Improving health insurance coverage in Ghana: A case study

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Introduction

In the previous chapters, the multi-stakeholder problem-solving programme (MSPSP), aimed at improving enrolment and retention in Ghana’s National Health Insurance Scheme (NHIS) was described. In the next three chapters (six, seven, and eight), I address the main question of the study: how effective were problem-solving groups (PSGs) for improving enrolment and retention rates in the NHIS?

This chapter opens with a brief overview of the phases of the study and the MSPSP and addresses the question what effect PSG activities had on health providers, DHISs’ staff and community members in the context of health insurance enrolment. It concludes with a brief overview of the survey results concerning the effect of the intervention on enrolment. Chapter seven will present and discuss the factors that enhanced the PSGs’ functioning and led to increased enrolment, and chapter eight reflects on the factors that limited the PSGs’ effort at improving NHIS enrolment and retention rates.

Phases of the study and overview of the MSPSP

The study was divided into three phases – pre-intervention, intervention and post-intervention. Phase one (pre-intervention) was the conduct of a pre-intervention household survey in 30 communities in Central and Eastern regions of Ghana (13 and 17 respectively). The results were used (in addition to rural, semi-urban and urban characteristics) to assign the communities to intervention and control groups
to ensure a fair representation of communities with similar characteristics in both groups. In phase two (intervention), the research team organised sensitisation durbars in the intervention communities to inform stakeholders about the MSPSP and select PSG community representatives. The community-elected PSG representatives met with health providers and DHIS representatives (already selected by their heads of institutions) immediately after the durbars to select two facilitators and a secretary to lead the group through the twenty-month intervention period. Next, a three-day facilitators’ workshop was organised by the research team during which the MSPSP’s rationale and implementation guidelines were discussed. Facilitators were also exposed to facilitation approaches and problem-solving tools and techniques to equip them perform their task competently. An important element of the workshop was the adoption of general guidelines for facilitating PSG meetings and intervention activities. Intervention activities were carried out in the selected communities and their respective health facilities and DHIS offices. No activity took place in control communities. The third phase was the repetition of the pre-intervention household survey in March 2011 to assess the effect of the MSPSP on NHIS enrolment and retention rates. In addition, I conducted follow-up key informant interviews, conversations and focus group discussions (FGDs). The survey results were used to measure the impact of the intervention on enrolment and retention in the NHIS. Participant observation, conversation, key informant interviews and FGDs were used to provide an in-depth understanding of ‘how’ and ‘why’ the observed impact occurred.

Assessment of the effect of PSG activities on stakeholders started before the end of the intervention and concluded with key informant interviews and FGDs after the post-intervention survey. The interviews and FGDs focused on observed changes in health providers’, DHIS staff’s and community members’ behaviour and practices that directly or indirectly resulted in increased enrolment. The survey results showed that the intervention had a positive effect on all stakeholders and led to increase in enrolment; but renewal rates did not improve. Details of the quantitative results are presented later in a section that examines the effect of the intervention on community members. Due to the limited observations at the end of the intervention and to avoid an overreliance on self-reports by community members, health providers and DHIS staff; I also relied on changes they observed at different levels. For example, I used community members’ observations at health facilities to verify what the health providers had told me.

**Effect of the MSPSP on health providers**

At the start of the intervention, health providers often complained that the NHIS led to increased utilisation of healthcare services and thereby resulted in an increased workload. Of particular concern, was the time spent filling out NHIS forms, which
prolonged the insured patients’ consultations and staff’s working hours. Health providers also indicated that delays in claim payments led to drug shortages and undermined their attempts to improve the quality of services. These challenges influenced some health providers’ to be unfriendly towards insured patients and give preference to cash-paying patients. It also led to staff collecting unauthorised fees. The effect of the intervention (MSPSP) was assessed in terms of how PSGs were able to encourage health providers to manage their workload and improve their behaviour towards insured patients. In this regard, all three categories of stakeholders (community members, DHIS staff and health providers) observed three changes that can be linked to the intervention – improved attitude towards patients, a decline in delays in treatment and a reduction in requests for unauthorised fees.

*Improved health provider attitudes towards patients*

The consensus among health providers at all FGDs was that although the intervention did not reduce their workload, it helped change their attitudes towards insured patients. The main explanation was that the discussions at the community durbars, stakeholders meetings and other activities influenced them to accept their workload since insured patients could not be blamed. Others attributed the change in staff attitudes to meetings with officials from the District Health Directorate who sensitised them to understand that the NHIS enabled patients to report early to health facilities and with fewer complications. As a result, the staff adopted more friendly ways of communicating the challenges they faced when providing healthcare to insured patients. A nurse explained why she changed her behaviour towards insured patients as follows:

> Though our workload has not reduced and treating insured patients involved a lot of writing, the benefit of fewer complications presented by them discussed at our meetings influenced many of us to stop blaming them for our heavy workload. We realised that it is better to encourage them to report early than come here in critical conditions, which make us spend more time on them. However, shortage of drugs still persists and undermines the quality service insured patients are asking for.

I also observed during my routine observational visits to health facilities that those who had used derogatory language when interacting with insured patients had now stopped. I engaged these staff in conversations to explore reasons for the change. I walked home with Nurse Julia who had been accused of being disrespectful and hostile to insured patients most often and had demanded that they pay cash for accessing healthcare in the evenings and weekends. She told me this:

> After the many complaints about us during meetings, we accepted that we have to improve our behaviour despite the problems we face providing healthcare to insured patients. Also, since we are involved in the intervention, we explain to insured patients the difficulties we face providing them healthcare and educated them about the need to come to the facility during normal working hours rather than in the evenings and weekends if it is not an emergency to reduce the suspicion that it is because they are insured.
Reduction in requests for unauthorised payments

PSG activities led to improvements in provider practices and the quality of service. For example, incidences of payment for drugs and other supplies at health facilities were curtailed. To confirm what Nurse Julia said, I asked Nurse Anas (a PSG member) who had told me at the beginning of the intervention that she was not happy about the behaviour of some of her colleagues’ towards insured patients, whether she had observed any changes in that respect. She stated:

Our involvement in the intervention created the awareness that whatever we do will be exposed. So we are careful about what we do. Nurse Julia for example, has stopped collecting money from insured patients who access healthcare in the evenings and weekends and talk to patients to enrol.

A medical doctor narrated how the PSGs’ exposure of a staff member made him institute measures that helped stop illegal payment for medicines and other supplies in the facility. He stated:

As I told you at the beginning of the intervention, we are pleased to be involved from the onset, so I told my staff that despite the workload and other challenges we face, we need to work like professionals. So we instituted measures that ensured both insured and uninsured patients are served as they come and stopped those who sell drugs covered by the NHIS to insured patients. We also talk to patients to enrol and encourage them to report difficulties they face here. My staff are now careful about what they do since they know their bad behaviour will be exposed. I believe this encouraged people to enrol.

Since it was not possible to use observation to validate all the reports such as collecting unauthorised fees, I engaged community members and DHIS staff in conversations and FGDs to verify what I was told. For example, I asked insured patients whether there had been any improvement in the way health providers treated them at the facility. One of them, who criticised the behaviour of nurses with passion at the beginning of the intervention, told me another story. She said:

The group has made them change their bad behaviour when people complained about them. The nurses who were disrespectful and collected money in the evenings and weekends changed after the durbar. I think they were afraid. What is left is to provide drugs in the hospital as drug shortages discourage people from enrolling and renewing their insurance cards regularly.

Decline in delays in treatment

DHIS staff also confirmed an improvement in health providers’ behaviour during a FGD and added this:

After discussions at stakeholders’ meetings the clear change in the hospital is a reduction in waiting time and improvement in the way the nurses talk to insured patients. The excuse that time needed to fill NHIS forms was the reason for giving uninsured patients preference has been resolved and the situation is better now. Many of them no more separated insured patients’ cards from the uninsured.

The observed effects of PSG activities on health providers’ behaviour and practices revealed that though their workload did not decrease, the facilities instituted measures that influenced the staff to adopt more positive attitude towards insured
patients. These measures helped improve the staff’s behaviour and service delivery and encouraged many people to enrol even in the midst of unresolved challenges. Both Nurse Julia and Nurse Anas’ statements indicate that awareness and frequent discussions about insured patients’ complaints at stakeholders meetings influenced them to adopt a positive attitude. I observed that the nurses stopped giving preference to uninsured patients in queues that were usually formed at the OPD and served everyone according to the order in which they presented their cards. Also, disrespect and use of derogatory language to describe insured patients as ‘difficult’ and ‘disturbing them’ gradually disappeared as the intervention progressed and by the end of the intervention period I rarely heard such language. Reports about payments for drugs and other supplies in health facilities and the demand for cash when assessing healthcare in the evenings diminished. As D’Ambruoso et al. (2008) observes, client-provider interaction and patients’ satisfaction about the care provided are particularly important in health insurance with the degree of participation determined by perceived quality of care. From this point of view, these positive health provider-patient relationships influenced many people to enrol and remain in the NHIS.

Various reasons may account for the positive changes in health providers’ behaviour. It was conscious effort to behave favourably towards insured patients during the intervention even in the midst of the difficulties they face. As Turner & Stets (2006: 29) have noted, social actors’ behaviour are often ‘self-directed’ to conform to what others expect from them. This implies that people sometimes alter their behaviour in particular situations to achieve an objective. Similarly, the positive change in health providers’ behaviour and practices was a result of self-initiated measures either to create good impression about themselves to show the researcher and/or District Directors of Health Services and District Health Insurance Scheme (DHIS) managers that the negative perceptions about them were not true and to redeem their image. To a certain extent, these views could be true, but there are good reasons to believe that the observed changes were real and not acted. My assertion is based on the fact that the multi-level approach used in gathering information made it possible for me to verify what I was told and observed. For example, I observed health providers increasingly show respect and not using derogatory language when interacting with insured patients; insured patients and DHIS staff confirmed this change during spontaneous conversations.

Another possible underlying reason for the positive change in providers’ behaviour was the feeling of being change agents in the intervention and a genuine commitment to help the intervention succeed. As pointed out, providers were previously not usually involved in intervention programmes from the onset and treated as objects. Now they were pleased to be part of the planning and execution, which motivated them to ensure that the objectives of the intervention were
achieved. Obviously, involving stakeholders in interventions from the onset to address barriers to public policy uptake, leads to a better appreciation of the challenges that accompany such policies and influence them to be committed to success.

Effect of the MSPSP on District Health Insurance Schemes’ staff

Barriers identified and addressed at the level of DHISs included: (1) inadequate equipment, (2) difficulties in processing NHIS registration forms, (3) lack of filing systems and (4) overcharging for fees and back door registrations. By the end of the intervention almost all DHIS staff mentioned the main effects that the MSPSP had on them that helped improve their performance and by consequence enrolment in the NHIS. They indicated that the PSGs’ sensitisation activities and stakeholders meetings had led to the adoption of strategies to manage the challenges they faced: providing cameras for collectors to take photographs immediately they registered people and being meticulous about people not using multiple names, improving their filing system (which made retrieval of information and NHIS cards easier), and exposing back door registrations and collectors and DHIS staff who overcharged for fees. These measures improved the registration process and made it possible for DHISs to issue NHIS cards by the end of the three-month mandatory waiting period.

Cameras, matching names, and improved filing systems

A DHIS representative during a FGD outlined measures that helped increase enrolment as follows:

The challenge the PSGs threw to us during our meetings made us introduce measures that helped improve the registration process. Our staffs now match names on registration forms with pictures and correct mistakes in the field. The collector was provided camera to help him do that. We also educated people about the problems created when they are not consistent with the names they use for registration and when taking pictures. These reduced delays in issuing NHIS cards, built confidence in the NHIS and encouraged people to enrol.

A DHIS manager, who had doubted that the PSGs could improve enrolment at the beginning of the intervention, gladly expressed his positive opinion about the group this time. He said:

Debates during stakeholders’ meetings and other activities made us seriously reflect on our work and devise ways of improving our work. We repaired our computers promptly, gave camera to collectors and made shelves for filing documents. These improved the registration process and makes retrieval of documents faster. Though I cannot give you exact figures, because our data is not organised by communities, I can say for sure that since the intervention started, revenue from the community increased significantly compared to others.

Changes at the DHISs mentioned by health providers’ during and at the end of the intervention were fairly similar to what others said. The following statement by a medical assistant captured their observation:
Before you [PSG] started work, we used to have problems with patients for having NHIS cards with their pictures but different names. We don’t have such problems anymore. This shows the DHIS has improved its work.

Such assertions from DHIS staff were corroborated by community members who noted that the NHIS cards were delivered by the end of the three-month waiting period. Two views were expressed. A PSG community representative in a FGD stated:

This is the second time I registered. The first time they could not find my card so I decided not to register until the intervention. You can ask the collector [pointing to her]. Some people also had their names mismatched with other people’s pictures. When I registered now, we all had our cards on time. No more missing cards.

**Overcharging for fees and back door registrations**

In addition, the PSGs’ exposure of some collectors’ and DHIS staff who charged more than the approved premium and registration fees for NHIS cards for people who were sick through the ‘back door’ led to reduction in this practice. For example, a DHIS manager applauded the PSG community representatives for their vigilance in helping to check their staff and collectors’ corrupt practices in the following statement:

The group’s exposure of the collector and DHIS staff who charged more than the approved fees and issue NHIS cards to people without waiting for three months led to the termination of the collector’s contract and the staff was seriously reprimanded. Regular discussion of such issues minimise back door registrations and the cheating that was going on. My staff are afraid of being exposed and punished.

I overheard a community member telling the facilitator about the improvement in issuing ID cards:

You [PSG members] have come to put things right at the DHIS office. I remember before you people came, things were not working well. When you register, you wait for some time before your picture is taken; you wait again for four months before you get your card. It happened to me and before I had my card, I had waited for six months. These things are not happening any more. Now it is left with the DHIS manager to identify and punish the few staff that still cheat to deter others and grant exemptions to poor people as we have discussed at our meetings with them.

**Summary**

These key stakeholder views and observations about the positive effects the intervention had on DHIS staff indicate that service delivery improves if resources are provided and a group is monitoring the activities of public sector workers. For example, PSGs reported that ‘undercover practices’ such as collecting more than the premium and registration fees and back door registrations that were hidden from DHISs’ managers diminished as a result of PSGs’ exposure of those involved. My analysis revealed that the negative behaviours and practices persisted because of two mutually inclusive factors: First, lack of commitment by authorities’ to sanction
those involved. Second, lack of courage on the part of victims to report those involved to the authorities. Together, these factors perpetuated malpractices among DHIS staff. Contrarily to Aryee’s (2005) observation, official responses to corruption in Africa range from lukewarm to hostility; this study found that the DHIS managers willingly sanctioned staff found to be cheating. This posture shown by the managers at the beginning of the intervention encouraged residents to report (and some even demanded) that the offenders were sanctioned as it happened to the collector whose contract was abrogated because of malpractice. So the fact that PSGs were ready to report DHIS staff and collectors to the authorities prompted many of them to change their behaviour, which reduced malpractices.

The positive changes in DHIS staff’s behaviour appeared to be a conscious effort to fulfil their promise at the beginning of the intervention that they would ensure that the intervention succeeded since expanding NHIS coverage was their core business. As Turner & Stets (2006) observe, social actors sometimes modify their behaviour to achieve an objective. It can be concluded that the changes in behaviour and practices was a self-directed action that improved the DHISs’ operations and increased confidence in the NHIS ability to fulfil their promise of supporting PSGs to achieve their goal. This indicates that involving implementers of a policy from the onset of an intervention and providing the required resources motivates them to improve their performance. These findings reinforce the previous observation that engaging stakeholders to address public policy challenges yields better results since it captures all perspectives and provides better insight of the real situation instead of a single-level approach, which misses out majority of people whose lives are affected by the policy (Van der Geest et al. 1990, Press 1990).

Effect of the MSPSP on community members

The NHIS policy requires registration and annual renewal of all household members (Government of Ghana 2003). However, community members’ poverty, low interest in protecting themselves against ill health, and political perception of the NHIS contributed to low enrolment and high membership non-renewal rates. The effect of the MSPSP was therefore expected to change community members’ attitudes towards the NHIS, reduce the political perception of the NHIS and influence them to enrol and renew their membership annually. Conversations about whether the PSG activities influenced people to enrol in the NHIS and renew their membership started before the end of intervention and ended with discussion of the survey results.

Three major changes

Information consistently mentioned in my conversations during the course of the intervention and FGDs at the end demonstrated three main effects of PSG activities
on community members that led to increase enrolment. First, many community members indicated that the PSGs’ educational activities helped them to understand the risk-sharing principles of health insurance and influenced many people to enrol all household members instead of the selective registration they had been doing. They also stated that the PSGs’ promotional activities created interest in the NHIS and made them appreciate the need for protection against ill health to avoid paying expensive direct out-of-pocket charges. Second, the PSG activities made them change their negative perception about health providers and improved their relationships with them. Last, involvement of their peers as PSG members and leaders in identifying and addressing NHIS challenges as well as implementing intervention activities removed the community members’ political perception of the NHIS.

Understanding risk-sharing and changing negative perceptions
The following comment by a boat owner captures the effect that the PSG activities had on community members.

The intervention improved our understanding of health insurance and changed our attitude towards health insurance. You know health insurance is not part of our culture, so many of us did not see why we should pay for health insurance. Now almost everybody including children knows that insurance is better than paying cash at the hospital. By discussing the problems at the hospital with us, we appreciate why insured patients have to wait longer than the uninsured and why they don’t always give us drugs at the hospital. Also, the testimonies given at durbars created confidence in insurance and influenced some of us to register everybody in our house instead of only those who needed healthcare. However, many people are still reluctant to register. But I think if the group continues their education with time they will change.

To verify what community members told me, I talked to DHIS staff and health providers to find out their opinion about the statements from community members about the effect of the MSPSP. A DHIS manager, who at the beginning of the intervention held the notion that community members were difficult and was worried about how the PSG could improve enrolment, spoke highly of the MSPSP in the following remarks at the end of the intervention.

I think the education at durbars, house-to-house visits, the film shows and other activities made them [community members] think seriously about health insurance. Before the group started work, people were not serious about health insurance. I think the group has been able to improve their attitude towards health insurance. The more than double increase in enrolment achieved is very good. We were unable to achieve this all these years. But the high membership non-renewal rate is because some people still wait until they are ready to go to hospital before they rush to renew their card. This attitude tells you how difficult it is to keep people in the scheme. I don’t know what can change that.

The above view was also shared by several health providers I engaged in conversations at the end of the intervention. The following example summarises their observation.

Before your programme started, not many people came here with insurance. I think your education has encouraged them to enrol. But there are still those who, though know insurance is good
for them, will wait till they have some serious sickness before rushing to register. They come here and cannot pay their bill and give the excuse that they registered about a month ago and their card is not ready.

Knowing how easy it is for people to tell a researcher what he or she wants to hear, I sometimes eavesdropped on conversations to obtain information healthcare providers would ordinarily not tell me. On one such occasion, I heard two nurses at the OPD, talking about how the PSG helped improve the enrolment of pregnant women and mothers. One of them said:

Have you noticed that since the group started work many pregnant women and mothers come here with insurance cards? They now understand the free enrolment for themselves and register their babies two weeks after delivery. You remember we used to have a lot of argument with them especially those who register late and their cards were still valid long after delivery and think their babies should also be given free treatment after six weeks without registering them. Now they register their babies early.

**Political perceptions**

A nursing mother also told me that though some problems still persist, the intervention increased her confidence in the scheme and influenced her to enrol. She said:

When health insurance started, we saw it as politics and many people were not interested, but your education at community durbars and the hospital and house-to-house visits helped us understand the benefits of the scheme and changed our perception. However, the problem of shortage of and paying for drugs at the hospital and going round looking for drugs is still there. But as I always say being insured is better than going to hospital without insurance.

**Health providers’ disappointment with outcome**

Despite the positive remarks some health providers who were involved in promoting the NHIS were not too impressed about the outcome of the intervention. A medical assistant (a PSG member), who showed her NHIS card to uninsured patients and encouraged them to enrol, expressed her disappointment about the results as follows:

As I’ve always been complaining, people still come here without health insurance. Despite our efforts at encouraging them to enrol not even half of the people are registered Many have seen the need to protect themselves against sickness, but still wait until they are sick before they think of health insurance. The men especially say they hardly fall sick. I don’t know what can change them.

In summary, I observed that the regular interactions among community members and leaders, health providers and DHIS staff, testimonies given at community durbars and the documentary films had positive impression on the community members. These activities influenced many people to appreciate the need for protection against sickness. The community members also appreciated the challenges health providers face when providing healthcare under the NHIS and talked about them in a more positive way. This helped increase confidence in the NHIS and
influenced people to enrol. My findings were verified through spontaneous conversations with several stakeholders throughout the intervention period, at PSG meetings and during key informant interviews and FGDs. Stakeholders could not have continuously made up their observations just to please me. Thus the reported observed changes were a fair reflection of the effect the intervention had on each stakeholder.

**Post-intervention survey results**

The positive effect of the intervention on community members comes out clearly in our post-intervention survey results on enrolment (currently insured) in the NHIS presented in Figure 6.1. The data covered 13,857 individuals at pre-intervention: 7,234 and 6,623 in intervention and control communities respectively. For the post-intervention survey, the data covered 12,810 individuals: 6,790 in intervention communities and 6,020 in the control group. Household heads were the respondents who gave information on the individuals (members of their households).

The results affirmed that PSG activities influenced people to enrol, but not to consistently renew their membership. Figure 6.1 shows the intervention significantly increased enrolment by 10.6 per cent (p=0.000) (from 29.7 to 40.3 per cent) and membership non-renewal rate by 6.9 per cent (i.e. from 15.5 per cent to 22.4). Further, we used a probit regression model to analyse the effect of the intervention on current and previous enrolment. The results showed that, holding all other factors constant, residents within the intervention communities were 17 per cent more likely to enrol and 5 per cent less likely to drop out of the NHIS compared to those in the control group following the intervention.

To find out whether the NHIS had reached the poor, the primary target of the policy and the intervention, the population was categorised into wealth quintiles using household consumption expenditure (see chapter three, Aryeetey et al. 2010). The health insurance status of all individuals covered in the survey was assessed and is presented in Figure 6.2.

Figure 6.2 shows the enrolment rate across the five wealth quintiles at baseline and post intervention. Enrolment in the poorest quintile declined from 23.6 per cent to 17.6 per cent. There was a slight improvement in enrolment for the poor quintile (28.6% to 31.3%). However, there were increases in enrolment for the third to the fifth quintile. A striking finding was that membership non-renewal rate was higher among the richest (23.7%) and rich (23.8%) than among the poorest (15.4%) and the poor (18.4%). This point will be discussed in the next chapter. The statistics indicate that although the intervention increased overall enrolment, it failed to achieve its main objective: to draw more poor people into the scheme.
**Figure 6.1** Changes in NHIS status in intervention and control communities

![Bar chart showing changes in NHIS status in intervention and control communities.]

<table>
<thead>
<tr>
<th>Status</th>
<th>Intervention Communities</th>
<th>Control Communities</th>
</tr>
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<tbody>
<tr>
<td>Currently insured</td>
<td>29.7, 30.2</td>
<td>15.5, 15.6</td>
</tr>
<tr>
<td>Previously insured</td>
<td>40.3, 34.4</td>
<td>22.4, 24.1</td>
</tr>
<tr>
<td>Never insured</td>
<td></td>
<td>54.8, 54.1</td>
</tr>
</tbody>
</table>

**Source:** Fieldwork, March 2009 and 2011.

**Estimated effect of PSG activities on enrolment and membership non-renewal rates**

<table>
<thead>
<tr>
<th></th>
<th>$\beta$ (95% CI)</th>
<th>Std. error</th>
<th>P-value$^c$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently insured</td>
<td>0.17 (0.12-0.21)</td>
<td>0.024</td>
<td>0.000</td>
</tr>
<tr>
<td>Previously insured</td>
<td>-0.05 (-0.01-0.00)</td>
<td>0.023</td>
<td>0.047</td>
</tr>
</tbody>
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**Figure 6.2** Changes in NHIS status by wealth quintiles in intervention communities

![Bar chart showing changes in NHIS status by wealth quintiles in intervention communities.]


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1. $\beta$ is the coefficient of the independent variable (dummy for intervention) on the dependent variable and used to predict the effect of the intervention on enrolment and non-renewal rates. Positive values show positive relationship and negative indicates inverse relationship.

2. Statistical convention holds that a significant difference exist between two variables only if the ’p-value is less than 0.05 at 95% confidence interval. A p-value close to 1 indicates no difference between the two variables.
The lower enrolment observed among the poor supports previous studies that enrolment in the NHIS increases with income (Asante & Aikins 2008, Sarpong et al. 2010). In their study in a rural district of Ghana, Sarpong et al. (2010) found that 38 per cent of the population was enrolled in the NHIS. In this group, 21 per cent belonged to low, 43 per cent middle and 60 per cent to high socio-economic status households. The poor respondents cited the cost of transport to health facilities as the cause of their low enrolment. However, the higher non-renewal rate among the average and rich categories contrasts with the health economic literature in Sub-Saharan Africa, which gives excessive weight to the cost of premiums as responsible for low coverage in health insurance schemes (Jutting 2004, Asante & Aikins 2008, Basaza et al. 2008, Sarpong et al. 2010). The findings in this study indicate that although poverty contributes to low enrolment, it does not determine renewal rates. Low enrolment among the poorest quintile was attributed to the failure of DHISs to exempt them from paying premiums as the policy stipulates.

With regard to the enrolment within intervention communities, 10 communities showed significant increases in enrolment (p=0.000), two had no change (p>0.05) and three recorded significant decreases (p<0.05). Of the fifteen communities, only two had approximately two-thirds of the population enrolled (68%, 63%), two about half (53%), six between 30 and 50 per cent and five less than a third (15% to 25%). The non-renewal rates were generally high – between 13 to 41 per cent (see Table A.9, Appendix 2). The reasons and explanations behind these figures are examined in the next two chapters.

Conclusion: Dialogue among stakeholders and trust

In the current study, the positive effects of the MSPSP on enrolment clearly indicate that creating space for regular dialogue among stakeholders made it possible to capture barriers at all levels and helped to develop activities that led to the reduction in NHIS implementation challenges compared to the DHISs working alone. Community leaders’ involvement encouraged members to develop interest in the NHIS and accept the need for protection against ill health. Moreover, since enrolment in an insurance scheme is partly about trust, health providers’ involvement in the intervention and the observed changes removed doubts that they (community members) might not be treated well. As Schneider (2005) points out, trust-building practices reassure the insured that they will receive care when sick and motivate them to enrol. Similarly, the increase in enrolment can be explained by health providers directly promoting the NHIS and the adoption of practices that improved trust between them and community members. This reassured the community members in their support of the NHIS and increased their confidence in the scheme. However, the PSGs’ inability to improve enrolment among the poorest quintile brings to the fore the reasons why the exemption is not reaching them, which will be discussed
elaborately in chapter eight. But, first in chapter seven we will examine the factors that enhanced the PSGs’ functioning more closely.