

Sustaining Health Care Financing Schemes in Ghana

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ABSTRACT: *The health of a people to a very large extent determines their productivity and wealth. The 2010 Population and Housing Census indicates that a significant proportion of the Bunkpurugu-Yunyoo District in Ghana (over 75%) are living below the poverty line of GH¢228.00 per annum (approximately US \$120 per annum). It then implies that approximately the same proportion or even a little above that might not be able to access health care under the 'cash and carry' system. Inability to access health care will lead to poor health status of the residents and thus lower their productivity. Eventually the poverty levels of these residents will worsen and thus increase the number of those below the poverty line. This study therefore seeks to identify reasons behind low renewal rates of members of Bunkpurugu-Yunyoo District Mutual Health Insurance Schemes. In Ghana, studies on renewal of health insurance are very few, if they exist at all. Most studies have documented issues and challenges the system faces in terms of accessibility, efficiency, quality of the health care delivery and initial enrolment. In consideration of the level of research done on health insurance renewals in the country therefore, the researcher adopted the exploratory design for the study. The study was to ascertain why majority of clients do not renew their cards and the main observations were that majority of respondents (63.8%) attributed the failure to renew membership cards to lack of money. Interestingly rather, majority of respondents (75.5%) who used a health facility in the past 12 months were satisfied with the quality of services provided and 73.5% of respondents said they were satisfied with the quality of services offered by the Scheme. It is recommended therefore that management of the various schemes intensify education on the need to sustain the benefits of the scheme by renewing their subscriptions every year.*

Key words: *health care financing, financial constraints, health insurance, sustainability, cash and carry system*

I. Background of the Study

The health of the people of every nation is normally considered to be the pivot of growth and development of that nation. Good health does not only minimise disease and infirmities but also enhances the social, economic, psychological and mental wellbeing of the individual (WHO, 1995). The international conference on health (WHO, 1998) declared that the wealth of the world varies directly with the health of the world's population. The declaration further called for action on all WHO member governments to increase resources for the health sector to ensure that people attain the level of health that will permit them to lead socially and economically productive lives. However, financing health care has been a very difficult task all the world over and various countries continue to explore several avenues to lessen the burden of financing health care on government and to further improve access to quality health care by all residents. Scarce economic resources, low or modest economic growth, constraints on the public sector and low organisational capacity explain why the design of adequate health financing systems in developing countries, especially the low income ones, remains cumbersome and the subject of significant debate. Earlier on, cost-recovery for health care via user fees was established in many developing countries usually as a response to severe constraints on government finance (WHO, 2003), and Ghana was no exception. However over the last decade, social health insurance is emerging as the most preferred form of financing health care costs in most countries, yet its

sustainability proves to be a more difficult task than its initial introduction (Gilson, 1998; Sauerborn & Nougara, 1994). Health insurance mechanism helps residents to pool their risks and transfer risks of unforeseeable healthcare costs for a pre-determined fixed premium thereby avoiding catastrophic financial burden (Griffin, 1992). Health insurance policies are generally one-year policies and to remain part of the insurance pool, policyholders are required to renew their policies each year. Maintaining member continuity through renewals year by year has been very difficult and this has very serious implications for sustainability of the system. This is especially compounded by the fact that the motives for health insurance renewal may not necessarily be the same as factors affecting the initial purchase decisions (Bhat & Jain, 2007)

II. THEORITICAL ISSUES

Overview of Healthcare Financing

In developing countries, we find very few studies that have analysed healthcare financing and challenges it faces. Most of the studies have documented issues and challenges the system faces in terms of accessibility, efficiency and quality of the health care delivery. It is observed that as a country's economic development evolve over time the more it tends to spend through public health expenditure as the population demand for better social protection increases (Drouin, 2007). Thus governments as they grow would need to find the most effective ways, in terms of policies, to extend social protection to as many people as possible. According to World Bank (2006), total health expenditure in recent years amounted to 7.7% of gross domestic product in high income countries, 5.8% in middle income countries and 4.7% in low income countries. The government public share of total health expenditure represented 70%, 62% and 52% of the total in high-, middle- and low income countries respectively. In Europe, government and national health insurance account for 70% of total health expenditure on average while covering nearly 100% of the general population. In Ghana, the health sector alone takes an average of 10% of the total annual budget of the nation (MOH, 2002). Rao (2004), in her discussions on challenges facing the health sector in India, identified financing to be one of the most important components to improve health system in India and advocated that health insurance should be given very high priority by the government as a means to financing healthcare. It is therefore not surprising that Ghana, which is now a lower middle income country and was even one of the fastest growing economies in the world in 2011 (Ministry of Finance and Economic Planning, 2011), has had to introduce the National Health Insurance Scheme (NHIS), as the citizens demand for better social protection policies.

Methods of Financing Healthcare

National health polices typically focus on improving the population's health and preventing diseases and health hazards so that their entire population can aspire to a healthy and happy life and thus productively contribute to the prosperous development of the country and its economy. The objectives of a national health system are usually established as the intention of the state and written in the context of national laws, policy documents and other sources that may not necessarily be confined to a single source and may have been adopted at different points in time. This constitutes the Health Plan of the nation which has been defined as a predetermined course of action that is firmly based on the nature and extent of health problems, from which are derived priority goals (Drouin, 2007). The scope of objectives of the national health system is eventually limited by the extent to which they are affordable in a national context as health objectives are competing with other government programmes. Scarce national resources need to be optimised and rationalised. Depending on the choice of financing mechanisms and sources, the achievement of national health objectives will be more or less independent of national budget constraints. Thus national health objectives are eventually achieved through the selection of an adequate method of financing as well as through the choice of an effective and efficient organisational delivery structure for health services and payment approach for health providers. In addition, other structural elements contribute to the achievement of health objectives, such as the regulatory frame work and programmes of public education (Russell, 2003). Health financing mechanisms are organisational options for a health financing system of how to offer financial risk protection to people against the costs of healthcare. The method of financing consists of the way in which financial resources are mobilised and utilised. It is multifaceted as it relates to different factors including:

- The approach to mobilise financial resources;
- The institutional and organisation delivery structure;

- The allocation of resources;
- The remuneration and incentive method for health providers

These methods include;

- a. Tax-based financing,
- b. Social health insurance,
- c. Private mutual health insurance,
- d. Out-of-pocket payments,
- e. And more recently the innovative financing method of medical savings accounts (Carren., Evans, and Xu, 2007).

The choice of method, however, will depend on the number, structure and performance of existing schemes, the political and cultural context, the size of the tax base, the size of the informal economy, the disease burden, the availability of infrastructure, the capacity to collect taxes and premiums, who bears the financial burden, the amount of resources available, who manages the allocation of resources and the possibility of enforcing legislation. For instance, in principle, the mobilisation of resources through tax-based financing requires that the target group to which resources are allocated and health expenditure incurred be the entire population.

Tax-based financing

In tax-based financing, individuals contribute to the provision of health services through taxes on income, purchases, property, capital gains, and a variety of other items and activities. These are typically pooled across the whole population, unless local governments raise and retain tax revenues. Health services are purchased by government, usually from a mix of public and private providers. This system can be considered as one leading to the most effective manner for national risk pooling across the whole population and redistributing between high and low risks and high and low income groups (Savedoff, 2003). It gives the potential for administrative efficiency and cost control. However, its potential to contribute to health care financing depends largely on macroeconomic performance and competing demands from other sectors, the quality of governance, the size of the tax base and human and institutional capacity of the government to collect taxes and supervise the system. In practice, government schemes often tend to be under funded which might lead to shortage of goods and services and to under-the-table payments and lack efficient governance (Carrenet *al*, 2007).

Social health insurance

In social health insurance, contributions from workers, the self-employed, enterprises and government are pooled into a single or multiple funds on a compulsory basis. These funds typically contract with a mix of public and private providers for the provision of a specified benefit package. Preventive and public health care may be provided by these funds or responsibility kept solely by the Ministry of Health. Within social health insurance, a number of functions may be executed by parastatal or non-governmental sickness funds or in a few cases by private health insurance companies. Social health insurance has the advantage of generating stable resources, often has strong support of the population, provides a broad package of services, involves social partners in decision-making and implementation and redistributes between high and low risk and income groups. However, administratively, schemes are complex and governance and accountability can be problematic. Further, from a macro-economic point of view payroll contributions can reduce competitiveness and lead to higher unemployment. This system can also lead to cost escalation if effective contracting arrangements are not kept in place (Singh, 2006).

Private health insurance

In private health insurance, premiums are paid directly from employers, associations, individuals and families to insurance companies, which pool risk across their membership base. Private insurance includes policies sold by commercial for profit firms, non-profit companies and community health insurers. Generally, private health insurance is voluntary in contrast to social insurance programmes that tend to be compulsory. It is worth noting however that, in some countries private insurance may also be compulsory for certain segments of the population especially the formal, employed sector. Private health insurance is often preferred to out-of-pocket payments as it increases financial protection and access to health services for those able to pay. It encourages better quality and cost-efficiency of health care providers. This system is however inequitable without subsidised premiums or regulated insurance content and price and it is ineffective in reducing cost pressures on public health financing systems. In environments where the impact of financial risk protection mechanisms has a limited impact, community health insurance schemes are introduced to improve the protection.

Contributions are not risk related, and there is generally a high level of community involvement in the running of such schemes (Carrenet *et al.*, 2007).

Out-of-pocket spending

Out-of-pocket spending (*also user fees*) on health services is the most common form of health financing in developing countries and represents a significant financial burden for households (Sekhri and Savedoff, 2003). Out-of-pocket payments is the most direct option of all the health financing systems and it involves each person bearing his/her own health risk by paying directly to health care providers, one's own health care cost without sharing the burden. Payments are done at the point of service delivery. The other dimension of out-of-pocket payments is the Medical Savings Account (WHO, 2002). These are individual savings accounts which are restricted to spending on health or medical care. They are a relatively new method and they have been introduced to: encourage savings for the expected high costs of medical care, enlist health care consumers in controlling costs, and mobilise additional funds for health systems. Only a few countries in the world (Singapore, USA, China, and South Africa) have experience with Medical Savings Account. To uphold the principle of health for all, the selected approach to financing health care should allow the collective pooling of risk that contributes to meeting the broader objectives of equity, solidarity and affordability. Equity takes place at different levels: equity in financing, equity in access to health care, equal level of health status and equity in terms of risk protection offered (Ku and Ross, 2002). It is also very important to note that the most important determinant of how fairly a health system is financed is the share of prepayment in total spending. Out-of-pocket payment is usually the most regressive way to pay for health and the way that most exposes people to catastrophic financial risk (WHO, 1993).

Financing Healthcare in Ghana: The Journey to National Health Insurance Scheme

In Ghana during the post independence period, health care was “free” and was being financed principally by tax revenue. In the 1970's token fee-for-service was introduced as the cost of financing health care increased and tax revenue alone was no longer able to finance health care services. The country then experienced a period of deteriorating health care in the late 1970s through the early 1980s with scarcity of almost all essential medical supplies and deteriorating infrastructure (Ministry of Health, 2004). To help address the situation, **Legislative Instrument, 1985 (L. I. 1313)** on fee-for-service for all medical conditions except certain specified communicable diseases was introduced in 1985. The exemption policy under L.I. 1313 was however badly implemented in that, although communicable diseases were supposed to have been exempted, in practice, nobody enjoyed this facility. This was because no guideline for implementation was provided and no conscious system was designed to prevent possible financial leakages (Ghana Health Service, 2001). This led to a further decline in the utilisation of health services. In spite of this, the government, in 1993 introduced full cost recovery but still, with exemption for the poor. The payment mechanism put in place was termed ‘cash and carry’. With the introduction of the cash and carry system, internally generated funds improved with concomitant increased availability of drugs and other consumables (Atim, Grey, Apoya, Anie, and Aikens, 2001). However, utilisation of health care as assessed by per capita Out-Patient (OPD) attendance decreased from between 0.6 – 0.9 of the proportion of population in the 1970s to between 0.3 – 0.4 in the 1990s. Thus the exemption policy that was introduced to mitigate the effect of ‘cash and carry’ on the poor became ineffective because of poor implementation which among other things was the result of the fact that no system for identifying the poor was put in place and also managers became obsessed with fees collection (Atimet *et al.*, 2001). However, most studies alert decision-makers to the negative effects of user fees on the demand for care, especially that of the poorest households. Alternative health financing systems exist, de-linking utilisation from direct payment, and thereby protecting the population, especially the most vulnerable groups, from having to resort to various coping mechanisms. In these systems, financing is based either on general tax revenues and/or social health insurance contributions. Risk-pooling is a core characteristic of these systems, enabling health services to be provided according to people's need rather than to their individual capacity to pay for health services (WHO, 2003). Given that social health insurance was emerging as the most preferred form of health financing mechanism in situations where private out-of-pocket expenditures on health are significantly high and cost recovery strategies affect the access (Gilson 1998; Sauerborn and Nougara 1994) to healthcare, the Ghana government introduced the **National Insurance scheme (Act 650, 2003)** to replace the market driven ‘cash and carry’ system of health care financing. The National Health Insurance Scheme (NHIS) was introduced because the ‘Cash and Carry’ System, which made it compulsory for everybody to pay money immediately before and after treatment in hospitals/clinics, was not within the means of most Ghanaians and many could not go to the hospitals and clinics resulting in needless deaths. The policy goal of the Ghanaian system was to institute a national health insurance scheme that would assure equitable universal access for all residents of Ghana to an acceptable quality package of healthcare services without the need to pay out-of-pocket at the point of services.

The policy objective was that within five years from the passage of [Legislative Instrument, 2004 \(LI 1809\)](#), every resident in Ghana was to belong to a Health Insurance Scheme. The health insurance allows everybody to make contributions into a fund so that in the event of illness contributors could be supported by the fund to receive affordable healthcare in health facilities.

The NHIS Act established three types of insurance schemes:

- The District-Wide Mutual Health Insurance Scheme (DMHIS),
- The Private Mutual Health Insurance Scheme (PMHIS) and
- The Private Commercial Health Insurance Scheme.

The latter is purely private and is conducted solely for profit making. The government however chose to support the establishment and running of only the DMHIS.

Funding for healthcare under the NHIS as established by the Act comes from a Fund created by the Act, with income from two main sources:

- the National Health Insurance Levy (NHIL) which is a 2.5% top-up of the Value Added Tax (VAT), and
- A 2.5% transfer from the existing Social Security and National Insurance Trust (SSNIT) worker contribution per month.

In addition however, the Act levies working persons who do not contribute to SSNIT a yearly premium ranging from GH¢7.20 to GH¢48.00 depending on one's level of wealth. The Act further provides for a certain category of persons to join the Scheme and benefit thereof without having to pay any premiums. These exempt categories include aged persons who are 70 years and above, children below 18 years whose parents have registered with the scheme, SSNIT pensioners and the indigent (or core poor persons). The exempt category was later expanded in 2008 to include pregnant women. The Scheme provides for a minimum benefits package including out-patient, in-patient, oral, eye care, maternity and all emergency services and prescriptions on the NHIS Drug List. The following services are however exempted from the benefits package: rehabilitation other than physiotherapy, appliances and prostheses, cosmetic surgeries and aesthetic treatments, HIV retroviral drugs, assisted reproduction, echocardiography, photography, angiography, orthoptics, dialysis for chronic renal failure, heart and brain surgery other than those resulting from accidents, cancer treatment other than cervical and breast cancer, organ transplantation, all drugs not listed on the NHIS Drug List, diagnosis and treatment abroad, medical examinations for purposes of visa applications, educational, institutional and driver licensing uses, VIP ward accommodation and mortuary services. A Scheme may however provide for its members services over and above the minimum benefits package subject to such additional premiums as may be agreed upon between the Scheme and its members.

Enrolment of Clients onto Health Insurance Policy

The process of enrolling members onto a health insurance scheme differs from country to country and from scheme to scheme. Group registration through group co-operatives, corporations, villages and families, individual registration and free enrolment are all channels to enrolling into schemes. In the United States of America, individuals and families can purchase private insurance or receive coverage through government sponsored programmes. Employers often offer health insurance coverage for their employees through group plans. Employer-sponsored insurance typically provides coverage for the qualified spouses and dependent children of participants. People who do not have access to group plans can often purchase coverage independently from an insurance company. Low-income individuals and senior citizens can often qualify for free or low-cost insurance provided by state, local, and federal governments. These state sponsored plans include the Medicaid, Medicare, State Children's Health Insurance Programme (CHIP) and Military Health Care (Insurance Information Institute, 2012). In the United Kingdom (UK) however, the National Health Service (NHS) provides free health insurance for all citizens of the UK with only a few exemptions in coverage. However, about eight percent of the populations are still enrolled with private insurance ([Rivett, 1998](#)). In a study conducted on the Save for Health Uganda (SHU) and the Ishaka schemes in Uganda ([Basazaet al, 2007](#)), families could join only as groups. A group, in that instance, was defined as a set of people who registered to join in the same community, organisation, workplace or village. For the Ishaka Scheme, a minimum of 60 percent of group enrolment was required, while that of SHU was a minimum of 100 persons for a village-based enrolment. No individual registrations were allowed so as to protect against adverse selection. The Ghana NHIS provides for all residents in the country to register and join the Scheme. Residents are categorised broadly into the formal sector workers (SSNIT Contributors), informal sector workers (premium payers) and the [exempt groups \(Act 650, 2003\)](#). The law required the parents of dependants to be registered with the Scheme before they could be enrolled as exempt. However, in 2008, an administrative directive was issued, decoupling all children from their parents and thus granting them the right to enrol as exempt even if their parents did not enrol ([BYDMHIS, 2010](#)). Basic personal information as well as group information is required in the process of

registering an individual or a group. For instance in the Community Health Fund in the Hanang district of Tanzania, information required from enrollees include name of person and name and address of household head; names, ages and sex of spouse and dependants; and passport-sized photographs (Cheet *et al.*, 2002). In Ghana, information needed to enrol clients onto a health insurance scheme includes (NHIA, 2008): name, sex, date of birth (DOB), locality; postal and residential address of clients; type and level of occupation; information on social security if applicable; information on incomes earned; marital status; type and number of children/dependants and; information on the next of kin (NHIA, 2008).

The enrolment process is as follows:

- a. The client is first given education on NHIS and this is done either by the Insurance agent or by Scheme officers
- b. His/her financial/SSNIT status is then assessed for categorisation
- c. Having been classified under one of SSNIT contributor or pensioner, indigent, aged, informal or under aged, the person's bio-data is taken.
- d. The client is then snapped a passport photograph
- e. The client pays the applicable premium/fees
- f. The data is finally carried to the office for processing and observation of applicable waiting period.

The Scheme will then proceed to issue a national health insurance identity card to the client after observing the applicable waiting period. After policyholders have been issued with the national health insurance identity card which is renewable every year, they can seek medical treatment from any accredited health facility in the country.

Renewal of Health Insurance Policies

Health insurance policies are generally one year policies and to remain part of the poll, one needs to renew his/her insurance coverage once every year. This process is especially very important in the United States of America as it helps insurers, particularly those in the state sponsored categories, to make sure one is in the right plan or program, based on ones age, health needs and monthly income (Insurance Information Institute, 2012). The renewal process could be done either online or by hard copies. One could update the insurance plan and personal information at the point of renewal and premiums are often paid on or before the renewal date. However, premiums could also be paid by instalments. The actual renewal process involves filling of forms either online or by requesting hard copies through post. In renewing group insurance, you need to get your group letter from your insurance carrier, your insurance agent or a letter from each of them. With this, one contacts the insurance company for update of information if necessary and the processing of the renewal. Similarly in the U.K., renewal of insurance policy could be done either online or through telephone (Rivett, 1998). The process involves filling of forms online or by using telephone contacts to activate the membership status. In Ghana however, the health insurance system is still mainly manual and cannot be done either online or by telephone, even though renewal is also required to activate once membership yearly. Unlike the enrolment of a member into the NHIS, renewal of membership takes a very simple process (NHIA, 2008). Upon expiry of a card;

- a. The bearer contacts either an insurance agent or the Scheme office for payment of applicable premiums/fees.
- b. The card is then activated on the Scheme's ICT platform and a sticker is attached to the ID card for physical confirmation of renewal
- c. Where necessary, the existing data of the client could be updated before the renewal is affected.

Factors Accounting For Initial Health Insurance Purchase Decision

Though the focus is on factors affecting low renewal rates of health insurance policyholders, reasons why people join health insurance schemes have to be examined in order to understand and appreciate the reasons for low renewal rates in Ghana. It must be noted however that, in Ghana, information or studies on health insurance purchase decision is rare and scanty. Bhat & Jain (2006), analyse the factors that affect health insurance purchase decision in a micro health insurance setting. The study was based on a household survey in the Anand District of Gujarat in India. According to them, the first factor that influences households' decision to buy health insurance policy was income level. Once a household has an "appreciable" level of income, the decision to buy health insurance policy is inevitable. An increase in income will result in purchase of health insurance as people now can afford to buy health insurance and it will save them from potential risk. However at higher levels of income, households do not allocate resources to health insurance and therefore purchase less health insurance. Household purchases of insurance decreases as households are willing to retain the risk. The role of education

in health decision-making has been well documented. Grossman (1972) and Muirinen (1982), found out that a better educated person is likely to be better informed about both the health services available in the system and the benefits of joining a health insurance fund and at the same time he/she is also likely to be healthier which would lower the probability of health risk. Surprisingly however in Ghana, majority (72%) of health insurance policy holders are households with no or low levels of education (NHIA, 2010). This is probably due to the fact that in Ghana, households with no or low levels of education take national issues very seriously for fear of being victimised. Another important variable which affects health insurance purchase decision is healthcare expenditure and knowledge about health insurance (Kronick & Gilmer, 1999). As household's health expenditure and knowledge about health insurance is high, insurance purchase decision is high and vice-versa. Other factors such as age, number of children in the household, and gender have been found to be important factors affecting health insurance purchase decision (Scotton, 1969; Savage & Wright, 1999). Evaluating the Nkoranza Scheme in Ghana, Atim and Madjiguene (2000) identified inappropriate registration periods, widespread misconceptions in the community about the schemes and massive adverse selection of members into the schemes as some factors contributing to low registration of members into the schemes. Further, in a survey report released by the International Labour Organisation (ILO) in March 2007, lack of public education on registration, distance of residents from health facilities and delays in issuance of membership cards were among factors that caused low patronage of the Dangme West District Mutual Health Insurance Scheme in Ghana.

Factors Accounting for Low Renewal Rates of Health Insurance Policyholders

Despite the initial challenges and difficulties in establishing health insurance schemes in various countries, persistent efforts by various schemes and institutions have yielded appreciable gains in enrolling members into health insurance schemes. Yet, the number of active members among these initial enrollees dwindles year after year as most members fail to renew their membership.

In Ghana, despite all the efforts employed to get members enroll with schemes, sustaining membership in the schemes seems even more difficult and less appreciated than the former, as most members fail to renew their membership after just the first expiry of their membership (NHIA, 2010). Since health insurance is not mandatory, it faces the challenge of ensuring all policyholders renew their policies, as these policies are not sold for long-term. Studies on renewal of health insurance policies in Ghana are almost non-existent and if they do, then they are very scanty. Generally, it is assumed that factors affecting the purchase will affect the renewal decision. In Guinea-Conakry, a study on declining subscriptions in Maliando Community Health Insurance Scheme identified two main causes of the decline: poor quality of care offered to members at health facilities and problems of subscription affordability amongst poor and/or large families (Criel & Waelkens, 2003). In a similar study conducted in Uganda in 2006 on two selected Community health Insurance Schemes: the Ishaka and the Save for Health Uganda (SHU) Schemes, Basaza, Criel and Van der Stuyft (2007) observed that despite the promotion of Community Health Insurance Schemes in Uganda since the mid 1990's, membership remained persistently low, with only about 30,000 people enrolled into the two schemes under study, comprising only about 2% of the catchment population. They also recorded declining subscriptions. The study pointed at a series of not mutually exclusive explanations for the under-achievement of the health care delivery system. The following reasons were identified:

- i. Low level of community involvement in the management of hospital based community health insurance schemes
- ii. Lack of trust in local financial organisations after previous depressing experiences with similar institutions
- iii. inability to pay the premium
- iv. The absence of a coherent policy framework to promote community health insurance amidst a backdrop of user-fee abolition in the public sector.

It is often argued that income may be a significant factor in influencing the insurance purchase decision in the first place but less significant in renewal decision. All things being equal, if policyholders' income remains just at an appreciable level, the tendency to renew is high for fear of a sudden occurrence of sickness for which they may not have enough income (Bhat & Jain, 2007). On the contrary, higher incomes will not influence renewal decisions as policyholders will be willing to absorb risks. However it must be emphasised here, that income and total health expenditure, which significantly influence initial purchase decisions (Bhat & Jain, 2006), were found in the study not to significantly influence renewal decisions. This finding is similar to the findings in Nouna-Burkina Faso that total household expenditure and distance to contracted health facility did not positively influence the renewal decision (Dong, Allegri, Gnawali, Soares, & Sauerborn, 2009). The recent hue and cry in the Ashanti region of Ghana over the introduction of capitation in health insurance being piloted in Kumasi is a major reason affecting renewal rates particularly in Kumasi, the regional capital. Under the capitation, clients are requested to select their preferred service provider in a hierarchical order given three ranks. However,

service providers were unwilling to render services to MHIS clients because they claimed Ghana Health Service pricing of health services under capitation was far below prevailing market prices of goods and services. As a result, majority of private health providers in Kumasi had resorted to the cash and carry system, thereby discouraging card bearers from renewing their policies (Agyepong&Yankah, Daily Graphic). In a study of the life insurance market, Durvasula, Lysonskiet. al. (2004) found that customer satisfaction was positively associated with customer's repurchase decisions. The satisfaction can arise from the experience of using product, from the seller and/or from after sale service. In the field of health insurance, this satisfaction may come from the experience and services provided by insurer and also policyholder's interaction with provider of services may significantly influence his decision. This is rightly confirmed in the study by Criel&Waelkens (2003) that subscription to the Maliando Community Health Insurance Scheme was declining due to poor quality of services offered by providers. It is worthy to note that, understanding the factors, which affect the demand and renewal decisions of continuing in health insurance programme, is imperative for growth and development of this sector in Ghana.

III. RESEARCH APPROACH

Research Design

In Ghana, studies on renewal of health insurance are very few, if they exist at all. Most studies have documented issues and challenges the system faces in terms of accessibility, efficiency, quality of the health care delivery and initial enrolment. In consideration of the level of research done on health insurance renewals in the country therefore, the researcher adopted the exploratory design for the study. Exploratory study is adopted where very little is known about the topic under study (Marlow, 2001). Such studies can adopt either the explanatory or descriptive approach, and in this case the researcher adopted the descriptive approach. Descriptive research describes, records, and reports phenomena. Descriptive research provides important fundamental information for establishing and developing social programs like the NHIS (Marlow, 2001). It also focuses on vital facts about people and their opinions and provides information on which to base sound decisions. Descriptive surveys interpret, synthesise and point to integrations and interrelationships among the various factors under study (Osuala, 1987). Descriptive research can be either quantitative or qualitative. It can involve collections of quantitative information that can be tabulated along a continuum in numerical form, such as scores of an exam, or it can describe categories of information such as gender. Descriptive research involves gathering data that describe events and then organises, tabulates, depicts, and describes the data collected (Glass & Hopkins, 1984). It often uses visual aids such as graphs and charts to aid the reader in understanding the data distribution. However, it is limited in its generalisability of findings to the entire population compared to other methods (Marlow, 2001).

IV. DETERMINATION OF SAMPLE SIZE AND SAMPLING PROCEDURE

Sampling Techniques

Sampling is the process of selecting a subset of population for the purpose of study (Ahuja, 2007). The rationale is to make generalisation or to draw inferences based on the study of samples about the parameters of the population from which the samples are taken (Yin, 1998). In view of the peculiar nature of the research topic, the purposive and quota sampling techniques were employed in selecting the respondents. In purposive sampling, we sample with a *purpose* in mind. We usually would have one or more specific predefined groups we are seeking. In picking the units through this method, one verifies that the respondent does in fact meet the criteria for being in the sample. Purposive sampling can be very useful for situations where you need to reach a targeted sample quickly and where sampling for proportionality is not the primary concern. With a purposive sample, you are likely to get the opinions of your target population, but you are also likely to overweight subgroups in your population that are more readily accessible (Ahuja, 1987). Quota sampling is often considered a sub-grouping of purposive sampling. In this method, you select people non-randomly according to some fixed quota. There are two types of quota sampling: *proportional* and *non-proportional*. In **proportional quota sampling** you want to represent the major characteristics of the population by sampling a proportional amount of each. The problem here is that you have to decide the specific characteristics on which you will base the quota. It could be by gender, age, education race, religion, or whatever characteristics apply (Sarantakos, 1998).

Non-proportional quota sampling on the other hand is a bit less restrictive. In this method, you specify the minimum number of sample units you want in each category. Here, you are not concerned with having numbers that match the proportions in the population. Instead, you simply want to have enough to assure that you will be able to talk about even small groups in the population. This method is the non-probabilistic analogue of stratified random sampling in that it is typically used to assure that smaller groups are adequately represented in your sample. The researcher therefore employed non-proportional quota sampling and identified the applicable characteristics of respondents as follows: zone, community, identity card status and availability of health facility in selected community. Respondents, with the aid of Collection Agents, were therefore selected from six villages out of the 535 settlements, employing the following criteria:

Zones: a village each from the 6 health insurance zones

Identity card status:

- Members with expired cards that have not been renewed
- Members that have renewed their cards after expiry
- Non-subscribed persons (non-card bearers)

Availability of health facility:

- 3 settlements without a health facility
- 3 settlements with a health facility

Focus Group Discussions (FGD) were conducted in 3 communities, 2 with health facilities and one without a health facility.

In-depth interviews were also conducted for persons from the Scheme, Providers and Collection agents

Sample size determination

Using the formula for computing sample sizes as developed by the National Education Association of the United States of America (Sarantakos, 1998), the sample size was computed by the formula below;

$$s = [\chi^2 Npq] / [d^2(N-1)] + \chi^2 pq, \text{ where}$$

χ^2 is chi-square for 1 degree of freedom and from mathematical tables is equal to 3.841;
 N is the population size which is 216,918;
 p is the population proportion and is assumed at 0.5;
 q = 1 - p = 1 - 0.5 = 0.5; and
 d is the maximum tolerable error and is set at 0.05.
 Substituting these values we obtain the following:
 $s = [3.841 * 216918 * 0.5 * 0.5] / [(0.05)^2 * (216918 - 1)] + [3.841 * 0.5 * 0.5]$
 $= 208295.5095 / 542.2925 + 0.9603$
 $= 385.0621$
 $\approx \mathbf{386}$

Therefore the sample size is 386.

Sample size distribution

The Researcher, by the characteristics set out above distributed the sample size of 386 as indicated in the table below:

Summary of sample size distribution

Method of Data Collection	No. of Respondents	Total Number sampled
Structured Questionnaire	<ul style="list-style-type: none"> • 6 non-subscribed persons • 7 renewed card bearers • 45 expired card bearers (In each selected community)	348
Interview guide	<ul style="list-style-type: none"> • 1 Scheme Officer • 4 Collection Agents • 3 Health Providers 	8
Focus Group Discussion	<ul style="list-style-type: none"> • 10 people for each group 	30
Total		386

Source: Researcher’s construct 2012

DATA COLLECTION INSTRUMENTS

Data for the study was collected from both primary and secondary sources. A primary source of data is a document or physical object which was written or created during the time under study. The second source of the data was from relevant documents and related literature on the topic. Secondary source interprets and analyses primary data. It is research based on the work of others. Secondary data is thus text that interprets or comments upon primary sources (Marlow, 2001). This included, but not limited to various enactments on financing healthcare in Ghana, reports and presentations by various institutions on health insurance, Journals and other publications. A research or data collection instrument is a tool for data collection. It is a device for measuring a given phenomenon, such as a questionnaire, an interview schedule, a research tool, or a set of guidelines for observation (Glass & Hopkins, 1984). The research instruments used were questionnaires for those who subscribed or did not subscribe to the Scheme and interview schedules for focused group discussions and key informants. The interview schedules were employed on a limited scale to provide a face to face interaction between the respondents and the researcher, and also to make room for researcher to probe on matters arising from some of the responses to the questionnaires which were not fully addressed by the questionnaire. Questions for the interview sessions were open-ended and provided an opportunity for the researcher to seek enough clarification on issues that were not clear and not understood. Also some key informants were interviewed to provide further information and clarification on certain issues. Key informants are persons identified as experts in the field of interest. Thus key informants were sampled from the Scheme and the providers.

Validity of instruments

The questionnaires and interview schedules were pretested on selected persons outside those to be sampled for the study. This was done to confirm the appropriateness of the test items. This provided an opportunity for the necessary corrections to be made on questions that were not clear and ambiguous, and also added items that were not captured in the first instance.

ETHICAL PROCEDURES

The preliminary to the questionnaire assured clients of confidentiality in their responses and the purpose of the questionnaire. When a respondent was chosen, the research assistant provided detailed and appropriate explanations about the purpose, nature, benefits and possible duration of the research, to the respondent in order to seek one's consent. They were made to understand that they could discontinue the research at anytime within the process if they so felt, without any penalty or punishment of any sort. It was only after a respondent's consent that the research was carried out.

Field challenges

Reaching some of the randomly selected settlements, especially in the Kulaw area was quite a challenging task. A number of streams had to be crossed with a motorbike in the canoe. This of course, was not restricted only to the Kulaw area. Also, the cost of fuelling motorbikes, maintenance cost and per diem for the research assistants was quite very high due to the wide geographical size of the district and the fact that in most places, the research assistants had to sleep for a number of days. Lastly, translating the questions into the local dialects for the respondents to understand was quite a daunting task. In some instances, it took about five minutes or more to explain a single question to some respondents to understand.

DATA PROCESSING AND ANALYSIS

Data analysis is viewed by Kama (1996) as the computation of certain measures along with searching for patterns of relationships that exist among data groups. In a related study Yin (1998) also stipulated that it is a number of closely related operations performed with the purpose of summarising the data collected and organising them in such a manner that they answer research questions. All responses gathered from the field were first examined to secure accuracy and consistency. The main trends of the answers were recorded. This was followed by tabulation, coding and processing using the Statistical Product and Service Solutions (SPSS version 16.0). Statistical tools such as percentages, tables and charts were used to analyse the data.

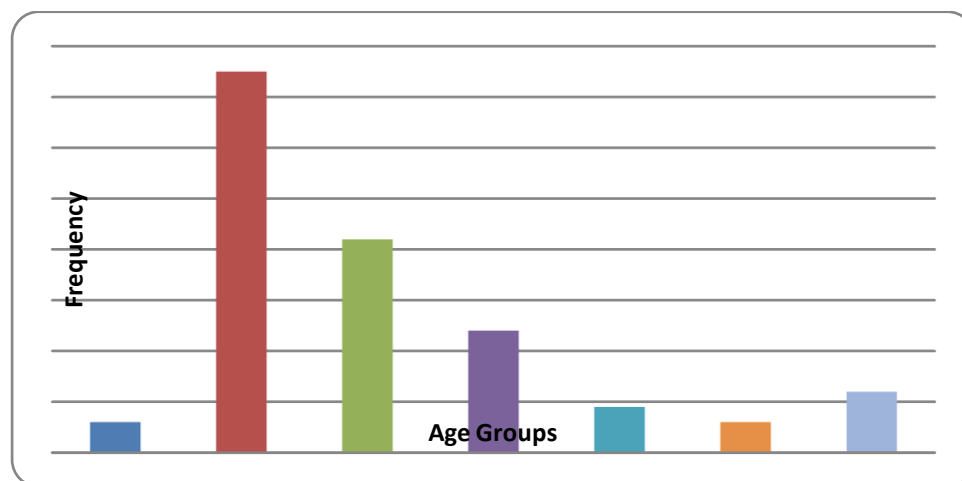
V. RESULTS AND DISCUSSION

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Demographic issues considered in this discussion include the age and sex of respondents, the marital status, household size and number of household members below 18 years of age, the religious background and

ethnicity of respondents. Also considered are their occupations as well as their educational and income levels. The age distribution of respondents is shown in Figure 4.1. Respondents were between the ages 19 and 80 years. They were clustered at the lower age categories, with the largest category being the age group 20 to 29 (43.1%). The mean of the distribution of ages was 35.10 with a standard deviation of 15.03. The wide variation between the mean and standard deviation is an indication that the ages were not normally distributed and this shows clearly in Figure 4.1. A cross-tabulation between the age groups and the respondent's membership status did not show any obvious relationship. This is confirmed by a high Chi-squared value of 0.083, indicating there is no significant relationship between a member's age and his/her status with the Scheme.

Figure 4.1: Age of respondents



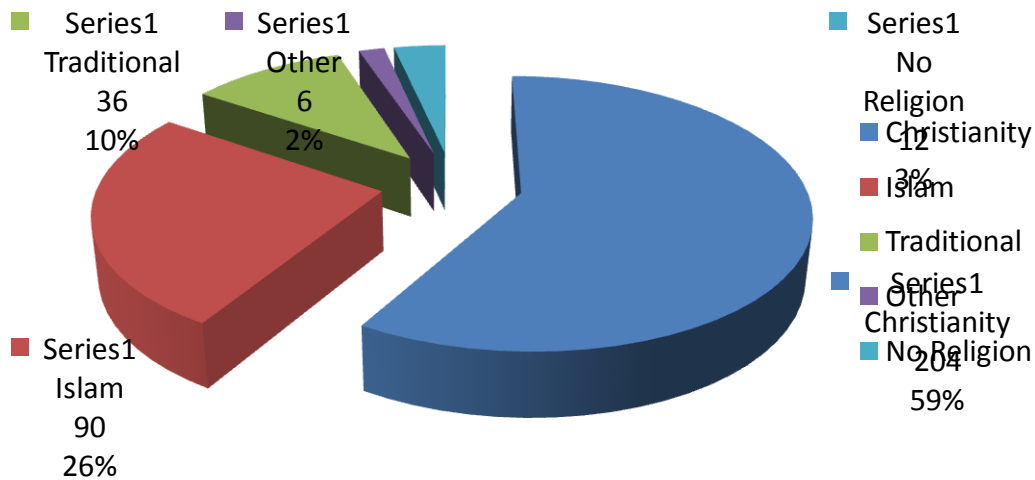
Source: Field work, 2013

Of the 348 respondents, 222 (63.8%) were males while 126 (36.2%) were females. About 86% of the female respondents were holding expired cards while 73% percent of the males had expired cards. Twenty-four male respondents did not enroll with the Scheme while females who did not enroll were 12. There was no significant relationship between the sex of respondents and their membership status and so one could not conclude that sex was a determinant of membership status. This is however at variance with the 2011 report of the Scheme which showed that females constituted about 60% of active members and 70% of total registered members at the end of 2011.

With regard to marital status, 58.6% of respondents were married, 36.2% were single persons while 3.4% were divorced. Among respondents with expired cards, married persons constituted 57.8% while single persons were 35.5%. Also, among those with active membership, married persons were 57.1% and the singles were 42.9%. There was no observed relationship between marital status and membership status as the high percentages of married persons followed by singles was only influenced by their proportionate representations in the sample. The mean, median and mode of the household sizes were 13, 10, and 10 respectively, while the minimum was three and the maximum was 40. Clearly, given that the mode was 10 while the minimum was three and the maximum was 40, the mean has been influenced by the extreme value of 40. Therefore the median is a better measure of the central tendency than the mean. Thus the average household size of 10 is a little above the size of seven indicated in the 2000 Population and Housing Census of the District. Similarly, the mean, median and mode of the household members below 18 years were 4.82, 4 and 4 respectively, with a minimum of zero and a maximum of 17. In relating both the household sizes and the number of household members less than 18 years to the membership status of respondents, there was no observed relationship between the variables. Therefore there was no evidence to the effect that these variables influenced the membership status of respondents. In response to religious affiliation, 25.9% said they were Muslims, 58.6% were Christians, and 10.3% were Traditionalists. The others were 'no religion', 3.4% and 'other religion', 1.7%. The high percentage of Christians was influenced by their dominance in the study area. Relating respondents' religious affiliation to their membership status, 66.7% of Muslims and 76.5% of Christians had expired cards. However, a Chi-squared test of independence did not show any significant relationship between respondents' religious affiliation

and their response to renewal of health insurance membership. Figure 4.2 details the religious affiliation of respondents.

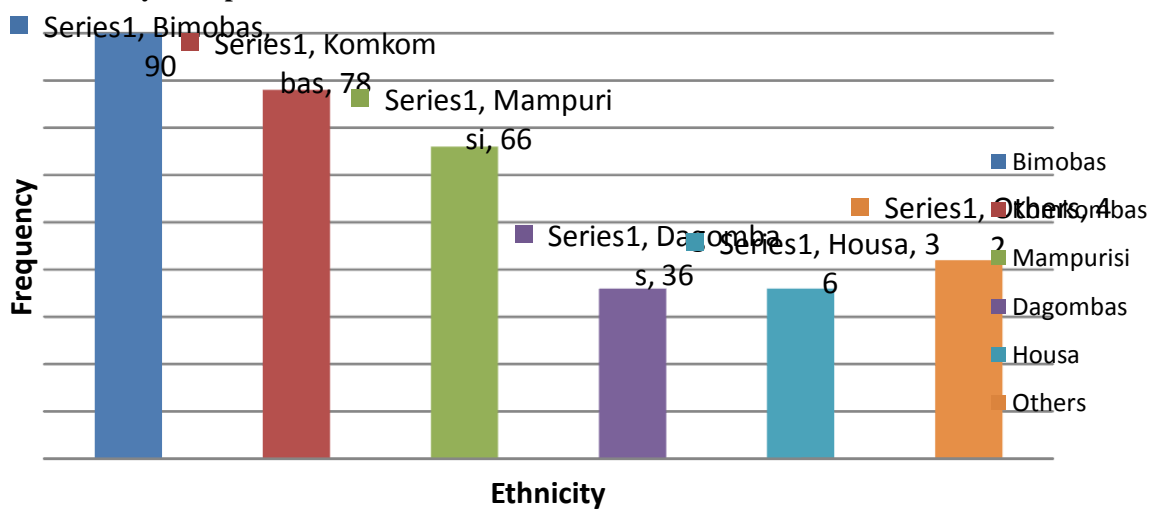
Figure 4.2: Religious affiliation of respondents



Source: Field work, 2013

The ethnicity of respondents was also enquired to determine if certain ethnic beliefs impacted upon respondents' involvement in health insurance. Out of the 348 respondents, 90 were Bimobas (25.9%) while 78 (22.4%) were Komkombas. The observed size of the Bimoba respondents was because it comprised of a wide category of clans including the Louk people, Tamomta, Bouk, Japaak people, Nadaung and many others. Figure 4.3 gives a complete picture of the ethnicity of the respondents. A cross-tabulation of ethnicity against respondents' insurance status yielded 90.9%, 80.0% and 76.9% for Bimobas, Komkombas and Mamprusis respectively on expired membership. However, a five percent significance test for independence did not indicate any significant relationship between the ethnicity of respondents and their status.

Figure 4.3: Ethnicity of respondents



Source: Field work, 2013

Table 4.1 depicts the level of education of respondents. Only 27.6% did not have any form of education, but the remaining 72.4% had one form of education or the other, ranging from non-formal to tertiary. Disaggregating the various educational levels into active membership and expired membership yielded results that seemed like the more educated persons were more concerned about the active status of their cards than the less educated. Thus those at tertiary level had 26.7% with active cards, Secondary level respondents had 6.7% and those without any education had 6.2% with active cards. However, a test of association between the level of education and status of membership did not yield any significant relationship between the two variables. This thus contradicts the finding by Grossman (1970) that a better educated person was more likely to join a health insurance Scheme and remain active than the less educated.

Table 4.1: Level of education

Level	Frequency	Percent
None	96	27.6
Secondary/SHS	90	25.9
Tertiary	90	25.9
Post Secondary	36	10.3
Primary	18	5.2
Middle/JHS	12	3.4
Non-Formal	6	1.7
Total	348	100.0

Source: Field work, 2013

The occupation and average monthly income of respondents were also enquired. The Agric Sector had the highest number of respondents (28.6%) and this is because majority of residents in the area are farmers. Salaried workers were 21.4% while the self-employed were 14.3% of respondents. Out of the 216 respondents that answered the question, the mean monthly income was GH¢254.50 with a standard deviation of GH¢210.43. The minimum observed monthly income was GH¢10.00 and the maximum was GH¢833.00. The large non-response rate (132 persons) was because people were not ready to disclose their monthly earnings and even where they did, they may not have indicated the right amounts. As clearly indicated in Table 4.2, majority of the respondents (66.7%) in the Agric sector earned less than GH¢200.00 monthly. The salaried workers, most of whom were teachers and on the government payroll, earned the highest monthly income across all the categories, with majority of them (90.0%) earning above GH¢201.00. However, majority of the self-employed (75.0%) earned less than GH¢100.00. It is however important to note that a test of independence between the earnings of individuals and their membership status did not yield any significant relationship.

Table 4.2: Occupation and average monthly income of respondents

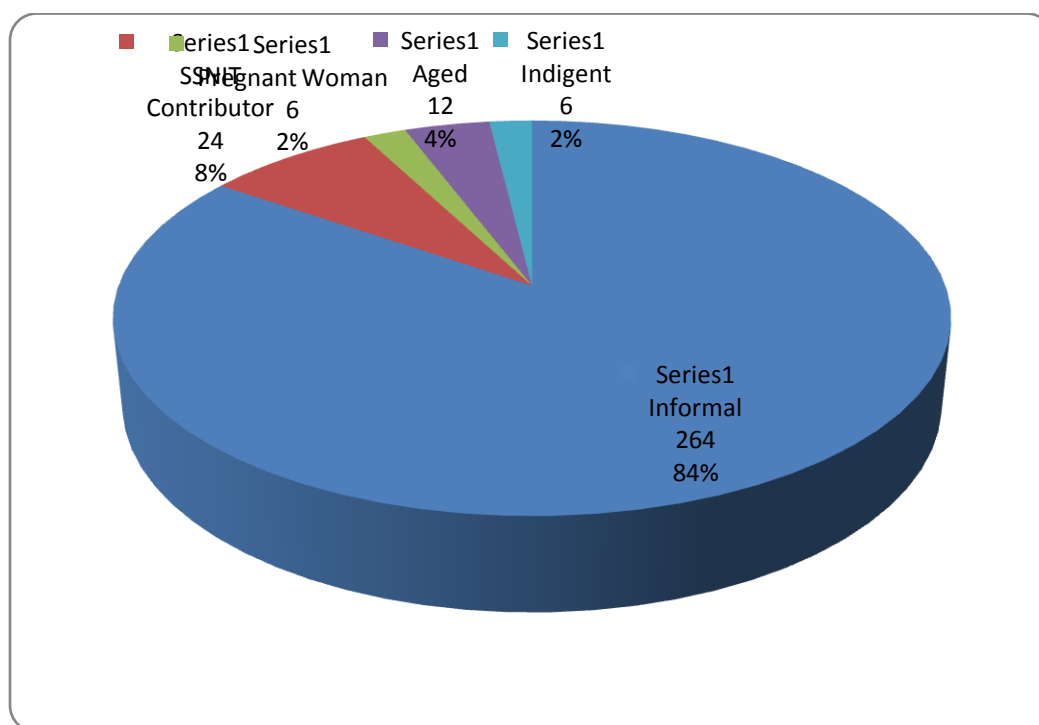
Average Monthly Income	Agric		Salaried Worker		Student/Pupil		Self-employed		Total	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
<=100.00	24	(26.7)	6	(10.0)	12	(66.7)	36	(75.0)	78	(36.1)
101.00-200.00	36	(40.0)	0	(00.0)	6	(33.3)	6	(12.5)	48	(22.2)
201.00-300.00	6	(6.7)	12	(20.0)	0	(00.0)	0	(00.0)	18	(8.3)
301.00-400.00	6	(6.7)	6	(10.0)	0	(00.0)	0	(00.0)	12	(5.6)
401.00-500.00	12	(13.3)	12	(20.0)	0	(00.0)	6	(00.0)	30	(13.9)
501.00-600.00	6	(6.7)	12	(20.0)	0	(00.0)	0	(00.0)	18	(8.3)
601.00-700.00	0	(0)	6	(10.0)	0	(00.0)	0	(00.0)	6	(2.8)
701.00-800.00	0	(0)	0	(00.0)	0	(00.0)	0	(00.0)	0	(00.0)
801.00+	0	(0)	6	(10.0)	0	(00.0)	0	(00.0)	6	(2.8)
Total	90	(100.0)	60	(100.0)	18	(100.0)	48	(100.0)	216	(100.0)

Source: Field work, 2013

HOW CLIENTS ENROL WITH SCHEMES

This section examined how clients were enrolled into the Scheme. It was thus enquired to know if respondents enrolled with the Scheme and if they did where they were registered, who registered them, which payment category they were assigned and finally how much they paid to enroll. Of the 348 respondents, 312 said they had enrolled with the Scheme while 36 said they had not enrolled. Out of the number that enrolled 73.1% said they got enrolled at the Scheme office, 15.4% said they got enrolled in their houses, 9.6% said they were enrolled at special registration exercises organised by the Scheme at their communities and 1.9% said they were enrolled at the Agent's kiosk. Enquiring further about who actually registered them, 80.8% of respondents said they were registered by Scheme officials other than the Agents, 17.3% said they were registered by the Agents and 1.9% said they were registered by other persons/institutions. The high number of persons registered at the office was an indication of ineffectiveness by the collection agents, as confirmed by a key informant in the Scheme office during an interview. He said the Agents were demotivated by the low remunerations they earned from the Scheme and so did not put in much effort to go round their catchment areas to register residents. The informant also explained that those registered by other persons/institutions were those that were assisted by NGOs to enroll as well as those registered under the Livelihood Empowerment Against Poverty (LEAP) programme of the Ghana government. Also during the focused group discussions it was disclosed that some people were registered through the National Youth Employment Programme (NYEP). Regarding the question of how one got enrolled as well as what information was taken from respondents during enrolment, responses from the questionnaire administered as well as from the focused group discussions and the interview with the key informant from the Scheme were very similar. They all indicated that one received education on the Scheme through one or a combination of the following sources: one-to-one contact with an Agent or Scheme official, durbars, leaflets distributed by the Scheme or discussions with friends and relatives. The work and financial status of one was then assessed by the person conducting the registration for categorisation and charge of premiums and fees. Having agreed on a category, which could be one of informal, SSNIT Contributor, above 70 years, SSNIT pensioner, below 18 years or a pregnant woman, one's personal information was taken and written down in the registration form. The data requested were summarised from the various responses to include the complete name, age and date of birth, sex and marital status, occupation, location/address, telephone number and household members. The applicable charges were then paid for a receipt to be issued and a photo of the client was taken. The documents were then carried to the Scheme office for processing and observation of the applicable waiting period. The procedure prescribed here was much in conformance with the prescriptions of the operational manual of the National Health Insurance Scheme (NHIA, 2008). However, the process of enrolment here is at variance with that adopted by the Ishaka Scheme and Save for Health Uganda both in Uganda (Basaza *et al.*, 2008). In their case, only group registrations were allowed and the information taken was more about the entire group than the detailed personal information taken in the case of the NHIS of Ghana. When asked which category, respondents were assigned when they were being registered, the responses brought out five main classifications: informal, SSNIT Contributors, pregnant women, Aged and indigent. Children below 18 years of age were not indicated because the questionnaires were administered only to adults. Majority of respondents (84%) belonged to the informal category who were the only premium payers among all the categories. Figure 4.4 throws more light on the categories among the respondents. These categories indicated the payment of various amounts as fees and/or premiums before being registered.

Figure 4.4: Membership categorisation of respondents



Source: Field work, 20113

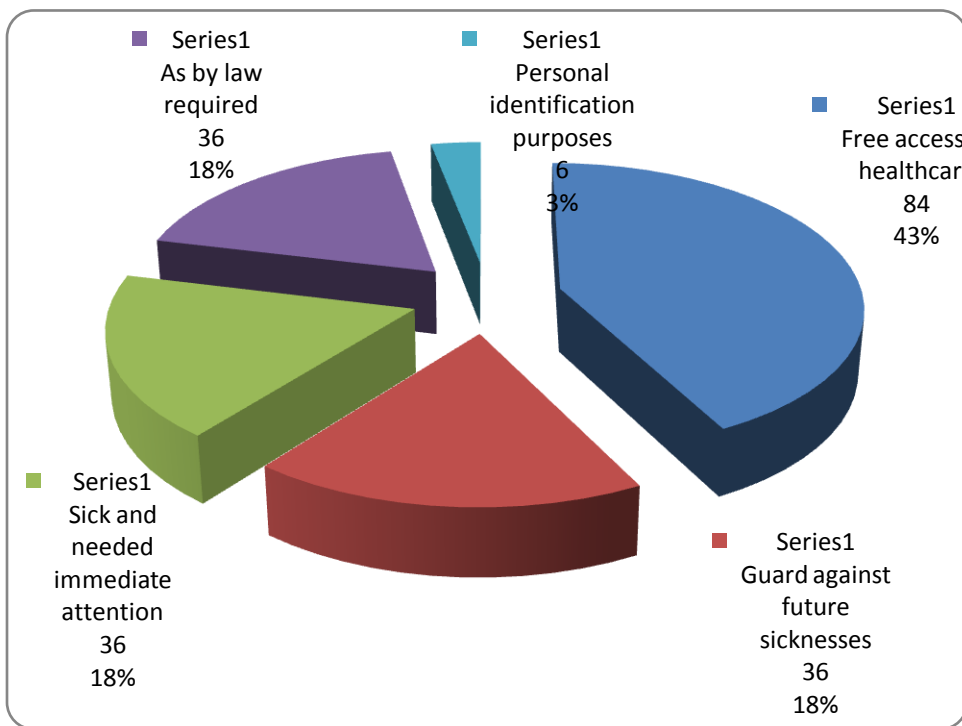
The amounts paid ranged from free registration to GH¢14.00. Majority of the informal sector respondents (88.6%) paid amounts ranging from GH¢7.20 to GH¢17.00. The SSNIT contributors as well as the aged indicated the payment of only GH¢4.00 as fees before enrolling into the Scheme.

HOW CLIENTS RENEW THEIR MEMBERSHIP CARDS

In determining how clients renew their membership cards, respondents were asked if their cards ever expired since joining the Scheme and whether they ever renewed their cards. They were also asked where they did the renewal and who did it for them; how much they paid for the renewal; the process of renewing the card and; why they renewed the card. Asked whether their cards ever expired since they joined the Scheme, all 312 respondents answered in the affirmative. When asked whether at the time of the research their cards were still expired however, 86.5% had their cards expired while 13.5% of them said their cards were still active. When it was further enquired from them whether they ever renewed their expired cards, 198 (63.5%) of them answered in the affirmative while the remaining 114 (36.5%) said they had never renewed an expired card. It implies that while some card bearers attempt to renew their cards, they do so very belatedly, probably when they encounter health care challenges. Management of the Scheme therefore needs to put in more strategies to improve client responsiveness to renewal of cards. The 198 who renewed their cards were further asked where they renewed their cards. They cited only two places: at the Scheme office (87.9%) and at a special renewal exercise (12.1%). Also, 90.9% of them said their cards were renewed for them by a Scheme official while 6.1% said it was an Agent and the remaining 3.0% said their cards were renewed for them by some NGOs and so they did not know who particularly handled the process. When the 198 respondents were asked how much they paid to renew their cards, only 192 of them gave responses. Of these, 71.9% said they paid GH¢14.00, 18.7% said they paid GH¢12.00 and the remaining 9.4% said they paid GH¢4.00. The mean amount paid was 12.80, which is lower than the mean amount paid (GH¢15.00) when they were

doing the initial registration. In an interview with a key informant from the Scheme it was disclosed that while premiums remained the same both for initial enrolees and those renewing their cards, the processing fees were GH¢4.00 for initial enrolees but it was GH¢2.00 for renewals. He thus suggested that it was the most possible reason why mean payments for renewals was lower than for the initial enrolment. On the issue of the process of renewing an expired card, responses from the administration of the questionnaire, interview with the key informant from the Scheme and the focus group discussions were similar. Most responses from the focus group discussions and the questionnaire said they simply paid the applicable charges to either an Agent or other Scheme official and waited for some internal office processes to be carried out. Thereafter, their cards were returned to them with a sticker attached at the back of the card as an indication of re-activation of the validity of the card. A few respondents however said they requested corrections of the information on their cards, especially the wrong spellings of their names and dates of birth. The processes indicated above were confirmed by the key informant from the Scheme, but he added that where a client had defaulted in renewing the card, the person after paying the applicable charges was asked to wait and observe a three-month suspension period beginning from the date of payment of the charges. After the waiting period, he said, the card would be activated for the client to use in accessing health care. These processes indicated are also in consonance with the process of renewal of a card in the NHIA Operational Manual (NHIA, 2008). Asked why they renewed their cards, respondents gave varied reasons including enabling free access to health care, guarding against future sickness, was sick and needed immediate medical care, as by law required and for personal identification purposes.

Figure 4.5: Reasons for renewing membership



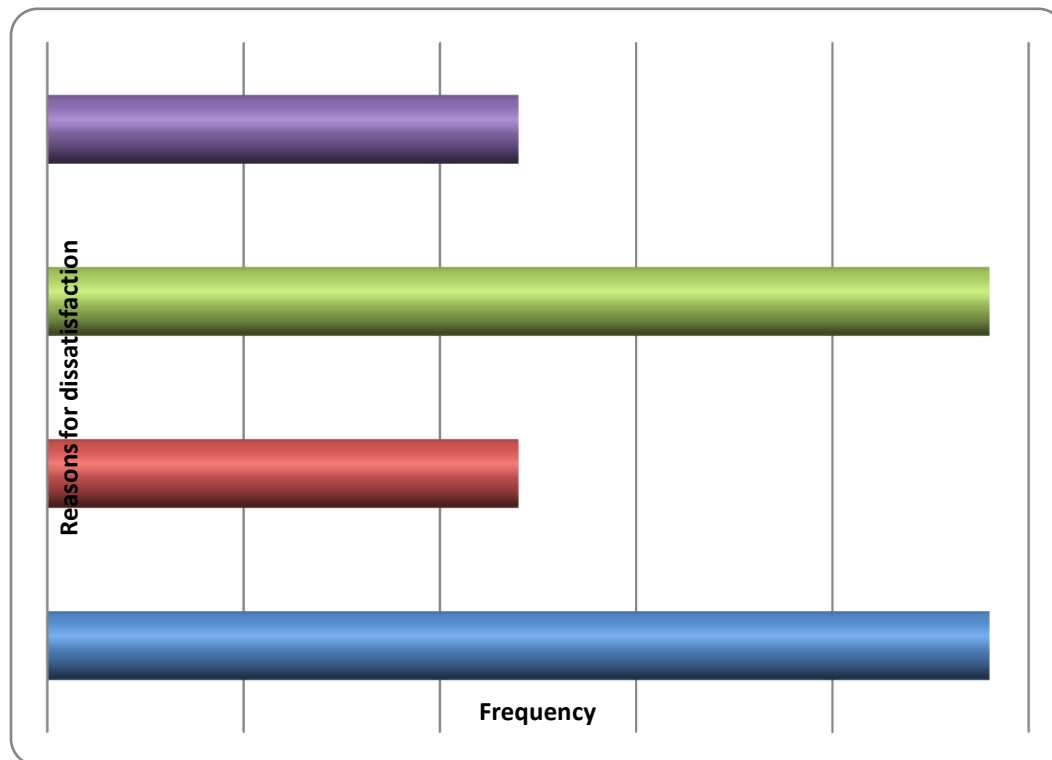
Source: Field work, 2013

Majority (43%) of the respondents said they renewed their cards just to have free access to health care. Of special interest was the group that said they renewed because the law required them to do so (18%). Most of them said they had never even benefited from use of the card but were constantly renewing because the law required one to renew annually. In addition to these, the key informant from the Scheme also added experience from the use and benefits of the Scheme fear of the three month suspension penalty, pressure from friends and relatives to renew and continuous education from the Scheme on the need to renew the cards.

WHY CLIENTS DO NOT RENEW THEIR CARDS

To ascertain the reasons clients do not renew their cards, respondents were asked if any of their household members used a health facility during the past twelve months and if they were satisfied with the services rendered at the facility. They were also asked if they were satisfied with the quality of services offered by the Scheme and to give reasons for their answers and finally, they were asked to state possible reasons why clients failed to renew their cards. Answering whether they had used a health facility in the past twelve months, 312 responses were received as the question applied only to those who enrolled with the Scheme. Of these, 294 persons responded in the affirmative while the remaining 18 answered otherwise. Of the 294 who answered in the affirmative, 75.5% of them were satisfied with the services they were rendered while the remaining 24.5% were not. Varied reasons were given by both groups for the responses they offered. The 75.5% who said they were satisfied offered two main reasons for their answer: the disease was well treated (72.2%) and good worker attitude (27.8%). These reasons were also mentioned by respondents during the focused group discussions, with a special stress on good worker attitude. Those who were not satisfied cited four main reasons for their responses as displayed in Figure 4.6. As clearly showed in the figure, 33% of them cited ‘discrimination against NHIS clients’ and ‘poor medication and treatment’ respectively and 17% cited long waiting period to see prescriber’ and ‘poor worker attitude’ respectively as the reasons for their responses.

Figure 4.6: Reasons for dissatisfaction with services of health care facilities



Source: Field work, 2013

During the focused group discussions, it came out that there were times that there were no prescribers at post to attend to clients even at the district hospitals. Some also accused some of the facilities of extorting money from clients. The key informant from the Scheme similarly cited dissatisfaction with the quality of services provided by some health facilities as one of the issues discouraging clients from renewing their cards. In responding to whether clients were satisfied with the quality of services of the Scheme, 73.5% of the 294 respondents said they were satisfied with the Scheme while the remaining 26.5% said they were not satisfied. For those who said they were

satisfied, 69.4% of them indicated ‘good worker attitude towards client’ as their source of satisfaction; 16.7% said they spent reasonably short periods at the Scheme in solving their problems and; the remaining 13.9% said for the fact that the Scheme enabled them to enjoy free access to health care, they were satisfied with the Scheme irrespective of other shortfalls. On the other hand four reasons were given by the 78 respondents who were not satisfied with the Scheme. The reasons were: poor worker attitude (61.5%), unable to deliver the promise of free health care (15.4%), long waiting periods at office (15.4%) and lastly, office does not accept clients after noon (7.7). The last and yet least response was a serious accusation on the Scheme and so the key informant was asked for his view on that. He explained that the accusation was inappropriate because there were only a few days when some clients, especially pregnant women, were asked to return home and come back to the office the following day as the Scheme was facing some technical difficulties in their ICT system and so could not meet clients’ requests for those days. This, he said, was not tantamount to a policy or practice by the Scheme to reject clients after noon. Respondents were further asked to explain why they thought clients failed to renew their cards. As showed in Table 4.3, majority (63.8%) of respondents attributed the failure to renew cards to lack of money and 10.4% said it was due to the perception by people that they would not fall sick.

Table 4.3: Reasons why clients fail to renew cards

Reason	Frequency	Percent
Lack of money	222	63.8
People think they don’t/won’t fall sick	36	10.4
Apathy by clients	24	6.9
Inadequate education/illiteracy/ignorance	18	5.2
Discrimination against card bearers at facilities	185.2	
Long distance from Scheme	12	3.4
Poor attitude of staff of Scheme	12	3.4
Discouraged by 3-month suspension penalty	61.7	
Total	348	100.0

Source: Field work, 2013

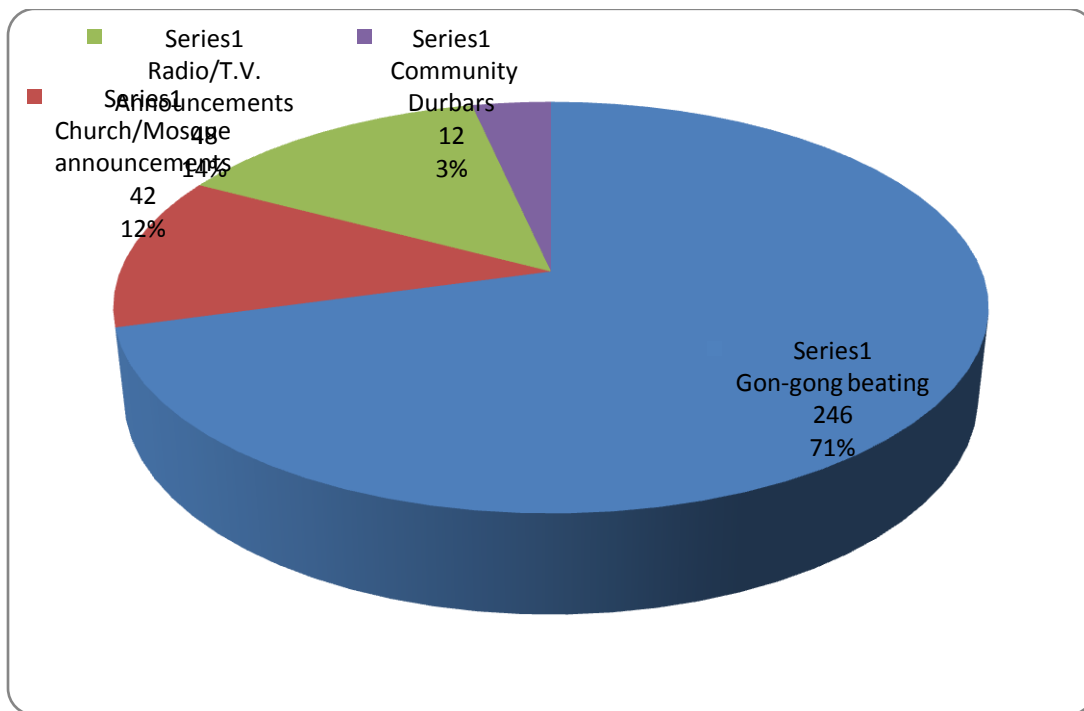
The rest cited reasons such as inadequate education or illiteracy and ignorance, discrimination against card bearers at facilities, apathy on the part of clients, poor attitude of Scheme staff towards clients, long distance of clients from Scheme office and discouragement to renew by defaulters by dint of the 3-month suspension penalty. Clearly from Table 4.3 except the mention of discrimination against card bearers at facilities, no mention was made of the quality of services of health care providers as a factor discouraging clients from renewing their cards. This is further consolidated by the majority of clients expressing satisfaction at the quality of services of the health care providers. This finding is similar to that of Basaza et al. (2007) in their study in Uganda on the SHU and Ishaka schemes where they found out that quality of care was not a reason for the high dropout rate of the two schemes. These findings however contradict those of Criel&Waelkens (2003) as well as Manuela et al. (2006) that quality of care was a reason for the poor enrolment and continuity in membership of the schemes. Furthermore, majority of respondents indicated their satisfaction with the quality of services offered by the Scheme and this is rightly confirmed as only 3.4% of respondents attributed lack of renewals of cards to issues relating to the Scheme’s operations. The most important reason for the poor renewal rates of the members of the Scheme is therefore subscription affordability problems. This finding is in consonance with the findings by Chee et al. (2002) in their study in Guinea-Conakry that lack of money was one of the most important reasons for the high drop-out rate of the Community Health Fund in the Hanang district of Tanzania. This finding is also similar to the findings of Criel&Waelkens (2003) in their study in Guinea-Conakry that subscription affordability problems among poor and/or large families was one of the major reasons for the declining subscription in the Maliando Community Insurance Scheme.

APPROACHES TO INCREASING RENEWAL RATES

To identify sustainable approaches to increasing renewal rates of clients of the NHIS in Ghana, respondents were asked how frequently, Collection Agents visited them in their houses, which medium of communication they found

more appropriate for dissemination of insurance policies, whether the current insurance charges were affordable and in what ways they thought clients could be encouraged to renew their cards. Enquiring about how frequently Agents visited respondents' home to solve insurance problems, respondents were asked to indicate whether the Agents did so weekly, monthly, quarterly, yearly or they did not even visit at all. In response however, majority (74.1%) of respondents said the Agents never visited them in their homes, 8.6% said they did so monthly and 6.9 % said they were visited once every quarter. This situation, the key informant from the Scheme said was true, especially as Agents were not well motivated to actively do their work. He said it had very serious repercussions on the operations of the Scheme, as the Agents were the front-liners if it came to health insurance work at the communities. On the appropriate medium of communication for health insurance in the community, most respondents preferred the use of gong-gong beating. This is especially so due to the absence of F.M/Radio stations in the district.

Figure 4.7: Preferred medium of communication



Source: Field work, 2013

Answering if the current premiums were affordable, 180 respondents (51.7%) said they were not affordable while 168 respondents (48.3%) said they were affordable. This goes to confirm the earlier concerns of subscription affordability problems by clients. When those who said it was not affordable were asked to suggest how much should be charged, they suggested a mean subscription fee of GH¢5.60. The minimum of the suggestions was to pay nothing and make the system entirely free while the maximum figure suggested was GH¢10.00 and the modal amount was GH¢5.00 with a frequency of 60 (33.3%). When asked to suggest other ways of encouraging clients to renew their cards, 41.9% of the 330 responses suggested continuous education/sensitisation, 18.2% suggested a reduction in the charges, and 12.7% suggested facilities should be encouraged to provide quality services. The others were: provide satellite offices in distant communities (7.3%), wave off the 3-month suspension penalty (7.3%), increase visitations to communities (5.4%), organise more special renewal/registration exercises (5.4%) and make it totally free (1.8%). participants at the focus group discussions agreed with these but added that the indigent bracket should be expanded to include all jobless people and that payment by instalments should be re-introduced. Most of these findings are consistent with the suggestions given by the key informant from the Scheme who suggested intensification of sensitisation and reactivation of Agent activities in the communities. However, his view on the

penalty for defaulters contradicted that given by respondents to the questionnaire. He rather suggested an increase in the penalty for late renewals, explaining that if clients realised the difficulties they would face if they defaulted, they would consciously make efforts at renewing the cards. In response to this question, the key informants from the health facilities suggested one main item: intensify education on the need for renewal of membership. They said this was the most important they could think of because once people are healthy, they do not think that they will ever fall sick and do not even think of preparing themselves for any eventualities. However with continuous reminders, they will be more tempted to renew their cards.

VI. CONCLUSION

Findings of the Study

The first objective was to determine how clients were enrolled by the mutual health insurance scheme. It was realised that majority (73.1%) of respondents who enrolled with the Scheme were enrolled at the Scheme office and 80.8% of the enrolled said they were enrolled by Scheme officials other than the collection agents. The procedure for registering a client was: education on insurance, assessment of work/financial status, assignment to a category, personal information taken, payment of applicable charges, snapping of photo and finally processing of information at the Scheme office. Meanwhile, applicable charges paid by clients ranged from free registration to GH¢14.00.

The second objective of the study was to examine how clients renew their membership status and the major findings emanating were that 63.5% of respondents whose cards ever expired had also ever renewed their cards and majority of respondents (87.9%) said they renewed their cards at the Scheme office. The mean amount paid for renewals was GH¢12.80 and to renew a card, one paid the applicable charges to an agent or Scheme official, the agent or official would take the card to the office for renewal processing and a sticker would be attached to the back of the card as evidence of renewal. Where necessary, updates of one's personal information could be done during the renewal. Furthermore, majority of respondents (43%) who renewed their cards said they did so to enable them have free access to health care.

The third objective of the study was to ascertain why majority of clients do not renew their cards and the main observations were that majority of respondents (63.8%) attributed the failure to renew membership cards to lack of money. Interestingly rather, majority of respondents (75.5%) who used a health facility in the past 12 months were satisfied with the quality of services provided and 73.5% of respondents said they were satisfied with the quality of services offered by the Scheme.

The fourth and last objective of the study was to identify sustainable approaches to increasing renewal rates of clients of the Scheme. Majority of respondents believed that continuous education/sensitisation is the most important means to increasing the renewal of membership cards. Secondly, 51.7% of respondents said the subscription charges were not affordable and suggested the payment of GH¢5.00 as subscription charges would encourage and enable more people to renew their cards. Also, Gong-gong beating was the preferred means of disseminating health insurance information as indicated by 71% of respondents.

Recommendation

Health insurance policies are generally one-year policies and to continue to access the benefits of the insurance schemes, policyholders are required to renew their policies each year. Maintaining member continuity through renewals year by year has been very difficult and this has very serious implications for sustainability of the system. The factors influencing renewals may be related to satisfaction of clients, subscription affordability, information/education and nature of renewal processes. The study found out that most clients went through similar procedures in enrolling with the Scheme and this involved educating one on the tenets of health insurance, assessment of work/financial standing, assignment of a category, taking of personal information, payment of applicable charges, snapping of photo and finally processing of data at the Scheme office. Similarly, the process of renewal was established as a simple process involving not more than four steps. The process is: pay the applicable charges, submit the card to official, card is activated in Scheme office via their ICT system, a sticker is attached and card returned to client. The study further established that quality of healthcare and scheme services were not reasons for the low renewals of membership. Rather, the single most important reason for the low renewals was lack of money. Lastly, intensification of education by the Scheme across all communities and using all mediums was suggested as the way to ensuring clients regularly renew their membership with the Scheme as well as reduction in

subscription charges. In conclusion therefore, the sex, age, household size, education and incomes of respondents did not show any relationship with their insurance status. Also, quality of care of healthcare providers and the Scheme were satisfactory and so while a reduction in the subscription charges could assist in improving the renewal rates, the most important consideration to increasing renewal rates is information, education and communication.

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