Improving health insurance coverage in Ghana: A case study

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Factors that limited problem-solving groups’ achievements

Introduction
The problem-solving group (PSGs) increased overall enrolment in the NHIS. However, disaggregation of the data by community showed that enrolment increased in 11 communities, declined in 2 communities and did not change in 2 communities (see Table A.9, Appendix 2). Thus the intervention failed to achieve positive results in four communities. This chapter examines first which factors might have impeded the functioning of the PSGs leading to some of these disappointing results. In the second half of the chapter, I will reflect on six challenges to health insurance enrolment, which the PSGs failed to improve appreciably.

Factors that impeded the PSGs’ functioning
The PSG members attributed their failure to the facilitators’ non-adherence to the multi-stakeholder problem-solving programme’s (MSPSP) implementation guidelines. Qualitative information revealed four PSG-specific issues that contributed to this failure: (1) facilitator domination of PSGs and lack of trust, (2) stakeholders in leadership and professional roles were not included in activities, (3) no local collectors, and (4) a lack of supervision.

Facilitator domination and lack of trust
Some facilitators down played the importance of making PSG members the designers of the intervention and adopting inclusive decision-making and interdependency approaches in facilitating activities. These facilitators dominated group activities, made decisions without members’ consent and did not allow members to play...
leading roles. This situation was revealed during my visits to the PSGs where members in a conversation complained about the facilitators’ behaviour. A PSG secretary explained the situation in the group as follows:

We lost interest in the intervention because of Gaby’s [facilitator, DHIS staff] domineering behaviour. He has turned the intervention into a one-man show. He does not call meetings and do things without informing us and rejects action plans we drew in his absence. This eroded the trust we had in him. Now the group just exists in name. No serious activity is going on.

To check what I had been told, I scheduled a meeting with Gaby and travelled on two occasions to discuss the allegations against him, but he gave excuses so we could not meet. I also sent Gaby a couple of emails about the accusations, but he did not respond or resume the PSG activities. I reported his behaviour to the regional supervisor. Below is an abridged version of an email communication from the supervisor. I changed the names of the community and persons mentioned in the email to protect their identity. Report on my investigation into PSG activities at Mensakrom (abridged version):

Per your request for further investigation into the activities of the PSG at Mensakrom, I made contacts with a number of PSG members to find out first-hand information on their activities. The key observations were:

- Gaby was solely responsible for the activities of the PSG to the extent that when he was not available, decisions and activities planned cannot be carried out. PSG meetings and intervention activities are postponed anytime he is not available.

- Ato [the community facilitator], who is a signatory to the PSG account disclosed that Gaby has about GH¢ 950.00 of the funds for the intervention with him. Gaby corroborated this revelation and pledged to make the money available for PSG activities.

Key stakeholders excluded from the intervention activities
Stakeholders in leadership and professional roles were not involved in the intervention and no activity was organised at health facilities or DHIS offices. An FGD with PSG members at the end of the intervention also confirmed the above observation. The following is an excerpt of their explanation as to why they could not increase enrolment.

Agnes: How can you explain your inability to improve enrolment and retain members in the NHIS?

Community representative: We [PSG members] were ready to work but for Gaby’s behaviour. He made the intervention his personal property. We went to his office to complain about the group’s inactivity. His behaviour discouraged us so we relaxed. For a long time, no meeting or intervention activity has taken place.

Health provider: We were unable to improve enrolment because we did not follow the intervention guidelines. We did not involve community leaders, health providers and DHIS staff in our activities. Even there is no collector to register those we managed to convince to enrol.
No local collectors
One significant issue was that there were no collectors in two communities out of the seven in the Central Region that registered people who decided to enrol after the intervention activities. Both the health provider above and a PSG community representative in the second group’s FGD (the group whose NHIS memberships had declined) below mentioned this problem.

Lack of supervision
Finally, the facilitators’ local supervisors – a DHIS manager and a DDHSs – were transferred during the course of the intervention and so did not benefit from supervision. Comments from the abovementioned FGD continue here.

**DHIS staff:** Our inability to improve enrolment was due to lack of supervision. The supervisors did not do their work well. This made it possible for Gaby to sideline us and do whatever he wants. It was an over expectation on your part that both the regional supervisor and Gaby would perform their task without your supervision.

Further evidence of these four issues related to problem-solving groups’ failures
To explore further why the two PSGs out of the seven in the Central Region could not increase enrolment, I engaged members of the second group in an FGD. They also mentioned the four obstacles above as causing their PSGs’ abysmal performance. They explained that these problems made people lose interest in the intervention. A PSG community representative explained why they could not improve enrolment as follows:

Our failure was obvious. No regular meetings and intervention activity has taken place for months. Even the few we carried out, health providers and DHIS staff were not involved. No activity was carried out at health facilities and DHIS offices as required. No collector here to register those who we convinced to enrol. The facilitator’s domineering behaviour made us lose interest in the intervention.

In summary, events in these two communities that did not improve enrolment and the comments illustrate the central role facilitators’ played in the intervention. The evidence indicates that the facilitators’ dominating behaviour failed to create the trust needed to sustain PSG members’ interest in the intervention and eventually stalled PSG activities. Previous findings in similar research have documented that trust is indispensable in collaborative relationships (Gambetta 2000, Currall & Inkpen 2006). Second, the two facilitators’ non-compliance with the intervention implementation guidelines largely accounted for the lack of intervention impact. This indicates that supervision was critical to the PSGs’ success, since some facilitators are not likely to do the right thing if left alone. As Durlak & DuPre (2008) premise that effective programme implementation is associated with better outcomes. Third, the facilitators failed because they did not follow implementation procedures, engage all stakeholders or make sure that collectors were available.
Finally, they did not promptly address challenges the PSGs faced or motivate them to resume their activities. All of the above mentioned issues could have been managed if the two facilitators had had appropriate supervision. Thus, supervision of facilitators’ programme implementation is as critical as the programme’s formulation and so must be given equal attention.

Why problem-solving groups failed to achieve maximum impact
This section examines some areas where the PSGs were less successful. The four factors that undermined the PSGs’ efforts to encourage significantly more people to enrol and regularly renew their memberships are presented in Figure 8.1. These were poverty and inadequate exemption for the core poor, community members’ negative attitudes towards health insurance, the shortage of drugs in health facilities and the requests for unauthorised fees at health facilities.

Figure 8.1 Factors that limited the problem-solving group’s achievements

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| Outcome | |
|---------| |
| Low NHIS enrolment | |
| High non-renewal rate | |

Poverty and inadequate exemptions for the core poor
The NHIS was introduced to ensure equitable access to healthcare particularly for the poor. The law stipulated premium exemptions for the core poor notably identified as indigents. However, literature on NHIS indicates that enrolment among the poor is low (Witter & Garshong 2009, Asante & Aikins 2008, Sarpong et al. 2010). Asante and Aikins (2008) in their study in Eastern and Brong Ahafo Region observed that the poor are not enrolling because the premium was expensive. In this
study, however, the poor indicated that the cost of premium was reasonable and
health insurance was better than on-the-spot-payments. So why is enrolment among
the poor and the poorest quintile so low? Based on the qualitative information
gathered during and after the intervention, two reasons were revealed: people had no
or inadequate income to enrol all household members and exemptions were not
being granted to the core poor.

The cumulative money required to enrol an entire household was too high for the
poor since they have many dependents. One woman explained: “I know insurance is
good and the premium is reasonable, but look at me, I don’t get much money from
the fish I sell and nobody helps me. How can I insure myself and my five children? I
wanted to pay for only the children, but the collector refused.” A boat owner, and
community PSG representative, also explained why few poor enrol in the following
statement in an FGD.

Many people could not enrol and renew their card because of poverty. These days we go to sea
and come back with almost nothing so the small income they get cannot be used to pay for
insurance. For the core poor, even money to buy food is a problem. So there are some people
who have to be exempted. Look at those people we [PSG members] recommended; only one
was exempted. Even that you have to persuade them [the collector and DHIS staff] before they
gave it to her.

These comments indicate that the poor’s inability to pay premium is a result of
low or no income. For example, the core poor are described as persons afflicted by
‘ohia buburoo’ (severe poverty). They did not have regular source of livelihood and
engaged in menial jobs that provided an income they could barely live on; therefore,
the health insurance premium was beyond their means. There were a few people
who wanted to enrol only their children because they felt their children needed to be
insured. Some of them came to me asking for help to pay the premium or get an
exemption. Others were introduced to me by community leaders for support.

The poverty literature suggests that the poor remain uninsured because of liquidity
and other behavioural constraints, even when they might be better off with
insurance. Schneider (2004) in his explanation of low enrolment among the poor in
low- and middle-income countries observes that they rely on solidarity from family
and friends to smooth out financial shocks related to ill health. However, community
support for the core poor in this study during ill health was virtually absent. The
reality was often described as follows: “Abusua da funu sen yarefo” (The extended
family loves a corpse than a sick person). This implies that support is more likely to
be provided to extended family members after death for a funeral than during ill
health. Thus, the absence of family support and no or little income to pay insurance premiums make it imperative to grant the poor an exemption to ensure their inclusion in the NHIS. However, like earlier studies, the majority of the core poor in this study did not benefit from exemptions. Witter & Garshong (2009), in their assessment of the NHIS coverage found that exemptions granted to indigents in 2008 formed only one per cent of Ghana’s population. Thus, the comments above (combined with our survey results show that 17.6 per cent of the core poor were insured) when compared with the 28.5 per cent of Ghanaians living below the poverty line (GLSS V) indicate that the poor are not benefiting from exemptions.

DHIS representatives often provide explanations as to why they did not grant exemptions to the core poor. They said that the law defines the poor as homeless. PSG members usually rejected this definition. They argued that the criterion was not reasonable, since no one is homeless in their communities, but people were very poor and could not pay the premiums, so they needed to be exempted. Further discussions with DHIS staff and collectors indicated that they were not enthusiastic about identifying indigents for exemptions, but were more interested in revenue generation. DHIS staff’s comments and countenance when discussing the issue revealed their unwillingness to undertake activities to identify the core poor who were referred to as indigents in the policy for exemptions. The criteria for identifying the core poor are stipulated in the National Health Insurance Regulations (NHIRs) 2004, LI 1809: 58 as follows:

1. A person shall not be classified as an indigent under a district scheme unless that person
   a. is unemployed and has no visible source of income.
   b. does not have a fixed place of residence according to standards determined by the DHIS.
   c. does not live with a person who is employed and who has a fixed place of residence
   d. does not have any identifiable consistent support from another person.

2. The conditions under sub-regulation (1) for ascertaining who is an indigent shall be incorpo-
   rated in the registration form of a district scheme.

3. A person assigned the duty by a district scheme of registering persons for the scheme, shall
   elicit the information required under the sub regulation (1) for the classification of indigents as
   part of the registration process.

4. Every district scheme shall keep and publish a list of indigents in its area of operation and
   submit the list to the NHIA for validation.

Though these criteria are restrictive, the DHIISs seemed uncommitted to undertake any activity to identify the poor. Their decision was often based on the financial implications for their offices and not the fact that the core poor could not be identified. As stated in 1b above, the DHIISs have the mandate to determine what applies in their district regarding the homelessness criterion. However, they used this criterion as an excuse for not exempting the core poor. The following comment by a DHIS staff illustrates their attitude towards granting exemptions to the core poor.
We use the homelessness criterion, which disqualifies almost everybody, but go to the aid of those who cannot pay their hospital bill when referred to us mostly by the facility authorities. We need money so if we go to communities and tell them about exemption for the core poor, how do we get revenue?

This comment indicates that although identification difficulties exist, the lack of commitment to ensure the core poor’s inclusion in the NHIS contributes to their low enrolment. This finding supports earlier work that exemptions in Ghana have not achieved their goal (Nyonator & Kutzin 1999, Garshong et al. 2001, Badasu 2004). In her review of exemptions under the user-fee regimes, Badasu (2004) cited a lack of specificity of identification criteria and financial reimbursement as the main causes of their failure. This study found that the problem is wider. The main problem was DHISs’ lack of interest in implementing the policy. They pursue activities to enrol premium-paying members and virtually do nothing to identify indigents thus causing their exclusion from the NHIS. Their emphasis on the homelessness criterion, a situation that does not exist in their districts, and disregard of the local conditions stated in the policy such as unemployment and no visible source of income that could be used to identify indigents, illustrate the DHISs’ staff and collectors in attention to the exemption policy. As the manager indicated, they waited until people cannot pay their hospital bill before going to their rescue and granting them an exemption. Throughout my fieldwork, I did not see DHISs’ staff or collectors make a conscious effort to ensure that the core poor were identified and enrolled.

To conclude, the condition of the core poor makes it imperative to grant them exemptions to ensure their inclusion in the NHIS. However, it appears that the DHISs focus more on their revenue-generating function to the exclusion of exempting the core poor from premium payments, thereby denying them access to healthcare. The revelation that the NHIS is not reaching the poor, as expected, calls for a rethinking of the exemption policy. Monitoring the implementation process and devising more effective strategies to ensure that the NHIS’ goal of removing financial barriers to access to healthcare services, are needed.

*Negative attitude towards health insurance*

By the end of the intervention, community members generally acknowledged that health insurance protects the insured against catastrophic healthcare expenditures and so perceived the NHIS as better than cash payment at health facilities. There was also the view that they had a better appreciation of the health providers’ heavy workloads and that discrimination against insured patients has reduced. As a result of these positive observations, all those who participated in the intervention expressed disappointment about the generally low levels of enrolment and high non-renewal rates. More surprising was the less than 50 per cent enrolment among the rich (46%) and richest (44%) quintiles and high non-renewal rates of 24 per cent.
This indicates that the general low enrolment and retention rates were not because of poverty. Collectors said they were not too surprised and maintained that only a few people renewed their cards promptly; others waited until they needed healthcare. The following excerpt from a FGD with PSG members provides some of the reasons that account for low enrolment despite the PSGs efforts to improve enrolment and renewal rates.

Agnes: Why have some people never enrolled in the NHIS?

NHIS collector: Despite the education about health insurance, many people still say I’m not often sick. As we have been discussing their participation in traditional mutual support groups influence their behaviour. People join only when they are sure of benefiting. We describe it as: ‘You reap as you sow’. Men in particular say health insurance is for children and women who often go to hospital.

PSG secretary [health provider]: The low interest in health insurance, though improved, has not changed much. They know health insurance is important, but will not enrol until they have a serious sickness. Many delay and come to the hospital with complications to disturb us.

Agnes: What about those who do not renew their membership?

Community PSG facilitator: Insuring against ill health, we all know, is not part of our culture. What we know is to regularly pay funeral dues because we know we will benefit. This explains why people are reluctant to renew their NHIS card every year, especially if they have not gone to the hospital. When you ask them they say meretwen kakra (I’m waiting for a little while). But they will rush to renew when they are sick. Some renew only after they have been admitted to the hospital.

Community representative [GPRTU1 chairman]: If health insurance was treated like motor insurance all drivers would have been insured. People don’t care because nobody is punished for not enrolling or having a valid health insurance card. We would have consistently renewed our cards if we were punished as it is done in the case of motor insurance.

Influence of mutual support practices

I also met a few people at DHIS offices who were renewing their NHIS cards because they were sick and others who came to enrol because they needed healthcare. For example, during one of my routine observational visits to a DHIS office, I met Joe who looked desperate and asked him what was wrong. He responded angrily: “Madam I thought I didn’t need health insurance but for this sickness. Now I’ve registered and my card is delaying.” When I queried him further, he said: “I need the card to go to hospital for hernia surgery.”

Joe’s comment and PSG members’ views expressed above reveal that the community members’ conceptualisation of the NHIS is still influenced by the traditional mutual support group they participate in. The comments also indicate that although many people accepted the NHIS as better than on-the-spot payment and recognised the need to enrol and renew their membership; this did not translate into action.

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1 Ghana Private Road Transport Union
Hence, there was a pervasive risk-averse attitude towards health insurance and adverse selection (enrolling only family members who appear to be at risk) that made it virtually impossible for the PSGs to get more people to enrol and renew their membership regularly. These attitudes are extensively reported in the literature on health insurance schemes in Sub-Saharan Africa as undermining their expansion (Arhinful 2003, Criel & Waelkens 2003, Kamuzora & Gilson 2007). In their study of a Community Health Fund (CHF) in Tanzania, Kamuzora & Gilson (2007) observed that non-acceptance of paying before falling sick undermines the expansion of the CHF, but they did not explain the reason behind this attitude.

This study found two main reasons underlying people’s decision to join or not join and remain in the NHIS. First, and ironically, local insurance traditions do not help convince people to join the NHIS, but rather discourage them to do so. Indeed, traditional mutual support practices have negative influence on people’s attitude towards health insurance. Analysis of their operation shows that though they have a health insurance element, their operational guidelines for risk-sharing principles are not the same. In a review of the concepts underlying traditional risk-sharing, Platteau (1997) noted that traditional mutual support schemes are based on balanced or generalised reciprocity, while insurance is based on conditional reciprocity. Under balanced and generalised reciprocity, people receive as much benefit as they contribute. For conditional reciprocity, on the other hand, insured persons receive a return only if they fall sick. The ‘reap as you sow’ principle observed among traditional support groups facilitates cooperation and exchange of services and obligations among members, but they are largely based on balanced reciprocity and the certainty of benefitting. In many of these groups, such as *mnoboa* and savings and loan arrangements used to manage livelihood activities, the benefits are largely proportional to one’s contribution and not need. As already stated, in the case of *mnoboa*, people join only when they need support to sow and harvest crops and weed their farm and pull out from the group until another farming season.

Other groups such as *pataase*, which focus on life events, mainly death, are well patronised because they cover the funeral costs of the members, their spouse, children and parents. So people join and remain committed because they are sure of benefitting. Explanations provided by key informants indicate that they perceive the NHIS’ benefit as limited in scope and only for the individual. For example, death is seen as certain so one has to contribute towards it, hence the preference to pay funeral dues. Sickness, on the other hand, is perceived as a random event, which the healthy believe might not befall them, so they are reluctant to enrol and remain in the NHIS. Thus the logic of not enrolling in the NHIS was that it is a risk-sharing arrangement where their investment may not benefit them. This explains why only household members who are likely to need healthcare are enrolled. This practice is
technically referred to as ‘adverse selection’ and contributed to the low enrolment and renewal rates among the average and rich quintiles.

Many respondents expressed the view that despite complaints of shortage of drugs and payments of unauthorised fees, being insured was still better than cash payment at health facilities. So they rush to register or renew their membership only when they need healthcare. This indicates that they appreciate the benefits of health insurance, but apply the reciprocity principle of traditional support groups. This attitude negates the policy makers’ assumption that because many Ghanaians already participate in traditional mutual support networks they will willingly enrol and remain in the scheme. Rather, the incentive for enrolling and remaining in the NHIS is based on individual gains and largely informed by their health status and not a motive of embarking on a risk-sharing endeavour that requires the commitment of all to succeed.

Unenlightened self-interest

Joe’s case conveys the pervasive nature of community members’ risk-averse attitude towards health insurance. PSG members’ assertions that apart from the core poor and poor people with many dependents, anybody willing to enrol all household members and renew their membership can pay a premium of GH¢ 14 [US$10.00] and registration fee of GH¢ 4.00 [US$2.50] per annum illustrates that the ‘wait and see’ attitude was not due to poverty. Thus the views and observations above show a pervasive negative attitude towards health insurance. This finding is consistent with earlier work on enrolment in SHISs and CBHISs. In his study, Arhinful (2003) explored the reason why people do or do not enrol in health insurance schemes in Ghana and found that the motive of enrolling is a self-interest goal of averting risk. In another study, Criel & Waelkens (2003) made the same observation when they explored reasons for low enrolment in the Maliando Scheme in Guinea Conakry. They found that poverty was not the most outstanding barrier to enrolment, but rather there were other behavioural constraints. In the current study, a careful appraisal of the discussions suggests that apart from the core poor and the poor, the ‘no money to pay’ and ‘I am waiting for a while’ excuses for not enrolling or renewing their membership were socially desirable reasons to cover less worthy motives. The fact that people quickly enrol or renew their memberships when they need healthcare illustrates that though people have accepted that the NHIS is better than on-the-spot payment and appreciate its implementation challenges, they comfortably adopt strategies to derive maximum benefit with minimum financial investment. I call this ‘unenlightened self-interest’ because eventually the situation will turn out to be less advantageous for the people. They will pay more when they have to access healthcare without health insurance since the cost of treating malaria almost equals the cost of premium. Their action is also a threat to sustainability of
the scheme, which requires regular contributions into a common fund so that those
who fall ill will be catered for to ensure individual and societal progress.

Summarising, some people’s reluctance to enrol and renew their membership in
the NHIS is influenced by their knowledge of traditional risk-sharing arrangements.
However, it needs to be pointed out that even in such networks, tendencies for
exploitation exist, but sanctions are used to ensure fulfilment of the agreed arrange-
ment based on trust. Mutually agreed sanctions are effectively applied to prevent
exploitation for individual benefits. Unfortunately, in the case of NHIS, lack of
enforcement of such mechanisms, perpetuates risk aversion and adverse selection
practices where people rush to renew their cards only when they needed healthcare
without paying penalties. As Putnam (1995: 67) points out: “When economic
negotiation is embedded in dense networks ..., incentives for opportunism arise.” It
is to check such opportunistic tendencies that the NHIRs 2004 LI 1809 59(1) needs
to be applied to sanction defaulters. As a GPRTU chairman indicated, many people
did not enrol or renew their membership because there was no sanction to discour-
age them.

Finally, for any intervention aimed at promoting the NHIS to achieve maximum
impact, it is critical to identify issues in the social environment and conditions under
which traditional risk-sharing network operate, educate people about the similarities
and differences, and enforce regulations that prevent exploitation of the scheme.
This suggests that a more practicable way of moving the NHIS towards universal
coverage is needed.

Shortage of drugs in health facilities

The shortage of drugs was a concern for both community members and health
providers. Both saw it as undermining healthcare delivery to insured patients and by
consequence limiting the PSGs’ efforts to improve NHIS enrolment and retention of
members.

In the case of the community members, there was consensus that people enrolled
because of the PSGs’ assurance that they would receive quality service, which to
them included being given drugs at health facilities. So when this expectation was
not met, and the community members were given prescriptions to get drugs else-
where, some decided not to renew their memberships. This situation also discour-
aged people from enrolling. Insured patients were mostly concerned about going

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2 The NHIRs 2004 LI 1809 59(1) states that a member of DHIS who defaults in the payment of contribution
for a period exceeding three months shall be suspended from the scheme and reinstated after paying all the
contributions in arrears, a penalty of 50% of the total contribution that is due. The defaulter is reinstated
but will only enjoy benefits after three months from the date of re-instatement.

3 Shortage of drugs may not always be the right term. The problem can also be the inability to obtain certain
drugs because they are not on the Health Insurance Drug List. The drugs may be available in the facility
but only for those who pay cash.
round looking for accredited pharmacy and chemist shops to fill their prescriptions. I must state that although these shops are supposed to augment the drug supplies at health facilities, they do not exist in all the communities where health centres and hospitals are located. In such cases, patients have to travel to other towns when given prescriptions. In this respect, insured patients blamed health providers and DHIS staff for not doing enough to ease their frustration of looking for drugs outside health facilities. Many of them spoke about how they had to pay for drugs covered by the NHIS in some health facilities and accredited pharmacy shops. One man expressed dissatisfaction about seeking healthcare with the NHIS card and did not renew his card. He explained why he made this decision:

I enrolled because I wanted to live without worrying about how to pay for my healthcare. I expect to get all my drugs at the hospital without payment. I was disappointed when I got a prescription to look for a drug store that serves people with health insurance card. I had to travel to another town. I did so but ended up paying for the drug. That’s why I decided not to renew my card. They should tell us the truth so we know what to expect when we seek healthcare instead of telling us 95% of diseases and drugs are covered; yet we end up paying. What then is the advantage of being insured?

In a FGD, a PSG community representative narrated how he had to pay for drugs at a facility as follow:

Though I protested when I was asked to pay for the drug, I had to give in. They explained they got it from a private person and gave me the option to take a prescription. Because of the trouble of going round to look for accredited shop, I decided to pay.

I also observed insured patients’ dissatisfaction from their facial expressions when they were given prescription to get drugs from outside health facilities. Their disappointment was about how to go round looking for accredited shops and having to pay for the drugs. The complaint about payment for drugs by insured patients was supported by our survey results which show that the majority (64%) of currently insured respondents in intervention communities agreed that: “Even though one is insured you still have to buy drugs” (Table A.11, Appendix 2).

Giving patients prescriptions is not new in Ghana, but insured patients have an extra burden of spending hours locating an accredited pharmacy or chemist shop to obtain the drugs without paying. Their dissatisfaction increases, especially when they had to travel outside the health facility’s location and have to pay. Many key informants argued that the burden of roaming around looking for accredited shops and paying for drugs did not make the economic sense of enrolling in the NHIS and consistently renew their card especially when they did not regularly access healthcare.

In the case of health providers, their concern was that though they strived to improve service delivery, they could not always meet insured patients’ expectation of providing all drugs they need at the facility. They attributed the situation to drug administration and acquisition guidelines under the NHIS regime outlined as
follows. Only drugs included in the Health Insurance Drug List are used to treat insured patients. These drugs are purchased from the Regional Medical Stores (RMS) and can only be bought from private suppliers after obtaining a non-availability certificate. They complained that the bureaucracy involved in obtaining the non-availability certificate negatively affected their stock management. They maintained that this arrangement for purchasing drugs in addition to delays in claim payment made it difficult for them to purchase drugs promptly and in enough quantities to meet patients’ needs. A Medical Assistant described the situation as follows:

We are expected to buy drugs from the Regional Medical Store and can only buy from private suppliers if we get non-availability certificate. Getting the certificate is not a one-day issue Sometimes we go there several times before getting it. So it is not possible to buy such drugs immediately to meet patients’ needs. Also, though claim payment has improved, sometimes only 60%, 70% or 80% is paid. For example, 60% of the April bill was paid in August and the remaining 40% this month [September]. We are yet to be paid the bill submitted for May. All these make it impossible to get drugs to meet patients’ needs and do not help in promoting health insurance.

Our post-intervention survey results confirm the concerns expressed by both insured patients and health providers that shortage of drugs in health facilities leads to dissatisfaction among insured patients. The result shows that an overwhelming majority (83.7%) insured respondents and (90.3%) previously insured respondents indicated that: “Availability of drugs at health facilities should be improved” (Table A.11, Appendix 2). This illustrates the critical role of obtaining drugs at health facilities in determining satisfaction about the quality of service and its contribution to the gap between what insured patients expect and what is actually delivered.

In Ghana, drugs are perceived as a significant component of healthcare delivery. Drugs are symbolic representation of health facilities and their availability creates a positive image of a particular facility and adds value to health provider-patient clinical encounter. As Whyte et al. (2002) point out, drugs are part of everyday life of Ghanaians and important for their survival. They show that drug use is common among Ghanaians and doctors give medicines to satisfy their patients. In another study, Van der Geest et al. (1996) observe that health providers see drugs as indispensable in their encounter with patients while patients also expect to be given drugs to solve their problems. Both studies thus show the significant place that drugs assume in any clinical encounter between patients and health providers in Ghana. Most insured patients in the current study asserted that the essence of enrolling in the NHIS was to seek care at a health facility and obtain drugs for their ailment. Therefore, the absence of drugs reduces the level of satisfaction of the clinical

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4 The non-availability certificate is given by the Regional Medical Stores to enable public health facilities buy drugs they do not have from private suppliers before they can be paid by the NHIA.
encounter. In fact, both insured patients and health providers’ concerns show how absence of drugs undermines quality of service. The finding thus confirms the observation that the shortage of drugs in health facilities eroded the confidence that the PSGs created in the NHIS and undermined their efforts to improve enrolment and retention rates. For many people, enrolling and remaining in the NHIS is determined by whether they were given drugs at health facilities or not. To such people, a single episode of paying for drugs or going round looking for an accredited shop may make them decide not to renew their membership.

*Payment of unauthorised fees at health facilities*

Though the NHIS has no co-payments, there were reports of payment of fees by insured patients at health facilities. This generated the most heated debates as a factor that limited the PSGs’ efforts at improving enrolment and retention rates. According to PSG members, the reason why this practice (though reduced during the intervention) could not be eliminated was because payment of unauthorised fees is a public sector phenomenon and impossible for PSGs to eliminate alone. They asserted that many public sector workers devise ways of collecting such fees for services rendered to clients to earn extra income. They explained the practice helps them ‘make ends meet’, that is, to be able to meet one’s expenditures considering the low salaries. This practice has already been discussed in chapter two and has also been documented by earlier studies (see Agyepong 1999, Armstrong 2006, Gyimah-Boadi 2004, Aryee 2005). Here, I discuss another component of the phenomenon revealed in the course of the intervention and emphasised during FGDs. It was observed that some health providers use the excuse of inadequate resources and delays in claim payment to collect money from insured patients. An insured patient explained the situation follows:

> We all know health providers have been collecting unofficial fees from patients under the user fees but people complain less because we are not sure which of the money we pay is approved fee or not. But now we [insured patients] know we don’t have to pay, so when I had to pay for drugs covered by the NHIS, I argued with them, but had to pay. I saw it as cheating.

Some health providers, reacting to these allegations cited delays in NHIS claim payments and insufficient logistics as reasons for collecting money from insured patients. Others agreed that the practice is bad and tarnishes their image. Community members and DHIS staff in their reaction did not accept the explanation of inadequate resources and accused health providers of exploiting insured patients. A facilitator, DHIS staff, shared the group’s frustration in addressing this allegation as follows:

> We could not eliminate the collection of unauthorised fees because it is an open secret that many of them [health providers] benefit from such fees they called welfare, ward funds, doctors’ fees and others. We do not have any way of checking whether the money is used to purchase essentials for the facility or goes into their pockets. For us, what we know is that when you have for
example, malaria and you go to the hospital; you don’t have to pay anything. So we see it as cheating and this discourages many from enrolling and renewing their card.

Nurse Anas, a PSG member, in her reaction to this allegation, accepted that collection of unauthorised fees is a challenge that could not be resolved by the PSGs alone. She shared her thoughts in the following statement:

We can’t deny that we sometimes collect unauthorised fees. Some of those monies are used to purchase certain things we need in the facility. To eliminate the practice, the authorities must provide adequate funds and the NHIS claims paid promptly. If that doesn’t happen, then those who hide behind that will not stop. We should also understand that it takes time for such changes to happen.

The above comment indicates that the practice has been going on in health facilities, but was not reported by patients because it was not evident which fees were legal. For insured patients, it is obviously illegal when they are asked to pay for services and supplies that they know are covered by the NHIS. The tag of cheating assigned to the practice indicated that insured patients see the fees as preventing them from enjoying the free service they are entitled to having prepaid. Thus, asking them to pay such fees was a disincentive to register all members of their household, especially those who did not have an immediate need for healthcare. In the case of the poor, such payments discouraged them from spending their meagre income to enrol and renew their membership. These findings indicate that while the NHIS is intended to ensure equity in access to healthcare and protect people against catastrophic expenditure, frontline staff expected to facilitate its implementation make it expensive (especially for the poor) to enrol and remain in the scheme.

To some extent, the health providers’ explanations could be a genuine attempt to maintain their stock level while they wait for reimbursement of NHIS claims. But the genuineness of these rationales is a matter of concern and needs to be addressed together with delays in reimbursement to increase confidence in the NHIS and build trust among stakeholders. As Mechanic (1998) observed, patients’ trust in health providers to act in their interest is crucial for health insurance enrolment. Failure to do this will make it virtually impossible to sustain confidence in the NHIS. The consensus among PSG members regarding payment of authorised fees was that no matter the genuineness of the intention, the practice added to the cost of enrolment. Illegal fees discourage people, especially those who do not use services regularly, from enrolling and renewing their membership consistently.

As a concluding remark on the PSGs’ limited achievements involving local level actors, though effective, could not adequately address all the NHIS implementation challenges within the twenty-month intervention period because some were systemic and needed policy level action. Other challenges were attitudinal and therefore difficult to change and required more understanding of the social environment. Extended time is needed to engage community members and their leaders for any meaningful change to take effect.
Conclusion

A multi-level approach was used to assess the impact of a MSPSP programme on enrolment and retention in the NHIS. The results show that the space the PSGs created for interaction among stakeholders led to significant increase in enrolment, but could not improve retention rates. The bottom-up, inclusive decision-making and interdependency approaches that facilitators employed in conducting PSG activities, monetary and non-monetary incentives for members and supervision of the group contributed to MSPSP’s success. These sustained the PSGs’ commitment to the intervention. In addition, effective involvement of community leaders and professional stakeholders in the intervention activities built trust between them and PSG members and nurtured synergy, which facilitators utilised to reach all target populations in the intervention. This finding makes it clear that the DHISs acting alone cannot manage the complex mix of problems and build the trust network required to address the issue of low enrolment in the NHIS.

However, the findings reveal multi-dimensional factors that hindered the PSGs’ efforts at improving enrolment in the NHIS and retaining members and made it virtually impossible to adequately address all the identified NHIS implementation challenges. Thus involving local level actors though effective, did not adequately address all the challenges. Factors that were identified that limited the PSGs’ success included poverty, community members’ negative attitudes towards health insurance, shortages of drugs in health facilities and payment of unauthorised fees. These were found to be systemic and their elimination was not possible within the twenty-month intervention period. There is a need for policy-level action to change some aspects of the NHIS operational guidelines. Other challenges were attitudinal and so they were difficult to change within the intervention period. This change requires more understanding of the social environment to develop appropriate intervention activities. Finally, working on the psyche of all actors involved in implementing the NHIS to make accessing healthcare with NHIS card more attractive needs extended time to engage DHIS staff, health providers, residents and their leaders for meaningful change to take effect.

The next chapter is the synthesis of the key findings of the study. I present an appraisal of the MSPSP and discuss why people enrolled or did not enrol in the NHIS, and why they renewed or did not renew their membership. I also provide the conclusions of the study, policy recommendations to enhance NHIS implementation and improve uptake and points out areas for further research.