Improving health insurance coverage in Ghana: A case study

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Discussion and conclusions

Introduction

With a shift in health financing policies from fee-free to cost sharing, many countries in Africa are setting up health insurance schemes to reduce inequity in healthcare access. In Ghana, the National Health Insurance Scheme (NHIS) was introduced in 2004 to ensure equity in access to healthcare as the cost of treatment denied many people formal care. However, NHIS’ coverage remains low and the poor, who are the primary target, are less represented. This study developed a multi-stakeholder problem-solving programme (MSPSP) to improve NHIS enrolment and retain members, especially the poor. Figure 9.1 presents the pathways of the MSPSP and outcomes. The programme started with the creation of problem-solving groups (PSGs) which consisted of representatives of community members, health providers and district health insurance schemes’ (DHISs) staff in intervention communities. The figure also shows the barriers identified by the PSGs at the onset of their work and the various activities carried out to address them. The intervention outcome shows that PSG activities led to a significant increase in NHIS enrolment, but could not improve retention rate due to poverty and inadequate premium exemptions, negative attitudes towards health insurance, shortages of drugs at health facilities and collection of unauthorised fees. This indicates that local stakeholder collaboration to address policy implementation barriers, though helpful, is not the panacea to all the challenges.

In this chapter, I synthesise the outcomes of the intervention in six main sections. I start with theoretical reflections taking up the concepts of multi-level perspective, resilience and trust to discuss factors that influenced people to enrol in the NHIS and renew their membership and how the PSGs were able to increase enrolment. Next, I
Figure 9.1  Schematic representation of the MSPSP and the outcomes

### Barriers to NHIS enrolment and retention for community members
- Poverty
- Traditional concepts of risk-sharing
- Poor quality of service
- Healthcare providers’ negative behaviour
- Payment of unauthorised fees and drugs
- Political perception of the NHIS

### Barriers to enrolment and retention for DHIS staff
- Inadequate office space and equipment
- Difficulties processing NHIS forms
- Problems regarding granting core poor exemptions

### Intervention activities at DHIS offices
- Stakeholders’ meetings
- Set registration points in communities and provided cameras for collectors

### Intervention activities at health facilities
- Stakeholders’ meetings
- Documentary films

### Intervention activities in the community
- Community durbars & stakeholders’ meetings
- Education at health facilities schools, P.T.A meetings churches and mosques
- Documentary films, drama

### Steps in the problem-solving process
- Identify and prioritise problems
- Analyse problems
- Develop solutions and implementation strategies
- Draw action plan
- Implement action plan

### Setting up problem-solving groups
- Stakeholders orientation
- Community durbar to select PSG members
- Selection of facilitators
- Training of facilitators

### Factors that hindered NHIS enrolment and renewal of membership
1. Poverty and inadequate exemptions
2. Negative attitudes towards health insurance
3. Shortage of drugs in health facilities
4. Collection of unauthorised fees

### Factors that induced NHIS enrolment and renewal of membership
1. NHIS provides financial protection
2. Reduces complications
3. Prompt delivery of NHIS cards
4. Improved quality of service

### Outcome
1. Low NHIS enrolment
2. High non-renewal rate

### Significant increase in NHIS enrolment
discuss the reasons for persistent low enrolment and high non-renewal rates. Then, I present my conclusions followed by recommendations. I end the chapter with areas for further research.

Understanding the findings

The introduction of the national health insurance scheme (NHIS) in Ghana was part of a social development agenda with the goal of ensuring equity in access to good healthcare. Promotion was based on stimulating solidarity values among community members to inspire them to enrol. In this section, I put the findings into theoretical context using the concepts of multi-level perspective, resilience and trust that were introduced in the first chapter of this book. Each section begins with a brief explanation of the concept and its relevance in understanding enrolment in health insurance and retention of members.

**Multi-level perspective**

The multi-level perspective (MLP) means looking at issues and events associated with a subject of study across different levels and actors to provide a more complete description and credible explanation. The perspective allowed me to conceptualise the NHIS based on the premise that it is an enterprise with various actors situated at different levels of the healthcare delivery system. These actors are stakeholders and include politicians, policy makers, district health insurance scheme (DHIS) staff, health providers and community members who are active agents involved in the NHIS policy making, implementation and uptake. I conceived the NHIS as a multi-level enterprise because enrollees and DHISs’ staff are only linked by premiums and the healthcare providers contracted to provide services for a fee. In this sense, the stakeholders involved in this transaction (the NHIS) strive to maximise their interests thus affecting the success or failure of the enterprise. The MLP helped me to capture stakeholders’ interests, behaviour and practices as well as contextual factors that affect the achievement of the NHIS’ policy goals. Critical analysis of the NHIS indicated that the interests of various stakeholders interacted to affect enrolment and retention rates. For example, although stakeholders generally accepted the NHIS as better than on-the-spot payment to ensure equity in access to healthcare, the pursuit of their own interests undermined the attainment of policy goals. For instance, politicians, in their desire to win power, rushed to introduce the policy without adequate public sensitisation and education about the scheme’s underlying principles. There was little opportunity to build consensus among other stakeholders or to scale up the capacity of health facilities to handle the expected increase in utilisation of healthcare services. These two issues created resentment among some community members and health providers who associated the NHIS with party politics and this undermined enrolment.
The MLP also revealed that a new policy can be introduced by a government to improve the wellbeing of the citizens, but the expected change(s) are affected by several factors from various angles that interact to either hinder or enhance its uptake. Long (2001), in his analysis of development policy, argues that discourses are introduced by an institution, such as the state, but it is the actors (individuals or institutional representatives) who use, manipulate and transform them. In the case of the NHIS policy, as a new healthcare payment mechanism to improve access to healthcare, the decision to enrol or not to enrol depended on community members’ ideas about health insurance despite the fact that all stakeholders appreciated the insurance scheme. Community members’ interpretation of the NHIS was often rooted in traditional discourse about risk- and cost-sharing. They applied existing knowledge and held their personal gains above attainment of policy goals. This indicates that targets of public policies are not just objects without agency, but play roles that determine a policy’s success or failure. Arhinful (2003: 150) also noted that enrolling in health insurance schemes is based on self-interest. He wrote:

People’s motive for participating in an insurance scheme in the present social context is therefore based first and foremost on what they believe would best advance their own self-interested goal of averting a risk or securing a gain for themselves.

In the current study, one can argue that since our post-intervention survey results showed that the majority (59.7%) of the general population did not have a valid NHIS card and 37.3 per cent had never enrolled the NHIS’ benefits of ensuring equity in access to healthcare was not appreciated or pursued equally by all stakeholders. As I discuss later in this chapter, the poor – the primary target of the policy – seem not to be the priority of politicians, policy makers, implementers and rich community members. DHISs staff held their institutional interest and personal gains above the attainment of policy goals. They focused on revenue generation at the expense of exempting the core poor. In the case of health providers, while some persuaded people to enrol, others were hostile towards insured patients because of the increased workload that accompanied the NHIS. The rich saw health insurance as a less pressing issue than funeral contributions, so they did not share the NHIS costs by paying premiums according to their incomes. They also did not help poor family members enrol, because it did not bring the same prestige as contributing towards their funerals. All these conflicting interests culminated in low enrolment and retention rates with the poor being the most affected.

A focus on the MLP helped reveal the complexity of health insurance. What seems to be an unambiguous concept to enhance equity in access to healthcare appreciated by all stakeholders can provoke diverse reactions. The MLP helped explain why and how various stakeholders at multiple levels (and sometimes even at the same level), reacted in ways that conflicted with policy goals. Their actions usually benefited the stakeholders themselves and not the objects of the policy goals.
– the poor. The MLP disclosed the pragmatic realities of the NHIS and provided information on the rather egocentric motives that engulfed it. The lack of enthusiasm to genuinely pursue policy goals and address the actual challenges that implementers and targets of the policy face became apparent.

Finally, implied in the MLP is its contribution to policy change. In this sense, stakeholders must participate in the process of bringing about change or accomplish change through advocacy. The MSPSP and the positive result – an increase in enrolment – demonstrate MLP’s relevance in intervention practice especially in anthropological research. In this regard, Scheper-Hughes (1990: 190-196) suggests:

We [critical anthropologists] are to put anthropological knowledge at the service of the power brokers. … Medical anthropology should exist for us as a discipline and as a field of struggle. Our work should be at the margins, questioning premises, and subjecting epistemologies that represent powerful, political interests to oppositional thinking.

Taking such a stance and pursuing this agenda means advocating for the poor and projecting how the interest of politicians, policy makers, service providers and community members undermine the attainment of NHIS’ equity agenda. We must engage these stakeholders to discuss the NHIS implementation challenges that arise and devise activities to improve their behaviour and practices. Such interventions should be multi-level-oriented, involve stakeholders and aim to: (1) develop community-oriented mechanisms to pursue the NHIS’ equity agenda and (2) improve the quality of healthcare service by making health providers and community members’ concerns the basis of reform. The long-term effect will undoubtedly be a reduction in health providers’ workload, improvement in their behaviours and quality of service and an increase in the exemptions granted to the core poor. At the community level, the continuous inclusion of all stakeholders in discussions is likely to result in positive attitudes towards health insurance, a reduction in adverse selection and ultimately move the NHIS toward universal coverage.

In conclusion, the earlier chapters have shown that the MLP provided an in-depth understanding of the factors that influenced enrolment and retention in the NHIS. It revealed the multiple layers of the NHIS and the need to use a critical medical anthropological lens to identify and address the challenges. It proved a useful approach for interpreting the stakeholders’ interests, behaviours and practices and the social context in which the health insurance scheme operates. The MLP thus proved an effective tool for PSGs to address the stakeholders’ conflicting interests and build an equitable health insurance scheme. This knowledge might help develop appropriate intervention activities to improve the implementation and uptake of health insurance in Ghana and other countries.
Resilience

Resilience refers to the ability to maintain normal functioning despite exposure to adversity. Niehof (2008: 217) in her analysis of the concept of resilience describes it as follows:

The concept of resilience overlaps that of vulnerability. The vulnerability context is an important factor in people’s ability to ‘bounce back’ when faced with adversity and it is the context in which entry points for supportive policies and programmes should be identified.

In the context of ill health, resilience refers to people’s strength to reduce their vulnerability to sickness and recover from or live positively with their disease. This strength is conditioned on both personal strength and a supportive environment. These two dimensions of resilience, inner power and external factors, interact to strengthen patients to regain their health or cope with their sickness. Thus people’s purposive action to harness external support is important in the development of resilience. The monetisation of healthcare has made economics a prominent feature for resilience during the therapeutic process especially in patients with chronic diseases. This makes resilience relevant in a health insurance discourse.

In Ghana, the NHIS was introduced to provide a fall-back position for people who were ill. From this perspective, I conceive the NHIS as an important mediating factor in the interface between vulnerability and resilience when someone is sick. Sickness often leads to a depletion of resources and decline in wellbeing; so, external support is needed to strengthen patients’ recovery from or ability to cope with their disease. Given the focus of this study – reaching the poor in the NHIS – the question is whether the NHIS is helping sick people mitigate the adverse effects of ill health? The concept of resilience is thus useful to address the question of whether or not the NHIS strengthens the poor and vulnerable to manage the adversities of ill health and maintain normal functioning. Resilience provides a framework to examine two main issues: why people enrol and remain in the NHIS and what contributes to low enrolment among the poor and core poor.

First, I interpreted the community members’ responses and actions in regard to the NHIS using the concept of resilience. This approach revealed that people enrolled and remained in the NHIS because it helped them address the adversities of ill health. It was apparent that the NHIS provides people who are ill with the security of healthcare and fills the gap of inadequate or no support from extended family members. In the past, seeking healthcare did not involve much money and payment could be in kind. Therefore, it was easier for extended families to arrange treatment for sick members and offer them material and emotional support (see Arhinful 2003). But this support has dwindled and is now virtually absent in Ghana. Kumado & Gockel (2003), in their study of social security in Ghana, also reported a breakdown in traditional social and economic support provided by the extended family for vulnerable members and called for a state-sponsored form of social security.
security. Traditional support that helped build resilience during ill health in the past has lost its value due to the monetisation of healthcare. As the cost of healthcare increases, more financial resources are needed to support sick family members. Nuclear family members, who now bear the burden of caring for sick members, might be in a precarious economic situation and unable to provide the needed financial support to enable sick people to seek healthcare and enhance their resilience during ill health. Health insurance is expected to replace the traditional family as a source of economic resilience in times of illness. As Arhinful’s (2003: 120) study in Ghana indicates, people had a favourable perception of health insurance: “Community people conceptualise the value of health insurance in terms of its economic, psychological and social support attributes.” Key informants mentioned similar attributes of the NHIS in the current study. People enrolled and remained in the NHIS because it guaranteed them access to treatment without catastrophic healthcare payments and helped them mitigate the worst effects of sickness. Health providers also mentioned that insured patients had fewer complications than the uninsured; thanks to early reporting. Our post-intervention household survey affirmed these observations and showed that the NHIS reduced household out-of-pocket healthcare expenditure by 86 per cent (see Aryeetey 2012). The post-intervention survey also indicated that insured poor suffering from acute illness were 5.5 times more likely to use primary healthcare outpatient department compared to the uninsured poor and 2.7 times at the secondary level (district and regional hospitals) (see Jehu-Appiah 2012). Other studies in Ghana have also reported that health insurance improves access to healthcare and leads to better health outcomes (Mensah et al. 2010, Durairaj et al. 2010, Amporfu 2011). Mensah et al. (2010) observe the dramatic differences in maternal and infant health indicators of insured and uninsured persons due to more preventive check-ups and out-patient attendance and prenatal care. Durairaj et al. (2010) also reported that the NHIS provides social and financial protection to insured patients and contributes to a decline in hospital deaths among the insured due to early treatment. These observations indicate that health insurance provides a safety net for community members and strengthens patients’ resilience to manage the disease.

Key informants suffering from chronic diseases mentioned characteristics of the NHIS that demonstrated its resilience-enhancing role. They reported that the NHIS provides quick and regular access to healthcare thereby strengthening them to manage their condition. In Ghana, like many African countries, local aetiological discourse holds that prolonged sickness is often not a natural episode but linked to some wrongdoing. For example, diseases such as HIV/AIDS, diabetics and hypertension may be socially interpreted and the patient often blamed for his or her predicament. The patient is usually accused of immoral behaviour or committing a crime (see Dapaah 2012) and often isolated by family members while financial
support is withheld. This phenomenon leads to what a key informant described as a feeling of shame (éye animguase). An insured patient describes the NHIS’ resilience-enhancing role as follows:

Health insurance has removed the shame. My husband nearly divorced me because I spent all our money on treatment. With health insurance I no more spend much money on treatment and he has stopped blaming me. So I don’t worry anymore about the diseases and have resumed my trading.

It is clear that people enrolled and renewed their membership because by taking care of the economic burden, the NHIS strengthened them not only to manage the debilitating effects of prolonged illness, but it also provided a safety net to offset the negative impact of accusations from family members and others. The insurance strengthens the sick not to succumb, but to see beyond the disease and live positively with their condition.

In theory, the NHIS is pro-poor, as discussed later in this chapter, but not in practice. From the perspective of health insurance as a resilience-enhancing tool, one would expect that the poor would be the most eager to join. However, the opposite proves to be the case. I do not want to revitalise Lewis’ (1971) much criticised concept of ‘culture of poverty’, but the low rate of poor NHIS members suggests that poverty may have affected people’s inner strength and reduced their ability to plan their life. Poverty not only reduces the external resources of resilience, but also the internal ones; it demoralises the families who cannot afford to pay the premiums for all members of the household. Thus they chose to practice adverse selection or wait until the last minute to buy insurance when they are in dire need of healthcare.

To conclude, this discussion has shown the relevance of resilience in the health insurance discourse. It shed light on the resilience-building attributes of the NHIS as a safety net that gives financial relief to patients and strengthens them not to be overwhelmed by adversity, but to see beyond their disease, reorganise their lives and bounce back to normalcy. Consideration of resilience provides an in-depth understanding about people’s exposure and response to the adversities of ill health. However, enrolment in the NHIS among the poor and core poor remains low. Apparently more is at stake than the mere need for resilience. The next section looks at trust and mistrust as concepts that may shed more light on people’s reaction to health insurance.

Trust
Many developing countries promote social health insurance to improve access to quality healthcare services. However, the low demand for health insurance has been shown to be based on a lack of trust in the promises of health insurance (cf. Criel & Waelkens 2003).

Trust is the expectation of honest behaviour by all agents to promote the interest of those involved in a transaction. In health insurance, trust is the assurance that the
premiums that are paid will guarantee access to decent healthcare. The decision to enrol is based first and foremost on trust (Schneider 2005). The concept of trust thus helped me understand the conditions that stimulate enrolment in the NHIS and retain members and the ones that create distrust and discourage people from enrolling.

I employed the concept of trust based on the premise that people might enrol and remain in the NHIS because they are sure of access to quality healthcare when sick (trust). Conversely, they might not enrol if they have doubts that their NHIS card will be promptly delivered to enable them to benefit from the premiums they pay (mistrust). Mechanic (1998) argues that trust in insurance is multi-dimensional with aspects varying in importance depending on the circumstances: (1) patients’ trust in providers, which is based on their ability to diagnose and treat illness and to act in the patients’ interest; (2) trust in insurers, based on their reputation of improving access to healthcare; and (3) trust generated by regulations and control mechanisms for the legal enforcement of commitments like contracts. As a result, personalised trust develops between insurers, health providers and insured patients and generalised trust between community members and the institutions involved in implementing the NHIS (DHISs and health facilities) and their employees. People may therefore decide to enrol with the expectation that the institutions and their staff will fulfil their promise of providing quality healthcare as stated in the NHIS policy.

In the current study, building trust was both a systemic and behavioural issue. Examining statements of insured patients and those who did not renew their membership, two main trust-building factors at the level of each stakeholder emerged. These were financial protection by the NHIS and good quality healthcare services. Poor quality services created distrust between community members and health providers and undermined confidence in the NHIS. However, creating trust-building conditions was a major challenge for DHISs. Delays in issuing national ID cards after the three-month mandatory waiting period prevented clients from accessing healthcare nationwide. Trust also depended on drug acquisition and administration guidelines, and the National Health Insurance Authority’s (NHIA) ability to promptly pay NHIS claims to enable health facilities to maintain their stock levels. These actions were beyond the health providers and even the health system’s control. Also, health providers’ workload, as a result of increased healthcare utilisation and lengthy completion of NHIS forms, undermined the quality of service and weakened trust in the NHIS.

With the challenges mentioned above, building trust in the NHIS was driven by the PSGs’ recognition of distrust among stakeholders of the NHIS. PSGs believe that trust between NHIS’ stakeholders (community members, health providers and DHIS staff) is fundamental in improving enrolment and retention rates. Therefore, they set out to first and foremost build trust among them to elicit their cooperation and commitment to achieve the intervention goal, As Gilson (2003) observes, trust
facilitates collective action to achieve common goals. The trust concept revealed that participation in collective activities depended on asking group members to lead intervention activities. This elicited cooperation and ensured the PSGs’ effective functioning and the commitment to achieve intervention goals. PSGs then engaged stakeholders to devise approaches to improve trust in the NHIS. The main strategy the PSGs used was to engage health providers, insured community members, opinion leaders and DHIS staff to project NHIS’ benefits, discuss challenges they faced in providing healthcare to insured patients and address their concerns. Insured community members shared their experiences regarding the NHIS’ protection from catastrophic healthcare payments compared to when they were not insured. They showed that NHIS’ benefits far outweighed the inconvenience of delays at health facilities, roaming about looking for prescribed drugs and the possibility of unfriendly interactions during clinical encounters. Health providers also explained the benefits of health insurance and discussed the challenges involved in providing healthcare to insured patients during clinical interactions and other intervention activities.

These friendly interactions did not only make people appreciate the benefits of the NHIS and the challenges involved in providing healthcare to insured patients, but also bridged the power differential gap between health providers and community members. The interactions influenced the former to eschew negative behaviours and practices that led to distrust. Though PSGs improved trust in the NHIS and convinced people to enrol, they could not solve the practical problems that should have retained people and encouraged many more to enrol even if they did not need healthcare. For example, key informants mentioned that the basis of trust in the NHIS was the guarantee of treatment, which reduced their worries about the disease and helped them lead normal lives. However, this trust is lost if their experience does not reinforce it.

Thus, trust helped explain the pre-condition for enrolment in the NHIS and membership renewal. These included: the NHIS’ attributes of financial protection, health providers’ competence in providing treatment and appreciation of health providers’ constraints in providing insured patients treatment (not necessarily the quality of services delivered). However, what constituted trust was fraught with ambiguities and contradictions. There were contradictions in what key informants mentioned as the basis of their trust and what actually influenced them to enrol and renew their membership. Key informants said they did not enrol or renew their membership because of health providers’ disrespect, request for unauthorised fees, and the burden of roaming to get prescribed drugs from accredited private pharmacy and chemist shops, and extra payments for drugs and other supplies.

Insured patients who had pre-paid for their healthcare felt they had greater entitlement to quality service, and drugs were the most important component for them.
Thus, the policy makers’ assumption that private pharmacies and chemist shops would augment drug supplies at health facilities and satisfy insured patients totally missed the point of what would create trust in the NHIS. Instead, this assumption caused discontent about clinical encounters. So, although PSG activities improved trust in the NHIS, their inability to resolve the practical problem of ensuring that all benefits stated in the NHIS policy were delivered reduced the level of trust. This contributed to the limited increase in enrolment and no improvement in retention rates. As Gambetta (2000) suggests, we can limit the extent to which we need to trust agents in cases of distrust. This implies that even when there is distrust, some level of trust still persists to keep agents in the transaction. In this study, though there was distrust, some insured members remained in the scheme because it served their interests; the NHIS gave them access to cheaper healthcare. An example is as follows. Some insured patients paid for drugs covered by the NHIS at health facilities. Although this created some distrust, they still had faith in the NHIS and perceived the payment as a problem that health facilities could not resolve. They preferred to pay instead of receiving a prescription since they could avoid the burden of roaming to obtain the drugs in accredited shops. They rushed to enrol or renew their membership only when they needed to go to the hospital. Thus, the benefits of the NHIS are still attractive to those who need healthcare.

In conclusion, the concept of trust helped to understand and explain barriers to enrolment and retention in the NHIS. It also revealed that the pre-conditions of trust depended on the social context in which the scheme operates. Though I have emphasised that health providers’ expertise in providing regular access to healthcare and the financial protection of the NHIS as the basis of community members’ trust, in resource-poor countries where providing quality services is a herculean task, trust can be improved and distrust reduced if structures are put in place for regular interaction between stakeholders of the scheme. However, if services promised in the policy are not delivered, it becomes difficult to attract many more people to enrol and to retain them. In the next section, I will focus on the four main obstacles to expanding NHIS’ coverage. I shall illustrate these with the concepts I just discussed – multi-level perspective, resilience and trust as well as mistrust on the enrolment and retention of members.

Re-examining low enrolment and retention

Community members generally acknowledged that the NHIS was better than on-the-spot payment at health facilities and the premium was affordable, but this did not naturally translate into the decision to enrol and remain in the scheme. Our post-intervention household survey results showed a less than 50 per cent enrolment among the general population (41%), the rich (46%), and richest (44%) quintiles and high non-renewal rates (22.4%). More worrying was the less than 30 per cent
enrolment (between 15.3% and 25.1%) in five of the 13 communities that had improved enrolment. These results are striking against the backdrop that the premium is heavily subsidised from value added tax. The cost of premium is GH¢ 14.00-GH¢ 48.00 (US$10.00-US$35.00) per annum and GH¢ 4.00 [US$2.50] as a registration fee to join the NHIS per person and GH¢ 1.00 administrative fee to renew membership. Exemption is provided for vulnerable groups: children below 18 years, SSNIT pensioners, older people above 70, pregnant women and the core poor. With the exception of pregnant women, people in all exempt categories pay the registration fee. In fact, all those who participated in the intervention were disappointed about the outcome. The reasons for their limited achievement were attributed to ‘missing links’ and contradictory expectations of various stakeholders. The missing links are differences in the stakeholders’ interests in the NHIS policy and expectations regarding what would stimulate enrolment and retain members and thus move the NHIS towards universal coverage.

For this concluding chapter, I have selected four important factors that discourage people from enrolling or remaining in the NHIS for further discussion because they deserve special attention if the NHIS is to move towards universal coverage. These are healthcare service delivery challenges, the politicisation of the NHIS, a lack of commitment to reach the core poor with the NHIS and adverse selection. Each of these challenges, which reduced the ability to achieve policy goals, will be addressed below.

Challenges to healthcare delivery

Policy makers often consider the NHIS as a panacea to the existing inequity in access to quality healthcare. The assumption is that the NHIS will provide adequate funds for health facilities to improve the quality of their services. However, a vital but often underestimated constraint is the limited capacity of health facilities to implement the policy. So the expectation that the NHIS will provide adequate funds promptly to enhance quality of healthcare was not evident. A key finding of this study was that policy makers did not sufficiently consider the details of what was necessary to enhance service delivery, build trust in the NHIS, stimulate enrolment and retain members to achieve universal coverage within five years as stated in the National Health Insurance Policy Framework (see chapter one). In this section, I discuss two main factors that I describe as missing links that undermine the quality of service and achievement of NHIS policy goals. These include health providers’ increased workload as a result of the introduction of the NHIS and the shortage of drugs on the National Health Insurance Drug List at health facilities.
Increased workload

This study found that the NHIS was implemented within a health system already overburdened with patient numbers without providing the adequate resources to cope with the increase in the utilisation of services. As critical medical anthropologists observe, new health policy initiatives introduce problems into healthcare delivery systems. For example, Pfeiffer & Nichter (2008), in their critique of global health initiatives, noted that the introduction of narrow interventions usually undermines the expected benefits when inadequate effort is put into institutional building. NHIS policy makers focused on stimulating enrolment and not much was done to increase the health facilities’ capacities to handle the growing number of patients. As expected, many people, who hitherto had not had access to formal healthcare or cut treatment short because they could not pay under the user fee regime (Asenso-Okyere et al. 1998, Nyanator & Kutzin 1999, Osei-Akoto 2003), do have access now. Though the increase is desirable, indicating that the NHIS is achieving its goal of improving access to healthcare, the result has been a heavy workload and long working hours that has undermined health providers’ ability to provide quality service. Consequently, insured patients experience delays and hostile treatment. Boakye (2008) made a similar observation in his evaluation of the Nzema-East District Mutual Health Insurance Scheme in Ghana. He found that increased workload affected the quality of service and patients waited for long hours before being attended to.

Following the increase in utilisation of services, health providers exercised substantial discretion and devised strategies to implement new policies while adopting ways to manage the burden. They categorised patients into insured and uninsured to address the increase in patient numbers and completion of the NHIS forms. Generally, clinicians are used to hurriedly writing only a few words or phrases and not spending time filling out long and complicated forms. The additional task of completing the NHIS forms for the many insured patients they attend to psychologically drew a negative reaction to these patients. In this respect, two types of health providers were identified during the intervention based on how they treated insured patients. One group of health providers explained the benefits of the NHIS and persuaded patients to enrol. Others were hostile, used defamatory language when interacting with insured patients, demanded cash payments from them and gave preference to uninsured patients. Insured patients described these practices as cheating, which created distrust between healthcare professionals and community members since the idea of enrolling in the NHIS was not to pay money at a health facility. The negative practices eroded confidence in the NHIS. Health providers are not a homogenous category in the way they treat insured patients and some of their actions conflict with the NHIS policy goal of providing access to quality healthcare and free treatment. Thus the NHIS does not automatically lead to better services.
This finding supports Ekman’s (2004) findings. In his review of the literature on non-profit making community-based health insurance schemes (CBHIs) in low-income countries, he observed that these schemes have weak or no effect on quality of service. His findings and my observation further strengthen the argument that both CBHISs and SHISs do not necessarily lead to quality service.

**Shortage of drugs**

Another missing link and contradictory expectation relates to insured patients’ conceptions about quality service. I observed that the quality healthcare service needed to build trust in the NHIS did not depend on health providers alone; it also depended on national level actors. In this respect, there was a misunderstanding about what insured patients expect, what will enable health providers meet their needs and what policy makers’ thought would satisfy the patients. Insured patients expected to receive all their prescribed drugs from the health facilities. Health providers anticipated prompt payment of NHIS claims to maintain their stock levels and meet insured patients’ drugs requirements. Policy makers on the other hand, felt that accredited pharmacies and chemist shops could augment drug shortages at health facilities and satisfy insured patients’ needs. Clearly, this illustrates a significant misunderstanding about what insured patients considered crucial to quality services and what policy makers considered reasonable. Community perceptions are often quite different from what policy makers have in mind.

Anthropologists have extensively studied the meaning of medicines and shown that providing drugs is a major issue in the appreciation of a clinical encounter (e.g. Whyte & Van der Geest 1994, Van der Geest et al. 1996, Senah 2002). A doctor or nurse without medicines is a contradiction in terms, like “a bar without beer” (Van der Geest, personal communication). In this study, the unavailability of drugs at health facilities led to patient dissatisfaction about the clinical encounter and by consequence discouraged people from enrolling and renewing their membership. Van der Geest et al. (1996: 156) writing on the value of drugs in the clinical encounter note: “Medical practitioners see pharmaceuticals as indispensable means in their encounter with sick people who come for help and advice. ... patients and their relatives expect medicines to solve their problems.”

In the current study, both health providers and patients saw medicines as an essential commodity in health facilities and a critical component of quality service. Their availability leads to satisfaction with care among all parties. Their shortage not only frustrated patients, but also health providers. Arhinful (2009) also identified a similar problem in his survey on the general pharmaceutical situation in health facilities in Ghana. He found that only 80 per cent of key drugs were available in public facilities and called for an improvement in the distribution of drugs. This indicates that shortage of drugs is not a problem only for insured patients.
To insured patients, the symbolic role of drugs in their clinical encounters clashes with drug shortages at health facilities. Almost all insured patients mentioned the shortage of drugs as a factor that reduced their confidence in the NHIS. This raises the question whether policy makers’ decision to contract with private shops to augment drug supplies at health facilities was sufficiently deliberated with regard to the expectations of insured patients. The shortage of drugs and risk of additional payments discouraged people from enrolling and renewing their NHIS membership. The burden of roaming and looking for accredited pharmacies and chemist shops to obtain prescribed drugs forced some patients to buy from non-accredited shops. A recent study indicates that households’ ability to access healthcare does not only depend on wealth, but also on perceptions about the quality of healthcare. Information that only poor quality service is available is likely to deter households from seeking healthcare. Conversely, if services are viewed as high quality, significant resources might be spent to access them (Save the Children UK 2008).

In the case of health providers, their concern was that drug shortages undermined their attempt to provide good service. They anticipated prompt reimbursement of fees charged to maintain their stock levels. This would allow them to have control over the treatment episode. Health providers know that the absence of drugs not only affects the quality of services in the eyes of the patient, but it also has a negative impact on treatment since some patients do not buy all prescribed drugs. Thus, health providers’ wish to provide good care during the clinical interaction explains why some facilities buy drugs from private sources without a non-availability certificate to maintain their stock level and sell them to patients.

Our survey results showed that 64 per cent of patients buy drugs despite being insured. For the poor, payments for drugs and other supplies was a burden on their meagre income and so discouraged them from enrolling and renewing their insurance membership. Thus, while the NHIS is intended to ensure equity in access to healthcare and protect the poor against on-the-spot payments, the lack of prudent planning to ensure its effective implementation makes healthcare expensive even for insured patients. This shows how macro-level policies targeted at the poor are bound to fail without adequate measures to achieve their goals.

**Politisation of health insurance**

The popular discourse in Ghana, especially among health experts and national level stakeholders of the NHIS, was that service delivery to insured patients has not improved because the NHIS has been politicised. As discussed earlier, the policy-making process was dominated by the political allies of the then government. Despite the bickering that went on in and outside Parliament in protest against the National Health Insurance Bill, the bill was passed into law under a certificate of urgency. As a result, the NHIS was perceived by many as a tool to build political
capital (see chapter one). This induced resentment towards the scheme instead of creating the perception that the NHIS was a social security scheme that would enhance the health of Ghanaians. As a result, the then opposition (now in government) capitalised on the protests by organised labour groups and discouraged potential members not to join. There were also accounts that some villagers, who were sympathisers of the opposition party chased DHIS staff out of their communities. They accused them of being government supporters. Another political issue raised by key informants was the lack of improvement in DHISs operations and poor quality healthcare services. They believed that this was largely due to a lack of collaboration among the three institutions involved in the NHIS policy formulation and implementation: the National Health Insurance Authority (NHIA), the Ministry of Health (MoH) (the policy-making body) and the Ghana Health Service (GHS) (the implementing body and main healthcare service provider). According to key informants from the MoH and the GHS, the improvements that should occur as the NHIS grows are not happening as expected because the NHIA does not involve the MoH or the GHS in efforts to improve the scheme. They mention that the NHIS is missing some of the critical implementation challenges. They asserted that the NHIS has been politicised and there is no transparency in their activities. One of the key informants described the situation in the following statement.

Very little information on the situation of the DHISs filters into the public domain and that has been the situation since the NHIS was introduced. No joint planning between NHIA and us [MoH and GHS] for monitoring and evaluation of DHISs and health facilities. This doesn’t help build systems that will improve service delivery, hence the numerous complaints. The typical example is piloting of ICT software to authenticate NHIS membership being carried out without involving GHS as the main service provider. The computerisation of health facilities with an internal network to be connected to DHISs’ system is taking much longer time than projected.

Presently, the capitation system of provider payment\(^1\) being piloted in the Ashanti Region is being opposed by some service providers (The Society of Private Medical and Dental Practitioners and the Ghana Registered Midwives Association), interest groups (The Asante Development Union and Asante Students Union) (Domfeh n.d.) and the main opposition party (the New Patriotic Party) (Ennin n.d.) due to a lack of consensus. The coordinator of the Asante Development Union expressed their reservations as follows: “Understanding of the policy is very minimal. … the policy is complex and technical and therefore requires much understanding before starting. … Stakeholders should be brought on board for consensus building and proper

\(^1\) Capitation payment system is a method of payment in which physicians are paid a fixed prearranged amount for each patient for a defined set of services within a specified period regardless of any treatments offered. The advantages are: it is less expensive to administer and cost of treatment per patient is lower. Its disadvantages include: the patient's choice of primary healthcare provider is limited to a particular physician or group of physicians and optimal treatment may not always be delivered since physicians are required to keep costs down to make more profit (Agyepong & Yankah n.d.).
education done.” Thus history seems to be repeating itself. The situation where the NHIS policy-making process was highly centralised and dominated by political associates of the government and the bill was passed in the midst of severe criticism by the opposition and civil society organisations (see Agyepong & Adjei 2008, Rajkotia 2007) to fulfil a campaign promise before the pending election. At the moment, the agenda appears to contain costs with or without stakeholders support. This seems to be based on the need to prove the regime’s legitimacy and the continuity of the NHIS policy that has a significant political ‘aroma’. This supports the key informant’s observation that there is no collaboration between stakeholders. Decisions on the NHIS were primarily based on political expediency. This posture by policy makers does not build confidence in the NHIS as a public good expected to promote the public’s wellbeing. In essence, the NHIS agenda seems not to be driven by concerns about public well-being, but rather by accumulating political capital. Clearly, this does not build trust in the scheme nor improve service delivery that could stimulate enrolment; hence the poor quality service being experienced by insured patients and the challenges health providers face implementing the policy. The excessive documentation, drug administration and acquisition difficulties and delay in claim payment, drug shortages, collection of unauthorised fees and inadequate exemption granted the core poor have been discussed in the public domain since the NHIS was introduced; but, these issues have not been given the attention required by politicians and policy makers.

Not reaching the poor

In Ghana, the NHIS was introduced to address the problem of inequity in access to healthcare that characterised earlier user-fee regimes. The NHIS was linked with the country’s poverty reduction strategy and expected to reach the poor first. This explains why the premium is heavily subsidised by a tax and formal sector workers’ Social Security and National Insurance Trust (SSNIT) contributions and why there is an exemption provided for the core poor. Ironically, this study found that the poor and the core poor were the least enrolled. Our post-intervention household survey results show that only 31 per cent of the poor and 18 per cent of the core poor were enrolled. Witter & Garshong (2009: 5) found that exemption for indigents in Ghana fell from fewer than four per cent of the population in 2005 to one per cent in 2008. This indicates that the inequity in access to healthcare persists and even grows. In fact, throughout my fieldwork I did not see the DHISs organising any activity to identify the core poor for premium exemptions. Why this is so, is examined in this section.

For the poor, the inability to pay the NHIS premium was the most important barrier to enrolment and renewal of membership. According to the respondents, although the premium is reasonable and the benefits far outweigh the costs of
becoming sick without insurance, they did not pay because of poverty. Appraisal of their situation revealed that due to the social responsibility of caring for parents and other close relatives in Ghana, the poor also have a large number of dependents to enrol. The heads of households (usually the men) had to enrol their wives, children, their own relatives and those of their spouses and other dependents. Given their low income, enrolling all these family members was beyond their means. In addition, extra payments for healthcare services and drugs discouraged some insured poor from renewing their membership. This supports the observation by Save the Children UK (2008) that poor families face barriers in accessing basic healthcare. The authors mentioned that compulsory or voluntary informal payment were a barrier to healthcare for poor families. They reported that about 25 per cent of the healthcare users in Ghana made informal payments to public health providers.

The inequality trend in enrolment was worst for the core poor because they were strapped because they have no stable source of income. Their low enrolment indicates that the exemption is fundamental to ensure they are not excluded from the NHIS. In a discussion of community-based health insurance schemes in developing countries, the World Health Organisation (2003) also points out that exemption for the poor are crucial to ensure they are enrolled. However, the exemption provided to prevent their exclusion is not reaching them. This defeats the purpose of the NHIS as a safety net, which is expected to provide the poor with access to healthcare and free them from expensive healthcare costs.

Though the NHIS has performed relatively well in providing protection against expensive healthcare payments among the general population, the mere 18 per cent enrolment amongst the core poor indicates that little attention has been paid to the equity goal. Critical analysis of the implementation gap revealed that it is not simply a problem of identification. The gap has other dimensions already mentioned in previous chapters. Further discussions and observations revealed other dimensions of the problems that will be considered in this discussion, because the situation cries for attention to ensure the NHIS reaches the core poor. I discuss two main dimensions of the implementation gaps: the lack of commitment of DHIS staff and collectors to pursue the equity agenda of the NHIS and government’s lip-service to ensuring that the core poor are exempted.

**Lack of commitment**

The exemption implementation gap can be explained as the DHISs’ inability to balance the two roles of the NHIS: to generate revenue and pursue equity in access to healthcare (McIntyre et al. 2003, Ekman 2004). As McIntyre et al. (2003) point out, there should be trade-offs to achieve both goals. However, in the case of the NHIS, DHISs’ staff and collectors, who are to pursue both policy goals, have gradually drifted their focus in favour of revenue generation. Less attention is paid
to the NHIS’ equity goal. The DHISs’ mandate to vigorously apply the exemption policy as implementers of the pro-poor NHIS has been relegated to the background. Like previous exemption policies under user-fee regimes that could not fulfil their goal (see Nyanator & Kutzin 1999, Badasu 2004, Aikins & Arhinful 2006), the NHIS has also failed to provide the core poor access to healthcare. These studies mentioned problems of identification of the poor and the governments’ delay in reimbursing health providers as the main causes of failure. In this study, the DHISs’ staff thought that the reasons they gave for the poor not being exempted were morally acceptable excuses to cover up for their lack of commitment to ensure that the core poor were not excluded from the scheme. Critical observation of DHIS staff and collectors’ countenance when discussing the issue and the NHIA’s inaction to resolve the identification problems demonstrated the lack of commitment to the policy goals. As Criel (1999) observes, the effectiveness of SHISs is the ability to reduce genuine exclusion. Thus, the NHIS’s inability to reach the core poor questions its viability as a health insurance scheme aimed at protecting the vulnerable. It must be noted that although children are exempted, those above five years are only registered if a parent or guardian is enrolled. This means lack of exemption to the core poor affects their children as well.

The main explanation for the DHISs’ stance is the requirement to generate revenue to meet some of their recurrent expenditures. This has influenced them to make revenue generation a priority. As a result, the DHISs use the most restrictive criterion, homelessness, which does not apply to the core poor in these communities – to disqualify potential beneficiaries. The local condition of unemployment, no visible source of income and inconsistent support from another person stated in the policy, are all criteria that apply to the core poor and yet are ignored (see National Health Insurance Regulations 2004, 58: 1-3). A key informant explained: “If we tell them [community members] about the other criteria and they come demanding exemption, how do we get revenue?” As stated in chapter three, apart from mad people everybody including those identified as core poor, lived in family houses, dilapidated structures or with friends. I did not find a single normal homeless person in the ten intervention communities (seven in Central Region and three in the Eastern Region) I visited during my fieldwork. In farming communities, the poor generally had no stable source of income. Some did menial jobs for friends and neighbours, some were farmers, but did not have a regular income. In fishing communities, some were engaged by boat owners as labourers only during the bumper harvest while others were totally unemployed and usually lived on the occasional kindness of family members or neighbours while struggling to survive. Thus, apart from homelessness, other community indicators share commonalities with what is stated in the policy, but are rarely considered by the DHISs.
At this point, it is necessary to mention that the study communities, just like many rural and urban communities in Ghana, are closely knit with many households living in one structure. In this living arrangement, the core poor are not difficult to find. They are not ashamed to seek help. Their neighbours, the community and opinion leaders often look for assistance so they can afford formal care. But, unfortunately, requests for exemptions during the intervention were often not granted on the basis of the homelessness criterion. In some cases, I had to intervene to get a poor person enrolled to prevent a fatality since they were seriously sick and needed to go to the hospital. The irony was that collectors and DHISs’ staff who were supposed to facilitate the exemption process were PSG members, but often reluctant to follow through. This showed their lack of commitment. The question then becomes, whose interest is the NHIS policy supposed to serve, the poor or the rich? If the former, then why use a criterion that excludes them? As social scientists posit, poverty is a social construct whose understanding requires a contextual approach (Hulme et al. 2001, Aryeetey et al. 2010, Aryeetey 2012). In their study of community concepts of poverty in the Central Region of Ghana, Aryeetey (2012) also observed that the national level indicators of poverty are inappropriate from the community perspective. They suggest that in developing such a policy, it is necessary to engage communities to ensure that there is an understanding of their situation and perspectives to inform the process.

The lack of interest from the collectors, who were expected to recommend the core poor to the DHISs to be certified as qualified for exemption, may have been to do with the fact that they were not paid for registering the exempt group. So, they usually do not disseminate information about exemptions. If they did give exemption information, then it was normally about homelessness. Thus, unlike other exemption categories with indisputable criteria such as age and pregnancy, the core poor’s exemption depended on the discretion of collectors to recommend them and ultimately the DHISs’ approval. Clearly, this stance by DHISs’ staff and collectors demonstrates a lack of commitment to prevent the exclusion of the core poor from the NHIS.

The findings of this study show how policies that target the poor are experienced and how the intended impact is not often achieved due to implementers’ attitude. In an analysis of the behaviour of frontline public service workers in the United States of America, Lipsky (1980:13) refers to street level bureaucrats and observes that they generally exhibit a high margin of discretion in resource allocation decisions especially in resource-constrained systems. He observes that the actions of the frontline workers then “effectively become public policy rather than the objectives of the documents and statements developed at the policy level.” Although Lipsky’s study was in another social context, the nature of public service in essence seems to be the same in most countries. The DHISs and collectors can be described as street
level bureaucrats who use their discretion regarding which aspects of the NHIS policy need to be emphasised and pursued: revenue generation or exemption. They found the latter less appealing, which made the policy largely pro-rich. These bottlenecks attest to the evidence in the literature that many healthcare interventions targeted at the poor, do not actually reach them as envisaged (Con & Walford 1998, Basaza et al. 2008, Kamuzora & Gilson 2007). In their study in Tanzania on the exemptions of the Community Health Fund, Kamuzora & Gilson (2007) also observed that the targets of exemptions did not know about their existence because of managers’ negative attitudes. They noted that the managers felt that the exemptions would erode their financial base and often refuse requests for exemptions.

*Lip service*

The homelessness criterion as the basis for granting the core poor exemption raises some intriguing questions about why it was put in the policy. Was it just a matter of a wholesale transfer of policies from other social contexts such as Western Europe and the United States of America where homelessness is a condition of the core poor? Or were policy makers not familiar with the reality at the local level in Ghana? Analysis of these questions reveals hidden insights regarding the motivation to establish a criterion that eliminates potential beneficiaries. Contrary to general opinion that the implementation gap is mainly due to identification difficulties, I think the explanation runs deeper. I point out the lack of commitment at the policy level to ensure that the core poor are enrolled as a factor. I put forward two possible explanations. First, if policy makers were genuinely committed to exempting the core poor, they would have paid collectors for enrolling them just as they do for the premium-paying category. This would motivate the collectors to pursue the NHIS’ pro-poor agenda and identify the core poor. Second, if the policy makers were really committed to running a pro-poor NHIS, some groundwork would have been done to ensure that all the criteria reflected the conditions of the target group. I explain why these actions were not taken by looking at the political situation at the time that the NHIS was envisioned and the financial implications of granting exemptions to those who would qualify as core poor. As mentioned earlier, setting a condition that eliminates the target equals a lack of interest in achieving the set goal. The question that comes to mind is why was such a condition set? From this perspective, I argue that setting such a condition could have been a strategy to lessen the financial burden of enrolling all core poor while also serving as propaganda to accumulate political capital for the election that was due in a few months before the NHIS was introduced. The scheme was introduced nation-wide in March 2004 and elections were held in December of the same year. Meanwhile, the financial implication of enrolling all the exempt categories was too significant for the country, so a criterion that would reduce the financial burden was needed.
One may question this explanation, but a critical analysis of the financial implications provides insight and strengthens my argument. The NHIS has a large exemption group (about half of Ghana’s population). For example, in the two regions used for the study, our household baseline survey showed that children (0-17 years) form 46.6 per cent of the population and people above 70 years form 3.6 per cent. The figure for pregnant women could not be computed from our data. In the case of the core poor, a recent Ghana Living Standard Survey shows that about a third (28.5%) of Ghana’s population live below the poverty line (Ghana Statistical Service 2007). The Ministry of Finance pays GH¢ 14 for each person exempted per annum to the National Health Insurance Authority (NHIA). Considering the core poor alone, it means that the government would have to pay premiums for about 2.5 million people. This equals a total cost of about GH¢ 35 million (US$25 million) per annum, which would be a significant demand on the country’s budget. A country with a cross-national per capita income of US$520 in 2006 (World Bank 2010) and already over stretched with unfulfilled needs in other sectors of the economy, such as education and roads, means that the money to cover the exemptions is not easily available. The International Labour Organisation (2006) made a similar observation in their financial assessment of the NHIS. They cautioned that with the large exemption group in relation to income, the National Health Insurance Fund might not remain viable over the medium to long term. For example, by the end of 2008, the National Health Insurance Authority owed health facilities about US$34 million (see Witter & Garshong 2009).

Thus considering the financial burden, there was nothing to lose if in practice the homelessness criterion eliminated almost all potential beneficiaries while appearing to be fulfilling the government’s moral obligation to the poor and showing the international community they were committed to ensuring equity in access to healthcare. The politics of the NHIS policy-making process has been described as characterised by political rhetoric (Rajkotia 2007, Agyepong & Adjei 2008). Witter & Garshong (2009) also observe that the original objective of introducing the NHIS was essentially political. Thus, what was important at that time was to win votes for the pending election. The practicalities of its implementation were overlooked, probably intentionally. If this was not the case, and the politicians were truly committed, whose definition of the core poor should have counted; the one by policy makers or by the community? The government had the option to set a criterion that reflected the realities of the core poor in Ghana. As Agyepong & Nagai (2011: 232) point out: “A policy is only as good as its implementation arrange-

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2 These figures roughly agree with the nation-wide figures. The 2008 Ghana Demographic Health Survey reported that 41% of Ghana’s population was below 15 years. The 2000 population census reported that 5.3% were above 64 years (Ghana Statistical Service 2002).
ment.” Poverty needs to be defined by the community. Aryeetey et al. (2010), in their analysis of various methods of identifying poor households, observe that the community criteria of classifying the poorest members correlated with mean testing and the proxy mean testing considered as the gold standard. This view starts from the assumption that opinion and community leaders understand local conditions of poverty and are in a better position to devise effective guidelines that could be used to identify them.

The argument is strengthened when one considers the fact that the non-applicability of the homelessness criterion has been discussed in the public domain since the inception of the NHIS, but both past and present governments seem not to be concerned and no solution is in sight. This is not to say that nothing is being done to improve the applicability of the exemption policy and enrolment of the core poor, but the moral urgency required on the part of both the DHISs and the government seems to be lacking. This is often the case when reforms are introduced and the economy is too weak to support implementation. These reflections underscore the need for civil society groups to look at programmes that target the poor with a lens that sees beyond the policy document and effectively monitor implementation. Otherwise, social security programmes targeted at the poor will not reach the majority since they have no voice to make demands. The poor are voiceless; they are the silent ones in society who cannot challenge DHISs for not granting them exemptions even when all indicators show that they qualify. Clearly, this shows that even if the implementation arena is littered with other barriers, it is ironic that policy makers’ professed goal of ensuring equity in access to healthcare is not being given the urgency it requires.

“I’m not often sick”: Adverse selection

Contrary to the philosophy of social health insurance schemes (SHISs) that requires people to enrol and consistently renew their memberships, whether they benefit or not, the NHIS is beset with pervasive adverse selection. The mutual cooperation that was expected to stimulate voluntary enrolment was absent. Many people enrolled with just the motive of benefitting and not of sharing the risk or cost. This is reflected in the less than 50 per cent enrolment among the general population (40%) after the intervention. The intriguing aspect was the enrolment level among the rich quintiles: rich (46%) and richest (44%) and high non-renewal rates (22%) within the same groups. This tendency contradicts the policy goal of attaining universal coverage by the end of five years against the backdrop of a heavily subsidised premium. The improbable reason given by the majority of all respondents was their inability to pay the premium. The majority (67%) and (73%) said they did not renew their membership and never enrolled because they could not pay premium (Table A.10, Appendix 2). Almost all key informants gave the same reason as their first
response when I asked them why they did not enrol or renew their membership. But, as I engaged them in further discussion, their real intention emerged. They said: "I’m not often sick" and "I’m waiting for a while." This indicates that the decision to enrol and remain in the NHIS for most people is not poverty, but rather a rational calculation.

The situation observed was that many household heads enrolled only those who needed healthcare and renewed their membership only when they had to go to the hospital. This contradicts the crucial assumption by policy makers that the solidarity principles exhibited by the rich kinsmen’s generous contributions to the funerals of the poor would be transferred to secure them against ill-health as well as motivate them to enrol and remain in the NHIS. In Ghana like other African countries, the NHIS was introduced based on the assumption that traditional norms that oblige kinsmen to support poor members will motivate people to enrol (see also Arhinful 2003, Sommerfeld et al. 2002). In contrast, people merely appreciated the NHIS’ benefits as reducing the financial burden of expensive healthcare costs. The need to share the costs and risks for their mutual benefit did not seem to impact people’s decisions; rather many looked for ways and means to get the maximum benefit with minimum contribution. As Arhinful remarked, the ‘solidarity’ that existed in community-based health insurance scheme (CBHIs) in Ghana was the unintended consequence of self-interest. People are not willing to pay for people they do not know, as would be the case in a national health insurance, because it will not produce social capital for them. Arhinful (2003: 150) states:

In the emerging mutual insurance setting, a contract that asserts payment of a fixed voluntary premium is the only social tie that binds members together. For most of these people there is no sense of emotional attachment to other members of the group, apart from the few that they probably know and live with. The absence of opportunities for the accumulation of social capital thus diminishes the binding feeling of solidarity and for that matter the binding force of reciprocity underlying such schemes.

This lack of solidarity to share the risks and costs that Arhinful noted was also observed in the current study. The risk- and cost-sharing principles only ‘worked’ for SSNIT contributors whose premiums were (forcibly) deducted at the source. Non-SSNIT formal sector contributors and informal sector workers were not willing to pay premiums based on their income. Almost everybody paid the minimum and in many cases discontinued paying if they did not benefit. For example, boat owners paid the same premium as their employees when they enrolled them. They enrolled their employees because fishermen are prone to accidents and need regular access to healthcare. However, the higher premium the boat owners were expected to pay because they earned more than their employees was rejected. The owners insisted on paying the minimum. Arhinful (2003) refers to this as: ‘solidarity of self-interest’: joining a group with a minimum contribution to satisfy personal needs. Other researchers also commented on people’s low interest in health insurance. In their
analysis of declining subscriptions in a mutual health organisation in Guinea-Conakry, Criel & Waelkens (2003) attributed low enrolment in health insurance schemes in Africa to a lack of risk perception. I have argued that the situation is more complex in Ghana. People perceive they are at risk, but wait until they need healthcare before rushing to enrol or renew their membership. A similar observation was made by Adusei-Asante (2009) in his study of a rural district in the Eastern Region of Ghana. He found that only mothers and their children and people with chronic sicknesses, who needed regular healthcare, enrolled and renewed their membership in the NHIS routinely. They opted out when their need for medical care was over.

Also, a nation-wide survey by the Ghana Statistical Service in 2008 found that Private Commercial Health Insurance Schemes covered less than one per cent of Ghanaians (Ghana Statistical Service 2009). These findings question the general notion, and the assertion of key informants of this study, that people will enrol in an insurance scheme if they are confident they will receive quality service. Like private enterprises, healthcare services to private insurance enrollees are provided by well-equipped health facilities with good quality service, positive staff attitudes towards insured patients and only rare incidences of drug shortages. The low patronage of private health insurance schemes confirms the observation that many Ghanaians have not yet accepted the conditional reciprocity embedded in health insurance. Nor do they use it as protection against ill health. Thus, the intervention outcome was influenced by the low interest in the NHIS, which was a country-wide phenomenon.

These observations indicate that the minimum solidarity needed to drive people to enrol and remain in the scheme was absent. People tended to enrol if they were certain to benefit; they did not accept cost redistribution and risk-sharing in health insurance. The selective enrolment of household members reveals an adverse selection and negative risk-averse attitudes towards health insurance as implied in the “I’m not often sick” and “I’m waiting for a while” reasons for not enrolling or renewing their membership. This indicates that these people fully perceive the risk of not being insured as more expensive, but wait and rush to enrol or renew their membership only when they need healthcare.

A more distressing finding was that these actions were encouraged by the lack of sanctions against defaulters and ‘back door registration’. Some people managed to enrol and access healthcare without waiting for the three-month mandatory period. This unscrupulous behaviour perpetuated by some DHIS staff and collectors was largely due to ineffective monitoring. According to some collectors, they did it as a favour for a small fee. This gave more people the hope of manipulating the registration process and so they did not enrol until they were sure of benefitting. Putnam (1995: 67) calls this a “dilemma of collective action” when people want to benefit from collective goods with minimum input. He notes that the dilemma of collective
action can only be resolved when civic engagements foster sturdy norms and social trust. But, I argue that for the intriguing phenomenon of mutual benefit being subsumed by individualistic tendencies, the problem can only be addressed when the rules are strictly enforced and effective monitoring mechanisms put in place. Otherwise, the NHIS will continue to suffer from parochial interests and the goal of attaining universal coverage will remain a mirage.

The problem of low achievement of health policy, in spite of massive support, has also been observed by critical observers of other health issues. Van der Geest et al. (1990: 1025) examined why Primary Health Care (PHC) so rarely worked, although there was “unanimous approval of PHC” at Alma Ata in 1978. They attributed the failure of PHC to the diverse interests that multiple actors at various levels had in the policy so the idea of using PHC as a strategy to attain health for all by the year 2000 was not accomplished. In their study, the authors mentioned the low financial appeal of PHC to health providers, inadequate funding by governments and the community’s cultural values that led to the acceptance of some of the proposals and rejection of others. In the same vein, although all stakeholders accepted that the NHIS improved access to healthcare and reduced complications among insured patients, the various interests undermined the achievement of the NHIS’ goal. Politicians saw it as a tool to secure electoral victory, so they did not wait to expand the health facilities’ capacity to handle the expected increase in patient numbers before introducing the scheme. They did not seriously consider what constitutes quality service to insured patients and also paid lip service to the exemption policy. Health providers saw it as increasing their workload, and hence were hostile to insured patients and charged extra fees. Community members thought that they could benefit with minimal financial investment, while the DHISs were more interested in revenue than granting exemptions to the core poor to ensure the equity agenda was achieved. These distinct – and often conflicting – interests converged to limit the PSGs’ efforts at improving enrolment and retention rates.

Conclusions

This study set out to generate evidence to show that local stakeholders can collaborate to improve enrolment in the NHIS and retain members. The study aimed to prove that in-depth information can lead to a better understanding of health insurance decision-making in Ghana. Three researchers (including the author of this book) set up a multi-stakeholder problem-solving programme (MSPSP) that engaged local NHIS stakeholders to identify barriers to enrolment and retention of members and developed and implemented solutions to expand coverage. I used a multi-level perspective as a conceptual framework and methodological tool to analyse and explain challenges to enrolment in health insurance and retention of members. I described the MSPSP and examined the approaches that the facilitators
employed in implementing the intervention. I examined the outcome of the intervention and factors that led to increase in enrolment and studied reasons for the PSGs’ limited success by employing quantitative and qualitative research methods. The results show that many factors mediated the effect of the intervention; therefore, drawing a decisive conclusion about the outcome is difficult. However, the following key conclusions are presented.

The study has shown that stakeholders’ engagement in the educational and advocacy activities in communities and health facilities stimulated enrolment in the NHIS. This approach led to a better understanding of the barriers to enrolment and increased confidence in the NHIS. For example, insured opinion and community leaders shared the benefits they derived from the NHIS with community members and convinced people that it was a viable alternative to on-the-spot payments. Health providers educated community members and their patients on the benefits of health insurance and persuaded them to enrol. In contrast, the PSG facilitators who dominated PSG activities and made unilateral decisions created distrust, stifled intervention activities and could not sustain the group through the intervention period. These facilitators did not engage stakeholders in intervention activities, so they could not establish the trust relationships needed to increase confidence in the NHIS. Hence, they failed to achieve a positive outcome. This finding demonstrates that the bottom-up, inclusive decision-making and interdependency approach that most facilitators employed in PSG activities and interactions among stakeholders created trust and ensured the stakeholders’ effective participation. This approach also sustained the facilitators’ commitment to achieve positive results.

The study also found that people (apart from the core poor and some poor households with many members), enrolled in the NHIS because the cost of the premium was affordable and relieved them from expensive healthcare expenditure. It also strengthened community members’ resilience to manage the adversities of ill health. However, quality service is yet to be the basis for enrolling and remaining in the NHIS. Almost all insured patients complained about the poor quality of healthcare services. Prominent complaints included delays at health facilities, disrespect, extra payments and the burden of roaming to obtain prescribed drugs from accredited private pharmacies and chemist shops due to the shortage of drugs on the National Health Insurance Drug List in health facilities. These issues all caused discontent, created distrust and eroded the confidence that the PSGs had built in the scheme. This shows that the NHIS is not the cure for poor quality healthcare service. Conscious efforts must be made to resource health facilities and position them to meet the expectations of insured patients. In addition, ‘back door’ registrations due to inefficient monitoring systems gave some people the hope that they could obtain the NHIS card to access services without waiting for the three-month mandatory period.
The PSGs’ limited achievement was attributed to the social and institutional context in which the NHIS operates. Community members were influenced by the generalised reciprocity embedded in traditional risk-sharing arrangements. This undermined the acceptance of the conditional reciprocity of health insurance and led to adverse selection as many household heads enrolled and renewed NHIS cards only for members who needed healthcare. Others did not regularly renew their memberships because of the lack of sanctions against defaulters. They rushed to renew their membership only when they needed healthcare. This finding contrasts the policy makers’ assumption that participation in traditional mutual support groups stimulates enrolment and the commitment to remain in the scheme.

For health providers, the NHIS can be described as a paradox; on the one hand, they saw it as reducing complications, which would encourage people to enrol. On the other hand, it was perceived as increasing their workload due to increased utilisation of healthcare and completion of NHIS forms. As a result, two categories of health providers were observed. One devised strategies to cope with the burden of work by being hostile to insured patients and giving preference to uninsured patients. Others charged insured patients to compensate for their heavy workload and to avoid filling out the NHIS forms. The second category treated insured patients well and persuaded people to enrol because the NHIS reduced complications among patients.

In the case of the DHISs, inadequate equipment especially cameras adversely affected their output of work. It created difficulties in processing of registration forms and resulted in delays in issuing NHIS cards. So collectors were provided cameras to take photographs as they simultaneously registered people. This facilitated registration processes and led to prompt delivery of NHIS cards, which influenced people to enrol.

I started this study to explore if PSGs could identify barriers and develop and implement intervention activities to improve NHIS enrolment and retain members. However, during the intervention, the focus was expanded beyond PSGs to cover a wider context and higher level actors involved in the NHIS. Issues arose that exposed more linkages that needed to be explored.

The findings indicate that although local level stakeholders can collaborate to increase enrolment, more understanding of the barriers is needed and national-level interventions are required to improve enrolment (especially among the poor) and retain members. Nonetheless, each of the three concepts – multi-level perspective, resilience and trust – employed in this study enhanced the understanding of health insurance decision-making and the reasons behind low enrolment and retention rates in Ghana. The findings without doubt contribute to the discourse about the potential of multi-stakeholder collaborative groups in helping reduce barriers and improve coverage of social health insurance schemes in developing countries.
Recommendations

This study has shown the potential of using local level stakeholders of Ghana’s NHIS to reveal and address the multidimensional factors that interact to undermine enrolment and retention of members. However, the PSGs’ achievement was limited because of the social environment in which NHIS operates and reservations about quality of healthcare service delivery. The practical and policy concerns are apparent from the preceding discussions on how to limit or eliminate adverse selection, improve enrolment of the poor and core poor, improve quality of service and scale-up problem-solving groups and ensure their effective functioning.

Policy Implications

Kinsmen and the entire community provide support during funerals. Cash and other donations are given to the bereaved family to enable them give the dead a befitting burial. This support did not transform to communal solidarity to share risk and cost of ill health. Relying on solidarity as a virtue to motivate people to enrol in the NHIS and consistently renew their membership does not seem realistic. Rather, policy makers should move away from the solidarity principle to promote health insurance and devise pragmatic intervention activities that emphasise enlightened self-interest and project the benefits of health insurance to the individual and immediate family. Overall solidarity will be the unintended de facto result of such self-interest (Arhinful 2003). Extensive education and promotion is required to convince Ghanaians that health insurance is first advantageous to themselves and their families.

The study also highlighted the adverse effects of self-interest and tendency of some community members and DHIS staff to manipulate the registration process to their advantage. Moreover, the PSGs’ intensive education and promotion had a limited impact on voluntary enrolment and renewal of NHIS membership. This makes it imperative for the DHISs to strictly apply the National Health Insurance Regulations, 2004 (LI 1809, 59: 1) and sanction defaulters to wait for three months before accessing healthcare services upon renewal of their membership. This will deter people from adopting the wait and see strategy and consistently renew their memberships.

History yields important lessons about how to address low enrolment in voluntary health insurance schemes. The initial stages of social security in Western Europe, where health insurance was made compulsory to all wage earners, indicate that some coercive action is required to compel all residents in Ghana to enrol. Some might argue that since it is more expensive to access healthcare without health insurance, there is no need to coerce people to enrol because without it, they pay more. Uninsured patients experience more complications and higher risks of death than the insured do because of delays at home and lack of access to healthcare. Since the
economic cost of prolonged illness does not only hinder an individual’s wellbeing, but the country’s development as well, it makes economic sense to ensure that all citizens are healthy. The following forms of coercion are recommended. One, a premium for formal sector workers who do not contribute to Social Security and National Insurance Trust (SNNIT which is a government pension scheme in Ghana for most formal sector workers) should be deducted at source. Two, NHIS enrolment should be made a requirement for obtaining voter identity cards, driving licenses, passports, marriage certificates and admission to educational institutions. At the same time, heads of health facilities and DHIS managers should institute measures to stop frontline staff that looks for opportunities to manipulate the system for personal gains.

The revelation that the NHIS is not reaching the poor and the core poor calls for strategies that will reduce their exclusion. In the case of the poor, the decoupling of the registration of children less than five years from their parents or guardians should be effectively implemented to reduce fatalities among them. For the core poor, the homelessness criterion should be removed from the exemption policy since it does not reflect reality. Since the NHIRs 2004 LI 1809, 58: 3 mandates DHISs to assign the duty of eliciting the information required for the classification of indigents according to standards determined by the scheme to collectors, the DHISs’ staff and collectors should engage opinion and community leaders to develop indicators that reflect their reality rather than national documents prepared by people who are usually not familiar with local conditions. Moreover, this study revealed that the core poor are not difficult to find. Community members described them as persons afflicted by ‘ohia buburoo’ (severe poverty) (see also Aryeetey 2012). Removing the homelessness criterion will be a first step in making it possible for the core poor to demand exemptions with the support of opinion and community leaders. This will force the DHISs to pursue the equity agenda of the NHIS.

Enrolling and remaining in a health insurance scheme is largely influenced by trust, which depends on health facilities’ ability to provide quality healthcare to insured patients. This requires the creation of an improved image for the NHIS that resonates with quality healthcare service and makes it easier and faster to obtain healthcare and not the reverse. This means that health facilities need to be strengthened to provide services that are responsive to patients’ needs. Since drugs are essential component of quality service, the priority should be to provide insured patients drugs at facilities with no extra payment. In the short term, the NHIA should allow health facilities to purchase small quantities of the drugs they need urgently from private suppliers without the non-availability certificate to reduce the incidence of drug shortages. Also, supervision at health facilities should be strengthened to check the collection of unauthorised fees and the selling of drugs covered by the NHIS to insured patients and to make sure that the staff performs their tasks
diligently. In the long run, the on-going electronic network to connect DHISs to the NHIA should be expanded to cover all accredited hospitals and health centres nation-wide for easy claim processing and payment. This will reduce the time spent treating insured patients and ease health providers’ workload. Since the fees charged will be reflected in the DHISs’ system, claims will be promptly paid to enable health facilities maintain their stock levels. These measures will build trust among insured patients and health providers and boost confidence in the NHIS. This will influence people to accept the NHIS as better than cash payment at health facilities. It will also make the compulsory enrolment more bearable and influence both the rich and the poor to enrol so that the cost and risk are shared.

For the above measures to be effective, stakeholders should be continuously engaged in identifying and addressing their concerns through conversations and key informant interviews. To achieve positive results, these measures should be seen as part of the quality assurance activities undertaken to reveal the NHIS’ implementation challenges across regions and districts, and efforts made to address them. The evaluation outcome should be incorporated into both the National Health Insurance Authority (NHIA) and Ghana Health Service’s (GHS) annual review reports. These reports should be discussed at joint annual review meetings by the NHIA and GHS at national, regional and district levels to provide a platform for sharing ideas that will lead to improvement in healthcare service and DHISs’ operations.

How to scale up PSGs and make them more effective

The results of this study confirmed that collaboration by local stakeholders leads to increase in enrolment. I therefore recommend that PSGs should be scaled up nationwide and used for intensive education and advocacy activities. When carried out over a long period, these activities will reduce the negative practices among stakeholders that undermine enrolment in the NHIS and retention of members.

The NHIA’s proposal that every DHIS should be divided into Health Insurance Communities and Community Health Insurance Committees (CHICs) was a laudable idea, but not implemented. The CHIC was to promote community ownership of the NHIS and ensure their efficient operations. They were supposed to oversee the collection of premium and registration fees and to ensure that monies collected were deposited in the District Health Insurance Fund. I recommend that the CHIC agenda be revisited and the membership expanded to include health providers and DHIS staff. Thus, PSGs should be established in every town. A number of small villages could collectively form a single PSG to save costs, since those communities patronise the same health facility and DHIS. The DHISs should facilitate the formation of PSGs and provide a small budget for their activities. The procedure for selecting members is described in chapter four. Lessons learnt show that consultation with opinion and community leaders and institutional heads to devise a selection ap-
proach, which ensures that only committed representatives are selected, is critical. Also, the low representation of women in PSGs and exclusion of the poor highlight the need to develop additional strategies to ensure that both are fairly represented in the group. Health providers and DHISs’ representatives should not be selected based solely on their work schedule; being an effective PSG member requires a specific set of skills and a volunteering spirit that not all employees have. Therefore, heads of health facilities and DHIS managers should engage their staff in a discussion and give them the option to accept or decline their nomination. In addition, all nominees should be confirmed or rejected by their colleagues through secret voting since they are likely to have better insight into the above mentioned characteristics. Facilitators should be selected at the first PSG meeting through secret voting and the DHIS manager should facilitate the meeting. These procedures will ensure that only people committed to promoting the welfare of others become PSG members and facilitators. This is important because the allowance paid for participation is usually not enough to keep those who do not have the spirit of volunteerism to be committed to the intervention.

Since how a programme is presented and run determines its success or failure, appropriate strategies at each stage of the life span of a programme must be developed. Five measures are recommended to make PSGs efficient. First, all PSG members should be given adequate orientation to ensure that they understand well the rationale of the intervention and their task from the onset. Second, a nurturing environment that creates space and effective mechanisms should be developed for community members, health providers and DHISs’ staff to freely express concerns about problems they face without looking over their shoulders. This means stakeholders need to be sensitised to accept the work of PSGs as part of quality improvement initiative that requires their commitment to succeed. The involvement of health providers and DHISs staff should focus on building trust between them and PSG members to encourage open and dispassionate discussion of issues. With trust in place, the PSGs can pursue the interest of all stakeholders and openly discuss challenges that undermine enrolment in the NHIS and retention of members, and develop intervention activities to reach all target groups. For example, the DHISs’ reluctance to grant exemptions to the core poor because of the homelessness criterion could be taken up by PSGs and engage them in discussions to develop locally tailored criteria to identify the core poor. Third, DHIS managers should not be part of PSGs. They should be supervisors who spend funds and closely monitor PSGs’ activities and ensure the money given out is spent on the intervention. Fourth, there should be an annual review meeting for PSG members, facilitators and DHIS managers at the district level. The meetings should be used to evaluate their activities, share experiences and learn about best practices to help improve their work and address their concerns. This will also motivate community members and facilitators
to remain committed and work harder to achieve positive results. Accountability on the part of facilitators will also be ensured. Finally, the NHIA regional managers should play an oversight role and incorporate PSG activities into their programme of work and reports. As mentioned earlier, PSG activities should be discussed at joint review meetings of the NHIA and GHS at the district, regional and national levels.

These recommendations when implemented will reduce the NHIS’s implementation challenges and stimulate enrolment and retain members. It will also ensure that the poor and the core poor are not excluded from the NHIS.

Implications for future research

The MSPSP, as a pilot project, provided insight into factors that enhanced and limited PSGs’ achievement at improving enrolment in the NHIS and retaining members. However, more qualitative research is needed to understand the specific factors to develop effective intervention activities for addressing them. For example, more understanding of local discourses on informal risk-sharing arrangements and how this affects enrolment is required. This will generate more knowledge to help develop effective intervention activities that will influence people to accept health insurance as a state social security policy that needs their support to ensure everybody has access to healthcare.

More research is also needed to develop appropriate criteria for exempting the core poor and how to cultivate the political commitment to include them. In the case of the poor, ways should be explored on how to ease the heads of households’ burden of many dependents.

Further research is also needed to find ways to reduce the bureaucracy involved in treating insured patients and thus, reduce the health providers’ negative behaviour towards them. In addition, more efficient registration processes and effective monitoring mechanisms need to be developed to make DHISs more efficient.

Further, the lack of transparency in the policy making and implementation process as a result of lack of collaboration among national level actors – MoH, NHIA and GHS – was identified as a hindrance to the development of efficient systems to build confidence in the NHIS. In this respect, further studies are needed to explore inculcating the notion of participatory, transparent and bottom-up approaches to policy making and implementation in politicians, policy makers and implementers. This will help improve collaboration among stakeholders to develop systems to improve DHIS operations and the quality of healthcare services to insured patients and make the NHIS more attractive. Moreover, intervention science is an underdeveloped yet crucial academic subject requiring theory building through empirical research, so further research on PSG formation and functioning is needed to inform policy makers and programme officers in the field.