



Improving Health Insurance Coverage in Ghana: A Case Study

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Summary

This study presents the outcome of a multi-stakeholder problem-solving programme (MSPSP). It aimed at improving enrolment and retention in the National Health Insurance Scheme (NHIS) in Ghana. The NHIS was introduced in 2004 following criticism that on-the-spot payments denied vulnerable groups access and did not achieve the overall benefit of quality healthcare. The aim was to improve the quality of service and ensure equity in access to healthcare. However, despite the heavily subsidised premium and exemption for vulnerable groups, enrolment among the general population has remained low and the poor, who are the target of the policy, are the least enrolled. The primary aim of this anthropological study was to assess if and how problem-solving groups (PSGs) could increase enrolment in the NHIS and retain members.

Chapter one is an introduction to the study, which is part of a larger multidisciplinary project involving economic and anthropological approaches. The chapter presents the research objective and questions and some relevant theoretical concepts. The theoretical foundation of the study is situated within critical medical anthropology based on the idea that medical anthropologists have both professional and moral obligation to explore and address the socio-economic, cultural and political contexts in which health inequities manifest. Taking note that many stakeholders are involved in the NHIS policy – politicians, policy makers, implementers, healthcare workers and community members – I employed the multi-level perspective (MLP) as a conceptual framework and methodological tool to describe and analyse how the multiple (sometimes conflicting) interests, views and practices of these various actors affected the policy uptake. My other standpoint was that stakeholder collaboration often fails because they do not effectively engage implementers and the target population of the policy from the onset.

Chapter two presents the study design, relevant information about the study sites, data collection tools, analytical techniques and a reflection on the researcher's role as a participant observer in the intervention group. This study draws on data from qualitative research in seven intervention communities in the Central region including: Anomabo and Assin Achiano, which I used as case study communities, and five others I visited during the study. Pre- and post-intervention household surveys were also conducted, in March 2009 and March 2011, respectively in 30 communities in the Central and Eastern Regions of Ghana.

To show the depth of the problem to be addressed, chapter three discusses barriers and enablers to enrolment in the NHIS and retention of members. It presents the experiences of users and implementers of health insurance within and outside PSGs. It also looks at the historical context in which the NHIS was introduced, which affected people's decisions to enrol or not and the work of the DHISs. Community members mentioned poverty, traditional

concepts of risk-sharing, disrespect of health providers towards insured patients, delays at health facilities, difficulties in obtaining prescribed drugs, collection of unauthorised fees and national politics. Health providers faced problems of heavy workloads as a result of the increased utilisation of healthcare, bureaucratic red tape and delays in claim payments leading to shortages of drugs. Staff of the DHISs complained about inadequate equipment, difficulties processing NHIS forms and granting exemptions to the core poor. The NHIS was perceived by many as a tool to build political capital, so some political opponents of the then government decided not to enrol.

Chapters four and five focus on the problem-solving intervention programme. Chapter four describes processes followed to set up the intervention group, PSGs, and the selection of facilitators. Four main themes are discussed. First, stakeholders' were sensitised about the problems of low enrolment in the NHIS and high membership non-renewal rates and the purpose of the intervention. This raised their interest in the intervention and made them willing to work together for change. How they were involved in the setting of PSGs forms the second theme of the chapter. I describe how community members, health providers and DHIS staffs were mobilised to assume the responsibility of forming PSGs. Heads of health facilities, District Health Directorates and the DHISs selected their staff based on their work schedules while community members devised an open election process. Opinion leaders and research assistants led events at community durbars to select their representatives. This strengthened trust among stakeholders, and laid the foundation for the intervention and a commitment to achieve set objectives. However, the low representation of women and exclusion of the poor indicate that unless extra strategies are developed to include them, the open election processes reduce participation to abstract theory. The third theme is the selection of facilitators for PSGs. Facilitators and secretaries were selected from PSG members to form the leadership. The fourth theme is facilitators training. Facilitators were the catalysts for PSGs functioning and were equipped with special skills in a three-day workshop. The workshop helped the facilitators provide the required leadership to create a shared vision among PSG members and stakeholders, facilitate meetings and mobilise the PSGs to effectively participate in intervention activities to achieve positive outcomes.

Chapter five discusses the tools and participatory approaches the PSGs employed to identify barriers to enrolment and retention of members, and develop and implement intervention activities to improve NHIS coverage. Barriers experienced by the community included: poverty, collection of unauthorised fees and traditional concepts of risk sharing. Health providers mentioned the heavy workload and delays in claim payments while the district health insurance staff complained about inadequate equipment and difficulties faced processing NHIS forms. Intervention activities developed and implemented to redress these barriers were durbars, documentary films, drama, and community leaders' and stakeholders' meetings, education at health facilities, churches, mosques, schools, lorry stations, setting registration

points in the community and provision of cameras to collectors to take pictures immediately as they registered people.

Chapter six presents the outcome of the problem-solving intervention programme. Overall, PSGs significantly increased enrolment by 10.6 per cent from 29.7 to 40.3 per cent but could not improve retention rates. Probit model analysis showed that residents in intervention communities were 17 per cent more likely to enrol compared to control communities. Ten communities showed significant increases in enrolment, two had no change and three recorded significant decreases. PSGs however, failed to influence the poorer and poorest quintiles to enrol. They had the lowest enrolment rates – poorest 17.6 per cent, poor 31.3 per cent – compared to the 46.4 and 44.4 per cent among the rich and richest quintiles. Disappointingly, membership non-renewal rates increased among the general population: from 15.5 to 22.4 per cent. Nonetheless, probit model analysis showed that residents in intervention communities were five per cent less likely to drop out of the NHIS compared to those in the control group.

Chapters seven and eight examine factors that enhanced the PSGs' functioning and factors that limited their efforts at improving enrolment and retention rates. Chapter seven discusses factors that stimulated enrolment. These were the awareness that NHIS provided prompt access to healthcare and financial relief from catastrophic payment and reduced complications among patients. The advocacy role of opinion and community leaders and health providers to promote the NHIS was another stimulating factor. Insured opinion and community leaders sharing the benefits they derived from the NHIS convinced people that it was a viable alternative to on-the-spot payment. Health providers educated community members and their patients on the benefits of health insurance and persuaded them to enrol. These health providers had a greater impact on community members than the regular education by DHIS staff and collectors. Rather than the traditional practice, where health providers and community members are considered only as implementers and consumers of the NHIS policy and excluded from planning and executing intervention activities, their involvement in this intervention led to increase in enrolment. Chapter eight revealed that contrary to the popular notion that the NHIS would ensure equity in access to quality healthcare services was not evident. The PSGs' achievements were limited by their inability to resolve some of the barriers identified in chapter three: poverty, inadequate exemption for the poorest quintile, negative attitudes towards health insurance, unenlightened self-interest, shortages of drugs at health facilities, collection of unauthorised fees at health facilities and payment for drugs covered by the NHIS.

The study concludes with a discussion of the key findings in chapter nine. I argue that although the NHIS improves access to healthcare, provides financial relief and reduces complications among patients, a range of factors including politicians, policy makers, implementers and targets of the policy continued to undermine equity and improvement of quality service goals. Politicians saw health insurance as a tool to secure electoral victory and failed

to expand health facilities' capacity to handle the expected increase in patient numbers before introducing the insurance scheme. They also did not seriously consider what constitutes quality service to insured patients, so there were missing links and contradictory expectations among the various stakeholders at multiple levels regarding what would improve quality of service and stimulate enrolment and retain members in the NHIS. The politicians only paid lip service to the exemption policy by setting homelessness as a criterion for poverty, a condition that rarely exists in Ghanaian communities, thus denying the core poor their exemption. Health providers who saw the NHIS as increasing their workload tended to be hostile to insured patients and charged extra fees. Community members thought they should benefit with minimum financial investment so usually enrolled only household members who needed healthcare. The DHISs staffs were more interested in revenue generation than granting exemptions to the core poor. They emphasised the homelessness criterion that eliminates almost all potential beneficiaries and ignored other criteria stated in the policy that more accurately reflect the status of the core poor in their districts. The DHISs' staff and collectors pursued activities to enrol premium-paying members and made no effort to prevent the exclusion of non-paying poor from the NHIS.

The multiple – and often conflicting – interests converged to limit the PSGs' efforts at improving enrolment and retaining members in the NHIS. Although the intervention could not achieve all objectives, by situating barriers and enablers at the level of local stakeholders and highlighting their concerns, the reality involved in implementing the NHIS policy and uptake is made clearer to policy makers. This study adds ethnographic information to the growing literature on social health insurance in Africa and sheds light on how to identify and address barriers to achieve policy goals.