UNIVERSITY OF CAPE TOWN

CRITICAL EVALUTION OF THE ROLE OF COMMUNITY BASED HEALTH INSURANCE SCHEMES IN EXTENDING HEALTH CARE COVERAGE TO THE INFORMAL SECTOR IN GHANA

By:

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DECLARATION:

This thesis in its original form is entirely mine and has not been submitted to this University or any institution of higher learning for any award. It is a product of my original work and data collection in Ghana between December 2005 and February 2006. Other sources are fully acknowledged.

Signed by candidate

... ...

Collins Akuamoah Danso

Date: ... ...

DEDICATION:

This dissertation is dedicated to my beloved mother, whose tired less efforts have brought me this far in life; and to the loving memory of my late father.

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EXECUTIVE SUMMARY

One major challenge facing the international development community is how to finance and provide health care for the large informal sector in low and middle income countries. This is as a result of the inability of the traditional tax systems in most of these countries to generate the needed revenue to help meet the health needs of the citizens. In recent times, many countries in developing countries are increasingly depending on Community Based Insurance Schemes (CBHIS) as an alternative health care financing mechanism.

In Ghana, the universal tax funded system of health care introduced in 1957 soon after independence could not be sustained because of economic recession in the 1970's and 1980's forcing the government to introduce user fees in all public health institutions. User fees resulted in a decline in utilization of health services especially the poor and vulnerable group. This situation forced many communities to set up CBHIS meant to cover user fees charged at the health facilities. The success of some of these schemes and the fact that many Ghanaians do not have insurance cover led the government to introduce a National Health Insurance Scheme (NHIS) which is mandatory for all citizens. The law mandates all formal sector workers to contribute part of their social security contribution to the National Health Insurance Fund as premium, thus making it compulsory for them. Those in the informal sector are however required to voluntarily pay directly into their district schemes. Also, even though a proposal has been made to exempt the poor, no mechanism has been determined to identify poor households for subsidy.

This study sought to undertake a critical evaluation of the role of CBHIS under the NHIS in extending health care coverage to the large informal sector (who are about 70% of the active labour force) in Ghana. Specifically, the study sought to determine factors that affect enrolment, to determine a practical mechanism to identify the poor and to gain an understanding of how other countries have increased health insurance coverage. It is a case study of three district schemes and employs qualitative techniques using focus group discussions, key informant interviews and record reviews.

Findings from the study show that enrolment levels in all the district schemes are low. One of the factors that contributed to low coverage was that the premium levels were not affordable to many households. The study found that flat premiums charged by all the schemes contrary to the initial arrangement under the NHIS to graduate premium according to income levels in each district served as a barrier to many households. Also, service delivery was found to be unsatisfactory. This includes poor quality of care and physical access barriers to health facilities in some districts. Another major problem identified was low public education on the NHIS.

Regarding Ghana's vision of achieving universal coverage, international literature shows that Ghana has followed most of the steps necessary to reach her goal. This includes mandating health insurance for all Ghanaians and exempting the poor. Also the current economic growth of Ghana is found to be promising. However, relatively low urbanization and a large informal sector was found to be unfavourable compared to other countries that have universal coverage.

To ensure that the poor are not denied access to quality health care, the study came up with a practical mechanism that can be used to identify the poor. A list of indicators that compares favourably with other studies both within Ghana and other developing countries have been identified. Also, the need to select committee members in each community to take advantage of rich local information in the selection exercise is presented. The study came up with a scoring system to ensure consistency in the application of the indicators at the community level.

To ensure equity in the contribution level, it is recommended that a mechanism should be put in place to help classify the population in each district into their socioeconomic group so that district schemes can charge premiums according to individuals' ability to pay. This study suggests further research on the quality of care at the health facilities on a national scale to consider both structural quality of care and client satisfaction levels. This will help the country to identify all the problems in the health institutions for immediate remedial action.

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ACRONYMS

AGM	:	Annual General Meeting
CBHIS	:	Community Based Health Insurance Scheme
CBT	:	Community Based Targeting
DANIDA	:	Danish International Development Agency
DDHS	:	District Director of Health Service
DHMT	:	District Health Management Team
DMHIS	:	District Mutual Health Insurance Scheme
FGD	:	Focus Group Discussion
GA	:	General Assembly
GDP	:	Gross Domestic Product
IDA	:	International Development Association
ILO	:	International Labour Organization
IMF	:	International Monetary Fund
LI	:	Legislative Instrument
MHO	:	Mutual Health Organization
MOH	:	Ministry of Health
NGO	:	Non-Governmental Organization
NHIC	:	National Health Insurance Council
NHIDL	:	National Health Insurance Drug List
NHIR	:	National Health Insurance Regulation
NHIS	:	National Health Insurance Scheme
NPP	:	New Patriotic Party
OPD	:	Out Patient Department
PCHIS	:	Private Commercial Health Insurance Scheme
PMHIS	:	Private Commercial Mutual Health Insurance Scheme
PWR	:	Participatory Wealth Ranking
SHI	:	Social Health Insurance
SSNIT	:	Social Security and National Insurance Trust
SHIR	:	Subsidized Health Insurance Regime
UNDP	:	United Nation Development Program
VIP	:	Visual Indicators of Poverty
WHO	:	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

How to finance and provide health care for more than 1.3 billion rural poor and informal sector workers in low and middle-income countries has in recent years become the biggest challenge facing the international development community (Preker et al 2002). Adequate, well managed financing of public health systems continues to be a problem in most countries. The difficulty is more severe in the low-income countries in which health systems struggle with meager and inequitably distributed resources (Palmer et al 2004).

The traditional tax funded health system in the developing world is unable to generate the needed resources due to the lack of a robust tax base and a low institutional capacity to effectively collect tax (ILO 2001). The last decades have seen reforms in health financing in many countries in the developing world. Community Based Health Insurance Schemes (CBHIS) have in recent times become an important alternative way of financing health care to help meet the health needs of the poor and the informal sector of many countries in Sub- Saharan Africa.

Financing health care in Ghana has gone through a checkered history. At independence in 1957, Ghana introduced a universal, tax-funded system of health delivery. Under this system, everyone was treated freely in the public health institutions and the cost was simply absorbed by the government and passed onto the taxpayer. So long as the economy was booming as the case was until the sixties, this system worked well, with just a minimal cost to the health consumer (Kwegyir-Aggrey 1998). The sustainability of this form of financing became questionable as the economy began to show signs of decline in the 1970's and 1980's, as there were competing demands for limited resources. The level of general tax revenue did not allow for a sufficiently large percentage to be earmarked for health resulting in under funding of the health budget (Ministry of Health 2002).

This situation continued until 1985 when the government introduced user fees for all medical conditions except certain specified communicable diseases, with the primary

objective of raising additional revenue and to improve efficiency of service delivery at the public health facilities. This system of financing, popularly known as the "Cash and Carry" system, resulted in the first observed decline in utilization of health services in the country, creating a financial barrier to access to health care among poor households (Waddington and Enyimayew 1989). It is estimated that out of 18% of the population who require health care at any point in time, only 20% are able to access it, implying that about 80% of the population who require health care cannot afford it (Ministry of Health 2002).

The problems associated with user fees prompted some communities in Ghana to find alternative ways of meeting their health care needs. In 1992, the first CBHIS was launched by the people of Nkoransa district in Brong –Ahafo region with assistance from the Catholic health service. Since then, several communities have initiated schemes that were meant to assist in meeting their health needs. These schemes are funded by prepayment contributions and cover user fees when a member uses a health service. Partners for Health Reforms, an International Non Governmental Organization (NGO), collected information on a total of 47 CBHIS in Ghana, in a nationwide survey in 2001. These schemes were located in 34 of the 110 districts in the country, 30% were fully functional while the remaining 70% were at various stages of gestation (Atim et al 2001). The study revealed that about 29% (13) of the schemes were targeted to cover the total population of the entire district while 71% of them were small localized schemes whose target varies in size and nature, from community level schemes through small professional associations, to ethnic or religious groups. Many of the individual schemes were small with only four schemes having more than five thousand (5000) members.

Additionally, most of the schemes charge flat premiums per beneficiary. In terms of benefit package, the survey found that the services covered fully by most schemes were drugs, x-ray, hospitalization and complicated delivery. Family planning, normal delivery and health center care were usually not included in the benefit package. While 28.6% of the schemes cover the full cost of normal delivery, about 71.4% only do so for complicated delivery. Also, about 22% of the schemes provided cover for only a percentage of hospitalization cost while the remaining portion is born by

insured members. Only a few schemes provided both inpatient and Outpatient Patient Department (OPD) services for their members.

The survey further found that even though the schemes were providing financial protection against the cost of ill health for their members, their small sizes did not allow for a large risk pool thereby threatening the sustainability of most of the schemes. The voluntary nature of the schemes and non-enforcement of household registration led to the registration of illness prone members leaving the strong and healthy ones unregistered. It was further noted that most of the management personnel of the schemes lack skills including risk management, community mobilization and participation as well as monitoring and evaluation of the schemes.

The success story of some of the schemes (improving financial access to poor rural dwellers) as well as some of the challenges aforementioned and considering the fact that a vast majority of the population still pay health care bills out of pocket prompted the government to find a national policy of financing health care that will help address the health care needs of the entire population. As a commitment to its election promise, the New Patriotic Party (NPP) government (the ruling government), when it assumed power after the 2000 national elections adopted national health insurance as a preferred health care financing system for providing access to health care for its citizens. Preparatory work started with the setting up of a Ministerial Task Team on Health Care Financing in 2002 to work out the modalities for the establishment of National Health Insurance Scheme (NHIS) in the country. The National Health Insurance Bill was passed in Parliament in September 2003.

The National Health Insurance Act, Act 650 (Government of Ghana, 2003) mandates the establishment of an independent body corporate known as the National Health Insurance Council (NHIC) with the primary objective of securing the implementation of the NHIS programme. The NHIC is responsible for the registration, licensing and regulation of health insurance schemes in the country. It also has the role of supervising the operations of schemes, to grant accreditation to health care providers and to monitor their performance. The council is further responsible for managing the National Health Insurance Fund.

The law allows three types of health insurance schemes to operate in the country namely: District Mutual Health Insurance Schemes (DMHIS), Private Mutual Insurance Schemes (PMHIS) and Private Commercial Health Insurance Schemes (PCHIS). The DMHIS and the PMHIS are to register with the registrar general under the company's code, Act 179 as a company limited by guarantee whiles the PCHIS are to register as a limited liability company. In addition, all the schemes are obliged to register with the NHIC before they can operate in the country. With the coming into force of the National Health Insurance law, all the existing CBHIS have the option of operating as a DMHIS, PMHIS or to cease operating.

The DMHIS receive government financial support and are under strict control of the state. All workers in the formal employment sector who contribute to the Social Security and National Insurance Trust (SSNIT) fund, whether in the public or the private sector will have their deductions made at source from their SSNIT contributions as their premium and later channeled to their DMHIS. Those in the informal sector will have to make direct contributions to their district schemes. The administration of DMHIS is decentralized to the district level with each district having its Board of Trustees (responsible for the direction of the policies of the schemes and appointment of employees). The day to day administration of the schemes is done by a six member management team namely: the Scheme Manager, Accountant, Management Information system Manager, Public Relations Officer, Claims Manager and a Data Entry Clerk.

The design of the DMHIS has an in-built equity in financial contribution mechanism based on ability to pay and not on need. To achieve this goal, the contributions in the informal sector have been categorized into socio-economic groups namely: the core poor, poor, middle income and the rich. The core poor (indigents) are exempted from paying any premium (Ministry of Health 2004). Also, the National Health Insurance Regulation (NHIR) 2004, LI 1809, (Government of Ghana 2004) stipulates a relatively comprehensive benefit package comprising both outpatient and inpatient care with few exclusions (see appendix 5). The law mandates every Ghanaian to be a member of a scheme that adequately offers financial protection.

1.1 STATEMENT OF THE PROBLEM.

The vision of government in instituting the NHIS is to ensure equitable universal access for all residents to an acceptable quality of essential health services without out of pocket payment at the point of use of service. To achieve this vision, the government has set short, medium and long- term objectives. Within the next five years (short term), it is envisaged that the necessary bodies will be established, and consensus building carried out and at the same time, efforts will be made to achieve at least 30-40% national coverage. In the medium term (within 5 to 10 years), the objective is to cover 50-60% of the population and eventually to cover every resident in the long term (Ministry of Health 2002).

The NHIS is aimed at fusing the concept of Social Health Insurance (SHI) and CBHIS (DMHIS). The National Health Insurance law mandates all formal sector workers to contribute two and half percent of seventeen and half percent of their contribution to the SSNIT as their premiums into the district schemes. This means that all the formal sector workers and their dependents will automatically be covered by the NHIS. However, those in the informal sector, who constitute about 70% of the population, will be required to voluntarily contribute to their district schemes.

The voluntary nature of the district – wide schemes and the fact that the poor and vulnerable dominate this overwhelming 70% of the population within the informal sector poses a serious challenge to the nation's vision of achieving universal health coverage even in the long term. Also, to ensure equitable universal access to affordable health care means that a mechanism should be put in place to identify the poor for subsidy. While in the NHIS, proposals have been made to exempt the poor, to date no practical mechanism has been developed to identify the poor. The understanding of the role which CBHIS can play in extending health care coverage to the large informal sector in Ghana will go a long way in helping the nation to achieve her vision of universal coverage.

1.2 RATIONALE/JUSTIFICATION FOR THE STUDY.

Evidence from the literature has shown that CBHIS in low and middle-income countries have a low coverage rate (Bennett Creese, and Monasch 1998; Atim 1998; Musau 1999) and sometimes there is evidence of a reduction in enrolment over the

years (Criel and Waelkens 2003). The implication of low coverage is that the vast majority of the people within the communities with CBHIS lack access to quality health care.

To date, the underlying reasons for low coverage have not been fully established and until this apparent problem is resolved, achieving universal health coverage will be difficult. This study seeks to fill the gap by exploring the underlying reasons for low coverage in CBHIS and the associated issue of identifying and exempting the poor, so that the findings can feed into national policy and assist in the implementation of mandatory health insurance in Ghana.

1.3 AIM AND OBJECTIVES OF THE STUDY

AIM

The aim of the study is to critically evaluate the role of CBHIS (under the NHIS) in extending health care coverage to the informal sector.

OBJECTIVES

- To determine factors that influence people's decision to join CBHIS in Ghana.
- To determine a practical mechanism to identify the poor.
- To gain an understanding of how other countries have increased health care coverage.
- To provide policy recommendations on how to promote greater coverage through the NHIS based on the findings of the research.

1.4 ORGANISATION OF THE STUDY

The report is divided into six chapters, including this chapter, which gives an introductory background of the study. Chapter two consists of a literature review relating to CBHIS, international experience of countries that have achieved universal coverage as well as various mechanisms of identifying the poor. Chapter three examines the methodology of the study. Research findings and analysis are presented in Chapter four. Chapter five contains a discussion of the findings. In Chapter six, conclusions of the study and recommendations for health policy and planning are presented.

CHAPTER TWO

2. 0 LITERATURE REVIEW.

This chapter reviews literature on CBHIS and its role in extending coverage to the informal sector. It first of all gives a definition and basic principles of CBHIS. A critical overview of enrolment and factors that influence the decision to join CBHIS is presented. It also gives information on mechanisms to identify the poor. International experience from countries that have achieved universal coverage is also presented. The chapter provides an overview, based on empirical evidence from previous studies conducted of what we currently know and gaps in current knowledge.

2.1 MEANING OF HEALTH INSURANCE

According to Arhin- Tenkorang (2001), health insurance is a mechanism of spreading of risk of incurring health care cost over a group of individuals or households. Kutzin (1995 p.17) also considered health insurance as "a means of financial protection against the risk of unexpected and expensive illness". A more elaborate meaning is provided by Ron, Abel-Smith and Tamburi (1990). In their opinion, when the risk and resources among large group are pooled together with different probabilities of requiring health care, the health security of each individual among the group is greatly enhanced and therefore adequately insured.

Three key themes emerge from the definitions above namely: uncertainty in ill health, risk pooling and financial protection. Because of uncertainty in timing of ill health, health insurance helps people to save towards future cost. This assists in protecting the individual against critical financial losses as a result of expensive illness. Again, within the group of insured, there may be healthy and rich as well as sick and poor ones. Health insurance is a mechanism for risk sharing where the healthy individuals cross subsidize the sick ones. Additionally, there could be income cross subsidy where the rich pay more to cross subsidise the poor. This ensures welfare gains among insured members.

2.1.1 Definition and principles of CBHIS

CBHIS, also known as Mutual Health Organization (MHO) can be defined as "an autonomous not- for –profit organization based on solidarity between members and

that is democratically accountable to them" (Atim 2000 p.4). The primary objective is to improve members' access to quality health care through risk sharing based on their own financial contribution. According to Dror and Preker (2002), CBHIS is a generic expression used to cover a large variety of health financing arrangements namely micro insurance, community based fund, mutual health organization, rural health insurance and revolving drug funds. This means that the name and design of scheme may differ from one geographical area or country to another.

CBHIS may develop around a geographical area (village or district), trade or professional groupings (such as trade unions or agricultural co-operatives) or health care facilities. These schemes are typically designed by and for the informal sector who are unable to secure adequate public, private or employer sponsored health insurance. Membership in the schemes is voluntary.

One fundamental principle of CBHIS is community solidarity, which is the expression of empathy with the more disadvantaged without expectation of direct reciprocal obligation from the recipient at the time of giving. However, the giver is assured of reciprocity in the future if he/she also becomes disadvantaged or in need (Atim 2000). Thus members willingly agree to contribute resources into a common pool to help each other when in need of medical care. Also, members enjoy freedom of association without any form of discrimination related to sex, religion, gender or political affiliation. While some CBHIS may be managed by central government organizations using local officials, others are managed by the community members or an NGO in cooperation with community members.

One common feature of CBHIS is its simplicity. Many people in the informal sector are illiterate and therefore cannot cope with complicated procedures. Therefore, CBHIS is designed in a way that makes its operation simple e.g. flat premium, uniform benefit package, forms are kept short and record keeping is generally manual (Tabor 2005). Additionally, CBHIS often depend on continuing external support. Such support may be provided by donors, central or local government or sometimes international NGOs. According to research conducted by Baeza, Montenegro and Nunez (2002) on CBHIS (in Africa, Asia, South Pacific, Latin America and the Caribbean) government provides support in 86% of the 256 schemes reviewed, and in

75% of the schemes, donors and NGOs support their operation. Also, CBHIS tend to complement publicly financed health care. Public resources contribute the bulk of the financing of the health risk of the schemes' members by providing preventive health care services and subsidizing certain portions of health care delivery cost (Tabor 2005).

2.2 INSURANCE COVERAGE UNDER CBHIS

Even though CBHIS have been found to provide financial protection to the informal sector by reducing out of pocket payments and by increasing access to health care as (demonstrated by an increase in utilization), coverage has been low (Ekman 2004; Musau 1999; Atim 1998; Bennett Creese and Monasch 1998). A comprehensive World Health Organisation (WHO) review of 82 CBHIS for the informal sector in developing countries indicated that few schemes covered large populations or even covered a large proportion of the eligible population. From a subset of 44 of the schemes, the median value of the percentage of the eligible population covered was 24.9%, 13 schemes had a coverage rate below 15% and 12 schemes had coverage above 50% (Bennett, Creese and Monasch 1998). Low percentages of enrolment were also observed in a study of five CBHIS in East and Southern Africa. In four schemes, enrolment percentages vary from 0.3% and 6.5% of the target population; one scheme is very small with 23 members out of a target population of 27 cooperative society members (Musau 1999). There are strong indications that the poor are excluded and perhaps those in need may still have difficulty in accessing quality health care (Ekman 2004). The low coverage rate makes it practically difficult to offer adequate financial protection for those who need health care especially the poor and vulnerable in the informal sector.

A few schemes have however made significant progress in increasing coverage. A study on the Bwamanda Hospital Insurance Scheme in D.R. Congo shows that in 1986, when the scheme was established, 28% (32,600 people) of the eligible population joined the scheme within four weeks. Membership climbed to 66% in 1993 and seems to have stabilized at 61% in 1997 (Criel 1998). Also, a study on the Lalitpur Scheme in Nepal shows that population coverage in the target area rose from 19-29% in 1983 to 48% in 1995 (Harding 1996).

Several factors may influence people's decision to join or not to join. Atim (1998) reports that the affordability of the premium can determine membership. For instance in the Nkoransa scheme in Ghana, the estimated cost of contribution varied from 5% to 10% of annual household budget thus serving as a barrier to enrolment. Contributions are also generally levied as flat sums, which do not favour inclusion of the poor. Flat rates are generally regressive, as on the average, a flat contribution as a percentage of income is higher for the poor than the rich (Carrin 2003). Therefore, graduation of the premium based on income levels has been found to help to make premiums affordable to poor households. One such scheme, which from the beginning of its operations introduced a pro-poor policy, is the Gonosasthya Kendra (GK) Scheme in Bangladesh (Desmet, Chowdury and Islam 1999). Contributions to the scheme vary according to one of four socio-economic groups namely: destitute, poor, middle class and rich. The contributions for destitute for instance were one – tenth of the contribution proposed for the highest income category. An important finding was that membership rates in the two lowest socio-economic groups are higher than in the other groups. Even though the contribution levels help bring equity in access to insurance, the scheme may face sustainability problems since drawing in more poor than the rich may jeopardize the scheme's financial viability.

Also, the technical arrangements made by the scheme management may influence people's perception about personal benefit. Using the household as a unit of membership may help avoid adverse selection but at the same time prevent families with large household size from enrolment if contributions are per beneficiary (Bennett, Creese and Monasch 1998). A more flexible arrangement where there is a greater probability of a larger households enrolling can help increase coverage. A study by Schneider and Diop (2001) on fifty four (54) CBHIS in three districts in Rwanda found that large households with more than five members had a greater probability of enrolling in CBHIS than others did. Contributions were kept flat, irrespective of household size up to seven members; the average contribution per household member was therefore less than for smaller families, thereby inducing enrolment.

Timing of collection of premiums may also matter for membership. Flexible payment systems with monthly, quarterly or semi annual payment will help reach out to people

who don't earn monthly income or have unstable income. In the ORT Health Plus Scheme in the Philippines, Ron (1999) reports that premium payment is flexible with monthly, quarterly or semi-annually options. Flexibility was introduced as it was found that few households were able to prepay a one year or six months membership. Also, schemes collecting premiums during the harvest period have been observed to help the poor rural farmer (Bennett, Creese, and Monasch 1998).

Furthermore, trust in the integrity and the competence of managers in CBHIS may affect enrolment. The existence of an entry point in the community such as micro credit schemes or other social groups and how such initiatives win the population's trust may influence enrolment (van Ginneken 1999). Trust can also be enhanced when people see that their preferences matter. People's overall satisfaction with the scheme is likely to increase when scheme administrators tend to be responsive to the community preferences and therefore involve them in decision making (Carrin, Waelkens and Criel 2005). A study by Jakab et al (2001) shows that in Rwanda, democratic management of the scheme led to the inclusion of poor households. Regular community level meetings and allowing members to vote at meetings were identified as key in shaping the preferences and attitude of households towards investment in their health.

Additionally, public education on CBHIS can influence membership. In the Philippians, Ron (1999) has observed that the ORT health plus Scheme managed to reverse the drop in membership encountered in the first year (1994) through intensive public education. It was reported that the scheme launched a competitive promotion campaign at the community level, spreading the message of the benefits the people stand to gain from enrolment, such as free hospital admission and OPD services. This campaign helped to motivate people to enroll and so by the end of 1996, membership increased from around 220 families (in 1994) to 400 families. By the end of 1997, membership reached 550 families. Conversely, low public education can have a negative influence on enrolment. In the Chogoria Hospital Insurance Scheme in Kenya, a market survey in 1998 among 1000 residents in the hospital's catchment area found that only 236 (24%) were aware of the existence of the scheme (Research International (EA) Limited 1999). Low public education was identified as one of the

factors that affected enrolment, which stood at 0.3% of the target population (Musau 1999).

The attractiveness of the benefit package can influence members' desire to subscribe to CBHIS. Devadasan et al (2004) report that in India, the ACCORD Community Health Insurance Scheme was able to enjoy high patronage from the community because of the creation of an attractive benefit package that suited the needs of the people. These include free OPD and inpatient care at the hospital and removal of exclusions. It was noted that these incentives made the health insurance acceptable to the community.

Criel and Waelkens (2003) have noted that quality of care offered through the scheme may also influence people's decision to enroll. This was highlighted during an evaluation of the Maliando Scheme in Guinea-Conakry. The poor quality of care offered at the contracted health facilities resulted in a drop in enrolment from 8% in 1998 to 6% in 1999. Also a study by Allegri, Sanon and Sauerborn (2006) to determine factors that influence demand for health insurance in rural West Africa observed that poor quality of care has a negative influence on enrolment. Out of 32 household heads interviewed, 16 expressed dissatisfaction with the quality of care at the contracted health facilities. Criticisms were focused on long waiting times, excessive prescribing and differential treatment depending on the patient's socio-economic status. It is however significant to mention that in schemes where the contracted service providers offer quality care, enrolment levels has been encouraging. For instance Criel and Kegels (1997) report on their evaluation of the Bwamanda Hospital Scheme (after 10 years of its operations) that the high quality of care offered at the hospital motivated more people to subscribe to the scheme resulting in high enrolment levels.

Household geographical location or distance to health facilities has been found to influence subscription to CBHIS (Carrin 2003; Allegri, Sanon and Sauerborn 2006). Schneider and Diop (2001) report that in Rwanda, households who lived less than 30 minutes from participating health facilities had a much larger probability of enrolling in CBHIS than those who lived far away. Also in the Gonosasthya Kendra (GK) scheme in Bangladesh, membership among the lowest socio-economic groups

appeared to be related to distance. About 90% of the target population from the nearby villages subscribed whereas only 35% did so for the target population in the distant villages (Desmet, Chowdury and Islam 1999).

2.3 INTERNATIONAL EXPERIENCE ON UNIVERSAL COVERAGE

International literature on countries that have achieved universal coverage has the potential of shaping policy decisions of countries whose health policy aims at achieving universal coverage. The section therefore highlights key factors that facilitate the journey to universal coverage.

One question that remains of paramount importance to the majority of countries in the world is the ability of their health financing systems to provide adequate financial protection for the whole population against the cost of health care. Universal coverage has always been the ultimate goal, which can be achieved either through general tax revenue or health insurance coverage (Carrin and James 2004). Kutzin (2000) defined universal coverage as "physical and financial access to necessary health care of good quality for all persons in a society. It implies protection against the risk that if expensive (relative to an individual family's means) health care services are needed, services of adequate quality will be physically accessible, and the cost of these services will not prevent persons from using them or impoverish their families"

Several countries both in the developed and developing world have struggled over the years to achieve this goal. Evidence from the literature shows that countries like Korea, Germany, Thailand, and Taiwan that have been able the achieve universal coverage adopted an incremental approach where insurance coverage starts from a certain group of people or workers and is later extended to other segments of the population. (Tangcharoensathien, Wibulpholprasert and Nitayaramphong 2004; Barnighausen and Sauerborn 2002; Peabody, Lee and Bickel 1994). In Korea for instance, the government incrementally established an employer- based health care scheme by first mandating coverage for businesses, then government employees and teachers. Coverage was later extended to the poor, self-employed and residents in the rural areas (Peabody, Lee and Bickel 1994).

A review of experiences of eight countries in the implementation of SHI and eventual achievement of universal coverage by Carrin and James (2005 p.2) indicated that the transition period in most of the countries was long. They defined transition period as "the number of years between the first law related to health insurance and the final law voted to implement universal coverage". Germany was noted to have had the longest transition period of 127 years, followed by Belgium 118 years, Israel 84 years, Austria 79 years, Luxemburg 72 years, Japan 36 years, Republic of Korea 26 years and finally Costa Rica 20 years. It was further noted that extending coverage to certain population groups is more difficult than extending to other groups (examples are casual workers and the self employed). In Germany for instance, coverage increased from 10% to 50% in 47 years (from 1883-1930). Another 58 years were needed to extend coverage to 88% by getting on board the self-employed workers to SHI. Likewise in Austria, it took 40 years (1890-1930) to move from 7% to 60%, but another 35-37 years were needed to extend insurance to farmers and civil servants, reaching 96% coverage.

Several enabling factors have been identified in the literature to contribute to the achievement of universal coverage. In Thailand, clearly sustained economic growth with an increasing public budget and a reduction in debt repayment played a role in achieving universal coverage (Tangcharoensathien, Wibulpholprasert and Nitayaramphong 2004). Also, Carrin and James (2005) have noted that economic growth in most of the countries studied was high during the transition periods. In Belgium and Germany, Gross Domestic Product (GDP) per capita had more than quintupled by 1970 whereas in Austria, GDP per capita had more than quadrupled. In Costa Rica, economic growth in the 1950's was quite high pushing GDP growth rates to 7 percent.

A legal requirement for health insurance coverage has also been observed as a key prerequisite towards achieving universal coverage. In Thailand, the incremental approach by the government could not achieve results until in 2001 when reform aimed at universal coverage was launched mandating every citizen to be covered by insurance scheme (Tangcharoensathien, Wibulpholprasert and Nitayaramphong 2004).

Carrin and James (2004) in their study on reaching universal coverage via social health insurance in European and Asian countries noted that in Western Europe and Asia the formal sector is growing and this enhances the enrolment of workers in a systematic way, including workers in mining and industry as well as the agricultural sector. For instance in Germany, agriculture and forestry workers were already covered by insurance by 1911. The relatively small informal sector makes universal insurance coverage easy.

The distribution of the population in a country has also been found to be key in the journey towards universal coverage. Growing urbanization and increased population density help in reducing administrative cost as a result of greater efficiency in identifying and registering SHI members and collection of premiums. In the Republic of Korea for example, the urban population was 36.6% of the total in 1966. This climbed to 48.4% in 1975 (two years after SHI became compulsory). In 1980, the urban population was 57.3% (Korea Bureau of Statistics 1980). Growing urbanization has been found to have contributed to the speedy transition to universal coverage in Korea.

To ensure that the poor and vulnerable are not denied access to affordable health care, government subsidizes the premium of those in low-income groups and where necessary exempts the poor from paying contributions. In Japan, 50% of the premium for self employed individuals covered by the NHIS is subsidized by the state and in Korea, farmers, taxi drivers and fishermen as well as the rural population enjoy subsidies in their premium payment (Peabody, Lee and Bickel 1994).

2.4 MECHANISMS TO IDENTIFY THE POOR

Evidence has shown that the very poor are seldom enrolled into CBHIS unless their premiums are subsidized, usually by government, NGO's or donors (Bennett Creese and Monasch 1998). To ensure that the poor and vulnerable groups in society are not denied access to basic social services such as health care, many countries in recent times have developed various mechanisms to identify the poor for subsidy. However there are several problems hampering this laudable equity goal. Ravallion (1993) has observed that lack of information is a serious constraint to targeting social programs effectively especially in less developed countries. As government and aid agencies are

not well informed about who is rich and who is poor, the rich can misrepresent themselves and claim benefits. Additionally, lack of clear identification criteria, non-availability of guidelines for implementers of the programme and lack of monitoring and evaluation have also been identified as some of the problems affecting targeting programmes in developing countries (Bitran and Giedion 2003). In effect, many public spending programs intended for the poor tend to enrich the ineligible to the disadvantage of the poor.

Two major problems result from poor targeting namely: under coverage (error of exclusion) and leakage (error of inclusion). Under coverage occurs when those who deserve the benefit (the poor) are denied protection from the programme. This error may arise when stringent screening mechanisms are used to identify the poor, reluctance of potential beneficiaries to be tagged as poor or lack of knowledge about the programme by potential beneficiaries (Bitran and Giedion 2003). For instance, Munro (2003) reports that in Zimbabwe, the stringent screening mechanism used to identify applicants for the Public Assistance programme introduced in 1988 (to cater for the needs of the chronically poor) is one of the factors that accounted for the low coverage. It was reported that in 1992, the programme covered only 0.5% of poor households.

Leakage on the other hand is where someone who is not poor is classified as poor. In effect protection is awarded to non-target individuals (Bitran and Giedion 2003). This problem normally arises when the screening process is relaxed such that the rich can manoeuver their way through to benefit from the program. In practice, no targeting mechanism can simultaneously prevent these two inappropriate targeting outcomes. The process involves a trade off. Newbrander and Collins (1999) have observed that effort to reduce leakage tend to reduce the number of the rich as well as the poor beneficiaries which increases under coverage. In the same vain, attempts to minimize under coverage by applying the screening test more generously may result in high leakage.

Conning and Kevane (2000) refer to targeting methods as a set of rules, criteria and other elements of a program design that define beneficiary eligibility. This means that different methods may have different results depending on the criteria used to identify

the poor at the community level and its effectiveness will also depend on how strictly the rules are adhered to. Three broad targeting methods are employed in practice, namely: geographical and categorical targeting, self-selection/targeting and individual/household assessment/targeting (Conning and Kevane 2000; Coady, Grosh and Hoddinott 2004; Alderman and Lindert 1998)

2.4.1 Geographical Targeting

This involves directing resources to areas in which on average poverty appears to be greatest (Akerlof 1978) and sometimes may involve restricting of benefits to identifiable social groups such as single women with children, ethnic groups or the elderly (Appleton and Collier 1995). Under this method, different parts of the country – region, province, district or city blocks are ranked by some measure of deprivation. This measure may be income based, or include indicators of health status, educational and nutritional status and access to basic services (Schady 2000).

The main attraction of geographic targeting is its simplicity. Regions can be assigned priority on the basis of existing data. No new or complex administrative mechanism for selecting beneficiaries individually is required. For instance given that a carefully conducted household survey shows that the vast majority of people (85%) in a defined geographic area are poor, it will be more cost effective and efficient to target the entire region than trying to assess individual characteristics to single out the non eligible population (Bitran and Giedion 2003). This method has become increasingly important in Peru in targeting the poor and the potential pay off is large (Schady 2000).

Additionally, this method has relatively little influence on household behaviour, since it is difficult and costly for a household to change its place of residence to become eligible for the subsidy (Bigman and Fofack 2000).

It is also possible to improve targeting by combining the geographic targeting with other eligibility criteria based on individual or household characteristics. For instance in Mexico, geographic targeting is used to identify communities with a high marginality score and access to education and health care providers, and then a proxy

means test based on household variables are used to identify poor households into their cash transfer programme known as PROGRESA (Coady and Parker 2002).

However, the 2000 United Nations Development Program (UNDP) Poverty report has indicated that geographical targeting may leave out poor communities in non-poor provinces. It also naturally includes many non-poor households. Therefore the leakage of the benefit can be significant. For instance, by targeting poor counties, China's poverty program allocates too few resources to poor townships and villages outside poor counties (UNDP 2000). Also, a simulation of geographic targeting in Venezuela at the state level by Baker and Grosh (1994) indicates that both under-coverage and leakages rates are very high. For example using a composite index ranking system, under-coverage was 66.5% of those the program was meant to help. In other words, although 30% of the population was poor and meant to be helped by the program, only 10.1% were correctly assigned to receive benefit. Also, leakage of the program benefit was 62.5 % of the program budget. In other words, about two thirds of the transfer budget leaks to the rich who are not meant to be reached by the programme.

Narrowing the geographic targeting to a town or village instead of targeting the entire region or state has been found to increase accuracy in identifying the poor. Baker and Grosh (1994) report that in Mexico, a simulation performed at the state and locality (corresponding to a village level) indicates that both leakage and under coverage improves as the geographic unit is narrowly defined. They observed that when targeting at the state level, leakage and under coverage were 61% and 59% respectively. These rates dropped significantly to 37% when targeting was done at the locality level.

Bigman and Fofack (2000) have noted that income disparities in smaller geographic areas tend to be similar since such areas have more homogeneous socioeconomic and geographic conditions. Therefore, targeting in such smaller areas reduces leakage substantially. Additionally, the selected villages will be spread across all regions rather than concentrating the program to a few regions. This will help minimize political and ethnic tension which normally accompanies regionally targeted programmes.

2.4.2 Categorical Targeting

This targeting method uses some basic characteristics of the person or household or area as grounds for inclusion in a beneficiary group. The most common characteristics used are individual demographics such as children, elderly, gender (e.g pregnant women). It is also possible to use ethnicity, race or language in targeting benefits (Leatt, Rosa and Hall 2005). Exemption policies in many developing countries use categorical targeting. For instance in Ghana, the government exempts pregnant women, children under five years and people over 70 years from paying user fees in public health facilities (Garshong et al 2001). In South Africa, both young children and the elderly are identified as in need of support on grounds that they are not able to provide for themselves by way of wage income (Leatt, Rosa and Hall 2005).

This method is fairly easy to implement and less costly since it does not require much information in identifying the individual. However, since the non poor can fall into the characteristics used, there is the likelihood that considerable leakage will occur. At the same time, there may also be under coverage as some of the poor may not fall into the exempt groups (Tien and Chee 2002). For instance being aged or pregnant does not necessarily means that you are poor and therefore this method could lead to poor targeting results.

2.4.3 Self- targeting

This method takes advantage of differences in participation cost (opportunity cost) across households to get non-target households to self-exclude. Under this method, the benefits of a transfer are ostensibly made available to all consumers, but the program is specifically designed so that the non-poor elects not to take up this transfer (Alderman and Lindert 1998). For instance this may involve:

- The use of low wages on public work schemes so that only those with low opportunity cost of time due to the low wages or limited hours of employment will present themselves for jobs.
- The restriction of transfers to take place at certain times with a requirement to queue. The assumption is that the opportunity cost of queuing is less for the poor than the rich.

- The allocation of point of service delivery in areas where the poor are highly concentrated so that the rich have higher costs of access, for instance operating a health center in a predominantly poor neighbourhood. Users of the facility will be the poor whereas fewer non-poor will seek health care there because of the stigma, long waiting times and lack of amenities.
- Price subsidies for inferior items. For such items, consumption declines as income increase. An example is yellow corn (Coady, Grosh, Hoddinott 2004).

One major advantage of this targeting method is that its information requirement is relatively less cumbersome. The choice of which commodity or services to subsidize is generally based on survey data on household behaviour (consumption patterns) which is less costly to collect than assessment of individual income or other indicators which are prone to inaccuracies (Besley and Kanbur 1988, Besley and Coate 1991). Also, self-targeting may be less vulnerable to bureaucratic corruption and manipulation than other targeting methods (such as means–testing which may require a beneficiary roster). Additionally, this method is less divisive and more politically acceptable than individual assessment and geographical targeting mechanisms since the decision to participate is made by the individual rather than the state or the agency offering the program (Alderman and Lindert 1998).

However, an evaluation of this targeting mechanism has been found to be disappointing. In India, there has been considerable experience with food for work and employment creation programs designed to attract the poor by offering below market clearing wage rates. Evaluation reports have revealed serious under-coverage. For instance in the 1990's the Employment Assurance Schemes offered an average of only 17 days of employment per person per year against a target of 100 days. Also the relatively high leakages in this targeting method have led to high cost in transferring benefit to the poor. Again in India, a comparison of Employment Guarantee Schemes and food subsidies suggest that the cost of transfer is almost double the benefit received by the poor (Weiss 2005). There are also indications that the opportunity cost associated with this method for the poor reduces the net gain from participation. For instance queuing the whole day before one can have access to an intervention can be

very frustrating. It is also possible for the rich to enjoy the benefit by delegating the wife or house help to join the queue thereby defeating the objective of self-targeting.

2.4.4 Individual/household targeting

Under this method, eligibility is directly assessed on an individual or household basis. One such approach is the means test, which involves the collection of information on household income and comparing the income with a predetermined threshold or poverty line (Behrman 2001). This method requires the existence of verifiable records and the administrative capacity to process the information and update it regularly (Coady, Grosh and Hoddinott 2004). One advantage of means testing is that it is aimed directly at poverty so in some respects, it is the standard which one can use to assess poverty and also other targeting mechanisms rely on it as a basis (Behrman 2001).

However, this targeting mechanism has been found to be plagued with serious problems especially in the developing country context. Firstly, households tend to underestimate their income particularly from self-employment and informal sector work, which is the main source of income of the poor in developing countries. This problem normally arises because of lack of formal reporting requirements such as income for tax, and also illiteracy as well as high variability of income of these categories of people and considerable information required to calculate net income on farm and other owner operated enterprises (Behrman 2001). For instance in Zimbabwe, Loewenson (2000) reports that the income criteria adopted to determine programme eligibility (Social Development Fund) for the poor proved rigid and hard to apply because only 20% of the population worked in the formal sector and most applicants had in kind or an irregular flow of income. The World Bank (1998) indicates that overall, in the Zimbabwean fund, only 20% of the population of the urban poor and 10% of the rural poor received assistance suggesting low coverage of the programme to the poor.

Another limitation of this method is that using household income rather than consumption as a central indicator can be misleading. This is because adverse shock (such as famine, theft, fire outbreak) may cause some households' income to fall below the predetermined threshold and this may call for social assistance. However, if

households have sufficient coping strategies, its consumption may not be much affected or at all. Using income rather than consumption as an indicator will warrant policy intervention when there is in fact, not a need for one (Behrman 2001).

Another method using individual or household targeting is a proxy means test. This method uses more easily observable household indicators to proxy for income to create an index that is then used to compare with a threshold to determine programme eligibility (Behrman 2001). These indicators are highly correlated with income and may include land ownership, location and quality of dwelling, ownership of durable goods, demographic structure of the household and the educational level of the adult members of the households. The indicators are used as a checklist to screen out better off households. Field staff visits each village and use the checklist to exclude the rich in each village and then make a personal visit to the remaining households to conduct interviews (Coady, Grosh, Hoddinott 2004).

This method has been found to be less subject to under reporting since the indicators are visible and verifiable compared to income (Behrman 2001). In Columbia, a proxy means testing instrument known as System for Selecting Beneficiaries of Social Spending (SISBEN) uses indicators such as availability and quality of housing, number of durable goods or assets and human capital development (educational level of adults in the household) to determine program eligibility. It is a statistically derived means test index that serves as an indicator of household economic well being (Castaneda 2005). Sanchez and Nunez (1999), report that programmes that use SISBEN show the largest gain in targeting. For instance, the Subsidized Health Insurance Regime (SHIR) meant to provide insurance cover for the poor and being the largest user of SISBEN has been found to improve targeting performance. The report indicates that coverage of the poorest quintile increased from 8% (in the urban areas) and 2% (in the rural areas) in 1993 to an overall average of 47% in 1997.

Similarly, a CASHPOR House index developed by a network of Grameen Bank replications in Asia Pacific regions for their members uses houses and sometimes the compound as a crude indicator to eliminate the non poor households. A more detailed household interview is conducted to determine programme eligibility among the remaining households (Simanowitz, Nkuna and Kasim 2000). This method has been

found to be cost effective and powerful in identifying the poor but the authors cautioned that the method is only good in areas where a relationship exists between poverty and housing. In other words, where it is clear that living in a bad-housing structure indicates poverty and a better one indicates (relative) wealth. For instance, where the poor have benefited from a public housing programme, this method cannot be used to distinguish between the poor and non poor.

Differences in individual country characteristics and possibly different areas within countries must therefore be considered in making targeting decisions. Munro (2003) has indicated that in developing countries where illiteracy is high, it makes little sense to require a potential beneficiary of a program to fill in forms as part of a means test as such requirement may only serve to discourage an otherwise eligible beneficiary. Coady, Grosh, Hoddinott (2004) have observed that most interventions using means and proxy means – testing are concentrated in Europe, Central Asia, Latin America and the Caribbean. A legacy of the central planning era in Europe and Asia is an extensive administrative system suited to individual assessment using some form of means or proxy-means testing.

An increasingly popular approach to household targeting, especially in developing countries, has been to decentralize the selection process to the local people using community leaders or a group of community members to identify the poor. Conning and Kevane (2000 pp. 376) define Community –Based Targeting (CBT) "as a state policy of contracting with community groups or intermediary agents to have them carry out one or more of the following: identify recipients for cash or in- kind benefits, monitor the delivery of those benefits and/or engage in some part of the delivery process". The community agents may include social or religious groups, Non- Governmental Organizations (NGO), local elected officials or governing body, traditional leaders and semi formal or informal village council.

One of the earliest and most studied examples of CBT mechanisms was the English system of poor relief. For several hundreds of years, until the reforms in 1834, the English poor law implemented a highly decentralized system of poor relief administered by local parishes. Even though the parishes were serving as local church

institutions, they were responsible for deciding who is unable to work and deserves to be given assistance.

Another historical example of CBT comes from colonial experience. Indirect rule using local authorities by the French and British to administer their colonies especially in Africa also serves as a reference point of community intermediation. Chiefs, Sheikhs and Emirs were supposed to be more accountable to their subjects and seem to know more about their needs than expatriate administrators (Conning and Kevane 2000).

A recent survey of dozens of country experiences of social safety nets conducted by Subbarao et al (1997) for the World Bank contends that programs that involve communities, local groups and NGOs can achieve better targeting outcomes. One argument in favour of CBT is access to better information. Local community agents often have better information on household characteristics, needs and recent events upon which to condition beneficiary eligibility than an outside welfare agent who must rely on crude or outmoded proxy indicators (Cremer, Estacha and Seabright 1996; Rai 2001, Conning and Kevane 2000). For instance, Alderman (2002) concludes in his evaluation report of the Economic Support programme in Albania that local officials may know that some households have income sources, including transfers and savings that were not covered by questionnaires. Similarly, they may know transitory income shocks such as illness or crop failure that can bring current income levels down.

Additionally, community agents may be in a position to employ more socially desirable or locally adapted criteria for assessing needs. It also ensures better enforcement of rules for selection and may involve relatively small administrative cost (Conning and Kevane 2000). Also, households will be less able to conceal information about their economic situation from the locally based authorities than from those at the national level (Alderman 2002). Another advantage might include the fact that such participation and ownership by the community members might increase political support and sustainability of the programmes at the local level (Behrman 2001). The net effect is that CBT helps improves targeting accuracy. Alderman (2002) noted in his evaluation report in Albania that virtually 50% of the

poorest families receive assistance from their Economic Support programme. In contrast, relatively few of the comparatively well off households receive assistance which implies that leakage was relatively low.

One problem with this method is that it may lead to or increase conflict and division within the community. This could also undermine political support for other more effective targeted approaches (Conning and Kevane 2000). Conflict may arise where there is unfairness or favouritism in the selection exercise. Bitran and Giedion (2003) report that in Thailand, community leaders had incentives to allocate exemptions to provide personal and political favours and lacked the skills to identify the poor by themselves.

A more innovative approach to CBT has emerged in recent years where investigators use community members themselves instead of community agents to identify poor households (Dzikunu and Wajangi 2004; Simanonitz 2000). One of such approaches is Participatory Wealth Ranking (PWR). This involves using reference groups from the community to define their own concept of poverty and sorting households according to their criteria. This process involves writing the names of all households in the community on cards and asking various reference groups to sort these households into piles according to their wealth status. The rankings by one reference group are then crosschecked with other reference groups for any inconsistencies until the final list of poor households is generated.

A pilot study by Simanonitz (2000), comparing this targeting method with Visual Indicators of Poverty (VIP) which focused on physical characteristics of a house which could easily be assessed by a field worker without entering the house such as the physical condition of a house, the size, type of roofing and type of construction of house as a checklist to identify the poor, observed that the PWR appears to be very accurate in identifying the poor household compared to VIP. The VIP failed to identify over a quarter of the poorest households but falsely classified over a quarter of the richest households as among the poorest. These results convinced the local NGO – Small Enterprise Foundation - which was involved in poverty focused micro-credit program in the northern province of South Africa to operationalise the PWR in place of VIP.

One limitation of this method is that sometimes it may be difficult to obtain full or open participation from a community. For example, problems have been reported when participants are reluctant to exclude fellow villagers from participating in a credit programme leading to high number of people being ranked as poor. Additionally, in Mirzapur, Uttar Pradesh, India, it was found that the methodology required lengthy periods (days) of gaining confidence from the villagers before agreeing to have an open discussion on sensitive issues such as who is poor and who are better off (Simanowitz, Nkuna and Kasim 2000).

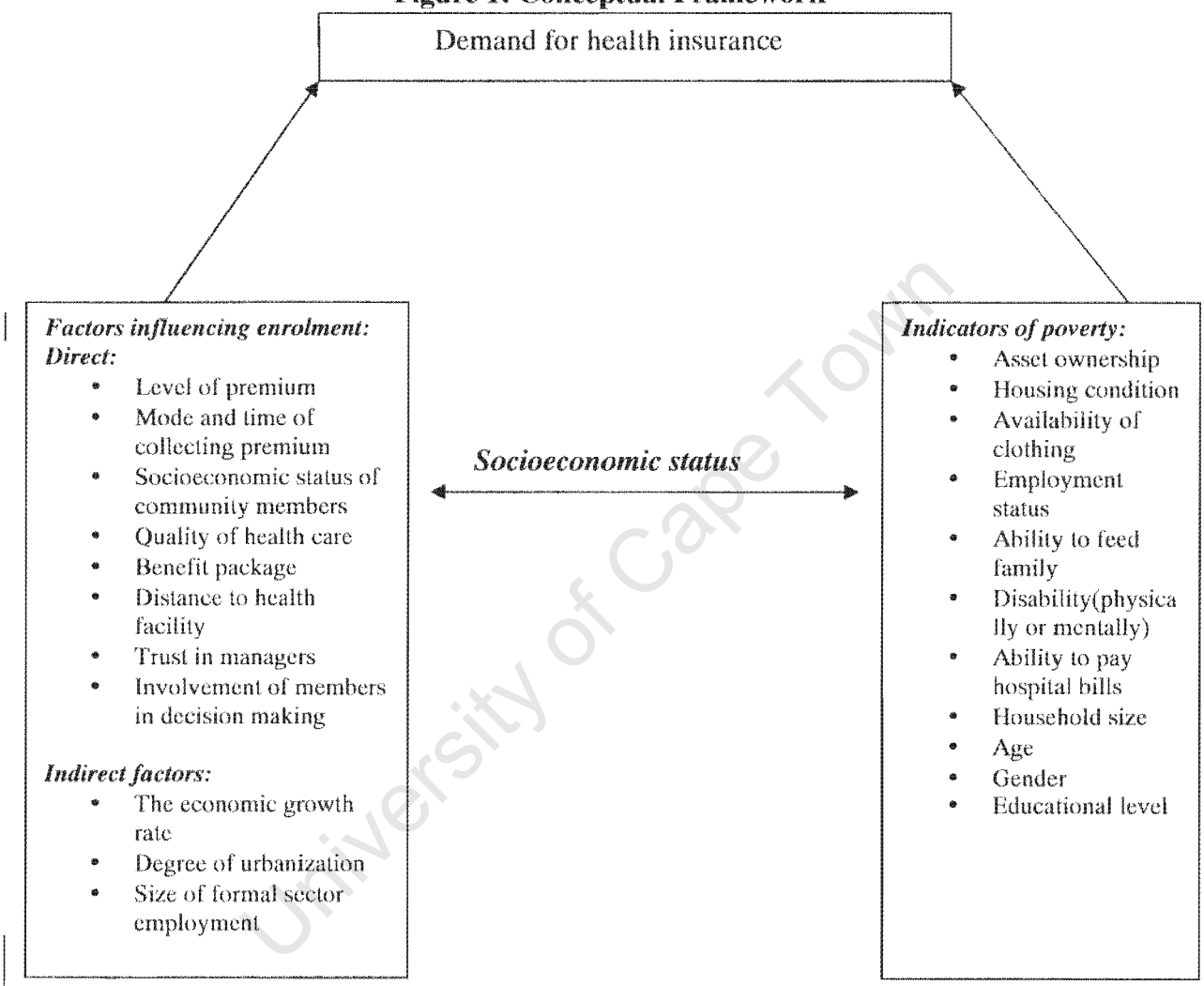
Another pilot project on mechanisms for identifying the poor using community members has been reported in northern Ghana. The investigators conducted a consensus-building workshop of all stakeholders on criteria for defining who is poor. The participants came up with a definition of poverty and how one could practically identify the poor. The indicators developed at the workshop were tested in 60 communities in each of the five health sub-districts using focus group discussions. The purpose of the test was to find out whether the people at the village level agree with their colleagues who attended the workshop. The findings from the focus group discussions were used to finalize the checklist of who should be considered as poor to enjoy health insurance subsidies. Some of the indicators identified in the study include: availability of clothing, the condition of the house (dilapidated), ability of pay school fees and health care bills, aged and disability (physically or mentally) (Dzikunu and Wajangi 2004).

2. 5 CONCEPTUAL FRAMEWORK

This section summarizes the literature review in this chapter and provides a framework for analyzing demand for health insurance. Fig 1 outlines the framework for analyzing factors that influence people's decision to join CBHIS. It also looks at the criteria to look for in identifying the poor in the community. Favourable factors, all other things been equal, may encourage more people to demand health insurance. However, the socioeconomic status of certain individuals or households especially the poor and vulnerable groups may not necessarily allow such people to enroll. Therefore the framework further highlights key characteristics of such poor

households who should be identified within the community to enjoy a government subsidy. Proper identification of such poor households and also addressing the concerns of the people such that health insurance becomes more attractive to the people, will increase enrolment as indicated by the arrows.

Figure 1: Conceptual Framework



CHAPTER THREE

3.1 STUDY DESIGN

The study design for the research is that of case studies of selected CBHIS, employing largely qualitative techniques to critically evaluate the role of CBHIS in extending health care coverage to the informal sector. A qualitative approach was chosen because it allows the researcher to understand how the subjects of the research perceive their situation and their role within the context (Katzenellenbogen et al 1991). Qualitative research also studies things in their natural setting, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them. As the aim of the study is to solicit people's views, opinions and perceptions on insurance, this method was found to be helpful in getting a deeper understanding into the research topic.

3.2 POPULATION

The study population was all the 47 district-wide schemes that were currently operating under the NHIS in Ghana, the scheme managers and all members and non-members of the scheme.

3.3 SAMPLING

Purposive sampling was used to sample schemes. Three schemes were selected out of the 47 schemes currently operating under the NHIS. The main criteria for selecting the schemes were the number of years of operation of the scheme before the institution of NHIS, the scheme must have been integrated into the NHIS program and the income levels of the people within the district. These criteria were chosen because long-term experience with CBHIS will help in soliciting the required information from people. Also, differences in income levels across the districts will influence the decision to join or not to join.

3.3.1 First District Scheme

The Nkoransa district is located in the Brong – Ahafo Region. The Nkoransa District scheme was established in 1992 and happens to be the oldest scheme in Ghana. The district has a total population of 147,946. Major economic activities in the district are farming and petty trading. Nearly 45% of the population is poor and 17% are hard-

core poor (Atim and Sock 2000). The scheme has officially been registered under the NHIS programme.

3.3.2 Second District Scheme

Dangme West district is located in the Greater Accra region. The district scheme was established in the year 2000. The total population of the district is about 115,000. The District is one of the purely rural districts in the Greater Accra region. The population is engaged predominantly in subsistence agriculture and fishing. Poverty is widespread with a mean annual household income of c369, 800 ($US 513.61), (Arhin 1995). This Scheme has also been integrated into the NHIS programme.

3.3.3 Third District Scheme

The Kwahu South district is located in the Eastern region of Ghana with a population of 230,000. The scheme was established in November 2001. The major economic activities in the area are cash crop farming and commerce. The inhabitants of Kwahu are noted for high skills in trading in urban centres, therefore wholesale business and retailing have also become major economic activities. Income levels are relatively higher than the other districts selected. The scheme has been registered into the NHIS programme

3.4 FOCUS GROUP DISCUSSIONS

Twelve Focus Group discussions (FGD) were conducted in the three districts with four in each district. Each group consisted of 6-8 respondents. Membership status (insured or non- insured) and gender were considered in constituting participants in each FGD. Additionally, discussions were restricted to only household heads. This is so because in the Ghanaian context, household heads decide over allocation of resources and therefore their acceptance of an intervention, which requires households to invest a considerable amount of their income in paying premiums, will matter in insurance enrolment. Separate FGD were conducted for household heads of the opposite sex since again, in Ghana, women don't normally feel comfortable to express their views when their male counterparts are there. In all, there were two FGD each for the insured and the non- insured respectively in each district. Information on insurance status was collected from various schemes records and was used to select

participants. The selected insured members were used as key informants in selecting the non-insured in each community for the FGDs.

3.5 KEY INFORMANT INTERVIEWS

Purposive sampling was employed in selecting participants for interviews. The rationale for this technique was to select people who have experience and ideas about CBHIS and can share their experience. Also as one of the objectives of the study is to find a practical means of identifying the poor, it was necessary to get ideas from community leaders within the study area. In all, a total of 18 people were selected and they include:

- Insurance Manager/ Coordinator (1from each scheme) 3
- Traditional leaders (2 from each district) 6
- Assembly members (2 from each district) 6
- District Director of Health Services (1 from each district) 3

3.6 TRAINING OF RESEARCH ASSISTANTS AND PILOTING

Two research assistants were trained for two days. Areas covered included how to observe and record proceedings as well as how to take notes during the discussions. The principal investigator led both the FGDs and the Key informant interviews (as it required considerable experience and skills in leading people) while the research assistants' role was to record proceedings and to take notes. As part of the training, role-play FGDs were conducted to offer practical experience to the research assistants. The guide for key informant interviews was pre- tested with the Scheme Manager, an assemblyman, a chief and the District Director of Health Services (DDHS) all in the Birim South District of the Eastern region. Also, four pilot FGDs were conducted; two with the insured and two with the non-insured in the same district. All the questions were asked in Akan language. Piloting served the dual purpose of ensuring that all relevant issues were included and also to resolve any ambiguities in the questions. At the end of piloting some of the questions had to be rephrased to make the meaning clearer.

3.7 INSTRUMENTS FOR DATA COLLECTION

The main data collection instruments were interview schedules (both structured and semi- structured) and record review.

3.7.1 Key informant interview schedules

Information from respondents was collected by means of semi – structured interviews (see appendix 3 and 4). All selected individuals were initially contacted and asked whether they would be willing to participate in the interview to share their opinions on the NHIS regarding factors influencing enrolment as well as how to identify the poor at community level. If interested in participation, an appointment was booked for the interview. Before conducting the interviews, the interviewer and two research assistants introduced themselves, explained the aim of the visit and asked for explicit consent to record the interview. Also, notes were taken by one research assistant. With the exception of interviews with the DDHS and Scheme Managers which were conducted in English, all the remaining interviews were conducted in Akan language (local language in Ghana). The length of the interviews ranged from twenty to thirty minutes. No one refused to be interviewed or to have the interview recorded.

3.7.2 Focus group discussion.

In all 12 FGDs were conducted, 4 in each district using semi- structured open-ended questions (see appendix 2). Topics covered centered on their views on the NHIS and factors that influence their decision to register or not. Questions were also asked on whom they think should be considered as poor to be eligible for government support, the suitable community structure to identify the poor and how the selection exercise could be monitored. Before conducting the interviews, the interviewer and two research assistants introduced themselves and explained the aim of the FGD. Participants were informed to express their views freely on all the topics and were assured of the anonymity of their responses. The principal investigator led all the discussions. Proceedings were recorded on tape (after seeking consent from participants) as well as through note taking. One research assistant was responsible for recording proceedings while the other took notes. All discussions were held in local Akan language and later transcribed and translated into English by the principal investigator. The average length of the discussions ranged from thirty to forty five minutes.

3.7.3 Record review

Secondary data were collected from the schemes regarding their total enrolment over the years disaggregated into formal sector and informal sector. Other information included reports on their annual general meetings (if any), the number of service providers contracted by the schemes, contractual agreement with providers (if any) as well as the marketing strategy they have adopted in reaching the informal sector especially at the village level.

3.8 DATA PRESENTATION AND ANALYSIS

Data is presented using tables and narratives. The results of the FGD and key informant interviews were transcribed and translated from the local language into English by the principal investigator. Translations were checked for accuracy and omissions. All the responses were first coded. Major themes were identified using the conceptual framework in Fig 1. All codes that relate to a particular theme were pooled under one heading. For instance all responses regarding the affordability of the premiums were grouped under the label 'contribution level'. The major themes identified from the FGD were analyzed in conjunction with information from the key informant interviews and record reviews. Analyses of the findings were conducted using the conceptual framework in Fig 1.

3.9 ETHICS

An introductory letter from the Health Economics Unit, (UCT) and letter of approval from the UCT Ethics Committee were obtained and given to the DDHS as well as the management of the schemes for their permission to conduct the study in their districts. Informed consent of all participants of the interviews was sought and participants were assured of the anonymity of their responses. Participant's consent was also sought before recording proceedings at the interviews and the FGD. Study subjects were informed that participation was entirely voluntary and were free to withdraw at any time (see appendix 1)

3.10 LIMITATION OF THE STUDY

One limitation of the study is the relatively small sample size considering the fact that Ghana has 138 administrative districts. At the time the study was being conducted, only 47 of the districts have started the implementation of NHIS in their districts.

Many of those in operation however did not meet inclusion criteria since most of them were new schemes (less than one year) and therefore had no insurance experience. Therefore, the study does not provide a reflection of the socioeconomic and cultural conditions of the entire country and therefore caution should be taken in generalizing the findings to the entire country. However, it is significant to mention that many of the districts in the country have visited one or two of the study district schemes for practical implementation guidelines because of their relatively long time experience in CBHIS and so serve as model schemes for the country. Therefore conducting a study on their operations could give useful information on CBHIS in the country.

CHAPTER FOUR

4.0 FINDINGS

This section presents the findings of the study in relation to the objectives. It is divided into three sections. The first section describes the background, operations and administration of schemes, section two looks at data on enrolments and factors influencing enrolment and the final part focuses on identification of the poor for subsidy.

4.1 BACKGROUD AND OPERATION OF THE SCHEMES

4.1.1 Nkoransa District Insurance Scheme

Background

The idea of starting a health insurance scheme in the district was raised at a meeting of Catholic Church Hospital Administrators in Sunyani in 1989. This was as a result of patient's inability to settle medical bills at health facilities following the introduction of user fees in 1985. Approval for a pilot project in St Theresa's hospital at Nkoransa was obtained in 1990/91 under the leadership of Dr. Ineke Bossman, the then Administrator and district medical officer of health in charge of Nkoransa. The scheme was officially launched in 1992 with a funding pledge from Memisa, a Dutch Christian NGO which promised to meet any expenditure shortfalls (deficit) by the scheme for its first three years of operations. Membership is open to all residents in the district. The scheme has been formally integrated into NHIS programme.

4.1.2 Dangme West District Insurance Scheme

Background

The need to set up an insurance scheme for the informal sector in the district was raised at a discussion held between the then Director of Ghana Medical Stores, Dr. M. Adibo and then DDHS in Dangme West in 1991. Following the discussion, he linked the DDHS to Dr. Dyna Arhin, formerly with the planning unit of the Ministry of Health (MOH) but then studying for a PhD in Health Economics. As part of the fieldwork of her PhD thesis, Dr Dyna Arhin worked with the Dangme West District Management Team to collect empirical data on the possibility of setting up an insurance scheme in the district. The results of the study suggested that households in the study area were risk averse and were prepared to be part of a solidarity group that

collected contributions regularly from members and used the contributions to take care of health care costs. As a follow up to this study, in 1996, the District Health Medical Team (DHMT) decided to work with the District Assembly, other stakeholders as well as the community to set up a district insurance scheme. The scheme was officially launched in the year 2000 and is open to all residents in the district and any resident of areas surrounding the district who are interested in joining. Many of the target population of the scheme are in non-formal employment or self-employed and are living at or near the poverty line. The scheme has officially been integrated into the NHIS program.

4.1.3 Kwahu South District Insurance Scheme

Background

The idea of establishing the district health insurance scheme was conceived by the Management of Holy Family Hospital (a mission health provider) in 1999. This was motivated by the financial troubles encountered by the hospital as a result of patients' inability to settle their bills after they have been discharged. This resulted in many unpaid bills crippling most activities of the hospital, as there was no way of recovering such bills. Not willing to compromise on the quality of service offered to patients, the hospital settled on health insurance as a way out with support from the Danish International Development Agency (DANIDA). The scheme was officially launched in 2001 and is open to all residents in the district without any discrimination related to sex, ethnicity, class, political or religious conviction. The scheme has been formally integrated into the NHIS.

4.1.4 District Profile of the Schemes

The Nkoransa District is located in the Brong Ahafo region (in the middle part of Ghana) while the Dangme West and Kwahu South Schemes are located in Southern Ghana in Greater Accra and Eastern regions respectively. The Kwahu South district has the highest population size while the Dangme West District has the lowest. Agriculture is the major economic activity in all the districts and in the case of the Nkoransa District, it employs about 95% of the economically active labour force as shown in Table1.

Table 1 DISTRICT PROFILE

	NKORANSA	DANGME WEST	KWAHU SOUTH
REGION	Brong Ahafo	Greater Accra	Eastern
POPULATION	147,947	115,000	230,000
MAJOR OCCUPATION	Agriculture	Agriculture and fishing	Agriculture and trading
% OF POPULATION ENGAGED IN AGRICULTURE	95	32	54

4.1.5 Operations of the Schemes

Registration into the schemes is by entire household. This mode of registration is designed to avoid the risk of adverse selection (where members select and register the illness prone dependants and don't register the healthy ones). A new entrant is obliged to observe a three months waiting period after the full payment of the contribution without benefiting from the services offered by the scheme. With the exception of Kwahu South District where a formal contract was signed with service providers in 2005, the remaining districts only discussed the contract document with health facilities but no contract was signed. All the schemes reimburse providers on a fee for service basis (payment is based on the number of patients treated and services offered). As indicated on Table 2, apart from the Dangme West District where the gatekeeper system (patients first attending a health centre and can only go the hospital on referral) is strictly enforced, all the other districts allow insured members to attend any health facility depending on their choice. The schemes offer to their members the minimum health care package as stipulated in the NHIR 2004, LI 1801 which comprise both OPD and inpatient services (see appendix 5).

Table 2 OPERATIONS OF THE SCHEMES

	NKORANSA	DANGME WEST	KWAHU SOUTH
MODE OF REGISTRATION	Household	Household	Household
WAITING PERIOD	3 months	3 months	3 months
CONTRACTUAL AGREEMENT	Contract discussed but not signed in 2005	Contract discussed but not signed in 2005	Contract discussed and signed in 2005
PROVIDER PAYMENT MECHANISM	Fee for service	Fee for service	Fee for service
GATE KEEPER SYSTEM	Not enforced	Strictly enforced	Not enforced
BENEFIT PACKAGE	OPD and inpatient services	OPD and inpatient services	OPD and inpatient services

4.1.6 Registration fees and contribution level

Under the NHIS program, certain persons are exempted from the payment of contributions but are required to pay registration fees before they can be enrolled into district-wide schemes. Payment of registration fees is per person per annum in the household whereas premium is per adult per annum (18years and above to 69 years). The persons exempted from premium contributions are:

a) Children under eighteen years of age and both of whose parents or guardians are contributors.

b) Children under eighteen years of age and whose parents or guardians are proven by the scheme to be single parents.

c) A pensioner under the SSNIT Scheme.

d) Seventy years or over seventy years of age.

e) Indigents.

A summary of the registration fees and premiums of the three schemes is presented in Table 3 below. Kwahu South District scheme charges the highest premium. Whereas the Dangme scheme charges a flat premium of ¢72, 000 (US$8) per adult that of the Kwahu South Scheme is ¢100, 000 (US$11.1) about ¢28,000 higher. In terms of the registration fee, the Nkoransa Scheme is charging the highest, three times that of Dangme West. Overall the Dangme West scheme charges the lowest registration fees and premium. Under the NHIS programme DMHIS are allowed to set their own contribution levels, but the minimum premium should be ¢72,000 to qualify for the minimum benefit package. At the time of this study, the average cedi/dollar rate was 9,000 cedis per US$1dollar.

Table 3 REGISTRATION FEES AND PREMIUM- 2005/2006 INSURANCE YEAR

SCHEME	REGISTRATION FEES (¢)	PREMIUM (¢)
NKORANSA SCHEME DISTRICT	30, 000	80,000
DANGME WEST DISTRICT	10, 000	72,000
KWAHU SOUTH DISTRICT	20, 000	100,000

4.1.7 Timing for premium collection

All of the schemes have scheduled their premium collection period towards the end of the year (see Table 4). This normally coincides with the harvesting season since the majority of the inhabitants in the districts are farmers. The Kwahu South Scheme has a longer period for registration (four months) while that of Nkoransa is only two months.

Table 4 PREMIUM COLLECTION PERIOD

DISTRICT	Period
NKORANSA	November - December
DANGME WEST	October - December
KWAHU SOUTH	September - December

4.1.8 Service Providers

Table 5 shows that Dangme West Scheme operates with more hospitals (5) than the other schemes. These hospitals are located in three different regions (one in Volta, two in Eastern and two in Greater Accra) and they serve as referral hospitals for insured members in the district. This is made possible because the district shares a common boundary with both the Volta and Eastern regions. There is no hospital in the district. The Nkoransa Scheme has only one hospital serving the entire district and eleven clinics to provide primary level care. So far Kwahu South has more clinic and health centres (20) than the other Schemes.

Table 5 SERVICE PROVIDERS

DISTRICT	Clinics/Health centres	Hospitals
NKORANSA	11	1
DANGME WEST	13	5
KWAHU SOUTH	20	2
TOTAL	44	8

4.1.9 Management of the Schemes

The highest decision making body of the schemes is the General Assembly (GA), which comprise of all members who are up to date in their subscriptions. It is the supreme organ of the schemes. The GA meets at least once a year to take major

decisions regarding the operations of the scheme. With the enactment of the National Health Insurance Act, Act 650, all such decisions must be within the confines of the law. Unfortunately, in the case Dangme West Scheme, annual GA meetings have not been possible for the past two years, so the fourteen- member Board of Directors serve as the highest decision making body. Kwahu South Scheme has the lowest number on the Board of Directors. The Board members meet at least once every quarter. The day-to-day administration of the schemes is done by a six - member management team made up of the Scheme Manager, Accountant, Public Relation Officer, Management Information System Manager, Claims Manager and the Data Entry Clerk. In addition, the schemes have engaged supporting staff to assist the management team. Table 6 below gives a summary of the schemes' management.

Table 6 MANAGEMENT OF THE SCHEMES

	NKORANSA	DANGME WEST	KWAHU SOUTH
HIGHEST DECISION MAKING BODY	General Assembly	General Assembly	General Assembly
NUMBER OF AGM FOR THE PAST THREE YEARS	3	3	1
NUMBER OF BOARD OF DIRECTORS	14	14	11
NUMBER OF MANAGEMENT TEAM	6	6	6
SUPPORTING STAFF	3	3	4

4.2 ENROLMENT

A summary of enrolment levels is presented in Table 7. Generally enrolment levels in all the schemes are low. So far the Kwahu South district seems to have had a steady increase in enrolment over the past three years. For example, the percentage increase in enrolment from 2003 to 2004 was about 55%. In 2005, the enrolment more than doubled to an overwhelming 69,314 (136%), which was very impressive. Although the Dangme West had the lowest enrolment, there was quite a good performance in 2004 (about 51% increase). However the enrolment for 2005 was not encouraging, as the membership increased by a small margin (about 10%). In the case of Nkoransa, there was a decline (8% decrease) in 2004. The trend however changed in 2005 as

enrolment increased by about 55%. The general trend indicates that apart from the Dangme West District that registered relatively few new members, all the other districts had a considerably higher enrolment levels in 2005 than in 2003.

Table 7 ENROLMENT

YEAR	NKORANSA DISTRICT SCHEME	DANGME WEST DISTRICT SCHEME	KWAHU SOUTH DISTRICT SCHEME
2003	47,314	8,108	18,958
2004	43,513	12,273	29,290
2005	67,389	13,523	69,314

4.2.1 Enrolment percentage coverage

Even though in absolute terms some of the schemes seem to be doing well in terms of percentage increase in enrolment, when one compares the enrolment levels to the target population, less than half of the population is covered as shown in Table 8.

Table 8 ENROLMENT PERCENTAGE COVERAGE- 2005

SCHEME	TOTAL ENROLMENT	TARGET POPULATION	PERCENTAGE (%) COVERAGE
NKORANSA DISTRICT	67,389	147,947	45.5
DANGME WEST DISTRICT	13, 523	115,000	11.75
KWAHU SOUTH DISTRICT	69,314	230,000	30

For instance using enrolment levels in 2005, the Nkoransa scheme, which has been in operation for thirteen years, has the highest coverage of about 46%, which is still not encouraging considering its long years of operations. The Kwahu South District although having the highest absolute number of members, only has percentage coverage of 30%. The Dangme West Scheme so far has the lowest coverage (11.7%) meaning that almost 88% of the target population have no insurance cover.

4.2.2 Composition of enrolees

Table 9 shows that children under eighteen years constitute the highest number of enrolees in all the schemes, and for Nkoransa and Kwahu South districts they form about half of their total enrolments. The informal sector adult contributors are the

second largest group of enrolees. The formal sector however, forms a small fraction of total enrolment of the schemes. For instance, in the case of Nkoransa District scheme, the formal sector employees form only about 3% of the total number registered. The government deduct two and half percent from their SSNIT contribution and pay this to the schemes as their premium. Apart from the aged group whose number is quite high, the remaining categories (pensioners and indigents) form a small fraction of total enrolment. The Dangme West District however, has an overwhelming 16% of its members being indigents. The explanation given by the scheme's management to this high percentage was that the International Labour Organisation (ILO) initiated a pilot project in the district two years ago to identify indigents and pay their insurance premiums for them. Therefore, those lists were submitted in the district for government subsidy.

Table 9 COMPOSITIONS OF ENROLEES (2005)

	NKORANSA DISTRICT	DANGME WEST DISTRICT	KWAHU SOUTH DISTRICT
SSNIT (FORMAL SECTOR	1,971(3%)	816 (6%)	4,568 (6.6%)
INFORMAL SECTOR (ADULT CONTRIBUTORS)	25,089 (37.2%)	4,786 (35.4%)	24,159 (35%)
PENSIONER UNDER SSNIT	107 (0.2%)	32 (0.2%)	210 (0.3%)
AGED (70+)	4,072 (6%)	525(4.0%)	5,222 (7.3%)
CHILDREN < 18YEARS	35,804 (53.1%)	5197 (38.4%)	34,967 (50.4%)
INDIGE NTS	346 (0.5%)	2167 (16%)	188 (0.3%)
TOTAL	67,389(100%)	13,523(100%)	69,314 (100%)

4.3 FACTORS THAT INFLUENCE PEOPLE'S DECISION TO JOIN CBHIS

Several factors may influence people in their decision to enrol or not to enrol. Factors identified in this study are: the contribution level, socio-economic status of the people, timing of premium collection, mode of registration (household registration), quality of care, distance to health facilities, education on the insurance scheme and finally politicisation of the insurance scheme.

4.3.1 Contribution levels

The majority of the respondents were of the view that the current premium was too high considering the low-income levels in their communities. They fervently appealed for a reduction in the premium to allow more people to register as remarked by a participant in the FGD: "*The premium is too high. Over here we don't have any major source of income. The insurance people should reduce the premium for us*" (*FGD, Dangme West, Insured member).*

Others saw the annual increment in premium as problematic since there was uncertainty about the premium level for the next year and therefore households couldn't budget. In the Kwahu South District where the premium has been increased from ¢72000 (US$8) (the previous year) to ¢100,000, (US$11.1) interviewees were not happy with the way the scheme officials increased the contribution level every year. The fear of some respondents was that if that trend should continue then in the near future many people would not be able to register since the premium will be beyond the reach of most poor households. Quotations below summarise the situation in the districts:

"*My major problem is the annual increment in the premium. If the premium can be maintained for say two or three years, then it will help us. In Ghana, if you keep on increasing price, people get worried" (FGD, Kwahu South insured).*

"*If you can stabilise the premium for some time, it will help us budget for the year. Increasing the premium every year doesn't help us*" *(Key informant, Kwahu South).*

A few respondents saw the premium as affordable and this was linked to the benefit package. They were of the view that currently health care is expensive and therefore paying the premium to enjoy both OPD and inpatient services was fair and reasonable. One key informant has this to say: "*The current premium is fair because one hospital visit may cost about ¢90, 000, so paying ¢100, 000 for both OPD and inpatient services is reasonable" (Key informant, Kwahu South).*

4.3.2 Socioeconomic status

Almost all respondents, irrespective of their socio-economic status, identified poverty as a major obstacle to enrolment. From the discussions it became obvious that poverty levels are generally high and that this negatively affected enrolment of the schemes. A

remark made by a key informant summarises the poverty levels in the districts: "*The poverty level of the people in this district is high. People complain they don't have money. Some of them you will realise that they are genuinely poor and therefore cannot pay*" *(Key informant, Dangme West).* Most of the non-insured members expressed their desire to join the scheme but said financial constraints were a barrier as pointed out by a participant in the FGD: "*I have interest in joining the scheme but my problem is money*" (FGD Dangme West). To most of the non- insured, the NHIS is dear to their heart and they were looking forward to anybody who may assist them financially to register.

4.3.3 Timing for premium collection

With the exception of the Nkoransa Scheme, where the respondents saw the timing of premium collection as inconvenient, most of the other interviewees were satisfied with the timing in their district since to them, the period coincides with their harvesting season. They were of the view that in the rural areas where the majority of people are farmers, collecting premiums during the harvesting season enables farmers to mobilise funds to pay the premium:

"Most of us here are cocoa farmers and normally we harvest our crops during this period. At this time, there is money in the system to pay for the insurance premium"
(Key informant, Kwahu South)

"The timing is convenient because it coincides with our harvesting season by which time people have money to pay for the insurance premium"
(FGD, Nkoransa insured)

An interesting revelation during the FGDs was that collecting premiums during the harvesting period was not a guarantee that people will have money to pay for the insurance especially where demand for the crops is low. In one of the Districts (Dangme West), it came to light that even though some farmers had harvested their crops, there was no ready market and so were exploring the possibility of paying the premium in kind (using rice to pay for the premium). An affected non-insured member had this to say: "*Most of us are rice farmers. Even though we have harvested our rice, there is no market for it so we have difficulties in paying the premium. If the insurance people will accept our rice as premium then we can register*" *(FGD, Dangme West non-insured).*

All the affected farmers who were interested in joining the scheme were concerned that they were not likely to be able to register if the current demand pattern for the rice didn't change.

In the Nkoransa district, some interviewees identified the timing as really not convenient and called for a change in the registration period. According to them changing the registration period will allow more people to register. The scheme manager confirmed this as he remarked: "*I think the timing is not convenient. The correct time will be January and February by which time many farmers might have harvested their produce*" *(Key informant Nkoransa).*

As a way of motivating more people to enrol, suggestions were made during the FGD that schemes should adopt more flexible terms of payment such as monthly, quarterly or semi-annual payment instead of the current annual payment system. According to them, those who cannot mobilise sufficient funds within the registration period will be automatically excluded from the scheme. A flexible system will allow all interested persons to register especially those with irregular flows of income.

A few respondents were against the idea of allocating a time period for the registration exercise since to them such an arrangement serves as a barrier to those who may not have the means within the period. A suggestion was therefore made for the registration to be opened throughout the year to enable people to register at any time they have money.

"I *don't support the idea of giving a time period for the registration exercise. The registration process should be ongoing to allow people to register any time they have money*" *(Key informant, Kwahu South).*

4.3.4 Household registration

Many respondents identified the unpredictability of sickness as the biggest challenge to human existence and therefore enrolling the entire household into the scheme was seen as a protection against any future cost of ill health. Some participants were of the view that registration of the entire household will help extend insurance cover to each member of the family.

"The entire household registration is good because one cannot predict who among the family will fall sick in the year" (Key informant, Kwahu South).
"The policy is good. As the head of my household, if I insure myself and leave my wife or children, I will be responsible for paying their medical bills if they fall sick. Paying for the entire household is the best option" (FGD, Nkoransa non-insured).

Others were more concerned about the sustainability of the scheme. In their view, allowing people to register individually will result in the situation where only the sick and vulnerable household members will be enrolled leaving strong and healthy ones unregistered (adverse selection). According to them, such practice can adversely affect the sustainability of the scheme. One way to make the schemes viable is to enforce the household registration exercise as remarked by a key informant: "If *you allow individuals to register, some may intentionally register the sick leaving the healthy ones. This may lead to the collapse of the scheme" (Key informant, Dangme West).*

Those with a large family size on the other hand saw this mode of registration as an obstacle to enrolment. According to them, since one cannot register some members of the household and leave the rest they end up not registering at all. Interviewees indicated that large family size becomes a problem if most of the household members are above eighteen years. One participant in the FGD pointed out the difficulty she was facing because of her large family size as follows: *"I have seven people in my household all above eighteen years. Paying ¢82, 000 for all of them is really difficult for me this year" (FGD, Dangme West non insured).* A suggestion was made by respondents to offer discount to students (in secondary schools) and apprentices who were above eighteen years. Such discount will ease the financial burden on parents since this category of people do not earn any income and therefore their premium is borne by their parents.

As a way of ensuring that the entire household is not denied access to insurance cover because of the entire household registration, those with large family size have adopted a tactics of adding some members of their household to another household list so that they can register them. This was revealed during the FGD as a participant explains: *"Because of financial difficulties, some people in this community are forced to add the*

names of some members in their household to other household list. To me this may *defeat the purpose of the exercise" (FGD, Dangme West).* This practice was seen as dangerous since invariably, those whose names will be added to another household list are the illness prone ones. Others saw it as a necessary evil since in the circumstance that was the only way they can insure themselves.

In one of the districts (Nkoransa), there was ambiguity in the definition of a household and that was seen as a big challenge to enrolment. The community members' understanding of household is all family members whether staying in the community or outside. Therefore during the compilation of the household register, some mentioned the names of all household members including those who were not residing in the community. The problem then arose when it came to the actual payment of the premium. The scheme officials were not prepared to issue ID cards to household members if some of them had not paid, even though those persons may not reside in the community. From the scheme's point of view, until final payment is made to cover all household members on the list provided, no individual in the household will enjoy benefit from the scheme. The sad aspect is that the scheme will never refund the money to those who have paid until those owing make the final payment. When insured members in the district were asked whether they have intentions to renew their membership, some affected members indicated that they were not going to register again. One participant in the FGD narrated her plight as follows: *"Anytime I go to the hospital, they collect money from me with the reason that one of my children who is no more residing here has not paid. Because of this I will not register this year" (FGD, Nkoransa, insured).* The affected scheme members complained bitterly about the position of scheme officials on the matter and called for immediate review of the definition of a household in the district. The remark by a key informant summarises the situation in the district: *"The definition of household is quite problematic in the district. During the data collection exercise some people mentioned the names of all their children in the family whether resident or not. However, when it came to the actual payment, they were unable to pay for all, which sometimes create problems. The system should be a bit flexible for those who cannot pay for people not residing in the district" (Key informant, Nkoransa).*

4.3.5 Quality of care

Interviewees were generally not satisfied with the services they receive from the contracted providers of the schemes. One area that took centre stage in the discussions was the long delay (waiting time) at the health facilities. Participants indicated that the introduction of the NHIS has led to an increase in hospital attendance but the staff strength has not increased. Long queues were reported in Kwahu South and the Nkoransa Schemes where the gatekeeper system was not strictly enforced and so patients have the option of attending either a hospital or health centre. Insured members complained bitterly that sometimes they have to spend almost the whole day at the hospital before they are given treatment. To most of them the frustrations they go through at the hospital are unbearable and that has discouraged some of them from registering in the coming year. They therefore requested that the scheme officials should do something about the situation. *"Because insured members go through hardships before they are attended to at the hospitals, most people are discouraged from registering into the scheme" (FGD, Kwahu South insured)*

Another revelation, which further worsens the plight of insured members was discrimination by health professionals. It was noted that preferential treatment was given to the non- insured members as opposed to the insured members and that insured members had to stay longer at the hospitals before they are attended to by health professionals. When the matter was further probed, it was noted that the hospital staff were more interested in patients who make direct cash payment (since they get incentives) as apposed to insured members who don't pay at the point of service delivery. A participant sharing her experience at the hospital had this to say: *"Because the staff at the hospital do not have financial benefit from us, they feel they are losing out so, they don't mind us" (FGD, Kwahu South insured).*

Also, it came to light during the FGDs and the key informant interviews that the reception given to insured members by health professionals at the hospital was bad. They complained that the hospital staff do not pay attention to insured members when they attend hospital. Respondents were also not happy with the way health professionals talk to insured members.

"It seems the doctors and other health professionals don't like the insurance. Some talk harshly to insured members. To improve service delivery, you need to talk to them about the importance of the NHIS" (Key informant- Dangme West).
"The attitude of health professionals towards insured members is very bad. Insured members are not given the due attention when they visit hospital" (Key informant- Kwahu South).

The concern of the insured members was that if that practice was not reversed, very soon nobody will register with the scheme but would rather pay their bills out of their pocket since that is the only way they can be given proper attention at the hospital.

Another area where respondents felt disappointed was the exclusion of certain drugs in the NHIS. Some complained that they were made to believe that both OPD and inpatient services were going to be free but when they go to the health facility they are made to pay for certain drugs labelled as "non essential drugs".
"*A friend of mine who is insured was admitted to the hospital, and when he was discharged he was asked to pay for the cost of drugs amounting to ¢240, 000 being drugs outside the NHIDL. If insured members are asked to pay for the cost of their drugs, then there is no need insuring myself" (FGD Kwahu South, Non insured).*

Others were of the view that the drugs given to insured members were inferior since only cheap drugs are given out freely. They considered that it takes a longer time to recover when treated with cheap drugs as indicated by a participant in the FGD: "*The problem we face is that when you go to the hospital with insurance card, they give you low quality drugs. Sometimes you go and after taking the drugs, the sickness is still there*" *(FGD, Dangme West- insured).* Another participant in the FGD indicated that she has decided not to renew his insurance membership because of the low quality of drugs they give to insured members as she remarked: *"Anytime I go to the hospital, they give me inferior drugs. Because of that I have decided not to register this year" (FGD, Dangme West- insured).* The issue of inferior drugs was hotly debated among participants, because to some of them, not all cheap drugs may be inferior.

Also, some service providers were found to be collecting money from insured clients, which according to the Scheme Managers was against the terms of the contract they signed with them. For instance, in the Dangme West Scheme, it was noted that some referral hospitals ask insured members to pay for their bills when they are admitted. In The Kwahu South Scheme, it was also revealed that some providers extort money from insured clients for services that were supposed to be free. This behaviour of some providers was seen by insured members as quite frustrating and discouraged many of the insured members from renewing their membership.

Only three key informants and a few members in the FGD were satisfied with the service they receive from service providers. According to them the hospitals are doing their best as indicated by one key informant: *"I have been to the hospital once, and they took very good care of me" (Key informant Nkoransa).*

Overall, the perception of poor quality of care was seen as a major concern by almost all respondents and was also identified as a major obstacle to enrolment. When the matter was further investigated as to how the problem could be resolved, some respondents called on the government as a matter of urgency to provide more resources at the health facilities to ease the pressure on the hospitals and clinics. Additionally they were of the view that the waiting time at the health facilities could be reduced if more health personnel were employed. Also as a way of retaining the few existing staff, some key informants called on the schemes to provide incentives to health staff since the current workload on them was too great: *"The scheme should give little allowance to nurses and other health professionals because they are filling a lot of forms for insured members. With the introduction of NHIS, attendance has more than doubled but the same staff are attending to them" (Key informant, Dangme West).* The argument for these incentives was that if health professionals are assured of receiving something in return for the services they offer to insured clients then they will be prepared to work for extra hours. The situation at the moment does not motivate them since no matter how many patients they attend to, they will receive the same pay at the end of the month.

The need for effective collaboration between scheme Managers and service providers was also highlighted as one way of making the schemes function well in the districts.

The need to have regular review meetings with providers was considered one effective tool to monitor quality of care and according to the scheme managers that was what they were going to do in the coming year. It was also suggested that service providers should be involved in taking decisions concerning the schemes since they deal directly with insured members. Ignoring them in the running of the schemes was found to be one of the reasons why things were not going as expected.

4.3.6 Distance to health facility

From the responses, Dangme West District was the only district where distance to a health facility was a barrier to enrolment. It was noted that some of the villages are too far from the health facilities and therefore community members in such areas were reluctant to register since to them, paying the premium will yield no benefit to them. This was pointed out by the scheme manager as he shared his fieldwork experience: *"Sometimes when you talk to people and you too coming to realities, you realise that the distance from where they are living to the health facilities is too far. Therefore when you talk to them they are not prepared to register since there is no nearby health facility" (Key informant, Dangme West).*

However, during the FGDs, respondents did not specifically mention access to health facility as an obstacle to enrolment. Their major concern was the fact that there is no district hospital and so they always have to travel to other hospitals in other regions on referral, which indeed poses a problem for them.

4.3.7 Trust in scheme managers

Respondents were generally satisfied with the performance of their scheme administrators. Some praised them for good work done over the years considering the limited resources they have at their disposal. Throughout the discussions, no mention was made of any financial embezzlement in any of the schemes. Interviewees saw them as trustworthy people who are capable of managing the affairs of the scheme as one participant in the FGD indicated: *"There is no problem with the insurance management. Their work is genuine. If there has been any financial embezzlement,* the *auditors will have reported it at AGM. For the past four years there has not been any report of financial malfeasance" (FGD, Kwahu South insured members).*

One major concern raised related to the photo ID cards issued to members. In the Kwahu South District, insured members complained about the poor quality of pictures used on their ID card. To most of them, the ID cards are valuable to them and so called on the scheme officials to change the cards in the coming year. In the Nkoransa District, it was also noted that most of the pictures taken by the scheme got spoiled and that most of the members didn't have ID cards at the time the interview was conducted. According to them, the health facilities were not willing to offer free care to members without ID cards and so they are made to pay for the cost of their health care. The sad aspect of the situation is that the scheme officials are not prepared to refund their money to them after they have paid. The position taken by the scheme management on the matter was considered by insured members as unfair since, they are entitled to all benefits as paid up members of the scheme.

"The photo taking exercise was poorly done. About 75% of the pictures got spoiled and that affected the processing of photo ID. To date, so many people don't have ID cards" (Key informant, Nkoransa).
"There was a problem with the picture taking exercise. As at now two thirds of the people don't have ID cards. The hospitals are not prepared to give treatment to those without cards. This is really a problem in the district" (Key informant, Nkoransa.)

4.3.8 Involvement of members in decision making

Participants in the FGD indicated that though they are not directly involved in decision-making, the scheme invites delegates from their communities to represent them at the AGM. They were therefore satisfied that they are indirectly involved in decision making since their representatives speak on their behalf.

Whereas some key informants reported being involved in decision making of the schemes, others (insured assemblymen and chiefs) however, were not happy about the way the scheme management ignore them in all their meetings. According to them, they usually interact with community members and therefore if they were fully involved they can assist in educating their people about the insurance. When the matter was further probed as to the possible ways they want to be involved in decision-making, they indicated that the scheme officials should invite them to the AGM so that they can participate in the major decisions taken.

"We are all stakeholders in the scheme. You can invite us for a workshop on the NHIS so that we in turn can educate our community members. In that case there may be no need coming down to the community for education since we can do that on your behalf" (Key informant, Kwahu South).

4.3.9 Education on the NHIS

The marketing strategies mentioned by respondents in both FGDs and the key informant interviews in communicating information about the schemes included community durbars (meetings with the entire community), radio announcements, mobile vans announcements, dawn and evening broadcast, churches and mosques campaign, television education, posters, house to house education and sometimes education at health facilities.

These strategies, though many, were seen as not enough. According to respondents, many people have not registered because they have not been properly educated on the new national policy as rightly pointed out by one key informant: *"I want to emphasize that education on the insurance is not enough. I will give them 30%. So many people don't understand the NHIS policy. I will urge them to intensify community education" (Key informant, Kwahu South)*. Some respondents were particularly emphatic on the inability of the scheme officials to explain the specific diseases and drugs covered under the NHIS. According to them, they only get to know about the exclusions of the benefit package when they visit the health facility. Limited public education was also confirmed by all scheme managers as one of the barriers to enrolment in their respective districts. The managers complained that they find it difficult to reach out to communities in remote rural areas since they don't have any vehicle. They therefore called on the NHIC to provide them with vehicles so that they can intensify public education on the insurance.

4.3.10 Politicisation of the NHIS

One major concern raised by the scheme managers was the politicisation of the insurance programme. According to them, some people think the insurance scheme is for the ruling government and that the NHIS was introduced so as to enable government to win power in the next elections. It was alleged that some politicians in the opposition party normally give negative comments about the whole insurance

scheme. Those in the opposition party are reluctant to register. This was reported in areas where the major opposition party has more supporters.

"We have had some political talks about the NHIS in our district. Some people say the government want money to campaign for the 2008 elections and that is why they are bringing the insurance" (Key informant, Dangme West). The managers were hopeful that if politicians could desist from making such negative remarks but consider the health of the people, it will go a long way to making the NHIS successful.

4.4 IDENTIFICATION OF THE POOR

To ensure that the poor are not denied access to quality health care, there is the need to find a practical mechanism of identifying poor households for subsidy. Almost all participants in both FGDs and the key informant interviews indicated that there were poor people in their respective communities who need government support in premium payment. However, they saw it as a difficult task to define who is poor. To most people, poverty is relative and depends on where one finds himself/herself. Somebody in a city may be considered as poor but when he comes to the rural area he may be counted among the rich persons there, as indicated by one key informant: *"Over here I may be classified as poor, but when I go to my village near Anomabo I am counted among the rich people there" (Key informant, Dangme West)*

Another key informant giving his opinion about who is poor described it as follows: *"Poverty is like heat, you can't see it but you can feel it" (Key informant Nkoransa).*

The meaning of the second quotation is that it is the poor people themselves who can describe or define poverty since they feel the impact. Therefore a consensus on a single definition of poverty or a poor person could not be reached. Participants however came up with critical signs or criteria one can use to identify who is poor at the community level. The main critical /signs include: sicklers and persons with disabilities (physically and mentally challenged), housing conditions (dilapidated), malnutrition status of the household, orphans and the aged.

Sicklers (chronically ill) and people with disabilities (physically and mentally) were identified as people who in most cases are helpless since their condition does not permit them to engage in any meaningful employment. Specifically, those paralysed, the blind and stroke survivors were seen by participants as people who need support. In the rural areas where farming activities were the only source of employment, it was

noted that anybody who is a chronically ill or disabled and therefore cannot go to the farm will need government subsidy.

"In the rural areas, sicklers are poor. In towns and cities somebody may be a sickler but runs a store business. Over here, our major economic activity is farming. If you are sick you can't go to farm" (FGD, Nkoransa District).

The implications of the above quotation is that, it will be unfair to make a blanket statement to consider all such chronically ill as poor persons since some may be engaged in some form of employment especially in towns and cities. For instance, somebody may be chronically ill but may run a business, which may fetch him/her sufficient income to support the family. The emphasis was on the chronically ill and people with disabilities who by virtue of their condition do not permit them to engage in any gainful employment.

Still on income, interviewees agreed that there are some people who may be healthy but may not have a permanent source of income or the income they earn is so small that they always find it difficult to support their families. The plight of such people becomes worse if there is no support from relatives or friends. It was noted that such individuals should be given support.

The malnutrition status of the family was also identified as another indicator of poverty. It came up during the interviews that there are some households who cannot afford three meals a day. This has resulted in the stunted growth of the children. Inability to meet such a basic necessity of life was considered as a sign of poverty since ordinarily, anybody who has the means should be able to feed the family well.

Another basic necessity of life that took centre stage in the discussions about poverty was housing. Participants mentioned specifically that people with no permanent place of abode are helpless and will require a subsidy. Others may have a house but the housing condition may be bad (dilapidated). For instance, it was noted that in some houses, there are no doors to the bedroom. In others the roofing sheets may be leaking or the physical condition of the house is very bad. A contribution by a participant in the FGD provides a picture of such poor households as she explains:

"If you visit such poor households in our village, you will find no kitchen (they cook by the side of the house), bedrooms are not cemented and have no doors and sometimes they don't have a bed to sleep on". (FGD, Dangme West- insured)
Participants saw the deplorable state of such houses as a sign of poverty since a rational human being with adequate means will not sleep in a room without a door.

One group of people identified as highly vulnerable are orphans. They were seen as children without any parental care and support and where they are under the care of somebody other than a parent; their upkeep is not always the best. The general consensus was that orphans in orphanages and those in other people's care should be identified and be given a subsidy.

The last group of people mentioned was the aged. The argument here was that in rural communities, and even in towns and cities, the aged are so weak that most of them cannot go to the farm anymore, or do any other meaningful work. The problem becomes compounded if such people have no support from children and other relatives.
"Some people are very old. They can only eat but can't do any meaningful work. Such people are always poor" (FGD, Nkoransa non-insured).

Other indicators mentioned by a few participants were: availability of clothing, ability to pay school fees and hospital bills, widows with large family sizes and asset ownership.

There were divergent views on availability of clothing as an indicator of poverty. To some people, the dressing of some household members especially at public gatherings is so bad that if such people have the means, they wouldn't have put on such attire. Others were of the view that some people are born with such lifestyle and therefore even if they have money they will prefer to be in such attire. There was a caution from respondents that using dressing alone as an indicator of poverty can be misleading, and so called for consideration of other indicators as well before drawing a conclusion.

Ability to pay school fees and hospital bills were also highlighted as a possible sign of poverty. In some homes, it was noted that parents always have problems in paying their children's school fees, and therefore their children are always turned away from school. This affects the children's education. Some poor households were also found to face difficulties in paying the medical bills anytime they visit the hospital. This situation has compelled such households to resort to self-medication or use traditional medicine instead of seeing a physician. Participants considered such households as poor because access to education and quality health care are basic needs of life, and where they are lacking can negatively affect the survival and progress of the family and the nation at large.

Widows with large families were also seen as an indicator of poverty. In the African traditional family system, husband and wife are supposed to cater for the needs of their children. Participants indicated that where the breadwinner (husband) is dead it becomes a challenge to the widow especially, if the household size is large. Most of these widows normally depend on support from other family members and friends.
"In some families, the husband is dead leaving the widow and many children behind. Such households normally face financial difficulties" (Key informant, Nkoransa).

The last indicator of poverty is ownership of assets. In rural communities, people who do not own assets such as land, livestock, and the like, were considered as poor. For instance it was noted that lack of ownership of land was a very important determining factor of poverty in a farming community since those who don't have land find it difficult to support the family.

4.4.1 Suitable community structure to identify the poor

All interviewees indicated that assigning somebody from outside the community to identify the poor would not yield good results since they may not know the socio-economic status of the people. They therefore agreed that community members themselves should be given that duty. They however recognised the difficulty in assigning the exercise to the entire community since it may take too long to identify poor households. Assigning the task to an individual was also seen as dangerous since that person may introduce bias and favouritism in the selection exercise. The general

consensus at both the FGDs and the key informant interviews was that a committee should be formed in each town or village to oversee the selection exercise.

When the matter was further probed as to who should constitute the committee, four categories of people were mentioned by almost all respondents namely, Chiefs, Assembly members, Pastors/Imams and revenue collectors. Almost all key informants and participants in the FGDs mentioned the name of chiefs. According to them the traditional rulers are the heads of the communities and in most cases know almost all the people in the area. They are there to ensure the welfare of everybody. Participants were hopeful that their inclusion will bring fairness in the selection exercise.

"The chiefs being the head of the community have integrity to protect. If the town or village progresses, it will be to their credit, but if there is a disgrace, they will be affected" (Key informant, Dangme West).

"Chiefs have a reputation to guard, so before they select somebody, they will be very careful". (Key informant, Kwahu South).

Assembly members are people who are elected representatives in the decentralised local government administration in Ghana. They are at the grassroots and often interact with people in their electoral areas. They are elected by the community to represent them at the District Assembly meetings and to present the problems of their people at such meetings. In some communities, the assemblyman/woman and the chief play vital roles in handling problems as well as organising communal labour and initiating development projects. Participants were optimistic that their inclusion in the exercise will make the committee a dependable one since most of them are trustworthy people.

Pastors and Imams were also identified as people who can help in this humanitarian assignment. Ghana being a predominantly Christian and Muslim country, it was felt that including these "God's people" will bring the fear of God into the whole exercise. According to participants, Pastors and Imams interact with their congregation/members and seem to know much of their problems. It was also revealed that in some churches, a special fund has been set up to help the poor, which suggests that some pastors are already used to identify the poor. Participants were

convinced that pastors could bring their rich experiences to bear in the selection exercise. One key informant has this to say: *"In my church we have a special fund set aside for the poor members. Before one can access the fund, he/she should talk to the church committee made up of the pastor and other members of the church. If you are found to be genuinely poor, they will give you support" (Key informant, Dangme West).*

Furthermore, revenue collectors were identified as people who can play an indispensable role in the selection exercise. These collectors are contracted by the schemes in each district to collect premiums. They move from house to house to explain the policies of the NHIS to community members and those who are interested are duly registered. All participants in the FGDs were convinced that the collectors know almost all the people in their respective communities and are trustworthy people.

"It is the revenue collector who knows all the people in this community. As he goes round to collect the premium, he will know those who are poor" (FGD, Kwahu South insured).

"The revenue collector in my community is trustworthy. In my opinion, he can help in identifying the poor". (FGD, Dangme West insured)

The other group of persons identified although not apparently the popular choice of the people were unit committee members, health insurance committee members, Department of Social Welfare staff and head teachers.

The unit committee members are people nominated by the community to oversee the development of their towns and villages. They work hand in hand with the assemblymen/woman in the area. Some participants were of the view that such an existing committee could help in the exercise. Others however indicated that they were not satisfied with their work in their communities and so cautioned that giving such a national assignment to them could create problems.

Another committee which came up during the discussions was the health insurance committee. Under the NHIS program, each community is supposed to have a health insurance committee to oversee the day- to-day operations of the scheme at the

community level. This committee is supposed to have a chairman, secretary and organiser. The idea here was that if the committee could be strengthened they could be relied upon in the identification of the poor. The problem, which came up during the discussions, was that few communities have established these committees and therefore relying on them will not be possible. In the Dangme West district it was noted that none of the communities had such health insurance committees in place.

A few respondents mentioned the Department of Social Welfare as an organisation that that could assist in the exercise. The Department deals directly with the poor and was there to promote the welfare of people in the country. Participants were of the view that they will be in a good position to assist in identifying poor households.

The last category of people mentioned was head teachers. The idea here was that teachers know the parents or households who are unable to pay their children's school fees. It was argued that including head teachers in the selection exercise would enable the committee to trace such poor households through their children in schools. In one of the schemes, the scheme manager explained how the head teachers helped them in identifying poor households in their district as follows: *"In our scheme here, we rely on head teachers in identifying some poor households. They know pupils whose parents cannot pay school fees. If you trace such pupils to their homes you will see that they are from poor households" (Key informant- Dangme West).*

4.4.2 Monitoring of the exercise

Even though the committee proposed by respondents were seen as trustworthy people in their communities, participants were of the view that so far as the committee members are humans, there could be unfairness in the exercise. Respondents saw monitoring of the exercise as a very important tool that could be used to ensure fairness and transparency in the identification programme. They therefore called for an independent body to verify the list submitted by the committee members.

The first independent body suggested was district health insurance staff. It was unanimously agreed that officials from the district insurance office should visit the communities to independently verify the list submitted by the committee. According to them, some of the selected people can be visited in their homes and asked a few

questions about their socio-economic status and possibly look at their environment as well as other indicators or signs of poverty. Those found to be wrongly included could be queried and eliminated from the list. It is after this independent scrutiny that the scheme can determine the final list to be submitted to the NHIC for subsidy.

"To monitor the exercise, I suggest that officials from the insurance office should come down to the community to interview the selected people. This will help them to verify the socio-economic status of those selected by the community before they are finally accepted" (FGD, Nkoransa non – insured).

Another monitoring tool mentioned by some participants was that the selected people should be made known to the entire community at a public gathering. Community members should be allowed to scrutinise the selected people before the final list is submitted to the schemes as remarked by a key informant: *"If possible, there should be a durbar where the selected people can be presented to the community. The public should be allowed to critically scrutinise them. If somebody is not qualified, it is the public that will point it out. This will be the best monitoring plan" (Key informant, Nkoransa insured).* Whereas some respondents hailed this monitoring tool because to them, the people who will finally be included will be the genuinely poor, others saw it as an embarrassment to the poor. During the interviews, those who were in favour of this tool argued that if you are reluctant to be labelled as poor then really you don't need to be helped since that was the only way the exercise could be properly monitored.

"If you are poor you should be bold to come forward. Those who will feel shy to be presented to the public should be made to pay their own insurance premium" (Key informant, Nkoransa).

A few respondents also mentioned the formation of a vetting committee at the community level instead of allowing the entire community to scrutinise the selected people. According to them, such a committee should be tasked to independently verify the list submitted by the first committee before the final list is submitted to the scheme.

Finally, some key informants suggested that the list submitted by the committee members should be given to the District Social Welfare Officer who will in turn go to

the communities to crosscheck the list submitted. In their opinion, social workers are good in community work and issues related to poverty and so were optimistic that they were well qualified to confirm poverty status before the final list is submitted to the schemes.

"We have social welfare workers in this district. When we get the list, we can hand it over to them to verify how genuine those lists are. They have skills in identifying the poor". (Key informant, Kwahu South).

SUMMARY

In summary, enrolment of the schemes in the case studies is generally low. Factors that influenced the low coverage rates include non affordability of the premiums making it difficult for those with large a household size to register, and inappropriate timing of premium collection in some districts. Other problems include poor quality of care offered by contracted service providers, low public education on the NHIS as well politicization of the insurance programme. In order not to deny the poor access to health care, participants came out with indicators of poverty as well as suggesting the formation of a committee at each community level to identify the poor. Also an independent body was suggested to monitor the work of the committee in each community.

CHAPTER FIVE

DISCUSSION

5.0 INTRODUCTION

The vision of the government of Ghana in introducing the NHIS is to ensure universal access to quality and affordable health care to all citizens irrespective of individual socio-economic status. The passage of the National Health Insurance Bill in 2003 therefore mandates every Ghanaian to belong to a health insurance scheme that provides adequate financial protection against the cost of ill health. All the schemes surveyed in this study operated under the NHIS and 2005 is the first year the schemes started giving benefits under the national programme. This chapter provides a critical discussion on the findings of the study in relation to the vision of government in establishing the NHIS.

5.1 COMPARISON OF INTERNATIONAL EXPERIENCE ON UNIVERSAL COVERAGE WITH THE GHANAIAN CONTEXT

One objective of this study is to gain understanding of how other countries have increased coverage so as to inform policy makers as to what works better and what doesn't.

International literature on universal coverage has identified several enabling factors in the journey to universal coverage. Making health insurance a legal requirement is one of the factors. Therefore the decision taken by the government to mandate health insurance set the pace for achieving the set goal. However in the Ghanaian situation, enrolment into the district schemes is voluntary for informal sector employees who constitute about 70% of the population. This is in contrast with most of the countries that have universal coverage as in those countries the formal sector rather forms a higher percentage thus making SHI payroll deductions fairly easy (Carrin and James 2004). The challenge facing Ghana is how to attract this large informal sector mostly dominated by the poor rural dweller. Also, the proposal to exempt the poor falls in line with international experience as in most of the countries such as Thailand, Japan and Korea, government provides a subsidy for poor households. However, in Ghana no practical mechanism has been put in place to identify the poor thereby raising serious equity concerns.

Available evidence also shows that sustained economic growth and a reduction in debt repayment provide an enabling environment in peoples' ability to pay an insurance premium. Recent economic indicators in Ghana show significant improvement in economic growth. Ghana's real GDP growth, which stood at 3.7% in 2000, has witnessed accelerated growth reaching 4.4% in 2002 and 5.8% in 2004 (Government of Ghana Budget Statements 2001, 2003, 2005). Even though the growth rates do not match most countries with universal coverage, the prudent monetary and fiscal policies put in place by the government gives confidence in the management of the economy. Also, apart from Thailand, (which is a developing country) all the remaining countries are either middle-income country or a high-income country (e.g. Germany, Japan, Korea etc) and so comparison is quite difficult. Additionally, Ghana now enjoys debt relief under International Monetary Fund/ World Bank enhanced Heavily Indebted Poor Countries (HIPC) initiative following the country's ability to reach completion point in 2004. The debt relief is currently being used to fund pro-poor programmes (IMF/IDA 2004). The above picture gives hope for the Ghanaian economy and it is expected that it may reflect in income levels of the people and hence increased ability to pay for insurance premiums.

Also, growth in urbanization has been found to facilitate identification and registration of people into SHI. Available statistics in the Ghanaian context indicate that about 43.8% of Ghanaians are urban dwellers as at the year 2000. At a current urban growth rate of 2.6% per annum, it is expected that urbanization may double in seventeen years time (Ghana Statistical Service 2003). Though Ghana is experiencing some level of urbanization, it is still below that in other countries with NHIS. For instance, in Korea, the urban population as at 1980 was 57.3% (Korea Bureau of Statistics 1980). The relatively large rural population in Ghana therefore means that an innovative approach will have to be employed to get people to register with the NHIS.

From the foregoing discussions, it becomes obvious that Ghana has followed the due processes necessary to achieve universal coverage but the challenge is how to effectively implement the policy. Also whereas some factors are favourable others are

not. It is therefore important that proactive measures are put in place to mitigate any adverse impact of those factors (finding a way of attracting the large informal sector).

5.2 ENROLMENT

Findings from the study show that enrolment in all the schemes is generally low. In percentage terms, none of the schemes cover half of the district population. The Nkoransa district had the highest coverage of about 46% followed by Kwahu South (30%). The Dangme West district had the lowest enrolment of about 12%. As the short-term objective for the establishment of the NHIS is to achieve 30-40% national coverage within the next five years, one can conclude that apart from the Dangme West Scheme, the remaining two schemes are within the national enrolment target. However generalizing this to the entire country may be unrealistic since these schemes have long-term experience. For instance the Nkoransa Scheme is the oldest scheme in Ghana with thirteen years of experience and so the 46% coverage is still relatively low. The generally low enrolment levels are however consistent with the studies on enrolment of CBHIS as reported by Atim (1998) covering twenty two CBHIS in West and Central Africa and a comprehensive WHO study of eighty two CBHIS by Bennett, Creese and Monasch (1998).

The composition of enrollees indicates that informal sector adult contributors form a higher percentage as compared to the formal sector. Ghana, being a developing country has the majority of its active labour force in the informal sector made up of petty traders, artisans, farmers and other self-employed. Also the poor and vulnerable group dominates this sector. In percentage terms, informal sector adult enrollees range from 35% to 37% with the Nkoransa district having the highest (37%). The formal sector contributors however form an insignificant percentage of total enrollees with an average of 5%. This trend is in contrast with international experience of countries that have achieved universal coverage, as in those countries, the formal sector forms a larger percentage of the active labour force and that makes it easier for payroll deduction of premiums into the SHI Scheme (Carrin and James 2004). The challenge facing the schemes is that they have to find innovative ways of attracting the large informal sector, considering the fact that a small percentage of their members are in formal sector employment.

Also, the percentage of enrollees who are indigents form less than 1% in both Kwahu South and the Nkoransa districts. The situation is quite different in the Dangme West Scheme where 16% of members are indigents. This high percentage was attributed to the fact that there was a special ILO pilot programme to identify the poor in the district for subsidy. The other districts were however constrained since they had no guidelines for identifying poor households. One scheme Manager when asked how he managed to get the poor from the community had this to say: "*To avoid being blamed for being biased, I only selected orphans in the orphanages in the districts and submitted them to the NHIC. With these vulnerable children I am sure nobody has something against their selection.*" It therefore means that the other districts could have equally enrolled more indigents if they had any practical mechanism of identifying poor households.

5.3 FACTORS INFLUENCING ENROLMENT

Several factors have contributed to the low enrolment levels in the districts. In the first place, the technical arrangements made for the collection of the premiums served as a barrier to many households. For instance, although collecting premiums during the harvesting season was found to help farmers, in the district where marketing of the produce was a problem; the affected households faced problems as schemes do not accept payment in kind. Also, the entire household registration was identified as another obstacle especially for those with large a family size. Many large households are unable to afford the payment especially those whose members are above eighteen years. Additionally, low public education was highlighted as one reason why many people have not registered. Many people in the districts have not been properly educated on the benefits package under the NHIS. This confirms literature on CBHIS which shows that low public education can negatively affect enrolment, as was the case in the Chogoria Hospital Insurance Scheme in Kenya. Low awareness creation about the scheme was found to have negatively contributed to low enrolment which stood at 0.3% of the target population (Musau 1999).

Two other key factors that have been highlighted in the literature to have profound impact on the success of any health financing arrangement and were found to particularly influence enrolment in this case study are service delivery and the contribution level.

5.3.1 Service delivery

The successful development of health insurance depends in part on the availability of quality and appropriate health service for the insured population (Normand and Weber 1994). This case study however found that the quality of care offered to insured members is generally poor and is one of the main criticisms people have about the NHIS. One possible explanation for this situation is the inability of the scheme managers to strategically purchase health service for insured clients which is one essential sub-function of health financing as highlighted in the World Health Report 2000 (WHO 2000). According to Baeza, Montenegro and Nunez (2002 p.330) a scheme is considered to do strategic purchasing "if convincing evidence exists that the scheme discusses or negotiates with providers on the type, price, and or quality of services to be provided to participants and/or establishes contracts that include these issues and define payment modalities" This means that quality of care to insured members could be included in contract agreements with service providers.

Record reviews of the schemes shows that only one of the district schemes (Kwahu south) has signed an official contract with service providers for the provision of health care for insured clients. The remaining districts mentioned that they had only discussed the contract document with the service providers. Inability to sign a formal contract means that the contract is not binding on both parties and therefore not legally enforceable, which makes it difficult to enforce quality assurance. Also, in the scheme where there was an official contract, no mechanism was put in place to ensure that the terms of the contract were strictly adhered to. For instance, it was reported in some of the districts that some service providers collect money from insured clients for services that are supposed to be free. This practice was reported in Kwahu South (where there was a formal contract with providers) and Dangme West (where there was no formal contract signed). It therefore means that signing a contract alone is not enough. There is the need for scheme administrators to ensure that the terms of the contract are strictly enforced since that is the only way they can protect their members from the disappointments they go through at the health facilities. Another option is to educate the scheme members on their entitlements and to report to scheme management any time they face such problems.

Under the NHIS program, the NHIC is required to accredit to all health facilities in the country meeting appropriate standards before they can offer services to insured members, but the formal contract signing is decentralized to the district level. For a facility to qualify for accreditation the LI explicitly states that the health facility must accept the quality assurance standards and utilization reviews specified by the NHIC. In addition, the facility must have its own formal quality assurance programme. Accreditation is supposed to be given to all health facilities (both public and private) (Government of Ghana 2004).

At the time this study was being conducted, the NHIC had officially accredited only public and mission facilities and so compelling the schemes to neglect the other private health institutions. This has given monopoly power to the contracted facilities (especially in districts where mission hospitals serve as the only district hospital or vice versa) and that might have contributed in part to low quality services as there is no competition among providers.

Gaps in the implementation of the NHIS and inability of scheme managers to negotiate effectively on quality of care is reflected in the responses in the interviews. Quality issues raised centered on poor staff attitudes, discrimination and improper attention offered to insured clients. Most insured members are discouraged from renewing their membership as they thought paying out of pocket would rather help them get quality care. This confirms evidence from the literature on CBHIS which shows that poor quality of care has a negative influence on enrolment. For instance in the Maliando Insurance Scheme in Guinea Conakry, it was observed that poor quality of care offered to insured members by the contracted service providers resulted in a drop in enrolment from 8% in 1998 to 6% in 1999 (Criel, and Waekens 2003).

Another service delivery issue that has a negative impact on quality is the non-enforcement of the referral system (gatekeeper system). The study shows that only one district strictly enforces the system while the remaining districts allow their members to attend any facility of their choice. This practice is contrary to the initial arrangements made for the establishment of the NHIS which require all insured members to visit the primary health facilities as the first point of call and can only visit the hospital upon referral (Ministry of Health 2004).

Non-enforcement of the referral system has two policy implications. In the first place, allowing people to seek health care directly at the hospital will lead to inefficient resources allocation at the different levels of the health care system (allocative inefficiency). In Ghana, the cost of health care at the health center or clinic is considerably cheaper than at the hospitals, so schemes could save more money if they enforce the gatekeeper system. Secondly, the perceived quality of care expected from the hospital by insured members eventually eludes them since they have to wait for longer hours before they receive health care.

Evidence shows that enforcement of the gatekeeper system does not only improve quality of care but also helps make the financing mechanism sustainable. Bennett, Creese and Monasch (1998) have noted that one of the major factors that contributed to the UMASIDA Scheme in Tanzania becoming self – financing was the development of a strict gatekeeper mechanism. It therefore means that the referral system could be used to ensure that patients are treated in the most appropriate and cost -effective manner.

Poor quality of care is one reason raised by respondents for by-passing the primary level care. Therefore, for the system to work, it will require more facilities, equipment and staff training and most of all, career structures and status for primary care staff which match with those in the secondary and tertiary care. This will help attract qualified health personnel to the rural and less deprived areas of the country.

Also, physical access to health facilities in some districts in this study raises equity issues in the geographical distribution of resources in the country. People subscribe to insurance schemes with the hope that when they need health care, they can easily have access without any barrier. In the Dangme West District where there is no district hospital, some community members are reluctant to register since there is no nearby health facility. Those on referral have to travel to other regions and this seems to discourage people from registering. This confirms the study in Rwanda by Schneider and Diop (2001) which show that households living closer to health facilities had a much probability of enrolling than those living far away. It is therefore necessary that the government put up hospitals in such districts where there is none.

This will help bridge the gap in access to health care among districts in the country and also to increase coverage.

Access to quality health care is important considering the voluntary nature of the NHIS programme for the large informal sector employees. In order to extend coverage, people should be encouraged to register by offering real benefits.

5.3.2 Contribution level

The study indicates that all the schemes charge flat premiums. The Kwahu South District charges the highest premium (¢100,000) (US$11.1) while the Dangme West charge the lowest of ¢72,000 (US$8). This amount is paid by adults (18 years and above) in the informal employment sector.

The current flat rates are contrary to the initial arrangement made for the establishment of the NHIS. Cost analysis before the implementation of the NHIS indicated that the minimum benefit package would be offered at a minimum premium of ¢6,000 (US$0.66) per adult per month (¢72,000 per annum) (US$8). Each district scheme was supposed to categorize the population in the informal sector into their socioeconomic groups and charge them a premium according to their income level and ability to pay. The social groups include: the very rich, rich, middle income, poor, very poor and core poor. The ¢72,000 (US$8) per adult per annum is the minimum that would be paid by those classified as poor. The ultimate goal of this policy is to ensure equity in contribution based on ability to pay. It will also ensure cross-subsidization where the rich pay more to cross subsidize the poor.

However, this equity goal has not been realized because according to some of the scheme managers the social classification is very difficult especially in the informal sector. Most of the people are farmers, traders and other self employed businesses and so is practically difficult to assess their income. Therefore, the only way they could collect the premium is to charge a flat premium until such a time the NHIC comes out with a mechanism to use in classifying the people in the districts.

The current implementation difficulties in the NHIS have resulted in highly regressive contribution rates, as on the average poor households pay proportionally more than

the rich. Those in the low-income group have suffered from the consequences of the current implementation problems. Both non-insured and insured members complained that the premium is too high and called on the schemes for a reduction. Perhaps if the premium graduation has been possible, most of the people in the low-income group could have joined. Available literature on CBHIS has shown that premium graduation according to income levels helps to attract the low income group as was the case in the Gonosastha Kendra (GK) Insurance Scheme in Bangladesh (Desmet, Chowdury and Islam 1999). Conversely, flat premiums have been observed to negatively influence enrolment (Atim 1998; Bennett, Creese and Monasch 1998).

Another finding of the survey is that all the schemes charge members (both the exempt group and the adult contributors) annual registration fees. The fees ranges from ¢10,000 (US$1.1) to ¢30,000 (US$3.3) for all new entrants. This money is used to pay for the cost of ID cards and other administrative expenses of the registration exercise. Record reviews of the schemes indicate that the registration fees keep on changing every year at a faster rate for new members. For instance in the Kwahu South Scheme, the registration fee for the 2004/2005 insurance year was ¢8000 (US$ 0.8). This has increased to ¢20,000 (US$2.2) (about 150% increase) in the 2005/2006 insurance year. Similarly, in the Nkoransa Scheme, the registration fee has increased from ¢5,000 (US$0.5) to ¢30,000 (US$3.3) which is a 500% increment for the 2005/2006 insurance year. Only the Dangme West Scheme maintained the fee at ¢10,000 (US$1.1). The current registration fee for Nkoransa Scheme is over a third of the minimum contribution level of ¢72000 (US$8). The fear under this current arrangement is that many exempted individuals may not be able to pay the registration fees as it may be beyond the reach of some of them (for example the aged). Additionally it puts an additional burden on those with large family size as the registration fees has to be paid for every family member, while the premium only needs to be paid per adult member.

This problem has come about because the national health insurance law does not explicitly state any registration fees to be charged by district schemes but allow their General Assembly to set fees depending on the income levels of the people in the district. The above observation means that the discretion given to the schemes may require a review by the NHIC. It may be necessary to set a ceiling beyond which no

scheme can charge registration fees. This will help protect the poor and other vulnerable individuals exempted under the insurance programme as well as those with a large family size, thereby increasing coverage.

5.4 IDENTIFICATION OF THE POOR

The need to find a practical mechanism to identify the poor for subsidy has been identified in the literature as a prerequisite for the achievement of universal coverage (Peabody, Lee and Bickel 1994). Ghana being a developing country has a high proportion of the people being poor. According to the Ghana Living Standard survey 2000, about 40% of the population live below the national poverty line (Ghana Living Standards 2000). Therefore to ensure that the poor are not denied access to health insurance coverage, the National health insurance law has made provision for providing a subsidy to such poor households. It is imperative that a practical mechanism is adopted to identify the poor who may not be able to afford the premium. This will help bring equity in access to quality health care.

Studies on mechanisms to identify the poor identify three broad targeting methods namely: geographical and categorical targeting, self-targeting and individual or household targeting (Conning and Kevane 2000; Coady, Grosh and Hoddinott 2004; Alderman and Lindert 1998). The geographical and self-targeting methods as extensively explained in section 2.4 in the literature review and have been found not suitable for exemption policies. Also, although categorical targeting has been used to exempt the poor in some countries; evaluation reports show poor targeting results. Individual/ household targeting has been widely used and appears to be the preferred choice. However, assessing poverty status using a means test has been found to be difficult to apply especially in a developing country context because of the problem of under reporting. In recent times more emphasis is put on using more observable indicators to proxy for income to determine programme eligibility. This method has been found to be less subject to underreporting since the indicators are visible and verifiable compared to income (Behrman 2001).

Participants in this study could not give a single definition of poverty but came up with indicators of poverty to be used to identify the poor.

Table 10. COMPARISON OF INDICATORS

Indicators	Danso 2006 (Ghana) Current study	Dzikunu and Wajangi 2004 (Northern Ghana)	Dzikunu and Williams 2005 (Southern Ghana)	Zambia study 2006	Castaneda 2005 (SISBEN – Colombia)
1.Chronically ill and persons with disabilities	✓	✓	✓	✓	
2.No permanent source of income	✓	✓		✓	
3. Housing condition	✓	✓	✓		✓
4. Malnutrition status of the household	✓	✓	✓	✓	
5. Aged	✓	✓	✓	✓	
6. Availability of clothing	✓	✓	✓		
7.Ability to pay school fees and hospital bills	✓	✓	✓	✓	
8.Widow with large family size	✓				
9. Ownership of assets	✓	✓		✓	✓
10. level of education					✓
11. Orphan	✓		✓	✓	
12. Ability to pay development levy		✓	✓		

Table 10 provides a summary of the indicators identified by respondents in this study and compares the study with similar studies in developing countries. As indicated on the table, the indicators compares favourably with studies both within Ghana and other developing countries. The studies in Ghana were conducted in Northern and Southern Ghana in the Saboba Chereponi and Nkwanta Districts respectively. The aim of those studies was to set up a mechanism for identifying the poor for subsidy into the district insurance scheme. The investigators used both consensus-building workshops of all stakeholders (traditional leaders, opinion leaders, health providers etc) and FGDs to arrive at key indicators (Dzikunu and Wajangi 2004; Dzikunu and Williams 2005). Comparison of the Ghanaian studies with the current studies show that apart from the widows with large family size and ability to pay community levies, all the other indicators are similar. This attests to the fact that the indicators in this study correlate well with poverty indicators identified by other communities in Ghana.

Also, an evaluation report on waiver scheme in Zambia where the poor are identified using proxy indicators is presented. It is a pilot project (2002-2004) implemented in

the Kafue District, Zambia to help increase health care utilization by the most vulnerable population following the introduction of user fees in that country (Kafue District CHEW Team 2006). Again as shown on Table 10, apart from housing condition, widow with large family size and availability of clothing, all the other indicators are the same. The differences may be due to differences in country context. Additionally, the indicators used in the SISBEN system in Columbia are comparable with the current study except the level of education. This difference may be due to the fact that the relationship between poverty and education are different in the two countries. For instance it can be noted from Table 10 that none of the studies in Ghana has education as indicator of poverty therefore suggesting that lack of education may not be a sign of poverty in the Ghanaian context.

It has been observed that lack of clear guidelines on the implementation of many exemption policies in developing countries partly accounted for poor targeting results (Bitran and Giedion 2003). International experience shows that it is useful to provide general guidelines to ensure consistency between different geographical areas. However, because of differences in socioeconomic conditions in both urban and rural areas, it is important to allow some amount of local discretion to community agents (for example, housing conditions in rural and urban areas may differ).

In recent times, many targeting programmes use a scoring system based on the indicators to determine eligible households. For instance in the Zambian study, the indicators were categorized into primary, economic and "other" qualifiers. The minimum for an individual or household to qualify for a waiver is to meet one primary and two economic qualifiers. The category of "other" qualifiers was used to gauge the level of vulnerability. The more ticks one has the more vulnerable the person is. The Ghanaian studies have a more simplified scoring system where a checklist of the indicators is used to score households. "Yes" response equals one (1) and "no" response equals zero (0). All results are in percentages. For the individual or household to qualify for subsidy, the score should be 50% for the Northern Ghana Study and 60% for the Southern Ghana. Also, in Columbia, thirteen variables are used for the calculation of the SISBEN index. The index gives a continuous score from 0 to 100 (from poorest to richest) divided into levels (levels 1 to 6). Level 1 and 2 are

people who are in poverty and are the subjects of most national and local programmes.

Considering the statistical and information requirements of the SISBEN approach, its usage will not be feasible in Ghanaian context. Similarly, the Zambian matrix was found to have implementation difficulties and so the authors recommended the redesign of the matrix. A simplified version will help in Ghana since most of the users may not be able to use any complex system. This study therefore endorses the scoring system used in the studies in Ghana (see appendix 6).

Another area of concern in targeting the poor is to identify the person or group of persons to select the poor. This is because where the selected people are not well informed about the socioeconomic status and the cultural background of the people, they may end up selecting the non poor, excluding the very poor who may need assistance. The general consensus in this study was that the community members themselves should be allowed to select the poor. To ensure effective work, it was agreed that a committee should be formed in each town or village. This finding is consistent with literature on community based targeting. Evidence has shown that local community agents may have more information on household characteristics upon which to determine beneficiary eligibility than an outsider who may have to rely only on crude indicators (Conning and Kevane 2000; Alderman 2002).

The formation of a committee for the selection exercise is in line with similar studies on CBT. For instance in Thailand, the identification of poor households for the Low Income Card is done at the community level by a committee headed by the community leader (Bitran and Giedion 2003). In the Zambian study, a community-based institution (a community welfare assistance committee) is delegated to identify poor households. Similarly, an elected commune council in Albania determines allocation of the country's Economic Support programme to poor households (Alderman 2002). All the studies in Ghana use village committees made up of traditional and religious leaders as well as leaders of different ethnic groups in the area.

One major advantage of this targeting method is lower cost of administration simply because community agents, living in low cost rural areas do not need to be paid as much as educated bureaucrats (Conning and Kevane 2000). However, literature on CBT show that community agents may allocate exemptions to provide personal and political favours and may lack the skills in identifying the poor leading to poor targeting results as was the case in Thailand (Bitran and Giedion 2003). Again in the Zambian study, it was noted that the community agents favoured households of acquaintances in the group of vulnerable eligible households (Kafue District CHEW Team 2006). The above revelation means that there is a trade off between lower administrative cost and accurate targeting and will therefore require that measures be put in place to monitor the work of the committee at the community level.

Evidence has shown that lack of monitoring and evaluation of programmes meant to protect the poor can lead to poor targeting results. Bitran and Giedion (2003) have observed in their case studies of seven developing countries that have implemented waivers and exemptions (meant to preserve equitable access to health care for the poor when user fees were introduced) that none of the countries systematically monitor performance in terms of who beneficiaries are and the influence of the protection mechanism on the poor resulting in poor targeting results.

The need to get an independent body has been suggested by participants in this study to monitor the selection exercise. The key issue is the person or the group of persons qualified to do this assignment. Traditionally, most exemption schemes rely on Social Welfare Officers for the selection exercise as they have been trained specifically in that area. In the Ghanaian context, a directive from the NHIC requires all districts schemes to have the District Social Welfare officer on their Board of Trustees and the idea was that the Officer would assist in the selection exercise. Therefore delegating the monitoring exercise to the Department of Social Welfare as suggested by some participants in the study will be appropriate as it is within the design of the NHIS programme.

Once an individual or group of persons have been given an exemption, it is important to define the time frame within which the eligibility status is valid. Health status, income, age and employment, which changes over time, are all factors that influence

the decision whether an exemption is granted to an individual or not. Newbrander, Collins and Gilson (2001) recommend that to avoid excessive under coverage and leakage, regular review is necessary. For example, an individual can lose his job or his income decreases so that he/she becomes eligible for exemption. However, because there are no formal or regular review periods, his/her change in status is not recognized and under coverage could occur. The reverse holds for an increase in income. The critical issue is the administrative cost involved in this exercise. A shorter period would involve a higher administrative cost but at the same time will help reduce under coverage and leakage. International experience indicates that exemption eligibility status should be for a year or more. In Thailand for instance, the validity for the Low Income Card is three years. Considering the low-income levels of Ghana, an average period of two to three years will be reasonable.

SUMMARY

This section provided a critical discussion on enrolment, and a mechanism to identify the poor. Enrolment levels are generally low in all the schemes. Institutional and technical arrangements used by scheme management were found to have contributed to low coverage. In particular, poor service delivery and the highly regressive contribution levels had a negative impact on enrolment. A practical mechanism to identify the poor using town and village committees with a list of indicators has been presented. This section also made a comparison between international experience on universal coverage and Ghanaian context and found that even though some of the factors that favour universal coverage do not exist in Ghana, there is hope for Ghana if proactive measures are put in place to mitigate their effect.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

CBHIS has been identified as an alternative way of providing health insurance coverage to informal sector workers who are usually excluded from any form of employer – based insurance or any social security arrangement. These schemes have the potential of helping the rural poor to mobilize money during harvesting periods to pay for the future cost of ill health. The aim of this study is to critically examine the role of CBHIS in extending health care coverage to the informal sector in Ghana.

6.1 COVERAGE

Findings from the study show that enrolment level in the districts schemes is low. In line with the objective to determine factors that influence peoples' decision to subscribe to CBHIS, the study found that certain institutional and technical arrangements put in place by scheme management negatively affected enrolment. All the schemes charge flat premiums irrespective of the individual socioeconomic status, thereby serving as a barrier to poor households especially those with a large family size. Additionally, the study found that even though some people are exempted from paying the premium, the current registration fee charged by the schemes is high and so serves as an obstacle to some of the exempted groups. Also, it was noted that even though collecting premiums during the harvesting period enables farmers to mobilize money to pay the premium, those farmers who face problem with the sale of crops find it difficult to register as schemes do not accept payment in kind.

Another area of concern is the poor quality of care offered at the health facilities. Quality issues raised in the study include long waiting time, poor attitude of health staff and discrimination against insured members. A possible explanation for low quality of care in the schemes is the fact that some schemes have not officially sign contracts with provides and do not have any mechanism to monitor quality at the facilities. Also, physical access to health facilities also serves as a barrier to enrolment especially in districts where there is no district hospital. Another obstacle identified is low public education on the NHIS. Many respondents complained that they have not been properly educated on the NHIS programme.

The establishment of the NHIS was meant to address most of the issues raised above but findings from this study indicate that the implementation of some of the policies has proved to be difficult. For instance the proposal to categorize the population in each district into their socioeconomic groups and charge premiums according to income has been found to be difficult to implement so schemes continue to charge flat premiums. On quality of care, the NHIC was supposed to accredit health facilities before district schemes could contract with them. This has taken place for only government and mission facilities but other private facilities have not yet been included. Additionally, the gatekeeper system which is one of the pillars of the design of the NHIS is not fully implemented in some of the districts resulting in long waiting times at the hospitals. Perhaps if some of the aforementioned problems are solved, it would help increase enrolment.

Another objective of the case study is to gain an understanding of how other countries have achieved universal coverage so as to help policy makers make informed decisions about universal coverage. Comparison of the NHIS programme with the international literature on coverage shows that Ghana has provided the enabling environment that can assist in achieving universal coverage. This includes the passage of the National Health Insurance Act, Act 650 mandating every Ghanaian to belong to an insurance scheme that provides adequate cover and making provision to exempt the poor. Also, although Ghana's economic growth does not seem to match with some countries, the current trends offer hope for the Ghanaian economy. However, certain factors have been identified as unfavourable compared to international standards. These include a high proportion of informal sector employees and relatively large rural population. It therefore means that more innovative and effective systems will have to be put in place to attract the large informal sector and rural dwellers. It will also require all stakeholders in the NHIS to work hard to ensure that the policy is properly implemented in line with the vision of the national program.

6.2 IDENTIFICATION OF THE POOR.

In line with the objective of determining a practical mechanism to identify poor households for subsidy as enshrined in the NHIS program, participants in this study identified key indicators that compares favourably to many studies on proxy means

testing. Additionally, a proposal to use village /town committees to take advantage of rich local information has been highlighted. The study further found that lack of clear guidelines in most targeting programmes result in poor targeting results. In this regard, a simplified scoring system has been suggested to ensure consistency in the application of the indicators. Also, to minimize any possible bias by the committee's members, participants in the case studies have proposed the setting up of an independent body to monitor the selection exercise. The successful implementation of this targeting mechanism will help ensure equity in access to quality health care among poor households in the country.

Finally, the bold step taken by the Ghana government to provide universal coverage to the citizens requires commendation. The success of this programme will offer hope for many countries in Sub Saharan Africa who aspire to embark on a similar health policy goal. This report is not intended to discredit or undermine the good initiative taken by the government but to provide information and critical suggestions at this early stage of the NHIS programme so as to shape policy decisions of the implementers of the programme. This report therefore serves as a call on all stakeholders to expedite action on areas of weakness identified in the study so as to help Ghana reach her ultimate goal.

6.3 RECOMMENDATIONS

The fourth objective of this study is to make policy recommendation for addressing problems identified in the case studies for the successful implementation of the NHIS programme. In line with this objective, the following recommendations are made:

- The study recommends capacity building of scheme managers on strategic purchasing of health service for insured members. They should be equipped with the skills of how to negotiate with providers on price and quality of services to be provided to insured members. A national workshop on how to design contracts would be desirable.
- Findings from this study have shown that signing a contract alone is not a guarantee that service providers will adhere to the terms of the agreement. In this regard, it is suggested that schemes should initiate regular review meetings (monthly, quarterly or semi-annually) with service providers. The

meeting would serve as a platform for both parties to revisit some of the terms of the contract to find out how far service providers have adhered to the contract terms. This will also enable service providers to raise any problems they face in the course of their duties. It is further suggested that minutes of the proceedings of such meetings should be taken and later sent to all the providers to serve as a reminder of issues that have been discussed at previous meetings. This collaboration and frequent interactions will help ensure improved quality of care at the facilities.

- To avoid long waiting times at the hospital, it is suggested that the NHIC should enforce the referral system in all districts in the country. Apart from emergency cases, all insured members could either be asked to go back to the primary level care or be asked to pay a circumvention fees (fees for by-passing the primary level care). Also, poor quality care at the health centers and clinics have been cited as a key reason why people by-pass primary care level. In this regard, it is recommended that the government as a matter of urgency may need to resource the facilities in terms of drugs, equipment, infrastructure and be managed by competent medical assistants or nurses. In this way, insured members will have no incentive to go to the hospital if similar services could be obtained at the primary care level.
- To ensure equity in financing, it is recommended that the initial arrangements made to categorize the population in each district into their socioeconomic group to charge graduated premiums need to be revisited. The NHIC may have to come out with a framework or a mechanism that would assist the scheme managers to classify the population in their respective districts. Also, it is suggested that the NHIC may have to regulate the registration fee set at the district level. This could be in the form of setting a ceiling for the fees every year. To ensure that the exempt groups are not denied access to insurance cover, government may have to fully subsidize their registration fee. This will help bring majority of the low-income group in the informal sector into the schemes.
- Evidence from the study shows that non-acceptance of payment in-kind prevented many interested farmers from subscribing to the schemes. It is therefore suggested that the NHIC and the Ministry of Food and Agriculture

collaborate to find a way of absorbing the farmers' produce and giving them an acceptable price especially during the registration periods. Another alternative is for district schemes to accept payment in kind and later negotiate with the Ministry of Food and Agriculture for resale. This will provide relief for farmers who go through difficulties in selling their produce.

- To ensure that people understand the NHIS programme, this study recommends an intensive public education drive both at the national and district levels. Innovative marketing strategies could be put in place at the national level using national television, radio and posters. At the district level, it is suggested that a campaign team (made up of the insurance staff, some members of the Board of Trustees and some beneficiaries of the scheme) could be formed in each district. The team could liaise with the traditional rulers and the assembly members of the communities for frequent community education. At such meetings beneficiaries of the insurance scheme could be allowed to give testimonies of the benefit they have gained from the insurance scheme. This will help arouse interest of those who are reluctant to register.
- To avoid confusion at the community level regarding the definition of a household, it is suggested that the NHIC comes out with a clear definition of a household. This definition could form part of the campaign message of the campaign team so that as people register into the schemes, they may know the people they have to include in their household list and who to exclude.
- To ensure consistency in the application of the indicators, it is recommended that the scoring system in (appendix 6) be adopted in determining individual or household eligibility for subsidy.
- Considering the differences in socioeconomic and cultural situations pertaining to towns and cities, it is suggested that some flexibility should be given to the committee members in applying the scoring system. This will help capture conditions in the local context so as to ensure fair treatment to all eligible households (e.g. housing conditions in rural and urban areas may differ).
- It is recommended that the identification exercise should be piloted in some selected districts for some time (e.g. two or three years) to test for its

accuracy in targeting the poor. This will allow scheme managers to assess any possible weakness in the system for redress before it is finally extended to other districts.

AREAS FOR FURTHER RESEARCH

The removal of financial barriers to accessing health care has the tendency of increasing utilization and thereby influencing cost. Also, considerable administrative resources are required to put structures in place for the NHIS to succeed. There is therefore an urgent need for further research on the sustainability of the programme.

Also, evidence from this study shows that poor quality of care is the main criticism insured members have about the NHIS programme. This study only solicited views on client's satisfaction. It is therefore suggested that further studies be conducted on a national scale to consider both structural quality of care and customer satisfaction levels so as to give a broader picture of the overall quality of care in the country's health facilities.

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APPENDIX 1

INTERVIEWEE'S CONSENT FORM

PART A

PURPOSE OF THE STUDY

The purpose of the study is to determine factors that influence people's decision to join CBHIS and also to find a practical mechanism to identify the poor who cannot afford the premium and would be eligible for a government subsidy. This is an academic exercise and not intended for any commercial purpose.

CONFIDENTIALITY

All information obtained from you will be kept confidential and reporting of information will be anonymous.

BENEFIT

The findings of the study will help policy makers of the NHIS to design programs and policies that will address the expectations of members and potential members of the scheme in your district.

PROCEDURES

It is a private interview about your views and perceptions about the NHIS program. The interview will be approximately thirty minutes. I will like to seek your permission to tape record all proceedings. Your participation is entirely voluntary and you are free to withdraw at any stage.

SECTION B

The purpose of this study has been explained to me satisfactorily. I understand it and agree to participate in the study.

Name of interviewee ... ...

Signature ... ...

Date ... ...

APPENDIX 2

A GUIDE FOR FOCUS GROUP DISCUSSION

(INSURED MEMBERS)

1. How much is the annual premium?
2. Do you find the premium affordable?
3. Is the time for collecting premium convenient to you? If no can you suggest an alternative time period for the exercise
4. Unit of registration into the NHIS is by entire households instead of individual members. Do you consider this mode of registration convenient? If not can you suggest alternative mode of registration?
5. Are you satisfied with the services you receive from the contracted service providers of your scheme? If no what should be done?
6. How do you view the performance of your scheme administrators?
7. How do you receive information from the scheme? Do you find it adequate?
8. Are you involved in taking major decisions concerning the scheme?
9. Do you have intentions of renewing your membership this year? If yes why? If no why?
10. Are there experiences of people within your community who are willing to join the scheme but unable to pay the current premium?
11. In you opinion, who should be considered as poor? Can you suggest critical signs or criteria to use to identify the poor?
12. In your view what will be the most suitable community structure for identifying the poor?
13. How can this exercise be monitored to prevent abuse or fraud?

NON-INSURED

1. Do you know the annual premium being charged by your district scheme? If yes,
2. Do you find the premium affordable?
3. Is the time for collecting premium convenient to you? If no, can you suggest an alternative time period for?
4. Do you consider the current entire household registration convenient? If not, can you suggest alternative mode of registering people?

5. How does your community receive information from the scheme? Do you find it adequate?
6. How do you view the performance of the scheme administrators?
7. What are other possible obstacles to more people joining the scheme?
8. In your view, what should be done to encourage more people to enroll into the scheme?
9. Do you have intention of registering this year? If yes why? And if no why?
10. Are there experiences of people within your community who are willing to join but cannot pay the current premium?
11. In you opinion, who should be considered as poor? Can you suggest critical signs or criteria to use to identify the poor?
12. In your view, what will be the most suitable community structure or who should be assigned the duty to the poor?
13. How can this exercise be monitored to prevent abuse or fraud?

APPENDIX 3

A GUIDE FOR KEY INFORMANT INTERVIEWS WITH COMMUNITY/OPINION LEADERS AND DISTRICT DIRECTORS OF HEALTH SERVICES

INSURED MEMBERS

1 How much are you paying as annual premium? Do you find the premium affordable?

1. Is the timing for the collection of premium convenient to you? If no, can you suggest an alternative time period for the premium collection exercise?
2. Unit of registration into the NHIS is by entire households instead of individual members. Do you consider this mode of registration convenient?
3. Are you satisfied with the services you receive from the contracted service providers of your scheme? If no, what should be done to improve the service?
4. How do you view the performance of your scheme administrators?
5. How do you receive information from the scheme? Do you find it adequate?
6. Are you involved in taking major decisions concerning the scheme?
7. If no, what possible ways do you want to be involved?
8. Do you have any other concerns about the running of the scheme?
9. Do you have intentions of renewing your membership this year? If yes why? And if why?
10. Are there experiences of people within your community who cannot to pay the current premium?
14. In you opinion, who should be considered as poor? Can you suggest critical signs or criteria to use to identify the poor?
14. In your view, what will be the most suitable community structure for identifying the poor?
15. How can this exercise be monitored to prevent abuse or fraud?

NON-INSURED

1. Do you know the annual premium being charged by your district scheme? If yes, is the premium affordable?
2. Do you find the timing for the collection of premium in your district convenient? If no, can you suggest an alternative time period for the exercise?
3. Do you consider the current entire household registration convenient? If no, can you suggest alternative mode of collecting the premium?
4. How does your community receive information from the scheme? Do you find it adequate?
5. How do you view the performance of the scheme administrators?
6. What are possible obstacles to more people joining the scheme in your community?
7. What do you suggest should be done to encourage more people to enroll into the scheme?
8. Do you have any intention of registering this year? If yes why? And if no why?
9. Do you have people within your community who cannot pay the current premium?
10. In you opinion, who should be considered as poor? Can you any suggest critical signs or criteria to use to identify the poor?
11. In your view, what will be the most suitable community structure for identifying the poor?
12. How can the exercise be monitored to prevent abuse or fraud?

APPENDIX 4

INTERVIEW WITH SCHEME MANAGERS

DISTRICT………………………………………………………………………………..

FULL NAME OF SCHEME……………………………………………………….

DATE OF ESTABLISHMENT……………………………………………………

1. What is the total population of your district?
2. What is the registration fee for new entrants?………………………………
3. What is the current premium for adults? ………………………………….
4. Which time of the year do you collect premium from members?
5. Do you think this period is convenient for the people? If no, do you have any plan of changing the period?
6. List the marketing strategies you use in getting information to the community
   i………………………………………………………
   ii………………………………………………………
   iii………………………………………………………
   iv………………………………………………………
7. How many service providers do you work with?
   Hospitals……….
   Clinics/health centers………
8. What type of contractual agreement do you have with them?
9. Are you satisfied with the services they offer to your clients? Yes/no
10. If no, what have you done about it?
11. How many annual general meetings have you had for the past three years?
12. What is your enrollment for the past three years

Year	Formal sector	Informal sector	Total
2003			
2004			
2005			

13. In your views what are the major obstacles to more people joining the scheme?
14. What do you suggest could be done to increase coverage?

15. In your opinion who should be considered as poor to be exempted from paying premium? Can you suggest critical signs or criteria to use to identify the poor?

16. In your view, what will be the most suitable community structure for identifying the poor?

17. How can this exercise be monitored to prevent abuse or fraud?

APPENDIX 5

MINIMUM HEALTH CARE PACKAGE UNDER THE NHIS PROGRAMME

1. **Out-patient Services**
   A) Consultation including reviews. These include both general and specialist consultations.
   B) Requested investigations including laboratory investigation, x-rays and ultrasound scanning for general and specialist out-patient services.
   C) Medication, namely, prescription drugs on National Health Insurance Drugs List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional practioners.
   D) HIV/AIDS symtomatic treatment for opportunistic infection.
   E) Out- patient/Day Surgery Operations including hernia repairs, incision and drainage, haemorrhoidectomy.
   F) Out-patient Physiotherapy.

2. **In-Patient Services**
   A) General and Specialist in-patient care
   B) Requested investigations including laboratory investigations, x-rays and ultrasound scanning for in-patient care.
   C) Medication, namely, prescription drugs on National Health Insurance Drugs List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional medicine practitioners, blood and blood products.
   D) Cervical and Breast Cancer Treatment
   E) Surgical Operations
   F) In-patient Physiotherapy
   G) Accommodation in general ward
   H) Feeding (where available)
3. **Oral Health services**
   A) Pain Relief which includes incision and drainage, tooth extraction and temporary relief
   B) Dental Restoration which includes Simple Amalgam Fillings and Temporary Dressing
   C)

4. **Eye Care services**
    A) Refraction
    B) Visual Fields
    C) A-Scan
    D) Keratometry
    E) Cataract Removal
    F) Eye lid Surgery
5. Maternity Care
    A) Antenatal Care
    B) Deliveries, namely, normal and assisted
    C) Caesarian Section
    D) Postnatal care
6. Emergencies

    All emergencies shall be covered. These refer to crisis health situation that demand urgent intervention and include:

    A) Medical emergencies
    B) Surgical emergencies including brain surgery due to accidents.
    C) Paediatric emergencies
    D) Obstetric and Gynaecological emergencies including Caesarian Sections
    E) Road Traffic Accidents
    F) Industrial and workplace accidents
    G) Dialysis for acute renal failure

EXCLUSION LIST

The following health care services are excluded:

A) Rehabilitation other than physiotherapy
B) Appliances and prostheses including optical aid, hearing aids, orthopedic aids, dentures
C) Cosmetic surgeries and aesthetic treatment
D) HIV retroviral drugs
E) Assisted Reproduction e.g. Artificial insemination and gynecological hormone replacement therapy
F) Echocardiography

G) Photograph

H) Angiography

I) Orthoptics

J) Dialysis for chronic renal failure

K) Heart and Brain surgery other than those resulting from accidents.

L) Cancer treatment other than cervical and breast cancer

M) Organ transplanting

N) All drugs that are not listed in the NHIS Drug list

O) Diagnosis and treatment abroad

P) Medical examinations for purposes of visa applications, educational, institutional, driving license

Q) VIP ward (Accommodation)

R) Mortuary Services.

APPENDIX 6 SCORE SHEET

Yes score 1, No score 0

INTERVIEW METHOD			**OBSERVATIONAL METHOD**		
Availability of food	**Yes**	**NO**	**Physical appearance**	**Yes**	**No**
1. Cannot normally feed family a meal a day?			2.Family/children emaciated or malnourished?		
Availability of clothing					
3. Has no attire for market day, or church or mosque?			4. Family or children in tartered clothes every time?		
			5.Family/children in same dirty clothes all time?		
			6.Naked grown up children?		
Adequate shelter					
7. Does not own house/hut ?			9. Cracked and gapping walls?		
8. Cannot rent house/ hut?			10. Leaking roofs or parts of roof off?		
			11. House/hut looks deserted?		
Secondary needs					
12. Has no children in school?					
12. Cannot attend/pay for health when sick?					
Societal position/personal characteristics					
13. A widow with large family size					
14. Old person without support?					
15. Chronically ill and disabled (physically and mentally)?					
Wealth of individual					
16 Does not own assets (land, livestock, etc)?					