Improving health insurance coverage in Ghana: A case study

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Barriers and enablers to enrolment and retention in the National Health Insurance Scheme in Ghana

Introduction

The focus of this chapter is to explore barriers and enablers to enrolment in the National Health Insurance Scheme (NHIS) and member retention. The operation of NHIS, has earned Ghana the reputation of having a relatively reliable nation-wide health insurance. Despite this achievement, there are barriers that have resulted in low enrolment and high membership non-renewal rates. The pre-intervention household survey carried out in March 2009 in Eastern and Central Regions showed that only a third (30.1%) of the 3,301 households were currently insured, 14.3 per cent had been previously insured and 55.6 per cent had never been insured. Current enrolment of households varied considerably among communities ranging from 9.2 to 56.9 per cent and non-renewal rates from 2.7 to 27.5 per cent. Of the 13,857 individuals covered in the survey, only a third (30%) was currently insured, 15.6 per cent had been previously insured and 54.4 per cent had never enrolled. Individual enrolment also varied among communities ranging from 4.8 to 66.2 per cent (Table A.3, Appendix 2). The reasons why enrolment is low and non-renewal rate high are discussed in this chapter.

A multi-level perspective (MLP) was used to analyse stakeholders’ (community members, health providers and DHIS staff) behaviours and practices and the challenges of implementing the NHIS that influence enrolment and retention rates. The MLP emphasises that stakeholders and events at all levels of social organisation
must be considered when studying a phenomenon (instead of focusing on one level (see chapter 1).

This chapter presents the problems of the NHIS that are the focus of this study – to identify barriers to enrolment and establish interventions to expand coverage and retain members. It should be noted that despite the barriers presented here, health providers\(^1\) and district health insurance scheme (DHIS) staff are acknowledged for their contribution to promoting the scheme despite the challenging circumstances under which they work.

For my analysis, I draw on qualitative information from seven intervention communities in the Central Region and data from the baseline household survey we conducted in 30 communities in the Central and Eastern Regions of Ghana. Both techniques were used in an effort to present holistic information on barriers and enablers to enrolment with the NHIS and retention of members (see chapter 2).

In health economic literature, low coverage of health insurance schemes is generally linked to economic determinants that give excessive weight to the ability to pay and the cost of premiums (Asante & Aikins 2008, Basaza et al. 2008, Jutting 2004). This chapter looks beyond economic determinants by engaging the three key NHIS stakeholders (community members, health providers and DHIS staff) to explore factors that influence people’s decision not to enrol or renew their membership. Attention is also paid to the historical antecedents to the introduction of the NHIS and their effect on enrolment.

**Barriers experienced by community members**

In everyday conversation in the community, people described the NHIS as an advance payment towards healthcare and asserted that it was a good arrangement to ensure that everybody had access to healthcare. Views gathered from key informants and discussions in problem-solving group (PSG) meetings indicated that almost everyone has heard about NHIS and believes that it has improved access to healthcare. A community member described the NHIS as: “Advance payment that gives access to healthcare. When you have the hospital card [NHIS card] you do not have much problem when sick. It is helping many people go to the hospital nowadays.”

However, the overwhelming endorsement of the scheme does not translate into high enrolment and regular renewal of memberships. The actual decision to enrol and stay with the scheme is influenced by a number of factors categorised as poverty, “not often sick” and traditional concepts of risk-sharing, poor quality of

\(^1\) Health providers referred to in this study include medical doctors, medical assistants, nurses, disease control officers, dispensary assistants, health assistants and laboratory technicians among others who are in contact with insured patients and work on NHIS forms in public health facilities.
service delivery, payment of unauthorised fees and political overtones in the perception of the NHIS.

“No money to pay premium”
When I engaged community members in conversations on why they were not enrolling or renewing their membership in the NHIS, poverty was often mentioned. “No money to pay” was normally the first response given by previously or never-insured informants. This trend was reflected in pre-intervention household survey (N=3301) results in which an overwhelming majority said they did not enrol (72.5%) or renew their membership (61.4%) in the NHIS because they could not afford the cost of premium (Table A.4, Appendix 2).

Serwa, a disease surveillance volunteer and community-based growth promoter used by Ghana Health Service for field activities, told me some people could not pay the premium and needed help. For example, she wanted me to help Ama to get exemption from paying NHIS premium. Ama was known by almost everyone in the community as being extremely poor. Serwa summarised the situation of the core poor as follows:

They are very poor individuals who have no stable source of income. They live on the benevolence of family members, friends and neighbours. They struggle to survive. Even to get one meal a day is a problem and they cannot afford the cost of premium.

I discussed Ama’s situation with the NHIS collector and requested she submits her name for exemption. But when I asked the collector what had happened after two months, she had not submitted her name for an exemption. I decided to speak to Ama to ascertain if what Serwa had told me was true and to ‘push’ for Ama’s exemption. What I saw actually confirmed that Ama could not enrol in the NHIS because of poverty. She was living with a woman, an acquaintance, who decided to house her when she first came from a nearby village to the town looking for a job. Ama described her situation as follows:

I have five children, including twins. I want to enrol because if I compare the cost of premium to the cost of healthcare it is cheap, but I have no regular source of income and even what to eat is a problem. I do menial jobs and live with this woman. Though she is not a relative, she was kind enough to host me. People in this house support me, but they are not ready to give me money to enrol. As you know, one of my twin daughters died because I had no money to take her to the hospital when she was sick. It was so painful that I lost my daughter because of poverty.

The death of Ama’s daughter and her inability to obtain an exemption illustrates that poverty accounted for some people’s failure to enrol, even if they wanted to. Ama’s complaint also indicates that she knew the NHIS would give her access to healthcare and could have prevented her child’s death.

That said, I talked to a number of people who were not poor by local standards to explore further the “no money to pay” response and found that the issue goes beyond the premium. For example, although the premium and registration fees are
relatively low, enrolling all members of large households in the Ghanaian social context is problematic since it may not be affordable despite families owning cocoa and food crop farms and engaging in fishing (both of which create substantial incomes). Therefore, some households did selective enrolment of specific household members – often those who needed healthcare. Kwame, a cocoa farmer and a father of six children (one above 18 years) and two adult dependents (his mother and a nephew) said he could only enrol his wife and four children because he did not have money to pay for everybody. Paying GH¢ 4.00 (about US$2.5) for each child and his mother to cover the registration fee and premium for an adult dependant was a problem. When I asked him why he made this choice, he replied:

Though premium and registration fees are low, enrolling the whole household is expensive so I enrolled my wife and four children and left the others because there was no money to pay for everybody. I enrolled those who go to the hospital and are likely to use the NHIS card.

Nonetheless, other respondents gave additional reasons for not paying: “not getting sick often”, poor quality healthcare service delivery, negative behaviour of health providers and health insurance is not a priority. Discussions in PSG, stakeholders’ and community leaders’ meetings indicated that the core reasons for not enrolling or renewing NHIS cards was neither poverty nor the high cost of premiums. There was a consensus that the premium cost was reasonable: GH¢ 4.00 (US$2.5) initial registration fee and GH¢ 14.00 (US$10) per year premium (if applicable – GH¢ 1.00 annual administrative renewal fee). Although income is seasonal, the respondents stated that anyone really committed to enrolling could do so during harvest time when most healthy people could afford to pay.

This assertion by most key informants caused me to question the “no money to pay” response. So, I analysed the poverty situation in both the farming (Assin Achiano) and fishing (Anomabo) communities to explain the difference between the pre-intervention household survey and qualitative results from my conversations. The pre-intervention household survey was conducted at the peak of the dry season when poverty was at its worst. Qualitative data on the other hand was gathered throughout the year and the inhabitants’ poverty was observed and discussed. Views from key informants, community leaders and PSG members indicate that poverty is seasonal. People experience less poverty during a bumper harvest when almost everyone has income. In the fishing communities, men work for boat owners or do canoe fishing while women sell fish and other goods. Similarly, in farming communities, people have income either from their own cocoa or food crop farms or work for commercial farmers. After the harvest time, income levels fall drastically for the majority of fishermen and farmers (except those who own boats and do deep-sea fishing or large food crop farmers who still earn substantial income). The respondents’ financial status on the pre-intervention survey was not recorded during harvest time; therefore, their reported income did not reflect their average financial situation
throughout the year. This explains why the majority of respondents said they could not afford the cost of premium. An uninsured fisherman summarised the situation as follows:

It is a pity that most of us have not enrolled when in fact we can afford to pay GH¢ 18.00 [for premium and registration fee] to enrol and GH¢ 15.00 [~ US$10] to renew our card every year at least during harvest time. The low level of enrolment in our community shows how insuring against ill-health is not our priority. Ghanaians in general don’t prepare for sickness until it happens.

The “no money to pay premium” response can be questioned when the pre-intervention household survey results are compared across communities. With the exception of Koforidua and Akosombo (in the Eastern Region), where the majority of the respondents are Social Security and National Insurance Trust (SSNIT) contributors, a low poverty incidence does not necessarily lead to high enrolment in the NHIS. The poverty incidence was calculated using data from detailed consumption expenditure on food and non-food items and the dwelling characteristics (e.g. water supply and availability of electricity among others) that are used in the Ghana Living Standard Survey (GLSS V) (Ghana Statistical Service 2007). Durable goods were not limited to the month preceding the survey since their prices are more stable and less amenable to seasonal fluctuations (Deaton 1997, Deaton & Zaidi 1999). The GLSS V (chosen to have uniformity with existing data) set the lower poverty line at GH¢ 288/year (US$ 206) and the upper poverty line at GH¢ 370/year (US$ 264). We also estimated monthly household per capita expenditures as the monthly consumption expenditure divided by household size. This represented the total amount of money needed to meet food and non-food consumption requirements of household members (for more details see Aryeetey et al. 2010). Thus, all households whose monthly per capita expenditure fell below the upper poverty line (GH¢ 370/year) were considered poor. Households whose monthly per capita expenditure fell below the lower poverty line (GH¢ 288/year) were considered to be extremely poor. For this study, poverty incidence (PI) is defined as the number of households identified as poor divided by the total number of households in the community (see Ghana Statistical Survey 2007, Aryeetey et al. 2010). We considered this as proxies for household wealth and used principal components analysis to estimate a household socio-economic status (SES) score. Finally, households were ranked into wealth quintiles based on their SES (core poor, poor, average, rich and very rich) quintiles (see Jehu-Appiah et al. 2011 and, Aryeetey et al. 2010 for details).

2 The Census enumeration areas in Koforidua and Akosombo are communities where the majority of residents contribute to SSNI and NHIS registration is compulsory for them. Their premium is directly deducted from their salary. They only pay registration fee of GH¢ 4.00 [about US$2.5] and GH¢ 1.00 [about US$0.75]. In Koforidua for example, where I was part of the household survey team, the community is popularly called SSNI Flats, an estate built for government workers. Almost all household heads, who were interviewed, were SSNI contributors.
Table 3.1 is an extract from the analysis of our pre-intervention household survey data showing the PI and the individual insurance status in 30 communities. It shows that Winneba (Central Region) with 11.8 per cent PI had only 8.7 per cent current enrolment and 12.4 per cent previously insured compared to Burukum Maumi (Eastern Region) with the highest (56.4%) PI had higher current enrolment (31%) and lower previous enrolment (11.5%). Also, Oframase (Eastern Region) with a PI of 29.4 per cent had the highest current enrolment (66.2%) and one of the lowest non-renewal rates (5.2%). This was in contrast to Koforidua (Eastern Region) where no one is below the poverty line and NHIS premiums for the majority of respondents are directly deducted from their salaries here, only 56.1 per cent of the population were currently insured and 22.7 per cent were previously insured (Table 3.1). These examples indicate that enrolment does not neatly correlate with economic status; there is more to the “no money to pay premium” response.

Table 3.1  Poverty incidence in selected communities and NHIS status of individuals

<table>
<thead>
<tr>
<th>Community</th>
<th>Poverty incidence (%)</th>
<th>Current enrolment (%)</th>
<th>Previous enrolment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winneba (Central Region)</td>
<td>11.8</td>
<td>8.7</td>
<td>12.4</td>
</tr>
<tr>
<td>Anomabo (Central Region)</td>
<td>32.1</td>
<td>4.8</td>
<td>11.3</td>
</tr>
<tr>
<td>Burukum Maumi (Eastern Region)</td>
<td>56.4</td>
<td>31.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Akosombo (Eastern Region)</td>
<td>11.9</td>
<td>35.7</td>
<td>33.6</td>
</tr>
<tr>
<td>Oframase (Eastern Region)</td>
<td>29.4</td>
<td>66.2</td>
<td>5.2</td>
</tr>
<tr>
<td>Koforidua (Eastern Region)</td>
<td>0</td>
<td>56.1</td>
<td>22.7</td>
</tr>
</tbody>
</table>

See the complete Table A.3 in Appendix 2 for further details

Multinomial logistic regression shows that current enrolment is significantly (p=0.000) higher among the richest quintile (41%) than the poorest quintile (27%). The non-renewal rate is significantly (p<0.000) lower among the core poor (13%) than the richest (17%) (for details see Jehu-Appiah et al. 2011). This indicates that although poverty contributes to low enrolment, it is less significant for renewing membership. This findings supports the large number of informants who state that poverty is the main reason why they do not enrol, but does not explain why affluent communities, like Koforidua (SSNIT Flats) where residents’ premiums are deducted from their salaries and they pay only registration fees, had lower enrolment and higher non-renewal rates than Oframase, for example, which is a relatively poor farming community.
The NHIS was introduced as a poverty reduction strategy to provide accessible, affordable and good quality healthcare to all Ghanaians. Therefore, the minimum premium for informal-sector workers was fixed taking into consideration the prevailing economic conditions of the majority of Ghanaians. Premiums are therefore heavily subsidised with a value-added tax (VAT) and SNNIT contributions (Government of Ghana 2004, Witter & Garshong 2009) to minimise the exclusion of poor people. Also, participants’ comments and my observations indicate that for most people the “no money to pay” response was a convenient excuse to rationalise non-enrolment and non-renewal of their membership in the NHIS. “No money” served as a socially accepted idiom to hide negligence and lack of responsible parenthood. Key informants suggested that most uninsured people have the ability to pay, but are just apathetic towards the NHIS. Yet, the key informants did accept that the NHIS was a better alternative to ‘cash and carry’. The conclusion at all PSG and stakeholders’ meetings and interviews was that apart from the core poor and poor people with large households, household heads willing to enrol and renew NHIS cards for their members can do so during harvest time. This suggests that the significant factor that influences the average Ghanaian and rich Ghanaian’s decision to enrol and remain in the NHIS is neither the high cost of premium nor the affordability of the premium. This view differs from previous studies in which poverty was found to be largely responsible for low enrolment with SHISs (De Allegri & Sauerborn 2007, Asante & Aikins 2008). Poverty as an excuse for most respondents who did not enrol or renew their membership in the NHIS is ingrained in other factors, which will be discussed below.

“I’m not often sick” and traditional concepts of risk sharing
Another typical response from the previously insured or never insured respondents was: “Mentaa nyare” (I am not often sick). They saw themselves at very low or no risk for illness, so there was no need to enrol or renew their NHIS membership. A community key informant asked me in an interview: “Why should I pay for or continue to pay toward something I’m not likely to benefit from?” Others said they only registered their wives and children because they were most in need of healthcare. During a PSG meeting, one member explained his non-enrolment as follows:

You know health insurance is new and means little to most of us. We, Ghanaians don’t think about securing ourselves against ill health until we are seriously ill. Health insurance is not our priority. I registered my children and wife because they have the greatest need for healthcare. I did not enrol because I hardly get sick.

The perceived health status of each household member influenced the decision by the head of the household to enrol in NHIS and who to enrol. Healthy individuals were less likely to enrol, while those who thought they would need healthcare were more likely to enrol and regularly renew their membership. Criel (1998) also found
this phenomenon in his work on Masisi hospital insurance in Eastern Congo where women of child-bearing age enrol because of the prediction of need for healthcare.

Further discussions at PSG meetings revealed that community risk-sharing arrangements also influenced their enrolment decisions. Two prominent informal mutual support groups similar to the NHIS were identified: pataase in fishing communities and nnoboa in farming communities. The two groups are somewhat similar to the NHIS; the difference lies in the reasons for joining the groups and the benefits. Pataase members see death as a greater concern than ill health. One pataase member argued: “Death is a certain event, so one must prepare for it but sickness may or may not befall you.” In the case of nnoboa, people join when they need support on their farms and withdraw afterward. Benefits for both support groups are commensurate to one’s contribution and not need. These operational principles contrast with the NHIS’ risk- and cost-sharing based on need. In many of my conversations, I noticed that those who see health insurance as a kind of large pataase or nnoboa often gave the “I’m not often sick” response. They compared the two programs and did not understand why people who have expensive operations, such as for a hernia, and those who continuously access healthcare pay the same amount as those who have not gone to the hospital in the past year. They felt cheated and argued that their premium for subsequent years should be reduced if they had not accessed the healthcare system. This argument conflicts with the fundamental principles of health insurance where premiums are based on income irrespective of a members’ risk level. The respondents’ behaviour and argument suggest that they have not fully understood the redistribution principles of health insurance and have confused it with their mutual support groups. As Vander Geest et al. (1990: 1026-1030) wrote: “differences in stakeholders’ interpretations affect policy outcomes.” Thus, although the aggregate meanings of risk-sharing of traditional mutual arrangements and health insurance could be the same, the differences make it wishful thinking that people will easily appreciate the need to enrol in the NHS and consistently renew their membership because of the policy makers’ assumed benefits.

Those who did not enrol in the NHIS because they did not have a need for healthcare pursue their short-term self-interest with little consideration for what may happen to them in the long term or in the event of rare adversity. This phenomenon could be the influence of traditional risk-sharing groups where every member is certain to benefit according to his or her contribution, while an insured person has largely unlimited access to healthcare when sick but receives nothing if they are well. As Van der Geest (1992) posits, a cultural perspective limits the possibilities for thinking and acting in new situations. Though solidarity and reciprocity are predominant features of both traditional mutual risk-sharing arrangements and health insurance, the respondents’ reaction to the latter is influenced by the principles of the former. Thus, people’s existing knowledge largely determines their
reaction to new policies and not simply the benefits; traditional ideas undermine enrolment in health insurance schemes. Therefore, more education is needed to improve Ghanaians’ understanding and appreciation of the cost-and-risk-sharing embedded in the NHIS so they do not consider the operational principles of the NHIS as the same as traditional mutual support groups.

**Quality of service**

Medical practice in many countries including Ghana has come under scrutiny in recent years since clients are demanding better care. A study by Ballard et al. (2004) observes that quality healthcare should aim at providing care that is timely, efficient, equitable and patient-centred. Literature on the quality of care is generally categorised as the quality of technical care and service delivery. Technical care includes doctors’ diagnoses, the effectiveness of treatment and the quality of drugs. In this study, the technical quality of care did not seem to influence the participants’ NHIS enrolment or renewal decisions; the respondents were, however, concerned with healthcare service delivery.

In developed countries, healthcare services have become market goods supplied by healthcare providers to satisfy patients’ needs. Insured patients are guaranteed quality services, while uninsured patients have difficulty navigating the health system (Ferlie & Shortell 2001) and in some cases face delays in obtaining care. This study found the opposite – NHIS insured patients in Ghana experience delays at health facilities while uninsured patients are served earlier and better. Respondents who were insured complained of health providers’ negative behaviour, long waiting times and the lack of drugs at health facilities.

**Complaints about healthcare providers’ negative behaviour**

This section describes the behaviours of health providers during their clinical encounters with insured patients and the influence of this on enrolment and retention in the NHIS. I used behaviour as a term to describe how health providers interact with clients and not as a theoretical concept. The behaviours that discourage people from enrolling and remaining in the NHIS are referred to as negative and those that encourage people to enrol and renew their membership are labelled as positive. I dwell more on the negative behaviours in this section because that is the focus of the study; positive behaviours that encourage people to enrol are acknowledged later in the chapter.

The issue of health providers’ negative behaviour towards insured clients (as opposed to uninsured) arose at all the PSG, stakeholders’ and community leaders’ meetings and community durbars I attended. Forms of negative behaviour mentioned by respondents were not showing respect to insured patients and using derogatory language. The phrases the insured used to describe their treatment was: “Wommu yen” (They don’t respect us). In Ghana, showing respect is crucial in
social life and is the basis for judging the quality of interaction between people. This compels people to initially respect those they come into contact with. Good communication between health providers and patients leads to patient satisfaction while poor communication results in frustration. In Ghana, it is common that health providers do not show respect to patients. As Senah (2002) observed, practicing and assessing biomedicine is embedded in and influenced by master-servant relationship where patients must submit to the authority of health providers.

To explore the veracity of these reports in my two study locations, I spent time at health facilities and observed that some health providers capitalise on the difference in their power and the patients’ power and show disrespect. Further discussions with participants show that after the introduction of the NHIS, new patient categories have emerged – the insured and the uninsured – with implications for health provider-patient encounters. While it is acknowledged in Ghana that health providers do not respect patients, the categories of insured and uninsured patients have introduced a new dimension to this phenomenon. Andersen (2004) discussed the various ways that patients were treated in a regional hospital in Northern Ghana depending on their social status such as education, wealth and relationship with staff members. This study found that being insured exposes a patient to worse treatment by the health providers resulting in a greater dissatisfaction among insured patients. The informants believed that these experiences contributed to the high membership non-renewal rate. The level of disrespect shown by healthcare staff differed across Ghana. In one research site, people spoke unfavourably about their experience at the health centre. However, participants in a second research site said that they occasionally experienced such behaviour at the district hospital, but rarely at the health centre. In the second site, a medical assistant asked me in a conversation: “Who should I give preference to; is it someone whose bill will be paid even if there are delays or one who I’m not sure can pay since the uninsured sometimes abscond after treatment?”

Health providers’ negative behaviour is a sensitive issue. Since they knew that I was a researcher, the providers did not openly show negative behaviours in my presence. Nonetheless, what they told me suggests that it does happen. For example, I overheard nurses making derogatory remarks about insured patients several times. At PSG meetings, nurses also described insured patients as ‘difficult’. A typical phrase when discussing issues related to insured patients was: “Wenh a wokuta apomuden nsiakyiba krataa no ha yen adwene” (NHIS card holders disturb us). One respondent narrated his experience when he accompanied a relative to the hospital during a PSG meeting.

When you go to the hospital they talk to you anyhow. They make you wait for several hours. In fact, I nearly quarrelled with a nurse when we took a family member with insurance card to the hospital. But for the sick person, I would have insulted her and left the hospital. They don’t respect us.
During PSG meetings, healthcare providers’ reactions to complaints about the
disrespect of insured patients were divided. There were those who argued that
ideally health providers should strive to provide quality service to their patients
irrespective of their NHIS status. Others acknowledged accusations of disrespectful
behaviour, but argued that not all health providers show negative behaviour towards
insured patients.

I verified these accusations by exploring the views of other healthcare providers
who were not PSG members. One reacted.

These are genuine complaints; health workers’ behaviour is not predictable. I’ve spoken to some
of my colleagues several times on this. Some of us don’t respect patients and see the insured in
particular as giving us extra work.

Nurse Julia responding to allegations that she described as ‘false rumours’ ended
by saying:

They [insured patients] think because they have insurance they can come here [health facility]
anytime. They wait and come to disturb us after working hours with all sorts of complaints that
are not emergencies [meaning conditions they can manage at home or report the next day].

This implies that some health providers, and certainly those at that facility, are
not happy when the insured report for treatment when the outpatient department
(OPD) has closed. Their concern was that they were already overburdened during
the day, so when the insured come to the facility to complain about an illness that
started three days or a week ago, this was irritating. They consider these patients as:
“Disturbing them after a hectic day’s work.”

DHIS staff also confirmed the insured patients’ claims and emphasised that it was
hindering their effort to promote the NHIS. James lamented: “Some health workers
are not helping us. Their attitude and behaviour undermine our effort. We work hard
to get people enrolled, they [healthcare workers] do not treat them [patients] well
and we lose them.” Although experiences of disrespect could arise from the nurses
being overburdened with a heavy workload in busy health facilities, they are
exacerbated by the insured patients’ increased use of services. The healthcare
workers’ disrespect discourages people from enrolling and or remaining in the
NHIS.

Long waiting time
It is a common sight of patients waiting for hours in a busy health facility in Ghana.
The insured’s concern was that they wait longer than those who are uninsured. From
my observations, what makes the situation worse is that health providers do not
follow a ‘first come, first serve’ principle. Although both insured and uninsured
patients indicated their dissatisfaction with this approach, insured patients seemed to
be most affected. Evidence shows that long waiting times at health facilities are
partly due to an unorganised flow of patients and this undermine patients’ satisfac-
tion with their care (see Rondeau 1998). But the situation is more complex in Ghana. Abena’s description of her experience illustrates that delays for insured patients go beyond the lack of an organised patient flow. She showed me both her expired NHIS card and her six year old son’s and said:

I didn’t renew my card because health providers here do not treat us nicely. The only time I sent my son to the hospital, the nurse kept us waiting for a long time well over an hour without telling me anything. Others come, pay and go and nobody told me why I had to wait. I was fed up and asked her why she was not attending to us. She retorted, “You wait”. From that day I decided I was not going to renew my card. This actually discourages many of us from enrolling or renewing our card. If you have your money, why should you go and waste time at the hospital? They should be told to change their behaviour.

When I asked a health provider about insured patients’ complaints about delays at health facilities, he acknowledged their concerns and said:

Health providers are suffering from ‘patient fatigue’. The NHIS has come to expose the weakness of our health system; delay in service delivery and negative attitudes. If we improve our attitudes and everything remains the same, we will get better results. …When people go to an overcrowded facility they don’t mind waiting patiently, provided you explain to them why they have to wait. If you tell them politely that you are alone so they should have patience and you will attend to all of them, it will be fine with them. But when you shout at them, why are you now coming, and tell them because of health insurance you are coming to worry me, how would they understand the situation?

Even though this assertion is true in some cases, I also observed many instances where health providers were chatting with each other and showed no sense of urgency while patients were waiting. As one PSG member indicated: “They [health providers] think it is normal for patients to wait for hours, so they don’t care if they see many people waiting.”

Though insured patients attribute their long waiting times to the fact that they are not paying cash, this might not always be the case. The long waiting times may be legitimate and related to the providers’ heavy workload. However, the health providers lack good communication skills to explain the situation in the facility and tell insured patients why they have to wait. Most insured patients I spoke with were not even aware of the extra time needed to fill their NHIS forms – something that is not required for the uninsured. Unfortunately, due to poor communication, some health providers are not able to explain the staffing situation and administrative procedures that accompany the NHIS coverage and instead make comments that the insured attribute to their NHIS status. This echoes Criel’s (1998) observation that the low enrolment in health insurance schemes and the populations’ perceived quality care is influenced by the health workers’ lack of consultation skills.

Lack of drugs in health facilities
Being given drugs at health facilities was generally regarded as an essential aspect of quality service delivery. Access to drugs motivates people to seek healthcare and also to enrol and remain in the NHIS; a lack of drugs makes health insurance less
attractive. John told me he feels disappointed when he is not given medicine, but
instead is given a prescription to go and look for drugs in accredited pharmacy shops
that he sometimes must pay for. These assertions are supported by the pre-
intervention household survey, where an overwhelming majority (87%) of currently
insured respondents, previously insured (90.2%) and never insured (84.7%) indi-
cated that drug availability at health facilities needs to be improved (Table A.6,
Appendix 2). Kumah’s description shows insured patients’ dissatisfaction:

We don’t have an NHIS accredited pharmacy here so if all they give us at the hospital is a pre-
scription to go and look for drugs we could as well go to the store, describe our condition and
buy the drug. The last time, I ended up paying for a drug covered by health insurance in an
accredited pharmacy. Sometimes that is what happens and we don’t feel like renewing our cards.

These incidents make insured patients feel disappointed about the quality of ser-
vice at health facilities. Insured patients think that because they have prepaid for
healthcare, they have a strong entitlement and anticipate quality service including
drugs. A boat owner I conversed with told me:

I did not enrol or renew my membership because some health providers do not respect us.
Moreover, you waste a lot of time when you go to the hospital so why do I bother myself if I can
just go and buy drugs at the store when sick.

My findings are similar to Kroeger (1983) who noted that health system factors
influence health-seeking behaviour and lead to the decision not to seek care at a
health facility. The author mentioned health professionals’ attitudes, satisfaction
with treatment and the shortage of drugs as factors that determine health-seeking
behaviour in developing countries. Both findings show that there are similarities
between the factors that determine health-seeking behaviour and insurance decision-
making. Thus, there is a need to address factors that undermine patients seeking
formal care when promoting health insurance since these factors have implications
for enrolment.

The shortage of drugs on the Health Insurance Drug List in health facilities in
Ghana highlights the practice of Ghanaians depending on pharmacy and chemist
shops for treatment when they cannot afford the cost of treatment under user-fees.
This has been documented in earlier studies (Senah 1997, Asenso-Okyere et al.
1998), but has now taken a new direction. I found that under the NHIS, pharmacy
and chemical shops are being used as suitable options to health facilities not because
of financial barriers, but rather due to the lack of drugs at health facilities. This
situation should be of interest to Ghanaian health policy makers for two reasons.
First, an overreliance on pharmacy and chemist shop-keepers, who act like doctors,
discourages people from enrolling and remaining in the NHIS scheme. Asenso-
Okyere et al. (1998) observed that treatment from unqualified people at chemist and
pharmacy shops to health facilities has a negative effect on people’s health. Second,
this practice undermines the policy makers’ ambition of using the NHIS as a social
security to provide quality healthcare to all Ghanaians and might lead to the collapse of the NHIS in the long run.

The findings of this study also echo earlier findings that show a growing dissatisfaction with perceived quality of healthcare among insured clients in the Dangme West Health Insurance Scheme in Ghana (Bruce et al. 2008). Thus, participation in the NHIS does not necessarily lead to better healthcare services. It must also be noted that health facilities can hardly be blamed for not having essential drugs. The problem is partly due to delays in claim reimbursement by the NHIA and also the DHISs inability to taking steps to ensure that there are accredited pharmacy shops in every town where there is a hospital or health centre. In conclusion, the burden of having to travel outside healthcare facilities for prescribed drugs undermines health providers’ efforts to deliver quality service and has serious consequences for health insurance enrolment.

Accusation of corruption among health providers
Community members cited cases of corruption among healthcare providers associated with healthcare service delivery. Several instances of nurses, pharmacists and other health providers exploiting insured patients for private gains were reported. Information gathered from my interviews and informal conversations suggest that some health providers collect unauthorised fees from insured patients. They asked them to pay for drugs covered by the NHIS and hospital cards and also undersupply prescribed drugs.

A major complaint was that health providers demand cash payments before treating insured patients after normal working hours and on weekends. The phrase normally used to describe their behaviour was: *Wósi sì yen*” (They cheat us). At a community durbar combined with a mass NHIS registration campaign, Adjoa narrated her experience at the health facility the previous evening just after we had ended our monthly PSG meeting. Adjoa went to the facility at about 5 pm because of a sudden stomach pain. The nurse on duty told her she would not accept her NHIS card because she came late and demanded that she pay cash. She said the nurse did not listen to her explanation for arriving late, so she left without treatment and bought drugs from the chemist shop. Reflexively, I asked her whether she was telling me the truth. She quickly responded: “If you don’t believe me I can go and show you the nurse who demanded that I pay before receiving treatment even though I showed her my NHIS card.”

As a researcher, I asked myself if I should take such an allegation seriously and follow it up. I decided not to, since it was just about three months into my fieldwork and I was worried it might jeopardise my data collection. Moreover, the health centre where Adjoa had this encounter was where we usually held PSG meetings and had educational activities. However, to ascertain the authenticity of Adjoa’s
accusation, I spoke to Anas, a nurse, while walking home after the durbar. I asked her to comment on what Adjoa had said about the nurse’s behaviour. She replied:

It is true, I wish the people involved and my bosses were here. I won’t deny it because I’m a nurse. It is true that after normal working hours some of my colleagues don’t want to treat insured patients. The reason is that filling forms for insured patients is tedious, so they don’t see why they should wait till after OPD had closed before coming. They see it as giving them extra work especially when the condition is not an emergency.

I also asked her about those who pay cash. She replied: “Well with them you don’t have to fill any form for any claims. You treat them, they pay cash and that is all.”

In regard to the issue of paying for drugs and syringes covered by the NHIS, informants told me that sometimes they have no choice but to pay even though they know they are being cheated. An assemblyman, told me he paid for drugs when he took his insured child to the hospital after working hours. He said: “They told me to pay because the person to fill the claim form was not at work. I paid, though I knew I shouldn’t.”

In another incident, a volunteer, a PSG member and I intervened to collect money that an insured patient at a health facility had paid for a hospital card. The patient, unhappy about the demanded payment, reported the incident to the volunteer who happened to be at the facility and wanted to be reimbursed. The volunteer called me immediately and this time I decided to follow-up. I felt it was an opportunity for me to have concrete evidence to support the earlier reports that I had received. It is interesting that the provider refunded the money after a short argument. Though she tried to justify her action and said she thought the patient had misplaced her card, I observed that this was just ‘a facing saving excuse’. The patient insisted that she had told the healthcare worker that this was not the first time she had come to the facility. The volunteer told me after the incident: “When we talk, people think we are exaggerating. I often receive similar complaints almost every day in the community.”

Health providers respond about corruption
To check the authenticity of these allegations, I asked DHIS officials for their comments. They confirmed the community members’ complaints. One of them lamented: “Collection of unauthorised fees by health providers is undermining our effort. When we struggle to get people enrolled, they lose confidence and do not renew their membership because of the payment of unauthorised fees.” This comment and others that were similar suggest that building trust in the NHIS is heavily

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3 Assemblymen are part of the political structure in Ghana; they are non-partisan local representatives in the District Assemblies. They work with the district chief executive who is the representative of government at the district level.
dependent on health providers’ commitment to the scheme and the acceptance of NHIS as a viable health financing policy.

Health providers also confirmed the activities of some of their colleagues that undermined the credibility of the NHIS card. One health provider told me that his colleagues sell drugs that are covered by the NHIS to insured patients and ‘pocket the money’ and charge the DHISs; some do not supply drugs to insured patients, yet bill the scheme. They also told me about a recent case of health providers being investigated for charging insured patients a ‘lateness fee’ for coming to the facility late.

At a stakeholders’ meeting organised by a PSG, Dr Atte, who is a medical superintendent of a district hospital, confirmed the allegations of health providers’ negative practices and narrated the experience of two of his patients. One was supposed to come for a review after finishing his drugs, but came earlier and insisted he had taken all his drugs. When Dr. Atte followed up with the pharmacy, he discovered that the patient had not been given all his drugs. The second incident was when a patient suspected that she was not given all her drugs, so she reported this to the nurse. When the nurse and Dr. Atte followed up, they found that the patient had not been given one of her drugs. In both cases, the DHIS was billed for all the drugs. Kwesi, who is a DHIS staff and a PSG member, narrated his experience of receiving a prescription for his child to buy a drug. He followed up and found that the DHIS was billed for the drug even though the drug was not supplied.

These negative practices by health providers resulted in a lack of trust from community members, and the insured questioned their commitment to the NHIS. Thus, people who do not have regular need for healthcare prefer the user-fees or receiving treatment at a pharmacy or chemical shop, even though it is more expensive.

Basaza et al. (2007: 10) mentioned the “poor interest of health professionals” in community health insurance as a barrier to enrolment in Uganda. In Ghana, the health providers’ lack of interest in the NHIS must be added to their malfeasance as in the cases of the assemblyman, Adjoa, and Kwesi. A community leader describes the extent of distrust and scepticism about health providers’ commitment to the NHIS: “In fact, I don’t trust them [health providers]. I don’t think they like health insurance. I wonder if they genuinely support it.” The healthcare providers’ behaviour can be explained as an excessive pursuit of their parochial interests, which is to gain from the policy and not contribute to the goal of ensuring equity in access to quality healthcare by removing financial barriers.

**Accusation of inefficiency and corruption among DHIS staff**

Community members complained about delays in receiving their NHIS cards after registration and also waiting for hours in DHIS offices to obtain their cards. The
most common complaint was waiting for more than three months after registration before they had their ID cards to access healthcare. They complained that the mandatory waiting period of three months is too long and that some registrants even wait for as long as five to six months, while others never receive their cards. A typical response I got when I asked people about waiting was:

If you are lucky you get your card after waiting for three months. Otherwise you have to come here several times before you get it. Others never find theirs. This is not fair because while waiting for so long you may fall sick and have to pay, then when you receive the card you might not fall sick before it expires.

The other common complaint was that people have to spend about two hours waiting before they get their NHIS cards and in some cases the DHIS office could not find the card at all. Many DHIS offices I visited were crowded with people waiting to collect their ID cards. Several community members I spoke with told me that this is the normal situation. One of them expressed her frustration as follows: “I’ve been here for about two hours and have not yet got my card. I don’t understand why it is taking them so long to get me my card.”

I decided to inquire about the status of this woman’s card from the public relations officer (PRO) in whose office the cards were kept. I spent just ten minutes in his office, but even in this short time I had insight into the problem. The office had piles of cards in small boxes on the floor and a single staff member had to look for the cards for about thirty people waiting that morning. Obviously, this was an operational problem. The situation could be described as inefficiency regarding storage of documents and retrieval or insufficient funding for DHISs. Inadequate space, lack of cabinets and proper filing systems made card retrieval difficult and this resulted in clients waiting for hours.

The common complaint of malfeasance by some DHIS staff and collectors was unauthorised fee collection from their clients. Several reports of ‘fast track’ registration came up in the interviews, conversations, and discussions at PSG meetings. Fast track registration is when DHIS staff connive with collectors and register and issue NHIS cards to people through the ‘back door’ without their having to wait for the three months window. Some collectors also charge above the approved premium and registration fee, while others take money for transport before giving out the NHIS cards. Participants told me they were aware of such behaviours and described them as undercover activities that damage the credibility of DHISs and erode confidence in the NHIS.

Although most DHIS staff denied this behaviour, others confirmed the practice. For example, when I asked a collector why people were still not enrolling after a PSG community durbar:

My people are difficult. Some of them wait until they are in trouble then they run to me for help. Sometimes you have no choice but to try and help them. In such cases, I had to take them to the office and see somebody [DHIS staff] with some money to prepare the card for them instantly.
I observed another negative practice when I went to a DHIS office for a usual visit. While I was conversing with two DHIS officials, two men walked in and wanted to renew the NHIS card of a relative who had been involved in an accident and admitted to the hospital for three days. After complaining that people do not renew their card until they are sick, the DHIS staff told the two men to go and come back and see the manager. From their conversation, I understood that they were aware of their negative behaviour. When the two men left one of the DHIS staff turned to me and said: “This is how they worry us.” I went back to the DHIS office the following day to find out if the two men had renewed the card for their relative in the hospital. They had indeed renewed his card without having to wait for three months before accessing healthcare since his card had expired more than three months ago (see National Health Insurance Regulations 2004). These favours are not done for free; they are usually rewarded. Unfortunately, these rewards are difficult to verify since I could not observe what transpired between the DHIS staff and the two men when I left. Malfeasance by DHISs’ staff can be explained as an excessive pursuit of self-interest instead of supporting the sustainability of the NHIS. The staff seemed to have little concern about sanctioning defaulters to deter others and influencing people to develop a habit of voluntary enrolment and membership renewal.

Health providers’ and DHIS staff’s dishonesty are not uncommon in Ghana (Gyimah-Boadi 2004, Kpundeh 2004). Armstrong (2006) discusses cheating as a moral term and notes that although it is unacceptable, it is adopted because of the financial gains. In the same vein, the malfeasance reported in this study, which is against the ethics of public office holders in Ghana, occurs daily in public institutions. In Ghana, where salary levels are low and inadequate to meet expenditures, the problem of supplementing incomes by collecting unauthorised fees from clients in public offices is not peculiar to health providers and DHIS staff. This situation has bedevilled the health sector where payment of unauthorised fees has been a long-standing tradition (Agyepong 1999, Asenso-Okyere, 1998, Blas & Linbambala 2001, Aikins & Okang 2006). Thus, some public servants pursue extra income to have a comfortable life. This is often termed ‘the survival strategy’ of public servants and in certain circles it is not even perceived as a crime. Aryee (2005: 33), in his assessment of anti-corruption and public accountability, described official attitudes towards corruption as ranging from lukewarm to open hostility and calls it the ‘AIDS of democracy in Africa’. I found that corruption undermined the confidence and the trust people had in the NHIS and this threatened its long-term survival. Obviously, corruption does not lead to the development of moral responsibility that would make Ghanaians voluntarily enrol in the NHIS and religiously renew their membership to achieve NHIS’ goal of universal coverage.
Barriers experienced by healthcare providers

In this section, I focus on what health providers perceived as barriers to NHIS enrolment and retention. According to the health providers, both their heavy workload and delays in claiming disbursement undermine their quest to provide the quality healthcare service needed to build trust in the NHIS and make it a better alternative to cash payment.

Heavy workload

The introduction of the NHIS has increased both the clinical and administrative burden of health providers. Administratively, a significant amount of documentation is required to give service to insured patients. According to health providers, the NHIS has increased the utilisation of healthcare services and consequently, their workload. Filling NHIS forms prolongs the time spent attending to insured patients and this results in long working hours. Dr. Kasa’s, a District Director of Health Services, assertion typifies the health providers’ description of the situation:

Insurance has increased utilisation services. On some busy days the OPD closes at 4 pm and sometimes I leave here after 5 pm. In fact, the time spent treating one insured patient amount to two uninsured. You spend about five minutes filling forms for one patient. This is what insured patients don’t realise and make too much demand on us. They think because they are insured, when they come, you should leave everything and attend to them.

The NHIS form (see Appendix 3) requires information on patient’s personal data and all services provided at a facility. Providers complete the information about the diagnosis, drugs, and claim summary. The time spent to fill out the NHIS form carefully prolongs the insured patient’s consultation as described by Dr Kasa above. This NHIS procedure accounts for the long waiting that insured patients complained about. There were cases of NHIS forms having been rejected due to mistakes, which cause delays in claims reimbursement. So in facilities where patient attendance is high, filling NHIS forms is an arduous task for already overburdened health providers. According to the health providers, they fill endless forms every day, week and month. Thus the complexity of NHIS forms could explain why some health providers ask insured patients who seek healthcare after working hours to pay cash.

Moreover, although NHIS has increased the utilisation of healthcare, there has been no corresponding expansion in the capacity of health facilities to cater for the increasing number of patients. Health facilities still operate with virtually the same infrastructure, limited equipment and staff. This results in overcrowding, particularly in district hospitals and busy health centres. Thus the burden of the few health providers who attend to so many patients under difficult working conditions frustrates some providers. This may explain their negative reaction towards insured patients who appear to be making unnecessary demands on them. In the providers’ view, the insured patients’ conditions could be managed at home till the following
morning. They collect fees from insured patients, not only to make extra income, but also to scare them from using the service after closing times and to avoid filling out the NHIS forms.

**Delay in reimbursing NHIS claims**

Although NHIS helps improve health providers’ revenue, the health providers complained that delays in claim reimbursement negatively affect their cash flow and supplies. This leads to low stock levels of drugs in health facilities. As discussed earlier in this chapter, drug shortages in health facilities contribute to patients’ dissatisfaction about the quality of service and health providers see this as undermining their work.

The frequent shortages of drugs in health facilities were of great concern to health providers especially those working in facilities in communities where there were no NHIS-accredited pharmacies to augment the drug supply. A medical assistant lamented:

> Having drugs in health facilities increases the attendance of patients and a lack of drugs makes a facility less attractive to them. Insured patients in particular often show dissatisfaction about the outcome of their consultation when they are not provided drugs at facilities, especially when there are no accredited pharmacy shops and insured patients have to travel to other towns to get drugs or buy from anywhere and pay. Due to this, people prefer going to pharmacies and chemist shops to buy drugs directly or seek healthcare instead of coming here.

The medical assistant’s assertion confirmed the health providers and insured patients’ concerns that drug supplies in health facilities need to be improved as stated earlier.

The NHIS has increased healthcare utilisation as Dr Kasa indicated. However, the inclusion of a large exemption group that accounts for about 50 per cent of the general population (Table A.1, Appendix 2) does not make the NHIS cost-effective. Therefore, the NHIS must rely on the value-added tax from which the DHISs receive about 80-90 per cent of the revenue from the NHIA (Witter & Garshong 2009: 7). This reimbursement policy could be responsible for delays in claim payments. The authorities are not always able to provide funds promptly for the implementing institutions (including social intervention programmes), to perform their task efficiently. Although some improvements have been made recently in claims reimbursement decreasing the waiting time from five to six months (see Witter & Garshong 2009) to about three months, it is still far from the stipulated four-week period after submission. The delay in reimbursement makes it very difficult for health providers to meet all the drugs requirements of their clients. It also contributes to some health providers giving preference to uninsured patients or demanding cash payments from insured patients to ensure that the facility has enough money to meet their drug needs while they wait for their DHIS claims to be paid.
Patrick, a health provider expressed his frustration regarding drug shortages in health facilities as follows:

That is why I’m against the idea that facilities should generate income and spend. The business of health providers should be to provide quality healthcare and not to be concerned about income generation to manage their facilities. Due to this, health providers do anything to get money. There is a general overuse of drugs. Some providers are prescribing drugs they are not qualified to administer, while others are charging insured people in order to get money to meet some of their basic needs and maintain their stock levels, especially when the NHIA owes them huge sums of money. Things should be streamlined. The provision of equipment and drugs needed by facilities should be managed by a different body at the district level and controlled by a centralised body with very efficient monitoring systems. It should not be the business of facilities to generate income for internal use.

Patrick’s argument could also be considered as ‘generate and spend’. Facilities with low patronage are adversely affected in their internally generated fund (IGF), which in turn leads to low stock levels and low utilisation, thus perpetuating the problem of drug shortages. Therefore, to fulfil the objective of increasing access and providing quality service to all Ghanaians the government should make drugs available to all health facilities irrespective of their IGF, especially in communities with low enrolment. After all, health facilities can only encourage people to enrol and remain in the NHIS by providing quality service and that depends on drug availability to a large extent.

To learn about others’ perspectives on claim disbursement delays, I approached the staff that processes claim forms at the District Health Directorate and DHIS offices. A staff member explained that some clinicians are part of the problem. He said:

I think some of my colleagues, especially those at the facilities, have not yet come to terms with filling the NHIS forms as part of their job and carefully fill them according to the instructions. They see it as a burden and make too many avoidable mistakes. This makes the vetting difficult and slow, hence the delay.

He showed me some of the forms that were rejected because the basic instructions were ignored. This indicates that following the bureaucratic procedures in delivering healthcare to insured patients is yet to be fully accepted by service providers, which makes the vetting laborious and delays claim reimbursement.

Barriers experienced by staff of District Health Insurance Schemes

This section examines the challenges experienced by the DHIS officials when implementing the NHIS. These challenges undermine their efficient functioning and quality service, and consequently discourage people from enrolling and remaining in the scheme. The barriers include inadequate staff, office space and equipment, and problems processing NHIS registration forms and granting exemption to indigents.
Inadequate staff, office space and equipment

A major DHIS staff complaint is that inadequate staff undermines their desire to provide quality service. They asserted that although the volume of work has increased since the NHIS was introduced; the number of permanent staff remains the same, which puts pressure on them. However, a DHIS manager explained that although they have the option to hire extra hands, they have to pay them from their IGF which he claimed was not adequate to even meet their basic needs. Thus they are not able to hire enough temporary staff, and the heavy workload falls on the few permanent staff members.

Office accommodation for many DHISs was not adequate. Many of the offices I visited were congested. The office space used by two or three officers crowded in a small room made moving and serving clients difficult. During my visits, I observed that DHIS staff, especially those at the front desk attend to many clients every day. It was common to see many clients waiting for hours at the DHIS offices, which frustrated not only them but also the staff.

Another DHIS staff concern was the inadequate number of cameras to take people photographs for their insurance cards especially in communities outside DHIS office locations. As a result, the registration process takes much longer time. A PRO explained the situation as follows: “Collectors register people and arrange for their pictures to be taken later. It makes processing NHIS registration forms difficult and slow.” This complicates the registration process, since the two events take place at separate times and are performed by two separate persons.

The DHIS staff complained about the inadequate number of computers to process registration forms; the computers they have are often not functional. The staff told me their data entry clerks often work on a rotational basis because they do not all have access to computers. I saw non-functioning computers in many offices that the staff explained were as a result of a lack of funds to repair them immediately.

A lack of cabinets to properly file registration forms and other documents for easy retrieval hampered the DHISs’ effort to ensure that clients did not wait too long before receiving their ID cards. As mentioned earlier, when I visited DHIS offices, I saw piles of ID cards in small cartons on the floor and staff spending a great deal of time going through the piles before retrieving cards for their clients. Thus inadequate equipment and supplies made it difficult for DHIS staff to achieve efficiency in their work.

Problems regarding processing NHIS registration forms

Delays in issuing NHIS ID cards are also attributed to people providing more than one name when registering and having their photo taken. For example, when the person has three names ‘Benedict Kwesi Mensah’, he might use Benedict Mensah to register and Kwesi Mensah for his photo. Matching the two sets of names is prob-
lematic when processing the registration form. Data entry clerks told me they spend a great deal of time matching registration forms with photos. I was told about an incident when a man came to the office several times and could not find his ID card until they asked him for all his names. Next, they asked which name he had used for registration before they could retrieve his card.

I observed the same situation at a PSG mass NHIS registration exercise. Although the registration and photo taking occurred at the same time, each was performed by a specific person, so there were incidents of registrants using one set of names for registration and another for their photo. Although I drew the officials’ attention to the situation, they still had a difficult time matching photos with registration forms due to the differences in given names.

Problems of granting exemption to the core poor
The primary goal of social health insurance schemes (SHISs) is to ensure that everybody, including the poor, has access to healthcare. It is generally asserted that since wealth is unfairly distributed, some people cannot make wise insurance decisions because they simply cannot afford to do so (Clackson 2008). This implies that SHISs, and in this case the NHIS, need to have exemptions to ensure that those who cannot pay premiums are covered. Ensuring equity in access to healthcare and reducing the exclusion of the poor has always been part of all health financing regimes in Ghana. Unfortunately, attempts to provide exemptions have historically been challenging, dating back to the regime of insignificant fees in the 1960s and the hospital fee regulations policies of 1972 and 1985.

Ghana, as a low-income country, has decided to help the poor gain access to healthcare under the NHIS. Policy makers having recognised that no matter how small premiums are some people cannot pay and therefore, they have provided exemptions for them. But previous studies show that earlier Ghanaian exemption policies were not successful (Badasu 2004, Aikins & Arhinful 2006, Ministry of Health 2008). The Ministry of Health (2008) notes that the NHIS risk excluding the poor due to identification difficulties.

A key finding of this study is that exemptions under the NHIS have only been applied to a few indigents since the beginning. Witter & Garshong (2009: 5) found that exemptions for indigents were one per cent in 2008. There are many reasons for the implementation gap.

First, the DHIS staff claims the criteria set for identifying the core poor for premium exemption makes implementation difficult. However, after chatting with them, I realised that the problem is not so much the difficulty of identification, but rather the commitment to grant the poor an exemption due to bureaucratic procedures. So DHISs use the strictest criterion for an exemption that in fact eliminates almost everyone. The staff put homelessness at the heart of the conditions for a
person to qualify as an indigent, even if homelessness does not exist in their districts. They often ignore the other indications of indigent status that consider local descriptions of indigents as persons afflicted by severe poverty (see National Health Insurance Regulations 2004, LI 1809, 58: 1-3). Indicators that the local population and PSGs used to describe the poor are: individuals with no stable source of income who live on the benevolence of friends and neighbours with no or inadequate support from family members and struggle to survive while living in dilapidated houses. For this group of people, having a meal a day is problematic. Other conditions stated in the NHIS policy, such as unemployment, are often ignored. This makes the application of the policy quite restrictive since in Ghana, apart from the cities, only ‘mad’ people live in the street. Everybody has a home no matter how poor. Indigents normally live in family houses, with friends or acquaintances as Serwa and Ama mentioned when describing the core poor earlier in this chapter. So using homelessness as the core criteria for exemption means almost all potential beneficiaries are disqualified.

Second, in my interactions with DHIS managers and staff, it became clear that they rarely grant an exemption to people who are not sick. They wait until people are sick and cannot pay their hospital bill. Responding to my question about why they do not grant exemption to the core poor, a DHIS manager argued: “The criteria disqualify almost everybody but we occasionally give exemptions when health providers refer patients who cannot pay their hospital bill to us. In such cases, we go to their aide and register them.”

I describe this as ‘amnesty’ and not exemption since the person is rescued when in crisis, which is not the objective of the NHIS policy. DHISs are supposed to ensure that the core poor can access healthcare when ill. In other words, being insured will encourage them to seek treatment in spite of their inability to pay. The DHIS officials agreed that it is their moral obligation to ensure that the core poor have access to healthcare. However, my conversations with them revealed underlying issues that do not motivate them to grant exemptions to the poor. Their concern was that since the DHISs are expected to build up their IGF to meet some of their operational costs, giving exemptions to the poor means they lose money that they need. Therefore, considering their weak revenue base, it was not in their best interest to vigorously look for indigents to exempt from premium payment. So they were not keen to let people know about the exemption policy. One DHIS official said: “We have the problem of low enrolment and we need money so if we go to communities and continue telling them we want to exempt some people, the others won’t pay. So how do we get revenue?”

Collectors who are supposed to be on the frontline identifying the poor (NHIRs 2004, LI 1809, 58: 3) were found to rarely send people to be considered for exemption. When I asked Emma, a collector, why she has not registered a single indigent,
she told me that she had not found a core-poor person. At this point, I told her about Ama, the ‘core-poor’ woman mentioned earlier in this chapter and suggested she goes and verify Ama’s situation. A month later, I enquired whether she has gone to see Ama. She answered in the negative, so I presented the case at PSG meeting and all those present including the DHISs staff agreed that Ama should be exempted. After two months, when a mass registration was organised by the PSG in the community, Ama was still not registered. At this moment, Serwa, the volunteer who had introduced Ama to me, told me that one of Ama’s twin daughters had died. She had died at home since Ama did not have money to take her to the hospital. Even after discussing Ama’s misfortune with Emma, she still did not register her until the next mass registration campaign two months later. This time the volunteer brought Ama to Emma and so she had no choice but to register her. Emma’s attitude showed that she was not willing to register Ama, but could not refuse because PSG members were present watching her. This shows the collectors’ reluctance to register indigents for an exemption, even when they are easily identified and their impoverish situation is established.

I later learnt that collectors are paid a commission only on collected premiums and not for registration and administrative fees. So Emma’s behaviour and other collector’s behaviour show that processing exemptions for core poor is not in their interest, hence they lack motivation to do so. However, I observed that the collectors were registering children and the elderly. When I discussed the issue with DHIS managers and other officials, they admitted that they had not granted an exemption to any core poor person in those communities. Also, in my conversations with Ama and many community members, they revealed that they were even not aware of the exemption policy.

It is obvious that the exemption policy under the NHIS is far from achieving its objective, since the homelessness criterion does not reflect local conditions and excludes potential beneficiaries. I acknowledge that even if the criteria for identifying indigents is complex, my observation and discussions with DHIS staff, PSG members, community members and leaders show that at least in closely knit rural and urban communities (like Achiano and Anomabo), indigents are not difficult to find. People who are eligible for an exemption are known by almost everyone in the community as living in abject poverty, as the case of Ama shows (see also Aryeetey 2012). However, DHISs’ staff were not keen to identify indigents because it was not in their interest and did not help them increase their IGF.

Further discussions and observations suggest that the pressure put on DHISs to improve their IGF could explain the DHISs’ lack of commitment to grant exemptions to the core poor. A DHIS manager told me that their current premium revenue is only 5 per cent of their claims. He also said that all the DHISs’ revenue accounts for about 10 per cent of their total expenditures. The ratio of revenue to expenditures
is used to measure the DHISs’ performance. Thus, low revenues put the DHISs in a
dilemma about granting exemptions. Should they grant exemptions to indigents and
improve enrolment? Or is it better to apply the most restrictive exemption criteria
thus eliminating potential beneficiaries and rely on people who can pay cash, which
increases their IGF.

The findings above highlight three important issues for policy makers. First, the
homelessness criterion for granting exemption to indigents disqualifies potential
beneficiaries. Second, the lack of a commission to collectors for registering the core
poor does not motivate them to recommend indigents to be considered for exemp-
tion. Third, the inadequate funds provided to DHISs forces them to focus on revenue
generation rather than recruiting the poor for exemption. The three issues suggest a
need to rethink the exemption policy, particularly the homelessness criterion and
payment of registration fees by the core poor.

In conclusion, the decision of the average Ghanaian to enrol and remain in the
scheme is not necessarily influenced by poverty, but rather by factors such as a lack
of interest in health insurance, poor quality healthcare services delivery, delay in
receiving NHIS cards and the possibility of enrolling through the back door when
healthcare is needed. This calls for intensive education directed to healthcare
providers on the principles of the NHIS and effective mechanisms to stop corrupt
practices. In addition, the quality of the DHISs’ service needs to be improved to
attract and retain people, especially those in the NHIS rich category, by providing
adequate drugs at DHISs facilities and improving health providers’ behaviour
towards insured patients to assure better treatment. Also, the DHISs should give
equal attention to identifying the core poor for exemption to prevent their exclusion
to achieve the equity goal of the NHIS.

Effects of politics on enrolment

The politics surrounding the introduction of NHIS and the effect of politics on
enrolment are discussed in this section because politics as a barrier to implementa-
tion was mentioned by respondents in all three stakeholder categories and others
involved in NHIS implementation. Community members, DHIS staff and health
providers spoke about how the NHIS policy-making process and the timing of its
introduction had adverse effects on enrolment. The political undertones of the
concerns of the Ministry of Health (MoH), Ghana Health Service (GHS) and the
National Health Insurance Authority (NHIA) regarding the NHIS are also addressed.

The issue of politics and the NHIS arose when I asked community members,
DHIS staff and health providers why people were not enrolling in the scheme. Their
responses indicated that politics negatively affected NHIS uptake irrespective of
knowledge about the potential benefits. I was amazed at how the politics within the
Ministerial Health Financing Task Force set up at the Ministry of Health to draft the
NHIS bill had reached households in the remote communities I visited. The media had widely published the acrimony of debates in the Task Force (see Agyepong & Adjei 2008) and Parliament and this was keenly followed by community members and influenced some not to enrol.

Discussions with both uninsured and insured participants reflected their political sentiments about the NHIS. The respondents expressed their sympathy for either the New Patriotic Party (NPP) or the National Democratic Congress (NDC). NPP sympathisers described the NHIS as the best healthcare policy ever introduced in the country. Their typical response was: “You don’t mind them. It’s unto them [NDC supporters]. They are saying because they are NDC they won’t enrol. For me, I think NPP did well by providing such a good policy.” The NDC sympathisers, however, saw the policy-making process as acrimonious and felt that the only way they could show their disapproval was by refusing to enrol. They also said they were not happy about the process and the way NPP discredited the NDC government. John, a petty trader and NDC sympathiser did not hesitate to mention politics as a factor that influenced his decision not to enrol. He said:

I didn’t register because of politics I don’t belong to NNP who introduced health insurance. I hate what they did and said about my party who first conceived the idea even long before they won the elections. They should have acknowledged NDC as being the first to introduce the idea of health insurance even if it did not materialise before they left power. That was why I waited till now before registering.

Kwesi, a community member, also told me: “I thought the NHIS cannot survive any change in government and that it was going to be a ‘nine days wonder’ and will die when a new government comes to power.” I also had reports about how NPP politicians wrote people’s names and promised to register them in the wake of the 2008 general elections, however, they never returned after the elections to do so. This issue arose at the beginning of my fieldwork when people asked me whether I was part of the group that had come to write their names and promised to register them. Collectors at the PSG meetings confirmed the NPP politicians’ action and claimed that the politicians had contacted them during the campaign to compile lists of widows and the poor, but they never heard from them after the election.

Health providers also confirmed the situation described by community members and spoke about the effect of politics on enrolment. Dr. Gyena told me:

Politics influenced people not to enrol when health insurance was introduced. This still lingers on even after the change of government. I noticed in my consulting room that most patients from particular communities, which are strongholds of the then opposition party, are not insured.

DHIS staff believed that the politicisation of the NHIS, especially during its introduction, contributed to their operational difficulties. They said that the NHIS was used as a tool by both the ruling and the main opposition parties to canvass votes during their campaigns. As a result, political opponents who felt the NHIS was used by the government to secure electoral victory refused to enrol. DHIS staff believed
they were often perceived as political activists pursuing the interests of a single political party and not as public servants who were implementing public policy. This perception undermined the DHISs efforts to promote the NHIS. A DHIS manager described the situation in his district as follows:

The timing of the introduction of NHIS made it political and contributed to people’s reluctance to register. They thought because it was government ‘A’ who introduced it they should not join. In some communities we were treated as belonging to a political party and chased out when we went there to educate them. They hooted at us and said we had come to take their money for the electioneering campaign. Communities that were NPP strongholds were more receptive and attended our promotional activities. You can see it in our enrolment figures. Generally, communities that were NPP strongholds registered more than those that were NDC supporters.

A DHIS staff also told me they were chased out of a village because it was predominantly an NDC stronghold. He said:

Due to the timing of the introduction of the NHIS and the political climate at that time, just before national elections in 2004, politicians took advantage of the situation and played politics with it. The main opposition party criticised the policy, while the ruling party painted a vivid picture promising that the NHIS gives free treatment as if everything was covered. So people expect to get everything at the facility. When this doesn’t happen they feel disappointed and say all sorts of things against us.

Furthermore, MoH and the GHS staff expressed concerns about the lack of collaboration with the NHIA since the three institutions expected to ensure effective implementation of the NHIS. The staff told me that the politics were responsible for the lack of collaboration and this undermined efficient service delivery and ultimately enrolment. The main concern of the MoH and GHS staff was the lack of openness on the part of the NHIA. A GHS staff said that the lack of consultations and regular discussions were the main challenges they faced in service delivery. He asserted attempts to institute regular meetings of the MoH, GHS, NHIA and DHISs to discuss their activities and problems to make and implement decisions together failed after the first meeting. The NHIA stopped honouring their invitation and gave excuses including stating that the MoH could not summon them to meetings. He said:

Delay in claim reimbursement, which is at an average rate of five months, is because we [GHS] have no way of finding out what the real problems are in claim processing. We [GHS and NHIA] have not sat down at the national level to agree on exactly what to do. Facilities send both soft and the hard copies of NHIS claims. The question is why should we continue to make claim processing so difficult for health facilities? Also, when it comes to monitoring, they [NHIA] don’t involve us. They write to the facilities without due regard to us. They only come to us when there is a problem.

Moreover, NHIA piloted new software and set up their ICT system to authenticate NHIS membership without talking to us. They dealt with health facilities directly. We told them to involve us so we could send our staff with them to study the system. They refused and have gone ahead to do their own thing. Now that they are about to set up the second phase which requires all facilities to be computerised, have internal network and be connected to their system, they are now compelled to involve us so our facilities could prepare bills to fit the new system. As you
know some facilities don’t have electricity. It means we have to provide generators and train our staff to know how to use the new system; I don’t know at whose expense. We have not discussed these issues. These situations undermine operational efficiency and do not make NHIS attractive for people to enrol.

The MoH staff also told me that the major problem they faced as a policy-making body was the lack of collaboration. According to the official, NHIA claims they are under the Office of the President, so the MoH cannot call them to a meeting. The official said:

The biggest challenge facing us is not only lack of collaboration, but that the NHIA doesn’t share information. Their reports on NHIS are classified. This doesn’t help build systems that improve quality of service, hence the numerous complaints.

An official of the NHIA spoke about the MoH and GHS officials’ allegations of a lack of collaboration and transparency when discussing the NHIS issues:

NHIS is a pro-poor policy with premiums based on the poverty level in the country. Premium levels are low enough to make it possible for the majority of Ghanaians to enrol and exemptions are also in place for vulnerable groups. But, the problem is those implementing the policy. Some of DHISs and health facilities have not performed creditably while others engage in all sorts of corrupt practices. This has resulted in delays in claims reimbursement and other issues they are complaining about. They have not yet absorbed themselves into the NHIS. They read politics into whatever we do. The issues they are complaining about are measures aimed at improving and reducing corruption in the system. I’m sure we will get there soon.

When I asked why they did not want to give out information, another official quickly responded: “It depends on what you are going to do with the information.” This statement confirms the concerns expressed by MoH and GHS officials about lack of collaboration. This situation suggests that systems that could make NHIA more responsive to implementation challenges and the emerging needs of stakeholders to improve service delivery are not really being developed in a participatory manner. Thus, effective collaboration to ensure efficient implementation of the NHIS policy seems to be lacking at the highest level.

John’s and Kwesi’s decision not to enrol, the MoH and GHS staff’s concerns about the lack of collaboration and the NHIA not sharing information are underlying issues that are worth discussing. The situation shows that governments act in ways that elicit negative reactions towards the very policy they are trying to promote in pursuit of their political ambition. Community members who politicise the NHIS undermined the credibility of the scheme as a social security provision aimed at ensuring equity in access to healthcare. Concerns expressed by MoH and GHS staff suggest that the lack of collaboration does not build systems that will help improve service delivery, since initiatives by NHIA alone could miss important challenges confronting implementers and service providers. By politicising social policies such as the NHIS, politicians are stabbing themselves in the back. The more they try to ensure equity in healthcare access without effectively engaging key stakeholders, the
more they seem to miss the real challenges that need to be addressed, hence increasing the likelihood of failure.

**International politics and healthcare policy-making**

Events at the international level indicate that healthcare reforms, especially health insurance, generally generate fierce political debates. For example, the US 2008 elections were also characterised by intense debates when President Obama campaigned heavily on restructuring health insurance. This led to enactment of the Patient Protection and Affordable Care Act (PPACA) in March 2010, informally referred to as Obamacare. The main observation relevant in this discussion was the US approach to the policy-making process that included lobbying within the legislature and civil society groups as well. Powerful lobbyists were used to manoeuvre the legislation process to get the bill passed and safeguard transparency. This is not to say that the process was a perfect one, but as political scientists have argued, the formulation of successful public policy fundamentally depends on the political environment and the checks and balances that guide the process. Brinkerhoff (2004) observes that stakeholder engagement ensures accountability and compliance with procedures and improves performance in his study of health systems in the US. He argues that this engagement helps generate a system-wide perspective and reveals gaps that require attention and interventions to improve service delivery.

Another example is Mexico’s Ministry of Health that led the process of developing stakeholder support for a healthcare reform, which expanded social insurance coverage to the poor. They used strong persuasive arguments and an evidence-based approach to win the support of competing political and special interest groups. In Mexico, dissenting views did not lead to resentment. This effort has been acknowledged as one of the most successful policy reforms of President Fox’s government (see Frenk 2006). It demonstrates that the effective engagement of stakeholders ensures that public policy-making does not degenerate into bitter wrangling among key actors.

The Mexican and the USA approaches both provide relevant information and lessons for politicians and policy makers in Ghana. Their experiences show that lobbying and engaging political opponents in the policy-making process is essential. De Swaan (1988: 156), writing about state intervention to promote social security in nineteenth century Western Europe, provides insight into the role of politics in social policy making: “Creating social security was hard political work. It demanded strategic coalition building and tactical parliamentary and bureaucratic manoeuvring”. His observation shows that politicians should endeavour not to politicise health insurance to advance their careers, but rather use diplomacy and negotiation to allow for experts’ input to guide the policy-making process. This would build
trust in the NHIS and encourage people to enrol, while ultimately ensuring the equity that the politicians very much desire to achieve. Thus, when all stakeholder voices are heard, the possibility of failure is reduced.

Factors that encouraged enrolment in the NHIS and renewal of membership

During my fieldwork, I found issues that promoted the NHIS that deserve attention as well. These are discussed under two themes: (1) positive attitudes of health providers and (2) benefits derived from membership in the NHIS. These factors encouraged people to enrol and remain in the scheme. The NHIS provided financial relief for insured patients and reduced their vulnerability to ill health. For healthcare providers, the NHIS was perceived as reducing delays at home since insured patients presented with less complicated cases. They appreciated that the NHIS enhanced their work and encouraged their patients to enrol.

Positive behaviours of health providers

As stated earlier in this chapter, health provider-patient interaction affects NHIS enrolment and membership renewal. This study found that community members did not perceive all health providers as hostile and disrespectful towards insured patients. This observation is contrary to the popular perception that health providers do not support the NHIS. Some health providers were also seen as kind and helpful towards insured patients. They discussed the benefits of the NHIS with their uninsured patients and encouraged them to enrol. During my fieldwork, I heard some health providers advising their patients to enrol, especially those who had difficulty paying for their treatment. A key informant told me that he had registered because he was persuaded to do so by a medical assistant. He said:

> The Medical Assistant always convinces patients to register. The last time I was at the hospital, she advised me to register so that I can get some relief from paying my son’s hospital bill. It was because of her persuasion that I went to register. In that facility, the first thing they ask a patient is whether he or she has an insurance card.

Therefore, some health provider-patient interactions created the impression that the NHIS would benefit patients and encouraged people to enrol. This supports Arhinful’s (2003) observation that perceptions ultimately play a role in people’s decision to join SHISs and indicates that conscious efforts by health providers to behave favourably towards insured patients created confidence in the NHIS and encouraged people to enrol.

Benefits of the NHIS

Previous studies in Ghana show that health insurance has a positive impact on healthcare utilisation (Sulzbach et al. 2005, Ansah et al. 2009). Sulzbach (2008)
compared baseline data in selected districts before and after the NHIS, and found that it increased access to formal care and significantly decreased out-of-pocket expenditures. This study also found that the NHIS reduces healthcare delays at home and in facilities, thus resulting in fewer complications among insured patients. It also helps the management of vulnerabilities and adversity presented by ill health, specifically for people suffering from chronic diseases such as diabetics and hypertension. This confirms previous findings that the household cost of ill health contributes to impoverishment since poorer households that are affected by chronic disease that uses up resources which leads to the loss of livelihoods (Russell 2004, Save the Children UK 2005, Mulemi 2010).

Conversations with both insured and uninsured people suggest that NHIS benefits (for themselves or relatives) encouraged them to remain in the scheme. The insured, especially those who seek healthcare regularly, were happy about the benefit package and the economic and social relief of the NHIS. This is reflected in the survey results in which the majority (76.2%) of all respondents, in Anomabo (100%) and Achiano (75%) said they enrolled because NHIS gave them financial protection against illness, helped them save money when paying hospital bills and made them independent since they did not need to ask for money from elsewhere (Table A.4, Appendix 2). A typical statement made by the insured was: “Even if there are problems such as negative behaviour of healthcare providers, the benefits outweigh such inconveniences.” Akosua narrated how her persistent ill health and high cost of treatment caused her to spend her capital and her husband nearly divorced her, but she did enrol in the NHIS a year ago. She said:

I used to worry about my condition when I was paying for treatment every month. I think this even worsened my condition at a point because in addition to the disease I was also worried about how to pay for treatment and the threat of divorce. Now NHIS helps me get my drugs regularly. I don’t have crises anymore. Thank God I’ve regained my strength and able to go about my daily activities without feeling any shame. I was able to accumulate some capital and resumed my trading. I don’t spend all my money on healthcare anymore.

Furthermore, insured patients said that all that they think about is their transport to the healthcare facility and not how to get money to pay a deposit before treatment. This is what Anoma said when I asked him why he continues to be a member of the NHIS:

The premium compared to the cost of healthcare is reasonable. I was lucky to have insurance when I had to remove my hernia. I didn’t think of money to pay a deposit. Things would have been very difficult for me since it was during the dry season and I didn’t have money, it means I had to wait for the fishing season or borrow money. At the hospital too they just asked me of my NHIS card and immediately admitted me because I was in great pain. Otherwise they would

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4 She explained shame as her inability to get close to people because she was always sick and not contributing anything to the family or community’s activities. People sometimes were also unwilling to get close to her and her husband wanted to divorce her.
have asked me to pay deposit before treatment. All these delays would have ended in something else; maybe death.

Akua, a diabetic patient also narrated how the NHIS enables her go to the hospital regularly and have all her drugs. She said:

This hospital card [NHIS card] has reduced my burden and worries. I don’t have to spend the little money for my trading activities to pay hospital bills. Though the sickness is still there, because I know I can get healthcare anytime, I am relaxed. Insurance has given me peace and relieved me from thinking about ill health. So for me, I regularly renew my card even though I am not satisfied with the quality of service in this hospital. Sometimes you have to spend so much time there.

The above reports suggest that when the NHIS covers healthcare expenditures and insured patients are assured of receiving care, they are more likely to live positively with their disease. Thus, the NHIS reduces a person’s vulnerability to the adverse effects of ill health. Since this reduction in vulnerability occurs in a community, some people who are initially reluctant to enrol are ultimately encouraged to do so. Although people may be dissatisfied with health providers’ negative behaviour, this might be overlooked if drugs are available at the local healthcare facility.

Healthcare providers told me that the NHIS reduces delays at home and health facilities and solves the problem of deposits for healthcare as indicated by Anoma. Dr. Gyena described the benefits as follows:

The good thing about NHIS is that it has improved utilisation and reduced delays; many more people are coming to the hospital now. At least the insured are reporting early with less complicated cases. They also have fewer problems getting their drugs. This makes treatment more effective as people come for reviews regularly.

According to hospital administrators, the NHIS has improved their revenue despite the delay in the payments for claims. The NHIS has helped them recover funds from people who access healthcare and cannot pay. He said: “Comparing NHIS to the past when we lost so much money to people who cannot pay their cost of treatment to now when we contact the DHIS, they help such people with exemption and pay us.”

Dr Gyena’s account and the medical assistant’s persuading her patients to enrol show that some health providers see the NHIS as enhancing their effort of providing quality healthcare and advise their patients to enrol to ensure they have access to treatment when they need it.

Anoma, who faced the risk of death but for the NHIS, shows the linkages between SHISs and protection against health risk. Her example supports Criel’s (1999) assertion that SHISs avert risk. Akua, Akosua and Anoma also show that the NHIS helped them regain their livelihood in addition to providing economic relief from paying catastrophic healthcare costs. The NHIS helped to enhance their ability to cope with and adapt to their chronic condition and resume their economic activity. This underscores the importance of the exemption policy as a safety net for the core
poor in the midst of inadequate support from family and friends. The NHIS was therefore found to facilitate prompt access to healthcare and adequate treatment. Lack of membership in the NHIS can result in fatalities as in the case of Ama’s daughter who died due to lack of access to healthcare. This suggests that exemptions for the poorest households are critical.

Conclusion
This chapter has shown the multidimensional factors that affect enrolment and retention in the NHIS. Reasons given for not enrolling and renewing memberships seemed to be simple: “No money to pay premium and registration fees.” There are, however, more complex factors at all levels: community, health facility, DHISs and politics converge to influence member enrolment and retention.

Most of the participants indicated that neither poverty nor premium costs were a significant reason for not enrolling. Thus, in addition to the “no money to pay” response, people mentioned that they were “not often sick.” Since people could obtain ‘cheaper’ healthcare at chemical and pharmacy shops when they were sick, this encouraged them not to enrol in the NHIS or renew their membership. They did not see health insurance as a pressing need. Further, dissatisfaction about the lack of drugs at health facilities and health providers’ (including DHIS staff) negative behaviour and malfeasance all make people question their commitment to the NHIS. In addition to the community members’ low interest in health insurance, the outcome of insured patients’ encounters with health providers discourages people from enrolling and remaining in the NHIS. At the same time, health providers’ persuasion makes some uninsured patients appreciate the NHIS, as in the case of the medical assistant who showed her NHIS card to patients to increase confidence in the scheme and thereby encourage them to enrol and renew their membership.

For health providers, the increased utilisation of healthcare services and completion of the complex NHIS form both exacerbated their heavy workload and caused them stress, which resulted in some being hostile and showing disrespect to insured patients by asking them to pay cash or giving preference to uninsured patients. These issues, coupled with delays in claim payments, adversely affected the quality of service delivery health providers’ desire to provide quality service.

DHISs’ staff shortages, inadequate funding and lack of equipment adversely affected their work output and resulted in delays in issuing NHIS cards. To manage their distressed financial situation, DHISs are in a dilemma as to whether or not to focus more on revenue generation to increase their internally generated fund or to grant exemptions to the poor to improve enrolment.

Given the significance of trust in SHIS, this study shows that the lack of trust erodes public confidence in the NHIS and undermines its potential as a viable alternative to ‘cash and carry’ and to ensure access to quality healthcare for all
residents in Ghana. This was demonstrated by the alleged involvement of health providers, DHIS officials’ and NHIS collectors in malfeasance, which led to distrust among stakeholders and negatively affected the credibility of the NHIS.

Finally, situating barriers and enablers at the level of local stakeholders and highlighting their concerns, makes revealing the reality involved in implementing the NHIS policy to policy makers critical. This study provides a guide for developing interventions that can create confidence in the NHIS and encourage people to enrol and regularly renew their membership. How local level multi-stakeholders collaborative groups were set up and were able to develop and implement interventions activities to reduce these barriers, increase enrolment and retain members in the NHIS is the focus of the next three chapters.