

Quality Healthcare Service Assessment under Ghana's National Health Insurance Scheme

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Abstract

Ghana implemented the National Health Insurance Scheme (NHIS) in 2005 with the intention of providing residents with quality affordable healthcare. Over the past few years, concerns have been raised about the quality of healthcare clients receive. This study assesses the experiences of NHIS subscribers with the quality of care they receive under the scheme by both private and public hospitals. The results from the 56 interviews show that the majority of the subscribers were dissatisfied with the overall quality of healthcare they received in both private and public hospital because of the long waiting hours, the poor attitude of nurses and the demand for payment of additional money. Even though clients who visited the private hospital paid for all services, excluding consultation, their level of satisfaction with the quality of healthcare was relatively higher than those who visited the public hospital. The paper concludes that NHIS clients do not receive the quality of healthcare the scheme promised, and this has implications for premium renewals and health-seeking behaviour.

Keywords

National Health Insurance Scheme, quality of care, healthcare, satisfaction with healthcare, qualitative research, Ghana

Introduction

The last several years have witnessed an increasing drive towards the adoption and implementation of social health insurance schemes in many developing countries (Baltussen et al., 2006; Carrin et al., 2001). These schemes have emerged mainly because of the risk associated with the

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out-of-pocket payment system that existed and reduced people's utilisation of health services due to their inability to pay (Ekman, 2004; Wang et al., 2017). In 2003, the government of Ghana passed the National Health Insurance Act (Act 650) to establish the National Health Insurance Scheme (NHIS), with the aim of providing basic quality and affordable healthcare services to all residents in Ghana, especially the poor and vulnerable (Baltussen et al., 2006; Fenny et al., 2014). Specifically, the NHIS was established to 'ensure equitable universal access for all residents of Ghana to an acceptable quality of essential health services without out-of-pocket payment being required at the point of service use' (Ministry of Health, 2004: 7). A client under the NHIS is entitled to enjoy some minimum health packages such as 'out-patient services, in-patient services, oral health, maternity care and emergency care' among others (Atinga, 2012: 146).

Since its establishment, there has been an increase in the utilisation of healthcare services. For instance, under the scheme Out Patients Department (OPD), cases in Ghana increased from 597,853 in 2005 to 23,875,182 in 2012, even reaching as high as 25,486,081 in 2011 (Institute of Statistical, Social and Economic Development [ISSER], 2015). However, despite increased utilisation, there are issues with the quality of services that subscribers receive under the scheme. Whereas some studies have found that NHIS clients are satisfied with the quality of treatment, others have concluded otherwise. Fenny et al. (2014), for instance, found that a large proportion of NHIS clients were satisfied with the quality of healthcare they received compared to the non-clients. However, Dalinjong and Laar (2012) found that most insured clients waited longer at the hospitals compared to the uninsured. Sometimes, the nurses verbally abused them and doctors did not even physically examine them but only prescribed common medicines to them. Similarly, Bruce et al. (2008) found that those who make out-of-pocket payments spend relatively shorter time at the hospital than their counterparts who are insured under the NHIS. Again, findings from the Social Enterprise Development' (SEND-Ghana) and the World Bank's research in 44 districts in Ghana revealed that there is an inverse correlation between being an NHIS client and getting quality healthcare (Ghana News Agency [GNA], 2010). Specifically, the majority of NHIS accredited providers (76%) indicated that 'the scheme had negative effects on quality healthcare delivery' because the 'implementation of the NHIS had negatively affected their ability to acquire medicines both in terms of quality and quantity to cope with the increasing attendance' (GNA, 2010).

These conflicting findings mean that continuous evaluations and assessments of healthcare quality under the scheme are cardinal for policy makers and scheme managers to improve the quality of healthcare the scheme provides to Ghanaians. This is because the level of satisfaction of patients with the perceived quality of healthcare received has implications for healthcare service utilisation and health outcomes of people (Andoh-Adjei et al., 2018; Khamis and Njau, 2014; Nezenega et al., 2013; Sadlo et al., 2014).

Our study adopted a qualitative approach to gather clients' experiences and views on their satisfaction with the overall quality of care they receive under the NHIS. The study particularly assessed the various factors influencing the satisfaction of NHIS clients with the quality of treatment they received under the scheme.

The study adds to the literature by employing a different methodological approach to assessing the healthcare quality clients receive under the scheme. Unlike previous studies, which looked at clients' experiences in general, the study dichotomises the clients' satisfaction assessment by the type of hospital facility (private or public) that the beneficiary attended. This is particularly relevant, especially to give feedback to the National Health Insurance Authority (the governing body of the NHIS) regarding the kind of services the clients are receiving from the providers (private and public hospitals), and the policies and initiatives needed to ensure that the providers give clients the best healthcare services under the scheme.

Literature review: measuring quality healthcare

One of the areas the NHIS places greater emphasis on is the provision of quality healthcare that satisfies the expectations of its clients. Section 68 of the NHIS Act provides quality assurance measures that mandate the National Health Insurance Council to take appropriate measures that will ensure that healthcare providers give clients reasonably good quality health services (Atinga, 2012). However, the biggest concern is the conceptualisation of what constitutes quality healthcare, because quality of care is difficult both to define and to measure (Fenny et al., 2014). Policy practitioners and scholars alike, therefore, try to define or adopt a multi-dimensional definition that is more holistic, encompassing all the various dimensions of quality healthcare. Even though there are differing views and dimensions in the definitions of quality healthcare, there is a general consensus that quality healthcare encompasses services that are beneficial to clients and at the same time meet their needs (Fenny et al., 2014).

One of the most common and most widely cited definitions of quality healthcare is by the Nepal Institute of Medicine, which defines quality healthcare 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, as cited in Fenny et al., 2014: 11). Other scholars have defined quality healthcare using different but similar parameters. One of the oldest approaches and measures of service quality, dating back to the 1970s, was developed by Parasuraman et al. (1988). It is called the SERVQUAL (service quality) model or rater and it assesses the quality of services using five indicators: reliability, responsiveness, assurance, empathy and tangibles (Parasuraman et al., 1988). Many studies have used the SERVQUAL model to examine the service quality of many organisations even in the context of healthcare delivery (e.g. Al-Borie and Sheikh Damanhour, 2013; Chang and Chang, 2013; Javed and Ilyas, 2018; Khamis and Njau, 2014; Mostafa, 2005). Javed and Ilyas (2018), for instance, used the SERVQUAL model to assess patients’ expectations and satisfaction with the quality of care they received in Pakistani hospitals, while Mostafa (2005) conducted his study in Ethiopian hospitals. Based on his findings, Mostafa (2005) redefined the SERVQUAL indicators into three indicators: providers’ performance, providers’ reliability and the quality of facility. Javed and Ilyas (2018) also found patients’ satisfaction to be influenced by the empathy they received from health workers in public hospitals and health workers responsiveness to the needs of patients in private hospitals.

Alternatively, the World Health Organisation (2006) conceptualised quality healthcare using six dimensions, requiring/entailing that healthcare be effective, efficient, accessible, acceptable/patient-centred, equitable and safe. In the view of Mosadeghrad (2012), quality healthcare has, among other things, the following characteristics:

availability, accessibility, acceptability, appropriateness, affordability, technical competence, timeliness, privacy, confidentiality, empathy, attentiveness, caring, responsiveness, accountability, accuracy, reliability, comprehensiveness, continuity, equity, environment, amenities and facilities. It also includes efficacy, effectiveness, efficiency, ensuring safety and security, reducing mortality and morbidity, improving quality of life and patient’s health status, and patient satisfaction. (p. 258)

Mosadeghrad (2012) believes that 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 right result is about satisfying the patient by improving his/her quality of life and health status (Mosadeghrad, 2012).

From the foregoing definitions, the measurement of quality of healthcare has used different approaches and varying indicators. For instance, Fenny et al. (2014) adopted the Donabedian

model to study the quality of service NHIS clients receive in three districts in Ghana covering the three ecological zones (coastal, forest and savannah). Based on the model, they conceptualised the healthcare quality factors as structures, processes and outcomes. Based on their logistic regression analysis, Fenny et al. (2014) redefined quality healthcare as encompassing waiting time, friendliness of staff and satisfaction with the consultation process. Atinga (2012) also gathered data from 250 NHIS clients, and based on descriptive statistics and Chi-square analysis, concluded on four significant dimensions of quality healthcare; namely, interaction with service providers, provider demeanour, physical infrastructure/facilities and waiting time. Ghana's Ministry of Health's (2004) viewpoint is that quality healthcare should pay more attention to the perspectives of clients, improving the competencies and skills of providers and improving the working environment by better management, provision of medical equipment and supplies, and motivating staff by improving their conditions of service.

Theoretical approach

The paradigm guiding this study is social constructivism. This paradigm studies individuals' understanding, experiences, and meanings of the world around them (Creswell, 2013). According to Patton (2002), the basic questions a social constructivist seeks to answer 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?' Social Constructivists believe that people's life-world experiences generate multiple realities (Creswell, 2013), and hence why they are interested in unveiling these multiple realities as well as their implications for their lives and those they interact with (Patton, 2002). People ascribe different meanings to the issues they encounter in their life-world. The researcher adopting the social constructivist paradigm is interested in exploring these complexities in the views and meanings people hold about a social phenomenon 'rather than narrow the meanings into a few categories or ideas within a period of time' (Creswell, 2007: 20). In this study, the researchers believe that people's experiences in accessing healthcare under the NHIS are varied, and, given the same indicators for quality healthcare, people's experiences may differ. The focus is therefore to explore these complexities within a period of time.

Methodology

Quality of care indicators

Based on its greater applicability to Ghana, this study adopted the indicators used by Fenny et al. (2014), with some modification. In this study, 'structure', which Fenny et al. (2014: 11) defined as 'material characteristics and resources of the providers of healthcare', was measured using the availability of essential physical resources for healthcare and patient comfort, such as clean wash-rooms, seats (at patients waiting area) and diagnostic resources (laboratory/X-ray, etc.) on the premises of the health facility, which are all being basic services defined under the NHIS. The 'process' variable measures the attitude of clinical and other auxiliary workers towards patients, as well as waiting time at the facility. Finally, the 'output' variable is the overall satisfaction with the quality of care received under the NHIS.

Sampling

Making the proper assessment of the quality of an intervention calls for having different alternatives to choose from. This implied conducting this study in an urban setting so that we had several

healthcare facilities to choose from. Hence, the Greater Accra Region (GAR), which has about 60% of health infrastructure and healthcare personnel in Ghana (ISSER, 2015), and where there are many healthcare facilities (both private and public), which accept patients with NHIS, was purposively chosen.

The sampling was a mixed procedure, with an initial random selection of the Ga-East Municipality among the 16 districts in the GAR. Both purposive and snowball sampling techniques were used in the selection of the respondents. We were also interested in exploring whether healthcare experiences under the NHIS differed with regard to the type of health facility one visited: a public or private health institution. We therefore decided to select a community served by either a private or a public hospital. Within the Municipality, Kisseman is one such community served by both a private and a public hospital.

Kisseman is a low-income community characterised by traditionally large compound houses, which are highly clustered and with a population of 1101. The majority of the inhabitants are children and youths, with as high as 73% aged below 35 years (Ghana Statistical Service, 2014).

The study was conducted at the household level, mainly due to difficulty in getting clearance from the two facilities to conduct a survey at their premises. Household heads were targeted and interviewed. In their absence, any adult in the household who had either used the health insurance card personally or had taken an insured person within the household to a hospital within the past 12 months was interviewed. The 12-month time frame was to enable recall as accurately as possible regarding their last visit to a hospital. The selection of the participants was further refined to only those who accessed healthcare from either private or public facilities, or both. After visiting a few houses within the community and interviewing a person who met all the above-stated criteria, he/she was then asked to participate in the survey and to direct us to other people within the community who had visited either a private or a public hospital within the past 12 months. Given the strong social cohesion in Kisseman, it was easy for participants to identify two or more people who had visited the hospital over the past 12 months. In this way, a total of 56 participants were finally selected.

Verbal consent was sought from each respondent prior to the interview. Respondents were also informed that participation was not obligatory, and non-participation would not attract any penalty. They were further assured of confidentiality and told that they were at liberty to discontinue the interview at any point they felt uncomfortable. Pseudonyms were used for the participants in the tape recording and in the analysis. Most of the interviews were conducted in Twi (the most spoken Ghanaian language); a few interviews were, however, conducted in English. No interview exceeded one hour. The interviews were conducted between April and June 2017. The data collection instrument was pretested a month earlier in a nearby community with similar demographic characteristics, using five respondents, and was then finalised. The interview was mostly semi-structured and thus allowed for further probing.

Analysis of data

The variables used for measuring quality healthcare formed the thematic areas along which the analysis was conducted. The interviews were translated verbatim to English and transcribed, and those conducted in English were transcribed directly. Informed by the indicators for measuring quality healthcare as identified above, codes from the data were generated to reflect these variables. Some direct quotations reflecting these themes were used to support the discussions.

Table 1. Socio-demographic characteristics of respondents.

Variable	Freq
Gender	
Male	22
Female	34
Age	
20–34	12
35–44	27
45–54	8
55 and above	9
Marital Status	
Married	33
Single	19
Divorced/widow	4
Education	
Primary/Basic/JHS/O'level	18
Secondary/A'level	27
Tertiary	11
Employment	
Formal	10
Informal	37
Unemployed/Student	9
Hospital Attended	
Private	25
Public	31
Frequency of Hospital Visit	
1–2 times	18
3–4 times	32
5 or more	6

Findings

Profile of respondents

The data as shown in Table 1 show that of the 56 NHIS clients who were interviewed, the majority were females and a large proportion were 35–44 years old. All of them had at least primary school education. Many of the respondents were married. About two-thirds (37) of them were employed in the informal sector and very few (9) were unemployed. The majority of respondents visited 2–4 times a year.

Quality healthcare assessment

Ten variables were used to assess the quality of healthcare that the responding NHIS clients received. These variables were structured under three main themes: a) structure (hygienic state of facility and washrooms, access to seats, access to medicines, laboratory/X-ray, nutrition/dietherapy, dental and ophthalmic/eye services, and direction to different parts of the hospital), b) process (attitude of nurses and other healthcare staff, satisfaction with care at reception/records,

Table 2. Framework of indicators for measuring patient satisfaction with quality of care under the NHIS.

Variable	Indicators for measurement
Structure Variable	<ul style="list-style-type: none"> • Washrooms and hygiene state • Access to seats • Access to drugs, laboratory/X-ray, nutrition/dietherapy, dental, ophthalmic/eye services, etc. or referral to these, if needed • Direction to different parts of the hospital
Process Variable	<ul style="list-style-type: none"> • Attitude of clinical and other auxiliary workers <ul style="list-style-type: none"> ○ Satisfaction with care at: <ul style="list-style-type: none"> (i) Reception/records and information department (ii) Consultation (iii) Laboratory/X-ray, nutrition, etc. • Waiting time at the facility
Outcome Variable	Overall satisfaction with the quality of care received under the NHIS

Source: Authors, adapted from Fenny et al. (2014).

consultation, laboratory/X-ray and waiting time at the facility), and c) outcome (overall assessment of the satisfaction with the quality of care that respondents received under the NHIS (Table 2)). The results under each of these indicators are presented below.

Satisfaction with structure indicators

Hygienic nature of the facility and the washrooms. In both hospitals, the respondents acknowledged that there are cleaners who help in ensuring that the facility is clean at all times. Respondents acknowledged that each hospital has adequate washroom facilities in all the various units, and these are easily accessible. All those who attended the private hospital indicated that the washrooms were almost always clean. A greater proportion (22) of those who visited the public hospital also said the washrooms were clean. There were, however, others who were not fully satisfied with the general cleanliness of the public hospital, indicating that some of their amenities were too old and needed refurbishment.

You see, [the public] hospital is a big hospital but I will say they are doing well with ensuring cleanliness in the hospital premises. The only problem is with their washrooms, and some of the facilities are old. (Adri, public hospital)

I can say that there are enough washroom facilities at [the public] hospital and the cleaners are doing their best. However, some of the toilet bowls and the basins are too old. Some are even broken. [The public Hospital] is a prestigious hospital and government needs to intervene. Personally, I think the hospital needs a total refurbishment. (Kwaku, public hospital)

Access to seats. All the participants indicated that there are adequate seats for them in each hospital. When asked whether they have ever gone to any of the hospitals and have had to stand for a while due to the number of patients, none of them answered in the affirmative.

Directions within the hospital. The findings indicate that respondents answered the question on directions to various units and blocks within the healthcare facilities largely based on their levels of education. All respondents with a secondary or tertiary level of education indicated that there are

adequate signposts on where to go. Some respondents with basic education noted that though they see some writings on the walls, they find it difficult to locate certain places. As expected, this was peculiar among first-time visitors.

When the doctor asked me to go to the lab, I had to ask people before I was able to locate the lab. I saw some writings on the wall but even though I could pronounce some few words, I didn't know what they mean. (Ama, Public hospital, basic education)

The way [the private hospital] is, the cashier, lab and pharmacy are all at the ground floor and the consulting rooms are on top, so I had to ask for directions before I could find my way out. (Moro, private hospital, basic education)

Access to laboratory/X-ray services. Fifty-three of the 56 respondents indicated that they were made to pay for some or all their lab tests in both the private and the public hospitals. All the respondents who went to the private hospital said the doctors hardly prescribed medicines without asking them to perform some laboratory tests. However, when they went to do the laboratory tests, the laboratory technician told them that the NHIS does not cover laboratory tests, so they had to pay for them. Thus, for those who accessed healthcare from the private hospital, the NHIS did not cover any of their lab tests. For those who used the public facility, some of the lab tests were covered under the scheme while others were not.

The doctor after prescribing the test for me, when I went to do it, they asked me to pay for the urinal and blood tests because they said the health insurance did not cover those. (Last two years) Two years ago, when I went to the same hospital, the NHIS covered the same treatment, but this time, they said the NHIS does not cover these tests so I don't know whether they have reviewed their policies or not. Only the malaria test was covered. (Kofi, public hospital)

We did only one lab test and I paid for it. We paid GH¢55¹ for the lab test, because according to the technician, it is not covered under the NHIS. (Carl, private hospital)

Some of the lab tests were covered under the NHIS while others were not. I did three different lab tests – two blood and one urine tests. I paid for two of them. (Rose, public hospital)

I paid for all the lab tests. The NHIS covered none. (Betty, private hospital)

Access to medicines. Three major themes emerged from the analysis of the clients' access to medications. The majority of the respondents (34) indicated that the NHIS covered only the 'cheap medicines' among the list of the medications the doctor prescribed. The pharmacist asked them to go and buy the remaining (presumably costlier) medicines outside the facility because the NHIS did not cover them. The majority (25) of them accessed healthcare from the public facility.

For the drugs they wrote for me, I got some at the pharmacy, while for the rest, I was asked to go and buy them from outside. I was told the NHIS does not cover the rest. Those I bought outside were very costly. (Rose, public hospital)

I was asked to pay for all the drugs the doctor prescribed, except for paracetamol and folic acid. These drugs [provided at the hospital] combined do not even cost GH¢5.² (Ben, public hospital)

The NHIS did not cover medication for those who attended a private hospital.

The problem I have with the health insurance is that anytime I go to the hospital [the private hospital], it seems the only thing it covers is consultation. Even the other day, the doctor prescribed dichlofenac for me, but when I went there, it was not given to me. I was told to go and buy it outside. Dichlofenac is less than GH¢10.³ You see, less than GH¢10. So, if the health insurance does not cover such a drug, I don't know how beneficial it is. (Eli, public hospital)

Well, for [the private] Hospital, whether you have health insurance or not, you are required to pay for your drugs and lab tests. (Betty, private hospital)

Finally, only two of the respondents, all of whom sought healthcare from the public hospital, noted that the hospital had some of the medications the doctor prescribed for them, but they were not given to them.

Access to eye and dental services. These are services that only 12 of the respondents had ever accessed. Of the 12, six accessed the care from the public hospital, four (4) from the private hospital, and two (2) from both hospitals. Those who visited the public hospital generally did not pay any fee for these services, but those who visited the private health facility paid for all services and medications except consultation.

Access and quality of nutrition/dietherapy. In Ghana, hospital food is provided only for those who are admitted at hospitals but not for OPD patients. The study found that only the public hospital provides its in-patients with food, three times a day. However, for the few respondents who had been admitted to the hospital, all of them complained about the poor quality of the food.

They provided us with food three times daily for the four days I was admitted there but frankly speaking, the quality was very poor. I only ate the food the first day but for the remaining three days, I didn't even take a bite of it. (Jill)

They gave us food three times every day. In terms of quality, I will rate it as bad because we are sick people who need all the food nutrients to recover. What was served us is not the kind of food to make sick people recover but can even worsen a person's sickness. (Andy)

Satisfaction with process indicators

Satisfaction with care at the reception. The first contact of patients in a hospital is the reception. Hence, patients' assessment of quality healthcare usually begins from the treatment they receive at the reception. As presented in Figure 1, the majority of the respondents (36) were satisfied with how the staff at the reception treated them, but a little over one-third (20) were not satisfied. The disaggregation by type of hospital attended showed that, overall, the majority of the respondents for both the private and the public hospitals were satisfied with the treatment they received at either hospital's reception. Nevertheless, the disaggregated data showed that the vast majority (more than two-thirds) of the respondents who used the private hospital, compared to a fewer number (just a little over one-third) of those who attended the public hospital, expressed satisfaction with the treatment they received from staff at the reception. Respondents who were satisfied explained that the nurses at the reception were friendly to them and treated them well. Others (mostly those who attended public hospitals) considered the treatment they received as normal. Thus, they were treated in a way any professional hospital receptionist would normally treat them.

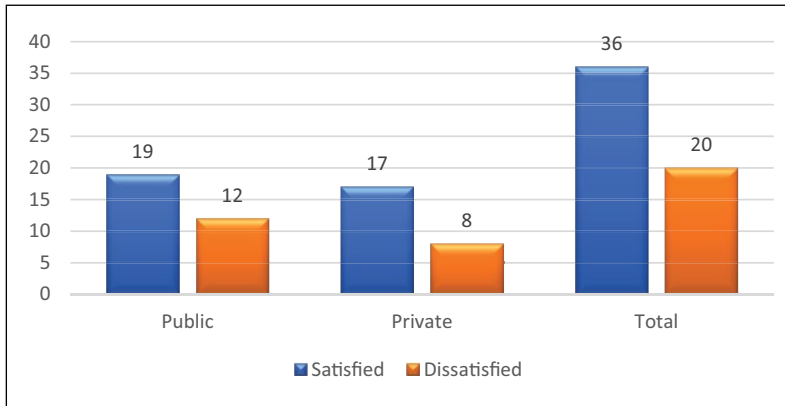


Figure 1. Satisfaction of clients with care at the reception.

The nurses were very responsive, especially in the case of emergency. I had a sickle cell crisis so even though there were people in the queue when I got there, the nurses told the people that my case is an emergency, hence the need to attend to me quickly. They rushed me to the ward, and the doctor attended to me quickly. They give similar treatment to almost all emergency cases. (Fati, private hospital)

They gave me a normal treatment like any nurse in a public hospital. Usually, it is mostly the private hospitals that give patients special treatment but in the public hospitals, they give normal treatment. Nothing unique or different from the normal. (Seth, public hospital)

On the other hand, those who were not satisfied (mostly those who attended the public hospitals) explained that they were treated unfairly at the reception. They explained that instead of attending to those who came in first (i.e., on first-come, first-serve basis), the nurses attended to those who were uninsured first even though they came in later. Others thought the staff at the reception were slow, explaining that they should have acted quicker, given that the number of people in the queue were many.

The fact is that when you have the health insurance, the nurses at the reception do not give you much attention like if you don't have health insurance. (Joana, public hospital)

When you go there with a health insurance card and someone also comes in without a health insurance card, normally, they take care of those without health insurance first before they take care of those with health insurance. So, in a way, it delays those with health insurance as compared to those without the health insurance. So, sometimes if I am in great pain and I need quick treatment and I have the money to pay, I don't show my health insurance card and within a few minutes, I will be out of there. (Eli, public hospital)

Satisfaction with consultation. Fifty-five of the 56 respondents were satisfied with how the doctors treated them. For many of them, the doctors patiently explained the patients' illness to them, the possible causes and how they could prevent it. Some indicated that they came to the hospital with so much fear, not knowing what was wrong with them, but the explanations the doctor gave them calmed their fears. For others too, the level of respect and dignity in the conversations they had with the doctors underpinned their satisfaction. Overall, the doctors were described as 'good, patient, friendly, caring, and empathetic' among others.

The doctor was good. He had time for me and he examined me well. I like the professional way he treated me. He talked to me with respect, using 'please' here and there and listening to me also. (Agya, public hospital)

For the doctor, he was really respectful and patient with such an old person like me. You know many of the aged can sometimes be irritating in even explaining to a doctor what actually worries us. But he had time to listen to all my statements, jotting down some points while I was talking. I thought he will even tell me I was talking too much, but he listened to all I had to say before asking me questions. Doctors are well trained. (Oddy, private hospital)

Attitude of nurses. Even though all the respondents were very satisfied with the quality of treatment the doctors gave them in their last visit, to a large extent, the reverse was the case regarding the nurses. The majority of the respondents stated that some of the nurses behaved rudely, talked to them disrespectfully and were not empathetic towards them. But this behaviour was not applicable to all the nurses because some of the nurses were noted to be respectful and friendly. Others believed that the use of mobile phones during working hours at the hospital contributed to the poor attitude of the nurses.

In the private hospital, there is an inscription that if you are not treated well by a staff, call this number [a number that has been provided]. So, most of them are quite cautious about how they behave towards patients. But in the midst of the inscription, some, especially the young nurses, are very rude as compared to the older nurses. (Abena, private hospital)

Most of them prefer to spend time on their phones rather than to attend to patients. In my last visit, one of the nurses was browsing or chatting on her phone. I asked her a question and she didn't even mind me. When I asked again, she rudely asked me, 'Why are you shouting on me, am I a child to be shouted at?' I quietly left her to ask another person. The government must ban nurses from using phones at the hospitals. (Gloria, public hospital)

Waiting time. Two dimensions of waiting time were assessed in this study: time spent before seeing the doctor and overall time spent at the facility. The analysis was conducted along the type of hospital the respondent attended.

Time spent before seeing a doctor. Figure 2 shows that respondents were most likely to spend between 30 minutes to one hour before seeing a doctor after arrival at the health facilities. As would be expected, however, waiting time before seeing a doctor was relatively shorter for attendees at the private hospital, compared to respondents who attended the public hospital. The respondents explained that, usually, a larger number of people attend the public hospital, causing them to stay in the queue for a longer time.

Because it is a private hospital, I didn't wait for a long time. For the government hospital, the number of people using insurance are many so the queue is very long and you will wait for a long time before they attend to you (Lizzy, private hospital).

As for [the public hospital], if you want to be treated early, you must wake up at dawn and go there to join the queue. When you get there around 5am, then you can rest assured that, all things being equal, you will see the doctor before 10am. (Deacon, public hospital)

Overall time spent at the hospital. Evidence from Figure 3 demonstrates that respondents were likely to spend between one hour to more than five hours for out-patient department (OPD) consultation.

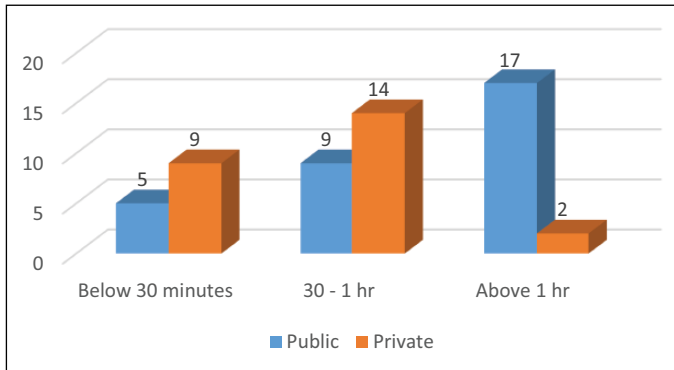


Figure 2. Time spent before seeing the doctor.

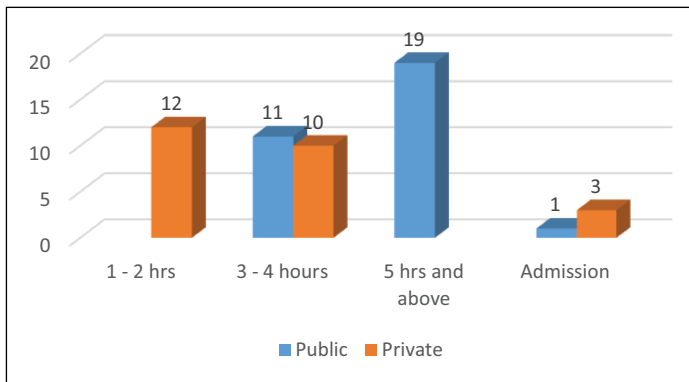


Figure 3. Overall time spent at the hospital.

Overall, the vast majority of OPD attendee respondents were likely to spend five or more hours at the public hospital, while the majority of those who patronised the private hospital were more likely to spend between one to two hours at the OPD. Conversely, the data show that respondents were more likely to be put on in-patient care at the private hospital than was the case at the public hospital (Figure 3).

We spent about five hours. From around 7am when we got there, we left around 1pm. You can imagine what we went through. (Faith, public hospital)

I was there from around 8am to around 3pm. It's like spending the whole day there because of the number of people there. (Yaw, public hospital)

I don't think I spend more than three hours there. Their services are a bit faster and effective so when you get there, you will not keep so long there, especially not in the afternoons or evenings. (Comfort, private hospital)

Overall satisfaction with the quality of treatment under the NHIS (Output)

Based on the indicators stated above, the respondents were asked to give an overall assessment of their satisfaction with the quality of treatment they received under the NHIS on their last visit.

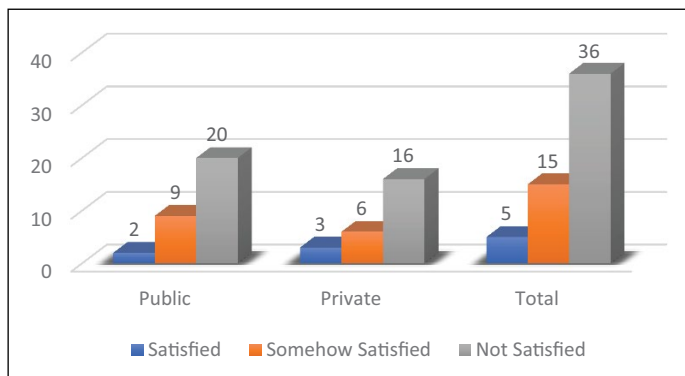


Figure 4. Overall level of satisfaction.

Interestingly, the majority of the respondents (64%; $n = 36$) were not satisfied (Figure 4), mainly because of the additional money they have to pay under the NHIS and the long waiting period. Notably, the satisfaction levels of the respondents in the public and private hospitals were not very different. However, a few (just over a quarter; $n = 15$) of the respondents said they were somehow satisfied. The latter were satisfied with the fact that the NHIS took care of part of their healthcare cost, but were not totally satisfied since they still had to pay additional money.

For me, there is only a thin line between the cash and carry system and the current NHIS system. Apart from consultation, cheap medicines, and malaria test, it seems you have to pay for every other thing. So, we are not being treated fairly. The quality of care under the NHIS is very poor and something must be done about it. (Yaw, public hospital)

The quality of care under the NHIS is really poor, because the NHIS is now not offering us anything substantial. It can't cover quality drugs, lab test and even x-rays and other important treatments. What is the essence of paying a premium if I can't benefit from the scheme? (Peter, private hospital)

I am highly dissatisfied with the treatment we receive under NHIS. What benefit is a health insurance scheme if it covers only cheap drugs and does not cover essential laboratory tests? It's only in Ghana you find an insurance scheme of this nature. Any serious-minded nation will not give their people such health package as health insurance. (Madam, public hospital)

We buy insurance with the motive that in case of any unexpected eventuality, the scheme can assist with some support. The current NHIS is not an insurance scheme. Because it doesn't provide any better healthcare support. We are still under the cash-and-carry healthcare system under the disguise of health insurance. (Kronti, public hospital)

Discussion

Three main variables were used for assessing the quality healthcare under the NHIS from the perspective of respondents. The results show that the satisfaction of subscribers with the structure and process variables were largely influenced by the type of hospital facility the person attended. The output variable, however, shows that, despite the type of hospital attended, the respondents were generally dissatisfied with the quality of care they received under the scheme.

The factors that accounted for this dissatisfaction revolved mainly around the long waiting time, the additional money respondents had to pay under the NHIS to access medicines and laboratory services and the poor attitude of most of the nurses who attended to them. These findings generally confirm the findings by Atinga et al. (2011), who found that the satisfaction of patients is a function of the support/care services they receive at the hospital, the nature of the hospital environment and the time (waiting time) spent at the hospital. The reported long waiting hours supports the study by Dalinjong and Laar (2012), who found that, in the Bolgatanga and Builsa districts in the Northern Region of Ghana, the insured clients disclosed that they wait longer at the hospitals compared to the uninsured. Similarly, in the Dangme West district of Ghana, Bruce et al. (2008) also found that the insured clients they studied spent a longer time at the facility compared to the uninsured. Generally, however, ISSER (2013) attributed the longer waiting time at the government hospitals to the increased use of healthcare facilities, occasioned by the easier access to healthcare for NHIS subscribers.

The complaint on receiving cheap medicines or being asked to buy all medicines supports the findings from the joint research by SEND-Ghana and World Bank Ghana Office (as reported by Ghana News Agency, 2010). They found that the providers themselves agreed that under the NHIS there is a lack of access to the quality and quantity of medicines needed to provide quality healthcare to clients. It is therefore not surprising that the clients complain that they get access only to cheap medicines or do not get any medicines at all. Others are made to buy and pay for medicines out-of-pocket from outside the hospitals.

Whereas all the clients were satisfied with how the doctors handled and treated them, the reverse was the case with the nurses. Many clients had issues with how most of the nurses treated them, irrespective of the hospital they attended. This supports Atinga's (2012) assessment and conclusion on the healthcare quality regarding the services provided by some selected NHIS accredited healthcare centres. The study found that some clients place a high value on the way providers interact with them and the demeanour healthcare providers show towards them. Clients rated the quality of healthcare they received as low when they were treated with disrespect. In Dalinjong and Laar's (2012) study, some of the insured reported that some of the nurses would sometimes abuse them verbally. Even though this study did not gather the views and experiences of the uninsured, it may be somewhat inappropriate to say that the attitude of the nurses is different towards the insured.

In many studies in Ghana and in some other parts of the world, the attitude of some nurses have been described as rude, uncaring, unkind, unsympathetic and often shouting at patients (Awuah-Peasah et al., 2013; Turkson, 2009). The attitude of nurses may therefore not be particular to only NHIS clients. For instance, at the Agogo Presbyterian Hospital in Ghana, Awuah-Peasah et al. (2013) found that nursing students doing their clinical internship at the hospital reported to work late, used mobile phone during clinical hours and showed no commitment to the work. Such nurses are more likely to exhibit uncaring attitudes to patients irrespective of whether they are NHIS clients or not.

Finally, even though all the respondents were satisfied with the cleanliness of the facilities, which supports the work by other scholars like Turkson (2009), concerns were raised with the state of amenities in public hospital. All the concerns centred on the worn-out nature of some of the amenities that need to be refurbished.

Disaggregating the findings by the type of hospital the respondent attended, our data show that the three issues underlying the dissatisfaction with the quality of healthcare were more dominant in the public hospital, but only the out-of-pocket payment was the issue that confronted those who attended the private hospital. The long waiting hours was an issue most of the insured complained about with respect to the public hospital. They, however, attributed this to the fact that the number

of people who attend the public hospital is far more than the number of people who attend the private hospital.

These findings support a recent work by Shabbir et al. (2017), who found that, although there are gaps in the expectations of quality services patients receive from both private and public hospitals, the quality of service rendered by private hospitals – mostly in terms of the quality of the rooms and housekeeping – is better than what is found in public hospitals, while medical services by physicians are better in public hospitals. The findings also support Fatima et al.'s (2018) findings from six private hospitals in Pakistan that patients were satisfied with the quality of healthcare services they received from private hospitals. Shabbir et al.'s (2016) findings also suggested that patients of private hospitals are usually more satisfied with the quality of services they receive, compared to those who attend public hospitals.

The number of people who visited the private hospital was smaller than the number of those who used the public hospital. This may explain why patrons of private NHIS-accredited hospitals get their treatment within a relatively shorter time period, compared to the government-run hospitals. At the private hospital, it was made explicit to clients that their card (membership of the NHIS) entitles them to only consultation and they will have to pay for all other services and supplies, including laboratory test and medicines. In the public hospital studied, respondents were asked to buy prescribed medicines out-of-pocket from outside the hospital. Even when they were lucky to be given medicines, only the cheap ones on the approved drug list were given. This confirms the findings by SEND-Ghana and World Bank Ghana Office. Overall, the NHIS clients who were studied were not satisfied with the quality of healthcare they received under the scheme. This corroborates findings by Fenny et al. (2016), which suggests that the poor quality of healthcare clients receive under the NHIS is a contributory factor to the low uptake and renewal of health insurance in Ghana.

The state of service delivery under the NHIS, as evident in this study, may be attributed to the reported challenges the scheme is facing. Some of these are low premiums, untimely payment of claims to service providers, corruption by some service providers, politicisation of the scheme and lack of clear guidelines to beneficiaries (ISSER, 2015). These challenges saddle the scheme and make it difficult to operate successfully. For instance, if beneficiaries are given prescriptions to buy medicines on the approved list out-of-pocket, will they be reimbursed? At where, and with what procedure? These are unclear in the policy. As found in this study, apart from consultation, the private hospitals make subscribers pay for all the other essential services and also ask them to buy their prescribed medication, mainly because of the delays they encounter in the processing and payment of NHIS claims. It is, therefore, not surprising that, in February 2016, Health Insurance Service Providers Association (HISPAG) and some pharmacies resorted to the cash and carry system because of delays in claims payments (Okertchiri, 2016).

The dwindling quality of care under the NHIS has long been recognised by the NHIA and was stated in its 2012 annual report. The NHIA acknowledges that the scheme is suffering from quality issues, explaining that

the increased attendance at many healthcare facilities coupled with poor attitude of some health workers has affected the quality of care received by NHIS subscribers. This is manifested in some providers extorting monies from the subscribers under the pretext of co-payment – an illegal form of cost sharing. In some cases, NHIS subscribers are given prescription forms to purchase medicines from pharmacies and chemical shops instead of being served at the healthcare facility. (NHIA, 2013: 40)

Despite this recognition, it seems little has been done to improve the quality of service.

Conclusion

The NHIS is a good initiative, which the respondents rightly acknowledge. Among its goals is the effort to provide Ghanaian residents with affordable quality healthcare. While results from previous assessments of the scheme indicate that it has contributed positively to the healthcare of the populace, such as increasing the timely utilisation of out-patient services, and thereby possibly reducing in-patient admissions and in-patient bed occupancy days (ISSER, 2013), the results from this study mostly confirm other factors in recent times: there are signs that NHIS clients are currently receive falling quality of care under the scheme. These discrepancies may be explained by the numerous challenges the scheme faces currently.

The NHIS clients in this study expressed dissatisfaction with essential structure indicators (such as access to lab/X-ray services, access to medication, eye/dental services and quality of food served during in-patient care) as well as the process variables (poor attitude of nurses and long waiting hours). The outcome indicator – the overall satisfaction with the scheme – also received a poor assessment, as the majority of our respondents were dissatisfied with it. As the quality of care under the scheme reduces, our study adds to the literature that confirms that the confidence of the populace covered under the scheme has the potential to reduce, with resultant negative repercussions on the utilisation of healthcare under the scheme as well as the quality of health outcomes in Ghana (Yaya et al., 2017). Undoubtedly, it will affect the continued patronage and thus the solvency of the scheme, due to the dwindling trust clients have in it. Consequently, there is the need for a re-evaluation of the quality assurance dimension of the NHIS given the emerging findings questioning the quality of healthcare the scheme is providing to its clients.

Improving on quality healthcare delivery under the NHIS will require consistent financial support from the government to pay the arrears and claims of providers so that they can enhance the quality of services they provide to clients. This should be done alongside putting in place clinical audit mechanisms to ensure that service providers are providing clients with the quality of care required. To reduce the time spent at healthcare facilities by NHIS clients, the NHIA should introduce innovative healthcare service delivery models that will be more community-based. Many community-based clinics and the Community Health Planning Services (CHPS) compounds (centres with basic healthcare personnel and services the Ghana Health Service sets up in some communities that lack such basic services with the aim of increasing geographical access to healthcare) can be accredited and resourced to provide primary services to NHIS clients, thereby reducing the pressure on the hospitals.

The NHIA must also endeavour to sensitise the public on the list of diseases, treatments and medicines covered under the scheme. These should be fliers posted at vantage points in the hospitals to inform clients of the benefits they are entitled to or otherwise. Periodic bi-annual patients-based national customer satisfaction assessments are needed to ensure that providers are delivering the high-quality service to clients. This can be a basis for the renewal of service provider certification and will hopefully put the providers on their toes to provide clients with the highest possible quality of service under the scheme that can meet their healthcare needs and enhance their health status. Finally, further research, including the use of qualitative methods, should investigate why NHIS subscribers are kept longer at public healthcare centres compared to the uninsured.

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Supplemental material

Supplemental material for this article is available online.

Notes

1. This translates into \$14.32 at a Ghana Cedi exchange of 3.84 as of 25 May 2017 when the data was collected. Source of Exchange rate: Oanda <https://www.oanda.com/currency/converter/>
2. This translates into \$1.30 at a Cedi exchange of 3.84 as of 25 May 2017 when the data was collected
3. This translates into \$2.29 at a Cedi exchange of 4.37 as of 14 June 2017 when the data was collected. Source of Exchange rate: Oanda <https://www.oanda.com/currency/converter/>

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