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Research Article

An Assessment of the National Health Insurance Scheme in the Sekyere South District, Ghana

D. Adei, E. Amankwah and I. Sarfo Mireku
Department of Planning, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

Abstract: As part of government's pro-poor strategy to increase access to and improve the quality of basic healthcare services, the National Health Insurance Act (National Health Insurance Authority, 2003, 2010 and 2013) was passed in 2003. The study assessed 379 heads of household, 5 heads of health facilities and the scheme managements' perception on quality of health service delivery, implementation of the capitation programme, operation of the National Health Insurance Scheme (NHIS) and performance of scheme operators and service providers in the Sekyere South District of Ghana. Findings indicate that 73.9% of the heads of household had registered for NHIS and out of this figure 74.5% had renewed their cards. Despite a high renewal level, 30.3% are not satisfied with the services provided. With the introduction of the capitation grant, 25% of private service providers have withdrawn their services due to inadequate per capita payment on the scheme and 17.3% of the heads of household had difficulty in tracing their names at their preferred choice of health facility which have the tendency of affecting the sustainability of the NHIS. The study therefore recommends that, the National Health Insurance Authority should ensure upward adjustment of the monthly per capita payment made to service providers to reflect reality and also intensify education on the capitation policy for both service providers and the scheme beneficiaries.

Keywords: Capitation, challenges, national health insurance scheme, risk pooling

INTRODUCTION

Financing healthcare in Ghana has experienced many transformations (Arhin-Tinkorang, 2001). The paradigm shifts in accordance with the various health policies implemented in Ghana have been through: free medical care, out of pocket payments, National Health Insurance Scheme (NHIS) and now the capitation grant. According to Abekah-Nkrumah (2005), Ghana's healthcare system was influenced by the British. Succeeding governments after independence provided free medical care to the citizenry through general taxes and donor support. However, this could not be sustained owing to inadequate resources and budgetary constraints which affected quality of service delivery in most health facilities (Agyepong and Adjei, 2008).

The implementation of the International Monetary Fund (IMF) and World Bank structural adjustment programme in 1983 cut down government healthcare expenditure and introduced user fees which further deteriorated the conditions of the people as they could not pay for the cost of healthcare delivery. The situation therefore led to a compromise in quality of healthcare delivery especially to the poor and vulnerable who resorted to self treatment, itinerant drug vendors and other alternative medical treatment which was disastrous to their health (Oppong, 2001).

The empirical evidence and growing global awareness by the World Health Organisation (WHO) indicated that the NHIS was the tool to reduce financial barriers to quality healthcare and better protect the people against catastrophic health expenses. This led to Ghana's adoption and passage of the National Health Insurance Act (National Health Insurance Authority, 2003), establishing the NHIS (Doetinchem *et al*., 2006; Yevutsey and Aikins, 2010).The scheme sought to enhance the performance of the health system, paying particular attention to the poor. It recognised the detrimental impact of user fees, the limitations and low coverage of Community Based Health Insurance (CBHI) and the fundamental role of public financing in the achievement of universal healthcare. The scheme thus focused on meeting the needs of the poor and providing social health protection based on the principles of equity, solidarity, risk sharing, cross-subsidization, reinsurance, client and community ownership, value for money, good governance and transparency in the healthcare delivery (NHIA 2013, Durairaj *et al*., 2010).

The scheme since its implementation has resulted in increased enrolment and utilisation of most health facilities (NDPC, 2011; NHIS, 2010; Dogbevi, 2012).By the end of 2005, the scheme was covering 27% of the population. By June 2009, coverage had

Corresponding Author: D. Adei, Department of Planning, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

gone up to 67.5%, with most poor and disadvantaged people finding their way into the system (Durairaj *et al*., 2010). The most significant strength of the NHIS is its generous benefit package including general out-patient and in-patient care, normal and assisted maternity care, oral health, eye care, diagnostic tests, generic medicines and emergency care. It is widely reported that about 95% of the diseases in Ghana are covered by the NHIS. There can be no doubt that the comprehensive level of care and treatment available is of enormous benefit for those who hold valid NHIS membership cards and are able to access these services (NHIA, 2013).

The 2009 nationwide evaluation conducted by the National Development Planning Commission 2009 and 2010 (NDPC) on the NHIS indicated some major challenges facing the implementation of the scheme. These included delay in issuing identity cards, low vetting capacity of district schemes and delays in settlement of claims.

As part of government's effort to address some of these challenges especially difficulty in the renewal and annual payment of the premium, the government in 2012 introduced the health capitation policy on a pilot basis in the Ashanti Region to improve cost containment, control cost escalation by sharing risk between schemes, providers and subscribers in ensuring efficiency through rational use of health resources (Gobah, 2011).

The selection of the Ashanti Region for the piloting was influenced by factors such as its proximity, ethnic balance, availability of various health facilities, ranging from Community Health Planning Services (CHPS compounds) to teaching hospitals and also the presence of both public and private health facilities. Capitation is advanced payment made by the scheme operators to the service providers on behalf of the beneficiaries as cost of treatment or service to be rendered at the facilities (service purchasing). The monthly per capita payment offered by the NHIA to service providers is of GH¢1.75 (Owusu, 2012).

The reform does not do away with any of the already existing provider payment methods. It rather introduces Capitation for specific level of care- the primary level of walk in outpatient care, which is the fundamental base of healthcare systems and reserves itemized fee for medicines system to the higher levels of care. By tying clients to a PPP of their choice, it reduces fragmentation of care and introduces continuity of care for clients. It will also enable proper implementation of a referral system. Capitation explicitly establishes relationship between the physician and the patients (Agyepong and Yankah, 2012). In a capitation payment structure, it is envisaged that 'patients have their needs assessed, when they enter the healthcare system and receive the care they need from a coordinated team-and that these teams would be encouraged and rewarded for providing g high quality and efficient healthcare' (Whelan and Feder, 2009).

Several researches have been conducted on the implementation of the NHIS such as the effect of the scheme on out of pocket expenditure, utilisation and beneficiaries assessment of the scheme (Agyepong and Adjei, 2008; NDPC, 2009; Witter and Garshong, 2009; NHIA, 2010). Few studies have however been conducted on the capitation grant policy and their sustainability prospects (Arthur, 2011; OXFAM, 2011; Ministry of Finance and Economic Planning, 2011; Asare, 2012).

This study thus assessed the implementation of the Sekyere South Mutual Health Insurance Scheme in order to map strategies for the effective implementation of the programme. The specific objectives of the study were to assess; heads of households perception on quality of service delivery, implementation of the capitation programme, operation of the scheme and performance of scheme operators and service providers in the Sekyere South District of Ghana.

Data sources and methods of collection: The cross sectional approach was employed in the study. This is usually designed to study a phenomenon, a situation or an issue by taking a cross section (representation) of the population at one point in time. In this regard, heads of household respondents' selection were based on all sectors of the economy, rural and urban areas and finally both public and private health facilities in the district. Data was collected from both secondary and primary sources. Secondary data were obtained from various reports from the health facilities in the Sekyere South District and the District Assembly's Development Plans, related articles and books. Primary data which served as firsthand information from the field was collected through direct observations, interviews and documentation with the use of both structured and unstructured questionnaires. The study was carried out from January 2012 to October, 2012.

The study adopted purposive, stratified and simple random sampling techniques in selecting the interviewees. Purposive sampling was employed in the selection of relevant institutions such as the District Mutual Health Insurance Scheme (DHMIS) office, the District Assembly and the District Health Administration in view of their uniqueness in areas of expertise for the study. However in selecting the health facilities for the interview, the facilities were stratified into public and private, after which three out of the five public and two out of the four private facilities were randomly sampled from their respective list (public and private) to ensure a fair representation. Communities in the District were stratified into urban and rural based on their population (less than 5000 for rural and above 5000 for urban) as indicated in Table 1.

The sample size of the heads of households in the selected communities was determined at a 95% confidence level "0.05 error margin". The

Table 1: Sample distribution for top ten selected communities

Status	No. of communities	Selected communities	No. of Households (2011)	Questionnaire distribution
Urban	35	7	10377	350
Rural	15	3	252	29
Total	50	10	10629	379

Sekyere South District, 2011

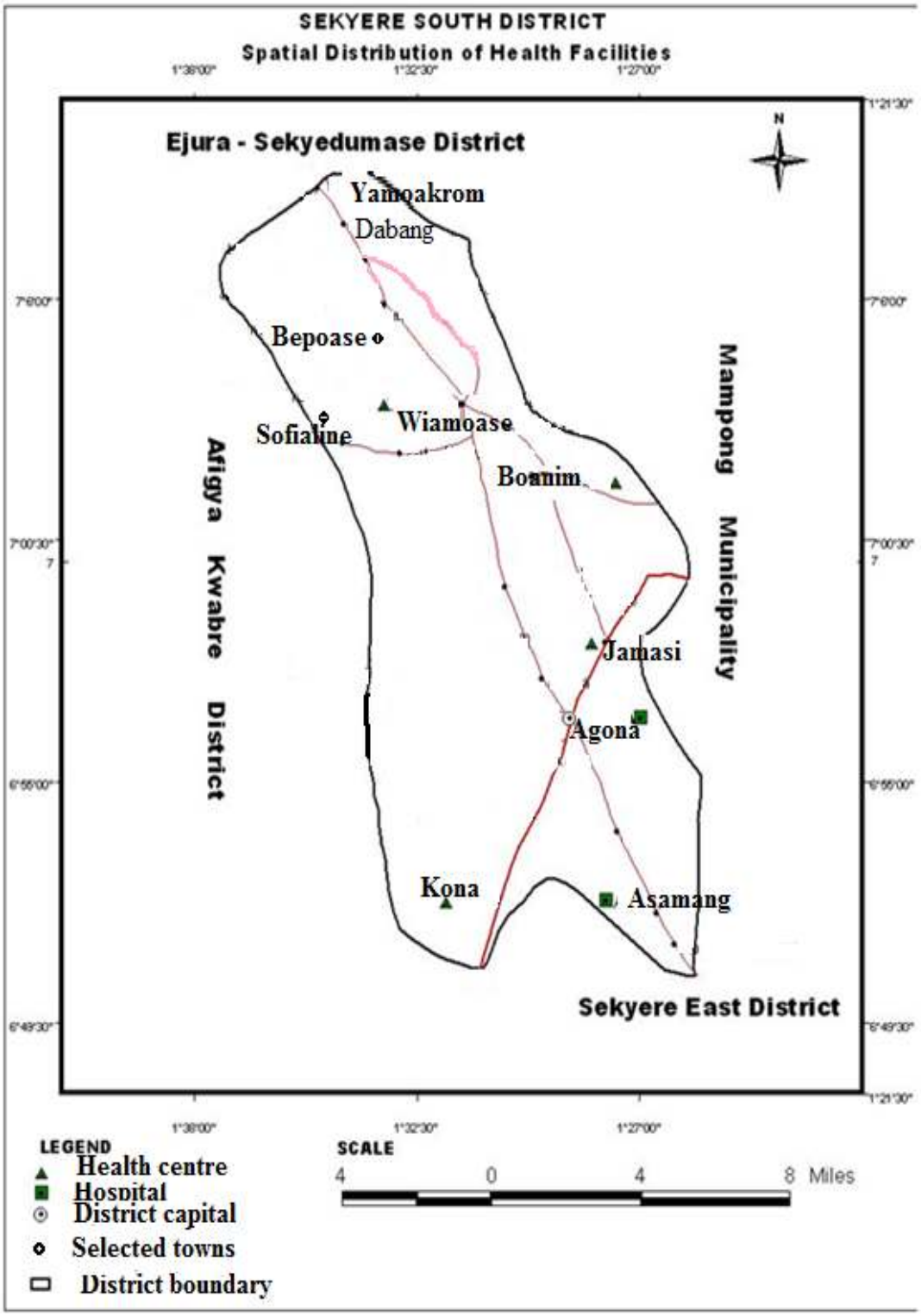

Fig. 1: Map of Sekyere South district showing spatial distribution of health facilities Sekyere South District, 2011

sample size for household respondents was determined by employing a mathematical formula given by Miller and Brewer (2003) n = N/ [1+N(α)^2] (Where n = sample size; N = sample frame, α = error margin). With the total households in the selected communities being 10629 (SSD, 2011), the sample size was calculated as follows:

$$n = \frac{10629}{1+10629(0.05)^2} = \frac{10629}{28} = 379 = n = 379$$

The various sample size distribution for each selected community has been calculated and presented in Table 1. Relating to the District's current rural-urban split of nearly 30 and 70%, respectively (SSD, 2010-2013). In view of the rural-urban ratio (i.e., 30:70), three rural and seven urban communities were selected with the aid of a spatial map (Fig. 1). In order to ensure a fair representation of health facilities, some form of stratification techniques were used to select communities based on how closest (within 1km), closer (within 5 km) or close (10 -20 km) they were to the people. Communities which fell within the criteria were randomly selected for the administration of the household interview. This was done based on the premise that people living closer to facilities would have the opportunity to visit the facilities easily when they fall ill or when the need arises. Systematic sampling technique with a random start was used to select houses where the respondents were picked and after selecting the first house, the subsequent fifth house (n^{th}) were selected based on the sample size chosen. In each of these selected houses, one respondent (mostly household heads) was interviewed based on his/her willingness.

In all 379 heads of household, 5 heads of health facilities and the scheme managements were assessed individually on the perception on quality of health service delivery, implementation of the capitation programme, operation of the National Health Insurance Scheme (NHIS) and performance of scheme operators and service providers in the Sekyere South District of Ghana. Data triangulation was carried out among these key stakeholders especially where inappropriate or inadequate responses were given to the specific questions on the above issues in a separate meeting. This was done to ascertain the reality or actual situation on the ground. In order to ensure accuracy, the questionnaires were initially pre-tested and errors corrected before actual administration.

The administered questionnaires were carefully edited, coded, processed and analysed with the Statistical Package for Social Scientist (SPSS-16.0 version) and the application of Microsoft Office Excel for the presentation of data into meaningful patterns and trends. Statistical analysis such as cross tabulation was employed to show relationship or association between variables. Calculation of mean and the use of charts were employed to give a visual appreciation of issues and trend of events in order to clearly understand and appreciate them. The Likert Scale was used in evaluating procedures, attitudes, perceptions and values in assessing their level of satisfaction or otherwise of the scheme's implementation.

RESULTS AND DISCUSSION

The findings of the study have been analysed in relation to head of households perception on quality of service delivery, implementation of the capitation programme, operation of the scheme and performance of scheme operators and service providers in the Sekyere South District. The implementation of the capitation and its challenges and prospects have also been analysed in this section.

Household characteristics:

Age and sex distribution: The survey covered 95.5% of heads of households between the age group of 19 to 69 years (Table 2). Only 0.5 and 4% belonged to the 0-18 and 70+ year's age groups, respectively. The survey covered 69.7% male and 29.3% female household heads. This only affirms the social and religious status and responsibilities usually assigned to the male as the head of a household and not a representation of males outnumbering females in the District. In spite of this proportion, the Public Relation Officer (PRO) of the Sekyere South Health Insurance Scheme (SSHIS) said "its participation rate is 41% males and 59% in favour of the females". The situation could be attributed to the fact that, by gender, females have more health problems and perhaps are more conscious and mostly associated with health issues/needs of the family than their male counterparts. It stands to reason that pregnancy related issues, ante-natal and sending children to seek medical attention are mostly synonymous with females. Again another factor that might have contributed to the situation was the exemption policy granted to pregnant women in terms of the free renewal and registration under the scheme, resulting in improving health seeking behaviour and increased utilisation in most facilities (NDPC, 2009; NHIS, 2010; Gobah, 2011).

Marital status: The survey captured 32.7% singles, 59.1% married, 6.6% divorced and 1.6% cohabitation heads of household. Out of the 59.1% who were married, 30.3% were females within the reproductive age and are most likely to join the scheme and ensures its sustainability when there is improvement in service delivery by both service providers and scheme management.

Table 2: Social characteristics of heads of household respondent

Social Characteristics	Frequency (n = 379)	%
Sex		
Male	264	69.7
Female	115	30.3
Age		
0-18	2	0.5
19-69	362	95.5
70+	15	4.0
Marital Status		
Single	124	32.7
Married	224	59.1
Divorced	25	6.6
Cohabitation	6	1.6
Literacy		
Male	226	59.7
Female	153	40.3
Educational Status		
None	79	20.8
Primary	39	10.3
JHS/MSLC	66	17.4
SHS/GCE O/A Level	75	19.8
Tertiary	120	31.7

Field Survey, October 2012

Educational status and literacy levels: According to Article 38 of Ghana's Constitution The Republic of Ghana (1992), the minimum acceptable level of education for literacy is one's ability to successfully complete a quality basic level of education (Primary to Junior High School). All things being equal, the higher one's level of education, the better his or her position in making well informed decisions most especially exercising his/her basic rights on education, health and requisite information. In establishing the relationship between heads of household educational attainment and registration status, it was observed that out of the 379 heads of household respondent, 68.9% had at least the minimum education up to the basic education level with break down was as follows; 17.4% had attained basic education, 19.8 and 31.7% had their secondary and tertiary education, respectively. In terms of literacy by gender, it was realised that 59.7% males household respondents and 40.3% female household respondents could read and write English and therefore could make good or informed decisions for themselves and their families (Table 2). In such capacity, there is the high tendency that such persons were likely to earn some appreciable level of income and could therefore assist them subscribe to the scheme and also the likelihood to educate their peers and family members about the benefits members could derive by being a beneficiary. This may go a long way in improving their health seeking behaviour and health status.

Employment status and occupational sector: Out of the employable age group, 93.9 and 6.1% said they were employed and unemployed, respectively (Table 3). By gender, the study further revealed that 53.5 and 40.2% of heads of households employed were males and females, respectively. With regards to sector of employment, 29.5 and 70.5% belonged to the formal and informal sectors, respectively. Out of the 29.5% employed in the formal sector, only 1.1% belong to the Agricultural sector whilst the rest directly or indirectly linked to the Service sector. The breakdown of the informal sector employment were as follows; Agriculture (21.7%), Industry (9.5%), Commercial (26.1%) and Service (13.2%). In most situations, people employed in the formal sector were Social Security and National Insurance Trust (SNNIT) contributors and do not pay any premium into the running of the scheme apart from initial registration fee. Unlike the formal sector, where members contributions are automatic (SSNIT deductions at source), the 70.5% household respondents in the informal sector which formed the majority, could also ensure the effective implementation of the scheme by enrolling and also ensuring prompt renewal. As the scheme thrives on risk pooling, it would be prudent for the scheme implementers to ensure that service providers improve upon quality of service delivery to beneficiaries in order to attract more people to enrol on the scheme in the Sekyere South District.

Income levels: It was observed that 43% of heads of household have their average monthly income below the national minimum average income of GH¢134.4. The figure at the Sekyere South District seems quite lower than that of the National figure where 8% of some public sector workers and 10% of private formal workers earned below the national minimum wage (Otoo *et al*., 2009). Again by gender, the study revealed that out of the 43% of heads of household, who earn

Table 3: Sector of employment and income levels of heads of household respondents

Respondent	Employed (%)	Unemployed (%)	Below min. wage GHC 134.40 (%)	Above min. wage GHC 134.40 (%)
Male	53.5	2.2	17.3	32.6
Female	40.4	3.9	25.7	24.4
Heads of Household Sector of Employment				
Sector	Formal	Informal		
Agric	1.1	21.7		
Industry	0	9.5		
Commercial	0	26.1		
Services	28.4	13.2		

Field Survey, October 2012

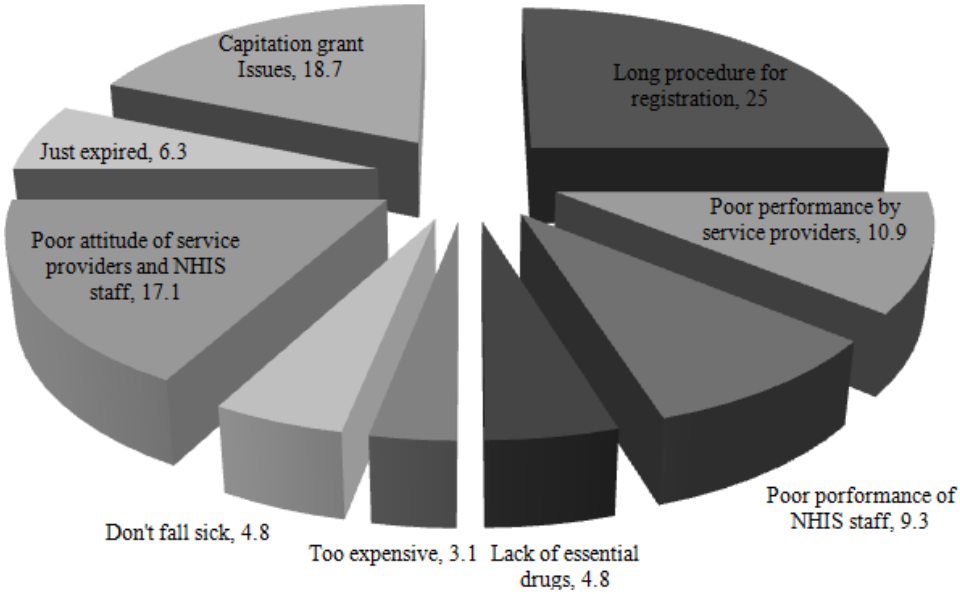

Fig. 2: Reasons for heads of household non-renewal of NHIS cards Field Survey, October 2012

below the national minimum wage, 38.5% were males and 61.5% were females. The gender wage gap in favour of males therefore has some implication as far as poverty reduction is concerned as women are more likely to spend a higher proportion of additional earnings on items that improve the living standard of the household (Williams, 2012). Though none of the heads of household was captured as 'core poor', under the NHIS (those unemployed with no visible source of income, no fixed residence and not living with someone employed and with a fixed residence) it is worth mentioning that 6.5% of card bearers mostly from the Agric sector lived below the proposed UN per capita monthly income of GH ¢52.70 (that is $1.00 (US) per capita daily), hence could be classified as the core poor that may need some assistance in paying their NHIS premium. As their incomes are inadequate, there is the tendency that most of them would hardly invest or save some of their income for the future or in the wake of any catastrophic events. Impliedly, there is the high probability that such population would find it difficult paying their NHIS premium and perhaps that of their immediate family.

Perceptions of individuals on the scheme: This section explored head of households' perceptions on the operation of the scheme. The major issues assessed were their knowledge on the scheme; sources of information and their enrolment levels (registration status). Issues such as renewals; their views on the amount of premium paid; the mode of collection of the premium; satisfaction of the operation of the scheme; and perceived challenges were critically examined. These were examined in relation to the quality of service delivery and in a quest to sustaining the scheme.

Knowledge on NHIS, sources of information and registration status.

All the heads of household respondents said they were aware of the NHIS, 31.1% went further to indicate that their knowledge was very adequate, 56.5% had adequate knowledge on the scheme and 12.4% had inadequate knowledge on the scheme. Their sources of knowledge included FM and TV Stations (27.4%), scheme operators (16.9%), service providers (6.7%), friends and colleagues (2.9%) and 46.1% through a combination of the sources. Out of the 73.9% of household respondents who had registered under the scheme, 74.5% had renewed their cards. With regards to the national figure, out of the 87.8% of beneficiaries that had registered under the scheme, only 34% had renewed their cards (NDPC, 2012). This shows that, the Sekyere South District was doing quite well as far as renewal of cards by heads of household was concerned.

Reasons for non-renewal of NHIS Cards: Findings from the survey indicated that out of the 73.9% of heads of household that had registered under the Scheme in the Sekyere South District, 25.5% had not renewed their cards as they are of the view that, the registration procedure took a long time and by the time they got their cards, they would have spent extra money visiting a health facility. They therefore preferred to pay for healthcare services when they were taken ill. Whereas 3.1% attributed their non-renewal to unaffordable charges for renewal, 18.7% attributed their non-renewal to the recent introduction of the capitation grant and its challenges. Other reasons given for non-renewal (Fig. 2), include list of similar reasons also stated by NDPC and NHIA (NDPC, 2009; NHIA, 2010).

Table 4: Level of satisfaction among heads of household about the scheme

Level of Satisfaction	Premium Paid		Mode of collect.		Service provided		Benefit package	
	No	%	No	%	No	%	No	%
Very satisfied	44	15.5	217	76.5	5	1.8	28	9.8
Satisfied	85	30.0	46	16.3	76	26.8	131	46.1
Indifferent	107	37.7	15	5.3	117	41.1	98	34.5
Dissatisfied	27	9.5	4	1.3	26	9.1	17	6.1
Very Dissatisfied	21	7.3	2	0.6	60	21.2	10	3.7
Total	284	100	284	100	284	100	284	100

Field Survey, October 2012

Although the assessment of the capitation policy is near impossible as it has been piloted in the Ashanti region for just a year, there have been some complaints by card bearers included inability/difficulties in tracing their names at their preferred choice (17.3%) and absence of quality treatment at the health facilities (82.7%). There were complains by service providers that the monthly payment of GH¢1.75 as medical bill for patients under the scheme by the NHIA was woefully inadequate and thus called for an upward adjustment to reflect reality.

Heads of household satisfaction with the scheme:

Premium payment and mode of collection: The amount of money paid as premium in the District was GH¢14.00 per person. As seen in Table 4, 15.5% of heads of household were very satisfied, 30% satisfied, 37.7% were indifferent, 9.5% dissatisfied and 7.3% very dissatisfied. It could therefore be inferred that 83.2% saw the amount as affordable. However, the remaining were of the view that, the current amount does not commensurate with services rendered at the facility. In assessing household respondents satisfaction with the mode of collection of the premium, 76.5 and 16.3% respectively indicated that they were very satisfied and satisfied as payment was made at the scheme's offices at the district capital (Agona), which was quite accessible to all.

Benefit package of the scheme: The benefit package enjoyed by household beneficiaries under the scheme include, outpatient services such as diagnostic testing and operations like hernia and in-patient services including specialist care, oral health treatments, maternity care services and all drugs prescribed under the NHIA medicine list. In assessing respondents' satisfaction of the operation of the scheme, 9.8% said they were very satisfied with benefit package, 46.1% satisfied, 34.5% indifferent, 6.1% dissatisfied and 3.7% very dissatisfied. The forgone presentation indicates that, majority of the heads of household respondents (55.9%) were satisfied with the benefit packages of the scheme and for that matter if challenges associated with the implementation of the capitation grant were addressed, it would go a long way in ensuring the sustainability of the scheme in the long term. However, some heads of household respondents indicated their plight as follows:

"*Service providers often give much priority to non-insured members by serving them faster than we the registered ones"*

"I am usually given paracetamol, multi-vitamins and other cheap drugs when I go for treatment at the health facility"

"*Whenever the drugs prescribed are expensive, we are told the scheme does not cover them and for that matter the only option was to buy them at the facility or outside depending on one's financial position".*

Quality of service delivery at the facility: Quality of service delivery by service providers was very paramount to beneficiaries. Some of the indicators used in assessing quality of services were the waiting time at the facility, availability of drugs and attitude of services providers to clients. About 24% of the heads of household indicated that previously they spent relatively shorter periods (less than 3 h) at the facility but after the introduction of the NHIS, they usually spend beyond 3 h at the heath facilities. It is an undeniable fact that when one perceives that service use had value for their money, their propensity to utilise the service increased (Griffiths and Stephens, 2001). About 69.7% of heads of household respondents perceived the quality of service delivery at the healthcare facilities as satisfactory. The rest (30.3%) did have different opinion. They complained of various challenges with regards to quality of service provided by service providers (Fig. 3).

Challenges of households on the NHIS operation: Heads of household respondents catalogued some major challenges facing the implementation of the NHIS within the study area, among such are:

Period of waiting for NHIS card: The issuance of the card, according to the heads of household respondents sometimes takes over three months. This, according to 20.3% of the respondents is an unfair means by the scheme to prevent them from their money's full worth and again one of the reasons which accounts for about 26.1% of non-registered members not joining the scheme.

Waiting time at health facility: About 67% of heads of households who access healthcare at accredited

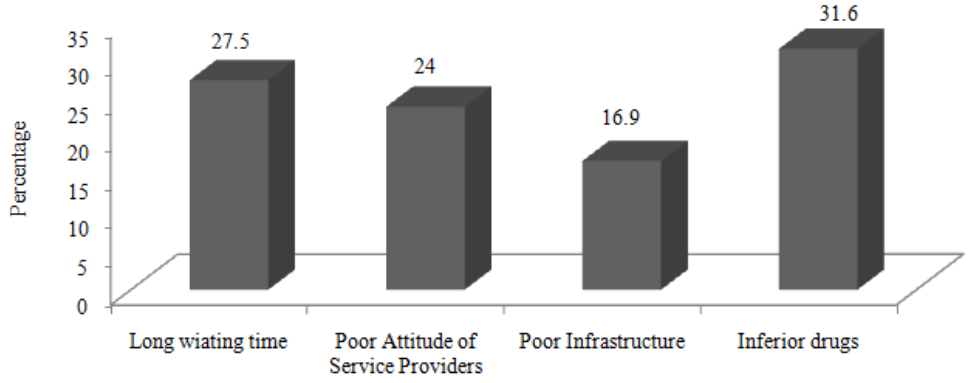

Fig. 3: Household respondents challenges with quality of service delivery Field Survey, October 2012

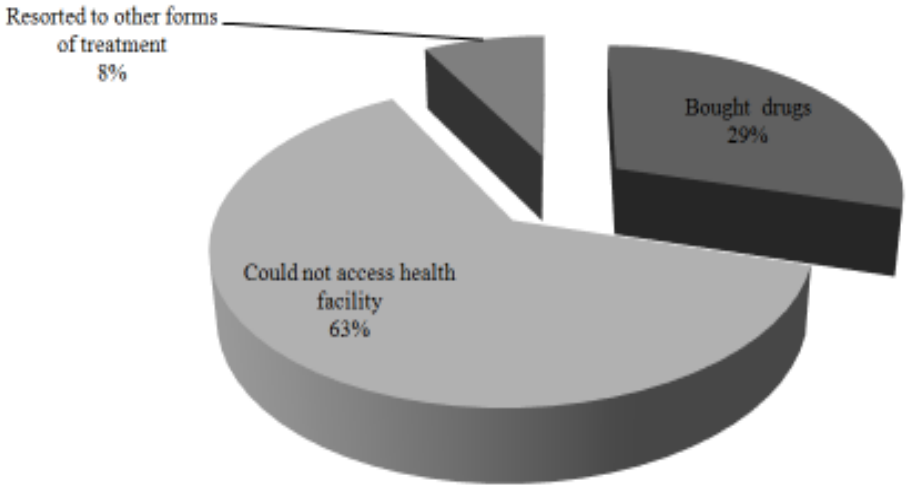

Fig. 4: Challenges associated with waiting time Field Survey, October 2012

Table 5: Challenges of heads of household respondents on the scheme

Challenges of accessibility	%
Distance travelled (more than 10 km)	3.2
Poor nature of road	10.2
High cost of transportation (Aveg. GHC 3.00)	14.8
None	71.8
Total	100
Time spent at the facility	%
< 1 h	12.0
1-2 h	21.5
3-4 h	42.6
4+ h	23.9
Total	100

Field Survey, October 2012

facilities spend more than two hours in the facility. Such prolonged time may have the tendency to discourage these beneficiaries from going for routine checkups and treatment when the need arise.

Accessibility to health facility: Physical accessibility is very important to sustaining healthcare delivery and for this reason physical accessibility was analysed. About 76.2% of the heads of household respondents said they can access healthcare within 1 km, 12.2% between 2 and 5 km, 8.4% between 6 km and 10 km; and 3.2% accessed between 11 km and 20 km. It could be inferred that majority of the people could access healthcare within a walking distance of 1km to 5 km and this could be attributed to some level of fairness with the distribution of health facilities in the district. However, 28.2% (80) of the 284 card bearers complained of physical accessibility as a major challenge: they elaborated their plight as, long distance travelled to the health facility (3.2%), poor nature of road to health facility (10.2%) and finally, 14.8% indicated high cost of transportation (an average of GH¢3.00) to the health facility as their major impediment to the effective utilisation of health facilities in the district (Table 5).

Capitation: The capitation is a new policy of the NHIS being piloted in the Ashanti Region of Ghana. The study covered heads of household, service providers and scheme implementers views on the health capitation policy.

Awareness and knowledge of heads of household on the capitation policy: Findings from the field indicated

that 74.5% of the heads of households had renewed their card. Even though, 85.9% of the heads of household respondents indicated they were aware of the capitation policy, only 14.1% had adequate knowledge about it. Again 62.3% of the respondents said they had some challenges with the implementation of the capitation policy. The following challenges were recorded; 17.3% mentioned inability/difficulties in tracing their names at their preferred choice of facility, 82.7% complained of absence of quality treatment at the facility as a result of the capitation. They claimed that some essential drugs had been removed from the regular drugs served at the facilities. The private service providers were of the view that the monthly payment of GH¢1.75 as medical bill for patients under the scheme by NHIA was woefully inadequate and therefore called for an upward adjustment. Twenty five percent of service providers had withdrawn their services for NHIS card holders whilst others were running parallel service of both the NHIS and cash and carry services in most health facilities. According to the 25.5% of the non-insured members interviewed, the current situation had become a disincentive to their enrolling unto the scheme.

According to the District Director of Health Services, "*the education on the capitation grant that preceded the piloted programme was inadequate and therefore called for intensified education of all stakeholders like the politicians, civil society, service providers, the community and the general public to appreciate the concept for its smooth implementation and sustainability"*.

Although the NHIS office claimed to have educated the community on the capitation policy, it appears majority (85.9%) of heads of household in the district had not grasped the concept and for that matter did not fully understand it. This had therefore resulted in the challenges with the implementation of the capitation grant policy in the district.

The service providers and the scheme implementers acknowledged the fact that the effective implementation of the capitation policy would help address most of the challenges associated with quality healthcare delivery. They were of the view that the concept was based on value for money and it could ensure effective and efficient use of health resources. In spite of the challenges encountered in the pilot stage, it was revealed by both service providers and the NHIS that, with the introduction of the capitation, release of funds (re-imbursement) by the NHIA for service providers which were always in three months arrears had been received on time. Moreover, the capitation policy when effectively implemented by the NHIA intends achieving the following, improve cost containment (moral hazards), control cost escalation, quality service delivery to beneficiaries, address difficulties in forecasting and budgeting and finally simplify claims processing.

Operation of the Scheme and Performance of scheme operators and service providers

Creating an enabling environment for effective implementation of NHIS: Five of the heads of the health facilities interviewed were of the view that, effective collaboration of all stakeholders will create a conducive environment for the implementation of the NHIS. According to them, their collaboration with the District Mutual Health Insurance Scheme (DMHIS) in one way or the other had led to increased awareness of the programme and its effective utilisation in all the facilities.

Institutional capacity of Sekyere South DMHIS staff and service providers: One of the key elements of an efficient and effective health delivery system is the institutional capacity (staff) in providing quality services. All things being equal, an institution with well-developed systems and requisite staff is more likely to remain viable in the future than one without.

For the provision of quality health services to clients, both the NHIS staff and Service providers indicated they have had capacity building trainings in their various fields of expertise. Whereas the NHIS manager reported of building capacity of the staff in the Information, Communication and Technology (ICT) unit, the District Director of Health Services on the other hand said, his outfit had organised training on customer care for all service providers as a way to improve service delivery in their respective facilities.

In a response to the frequency or number of times such capacity building programmes were organised, both the NHIS and service DHMT mentioned quarterly. Nonetheless, it appeared these training programmes had barely made the desired impact on the intended beneficiaries as findings from the survey indicated that 30.3% of the card bearers interviewed had some challenges with quality of services rendered under the scheme. A major contributing factor to the phenomenon could possibly be the absence of a system for designing and assessing staff training needs and finally evaluating performance of such programmes to assess the success or otherwise to determine the next line of action to be taken.

Another important factor that the survey brought to the fore was the assessment of the staff strength and capacity of the DHMIS and service providers in the implementation of the programme as seen in Table 6 and 7 below. It could be seen from Table 6 that almost all the staff of the DMHIS had the requisite qualification for their various positions; however it stands to reason that, there was the need to beef up three data entry staff to have the full complement for

Table 6: NHIS staff strength and qualification

Category/Position	Qualification	No. at post	No. required	Backlog
Scheme Manager	MBA	1	1	0
Accountant	HND Acct.	1	1	0
System Manager	Bsc. ICT	1	1	0
Claims Manager	MBA	1	1	0
PRO	MBA	1	1	0
Data Entry Staff	Dip. Statistics	7	10	3
Grand Total		12	15	3

Field Survey, October 2012

Table 7: Staff strength of service providers

Category of Staff	No. at Post	No Required	Backlog
Doctors	5	6	1
Medical Assistants	9	11	2
Pharmacists & Dispensary Technology	9	12	3
Nurses	148	160	12
MIS/Statisticians/OPD Staff	14	18	4
Disease control Officers	4	6	2
Accounts Officers	5	5	0
Orderlies(Cleaners/Labourers)	34	38	4
Grand Total	228	256	28

Field Survey, October 2012

Table 8: Heads of household assessment of the DMHIS Staff

Level of Satisfaction	DMHIS Staff	
	Frequency.	%
Very satisfied	29	10.1
Satisfied	73	25.6
Indifferent	118	41.4
Dissatisfied	47	16.6
Very Dissatisfied	18	5.3
Total	284	100

Field Survey, June 2012

optimal performance. With regards to Table 7, there was also the need for an additional 28 health staff for effective and efficient delivery of services to the populace. It was revealed that the scheme's data base was not up to date as at the time of the survey, which the Public Relation Officer (PRO) attributed to the inadequate staff especially data entry clerks, the use of obsolete computers and accessories, plant, frequent power outages, which at times destroys some of their equipment. He further mentioned that, the ever increasing number of card bearers without a commensurate data entry clerks usually result in untold back log of which the staff is working around the clock.

However according to the healthcare providers, issues of quality service delivery lies in the availability of essential drugs, having regular capacity building programmes, provision of appropriate tools and equipment, working under safer and hygienic conditions, regular re-imbursement by NHIA and provision of motivational packages to boost their morale. All things being equal, motivating one's staff may have the tendency to encourage them to come up with their best in terms of service delivery or output of work.

Heads of household assessment of Sekyere South DMHIS staff: It came to the fore that, 10.1% of the heads of household respondents were very satisfied with the performance of DMHIS staff, 25.6% are satisfied, 41.4% indifferent, 16.6% dissatisfied and 5.3% very dissatisfied with their performance as they complained of poor attitudes of some staff towards them at the facility as seen in Table 8. It stands to reason that when it comes to accessibility to healthcare provision and treatment of clients, attitudes of service providers were very important.

Financial aspects (including cost recovery measures) of operation of the scheme: One of the most critical issues relating to the effective implementation of the scheme and its sustainability was the issue of finance/ funding of the scheme. The financial position of the District Mutual Health Insurance Scheme (DMHIS) with regards to budgetary allocations, disbursement and utilisation of fund received from the National Health Insurance Fund (NHIF) was therefore analysed. It could be seen from Figure 4 that, the NHIL has been the major contributor of income from the NHIF and possible reason that could be attributed to the phenomenon was its mode of collection that is indirect payment made on goods and services which attract value added tax (VAT).

According to the Scheme's PRO and as seen in Fig. 4 and Table 9, the NHIL has maintained a steady and continuous growth since the inception of the scheme. With an average contribution of 59.8%, the figure rose from 56.7% in 2005 to 60% in 2008 and finally 62.6% in 2011, representing a corresponding increment of 5.8 and 10.4% from 2005 to 2011. With regards to SSNIT contribution, the trend in payment has not been consistent as the figure initially increased from 18.9% in 2005 to 19.2% in 2006 but experienced a sharp decline to 18.4% in 2007, increased to 19.4% in 2010 and again declined to 19.1% in 2011. Like the SSNIT contribution, the 'Other funds' which are mostly returns on investment by NHIC, allocations from Parliament and grants/donations made to the fund, disbursed to the DMHIS for onward payment on behalf of beneficiaries to service providers has been inconsistent. The figure

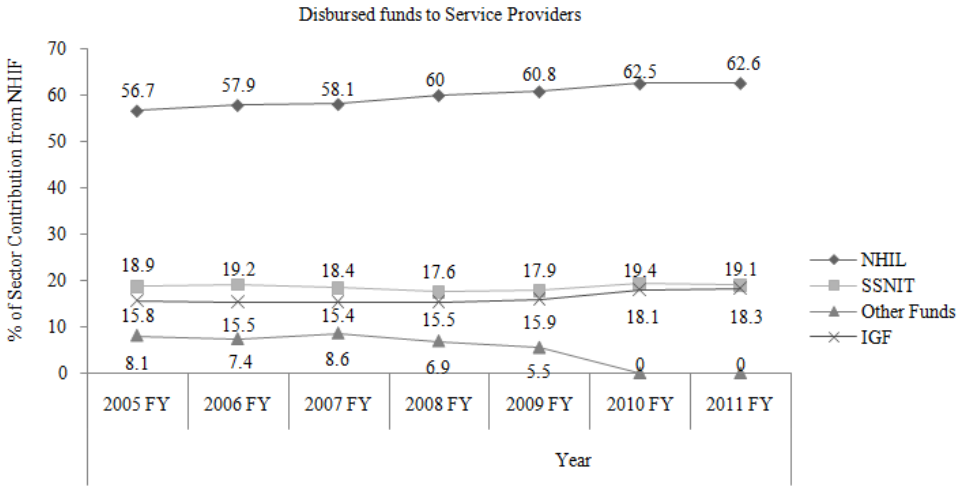

Fig. 5: Disbursement of funds to service provides from 2005-2011 in the Sekyere South District Sekyere South District, NHIS 2012

Table 9: Disbursement of funds from NHIF to Service Providers

Sector contribution from NHIF	Year						
	2005	2006	2007	2008	2009	2010	2011
NHIL	384, 028.30	576, 180.90	639, 974.20	1, 372, 574.80	1, 569, 923.00	1, 992, 925.70	2736117.20
SSNIT	128, 009.40	191, 065.20	202, 897.10	402, 621.90	462, 197.70	618, 604.10	834, 821.70
Other Funds	58, 247.60	73, 639.70	89, 221.80	157, 846.30	142, 016.10	0	0
IGF	107, 013.33	154, 245.30	169, 411.50	354, 581.80	407, 973.40	577, 151.30	799, 855.30
Grand Total	677, 298.63	995, 131.10	1, 101, 504.60	1, 933, 042.80	2, 582, 110.20	2,675, 303.30	4, 370, 794.28

Sekyere South District, NHIS 2012

Table 10: Enrolment Trend under the NHIS in the District

Year	2005	2006	2007	2008	2009	2010	2011
No. registered	36.482	41.112	44.306	47.612	48.648	49.392	50.061
Pop with Valid ID	21.056	29.437	33.249	35.058	36.591	36.811	36.997

Sekyere South District, NHIS 2012

declined from 8.1% in 2005 to 7.4% in 2006, increased to 8.6% in 2007 and further declined in the subsequent years that is 6.9% in 2008 and 5.5% in 2009. Interestingly, according to scheme implementers, the district ever since 2009 had not received any disbursement from the NHIA on the 'Other Funds' (i.e., returns on investment and allocations from parliament etc) and this has resulted in the scheme increasing portions of its inadequate Internally Generated Funds (IGF) for disbursement to service providers, hence reducing the portions meant for the day to day administration, investment and possible infrastructural development and maintenance.

Finally with regards to the contribution of the Internally Generated Funds (IGF), the trend appeared to be inconsistent as far as its disbursement was concerned. With an initial contribution of 15.8% in 2005, the figure declined to 15.4% in the ensuing two years but however increased to 15.9% in 2009. As at the time of survey, the figure had increased to 18.3%.

In order to ensure the effective implementation of the scheme and its sustainability in the district, there is the need to have an adequate and reliable IGF to supplement that of the NHIA contributions, hence the need to continue the disbursement of the 'other funds' to the DMHIS.

In assessing the implementation of the scheme from the national context, although the scheme operators complained of inadequacy of government allocations to the scheme and confirmed that their outfit initially received a subsidy of GH¢7.20 per "exempt" member from the NHIF, there has been an upward adjustment to GH¢8.00 since 2008.

Furthermore, in analysing government per capita expenditure towards healthcare delivery in achieving the MDGs by 2015, Ghana's per capita expenditure on health increased from $11 at the end of the 1990s to $21.66 in 2007 (Global Social Trust, 2003). This resulted in a shortfall of $34 per capita that the Commission on Macroeconomics and Health estimated as the minimum fund required to provide a basic package of health services.

One of the key challenges currently facing the scheme is financial sustainability in view of the increasing demand for health insurance and increase in utilisation in most facilities (NHIA, 2010; Dogbevi, 2012; MOH, 2012).

The PRO reported as follows; *"Our outfit makes sure that claims from service providers are properly vetted. We also undertake periodic monitoring of facilities (at least thrice a year) and educate stakeholders on challenges associated with moral hazards regarding the scheme's operation".* This is what the PRO claimed they did in their bid to recover cost. Even though, various health providers confirmed such monitoring and evaluation visits, it seemed, such visits were inadequate as according to the action plan of the DMHIS, this was supposed to be undertaken monthly. However according to management due to the heavy work load on the staff, such exercises were not implemented as planned. It is worth mentioning that; these monitoring and evaluation exercises stated in the action plan were not budgeted for and perhaps this accounted for its ineffective implementation.

Again with regards to the number of times the DMHIS outfit was audited, the PRO mentioned twice a year by both internal and external auditors. It appears however that, findings from such audits seems to be an exclusive preserve of management and for that matter not made available for public consumption and this does not promote transparency and accountability which might in turn assure public confidence in the scheme and their active participation.

The 2011 performance report of the Sekyere South District indicated an appreciable level of increase in enrolment by beneficiaries in all the facilities since the inception of the programme in 2005. The report further indicated that as at 31st December, 2011, the scheme had registered 36,997 card bearers representing 75.7% increment from 2005 Table 10. In comparing the current data with that of the regional and national, the number of card bearers in the Ashanti Region increased from 34% in 2010 (NHIA, 2010) to 39% in 2011 (NHIA, 2011). However at the national level, out of the total number of 21,274,392 registered applicants, only 34% have renewed their cards (NDPC, 2011), indicating that the Sekyere South District in particular and the Ashanti Region as a whole were doing quite well. It could also be inferred from the forgone analysis that, in spite of the challenges with the capitation grant, the scheme continued to attract new card bearers in the study area and the Ashanti Region. This phenomenal increase according to the scheme management could be associated with the implementation of pro poor strategies like the exemption policy resulting in increased utilisation by the exempt group especially pregnant women. This seems to corroborate the findings of the NDPC and the NHIA (NDPC, 2009; NHIA, 2010).

RECOMMENDATIONS AND CONCLUSION

Recommendations: In order to ensure the effective implementation of the scheme in the district, the following recommendations have been made:

- The scheme management and service providers should scale up their education on the NHIS especially the capitation policy on local information centres, radio (Fm) and various health facilities for beneficiaries to grasp the concept. Efforts should be made by scheme management in educating the general public on how the whole insurance works.
- The NHIA should also ensure upward review of the monthly per capita payment made to service providers to improve upon the quality of service delivery. This will go a long way in addressing beneficiaries complain of being served with inferior drugs and non-availability of quite expensive and quality drugs in most facilities.
- The service providers should furnish the DMHIS with their monthly claims on time in order to ensure quick processing and re-imbursement for effective implementation of their programmes.
- Individual beneficiaries should also ensure prompt renewal, avoid moral hazards and furnish the scheme management and service providers with relevant information for effective implementation of the scheme.

Conclusion: The study sought to assess head of households' perception on quality of service delivery, implementation of the capitation programme, operation of the scheme and performance of scheme operators and service providers in the Sekyere South District of Ghana.

For effective and successful operation of the NHIS, the implementation of the scheme in the Sekyere South District was assessed from the view point of supply and demand interplay. The supply side focused on the kind of services rendered by both scheme management and service providers as a way to attract more people to enrol and increase patronage in order to generate adequate revenue in complementing external sources of funds. The demand side on the other hand primarily focused on consumer satisfaction with the implementation of the scheme (benefit packages).

With the supply side (scheme management and service provision), findings from the survey indicated that, the pro poor strategy coupled with recent prompt renewal measures put in place by the scheme has led to an appreciable increase in enrolment ; however the DMHIS is unable to generate enough IGF hence its inability to reimburse service providers on time. The situation often leads to most services providers not being able to render the requisite quality services to their beneficiaries. On the demand side (membership satisfaction), about 69.7% of respondents (card bearers) were of the view that even though the scheme was good, some challenges such as long waiting time (27.5%), poor attitude of some service providers (24%) and prescription of inferior drugs (31.6%) have affected

quality of service delivery in most facilities, resulting in non-renewals by beneficiaries.

With these catalogues of challenges resulting in the inability of DMHIS to generate adequate IGF, significant level of non-renewals by some card bearers (25.5%) coupled with recent gradual withdrawal by some private service providers, the effective implementation of the scheme is likely to be compromised in Sekyere South District in the long run. Nonetheless, certain prospects exist which could be harnessed in a meaningful manner to ensure the successful implementation of the scheme in the district. All the service providers were willing to fully participate and ensure effective implementation of the capitation policy when the monthly per capita payment made by NHIA is increased to commensurate services rendered to the scheme beneficiaries. In addition, 89.5% of the non-insured (25.5%) are also willing to join the scheme when prevailing challenges associated with the implementation of the scheme addressed.

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