Improving health insurance coverage in Ghana: A case study
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Citation for published version (APA):
Kotoh, A. M. (2013). Improving health insurance coverage in Ghana: A case study

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Factors that enhanced problem-solving groups’ achievements

Introduction
This chapter provides insight into how the PSGs were able to improve enrolment in the NHIS and explains the results using both positive and negative cases to examine factors that influenced the outcome of the intervention. Five main factors were identified to enhance PSGs’ work and led to positive outcome of the multi-stakeholder problem-solving programme (MSPSP) are presented in Figure 7.1 These factors were mentioned and discussed at the facilitators’ training workshop, key informant interviews and FGDs and observed at PSG meetings and intervention activities.

A recent study suggests that emphasis on how multi-site intervention programmes are implemented is necessary for evaluating their impact (Oakley et al. 2006). In this study, the examination of the MSPSP implementation process revealed that facilitation approaches, stakeholders’ engagement, supervision of PSGs and motivation for members led to positive results. These factors created conducive group environment, built trust among PSG members and stakeholders, sustained their commitment to the intervention and led to an increase in enrolment. A synopsis of how these factors enhanced the PSGs’ work, ensured smooth implementation of the MSPSP and resulted in increased enrolment is provided in this chapter. Why some PSGs (those who did not employ these approaches) failed to increase enrolment is also examined and reference is made to particular cases to explain these outcomes.
Facilitation approaches

Quality of facilitation describes how facilitators conducted PSG activities in a manner that promoted group cohesiveness, cordial relationships among members and a sustained commitment to the MSPSP. Since the MSPSP’s objectives may not have been shared by every member to the same degree, facilitators needed to use approaches that would make them effective leaders and inspire the group to achieve positive results. Pillsbury (2008: 131) underscores the importance of facilitative skills as follows. “To be an effective leader, one must be driven by an impulse that solidifies a commitment to a vision…and connecting that vision and values to a position of responsibility for executing a programme.” With PSGs, it was not only the facilitators’ commitment to the vision of the intervention that was important, but also how to turn the intervention into a collective idea worthy of being followed by
members. Before they started work, facilitators were trained to adopt three main facilitation approaches: bottom-up, inclusive decision-making and interdependency.

**Bottom-up approach**
The bottom-up approach that the facilitators used was informed by Chambers’ (1992) description of what effective participation should be in his work on community development. Chambers’ proposition emphasised that community members should define their realities and mobilise resources to address their needs. This was discussed and adopted at the facilitators’ workshop as a key guiding principle in implementing the intervention to ensure the effective participation of PSG members.

Facilitators employed non-dominating processes in the conduct of PSG activities. PSG members designed the intervention, controlled the resources provided, and drew and implemented their own action plans. A typical strategy that the facilitators’ employed to achieve this was that they did not always lead PSG meetings and problem-solving sessions, but instead they often took a ‘back-seat’ after introducing the activities. This posture encouraged PSG members to come out with ideas that formed the basis of their discussion. For example, during the problem identification and prioritisation sessions, facilitators opened the meeting by briefing PSG members about the agenda and asked a community representative, health provider or DHIS representative to lead the activities. Members primarily controlled the discussion. Facilitators contributed ideas when necessary and ensured that the discussions remained focused on the agenda. In essence, the members identified the barriers, developed solutions and implementation strategies and drew their action plans. A PSG DHIS representative described how the bottom-up approach helped sustain members’ commitment in the intervention in the following statement.

We remained committed to the intervention because facilitators depended on our experiences and ideas to plan activities. This helped us identify the ‘real’ problems that discouraged people from enrolling in the NHIS and renewing their membership. Everybody’s contribution led to the development of intervention activities and strategies that made it possible for us to reach everybody.

**Inclusive decision-making and trust**
The inclusive decision-making adopted as a benchmark for PSGs’ effective functioning is in line with Lasker & Weiss’ (2003) observation that collaboration must allow for inclusion and the equal participation of members in the process. In this study, facilitators addressed this issue in the PSGs’ activities by ensuring that every member played a leading role in the identification of barriers, development and implementation of activities at one time or another, depending on their capabilities. The facilitators did not behave as if they knew all the problems and solutions. This approach created trust and allayed the fear of isolation while preventing self-alienation by members who were apprehensive about their effective participation from the beginning of the intervention. As Huckman (1987: 323) observed, “[g]roup
experience should satisfy rather than frustrate the personal needs of members.” This study also found that the facilitators’ encouragement of members to lead group activities and make decisions based on consensus satisfied the members’ sense of belonging. For example, Ebo who did not want to be part of the PSG because he could not speak English and feared alienation, became confident and contributed to discussions during PSG meetings and problem-solving sessions.

A brief background to Ebo’s case is useful to illustrate my observation. I noticed Ebo when he rejected his nomination during the PSG creation meeting. All attempts by his peers to convince him to accept his nomination failed. Realising that they saw him as somebody who could be an effective member, I persuaded him to agree to be elected. He accepted my plea and was elected. Later, I observed him closely. I noticed that Ebo did not talk during the first two meetings. The facilitator had to persuade him to contribute to discussions during the third meeting and later made him responsible for arranging PSG meetings and intervention activities at the community. Six months into the intervention, I had a conversation with him about how he felt as a group member. Ebo described his feeling as follows:

I’m happy in the group. At the beginning I didn’t want to be a member because I could not speak English so I felt I’ll be ignored, but when I became a member, the facilitator encouraged me to talk during meetings. We all decided how to do the work. I then realised I can do the work. Also, facilitators informed us about money received and we all decide how to spend it. There is no suspicion but trust among us. We are all working to achieve good results.

On the basis of Ebo’s comment and my observation as a participant in the PSGs, I can say that the inclusive decision-making and the active role everybody played in the conduct of PSG activities created trust and commitment to achieve the group’s objectives. Ebo’s statement indicates that the facilitators’ encouragement of less confident members and recognition of members’ contributions as important in the decision-making process led to their active participation. Also, since no PSG member dominated the problem-solving sessions, trust developed among them and sustained their commitment to the group and the intervention. According to Currall and Inkpen (2006) trust develops over time among groups and individuals. They observed that building trust is an incremental process; one may trust in small ways first, see whether it is upheld or violated, and then proceed with caution in trusting one step at a time. In the current study, I observed that trust developed slowly among PSG members as the intervention progressed as a result of respect for each other’s views. However, its sustenance depended on the leaders’ ability to engage all members in deciding the best way to get things done and distributing key roles across the group.

I must state however that this strategy was not applied in all PSGs. Some facilitators dominated the PSG activities. This created distrust and stifled the group’s work and so the groups did not achieve positive results. The details of what happened will be discussed in the next chapter.
**Interdependency and trust**

Interdependency means that the group members depended on each other to carry out a task instead of acting individually. In the context of the MSPSP, interdependency involved the facilitators’ dependence on PSG members to plan and implement intervention activities and seeing each other as equals. This required that PSG members learned from each other and contributed towards the achievement of their objectives. The approach was used to create a conducive group environment similar to what Schwarz (2006: 300) described as a culture of collaboration: “All parties involved jointly design ways to work together to meet their related interests and learn with and from each other, sharing responsibility, authority, and accountability for achieving results.”

In the case of the MSPSP, the PSG facilitators’ created a collaborative environment that made it possible to harness the members’ skills as the basis of their success. They achieved this by creating interdependent relationships so that the group could only function when everybody played his or her role. In applying this approach, the facilitators shared the roles for pre-intervention activities among members and ensured that each person played his or her role as expected. This led to smooth implementation of the group’s activities. A facilitator explained during a FGD how his reliance on the PSG members fostered synergy and ensured smooth implementation of their activities, which ultimately resulted in increased enrolment.

I make sure every member felt as part of the group and we saw each other as equals. Everybody contributed to our activities. This inspired everybody to actively participate in the development and implementation of intervention activities and remained committed to the group.

Interdependence among PSG members created a relationship based on mutual respect so that members saw themselves as equals and prevented dominance by a few members. For example, some members led group meetings and problem-solving sessions, while others wrote letters to invite guests, called members to remind them about meeting dates and time and arranged venue for intervention activities. These assignments made members accountable to the group and contributed to achieving positive results. Consistent with this finding is the observation by Williams (2001) that the presence of trust facilitates cooperative behaviour. In his study on ways of developing trust among dissimilar groups, he suggests that managers may structure tasks to ensure inclusiveness and cooperation among members.

In summary, the bottom-up approach, inclusive decision-making and interdependency approaches created a favourable group environment and made it possible for PSG members to talk about issues that bothered them. The PSG facilitators’ non-dominance and reliance on members encouraged the members to share their experiences and ideas as well as critically analyse stakeholders’ behaviours and practices that negatively affected enrolment. This led to the appreciation of each other’s
challenges and influenced the PSG members to see their contribution as valuable in the intervention process and put their shoulders to the wheel while contributing ideas to achieve set objectives. This discussion illustrates how the facilitation approaches influenced PSG members to attend meetings regularly and participate effectively in the intervention to ensure they achieved positive results.

Engaging stakeholders in leadership and professional roles

The key advantage of engaging all stakeholders, including leaders and professionals, in the MSPSP is that it helped reveal multiple perspectives of barriers to enrolment and retention in the NHIS and led to the development of appropriate solutions and implementation strategies. Instead of serving as targets of the intervention, the stakeholders in leadership and professional roles were engaged from the onset and participated in all phases of the MSPSP. The five PSGs (seven PSGs in total) that engaged with the community and opinion leaders, heads and staff of health facilities, DHIS managers and their staff were able to achieve a significant increase in enrolment. For example, in fishing communities engaging community and opinion leaders, chief fishermen, boat owners and pataase leaders in implementing intervention activities made it possible to access the difficult-to-reach community members. Similarly, chief farmers’ and cocoa purchasing clerks’ involvement in the intervention made it possible to reach all farmers. Difficult-to-reach community members included fishermen (who were mostly at sea) and farmers (who spent most of their time in their farms), who could not be reached with community-wide activities such as durbars and house-to-house visits. The support from key specific stakeholders contributed to an increased enrolment in those communities. The two other PSGs that did not engage specific key stakeholders (as mentioned above) failed to increase enrolment.

Health providers and DHIS staff’s involvement in the MSPSP helped reduce negative practices such as a preference for cash-paying patients and the sale of drugs covered by the NHIS to insured patients in health facilities. Their contribution as advocates of the NHIS in health facilities convinced people who were sceptical about their commitment to the scheme to change their attitudes. A PSG community facilitator explained in a FGD how they were able to increase enrolment as follows:

We were able to increase enrolment because of the support of boat owners, community leaders, health providers and DHIS staff. All of them took part in executing intervention activities. This made things easy for us to be able to reach everybody. For us [as] community facilitators, our leaders’ involvement in the intervention put pressure on us to work hard to sustain members’ commitment to ensure success. For example, the nurse who showed her NHIS card to patients actually helped convince many people to enrol.

A community member who enrolled during a mass registration exercise in a conversation explained why she enrolled:
I enrolled because of how our leaders are working with DHIS staff to explain health insurance to us and address our concerns. The nurses’ presence in particular showed they support it. Also, holding meetings here and hearing about benefits of insurance from people here convinced me to enrol. In addition, the collector’s and volunteer’s regular visits to my house, education at schools, churches and the mass registration exercises during the fishing season when we had money was helpful. The more they came to talk to us, the more my children harassed me to enrol them.

A DHIS staff in another FGD explained how they were able to improve enrolment.

The regular meetings made us see the intervention as a collective one and encouraged us to commit ourselves to change community members’ attitudes towards health insurance and health providers and DHIS staff’s practices that discourage people from enrolling.

These comments and events suggest that bringing stakeholders in leadership and professional roles together to share NHIS related experiences and implementation challenges led to better conceptualisation of the MSPSP and contributed to its success. PSGs’ mass registration exercises during fishing and cocoa seasons every fortnight when people had money contributed to PSGs’ success in increasing enrolment. These findings underscore the need for collectors to be situated in all communities whether rural, urban or within DHISs’ office locations.

The cooperation among these stakeholders built inter-institutional linkages and a synergy that helped achieve positive outcome. The linkages helped mobilise support for the intervention, removed explicit resistance and aided smooth implementation. The synergy that Lasker et al. (2001) point out creates an advantage in collaborations and in the case of the MSPSP it built trust, gave more credibility to the intervention, tapped information about the local environment and made it possible to reach target populations that could not have been reached otherwise.

Robertson & Minkler (1994) observe that treating stakeholders as targets of policies and consumers of problem-solving efforts undermines collaborative effort. The two PSG facilitators who did not involve stakeholders in leadership and professional roles and treated them as objects of the intervention were unable to achieve positive results. This indicates that the significant increase in NHIS enrolment was as a result of the effective engagement of stakeholders in leadership and professional roles.

Trust among stakeholders

The involvement of stakeholders from various levels helps to build ownership and create favourable conditions for the development of commitment to the intervention (Hawkes et al. 2004, Nastasi & Hitchcock 2009). In this study, stakeholder engagement in the PSG intervention fostered changes in behaviour, created confidence in the NHIS and encouraged people to enrol. I observed that the interaction between PSG members and their distribution of tasks to ensure that all parties participated determined their success. Mutual trust among stakeholders seemed to be an im-
portant condition for effective functioning since it reduced the power differentials among the individuals within the PSGs.

**Managing tension in PSG intervention meetings**

I noticed that the way that PSG intervention meetings were conducted diffused the tension apparent at the beginning that I was worried might lead to confrontation. In one meeting, I observed tension left over from a durbar (organised by the PSG) when people aggressively accused health providers of giving preference to cash-paying patients and malfeasance at the facility. For example, Nurse Julia put up a ‘very serious face’ before the start of the meeting. She did not smile at any PSG member as she usually does. I could see from her countenance that she was ready to respond in a hostile way if someone said anything negative about health providers. However, the facilitator presented problems identified at all three levels (community, health facility, and national), informed those in attendance about intervention activities that had been conducted so far in the community, and stated that the group was there to listen to the health providers’ side of the story. Thus, the tension in the room gradually disappeared. Nurse Julia contributed to the discussion and talked freely about her experience with insured patients.

**Supervision of PSGs: regional and local**

Supervision of PSGs was instituted to ensure that the facilitators adhered to the MSPSP’s general implementation guidelines. NHIA regional managers accepted adding the PSGs’ supervision to their routine monitoring of DHISs and DHIS managers or District Director of Health Services (DDHSs) were local supervisors. The supervisors agreed to visit the PSGs quarterly to ensure that they implemented the intervention activities outlined in their action plans at the regional stakeholders meetings organised by the research team.

This monitoring strategy aimed to create linkages between the regional, district and local levels and was informed by Glaser & Taylor’s (1973) and Davis & Howden-Chapman’s (1996) observations that if an organisational authority structure is bypassed when introducing change, the process can be inhibited. Involving authority structures becomes even more important when the change is initiated from outside the organisation and staff support must be solicited. It was observed in this study that engaging regional and district officials ensured a smooth implementation of the MSPSP and built support across levels. PSG facilitators and members told me that being supervised influenced them to remain committed to the intervention’s success. Moreover, since the ultimate goal of the study was to integrate the MSPSP

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1 Only one DDHS was involved in supervising PSGs, and this was because the DHIS manager was the facilitator.
into the DHIS structure, the NHIA regional and DHIS managers’ and DDHSs’ supervisory roles were expected to make them appreciate the MSPSP and understand how PSGs were formed and functioned so they could facilitate scaling-up if needed. A PSG health provider representative explained why she remained committed to the group:

> Our bosses [supervisors] are watching and will be disappointed if we don’t achieve positive results. So I have to uphold the confidence they have in me. Also, the Director’s presence in some of our intervention activities influenced me to work hard so we could achieve our goal.

**Regional supervisors did not perform well**

On the part of the regional supervisors, later events indicate that though they accepted monitoring PSG activities, giving them the responsibility over estimated their commitment to the MSPSP. For example, one regional supervisor participated in only one PSG meeting and two intervention activities during the twenty-month period instead of the quarterly visits required. A PSG facilitator shared his thoughts about regional supervisors’ performance and reasoned they did not perform their role diligently:

> The regional supervisor does not feel personally accountable for the success or failure of the intervention since he does not have to show results. When he came here, he only spoke with Gaby [facilitator and the DHIS manager]. He did not talk to any of us.

I also spoke to one of the regional supervisors to find out why he had not performed his task as expected. He told a research teammate during the course of the intervention that he thought the intervention was over. Though he gave reasons for his inability to visit PSGs, such as not receiving their action plans early enough, I suspect that he did not see himself as personally accountable for the MSPSP’s success or failure.

**Local supervisors performed well**

Local supervisors, on the other hand, showed more commitment and participated in PSG activities regularly. A PSG secretary praised a DHIS manager as follows:

> The DHIS manager [local supervisor], compared to the regional supervisor, performed his role better. Unlike the regional supervisor, who only participated in two intervention activities as against the quarterly visits required, he attended meetings and our activities regularly and asked what we are doing. This made us remain committed to achieving our objectives.

These comments suggest that PSG facilitators and members, knowing their supervisors were closely observing them, made a conscious effort to achieve the goals of the MSPSP. However, since enrolment also increased in communities where regional supervisors did not visit, the impression among PSG members was that the regional supervisors did not contribute much to their success. This indicates that more attention should be given to district-level supervision. It is better to engage supervisory authorities closer to the implementation site, in this case the DHIS
Managers, rather than those further away to oversee intervention groups. This also gives credence to a bottom-up approach as a major strategy to achieve intervention goals.

**Motivation of PSG members**

Personal commitment to promote the wellbeing of others was a key motivational factor for the PSGs’ success, but monetary incentives were also important. PSG members received a small allowance of GH¢ 8.00 [about US$5.00] for transport and lunch to encourage them to attend meetings. Nothing was given for participating in intervention activities. I observed that while many PSG members attended meetings regularly and participated in intervention activities, some did not. This raises the question of what actually motivated some to be committed to the MSPSP, while others were not bothered. The following excerpt from a FGD with PSG members reveals what inspired them to participate in the MSPSP and remain committed.

*Agnes:* Why did you actively participate in PSG activities?

*Community representative:* Though the allowance of GH¢ 8.00 for attending meetings was important, it was too small to be the main motivator. Nothing was given for planning and carrying out intervention activities. We remained committed because we were seen as capable of ensuring that the intervention succeeds. Also, the marked ‘T-shirts’ by which we were identified sustained our commitment to achieving positive results.

*Health providers’ representative:* We were not given any money for implementing intervention activities, which took many hours. So money was not the main motivator, but recognition of our potential to achieve results. Those who were not active often complained the allowance was too small; they were not bothered whether the intervention succeeded or not.

*DHIS facilitator:* The fuel I usually buy to come here is more than what I get for attending meetings. But I feel I have to get people enrolled and ensure they receive quality healthcare.

*Agnes:* What about those who were not regular at meetings and intervention activities?

*Community representatives:* It is because they were not concerned about the wellbeing of others. In this community, it is common to find individuals organising activities that promote the welfare of others. For example, Baaba [pointing to the volunteer] is not really paid for carrying out activities that promote the health of community members.

*Agnes:* Auntie Baaba why were you committed to the intervention?

*Baaba:* Though I’m not paid and only given ‘small’ money, just like what I do for the hospital, I’m happy to contribute to the community’s wellbeing and also happy that the community and health facility recognise my effort as helping improve people’s health.

**PSG members’ levels of participation**

I noticed during the course of the intervention that the PSGs devised various ways of making members feel more connected to the group and participate in its activities; unfortunately, insufficient monetary rewards resulted in apathy among some members. Though participation in group activities is often perceived as based on
self-interest (Olson 1965, Ostrom 1990), the findings here suggest that in the PSGs, it goes beyond that and is comparable to what Tocqueville (1840) describes as enlightened self-interest. He observed that though self-interest is seen as primary in people’s lives, they commit themselves to social institutions that transcend their private worlds. Tocqueville concluded that both self and social interests are necessary to prevent the pursuit of only private interests to ensure that the weak are not left behind. Thus, the behaviour of non-active PSG members could be described as lack of social interest. They were not ready to sacrifice their time to attend meetings or participate in intervention activities.

Conclusion

Olson (1965) in his analysis of group behaviour observed that most people value social status, personal prestige and self-esteem, which he termed social incentives to group-oriented action that makes the individual contribute towards the achievement of collective goals. In a way, the PSG members’ commitment to ensure that everyone enrolled in the NHIS and had access to healthcare was based on social incentives. As PSG members’ pointed out, their commitment to the MSPSP was not so much the money they got for attending meetings, but rather the desire of ensuring that almost every community member was enrolled, provided with quality healthcare and not cheated. But underlying this was the value of being recognised among peers and the ability to contribute to the welfare of community members. This notwithstanding, the allowance also contributed to sustaining PSG members’ commitment to the intervention. To some, it solved the problem of money for transport to attend meetings. Thus both self-interest and societal interest were necessary to sustain the voluntary spirit and keep people committed to intervention programmes to ensure that the vulnerable in society also have access to collective goods (in this case, healthcare through the NHIS). However, there were others who seemed to see money as their main motivation; hence they were not motivated by the token incentives given to PSG members.