adviced and educated on subscribing to NHIS which helps subsidize the cost in paying for health care serivice in the next visit. All these happen at the health facility. In a discussion with one of the health administrators of a health facility, he indicated that;

> "In many instances where a non insured clients cannot pay for all his medical bills because they don't have money and aslo do not have NHIS, we try to educate them on the why they need to subscribe and the various packeges that comes with NHIS subscription".

Furthermore, the results of the quantitative analysis showed that radio is a major source of information on NHIS (see Figure 4.1). The qualitative study also revealed radio as a major medum of acquiring information on NHIS. It came to the fore that radio, as a major point of information disseminination in the country, continues to play very important role in educating people on NHIS. Aside advertisement and other tools used, some repondents also noted that issues of NHIS are often discussed on talk shows and by politicians. As a result, they are often informed on NHIS issues via the radio. In an interview with one of the respondents, she noted that

> "I listen to the radio everyday and that has been a meduim to which I obtain information on what ever happening in Ghana likewise information on national insurance scheme. These politicians come and discuss it everytime. One party tries to talk about the problems the NHIS is having and the other tries to talk about the positives and how the challenges the other party is referrig to are just mere propaganda or how they have resolved these challenges" (28 year-old, female, individual interview).

The results presented thus far shows that family and friends, television, radio and health care providers constitute the major modes through which respondents are informed on NHIS issues in the GA West Municipality.

4.3.3 Perception of respondents on NHIS

This section presents an analysis and discussion on how respondents perceive the NHIS. To assess respondents' perception about NHIS, they were asked to either agree or disagree with various items that describes the NHIS. The results of the analysis is presented in Table 4.3. Table 4.3 shows six items that describe the purpose and aims of the NHIS. Generally, the results of the study revealed that majority of the respondents were aware of the implementation, objective, functions or benefits of NHIS. This finding is in line with the study by Andoh-Adjei, Boateng, Asante, Spaan, & Velden, (2018), where subscribers of Ghanaian NHIS expressed positive perception about the quality of care under NHIS.

Table 4.3 Perception of respondents on NHIS (Multiple Responses)

Items	Agree		Disagree	
	Freq.	%	Freq.	%
NHIS is a social health insurance	191	95.5	9	4.5
The government brought NHIS to the vulnerable and needy	190	95	10	5
You don't have to pay money when you use it as a health facility	192	96	8	4
Pregnant women can go a hospital with it at any time and not pay anything	199	99.5	1	0.5
Pregnant NHIS users are able to go health facilities for free anti-natal services and free delivery	173	86.5	27	13.5
NHIS subscribers whose children are under 18 years can access free health services at hospitals	166	83	34	17

Source: Fieldwork, 2017

For instance, the result shows that 95.5 percent perceive NHIS as a social scheme which is intended to benefit the individual in accessing quality healthcare in Ghana. Considering the benefits people have derived from the NHIS since its inception, it's not surprising that majority of respondents perceive it as a social insurance scheme on health. Additionally, all the respondents sampled were aware of the NHIS, it is expected that majority of respondents will be aware of the purpose, functions and benefits of the scheme. During the qualitative facet of the study, a 28 year old man reported that;

> "To the best of my knowledge, I know it to be a social scheme that help the poor to be able to have access to healthcare service delivery in Ghana" (28 year old male participant, individual interview).

Another respondents also mentioned that:

> "I know that the NHIS is a social scheme that enables as to access health services at a low cost." (48 year old female participant, individual interview).

The views expressed reflect the results of the survey. Whiles NHIS may help to lessen the burden of cost of payment for quality health care, often in varying forms, it also serves as a catalyst in ensuring that people access formal health care when ill. Additionally, 95 percent of respondent were of the view that NHIS was established by the government to help the vulnerable and needy to access free health care. For instance, the results of the qualitative study showed that majority of the respondents perceived NHIS was an intervention by government to assist the vulnerable and needy in society. One respondent noted that;

> "……..I know that the NHIS implementation was to bridge equity to healthcare accessibility which have to do with the poor and the rich" (38 year-old, male, individual interview)

The views of this respondents is in consonance with the study by Blanchet et al. (2012) which note that the fundamental aim of Ghana's NHIS is to improve affordability and utilisation of medicines and health provisions in general, and among the poor and most vulnerable people. According to the feature of the NHIS, sick people subscribed to the scheme can utilize healthcare services without incurring any cost. Blanchet *et al.* (2012) stated that, with this strategy, the poor is protected from financial burden and stress when accessing health care in Ghana. Some respondents expressed these views during the in-depth interview. A 33 year old woman who indicated that she had been a beneficiary of the NHIS since its inception. She always uses it to access health care and always renews when it expires. To her, this provides a good avenue for bridging the gap between the poor and the rich in terms health care accessibility. She remarked:

> "NHIS serves a greater good to the poor and socially excluded who might not have the resources to access some basic health services. It makes it possible for both the rich and the poor to access services in bigger hospitals like Korle-bu Teaching Hospital, Ridge Hospital and 37 Military Hospital. So I think, it allows the sick to have access to healthcare delivery at a low cost compared to the non-insured".

According to ACCA (2013), pregnant women are exempted from charges for NHIS subscriptions and still benefit freely at the point of service delivery. This makes the scheme an attractive one for pregnant woman to enroll on. Apart from the economic importance the insurance scheme provides, it also aids in enhancing quality health care utilization. Osei-Twum, a taxi driver indicated that;

> "During the time of my wife's pregnancy, she enjoyed healthcare service without making payment during all her pregnancy" (33 year-old, male, individual interview).

The views expressed by Mr Osei-twum gives credence to the importance of enrolling on the NHIS. Undoubtedly, it comes as no surprise that when most of the female turn up the National Health Insurance office to register, they are often asked if they are pregnant. One of the respondent indicated that, on a lighter note, she was asked whether she was pregnant when she went there to renew her card months after it had expired.

ACCA (2013) also stated that NHIS subscribers whose children are under 18 years can access free health services at hospitals. As shown in Table 4.3, 83 percent of respondents indicated that children under the age of 18 whose parents are subscribers of the NHIS are entitled to some benefits. For example, a 39 year old woman was of the view that;

> "My 5 year old child still benefits from the NHIS because the mother is still an active member of the scheme."(39 year old female, individual interview)

This excerpt further shows that, given the high level of awareness of the NHIS among respondents, they are aware of the objectives, function and purpose of the NHIS.

4.3.4 NHIS Subscriptions amongst Households.

Given that majority of respondents were aware of the NHIS including its objectives, purpose and functions, the study further sought the need to ascertain level of enrolment among respondents in the Ga West Municipality. This was done towards the ascertainment of the level of subscription i.e. if respondents has subscribed to the scheme. This was done in relation to socio-demographic variables such sex, age, level of education, marital status and income. All these variables are known in health care utilisation a role in health care decision making. Cross tabulations and chi-square test of significance were computed to test for the relationship

between the socio-demographic variables and NHIS subscription in the Ga West Municipality. The result of this analysis is presented in Table 4.4.

The results show that 64 percent out of the 200 respondents had subscribed to the NHIS whereas 36 percent were nonsubscribers. This suggests that even though all the respondents sampled were aware of the NHIS (see Table 4.2), 36 percent had not enrolled on the scheme at the time of the survey. This could be as a result of the challenges associated with the insurance scheme, thus making it unattractive for them to subscribe.

The results in Table 4.4 further show that about 50 percent of male respondents had not enrolled on the NHIS relative to 11 percent of female respondents. Put differently, a relatively higher percentage of females (88.7%) were NHIS subscribers compared to males (50.4%). In view of this, the results of the chi square test showed a significant relationship between sex and NHIS subscription in the Ga West Municipality (χ^2 statistic = 29.53, df (1), p value =0.0001<0.05). This finding is at variance with the study by Jehu-Appiah et al. on NHIS enrolment which found that more males had registered on the NHIS than females (Jehu-Appiah et al., 2011). Given the benefits of accessing free maternal health care with the NHIS and other health benefits, it is not surprising that a higher percentage of female respondents have subscribed to the males. In an interview with an officer at the NHIA office in the Municipality, he indicated that, usually, females are more likely to enrol than males because of the health benefits. More so, he noted that females tend to take particular interest in their health needs and are thus more likely to seek formal health when ill. In view of the burden of cost in accessing health care, they are more likely to enrol on the NHIS since it presents a better alternative to reduce the cost burden in accessing and utilising a health facility.

In terms of the age of respondents, the results show that there is a significant relationship between age of respondents and NHIS subscription in the Ga West Municipality (χ^2 statistic = 63.55, df (3), p value =0.0001<0.05). This is because all the respondents above 40 years (100%) and a majority of those within the ages of 26-30 years (82%) were NHIS subscribers as compared to those within the ages of 20-25 years (55.6%) and between 36-40 years (31.3%). Aging is normally associated with increasing health needs and the need for regular check-ups from formal health care providers. And this could explain why all the respondents above 40 years were NHIS subscribers relative to the other age groups.

Table 4.4 NHIS Subscriptions amongst Households

Socio-demographic Variables	NHIS subscription		Total
	Unsubscribed (N= 72) (% = 36%)	Subscribed (N= 128) (% = 64%)	
Sex			
Female	8 (11.3%)	63 (88.7%)	71
Male	64 (49.6%)	65 (50.4%)	129
	χ^2 statistic = 29.53, df (1), p value =0.0001<0.05		
Age			
20-25 years	20 (44.4%)	25 (55.6%)	45
26-30 years	8 (17.8%)	37 (82.2%)	45
36-40 years	44 (68.8%)	20 (31.3%)	64
Above 40 years	0 (0.0%)	46 (100%)	46
	χ^2 statistic = 63.55, df (3), p value =0.0001<0.05		
Level of Education			
No formal	15 (42.9%)	20 (57.1%)	35
Primary	8 (25.8%)	23 (74.2%)	31
SHS/Vocational/Technical	36 (80%)	9 (20%)	45
Tertiary	3 (4.2%)	69 (95.8%)	72
Postgraduate	10 (58.8%)	7 (41.2%)	17
	χ^2 statistic = 75.44, df (4), p value =0.0001<0.05		
Marital Status			
Married	20 (20.6%)	77 (79.4%)	97
Single	37 (43.5%)	48 (56.5%)	85
Divorced	0 (0.0%)	3 (100%)	3

Widowed	15 (100%)	0 (0.0%)	15
	χ^2 statistic = 40.41, df (3), p value =0.0001<0.05		
Income Group			
Less than 1000	10 (35.7%)	18 (64.3%)	28
1000 - 2000 cedis	30 (29.7%)	71 (70.3%)	101
2001-5000 cedis	32 (55.2%)	26 (44.8%)	58
Above 5000 cedis	0 (0.0%)	13 (100%)	13
	χ^2 statistic = 18.31, df (3), p value =0.0001<0.05		

Source: Fieldwork, 2017

Majority of respondents with tertiary education (95.8%) had subscribed to NHIS whiles only 20 percent of respondents with SHS or Vocational or Technical education had enrolled on the NHIS. Also, a higher percentage of respondents with postgraduate education had not enrolled on the scheme (58.8%) than those who had subscribed to the NHIS (41.2%). This could be because most of these people can afford health care given their level of education and the prospects of a better job. Thus, they don't see the need to enrol on the scheme in the midst of the various challenges confronting the scheme when NHIS subscribers access health care. The chi square test showed a significant relationship between NHIS enrolment and respondents' level of education (χ^2 statistic = 75.44, df (4), p value =0.0001<0.05). This suggests that NHIS subscription is aligned or associated with some level or category of education, as right explicated.

All the respondents divorced had enrolled on the scheme whereas none of the respondents who were widowed were subscribers of the NHIS. Comparatively, the results in Table 4.4 show that a higher percentage of respondents who were married (79.4%) had subscribed to the NHIS than those who were single (56.5%). The results also report a significant relationship between NHIS subscription and respondents marital status (χ^2 statistic = 40.41, df (3), p value =0.0001<0.05). This is because a relatively higher percentage of respondents who were married (79.4%), single

(56.5%) and all the respondents who were divorced had subscribed to the NHIS as compared to none of the respondents who were widowed.

Interestingly, all the respondents who indicated that they earn above 5000 cedis had subscribed to the NHIS relative to about 36 percent of respondents who earn less than 100 cedis but indicated that they are not subscribers of NHIS. Arguably, a higher percentage or proportion of people who earn less and cannot afford to pay for their health care should rather constitute the majority of people who would subscribe to the scheme, however that is not the case of this study. Also, whiles about 70 percent of respondents who earn between 1000-2000 cedis had enrol on the NHIS, 55 percent of respondents who earn between 2001-5000 cedis had not subscribed to NHIS. In view of this, the chi square test showed a significant relationship between NHIS subscription and income in the GA West Municipality (χ^2 statistic = 18.31, df (3), p value =0.0001<0.05).

During the qualitative facet of the study, some respondents revealed that they enrolled on the NHIS because it could afford them access to quality health in hospitals and other health facilities they couldn't have hitherto accessed. For instance, a 43 year old male respondents noted that:

> "Easy access to health facilities and affordable health care service is the reason why I subscribed to NHIS" (43 year-old, male, individual interview)

Another female respondent who had given birth four month before the survey and had enjoyed the full benefit of the NHIS also indicated that:

> "…….healthcare service is affordable under NHIS and that is the reason why I made the choice to subscribe" (26 year old, female, individual interview)

Another interesting theme identified was the "level of recognition". According to nine of our participants they chose to subscribe to NHIS because it is recognized and accepted by many health facilities as compared to the other type of insurance schemes. One of the respondents indicated:

> "……I subscribed to NHIS because most of the health facility accepts it when seek health care. It is known everywhere and accepted as a mode of payment for health care. I also witnessed how others could easily go to hospitals and clinics without paying for the cost of health care. I thought it would be wise to enroll……" (32 year old male, individual interview)

Interestingly, participant revealed that the need for prompt healthcare is the reason for not subscribing to the NHIS. This suggests that the perceived challenges associated with the insurance scheme, often in the form of longer waiting hours, poor attitude of staff towards NHIS users, account for the reason why some people do not enrol and use it as a mode of payment for health care. For instance, Mr, Tsatsu, a car dealer noted:

> "I needed prompt healthcare that's why i don't subscribe or use NHIS. They always give preferential treatments to those paying money. Those with NHIS are not given proper attention" (34year-old, female, individual interview)

This shows that poor services rendered to NHIS users account for reasons why people do not enrol on the NHIS. Even in the midst of varying experiences and lessening of cost burden, people opt not to subscribe to the NHIS due to poor services.

To predict NHIS enrolment as a function of socio-demographic variables such as sex, age, level of education, marital status and income, a binary logistic regression was computed. The results of the test is presented in Table 4.5. The Nagelkerke R^2 value of 0.42 suggests that the model predicts 42 percent of variance in the outcome variable (NHIS enrolment) and the Hosmer and Lemeshow test which is not significant at 5 percent level of significance shows that these sets of

selected predictor variables better predict the likelihood of respondents either enrolling on the NHIS in the Ga West Municipality.

In addition, the Omnibus tests of model coefficient computed rejects the null hypothesis that suggests that the model is not a good fit of the data ($\chi 2=17.93$, $p=0.02>0.05$). Also, the overall predictive accuracy of the model is 87.9 percent. In terms of the predictors, only sex and level of education significantly predicted the outcome variable of the model. Conversely, age, income and marital status were not significant predictors of NHIS enrolment in the Ga West Municipality. In view of this, the study fails to reject the null hypothesis which states that age, marital status and income has no significant influence on NHIS enrolment in the Ga West Municipality. On the other hand, the study rejects the null hypothesis which states that sex and level of education has no significant effect on NHIS enrolment in the Ga West Municipality.

Table 4.5: Summary results of binary logistic regression coefficients estimating the effects of predictors such as sex, age, level of education, marital status and income on NHIS subscription

Independent Variables	B	S.E.	Wald	Exp (B)	95% C.I. for EXP(B)	
					Lower	Upper
Country of residence						
Sex						
Female	*3.828*	*.680***	*31.663*	*45.98*	*12.12*	*174.46*
Male (RC)				1.000		
Age						
20-25 years	*-1.312*	*.623*	*4.428*	*.269*	*.079*	*.914*
26-30 years	1.035	.685	2.284	2.814	.736	10.764
36-40 years	.353	.505	.488	1.423	.529	3.825
Above 40 years				1.000		
Marital status						
Married	.353	.505	.488	1.423	.529	3.825
Single	-.600	.371	2.622	.549	.265	1.135
Separated	-1.757	1.452	1.465	.172	.010	2.968
Widowed(RC)				1.000		
Level of Education						

No Education	-0.262	.956	.0.75	0.784	.118	5.010
Primary	*2.677*	*.92***	*8.313*	*14.536*	*2.356*	*89.666*
SHS/Voc/Tech	-.371	.895	.172	.690	.119	3.986
Tertiary	*4.345*	*1.005***	*18.667*	*76.797*	*10.717*	*550.301*
Postgraduate (RC)				1.000		
Income						
Less than 1000	-.885	.363	5.953	.413	.203	.840
1000 - 2000 cedis	-.204	.380	.289	.815	.388	1.716
2001-5000 cedis	.273	.409	.446	1.314	.589	2.930
Above 5000 cedis				1.000		

Note: Note: R2 =0.42 (Nagelkerke); Cox & Snell)= .248; (Hosmer & Lemeshow)
Goodness-of-Fit $\chi 2$ (8) = 22.15, p=0.005; -2 Log Likelihood = 414.387; ***p<.05, **p<.01**,
Source: Fieldwork (2017)

The results in Table 4.5 show that the likelihood of enrolling on the NHIS in the Ga West Municipality increases with being a female than males. Females (OR=45.98, CI=12.12 – 174.46) are about 46 times more likely to subscribe on the NHIS than males. Also, the likelihood of subscribing to the NHIS increases with respondents with primary or basic (β=2.677, $p<0.05$) and tertiary (β= 4.345, $p<0.05$) education than those with postgraduate education.

4.3.5 Duration of subscription

The section sought to examine the number of years respondents had enrolled on the NHIS. Table 4.6 presents the results of this analysis. The results show that a relatively higher percent of respondents (37%) had enrolled on the insurance schemes for more than 5 years, followed by 32% of participants who have also been on the system for 2 to 5 years.

Table 4.6 Duration of subscription

Duration	Frequency	Percent
Between 6 months and 1 year	1	.5
Between 1 and 2 years	30	15.0

Between 2 and 5 years	64	32.0
More than 5 years	74	37.0
Non-subscribers	31	15.5

Source: Fieldwork, 2017

The results further indicate that less than 1 percent of respondent had enrolled on the NHIS in less than one year at the time of the survey. This shows that a higher number of respondent had been on the NHIS for a long time and the view of these respondents, especially regarding their experiences at the health facilities when they access health care, would reflect the actual situation that pertains in the Ga West Municipality.

CHAPTER FIVE

THE ROLE OF NHIS IN HEALTH CARE ACCESSIBILITY

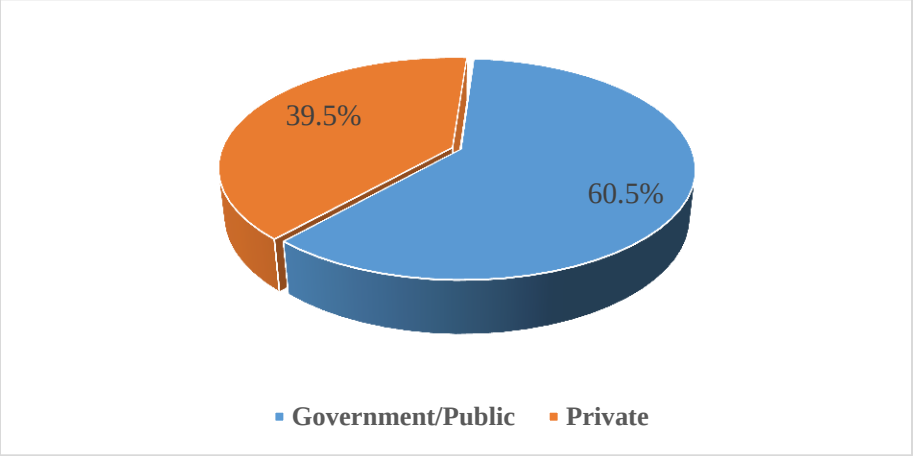
5.1 Introduction

This chapter presents the results and discussions on the role of NHIS in health care accessibility in Ga West Municipality, the proximate factors affecting NHIS utilisation and healthcare accessibility. The chapter also examines the various challenges to the operation of the NHIS in the Ga West Municipality.

5.2 The role of NHIS in health care accessibility

Aryeetey et al. (2016) note that the implementation of NHIS was to ensure increased access and use of health care services. In view of this, the second objective of the study sought to examine the role of NHIS in healthcare accessibility in the context of Ga West Municipality. This section begins with an analysis of the kind health facilities respondent often utilise when ill – either private or public health facility. The results of this analysis is presented in Figure 5.1.

Figure 5.1: Type of health facility respondents often utilise



Out of the 200 respondents, majority (60%) indicated that they utilise government or public health facilities whiles about 40 percent access health care from private health facilities. Given

that NHIS is accepted in all government owned health facilities, and a higher percent of respondents have subscribed to NHIS, it is not surprising that majority of respondents' access health care from government health facilities when they need to seek health care.

The study further sought the need to identify the specific types of health facilities both subscribers and nonsubscribers of NHIS utilise when they are ill. This was to ascertain if NHIS plays a role in the type of health facility respondents utilise when they are ill. The result of this analysis is presented in Table 5.1. The results show that hospitals (53.5%), clinics (39 %) and health centres (7.5%) are the three main health facilities often utilised by respondents, albeit a higher percentage of respondents indicated that they often access health care from hospitals. Comparatively, whiles a higher percentage of NHIS subscribers (75.7%) access health care from hospitals, a higher percent of nonsubscribers of NHIS access health care from clinics. Expectedly, none of the nonsubscribers of NHIS often seek health care from health centres (see Table 5.1).

In all, the results show that there is a preference for private health facilities among nonsubscribers of NHIS (68%) than NHIS subscribers (32%). On the other hand, the results also show that there is a preference for government or state-owned health facilities among NHIS users than nonsubscribers of NHIS. It is expected that NHIS subscribers would patronise government or state-owned health facilities because they accept NHIS than most private health facilities that do not accept NHIS as a mode of payment for health care. In an interview with some of the respondents, they reported that they often access health care from the district hospital because NHIS is accepted as mode of payment for health care. Even though they sometimes delay in seeking health care because of the high number of people that patronise these health facilities, they have other ways of circumventing the long delays. A 33 year-old female indicated that:

> "……..I like going to the district hospital when I am ill because they accept NHIS. Even though there are times there will be long queues and delays, I prefer to rather prefer to wait and not pay for health care from the private health facilities or instead come early to see the doctor and avoid the delays…" (33 year-old, female, individual interview)

Contrary to the views expressed by this respondent, one of the respondents who had not subscribed to the NHIS was of the view that he rather seeks health care from private health facilities because of the quality of services and attention they provide in these health facilities. To him, cost of payment was not in contention so far as he receives quality health care and avoid the delays and other barriers at these government or state-owned health facilities. He reported that;

> "…go to the district hospital and see the number of people. How can a physician or nurse get time to attend to you well? Because it is free, you will see a lot of people going there. Well, I would rather go to a private facility where they would give me proper attention because I am paying money" (28 year-old, male, individual interview)

The views of this respondent when juxtaposed with the views of the 33 year-old female in the earlier excerpt show marked differences in why people opt for certain health facilities and how NHIS influence accessibility of health care services in the Ga West Municipality. Additionally, it can be deduced that NHIS plays a role in influencing choice of health care even in the midst of the various barriers confronting the insurance scheme. Given the priority people give to their health needs and the lessening of the burden of cost when one accesses health care with NHIS, it is clear mode of payment plays a critical role in influencing health care accessibility.

In terms of respondents that utilise government or public health facilities, a relatively higher percentage often seek health care from hospitals (47.1%), followed by clinics (40.5%) and health centres (12.4%1). The results further show that all the respondents who indicated that they seek health care from government hospitals were NHIS subscribers. This suggests that

none of the nonsubscribers of NHIS access health care from government hospitals. This could be explained by the high patronage of government hospitals and the longer waiting time. Table 5.1: Percent of the type of health facilities often utilise and NHIS subscription

Table 5.1: Percent of NHIS subscription and the type of health facilities often accessed

Health Facility Type			NHIS subscription		Total
			Unsubscribed	Subscribed	
Government/ Public	Type of health facility	Hospital	0 (0.0%)	57 (100%)	57 (47.1%)
		Clinic	18 (36.7%)	31 (63.3%)	49 (40.5%)
		Health Centre	0 (0.0%)	15 (100%)	15 (12.4%)
	Total		**18 (14.9%)**	**103 (85.1%)**	**121 (100%)**
Private	Type of health facility	Hospital	26 (52%)	24 (48%)	50 (63.3%)
		Clinic	28 (96.6%)	1 (3.4%)	29 (36.7%)
	Total		**54 (68.4%)**	**25 (31.6%)**	**79 (100%)**
Total	Type of health facility	Hospital	26 (24.3%)	81 (75.7%)	107(53.5%)
		Clinic	46 (59%)	32 (41%)	78 (39%)
		Health Centre	0 (0.0%)	15 (100%)	15 (7.5%)
	Total		**72 (36%)**	**128 (64%)**	**200 (100%)**

Source: Fieldwork, 2017

This could pose as a barrier to health care utilisation and render the services of these hospitals unattractive to nonsubscribers. Often times, issues of quality of services also serve as a major reason why people often prefer to access health care from private hospitals. Additionally, the result further shows that none of the respondents who had not enrolled on the NHIS access

health care from government health centres. Comparatively, a higher percentage of respondents who do not access health care with NHIS prefer to access health care from private hospitals (52%) and clinics (96.6%) than those who had enrolled on the NHIS (see Table 5.1 for instance).

5.2.1 Accessibility to Quality Healthcare Using the NHIS

This section sought to examine the quality of healthcare delivery under the NHIS. The study by Alhassan et al. (2016) report that perceived poor quality of care in NHIS accreditated health facilities have a potential effect on NHIS subscriptions. According to Duku Opoku et al. (2018), being insured was associated with a significant lower perception of health quality. He indicated that once people are insured they tend to percieve quality of health care as poor compared to the non-insured. In an attempt to analyse the quality of healthcare under the Ghanaian National Health Insurance scheme, respondents were asked to access the quality of healthcare on some selected health care indicators such us “average waiting time”, “staff attitude” and the “availability of medicine”. Cross tabulations and chi-square test of significance were conducted to test for the relationship between the variables examined. Table 5.2 presents the cross-tabulation for clients waiting time between subscribers and non-subscribers.

The results show that that subscribers of insurance schemes or NHIS spend more time at the hospital against non-subscribers who spent less time at the point of healthcare delivery in the context of Ga West Municipality. It can be observed that out of 43.5% of total clients that wait for more than 2 hours at the health delivery points, 31% of these clients were subscribers to the insurance scheme. On the other hand, out of 6.5% of total clients that were seen in less than 30 minutes, 6% were non-subscribers to the insurance scheme (Chi2 = 50.34, $p=0.00<0.05$). Atinga (2011) in his study also reported that patients who accessed health care with NHIS spent longer hours waiting to see a physician. .

Table 5.2 Quality of Healthcare – "Waiting Time"

Waiting time	Subscribers		Non-Subscribers		Total Clients		Chi-Sq.	P-value
	No	%	No	%	No	%		
Less than 30 minutes	1	0.5	12	6.0	13	6.5		
30 minutes-1 hour	40	20.0	2	1.0	42	21	50.34	0.000
1-2 hours	43	21.5	15	7.5	58	29		
More than 2 hours	62	31.0	25	12.5	87	43.5		

Source: Fieldwork, 2017

In an attempt to find out the perceptions of participants, this study asked participants to describe waiting time during service provision in their various facilities. The qualitative findings revealed that managers at the facilities were aware of the delays consumers of health care face at the point of service delivery. One of the health administrators noted:

> "In most instances, there is delay with service provision especially with the NHIS subscribers because of the validation process they would have to go through before accessing service, however that is unlikely with non-subscribers".

Some studies suggest that there is higher patronage of private health facilities than public health facilities because of the quality of health services provided (Odame Darkwah, 2014). The quantitative data analysis showed that staffs of health facilities were very patient and attentive to non-subscribers (13%) than subscribers (3.5%). More so, even though staff were quite patient

it was also revealed that the only respondents who indicated that staff were not patients at the point of service delivery was a subscriber of an insurance scheme.

Table 5.3: Quality of Healthcare-"Staff Attitude"

Staff Attitude	Subscribe		Non-subscribe		All client		Chi-Square	P.Value
	No.	%	No	%	No	%		
Very patient	7	3.5	26	13.0	33	16.5		
Quite patient	99	49.5	19	9.5	118	59.0	94.1	0.000
Patient	30	15.0	9	4.5	48	24.0		
Not patient	1	0.5	0	0.0	1	0.5		

Source: Fieldwork, 2017

Some respondents were of the view that some staff were discriminatory towards clients. . One respondent indicated that:

> "Staff use to be patient with me at times but when there is pressure on them, they turn to be rushing and not listen to all story, especially when you have insurance. The just say "put the card inside the box and sit down" whiles those without insurance were quickly attended to". (32 year old male, individual interview)

Additionally, a 28 year old male respondent also indicated that;

> "I always visit the clinic with insurance and I wait for long before they attend to me but I once visited without insurance and I observed that the staff were readily to engage me more."

Conversely, some NHIS users indicated that they receive better care and attention from staff of the health facilities they utilise. They further indicated that they don't

see any distinction between how NHIS subscribers and nonsubscribers are treated. One respondents noted;

> "I'm always happy how the staff pay attention to me and take time to discuss my situation anytime i visit the hospital whether with insurance card or not. (32 year old female, individual interview) "

The views expressed by this respondent was re-echoed in the submission of a 34 year old Taxi driver. He remarked;

> "Anytime I visit the clinic, the staff were attentive, they listen to my situation and explains procedures to you well."(34 year-old, male, individual interview)

The last indicator employed to measure quality of healthcare under the study was the availability of medicine at the time of healthcare service delivery. The results is presented in Table 5.4. The results show that majority of the NHIS subscribers (72.7%) do not get medicine at the various health facilities when they access health using NHIS whilst a significant majority of non-users of NHIS (81.9%) indicated that medicines are always available in the various health facilities they access.

Table 5.4 Quality of Healthcare- "Medicine Availability"

	Availability of Medicine				**Total**
	Available		**Not available**		
NHIS Subscription	**Freq.**	**%**	**Freq.**	**%**	**Freq.**
Subscribers	35	27.3	93	72.7	128
Non-subscribers	59	81.9	13	18.1	72

Source: Fieldwork, 2017

This variation in response could be linked to the marked differences in the type of health facility they utilise and their mode of payment for health care services. During the interview with some respondents, they indicated that in situation where drugs are provided they are of low quality. One of the respondents indicate that:

> "…with respect to the consultation, the doctor will attend to you alright. But when he write any medicine for you, you will get to the dispensary and they will tell you they don't have that drug. So they would write it for you to purchase it outside. In situation where they are even provided, they are of low quality. They will prescribe paracetamol and other drugs I think are not good for you to buy…" (33 year-old, male, individual interview)

This finding is consistent with the study by Teye et al. (2014) on the achievements and challenges of the NHIS in Ghana, where patients who accessed health care using NHIS indicated that the drugs often prescribed for them are of lower quality as compared to those that pay-out-of-pocket. According to some participants, although they are insured, they still pay for medicine when they visit the clinic. And in most occasion, they were told the drug is not available and have to purchase it outside the clinic.

> "In many occasion I visit the clinic and just to be told they don't have some of the drugs prescribed to me by the doctor and have to depend on outside pharmacist to purchase to drugs "(44 year old male, individual interview)

This excerpt resonates with the study by Emmanuel et al. (2018), which noted that unavailabiltiy of medicine and percieved poor quality of care were major challenges to subscribers of insurance

5.3 Barriers to healthcare accessibility using the NHIS

Table 5.5 presents items that describe the perceived barriers to healthcare accessibility under the Ghanaian NHIS from literature. The survey request the respondents to agree or disagree to the listed barriers indicating whether or not they consider them as barriers to healthcare under NHIS. The have shown that poverty is perceived to be a barrier to NHIS utilisation for healthcare accessibility supported by 69% of the respondents.

Table 5.5 Barriers on healthcare accessibility under NHIS (multiple responses)

Items	Agree	%	Disagree	%
Poverty	138	69	62	31
NHIS covers only cheap drugs	176	88	24	12
Out-of-pocket payment	139	69.5	61	30.5
Poor services for NHIS users	144	72	56	28

Source: Fieldwork, 2017

In support with the earlier findings, the qualitative analysis also revealed that participants perceived poverty as barrier to NHIS utilisation and healthcare accessibility in the context of Ga West Municipality as stated by a 33 year old participants. He stated that;

> "My experience with most of the deprived have shown that they can't even afford to pay for the subscriptions" (33 year old, male, FGD)

Another respondent also supported the above statement indicating that:

> Some household individual cant affords the subscriptions even though it perceived to be inexpensive (28 year old, female, FGD)

It was also revealed that accredited facilities prefer cash and carry to the scheme supported by 88% of our respondents. During the interview participants 5 noted that:

> The facilities pay attention to clients that comes in to pay for all services than clients that walk in with NHIS card. He also noted that NHIS card holders turn to wait for a longer period before attended to.

As supported by the quantitative analysis, 72% of the participants agreed to a statement that supposed that "card holders of the scheme are usually left unattended to for a longer period"

5.4 Challenges to the Operation of NHIS

The last objective of the study sought to examine the challenges to the effective implementation of NHIS. In line with the fourth objective, this section presents the results and discussions of the study at two levels; at the institutional and individual levels. The institutional level challenges focused on how an administrative challenge affects the successful operation of the NHIS.

5.4.1 Institutional Level Challenges

Interviews conducted with administrators or stakeholders revealed the challenges facing the implementation of the NHIS in the study area. A thematic analysis revealed that "non-payment or rejection of claims" and "unavailability of drugs" were some of the challenges that come with quality healthcare provision under the NHIS.

Several studies show that non-payment or rejecting of outstanding claims have accounted to many challenges to quality of care under the NHIS. According to Ghana Medical Association (GMA), the National Health Insurance Scheme is collapsing due to outstanding insurance claims owed to service providers (Brocke, 2010). During the interview with the health care providers, it was highlighted that delays or non-payment of the insurance claims is the major challenge facing the successful implementation of the NHIS in their facilities. The NHIA

stipulates that insurance claims made under the NHIS should be paid as soon as possible after all the necessary checks have been done by the scheme administrators and managers. However, it became evident that there are times that claims made will take up to eight months before payment can be effected.

The hospital administrator at the Mayera Clinic stated that:

> The delay in the payment of claims has led to backlog of unpaid claims and as a result lead to issuing of threats among the service providers to turn out patients that visit the hospital with NHIS cards.

The Claims Manager at Mayera Clinic remarked that;

> "We have claims that date as far back as 2016 that are yet to be paid and the worrying situation is that day-in-out a sizable percentage of our customers are NHIS card bearers. Due to the unpaid claims, it is becoming very difficult to attend to NHIS card holders since we are not aware when the monies owed us will be paid and the situation here is not different from other health facilities across the region". (Focused Group Discussant, 2017)

The delay in payment of insurance claims is consistent with studies such as Fusheini *et al.* (2012). In their study of claim management of NHIS, they observed that delays in payment of pre-finance insurance contributed to the government owing the service providers across the nation to the tune of GH₵ 49 million in 2008.

The study also identified that in addition to reimbursement delays is the problem of claim rejections. It became evident during all the interviews with scheme managers and health care providers that there are times that the claims submitted have to be rejected several times before been finally accepted. However, scheme managers maintained that rejection of claims were as a result of lack of evidence for service rendered and use of expired cards to access health care delivery by NHIS. The negative impacts of claim rejections is similar to Sodzi-Tettey (2017)

study in the Northern of Region of Ghana where he observed that majority of claims subjected for payment were partially or totally rejected for reasons such as suspicion of fraud, lack of evidence for claims and use of expired card by members. One of the hospital administrators stated that:

> "In most occasions we encounter challenges that come with NHIS claims rejection. Before the introduction of the electronic system of claims submission we use to experience lots of claims rejections, however that challenges have been limited after the introduction of the electronic verification system even though we still experience the challenges in some occasion"

In support of the above statement, the pharmacist at one of the hospital also stated:

> "Yes, we do have claims rejection which is a challenge to us in addition to delay in payment of claims"

As presented in the quantitative analysis, the qualitative findings also showed that in relation to NHIS, "unavailability of drugs" was a challenge in healthcare delivery in most occasions. These findings were supported by participants as stated:

> "The hospital could not buy in stock some of the medication under NHIS because of the delay in payment of the claims"

One participant also noted that;

> The pharmacist in most occasions request the clients to go outside to purchase some of the medicines prescribed because of unavailability of the drugs

5.4.2 Challenges to Operation of NHIS at the Individual Level

Whereas the operation of the NHIS at the institutional level is bedevilled with a number of challenges as discussed above, it was also evident that there are a number of factors that affects the activities of the NHIS at the individual level.

Discussants in a FGD were asked to choose main challenges from six challenges - poor attitude of hospital staff, card rejection, lack of prescribed drugs, longer waiting times, lack of accessibility and high cost of transportation - presented to them by the researcher.

Some studies show that health workers are all times expected to be friendly and welcoming towards their patients (Muriithi, 2013). The behaviour of health workers such as nurses, doctors, dieticians and ward assistants have specifically been observed to influence patient's satisfaction which could either serve as factor to amplify or attenuate health care delivery. According to Odame (2014), most hospitals especially public health facilities were found to be sub-standard with regards to how they interact with their patients. However, encounter with patients at sampled hospitals within the study area revealed that neither the staff at public nor private hospitals were immune from unfriendly attitudes towards the patients as a patients took turns to reveal their ordeal in the hands of hospital workers.

Nonetheless, in order to unpack the exact complexity of the problem at hand as enumerated by patients or visitors to the hospital, hospital workers such as nurses, record keepers and ward assistants were also interviewed to verify the claims (with regards to unfriendly attitudes) made by the patients. The hospital workers countered that most patients do not follow basic procedures and directives given and the process of advising the patients are misconstrued as rudeness.

In summary, qualitative analysis discovered two thematic areas that described the challenges facing NHIS at the individual level. In no particular order, it was observed that among the individual level challenges facing the successful implementation of the NHIS were "poor attitude of hospital staff", and "longer waiting times" at the hospital. A 43 year-old discussant stated that:

> "Attitude of staff towards as at the public hospital is very bad, however the staff in private facilities are welcoming that's why I prefer to go to private facilities without insurance in most occasion. And also the waiting time at the public facilities is too long." (Male, FGD, 2017)

Similar to the views expressed by Osei, another respondent also indicated that

> "I prefer to visit the private hospital without insurance in most cases because of the time I will spend at the public hospital and the attitude of some of the staffs" (33 year-old, male, FGD, 2017)

In support with literature, Atinga, (2011) in his study also discovered that waiting time was too long amongs subscribers of NHIS in the context of Ghana.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of findings from the study. The chapter further presents the conclusions based on the findings and makes some recommendations based on the findings of the study.

6.1 Summary

This study examined the role of the NHIS in accessing health care services in the Ga West Municipality. Specifically, it assessed the awareness of households on NHIS and its benefits to its subscribers in the Ga West Municipality. It also examined the role of NHIS in quality healthcare accessibility in the Ga West Municipality. Additionally, the study examined the relationship between socio-demographic variables and NHIS enrolment amongst households in the Ga West Municipality. Lastly, it assessed factors affecting NHIS utilisation and healthcare accessibility in the Ga West Municipality. A mixed method approach was adopted to achieve the objectives of the study. A total of 200 respondents were sampled for the questionnaire survey and in-depth interviews were conducted with some respondents, health administrators and some officials of the NHIA. Below are the summary of key findings of the study

The results also showed that all the respondents (100%) were aware of NHIS. This is unsurprising because of the popularity and attention the scheme has received in the media. With respect to insurance schemes such as DMHIS and PMHIS, 99.5 percent of respondents indicated that they were not aware of these insurance schemes in the Municipality. In terms of access to information on issues regarding NHIS, that majority of respondents indicated that they became aware of NHIS via family and friends, followed by television (77%) and health

facilities (59.5%). Arguably, the communal nature of Ghana's socio-cultural set-up makes it easy for people to receive information via family and friends than via television or radio. Similarly, this finding is in line with the study by Adele et al (2016) in Nigeria where family and friends were the most important sources of information on NHIS. Again, health facilities were reported as a major source of information on insurance scheme. It can be argued without any equivocation that because these health facilities are the service providers of health services, there is a higher likelihood respondents are given some education or sensitization about the benefits of having an insurance when accessing health care at these facilities. This could partly account for why health facilities serve as a major source of information on health insurance in the Ga West Municipality.

With respect to respondents' awareness of NHIS, the results of the study revealed that majority of the respondents were aware of the implementation, objective, functions or benefits of NHIS. The result showed that 95.5 percent perceive NHIS as a social scheme which is intended to benefit the individual in accessing quality healthcare in Ghana. In terms of NHIS enrolment, the study reports that a relatively higher percent of respondents had subscribed to the NHIS whereas 36 percent were nonsubscribers. This suggests that even though all the respondents sampled were aware of the NHIS 36 percent had not enrolled on the scheme at the time of the survey. The result further showed that more females had enrolled on the NHIS than males. The study examined the link between demographic characteristics of individuals and NHIS subscription and access to health care. The results of the chi square test showed a significant relationship between sex and NHIS subscription in the Ga West Municipality. In terms of the age of respondents, the results show that there is a significant relationship between age of respondents and NHIS subscription in the Ga West Municipality. This is because all the respondents above 40 years and a majority of those within the ages of 26-30 years were NHIS subscribers as

compared to those within the ages of 20-25 years and between 36-40 years. Moreover, majority of respondents with tertiary education had subscribed to NHIS whiles only 20 percent of respondents with SHS or Vocational or Technical education had enrolled on the NHIS. The chi square test showed a significant relationship between NHIS enrolment and respondents' level of education. Interestingly, all the respondents who indicated that they earn above 5000 cedis had subscribed to the NHIS relative to about 36 percent of respondents who earn less than 100 cedis but indicated that they are not subscribers of NHIS.

The results of the binary logistic regression revealed that only sex and level of education significantly predicted the outcome variable of the model. Conversely, age, income and marital status were not significant predictors of NHIS enrolment in the Ga West Municipality. In view of this, the study fails to reject the null hypothesis which states that age, marital status and income has no significant influence on NHIS enrolment in the Ga West Municipality. On the other hand, the study rejects the null hypothesis which states that sex and level of education has no significant effect on NHIS enrolment in the Ga West Municipality. The study further reports that the likelihood of enrolling on the NHIS in the Ga West Municipality increases with being a female than males. Also, the likelihood of subscribing to the NHIS increases with respondents with primary or basic and tertiary education than those with postgraduate education. Moreover, the results of the study showed that a relatively higher percent of respondents had enrolled on the insurance schemes for more than 5 years. The results further indicates that less than 1 percent of respondent had enrolled on the NHIS in less than one year at the time of the survey.

With regards to the role NHIS plays in enhancing general accessibility of health care in the study area, the study reported that, in all, there is a high preference for private health facilities among nonsubscribers of NHIS than NHIS subscribers. On the other hand, the results also show that there is a preference for government or state-owned health facilities among NHIS users

than nonsubscribers of NHIS. It is expected that NHIS subscribers would patronise government or state-owned health facilities because they accept NHIS than most private health facilities that do not accept NHIS as a mode of payment for health care. In terms of respondents that utilise government or public health facilities, a relatively higher percentage often seek health care from hospitals, followed by clinics and health centres. The results further show that all the respondents who indicated that they seek health care from government hospitals were NHIS subscribers. This suggests that none of the nonsubscribers of NHIS access health care from government hospitals. This could be explained by the high patronage of government hospitals and the longer waiting time in these health facilities.

With regards to the kind of quality health NHIS subscribers experience at the various health facilities, the study reports that subscribers of insurance schemes or NHIS spend more time at the hospital as compared to non-subscribers of NHIS who spent less time at the point of healthcare delivery in the context of Ga West Municipality. This finding is consistent with the study Atinga (2011), which that patients who accessed health care with NHIS spent longer hours waiting to see a physician. The study also reports that the staffs of health facilities were very patient and attentive to non-subscribers (13%) than subscribers (3.5%). Furthermore, the results show that majority of the NHIS subscribers do not get medicine at the various health facilities when they access health using NHIS whilst a significant majority of non-users of NHIS indicated that medicines are always available in the various health facilities they access. The study suggested that this variation in response could be linked to the marked differences in the type of health facility they utilise and their mode of payment of health care services. This finding is consistent with the study by Teye et al. (2014) on the achievements and challenges of the NHIS in Ghana, where patients who accessed health care using NHIS indicated that the drugs often prescribed for them are of lower quality as compared to those that pay-out-of-

pocket. The study also showed that users of NHIS are confronted with various challenges at the health facilities. These challenges include delays and longer waiting times, charging of illegal fees and poor attitude of health personnel. The study also indicated that there are other institutional challenges that affect NHIS use in accessing health care in the Ga West Municipality. These include delay in release and payment of claims and delays in submission of claims by accredited health care institutions of funds.

5.2 Conclusion

Against the backdrop of the results and discussions presented thus far, the study concludes that NHIS remains central to ensuring universal health coverage and enhancing access to health care in the country. The study further concludes that family and friends are very important modes of disseminating heath information and ensuring the efficacy of health policies and interventions, albeit radio and television continue to play key roles in information sharing and sensitization. Clearly, sex and level of education, as evidenced in the context of this study, are useful predictors of NHIS enrolment in the Ga West Municipality. The study has shown that in the midst of all the various bottlenecks confronting the NHIS, there is high access to NHIS accredited health facilities. Thus, in circumstances where these challenges are resolved and the various gaps are bridged, NHIS would present itself as a potent tool to ensuring access to quality health care and enhancing the use of appropriate health care services. The results of the study are consistent with studies by Atinga (2011) and Teye et al. (2014) which reported that patients who pay out of pocket are given better treatment at the various health facilities than those who access health care with NHIS. Additionally, the results is in line with the Andersen and Newman's (1973) theory on health care utilisation which posits health insurance an important enabling factor to health care accessibility and utilisation.

Given that the study focused primarily on few proximate factors in assessing the role NHIS play in health care accessibility in the Ga West Municipality, the study suggests that future studies should focus on how socio-cultural and other socioeconomic factors influence NHIS subscription and health care utilisation.

5.3. Recommendations

The study makes the following recommendation on the basis of its findings

- The study recommends that operative educational programs should be developed for the public to create awareness on the NHIS and its benefits. This should be a concerted effort among the NHIA, the municipal assembly and other stakeholders within the health delivery chain. This would help bridge most of the information gaps and further orient the populace on the need to enrol on the scheme.
- The NHIA should put in stringent measures to monitor the activities of all the NHIS accredited health care providers. This would help resolve the numerous and varying challenges most users of NHIS are confronted with when they access health care. Some form of motivations should be provided by the NHIA to health care providers that treat NHIS users well and offers quality services. This would provide a major impetus to other health care providers to treat NHIS users well when they seek for health care from these institutions.
- There should be early and prompt payment of claims by the NHIA to these health institution. To avert some of the poor services they render to NHIS users, payment claims should be paid promptly and this would incentivise NHIS accredited health care providers to offer better services to consumers of their health care services.

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Appendix 1

University of Ghana

Department of Geography and Resource Development

Questionnaire **Serial Number……..**

Introduction

Hello, good morning/afternoon/evening, my name is ……, a student of the Department of Geography and Resource Development, University of Ghana. I am undertaking a study on the role of NHIS in accessing health care services in the Ga West Municipality. The outcome of this study is solely for academic purposes. Thus, the anonymity and confidentiality of respondents are guaranteed. Please note that even though you participation in this survey is very important, you are at liberty to withdraw from the survey if you don't want to participate anymore. Thank you.

Interview details

Date of interview:……. Start

Time:…….

End Time:……..……..…

Location:……

Consent Note:

Given the fact that you have detailed the purpose of this study and further given assurance of my anonymity and the confidentiality of my responses, I hereby give my consent to take part in this survey. Please go ahead and interview me:

Signature/Thumb **Print**

…….

Section A. Demographical Profile:

Q1. Gender of respondent:

1. Male [ ] 2. Female [ ]

Q2. Age of respondent:

1. Below 20years [ ] 2. 20-25 years [ ] 3. 26-30 years [ ]

4. 31-35 years [ ] 5. 36 to 40 years [ ] 6. 40+ years [ ]

Q3. Highest level of education attained:

1. Primary [ ] 2. MLSC/JHS [ ] 3. Secondary/SHS [ ]

4. Tertiary [ ] 5. Post-graduate [ ] 6. None [ ]

Q4. Marital status

1. Married [ ] 2. Single [ ] 3.Divorced [ ]

4. Widowed [ ] 5. Separated [ ]

Section B: Respondents' awareness of the Health Insurance and its operations

Q5a. Have you ever heard of any of these Health Insurance Schemes? Please choose all that apply

1. NHIS [ ] 2. DMHIS [ ] 3. PCHIS [ ]

4. PMHIS [ ] 5. No [ ]

Q5b. Where did you heard about it/them? Please choose all that apply

1. On the Radio [ ] 2. On Television [ ] 3. NCCE Van [ ]

4. At a health facility [ ] 5. From a friend/family [ ] 6. Other (specify)……...

Q6. What do you know about these schemes? **(Multiple Response Possible)**

1. It is a social insurance scheme on health [ ]

2. It was established by government to help the poor and the vulnerable in society [ ]

3. Sick people can go to hospital without paying money (cash and carry) [ ]

4. Pregnant women can attend hospital without paying [ ]

5. Pregnant women can attend anti-natal and deliver at the hospital for free [ ]

6. Children under 18 years whose parents are subscribers do not pay at the hospital [ ]

7. Other (specify)……

Q7a. Have you personally subscribed to any of the schemes? Please choose all that apply

1. NHIS [ ] 2. DMHIS [ ] 3. PCHIS [ ]

4. PMHIS [ ] 5. No [ ]

Q7b. For each scheme you selected in Q7a please state your reasons.

a……

…….

b……

…….

c……

…….

d……

…….

Q7c. For how long have you subscribed to the selected schemes?

1. Less than 6 months [ ] 2. Between 6 months and 1 year [ ]

3. Between 1 and 2 years [ ] 4. Between 2 and 5 years [ ] 5. More than 5 years [ ]

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

a……

……..

b……

……..

c……

……..

Section C: The role the Scheme to health care accessibility in Ghana

Q8. What benefits are there for a person who subscribes to the scheme? Please choose all that apply

1. They could seek health care even if they do not have money [ ]

2. Subscribers' children under 18 years could seek health care free of charge [ ]

3. They could have access to essential drugs even the don not have money [ ]

4. Pregnant women can attend hospital without paying [ ]

5. Pregnant women can attend anti-natal and deliver at the hospital for free [ ]

6. They basically insure their health against ill-health [ ]

7. Other (specify)……..

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

1. Yes [ ] 2. No [ ]

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

a……

…….

b……

…….

c……

…….

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

a……

…….

b……

…….

c……

…….

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

1. Yes [ ] 2. No [ ]

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

a……

…….

b……

…….

c……

…….

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

a……

…….

b……

…….

c……

…….

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

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

1. Less than 30minuts [ ] 2. Between 30-1 hour [ ]

3. Between 1 and 2 hours [ ] 4. More than 2 hours [ ]

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

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

Q11c. If a subscriber, why do you think so?

a……

…….

b……

…….

c……

…….

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

a……

…….

b……

…….

c……

…….

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

1. Very patient [ ] 2. Quite patient [ ] 3. Patient [ ]

4. Not patient [ ] 5. Very inpatient [ ]

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

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

Q13b. If a subscriber, why do you think so?

a……

…….

b……

…….

c……

…….

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

a……

…….

b……

…….

c……

…….

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

1. Reacted happily [ ] 2. Reacted angrily [ ] 3. No reaction [ ]

4. Frowned the face [ ] 5. Started abusing me verbally [ ]

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

1. Yes [ ] 2. No [ ]

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

a……

…….

b……

…….

c……

…….

Q15c. Were you given all the medicine you needed?

1. Yes [ ] 2. No [ ]

Q15d. If No to Q15c, why not?

a……

…….

b……

…….

c……

…….

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

Q15. What are the major reasons why some people are not able to subscribe to the scheme? Please choose all that apply

1. It is because of poverty [ ]

2. It is too expensive for the ordinary health seeker [ ]

3. The scheme covers only cheap drugs [ ]

4. The scheme covers only simple surgical problems (operations) [ ]

5. Health facilities prefer cash and carry to the Scheme [ ]

6. Card holders of the Scheme are usually left attended to for longer hours [ ]

7. Some people do not get sick often [ ]

8. People prefer to use traditional systems rather than orthodox method for cure [ ]

9. Unavailability of health facilities in their communities [ ]

10. Health facilities are too far from them (Time wasting to travel to one) [ ]

7. Other (specify)……

Q16. (For non-subscribers only). Why have you not personally subscribed to a scheme?

a……

…….

b……

…….

c……

…….

Section F: Exploring possible disparities in health care accessibility

Q17. Please respond "Yes" or "No" to the following statements on the table below:

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

9. subscribers have free access to essential drugs but non-subscribers [ ] [ ]
would have to pay for

Q18. What recommendations do have to make that will help improve the Scheme?

a……

…….

b……

…….

c……

…….

Thank you for taking part in this Survey