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EVALUATION OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) POLICY ON THE HEALTH CARE DELIVERY IN GHANA

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ABSTRACT

Healthy people make a healthy nation and so the need to establish National Health Insurance Scheme (NHIS) in Ghana to promote good health. This study aimed at evaluating people's perception on the benefit levels of NHIS policy, assessing the implementation strategies of NHIS in the District, examining the impacts of the scheme on the accredited service providers and subscribers in the District and assessing general challenges of the policy to the actors. Mixed approach was adopted for this research work. The research finding unveiled that, subscribers benefited from the services of the scheme. It was also revealed that majority of the subscribers in the Jasikan District are aware that the scheme does not cover all diseases. However, most of the respondents are not aware of those diseases covered or not covered by the scheme. It was identified that revenue generated during the period of NHIS is higher than what was generated during cash and carry period. It was also found out that client based in the health facilities have increased as a result of the introduction of the scheme. Public education, promotion and advertisement, community durbars and community sensitization programs were identified as the strategies adopted in creating awareness of the existence of the scheme in the District. Lack of or inadequate logistics was also identified as the challenge of the scheme in the district. The following conclusion and recommendations were outlined by the researcher. Majority of the subscribers are not aware of diseases conditions that are not on treatment list of NHIS. Treatment list should be expanded and good systems established for payment of claims on time. Also, educational campaigns on the diseases covered and those not covered should be organized in all the districts of Ghana. More so, logistics should be provided by NHIS authority to all the district offices.

KEYWORDS: *NHIS, Jasikan District, Health Care Delivery, Cash and Carry*

INTRODUCTION

Healthy people make a healthy nation. The health of citizens of every nation is a concern and worry issue to developing and developed countries which Ghana is no exception. Successive governments in Ghana have tried to provide basic health care services to citizens, most especially the poor and vulnerable by abolishing the "Cash and Carry" system. "Cash and Carry" system is when initial payment or deposit for the medical care services were made before services were provided even in cases of emergencies.

National Health Insurance Scheme (NHIS) policy system replaced the "Cash and Carry" system in 2003 out of political promises. The scheme was established under Act 650 of 2003 by the Government of Ghana to provide basic medical care services to the people living in the country (www.nhis.gov.gh. 2016 NHIS).

NHIS was introduced as a social intervention policy by Government with the intention of providing financial risk protection against "cash and carry" system of health care expense for citizens and non-citizens as well (*Draft* NHIS Strategic Plan 2010-2014).

NHIS policy has three types of the scheme. These schemes are: The District-Wide Mutual Health Insurance Scheme, the Private Mutual Health Insurance Scheme and the Private Commercial Health Insurance Scheme.

For this policy to work well, the government of Ghana decided to assist the District Mutual Health Insurance Scheme concept to ensure that: Opportunity is provided for all Ghanaians to have equal access to the functional structures of health insurance. Ghanaians do not move from an unaffordable "Cash and carry" regime to another unaffordable Health Insurance one, a sustainable Health Insurance option is made available to all Ghanaians and the quality of health care provision is not compromised under Health Insurance (en.wikipedia.org/wiki/National Health Insurance Scheme, 2016).

The Scheme seeks to make healthcare affordable to all, and to achieve equity of access based on need, rather than socio-economic status (Witter & Garshong, 2009). Though, the NHIS was established in 2003 it gained grounds in the year 2005. The scheme is being operated in 159 districts and regional offices in the ten regions of Ghana and 5 registration centers (www.nhis.gov.gh/districts, 2016 NHIS).

The National Health Insurance Authority (NHIA) was established under the National Health Insurance Act 2003, Act 650, as a body corporate, with perpetual succession, an Official Seal, that can sue and can be sued in its own name.

Act 852 has replaced Act 650 in October, 2012 to consolidate the NHIS, remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the schemes (www.nhis.gov.gh, 2016 NHIS).

The active membership base of the scheme as at December 2014 was 10.5 million. In 2014, over 29 million patients attended health facilities for healthcare delivery on an account of the NHIS. As at 2014, 69% of policy subscribers were exempted from the payment of premiums. These included SSNIT contributors and pensioners. Other categories exempted are; less than 18 years old, 70 years and above, pregnant women, indigents (core poor), persons with mental health conditions and persons who are physical challenged and designated by the Ministry responsible for Social Welfare, as well as beneficiaries of the Livelihood Empowerment Against Poverty Programme (LEAP). These exempted categories of members count for close to 69% of subscribers of the scheme, and as a consequence only an estimated 31% of members pay contributions, which contributions are also not at fixed determined rates (nhis.gov.gh/nhisreview.2016 NHIS).

On the sources of income for the operation of the scheme, the following sources as outlined are the main sources of income to the National Health Insurance Fund (NHIF) as provided under section 41 of the Act. NHIF was established for reinsurance of the District Health Insurance Schemes (DHIS).

- The National Health Insurance Levy (NHIL)
- 2.5 percentage points of SSNIT contributions.
- Money that may be allocated to the Fund by Parliament;
- Grants, donation, gifts and any other voluntary contributions made to the fund,
- Interest that accrues to the Fund from investments made by the Authority
- Fees charged by the Authority in the performance of its functions;
- Contributions made by members of the Scheme; and
- Monies accrued under section 198 of the Insurance Act, 2006 (Act 724) (*Source: 2012 Annual report –final*).

"Cash and carry" system was introduced in the mid-1980s, and before 2003 it was the system operating by health service providers. Under this system, the health needs of Ghanaians and non-Ghanaians were only attended to after initial payment or deposit was made for the health care service. Even

in cases when patients had been sent to hospitals on emergencies, it was required that money be paid at every point of service delivery. Citizens of the nation died because they were not having money to pay for their healthcare needs when they were taken ill (en.wikipedia.org/wiki/health_in_ghana, 2015). The "Cash and Carry" system was a challenge to Ghanaians in accessing health care which raised worries for the government and the citizens. One may ask, was this system the best for Ghanaians and non-Ghanaians in Ghana?

In addressing these problems, the government of Ghana established the National Health Insurance Scheme (NHIS) under Act 650 of 2003.The scheme is to provide basic medical care services to all populaces in Ghana. The policy having been implemented and operated for over 12 years, quite a number of researches have been conducted on a similar topic in some parts of the country. The following are some of the researchers and the topics conducted on; Agamah (2011) – (Financing health care in Ghana: evaluation of the Mutual Health Insurance Scheme in Sunyani Municipality), Send-Ghana (2010)-(Balancing access with quality health care: an assessment of the NHIS in Ghana (2004-2008)), Hassan (2008)-(Assessing the implementation of Ghana's NHIS law, paper prepared for workshop in political theory and policy analysis mini conference, spring 2008), Mensah (2011)-(The impact of National Health Insurance Scheme on health delivery of Jaman North District in the Brong Ahafo Region) and Boateng and Awunyor-Vitor (2013)-(Health Insurance in Ghana: evaluation of policy holders' perceptions and factors influencing policy renewal in the Volta Region).

Upon all these researches conducted on the health insurance in some part of Ghana, questions such as; what are people's perceptions about the benefits of NHIS?, what are the implementation strategies of NHIS in the District?, what are the impacts of the scheme on the clients and the service providers? and what are the challenges faced by the subscribers, the managers and health service providers of the scheme?, remained questions of the day. The researchers having conducted a brief study found out that no research has been conducted on the evaluation of the National Health Insurance Scheme in Jasikan District and some other parts of the country which perhaps left all these questions and many more unanswered. On this score the researchers were inspired to conduct study on this topic in the District.

The general objective of the study was to evaluate the National Health Insurance Scheme (NHIS) policy on the health care delivery in the Jasikan District of Ghana. Specifically to:

- ✓ evaluate people's perception on the benefits levels of NHIS policy.
- ✓ assess the implementation strategies of NHIS in the District.
- ✓ examine the impacts of the scheme on the subscribers and accredited service providers in the District.
- ✓ assess the general challenges of the policy to the actors.

LITERATURE REVIEW

Theoretical Review

This review covered the following areas of interest to the researchers. The summary history of National Health Insurance Scheme (NHIS) policy in Ghana, "the cash and carry" system in Ghana, framework of NHIS policy in Ghana, major types of Health Insurance Scheme in Ghana.

Summary History of National Health Insurance Scheme Policy in Ghana

The National Health Insurance Scheme (NHIS) policy was established under Act 650 of 2003 by the then Government of Ghana led by John Agyekum Kufour. The aim was to provide access (financially) to basic medical care services to the populace in Ghana.

NHIS was established as a social intervention policy by the Government with the aim of providing financial risk safety against cash and carry system of medical care expenses for citizens and non-citizens as well (Drafted NHIS Strategic Plan, 2010-2014).

Though this Act, National Health Insurance Act (Act 650) was passed in 2003, it however started full operation in Ghana as a scheme in the year 2005. NHIS started its official work in all the districts in Ghana where all residents could have access to the scheme offices for registration. The policy started as District-wide Mutual Health Insurance Scheme.

The scheme targeted to get all residents in Ghana hook onto the insurance scheme that will protect them against out of pocket payment popular known as "Cash and Carry".

National Health Insurance Scheme Act 650 of 2003 provides the legislative framework for the creation of a body for the regulation of activities of schemes in the country. This gave chance for the creation of National Health Insurance Council to regulate the activities of insurance schemes in Ghana.

Act 650 provided an opportunity for the establishment of three types of schemes which are; District Mutual Health Insurance Schemes, Private Commercial Health Insurance Schemes and Private Mutual Health Insurance Schemes. These schemes have been grouped into two major types, namely, District-Wide Mutual Health Insurance Scheme (DWMHIS) and Private Health Insurance Schemes

(commercial and mutual). These two main kinds of schemes are the only ones which can be registered and operated in Ghana under the "Act".

However, for the purpose of this research, the three types would be discussed. For the sake of achieving the aim of access to basic medical care and the sustainability of the policy, the government had decided to support the district mutual health insurance scheme concept.

The NHIS endeavors to make medical care inexpensive to all, and to also accomplish fair play of availability based on need, rather than on socio-economic status (Witter & Garshong, 2009).

There are categories of residents in Ghana who are being guaranteed by the scheme to basic health care services through exemption from paying premiums. These groups are under 18 years, pregnant women, the aged, and the indigents.

"Cash and Carry" system in Ghana

"Cash and Carry" system is a system where payment is made before medical care services at the health facilities are provided. The system operated regardless of emergency situation of the patients. "Cash and Carry" system, led to the death of many people in Ghana, especially those who could not make down payment for their healthcare needs.

This system partly operated from 1971 after the introduction of the Hospital Fee Decree in 1969, which later became the Health Fee Act 1971. When the user fee system was initiated, patients were paying a token fee for some medical care procedures, such as consultations. As time passed by, the same system of token fee was now being charged at a fixed fee for the procedures. Such procedures are; consultation, laboratory services, dispensary services, and other services (Nyonator & Kutzin, 1999 in Gissele & Owusua, 2013).

The fee Act 1971 was revised in 1988. The full cost of consumables to patients were now part. This reason of full charge of medications caused a serious challenge of the essential drugs supply and inequitable drugs distribution to the various health facilities. This then created a way for the establishment of "Cash and Carry" system, formally known as the "Revolving Drug Fund in 1992.

The system was initiated to finance 15 percent of recurring costs through the user fees paid by patients at the point of seeking medical attention (Nguyen et al, 2011 in Gissele & Owusua, 2013).

The inception of cash and carry system led to the maintenance of revolving fund. Healthcare providers were using the revolving fund for resupply of consumables and non-consumables. The cash-and-carry system created undesirable situation on people's access to healthcare services most importantly the poor (Waddington & Enyimayew (1989); Asenso-Okyere, Adote, Osei-Akoto, & Adukonu (1998) in Gissele & Owusua, 2013).

To counterpoise this issue of adverse effects of the system known as "cash and carry", some interventions such as exceptions were considered to that effect. Such exceptional interventions as provision of free medical care to those above 70, pregnant women, children under 5 years, the poor, and patients suffering from certain communicable diseases.

Having identified some associated problems of "cash and carry" system as stipulated above and to find solutions to these problems and other numerous ones, Government in 2003 decided to establish NHIS.

Framework of NHIS Policy in Ghana

The National Health Insurance Scheme was established in Ghana under Act 650 of 2003 to find a long-lasting, efficient and acceptable solution to the difficult situation of financing healthcare service in Ghana. Before the policy began, 80% of funding on the public health services bill was by the Government of Ghana through taxation and donor funds and 20% was by the Cash and Carry system. The NHIS policy was established to substitute the 20% of cash and carry system.

The Scheme vision is to make sure that there is equitable universal access to quality basic package of health services to all occupants in the country without being asked to make a deposit before receiving medical care attention. The scheme having predicted the difficulties of enrolling all the residents in Ghana has established long, medium and short term objectives to help achieve this vision. The scheme has developed policy objectives that state that; every resident in Ghana shall be a member of the health insurance scheme that sufficiently protects the person against "cash and carry" system at the point of service use to attain access to a defined package of acceptable quality needed health services. The scheme is to be guided by the following principles.

1. Equity
2. Risk equalization
3. Cross-subsidization
4. Quality care
5. Efficiency in premium collection and claims administration
6. Community or subscribers ownership
7. Partnership
8. Reinsurance

Source: Ghana Health Insurance review, A quarterly magazine of the National Health Insurance Authority (NHIA), October – December, 2008.

Major Types of Health Insurance Schemes in Ghana

National Health Insurance Scheme Act 650 (2003) has identified the registration and operation of two major types of schemes in Ghana. These schemes are District-Wide Mutual Health Insurance Scheme (DWMHIS) and Private Health Insurance Schemes. The Private Health Insurance Scheme is made up of two schemes, the commercial and mutual.

District-Wide Mutual Health Insurance Scheme (DWMHIS)

DWMHIS is the most functional with a high number of clients. It aims at instilling a spirit of being socially responsible, solidarity, equity and a sense of belongingness as a means of putting up a healthy and prosperous community. The criteria for registering the DWMHIS and the private or commercial insurance schemes are different. The district mutual and private mutual health insurances are registered as company limited by guarantee.

The DWMHIS is highly recognized and has received Government support in its activities. Government has decided to take this decision in order to sustain the scheme. The DWMHIS coverage is both the formal and informal sector workers. It also takes care of indigent in the society. Government supports the scheme through subsidy to enable the scheme provides medical services to citizens and non-citizens in Ghana.

The scheme has been decentralized, thus, the scheme has offices in all the districts except few of the newly created districts. DWMHIS is social in nature, thus it is not profit making body.

Private Mutual Health Insurance Schemes (PMHIS)

The scheme as the name depict is a private insurance scheme which could be established by an individual or a group of individuals. It can be registered as company limited by guarantee. PMHIS are community-based or faith-based schemes. Private Mutual Health Insurance Scheme (PMHIS) receive no subsidy from Government.

Private Commercial Health Insurance Scheme (PCHIS)

Private Commercial Health Insurance Scheme (PCHIS) is registered as a limited liability company under the company code 1963 (Act 179). This scheme is operated with profit making motive. The premium is pay base on the risk level of class of clients. A high risk class pays a higher premium. This scheme does not also receive subsidy from the central Government.

Empirical Review

This aspect of the review focused on the following areas. Implementation of National Health Insurance Scheme Policy, sources of financing of the NHIS policy, Benefits of the NHIS in Ghana, impact of NHIS on health care in Ghana, general challenges of the policy, administration of NHIS policy at all levels in Ghana, major actors of National Health Insurance Scheme in Ghana and development of National Health Insurance Scheme in some other countries.

Implementation of National Health Insurance (NHIS) Policy

The scheme after its establishment in 2003 went through the legal process including series of actions such as initial drafting of policy document by the Ministry of Health, Cabinet review, Attorney General review, passage by parliament, the approval by President's and gazette notification.

A number of interest party meetings were organized and taskforce was formed. The membership of this taskforce was made up of both technical and political players. These players of the policy were charged with responsibilities of providing implementation guidelines and recommendations for the scheme. The National Health Insurance Council and Authority were established to govern the scheme's operations in their various capacities. National Health Insurance Fund was also established for the scheme. The basic objective of the Council was to secure the implementation of a national health insurance policy that ensures access to basic health care services to all residents in Ghana. Its responsibilities included registration, licensing, regulation and supervision of the operations of all types of health insurance schemes. It was also responsible for granting accreditation to health care providers, monitoring their performance, and ensuring that health care services rendered to beneficiaries were of good quality (Agyepong & Adjei, 2008). The scheme was created with the aim of replacing the "cash and carry" system in Ghana then. With the existence of the policy a premium is required from residents of Ghana as a means of pre-financing of their ill health in the future. Apart from members' premium, the government supports the policy by providing a subsidy, Health insurance levies, and deduction from formal sector workers SSNIT contributions. The scheme was established for both formal and informal sectors.

The policy after its establishment was decentralized to the district level. This was known as the District-Wide Mutual Health Insurance Scheme (DWMHIS) and the Act 650 (2003) required that every Ghanaian must be a member of the District-Wide Mutual Health Insurance Scheme or the Private Mutual or Commercial schemes. However, in order to get more subscribers into the scheme, Government subsidies were provided to those who are subscribers to the District-Wide Mutual Health Insurance Scheme (Ministry of Health, 2004).

Sources of Financing National Health Insurance Scheme (NHIS) Policy

The Insurance policy Act 650 (2003) provides for the creation of a National Health Insurance Fund (NHIF). The main aim of this fund is to mobilize financial resources and manage the resources. This fund is funded by several sources. Among the several sources of financing are; premium levy by subscribers, this premium is pay based on categorizations and some categories are being exempted from this premium. 2.5 per cent Social Security and National Insurance Trust deduction from the formal sector workers salaries, 2.5 percent sales tax on almost all goods and services (Adobea, 2010).

In the year 2006, NHIF denoted about 31.6% of the total resource of the health sector and in 2008, the fund accounted for a rate of 32.6% of total health sector financing (MoH, 2006, 2008).

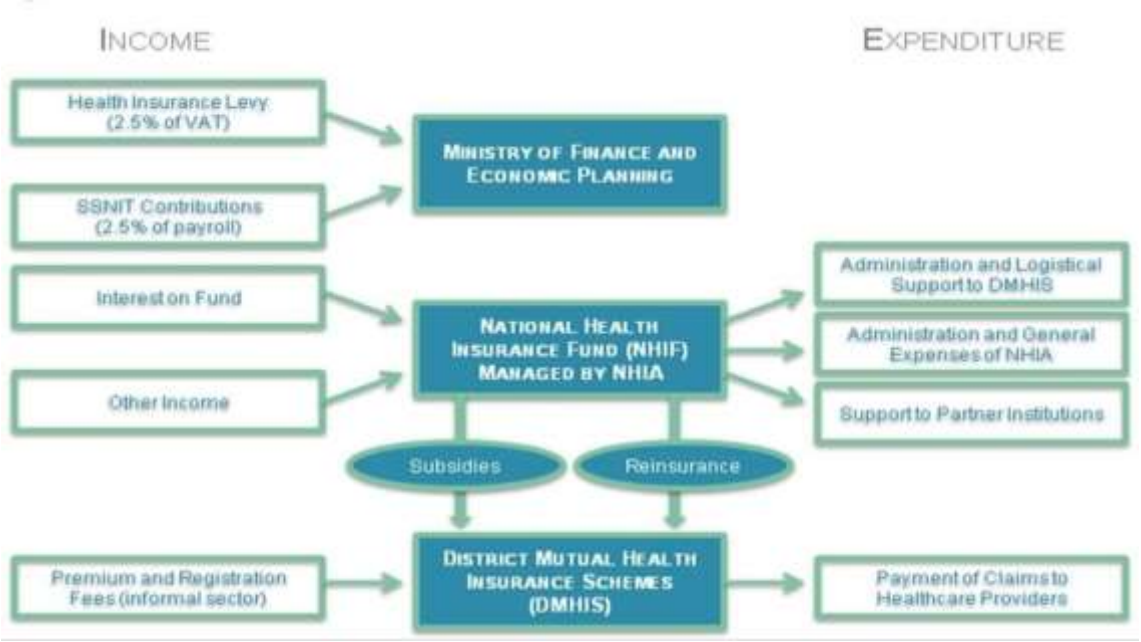

Figure 1: Cash Flow of the NHIS

Source: jointlearningnetwork.org/content/national-health-insurance-scheme-nhis 2013

Benefits of National Health Insurance Scheme (NHIS) in Ghana

The NHIS authority in designing the scheme policy outlined some basic benefits to Ghanaian residents. The cost of these benefits is to be paid by scheme. The benefits include; outpatient department (OPD) services, inpatient department (IPD) services, oral health services, eye care services, maternity care services and emergencies care services.

The scheme also provides the under listed benefits; feeding of patients on admission and medicines on the NHIS price list.

On the other hand there are some other services which are not covered under the scheme.

1. Rehabilitation other than physiotherapy
2. Appliances and prostheses including optical aid, hearing aids, orthopedic aids, dentures services
3. Cosmetic surgeries and aesthetic treatments services
4. HIV retroviral drugs
5. Assisted Reproduction example, artificial insemination and gynaecological hormone replacement therapy services
6. Echolcardiography
7. Photography
8. Angiography
9. Orthoptics
10. Dialysis for chronic renal failure
11. Heart and brain surgery other than those resulting from accidents
12. Cancer treatment other than cervical and breast cancer
13. Organ transplantation
14. All drugs that are not listed on the NHIS Drug list
15. Diagnosis and treatment abroad
16. Medical examinations for purposes of visa applications education, institutional, and driving license
17. VIP ward cost (Accommodation)
18. Mortuary services.

Source: Ghana Health Insurance review, A quarterly magazine of the NHIA, October – December, 2008.

The above mentioned services are not provided because they are considered to be unnecessary or very expensive. Records also indicate that about 95% of the diseases in Ghana are being considered under the NHIS benefit package (www.ghanaweb.com).

There are some categories of people who are under the benefit package of exemptions from paying premium. Even those who are paying, payments are within the range of GH₵10 to GH₵48 depending on their socio-economic status. Those in the exemption package are; the indigents, children under 18 years, those above 70 years, retirees under the social security scheme, and pregnant women.

In order to be able to achieve the objective of providing basic benefit package of services, the NHIS covers both public and private service providers on the basis of accreditation by the NHIA (GHS, 2007). As of December 2009, 966 private providers, 1,368 public providers, and 163 Christian Health Association of Ghana (CHAG) providers were enrolled in NHIS.

Impact of NHIS on Health Care in Ghana

The year 2013 was when the National Health Insurance Scheme marked 10 years after the establishment of the "Act", Act 650 (2003). By the end of 2013 the total active subscriber of the scheme was 10,145,196 from 8,885,757 in 2012 which covers 38% of the total population of the county. The new registrants for the year 2013 were 3,444,570 and 3,249,667 for the year 2012.

The region which obtained the highest active membership was Ashanti region with 1,715,388 and the least region was Upper West region with total active members of 422,417. The table below gives a clear picture of new registrants, renewals, active subscribers and the percentages of the total in every region.

Table 1: Active membership (2013)

Region	New	Renewals	Active Membership	Percent of Total
Ashanti	472,903	1,242,485	1,715,388	17%
Brong Ahafo	405,088	948,752	1,353,840	13%
Central	382,595	484,341	866,936	9%
Eastern	337,097	773,024	1,110,121	11%
Greater Accra	565,281	714,976	1,280,257	13%
Northern	391,728	488,789	880,517	9%
Upper East	166,538	476,740	643,278	6%
Upper West	99,620	322,797	422,417	4%
Volta	326,243	584,326	910,569	9%
Western	297,477	664,396	961,873	9%
Total (National)	3,444,570	6,700,626	10,145,196	100%

The differences in the numbers of active membership may be due to geographical locations and economical associated problems. Active membership of the policy has increased in 2013 over 2012 and also resulted in the increase in the Health care attendance. This indicates that the subscribers have benefited from free treatment at the health facilities.

Most importantly, it has been indicated by the authorities of health care providers (Health facilities) that the death rate in the health facilities for the subscribers of NHIS has reduced. This was associated to the early visits for treatment at the health care facilities (World Health Organization, 2010).

General Challenges of the Policy

The main objective of insurance scheme is to improve the quality of healthcare service delivery by getting rid of financial hurdles to healthcare services. One other objective is to eliminate administrative and clinical holdups that also hinder effective healthcare services delivery.

There are a number of factors which are hindering the success of NHIS and stakeholders in some African countries such as Ghana. These challenges can affect both the schemes, health care providers, and the subscribers of the scheme.

Political will and delay in repayment of claims are some of the numerous issues. To improve health care services delivery and to promote the understanding of patients' needs and expectations, there is the need to put measures which will bring sanity in the management of the scheme by National Health Insurance Authority (NHIA).

Findings from a research conducted by *Sakyi* et al. (2012*)* indicates that the biggest challenges facing effective healthcare service delivery is delay in payment of claims by the NHIA. It is being indicated that the Law that has established NHIS, warrants the payment of claims to service

providers by the NHIA four weeks after submission of claims (National Health Insurance Act, 2003). This law is however not adhered to. These delays have very serious implications on service providers. It can lead to shortage of consumables and non-consumables. Projects initiated by health service providers can be delayed as well. This issue can have corresponding effect on the willingness of the subscribers to renew their membership due to unsatisfactory healthcare services provided to them. Also the research identified the fact that the health facilities have not gone through significant technological revolution to muddle through the trends of the insurance scheme. The study further identified new managerial challenges to the health service providers after the establishment of National Health Insurance Scheme.

Administration of NHIS Policy at all levels in Ghana

The National Health Insurance Scheme "Act", Act 650 was established in 2003 and in the Act a council had to be formed and will be a body corporate and named National Health Insurance Council. The council is mandated to perform the following objective; execution of the scheme policy that ensures that all the residents in Ghana has access to basic health care services. In order to succeed in carrying out this objective, the council has to perform these responsibilities:

1. Registering, Licensing and regulating of health insurance schemes in Ghana
2. It is the responsibility of the council to supervise the operations of schemes
3. Granting accreditation to healthcare providers applicants and also to monitor the providers performance
4. The council is to ensure that all the healthcare services provided to beneficiaries of schemes by accredited service providers are of good quality
5. Determine in consultation with licensed district mutual health insurance schemes, contributions that should be made by their members
6. The council to approve health identity cards for members of schemes
7. To provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers
8. The council is to make proposals to the Health Ministry for the formulation of policies on health insurance
9. To undertake on its own or in collaboration with other relevant bodies a sustained public education on health insurance
10. Devising a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for
11. To maintain a register of licensed health insurance schemes and accredited healthcare providers
12. Managing the National Health Insurance Fund established under Part VI
13. The council is to monitor compliance with this Act and Regulations made under it and pursue action to secure compliance
14. To perform any other function conferred upon it under this Act or that are ancillary to the objective of the Council.

All schemes in Ghana have governing bodies. The governing bodies of District Schemes are Board of Trustees. These bodies are responsible to the direction of the schemes policies and the appointment of employees. The schemes have management bodies in charge of the day to day activities of the schemes. The management body of some of the schemes comprises of the Scheme Manager, Accountant, Management Information System Manager, Public Relations Officer, Claims Manager and Entry clerks. Managers are the heads of the various schemes and they are responsible for the day to day management of the schemes.

The headquarters of the various district mutual health insurance and private mutual/commercial health insurance schemes are within the concern districts or areas (National Health Insurance Act, 2003 (ACT 650)).

Major Actors of National Health Insurance Scheme in Ghana

National Health Insurance Scheme has four major actors in its operations. The four main actors are, service providers, service users (NHIS subscribers), regulators (Ministry of Health) and financiers.

Service Providers: These stakeholders are the health facilities which provide health care services to the clients of the NHIS. They are the accredited health care service providers in Ghana. This accredited service providers are; the three Teaching Hospitals in Ghana, Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Ghana Association of Quasi-Government Health Institutions (GAQHI), Community Practice Pharmacists Association (CPPA), Ghana Registered Midwives Association (GRMA), Association of Private Medical Laboratories (APML), Society of Private Medical and Dental Practitioners (SPMDP) and Chemical Sellers Association (CSA).

Ghana Health Service (GHS) comprises of, Community Health Planning and Services (CHPS) compounds, few maternity homes, health centers, polyclinics, district hospitals and regional hospitals.

The three teaching Hospitals are the Korle Bu, Tamale and KomfoAnokye Teaching Hospitals.

Christian Health Association of Ghana (CHAG) health institutions are the faith based service providers in Ghana. CHAG facilities belongs to the following religious bodies; Catholic Church which has majority of the health institutions, SDA Church, Church of Pentecost, Methodist Church, Salvation Army, Assemblies of God Church, Presbyterian Church, AME Zion Church, Manna Mission, Luke Society Missions, Baptist Health Church, Siloam Gospel, Church of Christ, Church of God, Global Evangelical Church, WEC Mission, Run Mission, Lighthouse Mission, Anglican Church, Evangelical Presbyterian Church, Savior Church and World Alive Mission. Most of these CHAG health institutions are located in the rural parts of Ghana (Christian Health Association of Ghana, 2014 Annual Report).

The private service providers operate maternity homes, clinics, hospitals pharmacies, chemical shops and diagnostic centers.

The public health service providers are made up of 49% of the total health care givers in Ghana. CHAG institutions represent 7%, private sector constitutes 21%, and private maternity homes are made up 17% and 6% for the others (National Health Insurance Strategic Plan 2011 – 2014).

Service Users (NHIS subscribers): Service Users are the registered members or subscribers of the NHIS. These subscribers are eligible to seek for health care service on the accounts of the scheme. By the end of 2013 the total active subscriber of the scheme in Ghana was 10,145,196 which cover 38% of the total population of the county. The new registrants for the year 2013 were 3,444,570 (2013 Annual Report, NHIA). The objective of the scheme is to drive the country towards universal coverage meaning that the total population of Ghana is potential clients of the policy. With this objective, the guaranteed subscriber base is all SSNIT contributors, SSNIT pensioners, pregnant women, people below 18 years, those above 70 years, and indigents. All these categories account for about 70% of anticipated total population of the policy (National Health Insurance Strategic Plan 2011 – 2014).

Regulators (MOH): This stakeholders group is the master regulator of the health sector. For the fact that effective and efficient is pivot to the regulators, the regulatory functions has been delegated to some statutory agencies in the ministry. These agencies include; Private Hospitals and Maternity Homes Board (PHMHB), Pharmacy Council, Nurses and Midwives Council (NMC), Medical and Dental Council (MDC), Food and Drug Board (FDB) and Ghana National Drugs Programme (GNDP) (National Health Insurance Strategic Plan 2011 – 2014).

Financiers: The financier of the policy is Ministry of Finance and Economic Planning (MOFEP). The Ministry is a care taker of National Health Insurance Fund. All the revenue collected from all sources, such as the Value Added Tax (VAT) and SSNIT are lodged in the Consolidated Fund and transferred by MOFEP to NHIS. Other financiers or Development Partners (DP) to the scheme are World Bank, Dutch Government through the Royal Dutch Embassy in Ghana, Danish Government through DANIDA and the British Government through DfID (National Health Insurance Strategic Plan 2011 – 2014).

METHODOLOGY

The research design adopted was both qualitative and quantitative (mixed method). Data was collected between the periods of April to June 2016.

The study covers Jasikan District in the Volta Region of Ghana. It considered the Accredited Service Providers, the scheme and the scheme clients as depicted in the table below:

Table 2: Population of the Study

Targeted categories	Population	Sample size
Scheme staff	16	9
Subscribers (Clients)	35,346	117
Accredited service providers	19	38
Total	**35,381**	**164**

Source: NHIS and DHD Jasikan, 2016

NB: Accredited service providers were 19 but 2 staff were chosen from each health facility (2@19=38).

The population of the study is the departmental heads and one other staff from each department of the health insurance, subscribers of the scheme and the service providers (two staff from each institution) within the catchment area of the study. These groups were used because the staffs of the scheme are the implementers of the policy and so the need to investigate them to know the strategies adopted during the implementation of the scheme and the challenges they faced. Subscribers were chosen because they are the most beneficiaries of the scheme. Service providers were also considered because they are providers of the services which the scheme seeks to make affordable. So therefore, they are key stakeholders and the sustainability of the scheme greatly depends on them. The researchers used questionnaire, observation, and interview to collect data. Simple random and purposive sampling techniques were utilised to select respondents. A simple random technique was used for subscribers of the scheme and purposive technique was used for the scheme officials and the service providers. Statistical Package for Social Science (SPSS) version 20 was used to analyze the raw data collected.

RESULT AND DISCUSSION

Table 3: Age distribution of Respondents

Age	Frequency	Percent
20-29 years	57	45.2
30-39 years	35	27.8
40-49 years	21	16.7
50-59 years	5	4.0
60 and above years	8	6.4
Total	**126**	**100.0**

Table 4: Educational levels of Respondents in the study

Qualification	Frequency	Percent
Primary School	4	3.2
JSS	15	11.9
MSLC	6	4.8
SSSCE/WASSCE	27	21.4
First Degree	14	11.1
Second Degree	18	14.3
Others	42	33.3
Total	**126**	**100.0**

Respondents' occupation, income level and health status

Respondent's occupation, health status and income level were asked in order to determine the standard of living of the respondents. As high income level implies good standard of living and therefore high possibility of being able to subscribe to the NHIS or renew their membership. Frequencies and percentages were computed and the results were summarized in Table 5.

Table 5: Respondents occupation, income level and health status

Variables	Frequency	Percent (%)
Occupations		
Farmers	7	5.6
Teachers	26	20.6

Traders	13	10.3
Students	17	13.5
Nurses	19	15.1
Police officers	2	1.6
Others	25	19.9
Missing values	17	13.5
Total	**126**	**100**
Yearly income level of respondents (GHS)		
100 – 1000	23	18.3
1001 – 2000	5	4.0
2001 – 3000	5	4.0
3001 – 4000	1	0.8
4001 – 5000	4	3.2
Others	22	17.7
Missing value	65	51.6
Total	**126**	**100**
Health status of respondents		
Very good	43	34.1
Good	48	38.1
Uncertain	4	3.2
Poor	6	4.8
Missing values	25	19.8
Total	**126**	**100**

SUBSCRIBERS

This section presented the benefits of the NHIS to subscribers, the impact of the NHIS on the clients and revealed the challenges faced by clients.

Table 6: How long have you been a subscriber

Duration	Frequency	Percentages (%)
Less than a year	4	3.9
1 to 3 years	25	24.5
4 to 6 years	37	36.3
7 to 9 years	20	19.6
10 to 12 years	16	15.7
Total	**102**	**100**

Benefits of the scheme to the clients

One of the objectives of the study was to assess the benefits of the scheme to subscribers. Questions were asked to find out if clients were satisfied with the various services of the scheme. Frequencies and percentages were computed and the results summarized in Table 7.

Table 7: Satisfaction of services provided by the scheme

	Yes		No		Total	
	N	%	N	%	N	%
Are you satisfied with the services of the NHIS?	65	64.9	35	34.7	100	100
Are you satisfied with the customer services?	30	30.9	67	69.1	97	100
Are you satisfied with number of services covered by NHIS?	41	41.4	58	58.6	99	100
Are you satisfied with the claims payment by NHIS?	12	12.2	86	87.8	98	100
Are you satisfied with the professionalism of the staff of NHIS?	28	28.6	70	71.4	98	100

Table 8: Rating the level of Satisfaction of Services provided by the Scheme

	Normal		Satisfactory		Highly Satisfactory		Unsatisfactory	
	N	%	N	%	N	%	N	%
Clients' satisfaction in relation to availability and accessibility of the scheme and health facilities?	28	34.1	44	53.7	9	11.0	1	1.2
Clients' satisfaction in relation to attitude of NHIS and the health facilities staff?	18	22.8	39	49.4	4	5.1	17	21.5
Clients' satisfaction in relation to types and availability of drugs in the health facilities?	21	26.3	24	30.0	10	12.5	25	31.3
Clients' satisfaction with regard to premium amount charge by the scheme?	30	40.0	33	44.0	6	8.0	6	8.0

Table 9: Descriptive statistics showing overall satisfaction of the subscribers

	Frequency	Percent (%)
Highly satisfactory	7	7.1
Satisfactory	78	79.6
Unsatisfactory	13	13.3
Total	**98**	**100.0**

Table 10: Does the scheme cover all diseases

	Frequency	Percentage (%)
Yes	16	16.5
No	81	83.5
Total	**97**	**100**

16 respondents represented by 16.2% indicated that the scheme covers all diseases and 81 respondents represented by 83.5% believed that the NHIS does not cover all diseases.

This implied that more Ghanaians and for that matter subscribers of the scheme in Jasikan District are aware that the scheme does not cover all diseases.

Table 11: Diseases which you think the scheme covers or do not cover

Diseases	Yes		No	
	N	%	N	%
Malaria	81	79.4	21	20.6
Diabetes	21	20.6	81	79.4
Anemia	3	2.9	99	97.1
Infection (Worm, Respiratory Tract, etc)	35	34.3	66	64.7
Rashes (skin diseases)	4	4.0	97	96.0
Pregnancy related diseases	8	7.8	94	92.2
Fever (Typhoid and Enteric)	29	28.4	73	71.6
Hypertension	9	8.8	92	90.2
Diarrhoea and vomiting	20	19.6	82	80.4
Organ transplanting	13	12.7	89	87.3
Cancer diseases	12	11.8	90	88.2
Plastic surgery	3	2.9	99	97.1
Brain and heart surgery	13	12.7	89	87.3
HIV treatment (retroviral drugs)	20	19.6	82	80.4
Dialysis chronic renal failure	1	1.0	101	99.0
Severe burnt	1	1.0	101	99.0
Appliance and prosthesis (optical, hearing, orthopidic aids, dentures services, etc.)	3	2.9	99	97.1
Gynecological problems	1	1.0	101	99.0

Table 12: Impact of the scheme on the clients

	Yes		No	
	N	%	N	%
Has the introduction of the scheme improved your finances?	66	67.3	32	32.7
Have you been able to save or has your saving increased after the introduction of the scheme?	57	58.8	40	41.2
Have you ever borrowed from friends for your hospital bills?	25	25.3	74	74.7
Payment with interest	6	5.9	96	94.1
Difficulty in repaying the money borrowed	6	5.9	96	94.1
Being embarrassed	4	3.9	98	96.1
Felt intimidated or harassed	3	2.9	99	97.1
It has affected my savings by reducing it	6	5.9	96	94.1
It has affected my academic performance	0	0.0	102	100.0
Free from embarrassment and harassment	13	12.7	89	87.3
It has helped me to take care of my family education	2	2.0	99	97.1
Has the introduction of the scheme helped you to pay your children school fees?	47	56.0	37	44.0

Table 13: General challenges faced by the clients of the scheme

Problems	Yes		No	
	N	%	N	%
NHIS does not cover all treatments and drugs	11	10.9	90	89.1
Poor service to NHIS card bearers	11	10.8	91	89.2
Time waiting during registration and renewals of cards	2	2.0	100	98.0
Payment for medications and others at the health facilities by card bearers	10	9.8	92	90.2
NHIS card bearers are not being given good medication like cash and carry counterparts	4	3.9	98	96.1

High rate of corruption in the NHIS system	1	1.0	101	99.0
Complaints are not treated with urgency	0	0.0	102	100.0
Delay in paying claims on time	4	3.9	98	96.1
Do you think your health concerns are being addressed by the NHIS?	71	71.7	25	25.3

Table 14: Suggestions for improvement of the scheme

	Yes		No	
	N	%	N	%
Improvement on network system	18	17.6	84	82.4
In-service training on customer relationship should be conducted for NHIS staff	15	14.7	87	85.3
Reduction in subscription and renewal fees	4	3.9	98	96.1
Claims payment should be promptly made	17	16.7	85	83.3
The scheme should cover all drugs and illness	32	31.4	70	68.6
Public education on diseases covered and those not covered should be given to clear misconception of ineffective	9	8.8	93	91.2
One-time payment and proper monitoring should be considered to help improve the scheme	2	2.0	100	98.0
More agents or offices should be cited in every community for easy accessibility	8	7.8	94	92.2
Recruitment of NHIS staff should be free from politics	1	1.0	101	99.0

SERVICE PROVIDERS

This section presents the benefit of the NHIS to service providers, the impact of the NHIS to the service providers and the challenges faced by service providers.

Table 15: How long have you been operating as an accredited service provider under the scheme

	Frequency	Percentage (%)
Less than a year	4	23.5
1 to 3 years	4	23.5
4 to 6 years	5	29.4
7 to 9 years	1	5.9
10 years and above	3	17.6
Total	**17**	**100.0**

One of the objectives of the study was to evaluate people perception on the benefits levels of NHIS policy to service providers.

Table 16: Benefits of the scheme to service providers

	Yes		No	
	N	%	N	%
The revenue generated from the NHIS is higher than what was being generated during cash and carry period?	12	75.0	4	25.0
Has your finances improved upon the introduction of the NHIS?	13	81.3	3	18.8
Has your clients' base increased?	16	100.0	0	0
Has the introduction of the NHIS benefited your facility?	14	87.5	2	12.5
It has increased both OPD and IPD attendance	15	88.2	2	11.8
IGF has been increased	8	47.1	9	52.9
The rate of mortality has reduced	4	23.5	13	76.5
The diseases occurrence in the district has been reduced	4	23.5	13	76.5

This section of the study sought to find out the challenges service providers faced.

Table 17: General challenges of the service providers

	Yes		No	
	N	%	N	%
The incidence of inability of clients to settle bills has been reduced at the facility	1	5.9	16	94.1
Delay in payment of claims	1	5.9	16	94.1
Lack of drugs	1	5.9	16	94.1
More NHIS card holders being returned because of expired cards	1	5.9	16	94.1
Were all the claims you submitted paid	5	35.7	9	64.3

Impact of the Scheme on the Service Providers

This section of the study was to examine the impact of the scheme on the accredited service providers.

Table 18: Impact of the scheme on the service providers

	Yes		No	
	N	%	N	%
Has the introduction of the scheme increased the attendance in your facility?	17	100	0	0
Has the establishment of the scheme made any impact on your IGF?	10	83.3	2	16.7

Has the introduction of the scheme impacted on facilities in your institution?	13	100.0	0	0
Increased in laboratory investigation	2	11.8	15	88.2
Increased in skilled delivery	2	11.8	15	88.2
Has the introduction of the scheme helped in the reduction of mortality cases in your facility?	15	100.0	0	0.0
Do you think NHIS has contributed in the health care delivery in the district?	16	100.0	0	0

SCHEME STAFF

This section presented the assessment of the scheme implementation strategies and the general challenges of the scheme.

Table 19: What were some of the strategies adopted in creating people's awareness of the scheme in the district

	Yes		No	
	N	%	N	%
Promotion programs	4	57.1	3	42.9
Advertisement	3	42.9	4	57.1
Public education programs	6	85.7	1	14.3
Organization of durbars in the communities	3	42.9	4	57.1
Sensitization programs in the community	3	42.9	4	57.1

Table 20: What strategies were used to get clients to register with the scheme

	Yes		No	
	N	%	N	%
Institutional contacts and enrolment	1	14.3	6	85.7
Free registration of aged and children below 18 years	1	14.3	6	85.7

Table 21: In your opinion, what other strategies do you think can be carried out to increase or cover the entire population of the district?

	Yes		No	
	N	%	N	%
More education	2	28.6	5	71.4
Intensify promotion	2	28.6	5	71.4
More community sensitization	2	28.6	5	71.4
Improvement on the network	1	14.3	6	85.7
Formation of clubs and associations	1	14.3	6	85.7
Make available the BMS machines	2	28.6	5	71.4

Table 22: General challenges of the scheme

	Yes		No	
	N	%	N	%
Lack of logistics	4	57.1	3	42.9
Delay in payment of claims	2	28.6	5	71.4
Difficulty reaching overbank communities	1	14.3	6	85.7
Bad nature of the network	2	28.6	5	71.4
No HR policy for staff progression	1	14.3	6	85.7
Frequent power outages	1	14.3	6	85.7

Summary of the Main Findings

This section presents the main findings of the research work. It was established that, most of the respondents were teachers, traders, nurses and students represented by 59.5%. These groups of people are capable of registering and renewing their membership with the scheme. It was also identified that farmers represented the smallest group with 5.6% as subscribers to the scheme in the district.

The findings also revealed that, about 62.3% of the subscribers had high yearly income levels and are capable of renewing their membership. These findings indicated that the sustainability of the scheme is high. The findings also revealed that 72.2% were in a good healthy condition in the Jasikan District.

98.8% of the scheme clients indicated during the investigation that they were satisfied with availability and accessibility of the scheme and health facilities. The research findings indicated 86.7% as the overall satisfaction of the subscribers with the services of the scheme.

83.5% of the subscribers of the scheme in Jasikan District are aware that the scheme does not cover all diseases. The findings, however, revealed that majority of the respondents are not aware of the diseases covered by the scheme.

The research found out that 67.3% representing the majority agreed that the introduction of the scheme has improved their finances.

The finding revealed that 89.1% of the respondents said that the inability of NHIS to cover all diseases and drugs were not challenges to the subscribers. The finding also indicated that time wasting during registration and renewal of membership cards is (98% respondents), payments by active subscribers for medications (90.2% respondents), subscribers of NHIS not served with good medications (96.1% respondents), high rate of corruption in the NHIS system (99% respondents), no urgent treatment to complaints (100% respondents)

and delay in payment of claims to service providers (96.1% respondents) are not challenges. 89.2% of the respondents also stated that poor service to NHIS card bears is not a challenge to the clients. It was further revealed that 99% of the respondents stated that recruitment of the NHIS staff influence by politicians was not a challenge to the scheme operations.

The findings deduced that 75% indicated that revenue generated during the NHIS is higher than what was generated during cash and carry period. It was also exposed that 100% of the respondents agreed that the client based has increased with the introduction of the scheme.

100% of the respondents indicated that the introduction of the scheme has impacted on facilities (laboratory and the maternity) in their institutions according to the finding of the research. The findings also indicated that 100% of the service providers stated that the introduction of the scheme has helped in the reduction of mortality cases and contributed to quality health care delivery in the district.

The report of the findings revealed the following as the strategies adopted by the scheme to create awareness of the scheme.

1. 85.7% of the respondents stated that public education was one of the frequently used strategies to create awareness of the scheme in the Jasikan district.
2. 57.1%, of the total respondents stated that promotion was used.
3. 42.9% as against 57.1% respondents stated that advertisement, community durbars and community sensitization programs were used to create people's awareness of the scheme in the district.

The research also revealed that the following strategies can also be used to cover entire population of the district. More education, intensify promotion, more community sensitization and availability of the BMS machines. Others were improvement on network and formation of clubs and associations.

The final findings of the research were challenges faced by the scheme. The findings revealed that 57.1% of the respondents thought that a lack of or inadequate logistics is a challenge of the scheme in the district.

71.4% of the respondents stated that delay in payment of claims and bad nature of communication networks is not a challenge of the scheme. 85.7% of the participants stated that difficulties of reaching overbank communities, no HR policy for staff progression, and power outages are not challenges to the scheme in the district.

CONCLUSION

This research work on evaluation of the National Health Insurance Scheme (NHIS) policy on the health care delivery in Ghana, the case of Jasikan District in the Volta Region evaluated people's perception on the benefits levels of NHIS policy in the Jasikan District and also assessed the implementation strategies of NHIS in the District. The study further examined the impacts of the scheme on the accredited service providers and subscribers in the District and finally assessed the general challenges of the policy on the three categories of people of the study.

The following observations were drawn from the research. About 289.9% of the subscribers were not satisfied with services provided by the scheme. The breakdowns are; customer service – 69.1%, services covered by the scheme – 58.6%, claims payment – 87.8% and professionalism of staff – 71.4. It was again observed that majority of the subscribers in Ghana especially Jasikan District are not aware of those diseases that are on the treatment list of NHIS. Education will assist create awareness of those diseases under the services of NHIS and those that are not.

Finally, it was also noted that lack/inadequate logistics is one of the problems of the district offices of the scheme. The researchers noted that improvement on network system was necessary though 17.6% subscribed to that idea.

LIMITATION AND FUTURE RESEARCH DIRECTIONS

The current study has limitations that should be mentioned. Most importantly, the findings come from a study of cross-sectional design, and limited to only Jasikan District of Ghana. Further research should be conducted on a larger scale for example regional base studies in order to widen the scope for the purpose of generalisation.

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