Graduate School of Development Studies

A Research Paper presented by:

"DECISION TO ENROL OR NOT IN HEALTH INSURANCE SCHEME":

VIEWS FROM NORTH TONGU DISTRICT (NTD).

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(GHANA)

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DEDICATION.

This work of mine is dedicated with LOVE to The Following Personalities:

My Dear Wife, Mrs Judith Emma Hottordze, Our Children, Bismark, Ian, Eureka and Rene,

My Mother, Victoria Ayawovi Vivor.

&

Mr. Kolly Dorcoo, CEO, AFROWOOD CONSULTING, Ltd., Accra.

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LIST OF ACRONYMS.

CBHIs	Community-Based Health Insurance Schemes.
CBOs	Community-Based Organizations.
CHIC	Community Health Insurance Committee.
DMHIS	District Mutual Health Insurance Schemes.
DHIF	District Health Insurance Fund.
DHIA	District Health Insurance Assembly
DHC	District Health Committee.
GDHS	Ghana Demographic and Health Survey.
HIC	Health Insurance Community.
KATH	Komfo Anokye Teaching Hospital
MASLOC	Microfinance and Small Loan Centre.
MHIS	Mutual Health Insurance Schemes.
MOH.	Ministry Of Health.
NDC	National Democratic Congress.
NHIA	National Health Insurance Authority.
NHIA	National Health Insurance Act.
NHIS	National Health Insurance Scheme.
NPP	New Patriotic Party
NTMHIS	North Tongu Mutual Health Insurance Scheme.
NTD	North Tongu District.
PMHIS	Private Mutual Health Insurance Schemes.
PCHIS	Private Commercial Health Insurance Scheme
WHO	World Health Organization.

ABSTRACT

Mutual Health Insurance Schemes (MHIS) have been developed and promoted as mechanisms to offer protection to poor households from the risk of ill-health, death and loss of assets. However, the introduction of the North Tongu Mutual Health Insurance Scheme (NTMHIS) witnessed some mixed feelings and mistrust for political reasons and fear about the workability of the scheme due to experience with collective arrangements.

Surprisingly, therefore, within its three year implementation period, the scheme recorded an impressive coverage of about fifty percent of the entire population. However, little evidence exists to explain reasons for this surprise at the district level.

The study investigated why households enrolled in the NTMHIS to that extent. The study arrived at evidence which suggests that the ability of enrolled households of North Tongu District (NTD) to construct a link between their choice for insurance and the trust they have in both the scheme management and service providers emanates from the fact that their expectations are being met and this, coupled with the fact that premium is within the reach of majority, contributed significantly to the increase in enrolment in the NTMHIS. Additionally, innovative public education strategy and balanced power relations within most households and preference for insurance to user fees have all explained why people enrol in the NTMHIS. The study, however, found that, in spite of government's effort at bringing premium within the reach of majority and her relief package for the core poor, some category of households still remain excluded due to lack of cash to pay. Scepticism among non-enrolled households, which was also partly bred by the failure of some enrolled households to participate in some sensitization activities of the scheme; hostile attitude of some health staff, and previous experiences with collective arrangements all explained why others remain uninsured.

It is suggested that to ensure generally improved access to health care for majority, Government should consider focusing on preventive health to

avoid possible premium increase that has the potential to exclude many more households in the scheme, sensitization programmes must be critically evaluated and bureaucracy in registration process minimized. There is the need also for service providers to be given adequate training to demonstrate high level of professionalism in the discharge of their duties. Besides, government should not only modify the relief package for the core poor but also ensure that those who have still been excluded due to lack of cash to pay are brought on board by paying premium in kind, using their farm produce. Finally, NTMHIS is to tailor its marketing strategies to cater for those with less or no education as a way of improving access to care for many more households.

RELEVANCE TO DEVELOPMENT STUDIES

'Health, it is said, is Wealth'

Unfortunately, the major development challenge facing greater population around the globe especially in low and middle income countries is inaccessibility to health care, occasioned by problem of health care financing. It is hoped that when factors that contribute to the surprisingly high enrolment in the new initiative in a typically low income environment like NTD is unravelled all other areas, for that matter, countries, will emulate and improve access to health care for their people.

Chapter 1
Introduction

1.1 Background

'Mutual Health Insurance Schemes(MHIS) are voluntary membership schemes that have been developed and promoted as mechanisms to offer protection to poor households from the risk of ill-health, death and loss of assets' (Sinha et al. 2005: 133). ' These schemes are typically owned, designed and managed by the community that they serve (Diop et al. 2006: 1) and 'provide financial protection from the cost of seeking health care. It has three main features: prepayment for health services by community members; community control, and voluntary membership' (Mladovsky & Mossialos, 2008: 1). What is more characteristic about them is that 'they often come out with premiums which are small, paid on regular basis and are often meant to off-set the catastrophic health expenditures incurred in the case of illness, injury, childbirth, or any other event that requires expensive medical care' (Diop et al.2006: 2). Schneider (2004: 352) maintains that 'most successful rural schemes collect contributions once or twice a year, timed to coincide with harvest and sometimes allow payment in kind'.

McIntyre et al. (2005: 30) further argue that 'ways by which people will be encouraged to enrol in a scheme is for the insurer to ensure that health services are actively purchased for the scheme members so also to negotiate reasonable prices, ensure that services in the benefit package are available and to monitor quality of care'. In the researcher's estimation, this depends upon the control mechanisms put in place, the calibre of people at the helm of affairs and the degree to which they live up to their responsibility.

MHIS typically develop around a geographical entity such as a district or village or a trade or professional group such as trade union as is the case of Self-Employed Women's Association in India (Sinha et al. 2005: 132). Where MHIS differ from commercial health insurance schemes is that they are always not-for-profit and are usually based on the ethic principles of mutual aid and social solidarity (Diop et al., 2006: 2).

In the researcher's view, MHIS are now beginning to be popular among countries in Sub-Saharan Africa and their contribution to improving health outcomes is increasingly attracting attention from governments and donors and Ghana's case is a shinning example. Tabor (2005: 13) maintains that 'MHIS provide one reliable way by which poor communities manage health risks in combination with publicly financed health care services'. He further argues that 'these schemes are small scale, voluntary, organized and managed in a participatory manner. They are often designed to be simple and affordable and to draw on resource of social solidarity and cohesion to overcome problems of small risk pools and moral hazards, exclusion and cost escalation' (ibid).

Recognition of MHIS as a mechanism for improving financial access to health care and for extending social protection to underserved population is gradually receiving political will and support and Ghana happens to be one of the countries to join the wagon having come out with its own unique health insurance strategy (Government of Ghana, 2004).

Households purchase insurance, as a market product, based on the market forces of demand and supply. Often, household's insurance decisions are informed by factors such as income level, premium rate, and information available about the insurance, level of household members' involvement in health decisions, benefits to get and household needs, constituting demand side.

On the other hand, these household decisions are again based on the way the insurer and service provider package the insurance as regards premium rate, public education, and trust that households have in them.

1.2 Problem Statement

In recognition of the potential of Mutual Health Insurance Schemes (MHIS) to eliminate user-fees, and increase access to health care, Ghana enacted the National Health Insurance Act (NHIACT650) in 2003, mandating the establishment of district-wide Mutual Health Insurance Schemes. A cross-section of the general public embraced this noble idea with some mixed feelings. Whilst some perceived the rashly implementation of the scheme by

the New Patriotic Party(NPP) government as a political gimmick to retain political power in the then forthcoming elections, others, based on their experiences with regard to collective arrangements in Ghana, were of the view that it was going to be the usual rhetoric of health care financing arrangements which would end up, not only aggravating their physical and financial inaccessibility to health care but also create an opportunity for few party activists to amass wealth. Government, in spite of all these interpretations and mixed feelings, went ahead and passed the NHIA (ACT650) in August 2003 and implemented the health insurance policy in all districts including North Tongu District (NTD) in December, 2005. The expectation was that, since NTD is the stronghold of the opposition National Democratic Congress (NDC), these perceptions were going to cause the scheme to perform abysmally. To the surprise of all, within its three-year period of implementation, the scheme has recorded coverage of about 50 percent of the entire population. There seems to be an appreciation in registration year after year (NTMHIS, 2008). However, little evidence exists to vividly explain the seeming success of the scheme at the district level. This study, therefore, seeks to explore why households in NTD enrol in the NTMHIS.

1.3 The objective of the Research

In the light of the foregoing, this study aims at finding out the supply and demand factors that have contributed to increase in enrolment in NTD, using two sub-districts-Mafi and Bakpa. of the Volta Region. In order to achieve this broad objective, the study found answers to the following questions:

The main question the study answers is: Why households in NTD enrol in the MHIS?

Sub-questions:

- How has premium charged by the mutual health insurance scheme affected households' decision to enrol?
- How have benefit package and quality of care affected the decision of households to enrol in the NTMHIS?

- To what extent has the public education carried out to promote the scheme informed the decisions of the house-holds of NTD to enrol in the scheme?
- To what extent has trust, if any, contributed to enrolment?
- How has income or poverty levels of households of NTD influenced their decision to enrol in the NTMHIS?
- How has power relations within the household affected the decision to enrol?

1.4 Justification for the Study

The study will review the design features (supply side) of the scheme so that when the findings are brought to the notice of the implementers it will help build households' trust in the scheme to ensure its sustainability. The policy directives as far as socio-economic issues of enrolment are concerned will be critically looked at and advice accordingly offered to give a policy guide to implementers. The study contributes to the growing body of literature on reasons why people enrol in health insurance.

1.5 Data Collection and Limitations

To answer the above questions, the researcher employed both field and desk study. With the desk study, documents such as the Act, 650, the Legislative instrument, 1809 of the scheme, annual reports of the scheme and the District Hospital were studied. The field work was conducted in July, 2008. Data collected were processed, using statistical programme for social sciences (SPSS)

1.5.1 Sampling Procedures

The researcher purposively selected two (2) key personnel from the District – the District Manager of the NTMHIS, and the Medical Superintendent in the District hospital for the study. The choice of this sampling method was important because it helped the researcher to handpick key informants who were deemed fit to provide relevant information for the study.

Out of the eight (8) sub-districts in NTD, two of them, specifically Mafi and Bakpa were selected through cluster sampling. These sub-districts were selected because Mafi is the largest and Bakpa the smallest. From each of these sub-districts, two (2) communities each were selected. From Mafi, the communities were Adidome and Mafi-Kumase; and from Bakpa, the communities were New Bakpa and Bakpa-Avedo. Thus, in all, the study was carried out in four communities. From each of these communities, 15 heads of household made up of eight (8) who are enrolled in the scheme and seven (7) non-enrolled were chosen based on purposive and quota sampling methods. Although influenced by community factors, ultimate decision to enrol rests within the single household hence the choice of household as the unit of analysis. The eight were from the bigger communities – in this sense, Adidome and New Bakpa. To take care of gender issues, four males and four females were selected from the bigger communities and from the smaller communities, at least, three or four males or females. The choice of the household heads was based on the understanding that in the local context, they decide on the allocation of household resources. These methods were considered ideal because they were less expensive. So in all, the sample size was 62.

1.5.2 Data Collection Methods

For all the 62 respondents, semi-structured interview methods were used in eliciting the desired responses. The use of this research instrument was based on the fact that it provided the opportunity for a face-to-face conversation to explore, among others, the reasons for joining or not joining the scheme in detail. It illuminated the voices of the disadvantaged like women, widows/widowers, disabled and the elderly. The semi-structured interview was centred on knowledge/ perception of public education on the scheme, poverty/ income level, trust, benefit package and quality of care, power relations within the households and the effects of these dynamics on the decision to enrol.

1.5.3 Practical Limitations

The interview time fell in the peak farming season of majority of the respondents which made it difficult getting heads of households to interview. This compelled the researcher to arrange with some of them to have their interviews at dawn and this inconvenienced both the researcher and the respondents. Secondly, the Medical Superintendent was on course in a different region for a month and had to be interviewed on phone, compelling the researcher to incur a cost not earlier anticipated.

1.6 The Organization of the Study

The paper contains five chapters. Chapter one gives a systematic sum up of MHIS and raises research questions. The chapter two discusses theories and relevant concepts. It also provides the relevant framework for theorising and analysing demand and supply factors that determine households' insurance decisions. Chapter three recounts the evolution of orthodox health system in Ghana and current administrative structures, antecedents that culminated in the current health financing arrangements, NTMHIS its components and structure and the research context. Chapter four outlines the main results and their explanations. The last chapter is summary of findings, conclusions and policy implications

Chapter 2
"Decision to enrol or not in Health Insurance": Theoretical Perspectives

2.1 Introduction

This chapter reviews related literature that addresses the variables indicated in the research questions and which also appear in the analytical framework by using theories such as consumer and decision-making theories under uncertainty to understand factors which explain household insurance decisions.

2.2 The Consumer theory

This theory assumes that consumers who are perfectly informed maximize their utility as a function of consuming various goods, given relative prices, their income and preferences. According to Begg et al. (2000), 'changes in prices and income influence how much of different goods rational consumers will buy'. They argue that 'health insurance is expected to be a normal good with a positive income elasticity of demand, implying that the people are less likely to insure, given a lower price'. They further maintain that 'a price increase of a substitute for insurance- such as user -fees is expected to raise the insurance demand, as is a decrease in insurance premium'. In the researcher's view, consumers' reaction to the price changes depends upon their socio-economic status since the rich, in particular, are likely to be insensitive to price changes, provided they are still getting quality of health care they expect at that exorbitant price. Cameron et al. (1988) also criticized the theory by arguing that 'since there are uncertainties about health insurance, choice is not made based on utility alone but on consumers' expectation about factors such as their health status. Thus, theories on decision-making under uncertainty better describe insurance enrolment.

2.3 Theories on Decision-Making under uncertainty

2.3.1 Expected Utility (EU) Theory

Manning and Marquis (1996) stated that, 'under expected utility theory, insurance demand is a choice between an uncertain loss that occurs with a probability when uninsured and a certain loss like paying a premium'. The theory assumes that people are risk averse and make choices between taking a risk that has different implications on wealth. At the time of insurance choice, households are uncertain whether they will be ill or not, and of the related financial consequences. Insurance reduces this uncertainty. Explaining this further, Hsiao et al. (2006:1238) argue that 'the choice of rural residents to join or not join a CBHI is a discrete decision process consistent with qualitative choice model' and that the farmers' choice of joining a community-based health insurance scheme in rural China was grounded in the comparison of the expected utility of having health insurance versus having none.' Despite these criticisms, expected utility is most commonly used in models of decision-making under risk. (Marquis and Holmer, 1996). The expected utility theory emphasizes choice between paying a premium at a rate, given income level and be certain about benefits in the form of access to health care.

2.3.2 State-Dependent Theory

The state-dependent theory suggests that consumers' utility level and taste are guided by their health or socio-economic status. As such differences in degree of risk aversion influences insurance decision and magnitude of what they expect as insurance pay-offs. Most people insure when they are healthy and this shows how central socio-economic status is in insurance decisions as in consumer theory.

Where a healthy person optimistically expects to remain healthy in the future insurance coverage may be below full loss coverage, if the anticipated insurance pay-off is below the real loss in case of illness. Hence, the anticipated need for medical care, given the current state, and the magnitude of the related insurance pay-off in case of sickness, will affect household demand (Schneider 2004:351). The state-dependent theory posits

that the insurance decision of a household is influenced by both demand and supply factors as income level and supply and insurance pay-offs. Similar view is shared by the prospect theory posits that households are risk-preferring and that their decisions to enrol based on the prospect of gaining when sick. It identifies supply factors such as premium and benefits as issues to inform households' insurance decisions.

2.3.3 The Endowment Effect Theory

The endowment effect theory assumes that decision-making is affected by households' risk aversion about something new. People perceive greater costs in giving something up than benefit in acquiring something new. According to Schneider (2004:351) 'households would rather stay with the old if they do not know whether the benefits of an unknown alternative exceed the cost of giving up something well known'. Households will insure if they are of the perception that benefits of insurance are higher than the cost related to giving up being uninsured and vice versa. In brief, the endowment theory is of the assumption that to replace an old thing with a new depends on how promising the new one is compared to the old one. In this vein, opting for insurance depends upon the extent to which it gives a better alternative to out-of-pocket payment.

2.3.4 Regret and Disappointment Theory

These theories are of the assumption that people have loss aversion and conservative preferences, and that individuals try to avoid regret and disappointment and do not just consider the eventual outcome, as suggested by the endowment and expected utility theories.

Schneider (2004:351), citing Bell (1982, 1986), argues that 'households factor in their feelings of regret, in case the decision would have been wrong, and of disappointment, if the outcome does not correspond to what they have expected.' Based on this, Schneider (2004:351) further argues that 'households may prefer to remain uninsured for fear of regret for their decision or be disappointed in case they do not benefit from an insurance pay-offs or they insure to avoid feelings of regret from falling ill while uninsured'(ibid). The theories are of the view that households make provisions in case they regret for

not making a decision or making the decision only not to have their expectations met in terms of outcome of their decision. In insurance, the theories supply factors as benefits and trust to influence household decision to enrol or not.

2.4 Gender dimensions of the decision to enrol in health insurance

The world population monitoring report (1996:180), citing Boland, 1995b, Cook, 1995, argues that the 'sister treaty to the political covenant recognizes the right of persons to enjoy the highest standards of health and calls for special attention to be given to women before and after childbirth and to the reduction of infant mortality

The report, in further citing Sen, Germain and Chen, (1994), indicates that 'some of the reasons that contribute to women's lack of access to health include lack of proper health centres and personnel, lack of means to transport persons to existing centres, poverty, lack of government commitment and funding'. It stressed that rural areas in developing countries are the hardest-hit because; health services are scarce in those areas (ibid). And NTD, the study area, is a typical rural area. Schneider and Dmytraczenko (2003: 3) confirm that 'women, especially the poor die because of serious exclusion from health care due to barriers that are always difficult for them to overcome.' At times, health financing schemes do not necessarily bring positive outcomes, for women are, at times, excluded from the scheme due to high premium rate, power relations within the households, class structure, political and geographical reasons. This was confirmed by Oxaal and Sally (1996), in their report on maternal mortality, in which they indicated, that 'as a result of power relations within the household, decisions to seek healthcare take place in a complex web of relationship'

. The social exclusion approach also reveals that the processes of deprivation in the society also serve as a barrier to the accessibility of interventions like health insurance. As put by Wuyts (2004: 9) 'socially determined structures and processes impede access of some members of society to economic resources, social goods and institution'. And women and

children are often the greatest victims in this case (ibid). WHO (2006: 10), confirms that 'within the class structure, health interventions often reach the rich rapidly than the poor'. It was further argued that 'gender inequalities in the society least prioritize women even within the family when it comes to health provision' (ibid).

2.5 Poverty Dimension of Enrolment

During the 1950s- 1970s, the poor were seen to be the small farmers who were mainly men. They were then being given credit to boost their productivity. From the 1980s-1995, the poor were seen to be the female micro entrepreneurs who were constrained by collateral to obtain loans. To date, 'the poor are looked at as diverse groups of vulnerable households with complex livelihoods and varied needs' (Stuart 2000: 13). To minimize this, the NTMHIS is designed in a way that people can enrol based on their economic strength and ability to pay through categorization of the population. It has been ascertained in the field that, in Ghana, income distribution is such that the income of a wealthy member of the household is used as a proxy to determine the poverty level of the household. Chen et al, 2005 cited in Van der Hoeven (2008: 10), have, however, indicated that 'earnings differentials between men and women are apparent across the various forms of informal work'. This was confirmed by Van der Hoeven (2008: 10) who also argues that 'women are disproportionately represented in lower paying forms of employment often with fewer social protections and less stable incomes'. It is, however, interesting to note that, in spite of all these inequalities, incomes of many men are spent outside their legitimate households on either purchasing drinks for friends or spending on their surrogate wives. Yet, women, as traditional care-givers within the households are compelled to spend their scanty incomes in providing for both healthy and sick members of the household including the man. These arguments point to the fact that it is, at times, erroneous to use the income of a wealthy member of the household as a proxy to determine the poverty level of that household.

2.6 Trust and Quality of Care

Consumers' decision to purchase a good is not only influenced by factors internal to them; but the extent to which external factors, as regards the packaging of the product by the producer, influence their decision.

Historically, quality of care has been defined in clinical terms focusing on biomedical outcomes. According to D'Ambruoso et al. (2008: 3) 'over time, conceptualizations of quality of care have broadened, acknowledging that care must be provided within the resource constraints of the health system and, therefore, also focus on resource use, cost, sustainability and other organizational aspect of care. They argue, in addition, that following the classic framework quality of health insurance, conceptualizations of quality of care have been proposed, incorporating elements related to the service user(the insured); interpersonal aspects of care and patient's satisfaction.' 'The client-provider interface, patient satisfaction and aspects of the user's experience of care are particularly important in health insurance schemes' (ibid). They further argue that 'the degree to which people who have and their immediate families engaged with these services will be, in part, dictated by the perceived quality of care, as defined by the interpersonal aspects, specifically the client-provider interactions'.

In emphasizing the importance of trust, Schneider (2004: 353) stresses that 'the trust-related components are of much importance in the MHIS context. He argues that 'many MHIS operate within weakly defined legal and political systems; and are based on mutual, non-written agreements that are monitored and enforced by members.' To him, 'MHIS managers often lack the technical capacities to manage an insurance scheme and negotiate with providers for better care. Besides, financial incentives created by the insurance design can result in inefficient service use and insurance failure, and providers' inferior quality of care which may negatively affect MHIS membership' (ibid). Mladovsky and Mossialos (2008: 5) from a 'health system' perspective also propose that 'trust decreases the likelihood of adverse selection and moral hazard and increases willingness to pay, but these do provide examples from the field and propose strategies to increase the levels of trust. These include improving behaviour of medical staff to patients, such as increased levels of

politeness, improving quality of care (through strategic purchasing); transparency and accountability among those managing the scheme; recourse to justice to punish fraud, increased community participation in the scheme management; attending scheme meetings; and significant proportion of staff working voluntarily'

2.7. Analytical framework.

The Researcher used the various variables (factors) influencing insurance decisions as tools in assessing reasons why people enrol or not in NTMHIS. In doing so the researcher considered insurance as a normal good thus classifying the relationship between the Scheme Management and the Service Providers, on one hand, and Households, on the other, as supply and demand one respectively. This was based on the understanding that for an insurance decision to be made in any household in NTD both demand and supply factors to come into play. In this research, household, as unit of analysis, is defined as the number of people who live and eat together since the last three months preceding the interview and the poor people of NTD refers to households comprising men, women, children and the disabled with complex livelihoods and varied needs especially health needs.

Here, demand factors such as income level/ poverty, preferences, and power relations within the households in NTD have the potential of either increasing or decreasing enrolment in the scheme. According to the regret and disappointment theories, level of trust and expectation of the enrolees also play vital roles when it comes to insurance decision.

The gender literature also points out the potential of power relations within the household to influence insurance decisions. At times, women's willingness to make some health decisions like enrolling in insurance is affected by some structural factors or decisions by their husbands. According to Pearson (1992: 301) 'the state through legislation, social policies and how public institutions are staffed and run, influences how women are viewed in various ways in society and this affects how women are seen as autonomous individuals or as dependents of men'. She argues that 'in some countries, women's civil rights in divorce, custody of children, ownership of property,

autonomy in matters of employment, financial contracts are discriminatory'(ibid.)

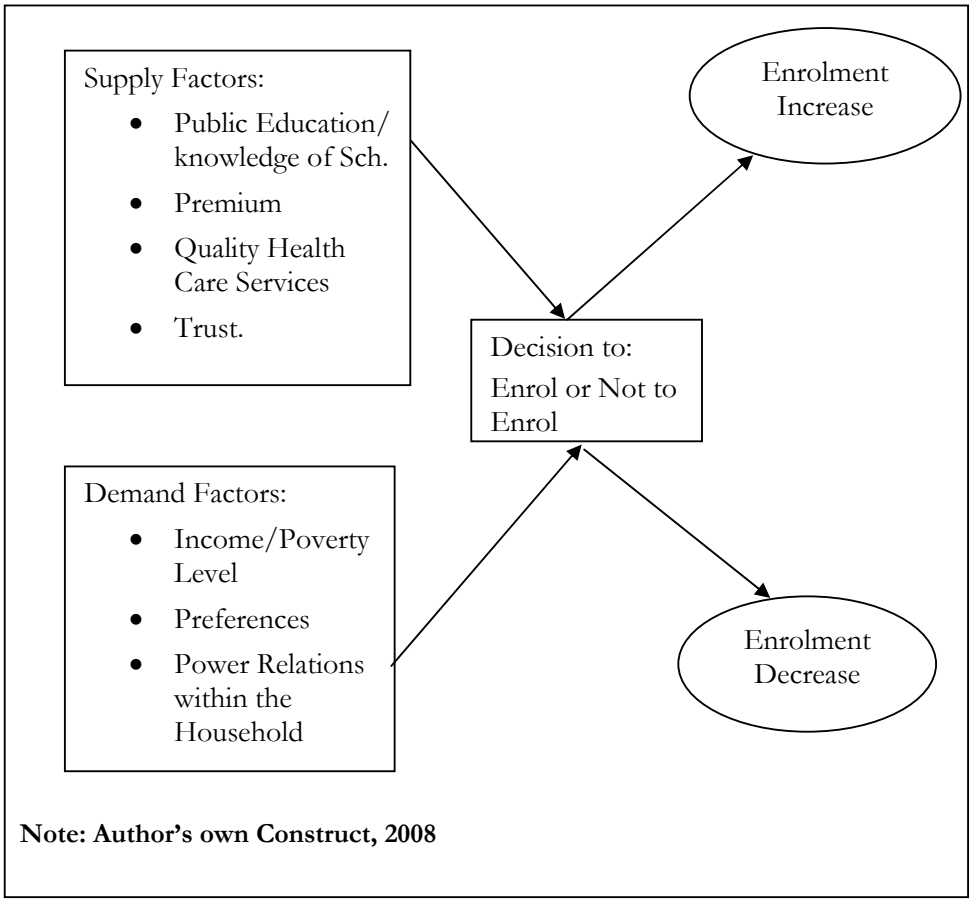
She concludes that 'entitlements to benefits such as health insurance, pension, and welfare payments are often linked to women's relationship with men, rather than women in their own right'(ibid). This may, however, not necessarily be the case in Ghana where awareness among women seems to be somehow enhanced as a result of the creation of some gender-sensitive institutions of state.

Supply factors, on the other hand, are those factors that bother on insurance design, health policy and informational context. Some of these factors include knowledge of the scheme/ public education, trust, premium, quality of health care and benefits.

Public education/ Knowledge of the scheme as regards what households know about the scheme, its duration, and waiting period after registration coupled with the degree of trust in scheme management and service providers, the benefit package and marketing strategies of the scheme has the potential to affect household decision to enrol or not in insurance.

DÁmbruoso et al. (2008: 3) maintained that 'the success of any insurance scheme is dependent upon the degree to which the service providers can successfully integrate with the members of the insurance scheme'. 'This integration, they emphasized, needs to be backed up with appropriate clinical skills to manage members of the scheme who are ill. These clinical skills are, in turn, contingent upon an enabling environment comprising equipment, supplies, infrastructure, education and training, supervision and supportive political and policy environment. Quality of care occurs when services are utilized and outcomes occur as a result' (ibid).

Figure 1:
Analytical Framework



Note: Author's own Construct, 2008

In figure1 above, the supply factors come from both the scheme management and service providers. These factors such as public education/ knowledge about the scheme, quality of care, trust and premium could either attract or scare away households from the scheme with its implications for enrolment. On the other hand, a household's insurance decision is influenced by the factors in demand side such as household income/poverty level, preferences and power relations within the households.

Chapter 3
Health Care Financing in Ghana

3.1 Introduction

This chapter illustrates the evolution of orthodox health system in Ghana, antecedents leading to the current health financing arrangements and the NTMHIS, its components and structure and the research context.

3.2 Ghana Health Care System: Evolution

Ghana, originally known as the Gold Coast, was a British colony for approximately one hundred years before independence in 1957. British rule brought modern or western health systems into the country. The country's health system at the time was described as focusing on hospital- based clinical care, initially serving expatriate Civil Servants and merchants and most facilities were concentrated in port towns and cities (Dovlo, 1996: 1).

Ghana operates on a two-tier health care system as briefly described below:

Administrative Structures

The public health system is organized hierarchically and decentralized from the national level to the local level. At the peak of the system is the Minister of health and his Deputy who take political decisions on health. The professional sector is called the Ghana Health Service (GHS) established by Act 525 of 1996 of the 1992 constitution of Ghana. The GHS is headed by a Director- General (GHS, 2005). The GHS has been established with autonomous powers to administer health services in the country. It controls the professional aspects of health services in the country.

At the Regional level, the Regional Co-ordinating Council (RCC) has the political responsibility for health in a region, while at the district level, it is the District Assembly. Health administration is in the hands of a Regional Health Management Team (RHMT) with the Regional Director of Health Services as chairman. The RHMT is politically responsible to the RCC. Among the team is technical staff for various aspects of health care. The highest health

institution at the regional level is the regional hospital that is supposed to be the final referral point within a region (ibid).

At the District level, a District Health Management Team (DHMT) that is responsible to the District Assembly under the new decentralisation policy manages health administration. In practice, however, there is a lot of 'bureaucratic red tape' in the system, with the dominance of the top-bottom approach in health decisions. Each district is divided into zones with a health centre catering for a zone. The district health administration is under the supervision of the District Director for health services..

Private health dominates the health system in Ghana, owning a greater quantum of the health institutions (Bour, 2004: 152). They operate on profit basis and are supposed to send periodic reports about their operations to the District Directors who will forward them to the Regional Directors, then to headquarters in Accra (ibid). Mission hospitals, which are supposed to operate not- for profit, receive some assistance in paying the salaries of health staff from government. They are also used as service points for primary health activities, like immunisation and child and maternal health services (GHS, 2005)

3.3 Evolution of healthcare financing in Ghana: Antecedents leading to the current financing arrangements.

At independence, Ghana provided free healthcare service to its population through public health facilities. This could not be sustainable in the light of the needs of other sectors of the economy, and government was compelled to find alternatives to this financing mechanism. As a result, in the 1970s, nominal fees were introduced, which later proved insufficient to meet the needs of the health sector. By the middle of the 1980s, full cost recovery for drugs, known as 'cash and carry' was introduced (Agyepong and Agyei, 2008: 13). However, 'cash and carry' decreased access to healthcare, particularly among the poor, resulting in a decline in utilization of basic health services (ibid). As a way of mitigating the effect of out-of-pocket payment for healthcare, the government came out with an exemptions policy (Badasu, 2004: 3). The policy exempted children under the age of 5, prenatal care for pregnant women, and healthcare

services for the indigent, the elderly (those above 70years), and for disease-specific service. However, 'a significant number of clients who qualified for exemptions continued to face barriers in accessing basic healthcare (ibid). 'In some hospitals, for instance, decision-making was decentralized and exemptions practices were inconsistent, so that exemptions would be granted for some but not all services' (Badasu, 2004:3).

Buor (2004:216), in a study of health services in Ghana, disclosed that outpatient utilization fell from 4,468,482 in 1984 to 1,607,386 in 1985 and 2,051,501 in 1985

Though the above development was not good for the country, it could not reflect negatively on the health status of Ghanaians over some period. Under five mortality, Infant mortality, and neonatal, as in table 3.1, have all, however, been intermittent. Maternal mortality has been stable yet high. Life expectancy had increased whilst post-neonatal mortality, crude birth and death rates had all dropped. Total fertility had also made a stride. Some of these developments could be attributed to preventive health care which is being encouraged in Ghana now. However, when these are viewed against the Millennium Development Goals 4-reducing infant and child mortality by 2/3s by 2015, Goal 5- improving maternal mortality by ¾ by 2015 and Goal 6 combating HIV/AIDS, malaria and other diseases by 50% by 2015, it is evident that Ghana still has a long way to go (ISODEC, 2006).

Below in table 3.1 are some health status indicators for 1988, 1993, 1998 and 2003:

Table 1:
Health Status Indicators in Ghana for the Various Years (1988, 1993, 1998 and 2003)

INDICATOR	YEAR			
	1988	1993	1998	2003
Infant mortality rate (per 1000 live births)	77	66	57	64
Under 5 mortality (Per 1000 live births)	155	119	108	111
Neonatal Mortality (per 1000 live births)	44	41	30	43
Post-neonatal mortality (per 100 live births)	33	26	27	21

Crude Birth Rate(per 1000)	47	44	39	33
Crude Death Rate (per 1000)	17	12.5	10	10
Life expectancy at birth (in years)	54	55.7	57	58
Total Fertility Rate	6.4	5.5	4.6	4.4
Maternal Mortality(per 100,000)	540	540	540	540

Source: GDHS.1993, 1998 & 2003, Ghana Statistical Service, 2007 &MOH/RCH ANNUAL REPORTS 1996-2003.

In Ghana, records have it that about 60% of all outpatient cases is made up of Malaria, Upper Respiratory Tract Infections, Diarrhoea and Disease of the Skin. Hypertension has consistently remained the 5th cause of Outpatient morbidity, constituting about 3% of all outpatient reported cases (GHS, 2005 annexure, 2a). However, the same records have it that pregnancy related complications, gynaecological diseases and malaria in pregnancy have improved from 2000 to 2004(GHS, 2005, annexure 2b). This improvement came about as a result of free maternal care and free ambulance service policies initiated by government to cut down on high maternal mortality rate.

As stated by Asante and Eakins (2008) 'it is to offset the negative effects of the 'cash and carry' introduced by the 1985 Hospital Fees Regulations (LI1313) and other issues especially on the poor that government commissioned various studies into alternatives, principally insurance-based that gave birth to the current health financing arrangement in Ghana'. This led to the emergence of schemes such as Nkoranza and Dangme West in the early 1990s which became models for other communities to replicate.

In August 2003, the Government of Ghana passed the National Health Insurance Act(650) the primary goal of which was to improve access to quality of basic health care services in Ghana through the establishment of mandatory district-level MHIS (NHI Act.650,2003).

The Health Insurance Act, (HI Act) provides the legislative framework for the establishment of a regulatory body, the National Health Insurance Authority (NHIA). The role of the NHIA is to register, license, and regulate health insurance schemes and to accredit and monitor healthcare providers operating under the schemes. It plays a key role in guiding implementation

efforts and management of the National Health Insurance Fund (NHIF). The Health Insurance Act stipulates three types of schemes: District Mutual Health Insurance Schemes (DMHIS) Private Commercial Health Insurance Schemes (PCHIS), and Private Mutual Health Insurance Schemes (PMHIS). A legislative Instrument, (LI, 1809) outlining the regulations for implementation at the district level, was approved and published in January 2005 (NHIAct. 650 2003).

.3.4 North Tongu Mutual Health Insurance Scheme (NTMHIS)

The NTMHIS is a fusion of two concepts; the traditional Social Health Insurance Scheme for formal sector workers and the traditional MHIS for the informal sector. The NTDMHIS received support with funds from Heavily Indebted Poor Country (HIPC FUND) from government which facilitated its set-up. It is a decentralized system with ownership belonging to members who have made their required contributions. It is social in character because it is not-for-profit. At the end of the year surpluses made are ploughed back into the scheme to reduce contribution levels or increase the benefit package (MOH, 2004). The (NTMHIS) is designed to ensure transparency, build subscriber confidence and, in particular, bring health insurance to the door steps of households in NTD. It is, however, in partnership with government, in that the NTMHIS receives subsidy from government in the form of risk equalisation and reinsurance for catastrophic events. The NTMHIS came into operation in December, 2005 (ibid).

A Community Health Insurance Committee is formed in each health insurance community to oversee the collection of contributions and supervise its deposit in the District Health Insurance Fund (DHIF). Members of these committees are again responsible for carrying out public education programmes in their respective communities. The committee comprises a chairman, secretary, collector, publicity officer and a member. The collector collects the contributions from residents under close supervision of other members of the committee (MOH, 2004).

Components of the NTMHIS

The NTMHIS, as any other DMHIS, also has the same components as in the National Health Insurance Scheme (NHIS).

Minimum contribution

One of the key regulations that the legislative instrument specified is the annual premium, set at a minimum of GHC7.20 per adult which currently stands at $7.20.US dollars. In a typical two-parent family the entire family would be covered for GHC14.40 per year (appropriately $14.40 U.S.dollars) for those in the informal sector whereas those in the formal sector contribute 2.5% of their 17.5% Social Security and National Insurance Trust (SSNIT) as premium which is deducted at source subject to renewal at GHC2.00 every year. Formal sector workers with spouses in the informal economy are to pay the premium for adults pegged at GHC7.20 to have them covered (NHILI) 1809, (2004). This contribution is according to the principle of ability to pay in order to enjoy a package of health services covering over 95% of diseases afflicting Ghanaians. The contribution levels have an in-built cross-subsidization mechanism whereby the rich pay more than the less privileged, the healthy cover for the sick and urban dwellers pay more than the rural dwellers. To mobilize additional funds to support implementation of the DMHIS, the government of Ghana instituted a National Insurance Levy of 2.5 percent on specific goods and services attracting Value Added Tax. However, the current arrangement is that parents especially those in the informal economy who cannot afford the current premium rate can go ahead to pay the registration fees of GHC2.00 for their children to benefit. The children also renew after every year as is the case amongst the elderly members. This current arrangement was, in response to the pressure on the (NHIA), to further upscale the registration of children by decoupling their registration from that of their parent(s) (NTMHIS, 2008). Contribution levels of the people are categorized based on their socio-economic stratification. There are six types of categorization as: core poor, very poor, poor, middle income, rich and very rich. All of these pay in line with the ability to pay. In order to overcome the difficulty of identifying indigents for free coverage, government has decided to collaborate with the Livelihood Empowerment Against Poverty Programme (ibid)

Minimum healthcare benefits

The NHIA developed the benefit package intended to cover basic healthcare services, including out-patient consultations, essential drugs, in-patient care and shared accommodation, maternity care (normal and caesarean delivery), eye care, dental, and emergency care. Certain public health services historically provided for free, such as family planning and immunizations, will be covered under the scheme. NTMHI must adhere to the defined benefit package. Some services deemed either unnecessary or too expensive are excluded from coverage. These include cosmetic surgery, drugs not listed on the NHIS drug list (including antiretroviral drugs), assisted reproduction, organ transplantation, and private inpatient accommodation (NHILI1809, 2004).

The Indigent policy

The scheme has an indigent policy. The indigent is therefore, defined as 'people who are unemployed and have no visible source of income; do not have fixed place of residence; do not live with a person who is employed and who has fixed place of residence; and do not have any identifiable consistent support from another person (LI.1809). Pre-determination of the poor is to be done at the district level by the District Health Committee (DHC) (NHILI. 1809, 2004).

Maternal care package

The maternal care package has just been introduced in 2008 in an effort to improve maternal health. Facility-based deliveries are encouraged as ways of minimizing maternal mortality which is at an alarming rate in the country at the moment. The package covers two normal deliveries, pre-natal and post-partum care, newborn care and family planning counselling. The nursing mother is catered for, for six weeks and the child three months (NTMHIS, 2008). Pregnant women could, therefore, avail themselves of services included in the maternal package in both the hospital and non-hospital facilities such as lying-in clinics, midwife-managed clinics and health posts. The pregnant women access health care at the time of registration without any waiting period and renewal (NTMHIS, 2008)

3.4.1 Membership Drive Strategies

Apart from the usual public education programmes in the form of announcements by mobile vans, posters, radio and television programmes and community meetings to explain the scheme to people, the NTMHIS has been organizing community durbars, visits to churches and mosques, funerals, and giving of support to traditional festivals the celebration at which scheme management is always given opportunity to explain the scheme to people (NTMHIS, 2008). These functions may be conducive atmospheres for getting people who do not respond to formal community functions of this nature but are, as tradition demands, regular at funerals. However, some of these functions like funerals and festivals are likely not to convey the information effectively to the target population since they are characterized by mourning due to pain, drunkenness and festive mood respectively. A micro-finance scheme instituted by the office of the President, known as Microfinance and Small Loans Centre (MASLOC) is being run in all Districts, access to which is tagged to the membership of the health insurance scheme and this is attracting especially women into the scheme (NTMHIS, 2008). A study by Chankova et al. (2008: 272) was confirmed that 'a number of microfinance organizations serving women in the informal economy have either initiated health insurance for their members or linked them up to existing independent ones'.

3.4.2 Management of Scheme in the District

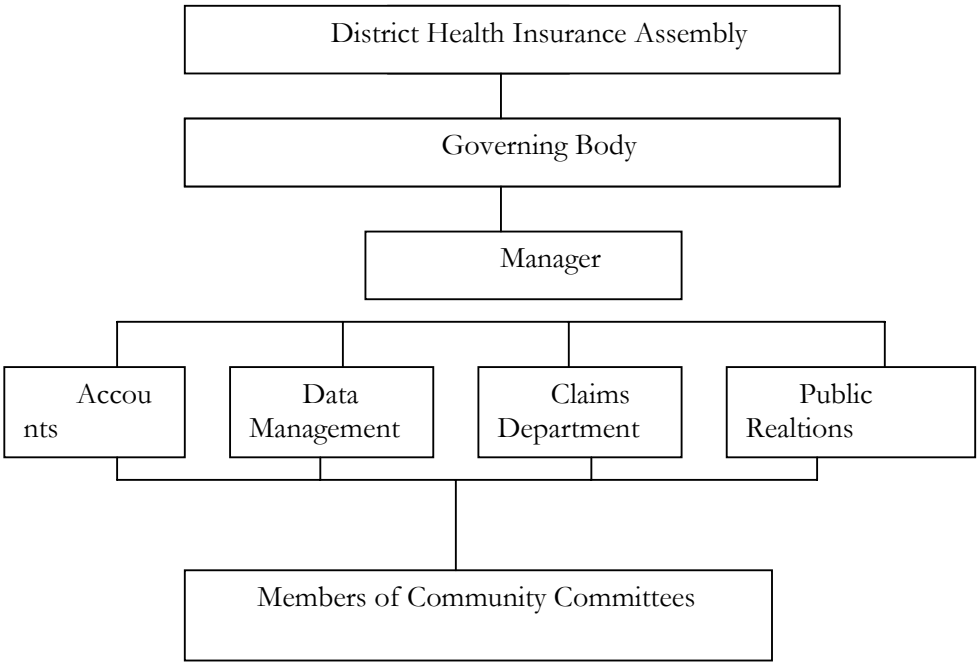
To protect contributions of households and facilitate access to quality health care by

Contributors, the chairman or secretaries of all Community Health Insurance Committees come together to form a 9- Member District Health Insurance Assembly (DHIA) (MOH, 2004). This is the highest decision-making body on health insurance in the district charged with the responsibility of preparing a constitution to provide general policy guidelines for the operation of health insurance in the district. This body also appoints a 15-Member Board of Trustees also known as the governing body, which, in turns, appoints a management team to handle the day to day administration of the scheme. It is also responsible for the enforcement of the constitution,

approval of budget, render operational and financial accounts to the DHIA. The 15-member Governing Body represents various interest groups, such as health providers, DHIA, Religious bodies, Traditional authorities, Department of Social Welfare, Insurance and Finance Experts and any other considered appropriate. The management of the scheme also comprises the Scheme Manager, Accountant, Management Information Manager, Claims Manager, Publicity and Marketing Manager and Data Entry Operator(s)(ibid).

Figure 2 below is the arrangement of the scheme in the North Tongu District::

Figure 2:
Structure of the North Tongu Mutual Health Insurance Scheme



Authors own construct,2008

3.6 The Research Context

NTD is one of the 167 districts of Ghana. It is deprived and located in southern part of the Volta Region of Ghana (Ghana Living Standard Survey, 1988/89). The district capital of the NTD is Adidome in the Mafi- Traditional Area. The people subsist mainly on agriculture but erratic rainfalls, coupled with low market for their farm produce have exacerbated their low income levels. Some farmers have diversified their income sources through rearing of cattle and other domestic animals and petty trading. Poverty is widespread, notably among rural households (North Tongu District Planning and Coordinating Units (NTDPCU), 2008). Given financial barriers imposed by user fees, health services are characterized by low utilization. This makes the health care situation equally unsatisfactory. Many households have difficulty in paying their hospital/clinic bills and payments for drugs pose the most difficult for patients. At times people are discharged after hospitalization and can not get money to pay and are detained and consequently abandoned by the care-takers, a situation which compels NGOs and Civil Society groups to pay for them (North Tongu Ghana Health Service (NTGHS), 2008). A cross-country analysis by Kent Ranson et al confirms that, in several developing countries, annually, more than 3% of all households faced catastrophic health expenditures(i.e. exceeding 40% of income remaining after subsistence needs have been met.)(2006: 708)

There are only two major hospitals in the District- the District hospital at the District capital, and a mission hospital at Battor, one of the biggest towns in the district. Unfortunately, unavailability of health facilities especially in the rural areas and personnel to man them in the NTD have taken health care out of the reach of many household. Abject poverty scares private practitioners away from investing in health in the rural areas thus increasing the vulnerability of the population in the district. Women are the most victims of this circumstance simply because their reproductive needs cannot be met. As a result, they have, over years, fallen prey to pregnancy related complications (Ref to Annexure 2a&b page 66). So do many young ladies who indulge in illegal abortion and lose their lives due, not only to unaffordability of health care but also, to poor public health facilities (ibid). These developments

contribute to the increasing maternal mortality cases in NTD, in particular and Ghana as a whole, which stands at 540 women per 100,000 live births (Ref table 3.1-Health Status indicators, 2003)

. Besides, among the ten causes of attendance and admission at the hospitals in NTD, malaria is still the leading disease for hospital visit and hospitalization, with anaemia, placing second, resulting in high infant and child mortality in the area (Ref. annexure 3a & B). Problem of sanitation has been the major cause of rampant malaria cases in NTD with children under five years and pregnant women being the hardest-hit. Other diseases of threat are tuberculosis, pneumonia, acute respiratory problems, diarrhoea, hypertension, and accidents (GDHS, 2003, Annual Report of the District Hospital, 2007 Ref. annexure 2a&b.) All these health problems, coupled with poor road networks, due to many rivers and creeks, do make patients delay in getting to a health facility, if they attempted to do so. This compels some of these rural poor to rely on some risk-coping strategies such as purchasing of unprescribed drugs, selling of assets, and transfer of money from their family and local networks to meet their health cost.

Government' s initiated of the scheme in the district for that matter the country, was preceded by extensive research, exploration of community preferences and willingness to pay for a benefit package, cost estimation analysis, risk perception and traditional networks of risk sharing, and health needs assessment (NTMHIS, 2008). All these, in a way, might have informed households' decision to enrol in NTMHIS.

Chapter 4
"Decision to enrol or not in Health Insurance Scheme": Views from North Tongu District

4.1 Introduction

The chapter outlines the main results and their explanations by discussing demographic characteristics of respondents, and supply and demand variables that influence enrolment in NTMHIS.

4.2 Demographic Characteristics of Respondents

In the researcher's view, health insurance decision of a household is more likely to be influenced by background characteristics such as age, sex, marital status, occupation and geographical area of the individuals who make up that household.

Ages of members of a household are likely to affect the health insurance decision of the members of that household. In the researcher's view, young people are of the belief that they are healthy and do not usually see the wisdom in being risk averse. Out of the 30 households the study interviewed, only a small number of the age group (30-39) that is only 16.7% enrolled in the NTMHIS as against a large number from the age groups of 40-49 (20%) and 50-59(33.0%) who appear to be more risk averse (Ref. to table 4.1 annexure 5).

In view of the researcher, sex, influences the decision making within the household especially in favour of the man. And as a result of the differences in the health needs of the members of the household, one gender is more often at a disadvantage to the other. Women, as care-givers for children and other sick members of the household, coupled with their vulnerability and physiological make up are likely to have positive attitude towards insurance decisions than do their male counterparts. Unfortunately, expectations of some women in some households are not met since they are not involved in decisions regarding their health choices.

In the estimation of the researcher, those married and have children and are faced with enormous responsibilities are more likely to adopt positive

attitude towards health insurance and vice versa. However, a different picture is the case in NTD where43.3% of heads of household enrolled are married and 36.7% of the thirty households interviewed are widowed.(Table 4.1 annexure 5). This category of households may be those who see themselves as poor and see the insurance as saviour against out-of-pocket payments and have therefore enrolled.

Besides, the occupation of a head of household, all things being well, is likely to affect the insurance decision of that household. In NTD, for that matter, Ghana, all formal sector workers, on regular income, have, by law, become automatic members of the NTMHIS with their children less than eighteen (18) years also covered. Their premiums 2.5% are deducted at source from their 17.5% Social Security and National Insurance Trust (SSNIT) contributions whilst their counterparts in the informal economy, who are not on regular incomes, are made to pay theirs at table. As in table 4.1, annexure 5, all those who are formal sector workers have enrolled in NTMHIS.

Finally, the geographical area of households has different implications for their insurance enrolment. Households in urban environments who are more likely to benefit from a lot of public education programmes which enhance their understanding and also have access to modern medical facilities are more likely to have positive attitude towards insurance and vice versa.

4.3 Supply Factors:

4.3.1 Premium and Enrolment

The consumer and the state-dependent theories emphasize household's income and socio-economic status respectively as important factors in household insurance decisions and their implications for enrolment (Chp. 2 of this study).

As discussed earlier, the premiums are set at GHC7.20 ($7.20) per adult and GHC14.40 ($14.40) in a typical two-parent family and dependents under 18 years would be covered.

As in tables (i a &b,) annexure 6, on the issue of high premium rate, 86.7% of heads of 30 enrolled households and 70.0% of heads of thirty (30) non- enrolled households interviewed found no problem with the premium rate and rejected the claim of those households, constituting 13.3% of the enrolled and 23.3% of the non-enrolled who strongly agreed that the premium is high.

From indications, the figure representing the enrolled who strongly disagreed with the view may all be formal sector workers and pensioners whose premiums are deducted at source and possibly households in the informal sector who are petty traders and those farmers who have diversified into rearing of cattle, domestic animals and artisanry. *'Ah!, the premium, compared to cost of treatment, is better and money not always the problem' (*Non-Enrolled Female Headed Household). Those enrolled (13.3%) who strongly agreed that the premium is high are likely to be those who claimed to be poor but have gone ahead to enrol. They may also be those households who have enrolled and now find it difficult to renew membership after its expiration (ibid*). 'I registered two years ago but could not renew because I have no money again'* (Enrolled Male.). As in table (ib), annexure 5, 23.3% of heads of the thirty (30) non-enrolled households who have strongly agreed that the premium is high are likely to be those who claimed to have depended only on farming as their source of livelihood and, therefore, find it difficult to afford the premium simply because they have no cash to pay due to lack of market for their produce. In table (ib), annexure 6, 70% of heads of non-enrolled households who also strongly disagreed to the view that premium is high may include those who, not for the high rate of the premium, but for various reasons such as political affiliation, superstition, scepticism and disinterestedness, lack of adequate information and poor service management decided not to enrol. They might have accessed health care and made upfront payment which might be catastrophic. *'I have not enrolled alright but frankly speaking, the premium, as it stands now is within reach'. (*A Non-Enrolled Head*).*

Additionally, as in table (ii) in annexure 5, 20% of the heads of the 30 non-enrolled household interviewed on reasons for non-enrolment assigned high premium as reasons for not enrolling which confirms the views of those

in table ib, annexure 5. Whilst 66.7% of the figure in that same table attributed their inability to enrol to poverty/low income level, others assigned different reasons such as disinterestedness (6.7%), inadequate information (3.3%) and poor management of health service (3.3%). On the issue of high upfront payment as in table (iiia) annexure 5, 80% of heads of 30 enrolled households claimed they had not made any high upfront payment whilst 20% of the figure who claimed to have made some upfront payment was quick to state that the payments made were mainly on drugs and were not expensive. As many as 95.5% of heads of the thirty (30) non-enrolled households interviewed as in table (iii b) annexure 5 admitted having made upfront payments for health care which was extremely expensive. Undoubtedly, these are likely to be some of the non-enrolled households who strongly disagreed (Ref. table ib, annexure6) with the view that the premium, as it stands now, is too high, having probably compared the upfront payments made at each medical event with the current premium for a whole year. Only 4.5% of the non-enrolled of the same figure interviewed claimed they had not made any upfront payment. They may not have accessed healthcare in order to be able to make a reasonable comparison of cost incurred with the premium for a whole year.

The Medical Superintendent of the District Hospital and some non-enrolled heads gave information which suggests that some people in NTD, particularly the non-enrolled are paying significant amounts for health care. For example patients from non-enrolled households paid GHC20.00 ($20.00) – GHC50.00 ($50.00) per hospitalization, and women from non-enrolled households paid GHC14.50 ($14.50)- GHC30.60 ($30.60) for delivery care(Adidome District Hospital, 2008). Considering the potentially catastrophic expenditures for a single medical event, the family premium of GHC14.40 ($14.40) appears reasonable. All these factors lend a strong argument in support of the nationally-established annual premiums of GHC7.20 per adult.

This shows that some households would have enrolled as a way of escaping this high cost but they can simply not pay. Research conducted in Burundi, on reasons for not enrolling, also confirmed this when it was realized that '27% of households reported financial inability as the reason for non-participation' (Bogg et al. 1996: 240).

How government will react to this if evidence supports an inability of some category of households to afford the nationally-established premium in spite of the indigent policy is another issue. Perhaps, introduction of Income Generating Activities as in the case of Bwamanda scheme in Democratic Republic of Congo (DR. Congo) which is part of the larger integrated development project could ameliorate the situation (Criel & Kegels 1997). In Ghana's case, the Microfinance (MASLOC) earlier spoken about is a step in the right direction.

The WHO (2003), in a discussion paper on CBHIS in developing countries 'points out that exemptions for poor households, donations both international and local have crucial role to play as a way of promoting increased membership and Universal coverage.'

However, according to the ILO (2008: 17), grants depend, in particular, on the will of the donors as their level is also a factor. Besides, the political commitment of the receiving country to use these grants for the purpose for which they are released is also crucial (ibid). To the ILO, the most effective way of promoting CBHIS is for governments to broaden their tax net. Undeniably, the NTMHIS for matter the National Health Insurance Scheme's premium structure actually benefits larger households, since without consideration of number of dependents in the household the total household premium remains the same.

The implications are that the premium set forth for the NTMHIS appears to be within reach of many people in NTD, particularly in light of average out-of-pocket payments revealed by this study. Since some households are still excluded, there is the likelihood of government of Ghana being pressurized to modify the proportion of residents of households she considers indigent. The policy is even likely to run into problem when it comes to identification of core poor as confirmed by Osei-Akoto (2003: 23) that 'experiences in Ghana show that exemptions do not work well mainly because it is often difficult to identify the poor and central government delays a lot in reimbursing providers who exempt them'.

From the foregoing analysis, it is evident that the premium rate of the NTMHIS is within the reach of many households and this explains the high enrolment. Those who cannot pay and enrol are simply cash-trapped but not that the premium rate is too high for them.

4.3.2 Public Education and Knowledge about the Scheme and Enrolment

According to the consumer theory, as in chapter two of this study, household insurance decision is determined not only by the price (premium) but also other important factors such as information available about the insurance, income level and preferences of that household.

As mentioned earlier, NTMHIS, in addition to the usual public education programmes such as announcements by mobile vans, programmes by the mass media and community meetings to explain the scheme to people, have been organizing community durbars, funerals, visits to churches and mosques and support for traditional festivals where management is always given opportunity to explain the scheme to people. As in table A (i) in annexure 5, out of the 30 heads of enrolled households interviewed, 100% claimed to have heard about the scheme.

Surprisingly therefore, there were still mixed views about the scheme among especially non-enrolled households. As in table A (ii) in annexure 5, 66.7% of the twenty-nine (29) interviewed admitted having heard about the scheme while 30% of the number interviewed claimed not to have heard much about it. 3.3% could not come out clearly as to whether they know something about the scheme or not. This 30% are likely to be households who, for reasons like political affiliation, superstition, bitter experience with collective arrangement in the past or for any other reason decided to close their minds about the new initiative.

Out of the number of the enrolled households interviewed as in table B (i) in annexure 5, 56.7% mentioned community meeting as their source of information about the scheme. Others mentioned varied sources such as Newspapers (10%), Announcements-Radio/Mobile vans (6.7%), TV (10%),

and other sources such as information from friends and family members (16.7%). From the table, a greater number of households seem to have patronized community meetings more than the rest of the sources simply because these meetings are compulsory in the area and those who default are made to pay a fine. Television is well patronized by those households who have it and family sources of information are seriously revered in the area because of traditional solidarity and cohesion. As portrayed in table B (ii) thirty (30) of the heads of non-enrolled households who admitted having some knowledge about the scheme gave various sources as: community meeting (26.7%), Newspapers (13.3%) radio/mobile vans (26.7%), Television (26.7%) and other sources like family and friends (6.7%). When the mixed feelings and the scepticism were over-growing among the populace at the infant stage of the scheme, the scheme management resorted to frequent community meetings which no one could easily default, constant television and announcements about the scheme through mobile vans and that explains why the percentages of those two sources seem to have gone up.

In table C (i) annexure 5, whilst 73.3% of the heads of the 30 enrolled household interviewed admitted having participated directly in most of public education programmes of the scheme, 26.7% of that figure said they availed themselves only of few public education programmes of the scheme. The default was possible for them with only those programmes the attendance of which is optional. They could not default to attend community meetings, for instance, which is punishable by fine in the area. The effect of the behaviour of the defaulters is that they failed to be well-equipped with scheme features. The people who participated fully in the scheme programmes are likely to be people who have trust in the scheme and are conversant with its features. In the case of the 30 non-enrolled heads of households, only 46.7% participated in the public education programmes of the scheme in a way while as many as 53.3% decided not to do so (Table C (ii) annexure 5). They have, for various reasons, decided not to enrol and have categorically and incorrigibly distanced themselves from any programme of the scheme which is not compulsory. As result, they are not conversant with features of the scheme and gave different views on their understanding of the scheme. Some claimed they were

informed about the plan on issues like terms of payment, the treatment of admitted patients only and the fact that the scheme was for the poor. *'We are told it is about a group which if you join and pay some money; you will be treated without paying again when sick' (*Non-enrolled Male).

On the other hand, as in table D (i) annexure 5, the role of NTMHIS as instrument to increase access to health care was perfectly understood by 83.4% of heads of the 30 enrolled households interviewed and 16.6% could not perfectly understand it because they were likely to be those who failed to avail themselves of some important programmes of the scheme which might have enhanced their understanding. In terms of access to health care, they clearly understood that one did not have to sell his or her property when sick. *'It helps much since one may fall sick at the time that one does not have money' (*Enrolled female farmer).

In the case of the heads of non-enrolled household, as in table D (ii) annexure 5, only 30% of the 30 heads interviewed perfectly understood some key features of the scheme with staggering 70% of the number interviewed having apparently no knowledge of the scheme. The latter category of households are likely to consist of people who are sceptical about the scheme for various reasons, ranging from politics, bitter experience, superstition to disinterestedness and many more and have nothing to do with the scheme. One of them could, however, not prove his level of knowledge about the initiative. A member of a non-enrolled household remarked *'Paying before falling sick may amount to buying a disease.'* Others argued as to why join when they were healthy. Especially, pooling of contribution in the NTMHIS was woefully misunderstood among the non-enrolled; most of them were sceptical about the value of pooling. One young man said: *'I think that if one pays and for some time he does not fall sick, then one should be exempted the coming year'*

From indications, those who did not fall sick and not benefit from the scheme felt that there were no 'benefits' in paying membership when not sick or without a patient. However, enrolled households saw the wisdom in pooling resources together since majority of them seem to understand key features of the scheme than do those not enrolled.

'There is the need to help one another because we can never know when we will fall sick' (Enrolled Female Head). Some remarked: *'We had a lot of sensitization about the scheme; we are aware and have no problem about it. Besides, it is a good policy which demonstrates the spirit of mutualism.'* Some non-enrolled households expressed their concerns about pooling as they remarked *'We are never happy with it because it appears that benefiting goes with paying and falling sick'*. Some enrolled households expressed their views on prepayment in varied ways. They saw the wisdom in preparing for the future health needs since sale of one's property when sick does not matter here. Some remarked: *'It's okay if we pay and do not fall sick because it is tantamount to buying your life so when you become sick you can quickly get treated'*

The non-enrolled, as evidenced in table D (ii) annexure 5, appeared to have poorly understood what pooling of contributions is. Prepayment is misconstrued as inviting diseases. On the other hand, as in table D (i) annexure 5 above, duly registered households seem to be conversant with pooling and prepayment. Poor knowledge about the components of the NTMHIS among some non-enrolled and few enrolled households may emanate from their refusal to take part in some public education programmes of the scheme. If communication and sensitization campaign could not manage to convey information in an effective manner especially among some enrolled households, then it means that NTMHIS communication campaigns may not been systematically evaluated. In this case, many unanswered questions regarding the effectiveness of different sensitization messages will still remain among illiterate rural populations. Though it was pointed out by Criel and Waelkens (2003) that knowledge alone does not secure enrolment, this study suggests that knowledge remains essentially an empowering tool in maintaining high enrolment. For example, the study has clearly pointed out the misunderstanding of the benefits of the NTMHIS: people complain not benefitting from the scheme because they have been well-as if they would have wished falling sick just to benefit from the scheme. In a study on community health fund in Tanzania, the tacit findings were that 'overall education and promotion was needed to increase understanding of the benefit and management of the fund' (Chee et al. 2002).

The issue of cross-subsidization in the NTMHIS appears not to have been understood hence the insistence among few enrolled that once premium was paid they should, at all cost, benefit else they should be exempted from subsequent payments. This may partially explain why some of the enrolled households have defaulted in renewing their membership. When one lady was asked as to whether she had since renewed her membership, she remarked: *'I have never fallen sick for the past two years I have enrolled and I shall do so when I have, at least, once benefitted.*' This poor understanding of cross-subsidization among few enrolled households has the potential of causing some of them who will feel cheated, by their understanding, to quit the scheme thus causing a lot of harm not only to enrolment but also to the scheme's finances. This perception can also misinform current non-enrolled households to insist on their decision not to enrol.

However, at times, some members of staff of the scheme may not be conversant with some issues of insurance that they explain to the people through public education. A study by Sinha et al. (2005: 132) has confirmed that 'lack of clarity among scheme staff regarding the scheme rules and processes was a barrier to access to benefits by members of Self-Employed Women's Association of India'.

From the way a greater number of enrolled heads of households demonstrate their rich knowledge and understanding of the scheme there is no gainsaying that public education played a significant role in the surprising enrolment of the NTMHIS. This also confirms the assertion of the consumer theory that in insurance decision, information is vital. Although most of the non-enrolled households could not demonstrate very well their grasp of some specific features of the scheme, they appeared to have been conversant with the principles of insurance and with further boost in public education; they could rescind their decision not to enrol.

4.3.3 Are the Expectations of People who have enrolled being met in terms of Benefit package and Quality of Care?

As in chapter two of this study, the regret and disappointment theories posit that, households factor in their feelings of regret in case their decision to

remain uninsured would have been wrong, and of disappointments if the outcomes, in the form of insurance pay-offs, do not correspond to what they have expected and all these shape households' insurance decisions. The endowment theory also stresses the importance of the insurance pay-offs which strongly underlie households' insurance decisions and their effects on enrolment. A study conducted in Burkina Faso by De Allegri et al. (2006: 16) reveals that 'the ability of Nouna insurance scheme to deliver the quality improvement to its enrolled members' demand resulted in a positive externality in terms of the trust that the community grants the new initiative'. In the case of NTMHIS, quality of care demanded by the population all pertain to the behavioural realm of the scheme management and service providers-patient encounter. It includes services received from both, distance to health facility, waiting time, trust, courtesy and convenience enjoyed when registering as a member and accessing health care.

In regard to registering to become a member of the scheme, as in table (a) annexure 5, 73.3% of heads of thirty (30) enrolled households interviewed indicated their satisfaction with almost everything, whilst 26.7% of the same number interviewed complained about few skirmishes which ought to be addressed. Those satisfied were likely to be households who started early when there was not much pressure on the existing facilities of the scheme. Those not satisfied mentioned one of the skirmishes as waiting period of three months which, together with the photo-taking for cards, ends up in six months to one year before one qualifies to benefit. Scheme management has admitted the problem, promising that plans were far advanced to get those issues resolved once and for all.

In the case of access to health care, as in table (b) annexure 5, 90% of the 30 heads of enrolled households interviewed admitted that the scheme had been of tremendous help to them. One Enrolled Head of household said: *'Now, I do not have to sell my property to access health care when sick'*. They had admitted having accessed health care ranging from hospital visits (60%) hospitalization (30%) delivery, surgery to laboratory investigations (10%) as in table (c) annexure 5. The 10% who claimed not to have accessed health care, at the time, said they had not fallen sick.(Table (b), annexure 6). As can be

inferred from table (e) annexure 5, 83.3% of the heads of enrolled household interviewed accessed government established facility whilst 10% accessed health care from facilities being run by NGOs, 3.3% accessed from others likely to be privately run. The rest 3.3% did not access health care. Some explained that the change of attitude among health personnel was significant among those in the government run health institutions. They attributed this quality of care to government's vigilance with the implementation of the new insurance policy. As in table (f,) annexure 5, 93.3% of the above households indicated their satisfaction with the services received so far. The Medical Superintendent of the district hospital confirmed this when he said '*Number of both admissions and Out Patient Department attendance is appreciating which is a clear indication that health insurance has not only broken the myth surrounding access to health care, as perpetuated by out-of-pocket payments some years ago, but also established a friendly atmosphere between health staff and clients'*. However, in that same table (f), annexure 5, 6.7% of heads of the above thirty (30) enrolled household interviewed indicated that they were not satisfied with services and raised some concerns as regards differential treatment being given to people depending on their socio-economic status; drugs still being sold to them, some being arbitrarily turned away from hospital and also being made to wait for long before receiving care (ibid). Findings of a survey conducted in Burundi also came out with this same allegation from card holders of the scheme that, in spite of a 50% higher utilization among card holders, quality of service was low; drugs were frequently out of stock and they received less attention (Bogg et al. 1996:240). However, when the Medical Superintendent of the Adidome District Hospital in NTD was consulted, he vehemently debunked the allegation, labelling it as an issue of perception since no formal complaint was lodged with management. He further explained that the procedures that enrolled households go through made them to delay whilst non-enrolled who make upfront payments do not go through such procedures because they have no documents, the authenticity of which, must be established before treatment.

The Scheme Management, in response to the above concerns, has this to say:

> 'Many people think that once they have enrolled in health insurance they must be given preferential treatment over others who have not yet enrolled, which, in any case, would never help matters. The reality, on the ground, is that the service providers have data entry clerks at all service providing facilities that enter the particulars of members of health insurance which is not applicable to those not insured and this is misconstrued as preferential treatment for those uninsured to the perceived disappointment of those insured' .

From this development, it appears that some members are not conversant with the categorization of contribution levels by the scheme based on socio-economic stratification. The idea of exclusions in the benefit package of the scheme as outlined by the legislative instrument 1809 also appears to be not well understood.

On the issue of distance, almost 80% of the thirty (30) enrolled households from rural areas interviewed, as in table (g) annexure 5, said distance from their place of abode to the hospitals was not a factor to inhibit their enrolment. On the contrary, 20.9% were of the view that distance was their problem. These categories of household are likely to come from the back of beyond where there are many creeks and rivers to cross and have less access to accredited service providers (ibid). Those satisfied with distance cited the gate-keeping system as their saviour. The gate-keeping system is infant and does not cover the entire district yet. This is an initiative by the MOH which demands that people from the hinterland use the nearest health facility as their first point of call unless there is the need for referral to a bigger hospital. Besides, the Community Health Improvement Project (CHIP) where health staff visit deprived communities to offer health services and the ambulance services provided by government to some parts, are all measures put in place to solve the problem of distance and this has helped in increasing enrolment in NTMHIS.

There is, however, the need for the scheme management to accredit more service providers in the rural settings rather than depending solely upon these arrangements. Besides, communities should be deeply involved in the design of benefit packages to avoid the feelings that they are being exploited. Dror et al. (2007:889), in a study on CBHIS in India indicated that 'rural and illiterate communities can participate actively in the design of benefit package and make judicious choices'. This was supported by a similar study in Burkina

Faso by De Allegri et al. (2006: 62) which shows that 'understanding and thereafter meeting consumers' preferences can, in fact, ensure that policy-makers set compound health interventions in line with people's needs and expectations, thus maximizing community participation.'

A study conducted in DR. of Congo by Criel & Kegels (1997) reveals that the high coverage of the Bwamanda scheme emanates from its associated with a network of 23 health centres, and a clear referral policy to the hospital that patient had to first be seen at the health centres. The ambulance service in Ghana is in the right direction since this was also the same arrangement that brought success to Rwandese scheme (Schneider, 2005:1436). As early indicated in tables (b) & (f) respectively in annexure 6, the heads of enrolled households seem to have been getting value for the premium paid, deepening trust between the scheme and households and this is likely to explain why people have enrolled in the NTMHIS. There is, however, the need to deepen education to explain some of the issues in the insurance design to avoid misconstruction.

4.3.4. Trust and Enrolment

As in the literature in chapter two of this research, trust is foregone condition for the success of any insurance scheme but the mixed feelings, mistrust and different interpretations that characterized the implementation of the NTMHIS made everyone to think that the scheme was not going to survive in NTD, in particular.

Surprisingly, greater percentage of heads of enrolled households has constructed a link between their choice and the trust they have in the NTMHIS management. As many as 73.3% of heads of enrolled households counted on NTMHIS to improve health service provision as in table 1, annexure, 5. They assigned various reasons for their decision to enrol as below: *'We have trust in those people because they have given us a card to keep after registering, so no cause for alarm'* (Head, enrolled household). In the same table, however, 26.7% of heads of the number of households interviewed have opposite view about the scheme. This category of enrolled households is likely to be those who could not avail themselves of some important public education

programmes of the scheme and have failed to understand some basic principles of insurance such as renewing membership after one year and also not knowing that all ailments and drugs are not covered. Some, when turned away for not renewing or asked to pay for drugs or ailment not covered, they become offended and give all kinds of interpretations to the scheme.

They further indicated that health personnel had demonstrated beyond reasonable doubts that they were up to the task.

'Even if I should not fall sick, my money is taken to care for others in my community who have fallen sick, I am likely to gain the blessing of God' (Enrolled Male Head). As in table 2a, annexure 5, 86.7% of the thirty (30) heads of enrolled households interviewed expressed trust in the capability of health personnel. This is likely to be due to the high level of satisfaction in the form of effective drugs or care from health personnel which most of the enrolled households claimed they had enjoyed when accessing health care. But 13.3% did not on grounds of lack of adequate knowledge and understanding about some features of the scheme, health providers' hostile attitude to some clients, long waiting periods and time, and previous bad experiences with collective arrangements (ibid). As pointed out by Criel and Waelkens (2003), 'respondents may also be somewhat sceptical of the health personnel's competencies, therefore, reporting no incentive to enrol in a scheme that grants access to services they do not deem worthwhile paying for. This was confirmed when 13.3% of the number of heads of household interviewed, as in table 2a, annexure 5, shared different views on capability of both the scheme management and health personnel. Their experience with some of the staff of these establishments might be guiding them in their decision.

In another development, as in table 3a, annexure 5, regarding trust in the scheme being linked to party membership of the ruling party introducing it 93.3% of the thirty (30) heads of households interviewed vehemently debunked any link, claiming they enrolled based on the fact that the initiative is credible. They made it clear that the issue was about life and the policy was a laudable government membership of which demands no party cards as a condition. However, very few of the thirty heads (6.7%) admitted that they had enrolled simply because they were members of the party that introduced it. In

the case of the non-enrolled heads as in table 3b, 60% of the thirty heads of household interviewed constructed a link between trust for the scheme and membership of the Political Party. In their conviction, all those who have enrolled share the ideals of the ruling party introducing the scheme. This view was, however, rejected by 40% of the non-enrolled who said the scheme was a good policy especially in the face of catastrophic nature of spending on health. These households may comprise people who have reasons other than politics to remain uninsured.

Clearly, the level of trust in the scheme was further demonstrated when, in table (4)a, annexure 5, 73.3% of the thirty (30) heads of household interviewed strongly disagreed with the view that workability of the scheme was questionable. *'Government,(Scheme Management) having been serious with the implementation of the policy has absolutely changed the hitherto hostile attitude, work ethic and corrupt practices among health workers for the better and that is what attracted me to enrol'(* An Enrolled community Leader).

However, as one 50year Enrolled Head of Household put it*: 'I personally see the scheme as a saviour because the traditional networks in the past that made it compulsory for relatives to ensure that they mobilize resources to cater for any sick member of the family no longer hold of late.'*

Schneider and Diop, 2001 cited in Schneider (2004:354) also disclosed that 'depletion of social networks due to widespread poverty could be one reason that motivates households to insure'. It stands to reason, therefore, that party colour, in reality, is no major reason for enrolment in NTMHIS.

It is crystal clear, from the study, that scepticism, as being demonstrated by especially some enrolled and non-enrolled households, is likely to be a barrier to enrolment. As in table 4a, annexure 5, as many as 26.7% of heads of the thirty (30) enrolled households interviewed were sceptical about the workability of the scheme in spite of the fact that they had enrolled and this, as supported by 63.3% of heads of the thirty (30) non-enrolled households, as in table 4b, annexure 5, could be detrimental to the survival of the scheme. The former were of the view that their past experience with collective arrangements keeps on haunting them. The latter still attributed

their scepticism to the fact that the scheme was a political opportunity created for few party activists to become well-off as has been the perception from the infant stage of the scheme. However, the view of the majority, as in table 4a, annexure 6, was supported by 36.7% of those households who have not yet enrolled as in table 4b, annexure 5. This category of non-enrolled households is likely to be those who are cash-trapped and can genuinely not pay to enrol.

On the issue of ability of scheme management being able to change the hostile attitude of some service providers as in table 5 a, annexure 5, 76.7% expressed no doubts about the capability of the scheme management to do so. Their trust was premised on the fact that government had already gone ahead to put mechanisms such as patients' charter and suggestions boxes at vantage points in all government-run health facilities to check misconduct of health personnel on grounds of anonymity. But if these are the measures in only government-run facilities, what of those facilities being run by the private sector some of which are accredited by the scheme? This lapse may, however, vindicate 23.3% of the same number of heads of households, in table 5a annexure 5, who doubted ability of scheme management to change the hostile attitude of service providers, answered in the negative. *'The insurance management promised that they would ensure that the doctors and nurses treat enrolled members well and fast… but they (providers) remain sceptical…the insurance alone cannot change their behaviour.'* (Non-enrolled Head).

'Some heads of enrolled households have demonstrated their trust in the scheme through the different interpretations they have given it. Most heads of enrolled households seem to understand pooling very well and strongly disagreed that membership of the scheme was based on party colours which could be easily hijacked by few. It must be pointed out that continuous scepticism or lack of trust among especially some few enrolled households may be very dangerous to the survival of the scheme in different ways:

Firstly, it may encourage some non-enrol households to still hold on to their position and remain uninsured. Secondly, some of the enrolled households who may feel cheated for not benefitting may back out from the

scheme. Thirdly, Scheme management is likely to invest more resources in public education more than normally expected just to dispel rumours.

In a different vein, this scepticism is likely to put management and providers on their toes to give of their best to promote the scheme and in so doing build trust among stakeholders.

Schneider (2004:352) defines 'trust as the expectation that arises among citizens of regular, honest and cooperative behaviour, based on commonly shared ethical norms and values, including reliability, loyalty and solidarity'. Schneider further looks at 'trust in insurance from three dimensions: First, patients' trust in providers, which is based on their previous experience with providers' ability to diagnose and treat illness and to act in patients' interest. Secondly, trust in insurers, based on the insurers' reputation of improving access to care. Thirdly, trust generated by the control mechanism for legal enforcement of commitments like contracts'. He concludes that 'insurers can build a reputation of trustworthiness by demonstrating expertise, responsiveness to consumers, and by ensuring quality of care in contracting health facilities'.

Trust among key players featured prominently to have explained why people enrolled in NTMHIS hence high enrolment.

4.4 Demand Factors:

4.4.1. Poverty/ Income Level and Enrolment.

The consumer and the state-dependent theories emphasize household's income and socio-economic status respectively as important factors in household insurance decisions and their implications for enrolment.

Berner (2008) defines poverty as a 'human condition that reflects failures in many dimensions of human life-hunger, unemployment, homelessness, illness, powerlessness, victimization and social injustice'. Poverty is not just an analytical category but a normative concept so its measurement defines what is being done about it (ibid). There is, therefore, income poverty when there is failure to attain a minimal living standard/ Level of consumption, usually in

relation to a shopping basket, low quality of other assets such as shelter, clothing, furniture and unsatisfied basic needs like not having cash to pay for health insurance in order to have access to quality of care for good health.

By these standards, some category of households in NTD is poor and this affects their income level seriously. This widespread poverty among some category of households is characterized by low quality employment opportunities in NTD for that matter Ghana. Out of 177 countries listed in the Human Development Index, Ghana rates 131. The per capita income of Ghana is about US$380. According to the Ghana living Standards Survey, lack of job opportunities and income generation make almost 40% of the population to live below the poverty line in 1989/99 (ILO, 2005). According to the GDHS (2003: 36), employment status of both men and women indicates that 0.5% of women within the age group of 45-49 are not working and 1.4% of their male counterparts of the same age group are also not working. This development is a true situation in NTD and may influence households' ability to purchase their health needs.

It is, however, interesting to note that poverty has presented two different pictures when it comes to household insurance decisions in NTD. As shown in table 4a, annexure 6, 70% of heads of thirty (30) households interviewed said they had decided to enrol based on the understanding that they were poor and could not afford any catastrophic health expenditure due to 'cash and carry,' These households are being risk averse as pointed out by especially expected utility and endowment theories. Others gave good health policy and preparation against sickness in the future as reasons for enrolling. *'We have enrolled because we are poor and need the help of others to defray our health costs'* (Male Enrolee). . Schneider (2004: 352) has confirmed that 'households who are likely to have credit constraints in the future may be more willing to sacrifice current income and insure in order to have less risk in the future'. In a different vein, as in table 4b, annexure 6, 66.7% of heads of thirty (30) non-enrolled households attributed their inability to enrol to poverty. They explained that the premium rate per se posed not much problem but the fiscal cash with which to pay and renew when it expires. In the same table, 20% of heads of households said the premium rate, even when reduced further, would not

enable them to enrol and their reason was that, since no reliable source of market exists for the their farm produce, there would be no guarantee that after the first payment they could renew. So what is the fate of these households who cannot genuinely pay to enrol? Other reasons for non-enrolment, as in the same table, include disinterestedness (6.7%), poor service management and lack of adequate information 3.3% respectively. In table 4c, annexure 6, it was evidenced that 20.0% of those households which have managed to enrol based on the understanding that they were poor are now unable to renew their membership after the expiration of their first premium. However, 80.0%, in that same table, had admitted renewing theirs. The poor households that have enrolled and are able to maintain their membership may have some family networks that might have assisted them to enrol or they might have adjusted their household budget to cater for their health needs which they considered crucial but are now unable to raise resources to renew. In table 4d, annexure 6, 50.0% of the number which could not renew attributed their inability to do so to lack of money and others,(33.4%) said they were ignorant about it which is likely to stem from their deliberate decision not to avail themselves of important public education programmes of the scheme. About 17% of the number claimed they had intentionally refused to do so because they had, ever since enrolled, not benefitted and this is a clear evidence of lack of understanding of pooling and cross-subsidization which are important features of insurance. This phenomenon is also traceable to lack of knowledge about scheme features resulting from non-participation or cheer negligence. These findings of poverty preventing households from enrolling are contrary to the ones in Nouna District of Burkina Faso and Maliando scheme in Guinea Conackry where poverty per se was not the most outstanding obstacle. Other behavioural constraints may cause some households to remain uninsured even when they might be better off with insurance. (De Allegri et al. 2006, Criel et al. 2003).

There is a clear message from the foregoing development that government of Ghana is likely to be pressurized to modify the proportion of residents she considers indigent. Poverty/income level features prominently as a reason for enrolment of some poor households but cause of the inability of

some poor households to enrol in the NTMHIS, hence the exclusion of some category of households. Here, differences in households' scales of preference are likely to explain households' choices regarding their health decisions.

4.4.2 Power Relations within the Household and Decision to Enrol.

As in the literature and analytical framework in chapter two of this study, social structure has positioned one gender, especially women to be subservient to the other. This often influences how women are viewed in various ways in society. Undoubtedly, this affects how they are seen as autonomous individuals or dependents of men. Women's entitlement to a benefit like insurance is often linked, not to them (Women) themselves in their own right but, to their relationship to men and this increases the power of men over their female counterparts. (Pearson, 1992: 301).

'Following Weber's classical definition, Berner (1998: 7) defines power as the capability of imposing ones will onto others. It is actually a relational concept which means that a person can be powerful in one situation (A patriarch in his family) and powerless in another (In his workplace)' 'All relations within a society can be seen as power relations, resulting in a specific hierarchy' (ibid). Relating this to the household in any traditional set up in Africa, it is the man who wields power and controls not only decision but also resources in the household. Hence, any decision to enrol or not in health insurance must receive authorization from the man and this affects enrolment.

The foregoing assertion is supported by a study by Buor (2004: 152) in Ghana on women's access and utilization of health services. In this study, it was revealed that 'in typical rural areas, women were supposed to be subservient to men who dominate decision-making'. Bour further argues that 'among some of those in which the agrarian occupation is predominant, the man takes custody of the income from farm proceeds. In the case of women in petty trading and other income-generating activities, men still have access to women's financial resources (ibid). Buor concluded that the ability of women to make health decisions and purchase health resource was dependent on the man, coupled with the generally low incomes in Ghana,(the percentage of

population below the national poverty line being 31.4% for the rural population (World Bank, 2000: p 62 cited in Buor, 2004: 152).

However, as in table P (i), annexure 6, 86.7% of thirty (30) heads of enrolled household interviewed denied having any power play within their households especially when it comes to health decisions. Their argument was grounded on the understanding that health is not only about life but also wealth. From indications, there is likely to be some degree of freedom to make decisions within the household and women are likely to take advantage of especially the one bothering on health. On the contrary, in that same table (p (i), 13.3% heads of households admitted that some degree of power play exists which was a clear indication that the decision to pick up the insurance was not an easy one. Even in the non-enrolled households, power play within the household appears not to be a reason for non- enrolment. This is so because, as in table P (ii), annexure 6, 76.7% of the thirty non-enrolled household heads interviewed denied having any power play within the household whilst 23.3% of the number admitted having it. The lack of dominance of power play within the households is likely to result from the positive impact the gender awareness programmes being carried out by some NGOs in the district has made.

On the issue of force, as in table P (iii), annexure 6, 80% of heads of the thirty (30) enrolled household interviewed said they were not compelled to enrol whilst 20% of the figure, mainly representing some formal sector workers, pensioners and indigents said they enrolled because they had no choice since their enrolment in the scheme was automatic. The indigents, in particular, were identified and hooked up to the scheme. The decision by that great number of 80% of enrolled households with choice, as in table P (iii), annexure, 7, to enrol demonstrates their level of trust in the scheme as a facility to offer solution to their myriad of health problems. The element of force could not feature prominently to explain reasons for enrolment or not. As in table P (IV), annexure 6, even 73.3% of the heads of non-enrolled household did not state force as their reason for remaining uninsured. They gave several other reasons ranging from poverty, political affiliation, and good health status to experience for remaining uninsured. But 26.7% of the same number

attributed their reason for non-enrolment to force likely to be circumstances beyond their control (ibid).

Absence of power play within the household resurfaced when as many as 80% of the heads of the thirty (30) enrolled households interviewed as in table P(v), annexure 6, admitted involving their spouses in decisions concerning health supported by 70% of heads of the same figure of the non-enrolled interviewed as shown in table P(vi). This demonstrates balanced power relations within the households in NTD which might have contributed significantly to the high enrolment. However, 20% of the heads of enrolled household as in table P (v) annexure 6, and 30% of thirty heads of non-enrolled household all claimed that they had not been involving their spouses in health decisions within the households. These households are likely to be typical patriarchal households where decisions affecting the entire household are made by a single individual. About 84% of thirty (30) heads of enrolled and 63.3% of non-enrolled households respectively as in table P(ii) &P(iii), annexure 6, indicated that spousal presence or absence could not affect their decisions to enrol or not. This was confirmed by the field report, which, at one point, revealed that some women, in particular, who became heads of household either as a result of death, divorce, travels or irresponsibility stemming from drunkenness of husbands had proved worthy to the tasks and enrolled.

From indications, some women have enrolled based on the understanding that the traditional role of care-giving for children and sick members of the household is bestowed upon them as women. Bogg et al (1996:240) confirmed this in a study conducted in Burundi that 'women interviewed thought that the health card was good for poor families, for families with seasonal income and for women with husbands who drink.' *'The responsibility was bestowed upon us by unforeseen circumstances and we have also accepted it in good faith (*One Enrolled widow remarked.). Chankova et al (2008:272) also found strong evidence that 'households headed by women are more likely to be enrolled than those headed by men and this reflects the traditional roles of women as the main caregivers of the family since they may be more likely to

internalize the cost and consequences associated with health care than their male counterparts.'

However, in a different vein, 16.7% of the heads of some enrolled households in table P (vii) interviewed were affected by the absence of their spouses as they claimed to have been overwhelmed with pressing responsibilities such as feeding, school fees and uniforms for the children. In the case of non-enrolled households as shown in table P (viii), 36.7% claimed they saw no wisdom in enrolling since they had never fallen sick before and more so they had no wives and children.

As in table P (ix), annexure 6, 50% of the number of heads of enrolled households interviewed who are women indicated that they were even motivated by their husbands whilst 26.6% of heads who were men said they were motivated by their wives and 23.4% by themselves. The motivation from husbands and women became absolutely necessary as a result of the increasing reproductive problems such as high infant, child and maternal mortality rates which are worrisome in the district for that matter Ghana (.Table 3.1). The motivation from wives to their spouses may be to make men more responsible when it comes to health decision-making, in particular. This also demonstrates that there is little power play within some households since the spouses appear to be involving each other in decisions concerning the enrolment in the NTMHIS.

Table 2:
District Hospital Records on Frequency of visits to the Hospital by Insurance Status from January-December, 2007.

Insured Patients-Jan.-Dec. 2007				Non- Insured Patients- Jan-Dec.2007			
NEW MALE	New Female	Old Male	Old Female	New Male	New Female	Old Male	Old Female
975	1687	1347	2628	2016	4034	501	2207

Source: Adidome District Hospital, 2008.

From the data, 'new' indicates those who accessed health care for the first time whilst 'old' means those who do so more than once. No data could, however, be traced for December 2005 and the whole of 2006.

It is also evident from the table, 4.1 that women, whether enrolled or not, had accessed health care more than their male counterparts. Surprisingly, even insurance coverage does not, in any way, deter women in NTD from accessing health care.

From indications, households see the scheme as a facility that could protect them against catastrophic health expenditures hence increase in enrolment. Women's patronage of the scheme is likely to be due to the weak public health system which denied them their reproductive needs for long. Government of Ghana's creation of some gender-sensitive institutions such as Ministry of Women and Children's Affair, National Council on Women and Development (Now Department of women) and efforts of an NGO called the 31ST December Women's Movement which championed the cause of women for the past decade or two ago may have enhanced awareness levels of women. Besides, adult literacy programme and girl child education policy may have given voice to women hence their realization to be deeply involved in decisions that affect their lives and health decision is no exception.

From the study, households' preferences for health insurance in NTD appear to have emanated from their realization that 'cash and carry' prevents access to health care. Superstition was also seen to have explained why few households remain uninsured. This is a serious hurdle for the scheme's public education machinery to surmount.

Chapter 5
Summary of Findings, Conclusions and Policy Implications

This study has reviewed literature that addresses the variables indicated in the research questions and also in the analytical framework, by using theories such as consumer and decision-making under uncertainty to understand factors that explain households' insurance decisions in NTD. Arguably, liquidity and behavioural constraints were identified to have caused some people in NTD not to enrol even when they might be better off with insurance. This explains why simply offering health insurance to people in low income settings may not be a foregone solution to access to health care.

The following findings and conclusions have been drawn and the policy implications offered:

5.1 The Findings are that:

- High enrolment in the scheme in NTD is due to the fact that, formal sector workers and few farmers who have diversified. into rearing of cattle and some domestic animals find no difficulty in paying the premium;
- Considering the amount of money that some non-enrolled households pay for a single medical event and women for delivery care, it can be argued that there is no justification that the premium is too high as expressed by some households,
- Premium rate favours larger families as no limit to family size as per premium,
- Empirical evidence suggests that information gap and poor understanding of the scheme could not negatively affect the enrolment so much,
- Poverty/low income level is a contributory factor to both enrolment and non-enrolment in NTMHIS,
- MHIS thrives on households pooling resources across communities and trust in the scheme management because of access to health

care is a sine qua non for enrolment and information plays a vital role,

- Hostile attitude of some health staff and past experiences with collective arrangements have significantly contributed to scepticism,
- Households' preferences for health insurance in NTD emanate from catastrophic health care expenditures,
- Spousal involvement in decision-making plays a major role in enrolment level in NTMHIS.

5.2 Conclusions:

- In NTD, enrolled households seem to have trust in both scheme management and health personnel and this positively affected enrolment;
- One major determinant of households' insurance decision in NTD, the study ascertains, is insurance pay-offs in the form of benefit package and quality of care,
- Poverty/low income level featured prominently as one major factor that both promoted and prevented some households to enrol or from enrolling,
- Premium categorization that brings it within the reach of majority and government's indigent policy, could not eliminate the canker of social exclusion in NTMHIS,
- That refusal of some enrolled and all non-enrolled households to participate in important sensitization programmes of the scheme is one major cause of scepticism among them,
- In the researcher's opinion, findings of this study have demonstrated that health decisions of some households in NTD go beyond political, monetary and experiential considerations because some households, in spite of over-politicization, bitter experiences with collective arrangements in the past and poverty/low income levels, still went ahead and enrolled in the NTMHIS in their numbers.

5.3 Policy Implications:

The scheme management has to critically evaluate its sensitization programmes to rectify some of the misconceptions highlighted in this study.

Scheme management should also endeavour to minimize bureaucracy in the process of registration. For example the number of cameras in each community for photo identification cards should be increased to avoid queuing.

Service providers should be given adequate training to demonstrate high level of professionalism in handling clients.

Besides, government should not only modify the relief package for the core poor but also ensure that those who have still been excluded due to lack of cash to pay do so in kind, by using their farm produce.

NTMHIS must, henceforth, tailor its marketing strategies to cater for those with less or no education.

Government should consider focusing on preventive health to avoid possible premium increase in future.

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ANNEXES

ANNEXURE 1

SECTION A

SEMI- STRUCTURED INTERVIEW WITH ENROLLED MEMBERS OF THE NORTH TONGU MUTUAL HEALTH INSURANCE SCHEME

1) Have you ever heard of the North Tongu Mutual Health Insurance Scheme?

   a) Yes b) No.

2) If yes, from which source? (Give source)
3) Are you/ your family covered by it?
4) Who makes the decision to enrol within your household? (Both couple, Husband, Wife, other.)
5) Does the benefit package of the scheme meet your expectation? In what ways? (Mention).
6) Why did you enrol in the scheme? (Give reasons)
7) Please, have you ever accessed health care since enrolling in the scheme? a) Yes b) No
8) If yes, what kinds of health care have you since accessed?

a) Hospital visit b) Hospitalization c) Laboratory services d) Delivery e) Surgery f) Others.

9) What type of facility is it (Primary, Secondary, tertiary, traditional, Pharmacy)?

10) Who operates it (Government, other organizations, private business, and private practitioner?)

11) Has the scheme improved health service provision for you? Yes No and how? (Give Reasons)

12) So, can you say your expectations been met when accessing health care? a) Yes b) No

13) How would you rate the services rendered to you a) Satisfactory b) Moderate c) Unsatisfactory.

14) Were you made to pay any money? a) Yes b) No

15) If yes, has any reason be given, if yes (State)

16) You were afraid that the scheme would be an opportunity for few people to amass wealth. a) Strongly agreed b) agreed c) strongly disagreed d) disagreed.

17 So, in principle, do you trust the scheme? Yes No. Why? (Give reasons)

18) You enrolled in the scheme because you are sympathetic to the ideals of the ruling government introducing it. a) Strongly agreed b) agreed c) strongly disagreed d) disagreed.

19) The premium is so high that people find it difficult to pay to enrol. a) Strongly agreed b) agreed c) strongly disagreed d) disagreed.

20) Most people do not know much about the scheme in North Tongu. a) Strongly agreed b) agreed c) strongly disagreed d) disagreed.

21) Were you forced to enrol? Yes No If, Yes, who?

22) Who motivates you to enrol? a) Husband b) Wife c) Self d) others.

23) Any power play within the household when it comes to health decisions? a) Yes b) No

24) Does your spouse involve you in crucial decisions affecting the household?

25) Does the absence or presence of a spouse within your household affect your decision to enrol? Yes No.

26) If yes, in what ways has it affected you?(Explain)

27). Will premium increase, in any way, affect your continuous membership? Yes No

28) If yes, in what ways will it affect you? (Explain)

29) If no, why? (Explain)

30) Did you face any difficulties when enrolling? Yes No.

31) What kinds of difficulties? (Mention)

32) Have you since renewed your membership? Yes No. If no, (Give reasons.).

SECTION B

SEMI-STRUCTURED INTERVIEW WITH NON-ENROLLED MEMBERS.

1. Have you heard about the North Tongu Mutual Health Insurance Scheme? a) Yes b) No.

2. If yes, do you have some here? a) Yes b) No

3. If yes, then what is it? (Mention all you have been told about it).

4Who within your household makes decisions regarding demand for health? (State)

5. Have you participated in any of their public education programmes? a) Yes b) No.

6 What are some of them? (State)

7 Do you really understand some features of the scheme? E.g. pooling of resources, benefit package, quality of care, cross-subsidization etc? Yes No.

8. If yes, what are some of the reasons for not enrolling? (Tick all that apply):

a) High premium;

b) Not interested

c) Low income level/Poverty.

d) Not member of the party introducing it

e) Service poorly managed.

f) Poor public education,

g) Poor interpersonal relationship of service providers

i) Mistrust for politicians

j) I am an illiterate

k) I am a healthy person.

l) Health system not the best.

M) Experiences of even those enrolled not the best

o) Because of my spouse's refusal

9) Should premium be reduced, will enrol? Yes No.

10) If yes, why? (Give reasons)

11) If no, why? (Give reasons)

12) Does the absence of a spouse within your household influence your decision not to enrol? Yes No

13) If yes, in what ways does it affect it?

14) If no, why does it not affect you? (Give reasons)

15). In general, how satisfied are you with the way health care runs in your District/Country? a) Very satisfied b) Fairly satisfied c) Neither satisfied nor dissatisfied d) Fairly dissatisfied e) Very dissatisfied.

16) In your estimation, can the scheme management effect any change in the health personnel to your satisfaction? Yes No.

16). Have you yourself or any of your dependents ever been to hospital since the scheme was introduced? a) Yes b) No

17). If yes, what kinds of health care did you/ they receive?

a) Hospital Visit b) Hospitalization c) Laboratory services d) Delivery e) Surgery f) others.

18). Before receiving service, did you pay upfront? a) Yes b) No.

19.) If yes, how did you feel seeing others issue just a card and allowed to go home? (State).

20). If given the opportunity, would you register for the scheme? a) Yes b) No

21) If yes, why? (Give reasons)

22) If no, why? (Give reasons)

BACKGROUND CHARACTERISTICS OF RESPONDENTS

Age…….

Sex…….

Marital Status…….

Position in Household……

Religious affiliation…….

Community…….

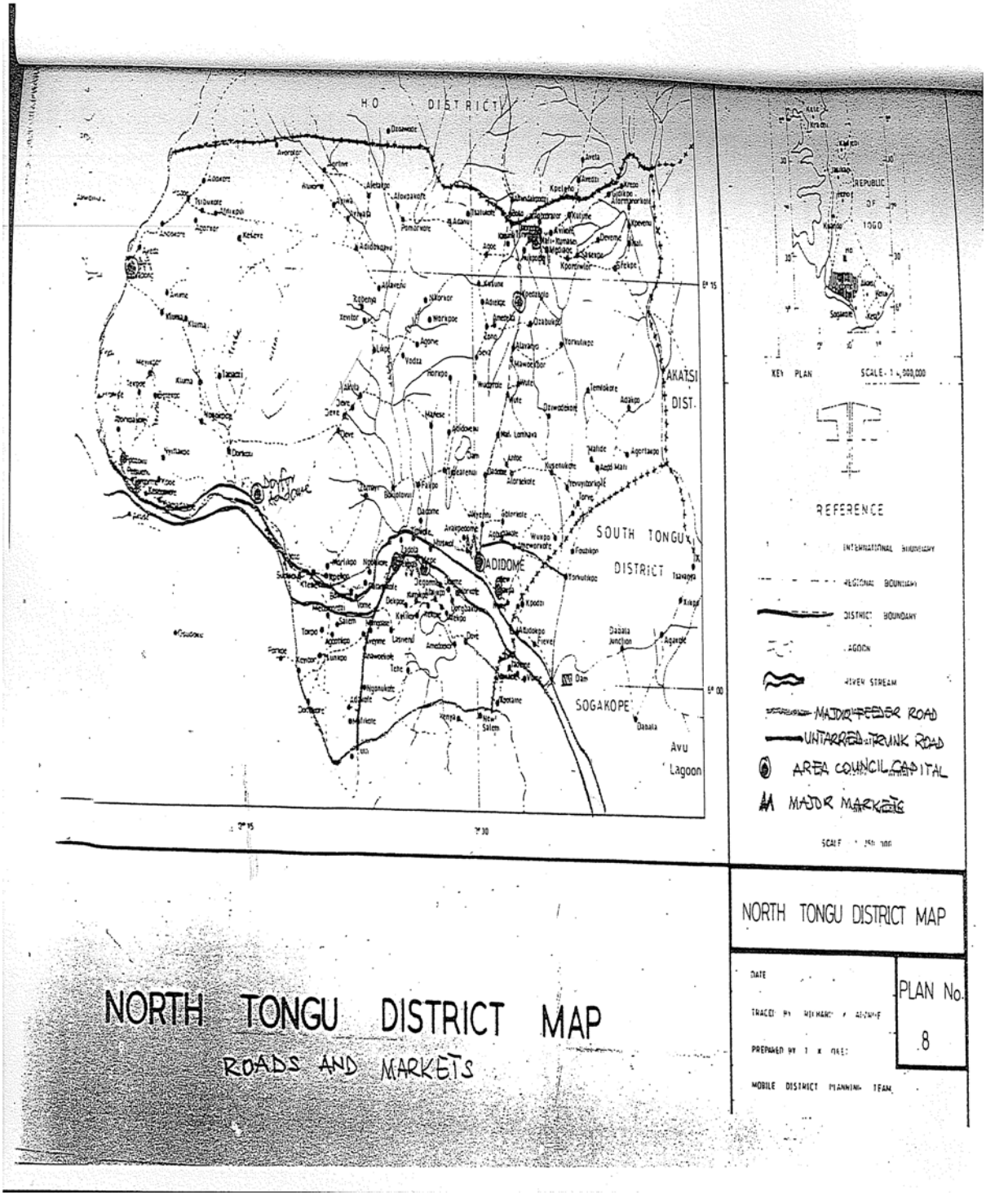
Occupation…….

SECTION C

INTERVIEW WITH KEY INFORMANTS (District Scheme Manager, Medical Superintendent of the District Hospital):

INTERVIEW GUIDE

1. Knowledge of the Scheme; (What do people know about the scheme it-self- premium, trust, duration of premium and benefits)
2. Perception of education on the scheme,(Programmes held, areas cov-ered so far and sustainability)
3. Power relations within the households.
4. Poverty/Income Level..
5. Quality of Services (Waiting time, trust, distance to facility, courtesy, convenience)



NORTH TONGU DISTRICT MAP

ROADS AND MARKETS

NORTH TONGU DISTRICT MAP

DATE

TRACED BY

PREPARED BY

MOBILE DISTRICT PLANNING TEAM

PLAN No. 8

ANNEXURE 2a
TOP TEN CAUSES OF HOSPITAL ATTENDANCE, IN NORTH TONGU FOR 2005, 2006& 2007

Table 3.2

	2005			2006			2007		
Rank.	Disease	Attd	%	Disease	Attd	%	Disease	Attd	%
1	Malaria	3440	32.5	Malaria	5070	40.0	Malaria	5550	45.1
2	Accident	544	5.2	ARI	699	5.5	ARI	1124	9.1
3	Hypertension	532	5.0	Hypertension	447	3.5	Home Accident	455	3.7
4	Anaemia	485	4.5	Accident	445	3.5	Rheumatism	380	3.1
5	URTI	460	4.3	Anaemia	427	3.3			
6	Pregnancy Relate Complications	427	4.0	Diarrhoea	398	3.1	Skin Disease	304	2.4
7	Diarrhoea	312	2.9	Pneumonia	398	3.1	Hypertension	258	2.1
8	Pneumonia	283	2.6	Pregnancy Related complication	308	2.4	Pregnancy Related Complications	253	2.0
9	Rheumatism	283	2.6	Skin Disease	278	2.1	Pneumonia	239	1.9
10	Intestinal Worms	184	1.7	Rheumatism.	238	1.8	Anaemia	236	1.9

Source: Adidome District Hospital, 2008.

Notes: Malaria in 2007 comprises malaria in pregnancy.

ANNEXURE 2b
TOP TEN CAUSES OF ADMISSION IN 2005, 2006, & 2007

Table 3.3

	2005			2006			2007		
Rank	Disease	Attd.	%	Disease	Attd.	%	Disease	Attd.	%
1	Malaria	753	34.1	Malaria	1103	43.7	Malaria	863	32.0
2	Anaemia	218	9.8	Anaemia	236	9.3	Malaria Cerebral	288	10.6
3	Pneumonia	123	5.5	Pneumonia	146	5.7			
4	Diarrhoea	110	4.9	Diarrhoea	132	5.2	Pneumonia	79	2.9
5	Hypertension	96	4.3	Abortion	92	3.6	Abortion	101	3.7
6	Preg.Rel.Com.	92	4.1	Tuberculosis.	76	3.0	Delivering Spontaneous	53	1.9
7	Accident	86	3.8	Hypertension	76	3.0	Hypertension	45	1.6
8	Tuberculosis.	67	3.0	Cellulites.	65	2.5	Anaemia	39	1.4
9	Gastroenteritis.	55	2.4	Gastroenteritis	52	2.0	Snake Bite	33	1.2
10	Snake Bite.	31	0.4	Hernia.	40	1.5			

Source: Adidome District Hospital, 2008

Notes: Malaria in 2007 comprises malaria in pregnancy.
Abortion includes abortion threatened.

ANNEXURE 3
Background Characteristics of Respondents

Table 4.1

ENROLLED **NON-ENROLLED**

Characteristics	Modalities	Percentage	Modalities	Percentage
Age	30-39	16.7	30-39	16.7
	40-49	20.0	40-49	36.7
	50-59	33.3	50-59	33.7
	60-69	6.7	60-69	10.0
	70-79	16.7	70-79	3.3
	80-89 and above	6.7	80-89 and above	-
		100.0		100.0
Sex	Male	50.0	Male	50.0
	Female	50.0	Female	50.0
		100.0		100.0
Religion	Christianity	53.3	Christianity	63.3
	Islam	23.3	Islam	20.0
	Traditional Religions	23.3	Traditional Religions	16.7
		100.0		100.0
Marital Status	Married	43.3	Married	40.0
	Never Married	6.7	Never Married	33.3
	Widowed	36.7	Widowed	16.7
	Grass Widowed	13.3	Grass Widowed	10.0
		100.0		100.0
Community	Adidome	26.7	Adidome	23.3
	Bakpa New Town	26.7	Bakpa New Town	23.3
	Mafi-Kumase	23.3	Mafi-Kumase	26.7
	Bakpa Avedo	23.3	Bakpa Avedo	26.7
		100.0		100.0
Occupation	Farming	23.3	Farming	50.0
	Trading	20.0	Trading	20.0
	Teaching	20.0	Teaching	-
	Artisanry	6.7	Artisanry	20.0
	Retired/Pensioners	6.7	Retired/Pensioners	
	Other Public Sectors.	23.3	Others	10.0
		100.0		100.0

Fieldwork, 2008

ANNEXURE 4
Some Institutional Care Indicators at the District Hospital in North Tongu for 2005, 2006, &2007.

No	INSTITUTIONAL CARE INDICATOR	2005	2006	2007 TARGET	2007 ACTUAL
1	Out Patient Department Attendance	12120	15947	16000	15395
2	No. of Admission	2206	2520	2750	2694
3	No. of Discharges	1992	2328	2500	2316
4	Bed Occupancy Rate	22.2%	23.9%	30%	26.7%
5	Average Length of stay days	4.9	4.5	4.3	5.1
6	No. of Deliveries	183	432	450	438
7	No. Major Surgical Operations.	59	127	150	111
8	Deaths	67	90	70	93
9	Deliveries of Caesarean	27	87	75	78
10	No. of Laboratory Investigations	19432	19633	20000	12339

Adidome District Hospital, 2008.

ANNEXURE 5

Voices of the Heads of Household from the Field on Supply Factors on Decision to Enrol or Not in Health Insurance Scheme.

i) Premium too High:

Table (ia)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLYAGREED	4	13.3
STRONGLY DISAGREED	26	86.7

Source, Fieldwork, 2008

Table (ib)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	7	23.3
STRONGLY DISAGREED	21	70.0

NEITHER OF THE TWO.	2	6.7

Source, Fieldwork, 2008

ii) Reasons for Non-Enrolment.

Table (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
HIGH PREMIUM	6	20.0
POVERTY/LOW INCOME LEVEL	20	66.7
DISINTERESTEDNESS	2	6.7
NOT WELL-INFORMED ABOUT SCHEME	1	3.3
SERVICES POORLY MANAGED.	1	3.3

Source, Fieldwork, 2008

iii) High Upfront Payment when accessing Care?

Table (iiia)

ENROLLED HOUSEHOLDS

.

CATEGORY	FREQUENCY	PERCENTAGE
YES	6	20.0
NO	24	80.0

Source, Fieldwork, 2008

Table (iiib)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	29	95.5
NO	1	4.5

Source, Fieldwork, 2008

PUBLIC EDUCATION/KNOWLEDGE AND ENROLMENT:

i) Some Knowledge about the Scheme.

Table A (i)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	30	100.0
STRONGLY DISAGREED	NIL.	00.0

Source, Fieldwork, 2008

Table A (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	20	66.7
STRONGLY DISAGREED.	9	30.0
None	1	3.3

Source, Fieldwork, 2008

ii) Sources of Knowledge about the Scheme:

Table B (i)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
COMMUNITY MEETINGS	17	56.7
NEWSPAPERS.	3	10.0
ANNOUNCEMENTS (RADIO &MOBILE VANS.	2	6.7
TELEVISION	3	10.0
OTHER SOURCES.	5	16.6

Source, Fieldwork, 2008

Table B (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE.
COMMUNITY MEETINGS	8	26.7
NEWSPAPERS	4	13.3
ANNOUNCEMENTS(RADIO &MOBILE VANS	8	26.7
TELEVISION.	8	26.7

OTHER SOURCES.	2	6.7
TOTAL INTERVIEWED.	30	100.00

Source, Fieldwork, 2008

ii) Participation in Sensitization Programme:

Table C (i)

ENROLLED HOUSEHOLDS

.

CATEGORY	FREQUENCY	PERCENTAGE
YES	22	73.3
NO	8	26.7

Source, Fieldwork, 2008

Table C (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	14	46.7
NO	16	53.3

Source, Fieldwork, 2008

iv) Level of Understanding of Key Features of the Scheme.

Table D (i)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
HIGH	25	83.4
LOW	5	16.6

Source, Fieldwork, 2008

Table D (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
HIGH	9	30.0
LOW	21	70.0

Source, Fieldwork, 2008

EXPECTATIONS OF ENROLLED HOUSEHOLDS IN TERMS OF BENEFITS & QUALITY OF SERVICE:

a) Registration with the Scheme:

Table a

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
SATISFIED	22	73.3
NOT SATISFIED.	8	26.7

Source, Fieldwork, 2008

b) Health Care access.

Table b

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	27	90.0
NO	3	10.0

Source, Fieldwork, 2008

c) Kinds of Health Care accessed:

Table c

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
HOSPITALVISITS	18	60.0
HOSPITALIZATION	9	30.0
OTHERS	3	10.0

Source, Fieldwork, 2008

d) Types of Facility accessed.

Table d

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
PRIMARY	22	73.3
SECONDARY	5	16.7
NONE	3	10.0

Source, Fieldwork, 2008

e) Who operates Facility?

Table e

ENROLLED HOUSEHOLDS

.

CATEGORY	FREQUENCY	PERCENTAGE
GOVT.	25	92.6
NGOs	1	3.7
OTHERS.	1	3.7

Source, Fieldwork, 2008

f) Service Ratings of Service Providers.

Table f

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
SATISFACTORY	28	93.3
NOT SATISFACTORY	2	6.7

Source, Fieldwork, 2008

g) Distance to Service Providers:

Table g

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
SATISFIED	24	79.9
NOT SATISFIED	6	20.1

Source, Fieldwork, 2008

TRUST & ENROLMENT:

a) Improvement in Health Service Provision:

Table 1

ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
YES	22	73.3
NO	8	26.7

Source: Fieldwork, 2008.

b) Trust in Capability of both Scheme Management and Health Personnel:

Table 2 a

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
SATISFIED	26	86.7
NOT SATISFIED	4	13.3

Source: Fieldwork, 2008

Table 2 b

NON-ENROLLED HOUSEHOLD.

CATEGORY	FREQUENCY	PERCENTAGE
SATISFIED	8	26.7
NOT SATISFIED	22	73.3

Source: Fieldwork, 2008

c) Member of Party in Government as reason for Trust.

Table 3a

ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	2	6.7
STRONGLY DISAGREED	28	93.3

Source: Fieldwork, 2008

Table 3b

NON-ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	18	60.0
STRONGLY DISAGREED	12	40.0

Source: Fieldwork, 2008

d) Fear about the Workability of Scheme.

Table 4 a

ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	8	26.7
STRONGLYDISAGREED	22	73.3

Source: Fieldwork, 2008

Table 4 b

NON-ENROLLED HOSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
STRONGLY AGREED	11	36.7
STRONGLY DISAGREED	19	63.3

Source: Fieldwork, 2008

e) Doubts about Ability of Scheme Management to change Hostile Attitude of some Service Provider.

Table 5 a

ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
YES	7	25.9
NO	20	74.1

Source: Fieldwork, 2008

Table 5 b

NON-ENROLLED HOUSEHOLD

CATEGORY	FREQUENCY	PERCENTAGE
YES	22	73.3
NO	8	26.7

Source: Fieldwork, 2008

ANNEXURE 6

Voices of Heads of Household from the Field on Demand Factors on Decision to Enrol or Not in Health Insurance Scheme.

POVERTY/ LOW INCOME LEVEL & ENROLMENT:

a) Reasons for Enrolment.

Table 4a

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
POVERTY/LOW INCOME LEVEL	21	70.0
GOOD GOVERNMENT POLICY	6	20.0
OTHERS	3	10.0

Source: Fieldwork, 2008

b) Reasons for Non-Enrolment.

Table 4b

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
POVERTY/LOW INCOME LEVEL	20	66.7
HIGH PREMIUM RATE	6	20.0
DISINTERESTEDNESS	2	6.7
NOT WELL-INFORMED	1	3.3
SERVICE POORLY MANAGED	1	3.3

Source: Fieldwork, 2008

c) Membership Renewal

Table 4c

ENROLLED HOUSEHOLD.

CATEGORY	FREQUENCY	PERCENTAGE
YES	24	80.0
NO	6	20.0

Source: Fieldwork, 2008

d) Reasons for Non-Renewal

Table 4d

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
NO MONEY	3	50.0
IGNORANCE	2	33.4
NO BENEFITS GOT.	1	16.6

Source: Fieldwork, 2008

POWER RELATIONS WITHIN THE HOUSEHOLD AND ENROLMENT.

a) Power Play within the Household and Health Decision.

Table P (i)

ENROLLED HOUSEHOLDS

.

CATEGORY	FREQUENCY	PERCENTAGE
YES	4	13.3
NO	26	86.7

Source, Fieldwork, 2008

Table P (ii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	7	23.3
NO	23	76.7

Source, Fieldwork, 2008

b) Force to Enrol or Not

Table P (iii)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	6	20.0
NO	24	80.0

Source, Fieldwork, 2008

Table P (iv) NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCETAGE
YES	22	73.3
NO	8	26.7

Source, Fieldwork, 2008

c) Involvement of Spouse in Health Decision-Making within the Households.

Table P(v)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	24	80.0
NO	6	20.0

Source, Fieldwork, 2008

Table P (vi)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	21	70.0
NO	9	30.0

Source, Fieldwork, 2008

d) Does the Absence or Presence of Your Spouse affect your Decision to Enrol?

Table P (vii)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	5	16.7
NO	25	83.3

Source, Fieldwork, 2008

Table P (viii)

NON-ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
YES	11	36.7
NO	19	63.3

Source, Fieldwork, 2008

e) Motivation to Enrol:

Table P (ix)

ENROLLED HOUSEHOLDS.

CATEGORY	FREQUENCY	PERCENTAGE
FROM HUSBAND	15	50.0
FROM WIFE	8	26.6
SELF	7	23.4

Source, Fieldwork, 2008