Public Policy and Administration Research
ISSN 2224-5731(Paper) ISSN 2225-0972(Online)
Vol.5, No.9, 2015

The Challenge of Concurrently Sustaining Private and Public Development Initiatives: A Case Study of Public and Private Mutual Health Insurance Schemes in Ghana.

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Abstracts
The direct and indirect economic cost associated with health care have a strong relationship with access to health care. Since the 1980s, user fees had constituted a well-documented barrier to health care in Ghana when patients were made to pay for the full cost of medication and care. The disadvantages of the user fee policy encouraged the introduction of health insurance scheme in 2003. However, the simultaneous implementation of this initiative alongside other private efforts has sometimes been problematic in terms of sustainability due to policy and strategic differences. The paper uses the packages offered by selected public (Atwima Nwabiagya District Mutual Health Insurance Scheme) and private St. (Peters Co-operative Credit Union Mutual Health Scheme) health insurance schemes to appreciate the sustainability of these schemes based on issues relating to client satisfaction. The data for the paper started in 2009 and continued in 2014 using a combination of quantitative and qualitative research approaches to gather the primary and secondary data from approximately 200 primary participants and 4 key informants. Owing to factors such as coverage area and conditions for membership as well as benefit packages, enrolment levels, attitudes of staff, types and availability of health facilities and drug and mode of premium contribution, the public initiative demonstrated comparatively greater prospects and sustainability after the first phase of data collection. However, due to a myriad of challenges, the private scheme had indeed collapsed during the second phase of data collection. The paper thus suggests that, both public and private health finance related initiatives should be given the necessary support by relevant state institutions such the National Health Insurance Authority (NHIA). This is due to the fact that, in favorable conditions, both sectors could contribute to alleviating the financial constrains of access to health services especially among the poor and vulnerable.
Keywords and Phrases: healthcare, health insurance, health care financing, public and private, sustainability, Ghana

1.0 Introduction

Good health is an indicator of development. However access to health care in most low income countries is limited due to poverty (Edusei & Amoah, 2014). Moreover, people in poor countries tend to have less access to health services than those in better-off countries, and within countries, the poor have less access to health services (Peters et al., 2008, p. 161). The financial or economic component in accessing health care is one of the key factors that attract or deter potential patients from using health services of their choice (Besio, 2003). The direct and indirect cost associated with health care including user charges and related costs such as cost of transport, drugs, lodging and expenses on food and even the opportunity cost of travel and waiting times to people have a strong relationship with access to health care (Besio, 2003; Peters et al., 2008). Governments, especially those in developing countries have therefore focused on reducing the direct and indirect economic costs in accessing health care through numerous interventions. These interventions often include scheduled payments, insurance systems, bill waivers and improvement of knowledge of users on these provisions and on health in general. Others also involves include subsidies for routine outpatient care, specific disease programs, hospital insurance, and services targeted at the chronically poor and socially excluded (Levesque, Harris, & Russell, 2013; Peters et al., 2008). Health insurance schemes have particularly emerged as alternative financing system globally. The objective of the scheme is usually to eliminate the financial barrier to accessing care while improving the way domestic resources for health are mobilized and allocated (Seddoh, Adjei, & Nazzar, 2011).

In developing countries where governments are not able to squarely meet the health care demands, the presence and works of private entities are sometimes indispensable for the survival of many poor groups and individuals. As a matter of fact, it has been evidenced that the private sector is the main provider of primary health care for the poor in many low and middle income countries (LMICs) (Berendes, Heywood, Oliver, & Garner, 2011). Private ownership in health care includes both for-profit and non-profit providers. These are often facilities/services owned or operated by individuals and groups who seek to earn profit—clinics and hospitals

owned by private employers, and those operated by religious missions and other non-governmental organizations (NGOs). Owing to the fact that financial issues are a major constrain to access to health care among poor groups in developing economies, many private firms, individuals and groups have taken up the challenge of providing financial aid to the poor alongside the effort of governments. These are often in the form of health insurance schemes (Di McIntyre, 2010). However, the sustenance of such private efforts leaves much room for concern especially in the face of similar efforts by public institutions. This paper gives an empirical appreciation of the sustainability of private health mutual insurance schemes in Ghana given the implementation of similar program by the Government of Ghana. The paper uses the packages offered by selected public and private health insurance schemes to appreciate the sustainability of these schemes based on issues relating to client satisfaction and enrolment levels. This helps to draw conclusions on the sustainability of the two schemes given their historical and current state.

1.1 Health Care Financing In Ghana: A Brief Background

Prepayments and risk pooling through social health insurance has been advocated by international development organizations. Social health insurance is seen as a mechanism that helps mobilize resources for health, pool risk, and provide more access to health care services for the poor (Berendes et al., 2011; Dalinjong & Laar, 2012). Since at least the 1980s, user fees have constituted a well-documented barrier to health care in Ghana when patients were made to pay for the full cost of medication and care. Hitherto, the country had been providing free health care services for her citizens after independence in 1957 (UAHCCC, 2013). However, with the increasing population of the years, the free health care services could not be sustained because of the economic crisis in the 1970s and early 1980s which adversely affected all sectors of the economy leading to budget cuts on social spending including health and education (Berendes et al., 2011; UAHCCC, 2013). However, the user fees policy affected the utilization of health care services by Ghanaians. The poor especially were undertaking self-medication and also reporting late to health facilities for treatment (Arhin-Tenkorang, 2001; Arhinful, 2003; Atim & Madjiguene, 2000). This prompted the need to look for other alternatives of health care financing.

As part of efforts to accelerate access to quality health services, the government of Ghana through the Parliament enacted the National Health Insurance Act, 2003 (Act 650) which provided guidelines for the operations of health insurance schemes. The Act stipulates the directives for the establishment, registration, licensing and operations of different types of health insurance schemes in the country including: (a) District Mutual Health Insurance Schemes (DMHIS); (b) Private Commercial Health Insurance Schemes and (PCHIS); (c) Private Mutual Health Insurance Schemes (PMHIS) (Seddoh et al., 2011; UAHCCC, 2013) .This was part of efforts to reduce financial related barriers to accessing health care. The objectives of the National Health Insurance Policy were spelt out in the National Health Insurance Law, 2004; LI 1809. The policy aimed at: (a) bridging the equity gap in access to quality health and nutrition services; (b) enhancing efficiency in service delivery and (c) ensuring sustainable financing arrangements that protect the poor (Ministry of Health, 2002). Its primary goal was to improve access to and quality basic health services in Ghana through the establishment of mandatory district-level mutual health insurance scheme (MHIS). The policy objective is that: every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services" (Government of Ghana, 2004; Owusu, 2010). The National Health Insurance Scheme has been in operation since 2004 in Ghana aside from a few districts that were chosen for the piloting of the program in 2003.

The development of the social health insurance program in Ghana as hinted earlier on did not focus on only the effort of public institution but also created avenues for private individuals and groups to form similar schemes. Thus, a pluralistic local health service industry exists, comprising public and private providers of preventive, diagnostic, therapeutic and to more limited extent rehabilitative services. The manufacturing sector also produces drugs, logistics and other inputs required for health service delivery. Moreover, the private sector is actively involved in the provision of health infrastructure such as clinics and hospitals and ambulance services (Ministry of Health, 2007). However, with respect to health financing, private sector schemes may be established but do not receive subsidies from government. These operate as insurance schemes based on a premium, contract and policy (Seddoh et al., 2011).

1.2 Methods

Both primary and secondary sources of data were used for the paper (Berg, 2007). Two mutual health insurance schemes were selected for the study: The Atwima Nwabiagya District Mutual Health Insurance Scheme (public insurance scheme) and that of St. Peters Co-operative Credit Union Mutual Health Scheme (private health insurance scheme). Atwima Nwabiagya District is one of the largest districts in the Ashanti Region in Ghana (Atwima Nwabiagya District, 2006). The Atwima Nwabiagya District Mutual Health Insurance Scheme (ANDMHIS) was purposively selected as a comparative case since it was one of the pilot schemes that was established immediately after the passage of the National Health Insurance; Act 65 in 2003. The St. Peters Co-

operative Credit Union Mutual Health Scheme (SPCCUMHS) which operates (d) within the Kumasi Metropolis was also purposively selected because it is (was) one of the few private health schemes which had operated for a longer period. The scheme coincidently also commenced its operations in January, 2003. This indicates that the St. Peters health insurance scheme started operation before the nationwide implementation of the National Health Insurance Scheme in Ghana. The scheme commenced after a critical observation and attention towards the health needs of the members of the Co-operative Credit Union. The executives of the Credit Union therefore took advantage of the discussions and awareness that were being created about health insurance at the time and initiated their own mutual health scheme. The purpose was to improve the health status of members so that they could work and improve their incomes and their saving ability as echoed by the current chief executive officer (CEO) of the Union.

The data for the study started in 2009 and continued in 2014. The time lag in the collection periods was an effective way to appreciate the sustainability of the schemes. The study used a combination of quantitative and qualitative research approaches. Simple random and snowballing techniques were used to gather the primary data from approximately 200 primary participants (consisting of 100 each of subscribers of the public and private mutual health insurance schemes) using structured questionnaires. Key informants interviews (using interview guides) were also conducted with the manager of district mutual health insurance scheme, the district heath administrator and the chief executive officer and health insurance scheme manager of the St. Peters Co-operative Credit Union Mutual Health Insurance Scheme (SPCCUMHIS). The Likert scale tool (Trochim, 2006; Vanek, 2012) was used to ascertain clients' satisfaction with the respective schemes. For the sake of lucidness of the presentation, analysis and discussion, the Likert scale (table 3) is added to findings and discussions section (section 1.2.4). The data was analyzed through the use of the Statistical Package for Social Scientists (SPSS). This was the preferred package in view of its flexibility and adaptability for both quantitative and qualitative data analysis.

1.3 Findings and Discussion

Provision of adequate health care and services is the primary objective and responsibility government. However, owing to insufficient resources among governments in the developing world, the role of private institutions and individuals in the provision of socio-economic support has become imperative in various facets of development in developing worlds. The International Monetary Fund has therefore recommended for countries to increase the scope of private sector provision in health related services (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012). Arguments have been forwarded to buttress the work of both the private and public sectors. Private sector healthcare delivery in low and middle income countries is sometimes thought to be more efficient, accountable, and sustainable than public sector delivery. Conversely, the public sector is often regarded as providing more equitable and evidence-based care (Basu et al., 2012, p. 1). However, the operations of these sectors especially in the implementation similar programs are sometimes unsmooth. The operations of one sector sometimes hinder the fluid progression of the other instead of promoting the efforts of each other. This section gives a classical example of this situation using the case of the operations of public and private mutual health insurance schemes in Ghana.

1.3.1 Operational Differences of the Two Schemes

The main objective of the National Health Insurance Policy was to set up preparatory ground for operations of National Health Insurance Schemes in Ghana. The idea was to limit the situation of instant payment of money at the point of health care delivery. This objective was shared by the two schemes selected for this study. The operations and activities of both schemes were similar. They included both curative and preventive health services. However, some basic differences were identified in terms of their sources of funding; benefit packages/service provision and; mode of premium contribution by members. Table 1 summarizes the differences in the basic operations of the two schemes.

Table 1: Operational Differences between ANDMHIS and SPCCUMHS)

N0.	Operational Criteria	ANDMHIS	SPCCUMIS
1	Source(s) of Funding	- Government Grant from the National Health Insurance Fund (NHIF[1]) - Internally Generated Funds (IGF) from the members premium contribution and printing of ID Cards	- No financial support whatsoever from Government or any agency. Contributions from members are used in aspects of the scheme's daily operations. - Internally Generated Funds (IGF) from members contribution only
2	Benefit Package (s)	- About 95% of all common diseases in Ghana are covered under the DMHIS. - Chronic diseases such as Renal Failures, Heart/Brian Surgery, HIV/AIDS, Dental care, Hearing and Optical Aids are not covered. - Prescriptions are made to patients based on the essential drug list provided by the National Health Insurance Council. - All Children/Dependants of members who are below 18 years are automatically covered by the scheme.	- The scheme caters for all common diseases - Chronic diseases such as HIV/AIDS and cases of infertility are exempted. - Prescriptions can be made from all types of drugs. - Children/Dependants of members are not covered under the scheme. Only contributors are covered.
3	Mode of Premium Contribution	Members pay their premiums through deductions on their SSNIT contributions or by once in a year cash payment at registration points	-Members pay their premiums through deductions on their saving with the credit union. -Cash payments.
4	Level of Claims paid for Health Care Provision.	The scheme pays for all expenses incurred by members at the health facilities.	-The private health scheme pays up to GH¢ 40.00 for OPD attendance and GH¢200.00 for admissions and surgery. -Any cost above these has to be paid by members themselves.

Source: Field Survey and Authors' construct, June, 2009/2014.

These operational differences had somewhat significant impact on the enrolment and satisfaction levels and sustainability of the two types of schemes. While the public (District) Mutual Health Schemes enjoyed funding from the Central Government for their operations, the private scheme solely relied on members' contributions for all their activities which rendered the scheme woefully inadequate with respect to funding. This difference in operations had effect on the enrolment levels as well as customers' general satisfaction with the schemes. Section 64 of the National Health Insurance Act, 2003 (Act 650) stipulates that a licensed health insurance scheme, be it Private or District Mutual, shall provide to its members the minimum healthcare benefits that the Ministry of Health may prescribe, on the advice of the National Health Insurance Council. Accordingly, Section 19 of the National Health Insurance Regulations, 2004 (LI 1809) spells out a minimum benefit package of diseases which every scheme must cover. This package covers about 95 percent of diseases in Ghana. The Atwima Nwabiagya District Mutual Health Insurance Scheme (ANDMHIS) adhered thoroughly with these indications. Diseases covered included Malaria, Diarrhoea, Upper Respiratory Tract Infection, Skin Diseases, Hypertension, Diabetics, Asthma, and a lot of other diseases ranging from head to toe. Common drugs for the treatment of these diseases were spelt out in the national health insurance drug list. Certain diseases were however excluded from the benefit package. This is mainly because such diseases are usually too expensive to treat. Diseases that were not covered by the ANDMHIS drug list are: Optical Aids, Hearing Aids, Orthopedic Aids, Dentures, Beautification Surgery, supply of HIV/AIDS drugs, and treatment of chronic renal failure, Heart and Brain surgery. All these constitute about 5 percent of the total diseases in Ghana. However, a scheme has the

[1] NHIF consist of five sources: i. Social Security and National Insurance Trust (SSNIT). This in real value constitutes approximately 14% of actual staff contributions; ii. Parliamentary approval from consolidated government annual budget allocation; iii. Funds that may accrue from the investments of funds collected by the National Health Insurance; iv Donations, grants, gifts and other voluntary contributions and; v 2.5% value added tax (VAT) levied on goods and services that are eligible for ad valorem tax

right under the law to organize its package to cover as many diseases and services as it desires, provided it is approved the National Health Insurance Council (Seddoh et al., 2011; UAHCCC, 2013). This is the very reason why the SPCCUMIS were able to enact and operationalize a policy to cover all forms of health problems under the scheme. These differences and others as stipulated in table 1 therefore had repercussions on the sustainability of the schemes as discussed later in the paper.

1.3.2 Enrolment Levels

Until the beginning of 2008, membership for the health scheme was automatic for members of the St. Peters Cooperative Credit Union. Payment for the health insurance was deducted from members' savings with the Union. This arrangement was reviewed in December, 2007 when subscription onto the health scheme became optional. In spite of this change, some members were reluctant to withdraw from the scheme so long as they remain members of the Credit Union. Yet, their level of satisfaction remained questionable.

The enrolment level in the Atwima Nwabiagya District mutual health insurance Scheme has been steady since it officially began operation in 2004. In 2004, only 7.53% of the people in the District registered with the scheme. This increased to 15.43 percent in 2005 and 24.15%in 2006. This trend indicates that in the first three years of operation, less than a third of the people actually registered with the scheme. However, in 2007 enrolment levels more than doubled to 52.97% and 84.10% of the projected population in 2008 compared to the National Average of 64 % as at 2008. Table shows the enrolment levels of the two schemes over their operational years.

Table 2: Enrolment Levels in Atwima and St. Peters Health Schemes

Year	ANDMHIS			SPCCUMHS		
	Total Population of Area	**Total N0. Registered with Scheme**	**Percentage of Population Registered with Scheme**	**Total Population of Area**	**Total No. Registered with Scheme**	**Percentage of Population Registered with Scheme**
2003	141,372	-	-	1,370,276	2,340	0.17 %
2004	145,613	10,968	7.53 %	1,444,271	5,250	0.36%
2005	149,981	23,146	15.43 %	1,522,261	7,010	0.46%
2006	154,481	37,303	24.15 %	1,604,463	8,105	0.51%
2007	159,115	84,290	52.97 %	1,691,104	8,525	0.50%
2008	163,888	137, 834	84. 10 %	1,782,424	9,220	0.52%
2009				-	-	-
2010				-	-	-
2011				-	-	-
2012				-	-	-
2013				-	-	-

Source: Field Survey and Authors' construct, June, 2009/2014.

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However, the comparatively phenomenal increase in enrolment levels in the Atwima District Scheme was as a result of multiplicity of factors and strategies adopted by the National Health Insurance Authority and the Management of the local scheme. These include the introduction of the free registration for pregnant women which began in July, 2008. The portability of the National Health Insurance (NHI) Cards was also a major contributory factor. Before August, 2007, the issuing of NHI cards used to be district-based. That means that the cards were only accepted within a particular district which issued the cards. However, in July, 2007, the National Health Insurance Authority began the issuing of cards which could be used in all health facilities across the country. This was an encouraging factor as compared with SPCCUHIS whose services covered only a specified number of health facilities. The strategic location of the District also enabled people from the adjoining densely populated communities/districts to register with the Atwima Nwabiagya Scheme.

With regards to the St. Peters mutual health insurance scheme, although enrolment levels increased over the years, the incremental change was not impressive as in the case of the ANDMHIS. The SPCCUHIS registered an average of about 0.5%of the population of the Kumasi Metropolis. This unimpressive performance was mainly due to the fact that, there were five other Sub-Metropolitan Mutual Health Insurance Schemes which offered stiff competition to the private schemes within the Metropolis. Also, enrolment onto the St. Peters Scheme was restricted to members of the Credit Union which was predominantly religious based as many of the members heard about the scheme through religious (church) group meetings. This also indicates that the private scheme was poorly marketed unlike the Atwima Nwabiagya Scheme which was compositely marketed by the National Health Insurance Authority together with other mutual health insurance schemes. This lag in their

operation was however associated to their inadequate funds. With the public health insurance scheme in operation and vibrant, spending part of their meager fans for advertisement seemed unreasonable to some extent. Moreover, the fact that children and dependants of members of the SPCCUMHS were not automatically enrolled on the program also affected the membership of the scheme. This was identified as one major source of dissatisfaction and disinterest among members of the St. Peters Scheme. They contended that after paying for their annual contribution, they still had to enroll their dependants on one of the district mutual health insurance schemes or register them separately as members of the SPCCUMHS. This, to them, is double payment for registration and enrolment.

1.3.3 Determination of Clients' Level of Satisfaction

In order to appreciate the level of satisfaction with the services and benefit packages provided by the two types of schemes, a Likert scale was used (Trochim, 2006; Vanek, 2012). The tool will help to measure the preferences and subjective reactions of the clients of the two schemes at study. Respondents were asked to rate their satisfaction using a 3 level nominal scale: Highly satisfied, satisfied, and unsatisfied as shown in table 3. This scale was used to rate 6 likert items which have direct influence people's satisfaction with the two schemes, on enrolment levels and consequently on the sustainability of the schemes. The likert scale is shown in table 3.

Table 3: Likert Scale

Likert Items		**Nominal Scale**		
1	Availability & Accessibility of Health Facilities	Unsatisfied	Satisfied	Highly Satisfied
2	Attitudes of NHIS & Health Staff	1	2	3
3	Types & Availability of Drugs	1	2	3
4	Premium Levels	1	2	3
5	Mode of Premium Collection	1	2	3
6	Overal Benefit Package	1	2	3

Source: Field Survey and Authors' construct, June, 2009/2014.

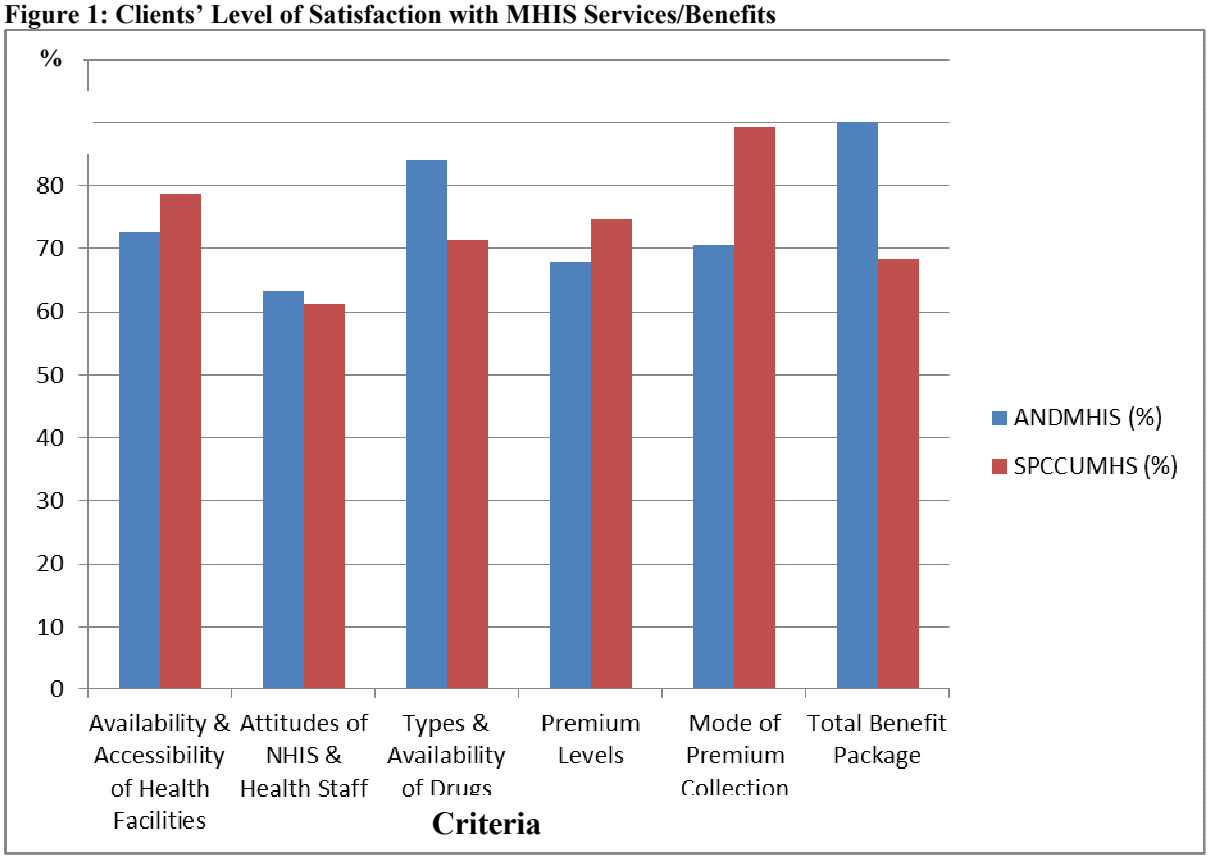
After the respondents had given their ratings with respect to the likert items (criteria), the total scores were converted into percentages and compared with the average percentage score. Any criterion which obtained a mark less than the average percentage scores was considered unsatisfactory by clients. Table 4 and figure 1 show how the respondents rated their level of satisfaction with the respective criteria.

Table 4: Clients' Level of Satisfaction with Public and Private Health Insurance Services/Benefits

Criteria	**Clients' Level of Satisfaction**			
	ANDMHIS		SPCCUMHIS	
	Total Score	Percentage Score	Total Score	Percentage Score
Availability & Physical Accessibility to Health Facilities	218	72.67 %	236	78.67 %
Attitudes of NHIS & Health Staff	190	63.33 %	184	61.33 %
Types & Availability of Drugs	252	84.00 %	214	71.33 %
Premium Levels	204	68.00 %	224	74.67 %
Mode of Premium Collection	212	70.67 %	268	89. 33 %
Overall Benefit Package	270	90.00 %	205	68.33 %
Total of Score for 100% Satisfaction Rate	**300** [3 (rating for highly satisfied response)×100 (number of respondents)]			
Average Percentage Scores		**74.78 %**		**73.94 %**

Source: Field Survey and Authors' construct, June, 2009/2014.

Figure 1: Clients' Level of Satisfaction with MHIS Services/Benefits



Source: Field Survey and Authors' construct, June, 2009/2014.

The average percentage scores were 74.78% for the public mutual health insurance scheme (Atwima Nwabiagya District Mutual Health Scheme) and 73.94% for the private scheme (St. Peters Health Mutual Insurance Scheme). Although, the difference in the average percentage scores was quite marginal, the actual criterion that accounted for the high scores are worth considering. Looking at clients' satisfaction with respect to the total benefit packages, the District Mutual Health Insurance Scheme had 90% score which was well above the average score as compared to only 68.33 percent in the private mutual health insurance scheme. This difference is accounted for by the fact that the dependants of members of members of the private scheme were not covered. Moreover, the fact that members' health care expenses were also not entirely borne by the scheme was a dissatisfying factor. This was due to the fact that more often than not, members of the private scheme had to bear extra costs in accessing health care. Owing to these reasons, it was common for the subscribers of the private schemes to also register with the District Mutual Health Insurance Schemes such as that of Atwima Nwabiagya district. According to the majority of the members of the members of the private scheme, this was a form of precautionary measure to fill the financing gap left by their primary insurance:*..."...many of our members also have the NHIS (public insurance)....especially those with children. The children are automatically covered by their parents' insurance under the NHIS"* (Monica, Osei, CEO of SPCCUMHIS).

Owing to the fact that members of the St. Peters Co-operative Credit Union Mutual Health Insurance Scheme were already members of the Credit Union, health insurance contributions were deducted directly from their savings instead of the direct cash payment as done in the District Schemes. As depicted in table 4 and figure 1, the clients of the St. Peter's Scheme were more satisfied with their mode of premium collection (89.33%) than those with the District Health scheme (70.67%). One member of the St. Peters Mutual Health Insurance Scheme thus stated that... *"...It is very convenient for me.... I do not feel any pinch in paying for my health insurance" (Awuraa Ama,* SPCCUMHIS member). The mode of premium payment therefore encouraged even the less satisfied to stay on the program. With this method, one did not necessarily have to make a full payment for health insurance. Thus, being an active contributor to the health insurance scheme automatically qualified members to benefit from the health insurance scheme upon agreeing to the terms of the scheme. This was a major motivation factor for the many who patronized the private scheme unlike that of the public insurance where people sometimes had to queue before they could even make payments for their subscription.

With regards to the types and availability of drugs, clients in the District Health Scheme scored it 84 % which is far above the average percentage score as compared to the 71.33 % in the Private Scheme. This is expected since the District Schemes pay for all drugs supplied to clients provided they are on the National Health

Insurance Drug List unlike in the Private Schemes where clients sometimes had to bear additional cost for drugs supplied.

Attitudes of NHIS and health staff leave much to be desired. The table shows much lower scores for staff attitudes in both schemes. In fact, the lowest scores among all the criteria, well below the average percentage scores. This means that clients were least satisfied with the attitudes of both the staff of district mutual health insurance scheme and the private scheme. This has been a major problem for the Ghana health services for an appreciable period as echoed by in its Quality Assurance Strategy Plan for Ghana Health Service 2007-2011. Moreover, this is also an effect of the inadequate health professionals all over the country due to constant brain drain in the health sector in Ghana(GHS, 2007; Ministry of Health, 2007). This substantiates the assertion of Jutting (2002) that such schemes sometimes lack sufficient administrative, managerial and technical human resource to implement and sustain the momentum of such health policies.

Moreover, the results from table 4 also confirm the assertion that health insurance only tackles one facet of access to health care. Thus, other factors may influence access to health care even though people may be financially capable of accessing the services. It is argued that the NHIS *initiative "... is not tackling the issue of equitable geographic distribution of health facilities across the country. It is sad that health centers are more located at urban areas than the rural areas, where many have to walk long distances before they can access community health facility"* (GNA, 2009). For instance, table 4 depicts that even though the percentage scores for availability and physical accessibility to health facilities criterion appear encouraging (72.67% for the District Mutual Scheme and 78.67% for the St. Peters Scheme) among members of both schemes, the difference in types and number of health facilities in their respective catchment areas had greater effect on their access to health care. While the SPCCUMHIS served people mostly within the Kumasi Metropolitan area—the second largest city in Ghana(Baah, 2007; KMA, 2010), the ANDMHIS served members majority of who live in small towns and villages. The subscribers to the private scheme therefore had more options than that of members of the public scheme with regards to availability of health services and facilities

1.3.4 Current State of the Schemes

The NHIS administered by the National Health Insurance Authority (NHIA) started with a highly enthusiastic audience including both the rich and the poor in Ghana. Patronage levels continually increased throughout the country and at district levels right from the start. As at June, 2009, about 67% of the Ghanaian population had subscribed to the NHIS (Asenso-Boadi, 2009). Cumulatively, the NHIS has had 22 million subscribers since its inception in 2003. However, as of 2013, only 9 million people remained as active subscribers (Dapatem, 2013; Mahama, 2013). It is therefore estimated that active NHIS coverage stands at only 35% whereas 65% of Ghana's population remain uncovered by the NHIS (UAHCCC, 2013). Public enthusiasm about the program has thus been reducing recently especially in the Ashanti region—where Atwima Nwabiagya district is located due the 'pilot' implementation of NHIS Capitation policy in the region (Ghanaian Chronicle, 2014; Heathcote-Fumador, 2014). In addition to this, untimely reimbursement of health service providers (hospitals and pharmaceutical companies) has discouraged some providers to opt out of the scheme (Daily Graphic, 2014; Ghanaian Chronicle, 2014). In actual fact, certain services which were free to subscribers in 2003 when the NHIS began were no longer free, including some requested services, such as laboratory tests, and diagnostics, for which subscribers are now required to pay in several public facilities (including Komfo Anokye Teaching Hospital). The situation at the Atwima Nwabiagya district was not different from that of the national level. The scheme manager of the district mutual health insurance scheme lamented on some of the challenges as follows:*"...the scheme is declining now. A lot of people have failed to renew their subscriptions especially from the last 3 years...Since health providers are not reimbursed promptly, we are losing a lot of our subscribers due to lackadaisical attitude of the providers to serve holders with valid health insurance cards...The capitation policy need to be explained better to the ordinary person because it is making people lose interest in the scheme* (NAME, ANDMHIS, scheme manager). With the declining subscription rates especially among members with informal jobs who had to make direct cash payments for their subscription, the future of the district mutual health insurance scheme looked bleak. Although this premium payment seemed to be a hindering factor to many people, it contributed less than 5% of total income of the district scheme just as that of the NHIS (UAHCCC, 2013). However, with almost half (42%) of its members working in the informal sector, the financial woes of the scheme could only worse as they constitute the group of people whose membership are redundant. The situation of the public scheme raised doubts regarding its financial sustainability as postulated by the NHIA (2011) that *"financial sustainability of the scheme remains a big challenge…it is projected that without any additional sources of funding to the current sources, the NHIF risks dipping down by the close of year 2012".*

The private insurance scheme; the St. Peters Co-operative Credit Union Health Insurance Scheme is currently nonexistent. The scheme collapsed in 2009 amidst a myriad of challenges which hindered its progression and sustainability. Aside from the comparatively low enrolment levels discussed earlier, the scheme faced serious logistical and staffing challenges. As a matter of urgency, there was no vehicle specifically earmarked for the scheme's activities and only two staff members worked full time on the scheme. The

workforce was inadequate as postulated by the chief executive officer (CEO) of the St. Peters Credit Union who also oversaw activities of the health insurance scheme*: "...staffing was part of our problem to a large extent.....we were short-handed but we could not afford to hire more people due to financial constrains...."*. To a considerable extent, the pressure on the staff culminated into the rating given by the respondents with regards to their satisfaction with the staff of the scheme as shown in table 4. The scheme thus sometimes relied on the staff of the Credit Union during busy periods. Activities such as reimbursements to members for health care expenses therefore delayed considerably sometimes. The delays in reimbursement no matter the level had implications for the debt stock of the scheme and threatened its sustainability. This is in line with the arguments of Wagstaff and Moreno-Serra (2009, p. 7) that *"...the way service providers are paid or reimbursed has implicit values for efficiency, which generally is not always achieved"* . The CEO of the scheme summed events leading to the collapse of the scheme as: "*members of the credit union and our bankers were no longer interested in the program... At a point, automatic deduction/billing for health insurance became compulsory for all members of the credit union—including both those that were interested in the scheme and those who weren't...This was done to expand the financial base of the program...We thought we could improve the benefit package with more contributions....In due course, some of the members especially the teachers amongst them thought that the premiums were too high and felt cheated. ...I think they were making comparison with the premiums and packages offered by the district mutual health insurance schemes...They therefore campaigned against the health insurance program....Along the line, the manager of the scheme died. We lost a lot of contacts with banks. Coordination of activities became increasingly difficult. Some members therefore argued for the suspension of the program while others redrew their savings accounts with us. Eventually, we had no option than to end the program due to acute financial constrains"*. The introduction of the public health insurance scheme and its enticing package therefore encouraged members of the St. Peters scheme to reconsider their choice. Thus, instead of cohabitating, the pubic initiative to some extent had a deteriorating effect on the private initiative. Moreover, a landmark event at the drop point for 2007-2009 is the election and change in government in 2008. The probability that this event affected change in enrolment may be inferred particularly because the government had promised a one-life-time payment. This was a big boost for many who had subscribed to the NHIS especially those on private insurance schemes (Seddoh et al., 2011, pp. 44-45).

However, owing to the recent decline in the NHIS due to policy changes and numerous challenges such as delay in reimbursement especially in the Ashanti region (Daily Graphic, 2014; Heathcote-Fumador, 2014), members of the SPCCUMHIS were calling for the reinstitution of the health insurance scheme. When she was asked of the possibility of restarting the program, Madam Monica Osei (CEO of SPCCUMHIS) emphasized that *"No, even though our members in the credit union are now asking for the health insurance due to decline of the benefit public scheme"*. She argued that, issues relating to financing were the main problems of many private health insurance schemes. In her view, *"...the government should subsidize the amount paid for clients/members of private insurance scheme..."* She further contended that *"...but will the government do that when it has an insurance program on its own?"* From her perspective, the only way that would make them revive the SPCCUMHIS is if private mutual health insurance schemes are financially supported by the National Health Insurance Fund.

1.4 Conclusion

As noted by Truman (1976) "...a healthy citizenry is the most important element in a nation's strength". In developing economies where some groups and classes of people could hardly make ends meet, interventions geared at reducing the financial burden and improving access to basic facilities and services such as health should be welcome and managed efficiently irrespective of who initiates them. While the NHIS in Ghana offers a generous benefit package, the package is currently only relevant to 35% of the population whereas the private schemes which are supposed to supplement the efforts of that of the public initiative are more of 'pro-rich' schemes. This leaves the majority of Ghanaians who live on low and precarious incomes excluded and with no alternative but to pay out-of-pocket in Ghana's archaic and inequitable 'cash and carry' system (UAHCCC, 2013). Moreover, with the deteriorating state of many of these public mutual health insurance schemes, it is imperative that the efforts of private individuals and groups are accorded the needed recognition and support. Efforts of private institutions should be regarded as more realistic alternative to achieving universal health care coverage especially in developing countries. The needed support—both financially and technically should be given to these private schemes in the foreseeable future by the National Health Insurance Authority. What is more, religious and community based organizations should be encouraged to enter into mutual health insurance schemes such as the one operated by the St. Peters Cooperative Credit Union Mutual Health Insurance Scheme. Key challenges facing private schemes should be identified and unitedly addressed as in favorable conditions, both sectors could contribute to alleviating the financial constrains of access to health services especially among the poor and vulnerable.

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