



University of Bergen

**Implementation of Public Policy at the Local
Level in Ghana: The Case of National Health
Insurance Scheme in Sawla-Tuna-Kalba
District**

BY

Donwazum Daniel Kipo

A Thesis submitted to the **Department of Administration and Organisation Theory**
University of Bergen, Norway in partial fulfilment of the requirements for the degree of Master
of Philosophy in Public Administration
Spring, 2011

TABLE OF CONTENTS

Table of Contents.....	i
List of Tables.....	vi
List of Figures.....	vii
Abbreviations.....	viii
Dedication.....	x
Acknowledgements.....	xi
Abstract.....	xii
CHAPTER 1: INTRODUCTION.....	1
1.0 Introduction.....	1
1.1 Brief Profile of Ghana.....	1
1.2 Significance of the Study.....	2
1.3 Background to the Study.....	3
1.4 Statement of the Problem.....	6
1.5 Research Questions.....	7
1.6 Theoretical Framework.....	8
1.7 Research Methods.....	8
1.8 Organization of the thesis.....	9
CHAPTER 2: THEORETICAL FRAMEWORK.....	10
2.0 Introduction.....	10
2.1 Use of Theories.....	10
2.1.1 Concepts and Perspectives on Policy Implementation.....	10
2.2 Developing Framework for my Study.....	16
2.2.1 Winter’s Integrated Implementation Model.....	17
2.2.2 Relevance of the Model and its application to the Study.....	22
2.2.3 The Design of the Policy.....	24
2.2.4 Implementation Structure.....	25
2.3 Analytical Framework for the Implementation of NHIS.....	28
2.4 The Dependent Variable for the Study.....	28
2.5 Variables and their Operationalization in the Study.....	28

2.6 Dependent Variable.....	28
2.7 Independent Variables.....	33
2.7.1 The Design of the Policy.....	33
2.7.2 Implementation Structure.....	33
2.7.3 Resources.....	35
2.7.4 Target Group Behaviour.....	36
2.7.5 Socio-Economic Conditions.....	36
2.8 Conclusion.....	36
CHAPTER 3: RESEARCH METHODOLOGY.....	37
3.0 Introduction.....	37
3.1 Research design.....	39
3.2 The Target Population, Selection of Respondents and Sample Size for the Study.....	40
3.2.1 Selection of Respondents.....	40
3.3 Interviews.....	41
3.3.1 Face - Face Interview (Individuals).....	42
3.3.2 Focus Group Discussions (FGD).....	42
3.4 Direct Observation.....	43
3.5 Documentary Sources.....	44
3.6 Data Analysis.....	45
3.7 Limitations of the Study.....	45
3.7.1 Addressing the Issues of Validity, Reliability and Generalization.....	45
3.8 Challenges Encountered During Data Collection.....	46
3.9 Ethical Considerations in the Research.....	47
3.10 Conclusion.....	48
CHAPTER 4: AN OVERVIEW OF GHANA’S NATIONAL HEALTH INSURANCE SCHEME.....	49
4.0 Introduction.....	49
4.1 Health Insurance Initiatives in Ghana.....	49
4.2 Ghana’s National Health Insurance Scheme.....	50
4.3 The Institutional Structure of the NHIS.....	52
4.3.1 The National Health Insurance Authority (NHIA).....	52

4.3.2 Regional Secretariats of NHIS.....	53
4.3.3 The District Health Insurance Secretariats.....	53
4.3.4 Service Providers.....	54
4.4 The Financial Structure of the NHIS.....	56
4.5 Provision of Health Care Services at the Local Level.....	59
4.6 Conclusion.....	62
CHAPTER 5: FINDINGS AND DISCUSSIONS.....	63
5.0 Introduction.....	63
5.1 Brief Profile of Selected Health Care Facilities.....	63
5.2 Accreditation of Health Care Facilities.....	63
5.2.1 Health Care Facilities and Accreditation Qualifications.....	64
5.2.2 Health Care Facilities and Accreditation Requirements.....	65
5.3 The Design of the Policy (NHIS).....	66
5.3.1 Health Care Facilities and NHIS Beneficiaries.....	67
5.3.2 Health Care Facilities and District Health Insurance Secretariat.....	69
5.3.3 Health Care Facilities and CHIC (NHIS Volunteers).....	71
5.4 Implementation Structure.....	72
5.4.1 The Administrative Structure of District Health Insurance Secretariat.....	73
5.4.2 Sub-Units of Health Care Facilities.....	75
5.4.3 The Role of Sub-Units in the Implementation Structure.....	77
5.4.4 Other Actors in the Implementation Structure at the Local Level.....	83
5.4.5 Beneficiaries Perspectives on the Implementation Structure.....	85
CHAPTER 6: FINDINGS AND DISCUSSIONS.....	88
On How Resources, Target Group Behaviour and Socio-Economic Conditions Affect	
Effective Implementation of NHIS.....	88
6.0 Introduction.....	88
6.1 Resources.....	88
6.2 Financial Resources.....	88
6.2.1 National Health Insurance Fund (NHIF).....	89
6.2.2 Internally Generated Fund (IGF).....	94
6.2.3 External Sources.....	95

6.3 Human Resources.....	95
6.3.1 Number of Staff in Sub-Units.....	96
6.3.2 Staff Educational Qualifications.....	98
6.3.3 Staff Professional Training and Supervision.....	99
6.3.4 Staff Knowledge/Skills and Capacity.....	103
6.4 Key Functions of Health Care facilities.....	105
6.5 Target Group Behaviour and Socio-Economic Conditions.....	107
6.6 Target Group Behaviour.....	107
6.7 Socio-Economic Conditions.....	109
6.8 Beneficiaries Choice of Health Care Facility for Treatment.....	112
CHAPTER 7: SUMMARY, IMPLICATIONS OF THE FINDINGS AND	
CONCLUSION.....	114
7.0 Introduction.....	114
7.1 Summary of Main Findings.....	114
7.1.1 The Design of the Policy (NHIS).....	114
7.1.2 Implementation Structure.....	117
7.1.3 Resources.....	117
7.1.4 Target Group Behaviour.....	119
7.1.5 Socio-Economic Conditions.....	120
7.2 Implications of the Findings.....	120
7.2.1 Theoretical relevance of the study.....	120
7.2.2 Emerging Issues.....	122
7.2.3 Limitations of the Study and Future Research.....	123
7.2.4 Contribution of the Study.....	124
7.3 Conclusion.....	124
References.....	125
Appendix 1: Interview Questions.....	131
Appendix 2: Data on Focus Group Discussion (FGD).....	134
Appendix 3: Ghana NHIS - Benefits Package.....	138
Appendix 4: Ghana NHIS – Excluded Services/Benefits.....	139
Appendix 5: Sample of Treatment Note.....	140

Appendix 6: National Health Insurance Identity Card (ID Card).....141
Appendix 7: Introduction/Recommendation Letter.....141

List of Tables

Table 1: Sample Size	41
Table 2: Some Achievements of the NHIS from 2005-2009 (in terms of enrolments)	60
Table 3: The Established Sub-Units of the two Health Care Facilities	76
Table 4: OPD Attendance of SHC and SFMHC	78
Table 5: Claims Payments from NHIF for the two health care facilities for 2009	91
Table 6: Date of Submission and Payment of Monthly Claims for SHC and SFMHC (2010)	93
Table 7: Number of Staffs in each Sub-unit	97
Table 8: Educational qualifications of staff of the two health facilities	98
Table 9: Staff Professional Profiles	100
Table 10: Non-Professional Staff Profiles	102
Table 11: NHIS Enrolment for 2009	110

List of Figures

Figure 1: An Integrated Implementation Model	21
Figure 2: Analytical Framework of the study	27
Figure 3: The Implementation Structure of the NHIS at the Local Level in Ghana	35
Figure 4: NHIS Institutional Framework	56
Figure 5: The financial structure of NHIS	58
Figure 6: Kinds of interactions between health facilities and other actors at the local level	67
Figure 7: The Implementation Structure of NHIS in STKD	73

Abbreviations

CCS- Cash and Carry System
CFHIS- Community Financing Health Insurance Scheme
CHAG- Christian Health Association of Ghana
CHIC- Community Health Insurance Committee
CHPS- Community based Health Planning and Services
DAs- District Assemblies
DHIF- District Health Insurance Fund
DMHIS- District Mutual Health Insurance Schemes
FGD - Focus Group Discussions
GHS- Ghana Health Service
GNA- Ghana News Agency
GNI- Gross National Income
GPRS- Ghana Poverty Reduction Strategy
HIC- Health Insurance Committee
HIV- Human Immunodeficiency Virus
ID- Identity
ID- Isaac Dramani
IGF- Internally Generated Fund
IMF- International Monetary Fund
LI - Legislative Instrument
MDAs- Ministries, Departments and Agencies
MIS- Management Information System
MOF- Ministry of Finance
MoH - Ministry of Health
NDPC- National Development Planning Commission
NGO- Non-Governmental Organization
NHI- National Health Insurance
NHIA- National Health Insurance Authority
NHIC- National Health Insurance Council
NHIF- National Health Insurance Fund

NHIS- National Health Insurance Scheme
NPP- New Patriotic Party
NS- National Secretariat
OHIS- Okwahuman Health Insurance Scheme
OOP- Out of Pocket
OPD- Out-Patient Department
PCHIS- Private Commercial Health Insurance Schemes
PMHIS- Private Mutual Health Insurance Schemes
PNDC- Provisional National Defence Council
PRDD- Project and Research and Development Division
PRO- Public Relation Officer
SAP- Structural Adjustments Programmes
SFMHC- Sawla Friends Maternity Home Clinic
SHC- Sawla Health Centre
STKD- Sawla-Tuna-Kalba District
STKMHS- Sawla-Tuna-Kalba Mutual Health Insurance Scheme
SSNIT- Social Security and National Investment Trust
THIS- Tano Health Insurance Scheme
US-United States
WB- World Bank
WGHIS- West Gonja Health Insurance Scheme
WHO- World Health Organization

Dedication

This work is dedicated to Kipo-Sunyezi Family of the Gbandi Section Sawla Northern Region and to all persons who believe in education.

Acknowledgements

My first and foremost thanks go to the Almighty God for the wisdom, inspiration, guidance, and strength He gave me throughout my study in Norway.

My deep acknowledgement goes to Norwegian State Educational Loan Fund (Lånekassen) for having offered me a two- year scholarship under Quota Scheme. This great scholarship enabled me to pursue my Master's degree in University of Bergen (UiB), Norway. I also thank our noble Faculty of Social Sciences, University of Bergen for financial support during the three months field work I conducted in Ghana.

My profound gratitude goes to my supervisor, Professor Harald Sætren of the Department of Administration and Organisation Theory, University of Bergen for the rich and tireless guidance offered me throughout, from proposal stage to the conclusion of my thesis writing. I appreciate his tireless assistance for this academic work so much.

I am also very grateful to the following Professors: Steinar Askvik, Ishtiaq Jamil and Alf-Inge. Jansen for their invaluable scholarly teachings, discussions and suggestions that helped sharpens my thoughts and ideas throughout my study period. In addition I wish to express my gratitude to our course co-ordinator Ms. Olga Mjelde for her care, pieces of advice and administrative support.

I appreciate good works of my mentors in University of Ghana: Prof Kwame Boafo-Arthur, Former Head, Department of Political Science and Dr Emmanuel Debrah, Lecturer, Department of Political Science.

I thank staff members of the two health care facilities: Sawla Health Centre particularly Mr Francis, Pharmacy Technologist. Sawla Friends Maternity Home Clinic especially Madam Veronica Ajara Bukari and staff of Sawla-Tuna-Kalba Mutual Health Insurance Secretariat (particularly Mr Gbaran Gbolo, Mr. Abdul-Rahman Adams, Mr Yaw Atu, Mr Seth K. Karley) for their cooperation during my field work in the district.

Abstract

Many developing countries have made efforts at improving welfare of their people by adopting number of health reforms, Ghana was not an exception in that endeavour. Many governments in Ghana adopted number of health reforms from free health care policy to 'user fees' and ultimately to health insurance initiatives from limited geographical coverage to nationwide. The study assesses the implementation of the National Health Insurance Scheme (NHIS) at the local level in Ghana, which compared two health care facilities one public (Sawla health Centre) and the other private (Sawla Friends Maternity Home Clinic) in one district. The purpose of the study is to examine the degree/extent of effectiveness in the implementation of the NHIS in terms of beneficiaries increase access to health care facilities and quality health care services. Also to ascertain if there are any significant differences between the public health care facility and the private health care facility with regard to financial, human resource endowment, implementation structure, staff knowledge (education and professional training) in administering NHIS forms, claims reports and treatment notes in performing their functional roles. The study was more qualitative; data was obtained from multiple sources (interviews, focus group discussions, observations and documentary reviews) and from different categories of persons (adults, aged, indigents and children under 18 years, staff of health care facilities and district health insurance secretariat).

Winter's integrated model provided framework of analysis in identifying factors and actors perceived as responsible for implementation variations/differences between two health care facilities. Key factors such are program design, target group behaviour, socio-economic factors, policy instruments including resources and implementation structure were analyzed. The study concludes the performance of the two health care facilities have been impressive, findings have shown the two health care facilities have adequate knowledge of the goals and objectives of the NHIS due to high educational levels and professional training. Also resources, implementation structure/program design provided higher explanatory powers (implementation differences between the two health care facilities) more than target group behaviour and socio-economic conditions of beneficiaries. However the study identified that delays in the disbursement of central government funds to health care facilities posed a major obstacle towards effective implementation of NHIS at local level in Ghana.

CHAPTER 1

INTRODUCTION

1.0 Introduction

Implementation of National Health Insurance Scheme (NHIS) is the process by which insured persons or beneficiaries¹ are provided free basic health care services² by health care providers and facilities³ (National Health Insurance (NHI) Act 2003 (Act 650); NHI Regulations 2004 (Legislative Instrument, LI 1809). The primary goal of NHIS is to increase access to health care facilities and improve the quality of basic health care services for all beneficiaries including the exempt groups in Ghana (National Development Planning Commission (NDPC) - Citizens Assessment of the NHIS 2008; Health Systems 20/20 Project and Research and Development Division of the Ghana Health Service (PRDD, GHS 2009).

The main purpose of this study is to examine the implementation process of the NHIS and its output with the view to identifying factors and actors responsible for the extent of effectiveness in the implementation of NHIS at the local level in Ghana.

This chapter is divided into nine (9) sub-sections. The introduction, brief profile of Ghana, this is followed with the significance of the study, background to the study, statement of the problem, research questions, theoretical framework, research methods and the final section is organization of the thesis.

1.1 Brief Profile of Ghana

Ghana was formerly called the *Gold Coast*. After independence from Britain the country was re-named Ghana. Ghana attained her independence on 6th March, 1957 and became the Republic of

¹ According to the Legislative Instrument (2004), beneficiaries (insured persons) refer to persons who have paid their annual premium and the exempt groups (children under 18 years of age, indigents/very poor persons, formal sector social security contributors, pensioners under social security scheme and persons 70 years and above, as at July 2008 and pregnant women as at July 2008).

² According to National Health Insurance Act (2003), basic health care services mean access to medical treatments, medicines and drugs under drug list at health facilities.

³ According to National Health Insurance Act (2003), health care providers and health care facilities mean hospitals, polyclinics, health clinics, health centres, maternity homes, pharmacies and licensed chemical sellers and medical diagnostics/laboratories.

Ghana on 1st July, 1960. Ghana is a democratic unitary state. There are ten regions in Ghana. The regions are subdivided into districts; there are 170 districts in Ghana. The Republic of Ghana has a land size of 238,533⁴ square kilometres, approximately the same land size as Britain. Ghana being a West African state shares borders with Togo to the East, Cote d'Ivoire to the West, Burkina Faso to the North and Gulf of Guinea and Atlantic Ocean to the South. In 2000, Ghana's population was 18,412,247.⁵ Currently, Ghana's population is estimated to be 24, 233, 431 million (2010 Population and Housing Census).⁶

1.2 Significance of the Study

In Ghana many reforms took place in the health sector. Prominently among these reforms was the introduction of NHIS, which replaced the two decades of "Cash and Carry system." Since the introduction of NHIS in 2003, not many studies have been done at the local level, where the success or failure of the policy (NHIS) can be felt more realistically. It is based on this that I was motivated to carry out an empirical investigation into what happened at the local level as a way of coming out with some knowledge that may contribute towards bridging the gap between regional/national and local (district) level concerning the implementation of NHIS.

Recent studies of Gyapong, et al. 2007, Agyepong and Adjei 2007, Wahab 2008 (NHIS Law) and NDPC- Citizens Assessment of the NHIS 2008, have focused on the impact implementation of NHIS at regional and national levels in Ghana. However, these studies did not assess the implementation of NHIS at the local level. Moreover, those studies were more descriptive and did not focus on identifying factors and actors responsible for the implementation of NHIS in Ghana. Furthermore, the NHIS is heavily finance by central government of Ghana. As such it is

⁴ The Library of Congress Country Studies; CIA World Factbook, available at: http://www.photius.com/countries/ghana/geography/ghana_geography_location_and_size.html (Assessed on October 29, 2010).

⁵ Ghana's Population and Housing Census, 2000. Available at: <http://www.ghanaweb.com/GhanaHomePage/geography/population.php> (Assessed on October 29, 2010).

⁶ The Provisional results of the 2010 Population and Housing Census, available at: http://www.ghana.gov.gh/index.php?option=com_content&view=article&id=4712:2010-provisional-census-results-out&catid=88:daily-news-summary&Itemid=236 (Accessed on March 1, 2011).

prudent for careful study to be carried out in assessing extent/level of effectiveness or otherwise of the policy (NHIS) at the local level.

Ayisi (2009) focused on the implementation of NHIS at the local level in Ghana. However, the focus of his study was not on identifying factors and actors responsible for the implementation of NHIS. His was a comparative case study of two districts in assessing the level of implementation success or failure. Ayisi's study and my study are similar because both studies consider the implementation of NHIS at the local level in Ghana. However, the difference is that Ayisi study focused on two (2) districts (one rural and one urban) and did not look at the extent of success or failure of the implementation of NHIS between public and private health care facilities, as this study focused on one public and one private health care facility in one (1) district.

This study will hopefully increase knowledge and add to existing literature on this academic field (policy implementation at local level). The experience gained from my study can bring to light how health care facilities at local level render quality healthcare services to NHIS beneficiaries. More importantly, implementation variations between public and private health care facilities in terms of design of the policy, resource endowment, implementation structure and target group behaviour and socio-economic conditions are examined. The study will also be more useful to National Health Insurance Authority (NHIA) which has direct responsibility for implementation of NHIS in Ghana. The study aims at providing useful information on perception of beneficiaries on the process of implementation and output of NHIS. Findings from the study may hopefully motivate other scholars or students to carry out similar studies in other districts in Ghana and possibly in other countries.

1.3 Background to the Study

Health Reforms in Ghana from a historical Perspective, Ghana's health policy at independence (1957) was free medical health care for all people. Under the free medical policy, health care services were offered free to patients at public (government) health care facilities by 1962. Government made efforts to ban private medical professionals and private health care facilities from charging patients after rendering health care services to them. In order for government to sustain policy of free medical health care, government had to replace payments of fees through

payments of annual allowances to health care providers. Under free medical health care policy, Government of Ghana increased the number of health care facilities in the country from ten (10) to forty-one (41) between 1957 and 1963. At the local level, thirty-five (35) new health care facilities were established as part of government's efforts aimed at bridging the gap between rural and urban areas between 1960 and 1966 (Nkrumah 1969: 85, cited in Ayisi 2009).

The free medical health care policy was not sustainable by successive governments due to the high cost of health financing and growth in population. Thus, in 1969 payment for medical care was introduced in all public hospitals and health care centres. Payments of fees for health care services continued in 1971 under Hospital Fees Act 387, 1971. The aim of the Act was to 'recover part of the cost of health care' in the country (Ayisi 2009: 65). This meant a marked shift in health policy from free medical health care to payments for health care services.

In 1985 government of Ghana introduced 'user fees' in the public health sector which became known as "Cash and Carry System (CCS)."⁷ The CCS was backed by the Provisional National Defence Council (PNDC⁸) Law (Legislative Instrument (LI) 1313 as part of World Bank (WB) and International Monetary Fund (IMF) Structural Adjustments Programmes (SAP). The adoption and implementation of 'user-fees' policy aims to mobilize revenue, make health care service delivery more equitable, promote efficiency, private sector development, self-financing of health care facilities and improvement of quality of health care services (Shaw and Griffin 1995). However, the CCS policy created a situation in Ghana where the rich has access to quality health care because they could pay while the poor were denied access to health care (Waddington and Enyimayew (1990) cited in Sunyazi 2003). Many health care facilities have been 'reluctant' in extending health care services to 'people who cannot pay' (Sunyazi 2003: 13). The CCS is also known as the "Out of Pocket" (OOP) fees at the point of service delivery (Agyepong and Adjei 2007: 150). Thus, CCS denied the poor access to basic health care services. The poor left at home to 'die' due to their inability to pay for health care services at the various health care facilities in the country. From the discussions above, it suggested that the CCS could not achieve much, particularly making quality health care services more affordable, equitable and accessible.

⁷ "Cash and Carry System (CCS) refers to the situation where patients were required to pay before health providers offer health care services to them.

⁸ PNDC was a military government in Ghana (from 1981-1992).

Based on some of these challenges of the CCS, many individuals, organizations and agencies have adopted strategies to protect themselves in times of ill-health.

Ghana's Past Health Insurance Initiatives: Ghana's constitution made provision of the right to good health care of the citizens and persons resident in the country (Constitution of Ghana 1992). The constitution made no direct provision on health insurance. Health insurance initiatives took place in many developing countries and Ghana was not an exception (Preker, et al. 2007; Shaw and Griffin 1995). However, the kinds of health insurance initiatives that took place in Ghana were mostly private and limited to certain areas. Thus, they were not national health insurance schemes. The first community health insurance was in 1992 at Nkoranza in the Brong Ahafo Region. The second to adopt and implement community health insurance was West Gonja Catholic Hospital at Damongo in Northern Region in 1995 (Atim and Madjiguene 2000; Sunyazi 2003). The Government of Ghana was motivated by such initiatives by the Catholic Church and hopes to adopt and implement nationwide insurance scheme. Government had to look for alternative means of making health care affordable and accessible to all persons across the country. Hence, NHIS was considered as a viable option by policy analysts, politicians and bureaucrats as a means of improving financial access to health care services in Ghana.

Present National Health Insurance Policy: In 2001, the government of Ghana under the New Patriotic Party (NPP) decided to reform the existing policy of 'Cash and Carry' payments of health care at the point of service delivery. This brought about the passage of the National Health Insurance Law by parliament and signed by president in September 2003. The NHI Act 2003 (Act 650) established NHIS. The Act seeks to "secure the provision of basic health care services to persons resident in the country through mutual and private health care schemes" (NHI Act 2003: 4). The Act allowed only three (3) kinds of schemes to operate concurrently; they include District Mutual Health Insurance Schemes (DMHIS), Private Mutual Health Insurance Schemes (PMHIS) and Private Commercial Health Insurance Schemes (PCHIS). The first scheme (DMHIS) is the focus of my study. Adults are to pay premium annually, while aged, indigents (poor) and children under 18 years are registered free of charge (NHI Regulations 2004). The government of Ghana's main concern for the introduction of NHIS was to correct some of the weaknesses of the past health reforms. For instance, the Free Health Care Policy was more

favourable to urban dwellers more than to those in the rural areas. Also, the policy succeeded in increasing patients' access (visit) to health facilities though with low quality health care. The Cash and Carry policy increased revenue of health care facilities and improved health care services. But it denied patients who could not pay access to health care facilities in times of illness. It is based on these challenges of the past health reforms that NHIS was introduced in Ghana. The NHI Act 2003 and NHI Regulations 2004 clearly specified the implementing institutions and their respective functions. Adequate provisions were also made for funding of NHIS at national level and decentralized in order to empower health care facilities to implement.

1.4 Statement of the Problem

Most developing countries pay more attention to policy making than policy implementation, governments in developing countries tend to formulate 'broad, sweeping policies' and their governmental bureaucracies often lacking the capacity to implement such policies (Smith 1973: 197). Policy makers in developing countries tend to ignore implementation or consider implementation the responsibility of another group. Also, mobilizing resources to sustain policy reforms, pose a challenge to policy makers and managers in developing countries. As policy proponents work to secure resources to implement policy reforms, policy opponents try to block the access to necessary resources, thus hindering policy reforms implementation (Grindle and Thomas 1991). This phenomenon may not be applicable to all developing countries when it comes to implementation. The types of policy reforms governments of developing countries pursue are very important as there may be some variations in implementation of policy reforms in some countries. Also, different factors may be viewed as being responsible for effective implementation of policy reforms in developing countries including Ghana.

A study on citizens' assessment of the implementation of NHIS (Ghana) in terms of people's access to quality health services indicated that there were variations in health status. The study indicated that variations in effective implementation at regional levels were partly attributed to geographical barriers, financial barriers, service delivery constraints and socio-cultural barriers (NDPC- Citizens Assessment of the NHIS 2008: 2). There is the assumption that transfer of responsibilities and funds from national and regional levels to local units (service providers) has improved the services rendered to NHIS beneficiaries by health care facilities. However, this

assumption is contested. While NHIS officials and government are of the view that health care services have improved tremendously at all levels due to the implementation of NHIS, some non-governmental organizations and individuals are of the view that the implementation of NHIS at local level has not been effective in terms of beneficiaries access to health care facilities and quality health care (free treatments, medicines and drugs). From these views there seems to be some difficulties in identifying factors and actors at the local level that could enhance effective implementation of NHIS in Ghana. It is based on these diverse perspectives and views that I decided to examine the effectiveness or otherwise of the implementation of NHIS at the local level, as I pondered a major question, “what factors may explain the extent of effectiveness of the implementation of NHIS in Sawla-Tuna-Kalba District?”

1.5 Research Questions

The main objective of the study is to examine the extent of effectiveness in the implementation of NHIS at local level. In terms of beneficiaries increase access to health care facilities; access to quality health care between public and private health care facilities in the district and health care facilities administration of the NHIS forms, claims reports and treatment notes. The main operational research questions of the study are:

- i) What factors may account for the overall policy implementation at the local level?
- ii) What factors may account for or explain the differences between the public and private health care facilities in the implementation of NHIS?

The study examined core objectives of the NHIS, implementers’ perception of the objectives and instruments used and benefits package of the policy to beneficiaries. These are crucial indicators used in assessing the extent of effectiveness of NHIS at the local level. The study was to examine implementation structures of implementing institutions; various sub-units in health care facilities were also examined. The level of cooperation, coordination and commitment among sub-units in each health care facility was of concern to these research questions. The creation of NHIS offices in each health care facility for the implementation of NHIS and the quality of services rendered by them were important for the research questions. The kind of relationship that exists between

District Mutual Health Insurance Scheme and health care facilities particularly NHIS offices may enhance or hinder the extent/degree of effectiveness of the implementation of NHIS.

In addition the study assesses financial and human resource endowment of the two health care facilities selected in the district. Another indicator is to assess the response and actions of target group (beneficiaries) of NHIS in terms of their willingness to carry out their roles. Positive and negative actions of target group are crucial for the research questions. Attitudes of staff of the two health care facilities are examined. The study then considers socio-economic conditions of NHIS beneficiaries on the implementation of NHIS. Thus socio-economic status of beneficiaries is crucial in accessing health care services.

1.6 Theoretical Framework

This study focuses on the process of implementation of NHIS at the local level in Ghana. The influence the design of the policy (NHIS), implementation structure of implementing institutions, allocation of resources (financial and human), target group behaviour and socio-economic conditions has on policy output. Winter's integrated model was selected to explain the cluster of factors/variables mentioned above. Winters' integrated/heuristic model takes into consideration policy design as well as policy implementation. Winter's model identifies four types of factors that may influence effective implementation of a policy. They include the character of the policy formation process prior to the law or decision to be implemented, the organizational and inter-organizational implementation behaviour, street-level bureaucratic behaviour and response of target groups and other changes in society and socio-economic conditions. Three of the factors were analyzed in the study. Other models developed by Van Meter and Van Horn (1975), Grindle and Thomas (1991) and Rothstein (1998) have been used in the study in addition to Winter's model. Details on theoretical model, variables of the study are discussed in chapter 2.

1.7 Research Methods

The study adopted a case study approach. A case study is one of the many ways or approaches used in the conduct of social science research. It is an in-depth examination of a particular event through data collection, data analysis and the interpretation of data. By this process a researcher is able to understand why a particular social or natural phenomenon happened. Yin defines case

study as a method when *“how’ or ‘why’ questions are being posed, the investigator has little control over events and the focus is on a contemporary phenomenon within a real life context”* (Yin, 2009: 2). This study focuses on a contemporary phenomenon in a real life context rather than a historical phenomenon. The case study approach was adopted in order to answer my research questions. My study adopted much more qualitative method rather than quantitative method in attempt to answer my research questions. Data for the study was obtained from many different sources of evidence (interviews, documentary reviews, direct observations), thus, triangulation of data (Yin 2009). Other secondary sources of data obtained include books, journal articles, newspapers, radios and the internet.

1.8 Organization of the thesis

This research is organized in seven (7) chapters. **Chapter One** covers Introduction (which entails Brief Profile of Ghana, Significance of the Study, Background to the study, Statement of the Problem, Research Questions, Theoretical Framework, Research Methods and Organization of the Thesis. **Chapter Two** discusses theoretical perspectives of the study, indicating the theoretical model, analyzing the variables in the model and how the variables guided the study. Also, specifying dependent and independent variables of the study (the linkage between them) and their operationalization (how each is measured). After discussions, an analytical model was developed for the study. **Chapter Three** discusses Research Methodology of the study. The various methodological aspects of the study being discussed are area of the study, research strategy, research design, the target population, selection of respondents and sample size for the study, data collection method, data analysis, limitations of the study: addressing issues of validity, reliability, generalization and ethical considerations. **Chapter Four** covers an Overview of Ghana’s NHIS. This chapter examines the efforts of Ghana in financing of health care through NHIS in making health care services available, accessible and of quality at local level. **Chapter Five** presents Findings and Discussions on two variables: policy design and implementation structure in relation to main research objective and research questions. **Chapter Six** involves Findings and Discussions on three variables: resources, target group behaviour and socio-economic conditions of beneficiaries with respect to main operational research questions. **Chapter Seven** involves summary of key findings, implications of the findings (linking research data collected to theoretical models and other relevant studies) and conclusion.

CHAPTER 2

THEORETICAL FRAMEWORK

2.0 Introduction

The purpose of this chapter is to develop a framework for analyzing the implementation of NHIS in Ghana. This chapter discusses theoretical models in which independent variables have been formulated and hypothesis outlined. This chapter focuses on identifying and analyzing factors and actors responsible for effective implementation of NHIS. The chapter intends to discuss public policy, implementation and some perspectives or approaches that have dominated policy implementation research. After review of theoretical models and perspectives, a framework is developed for analyzing factors and actors viewed as responsible for effective implementation of NHIS at the local level in Ghana.

2.1 Use of Theories

In the conduct of social science research theories play important role (King et al. 1994). Theories serve as guide in studying a particular phenomenon and help a researcher to understand, analyze and describe problem being investigated. According to Kerlinger theory is *“a set of interrelated constructs (variables), definitions and propositions that presents a systematic view of phenomena by specifying relations among variables, with the purpose of explaining natural phenomena”* (Kerlinger 1979: 64). No single theory is sufficient for the study. One theory may explain some variables adequately but cannot be used to analyze other variables. I intend to apply Winter Integrated Implementation Model. Other theoretical models/ perspectives have also been used.

2.1.1 Concepts and Perspectives on Policy Implementation

The Concept of Public Policy: The concept of public policy has been defined in various ways by different scholars. According to Thomas Dye a public policy is *“anything a government chooses to do or not to do”* (Dye 1972: 2 cited in Howlett et al 2009: 4). Dye sees public policy as decision of government, this definition exclude decisions of non-governmental actors or groups. Jenkins provides an improved definition of a public policy. He defines public policy as *“a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve”* (Jenkins 1978 Ibid)

:6). He recognizes decisions of governments as well as other actors in selection of policy goals and means of achieving such goals. Aryee explains that a public policy is as a “*broad statement of goals, objectives and means*” (Aryee 2000: 2). Public policy involves taking decision in addressing a public problem and the means of achieving the decision.

The Concept of Policy Implementation:

Policy implementation is the process of “*translating policy decisions into action*” (Howlett et al. 2009: 160). This definition suggests that government policies or legislations that have been formulated or enacted need to be put into action. Howlett et al argue that most policy decisions (be it national or local) contains the means of carrying out goals of the policy. Also, in order to execute public policy, funds must be adequately provided, requisite personnel assigned and ‘rules of procedure’ developed and followed (Ibid). Apart from factors identified for policy implementation, desired actors are also crucial for implementation to succeed. Some scholars emphasize the role of non-governmental actors (Ginsburg, 1992; Johansson and Borell, 1999 cited in Howlett et al 2009), others include street-level bureaucrats (Lipsky 1980) and community and religious groups (Kuo 2006). Bureaucrats are the most influential actors involve in policy implementation (Dye 2001). Van Meter and Van Horn define policy implementation as “encompasses those actions by public and private individuals or groups that are directed at the achievement of objectives set forth in prior policy decisions” (Van Meter and Van Horn 1975: 447). Pressman and Wildavsky view implementation as a “*process of interaction between the setting of goals and actions geared to achieving them*” (Pressman and Wildavsky (1984: xxiii). Both Pressman and Wildavsky and Van Meter and Van Horn see policy implementation as action taken to achieve objectives of a policy. Thus, policy implementation simply means carrying out or accomplishing policy goals and objectives.

Policy implementation study is quite new; it started in the 1970s especially with the publication of Pressman and Wildavsky’s influential book: *Implementation* in 1973. These two scholars are celebrated as the ‘founding fathers’ of implementation studies (Hill and Hupe 2009: 44). Even though policy implementation studies began and gained prominence in the 1970s, some scholars such as Van Meter and Van Horn (1975), Hargrove (1975) argued that there were some studies related to implementation in the years before the 1970s (Blau 1955; Kaufman 1960; Selznick

1949) cited in Hill and Hupe 2009). As such Van Meter and Van Horn disagreed with Pressman and Wildavsky's claim that implementation studies started in the 1970s. The divergence view on originality of implementation studies come from how the word 'implementation' was implicitly or explicitly used. Pressman and Wildavsky (1973) Oakland project marks the 'pioneering' work on policy implementation studies (cited in Hill and Hupe 2009). Findings from their study indicated that implementation of the Oakland policy did not produce the intended results for the benefits of the people of Oakland. Certain factors impeded the effective implementation of the Oakland policy: difficulties in translating the broad agreement into specific decisions, wide range of participants and perspectives and the existence of opportunities for blockade and delay due to the multiplicity of decision points (Pressman and Wildavsky 1984).

Two main approaches for a long time dominated implementation studies, the top-down and the bottom-up approaches or perspectives.⁹ There is also the third perspective, which aims to merge the two traditional approaches (Mixed Approach) addressing some weaknesses of the top-down and bottom-up approaches. These approaches/perspectives are discussed as follow.

a) The Top-Down Perspective

The top-down perspective is concern with two essential issues; political intent and administrative action. This perspective assumes decisions (policies) are made by senior politicians and officials (top) and carried out precisely as contained in the policy document by lower-level officials (bottom). The top-down perspective starts with policy decisions of government and examines how those decisions (objectives) are attained by administrators (Howlett et al 2009; Sabatier, 1986). This perspective assumed that there is hierarchy of command (Clarke 1992), where implementing officials or agencies carry out their jobs more effectively. Effectiveness of the implementation of public policies is defined by this perspective as "*keeping to the original intent of the public officials who had ratified the policy*" (Howlett et al 2009: 164). Effectiveness is the degree to which public policies attain their objectives (Aryee, 2000).

Sabatier and Mazmanian 1975; Mazmanian and Sabatier 1981 and 1983 cited in Hill and Hupe 2009, argue that implementation usually start with the passage of a statute (law) after which a

⁹ Perspectives and approaches are interchangeably used.

process of implementation may follow. Sabatier and Mazmanian identified three core factors that impact on implementation process: factors affecting the ‘tractability of the problem’, ‘non-statutory variables affecting implementation’ and the ‘ability of the statute to structure implementation’ (Sabatier and Mazmanian, 1980: 544). Hogwood and Gunn (1984) defended top-down approach to policy implementation on grounds that those who make policies are ‘democratically elected.’ The top-down perspective has the merit of promoting effectiveness on grounds that implementers carry out the original intent of policy makers. This implies that policy makers’ make known policy goals and objectives to the implementers. Hence, those at the top control implementation, they offer directions and rules to implementers. Top-downers argument support separation of policy formulation from policy implementation.

However, the top-down perspective has been criticized on grounds of focusing too much on top politicians and senior officials at the neglect of lower-level officials (street-level bureaucrats), private sector actors, local implementing officials and the general public (Lipsky 1977; Elmore 1978; Berman 1979 cited in Sabatier 1986). Thus, top-down perspective stifles local initiatives, does not make local level staff feel the ‘sense of ownership’ of policies and programmes they are implementing. Moreover, policies that lack legal mandates or dominant implementing agency are difficult to apply with the top-down perspective. Furthermore, critics of the top-down perspective argue that senior politicians and officials play very ‘marginal role’ in day to day implementation of public policies compared to lower-level officials and members of the public (Hjern and Porter 1993; Hjern 1982; Barret and Fudge 1981 cited in Howlett et al. 2009: 164).

b) The Bottom-Up Perspective

Proponents of bottom-up perspective oppose top-down perspective on grounds that it has some fundamental flaws and that it ignores the actions of those affected by the policy. This perspective gained prominence in the late 1970s and early 1980s as Lipsky (1980) Street-Level Bureaucracy model and other studies provided an alternative approach to implementation study (Berman and McLaughlin 1976; Hanf and Scharpf 1978; Ingram 1978; Elmore 1979; Browning et al. 1981; Barrett and Fudge 1981; Hjern and Hull 1982; Hanf 1982 cited in Sabatier 1986). This period marks shift from the hierarchical concept of implementation to focus on lower level staff. Proponents of this perspective argue for recognition and identification of number of policy actors

at local level. To them, policy implementation should involve those at local-level, their actions, views, goals, strategies and contacts must be sought by top politicians and officials. This perspective establishes local networks of actors, who may be at community, district or regional level and move upward to national level. The involvement of the lower level staff allows them to come out with their own strategies, plans that can enhance successful implementation of policies.

Key proponent like Lipsky, who is credited as a ‘founding father’ (Hill and Hupe 2009) of this perspective argues that the lower level staff do not only implement policies but they also make policies. He asserts that under certain situations lower -level staff make policies (Lipsky 1980). Lipsky argues that *“public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers”* (ibid. xii).

Hjern and Hull (1982) acknowledge not only field level actors but also the role of organizations in implementation of policies at the local level- establish local ‘implementation structure’. They argued that effective implementation study must be “organization theory” inclined (Hjern and Hull (1982). Sabatier (1986) in his later writing acknowledges some strengths of bottom-up approach, even though a key proponent of the top-down approach. Sabatier argument stems from the fact that public policy is formulated to address a problem. In this regard he argues that, those whose problem the policy seeks to address or solve must be part of the policy making as well as its implementation.

The bottom-up perspective allows for ownership of policies and programmes since implementers bring their views into the problem issue. However, it over emphasizes the importance of lower level staffs (implementers at the periphery) at the expense of those at the top (policy makers at the centre). Also, bottom-up perspective represents an extreme position (ability of periphery to frustrate the centre) vis-a-vis the top-down perspective. It is important to consider the problem issue first, in order to know which perspective may be more suitable to adopt. The concept of decentralization contributed to a shift in approach in some developing countries including Ghana to adopt a bottom-up approach to policy implementation as an alternative approach. The bottom-up approach gained prominence in Ghana in the late 1980s when the Local Government Law

(PNDC Law 207) of 1988 was enacted (Buabeng 2009). This law encourages the participation of local level staff in Ghana in both policy formulation and implementation.

From the above discussions on approaches to policy implementation, it is vital to note that there has been diversity of implementation research. While the top-down perspective focuses on ‘goal achievement’ as a standard for analyzing delivery performance of implementers, the bottom-up perspective focuses on ‘problem solving’ either from the perspective of those affected by the problem or from the view of the research’s own (Sabatier and Mazmanian 1981; Hull and Hjern 1987; Elmore 1982 cited in Peters and Pierre 2003).

c) The Mixed Perspective

The mixed approach to policy implementation seeks to put an end to the debate between the top-down and bottom-up perspectives, as it adopts a merger of the two approaches. One credit for adopting the mixed approach is to overcome some of the weaknesses of top-down and bottom-up approaches. Winter indicates the two traditional approaches play vital roles in implementation process. However, he thinks that the protracted debate between the “two approaches was not fruitful” (Winter 2006: 154 cited in Hill and Hupe 2009: 58). Winter made suggestions for further development of implementation research. He suggests that implementation research needs to provide theoretical diversity rather than looking for a common theoretical framework. Researchers should focus on developing and testing partial theories and hypothesis rather than trying to focus on constructing general implementation theory. Scholars or researchers should primarily try to explain implementation output. Finally, researchers should apply or make use of more comparative and statistical designs other than relying on single case studies “in order to sort out the influence of different implementation variables” (Peters and Pierre 2003: 151).

Elmore (1985) argued in favour of both top-down and bottom-up approaches. His reason is that each approach offers valuable insights for policy makers. Analyzing ‘forward mapping’ Elmore, indicates policy designers (policy makers) should consider policy instruments and availability of resources at their disposal as vital in order to ensure policy success. Thus, he argues that there should be proper incentive structure of the target group and the street-level bureaucrats (Peters

and Pierre 2003). Here there is recognition of the role of local actors and proper incentives for them in order to enhance successful implementation of a policy (addressing public problem).

Matland (1995) suggests a different type of merger between top-down and bottom-up approaches and that depends on ambiguity/clarity of goals and means of the policy and the extent of conflict. Matland focuses on policy's ambiguity and level of conflict. Matland's contribution to top-down and bottom-up theorists' disagreement on the question: what is a successful implementation? He indicates that while the top-down theorists' desire to measure policy success 'in terms of specific outcomes tied directly to the statute', the bottom-up theorists' prefer much broader scope in measuring implementation success (Matland 1995: 154).

Winter (2003) indicates that each approach tend to ignore significant portion of 'implementation reality' that could have been explained by the other approach. This implies that when policy implementation study focus on only one approach, other vital issues that could have facilitated implementation might be left out. Thus, the need for a merger of the two approaches. Winter explain further that apart from synthesizing various perspectives, another way is to develop a heuristic model that can integrate most of the relevant features of various perspectives and 'promising variables' in implementation research into a single model. To accomplish that, he developed the "Integrated Implementation Model" (Winter 1990, 1994 cited in Winter 2003).

Hybrid theorists seek the merger of the best features of the two main perspectives. The views of various scholars, both top-down and bottom-up approaches and the mixed approach, provided useful basis for the analysis of the implementation of public policies at the local level in Ghana.

2.2 Developing Framework for my Study

I intend to develop a specific framework to guide the analysis of this study. In my study, I employed Winter's integrated model as reference point. Also, I have made references to other models, views and perspectives on policy implementation as I deemed necessary for purpose of analysis. I applied some of features of top-down, bottom-up and mixed approaches as discussed above in analyzing or identifying factors and actors responsible for the implementation of NHIS at the local level in Ghana. I have chosen Winter's model because of its relevance to the

hypothesized study variables. The study tentatively identified five clusters of explanatory variables/factors; these include policy design, implementation structure, resources (financial and human), target group behaviour and socio-economic conditions (independent variables).

2.2.1 Winter's Integrated Implementation Model

Based on integrating top-down and features of bottom-up perspectives on policy implementation, Winter developed an '*Integrated Implementation Model*' consisting of four (4) set of socio-political conditions that affect implementation outcomes. While top-down approach compares policy or programme implementation outcomes with its stated official goals and objectives, Winter's approach addresses interest of implementation actors (bottom-up approach concerns) that affects policy outcomes. According to the model policy implementation is "*evaluated in terms of both output and outcome/impact*" (Winter 1990: 27 cited in Ryan 1996: 738). Winter's model in strict sense is not a causal model, but rather a 'framework of analysis' that presents key clusters of factors and mechanisms which affect implementation outputs and outcomes (Winter 2003). The model suggests a linkage between policy performance or output (by implementers) and outcome or impact (felt by policy beneficiaries). The four groups of factors identified in Winter Integrated Model which are required for effective implementation of policy are as follow: (i) the character of the policy formation process prior to the law (decision) to be implemented; (ii) organizational and inter-organizational implementation behaviour; (iii) street-level bureaucratic behaviour and (iv) response by target groups and other changes in society and socio-economic context/conditions (Winter 1990: 20-1, cited in Ryan 1996; Winter 2003). These factors or variables seem to be relevant in analyzing the implementation of NHIS at the local level in Ghana.

The first set of factors in Winter's analytical framework or model is impact policy formulation and design has on implementation results or outcomes (May 1999; Bardach 1977; Gunningham and Grabosky 1998; Moe 1989 cited in Peters and Pierre 2003). Winter outlines four components of policy formulation process: conflicts, choice of policy instruments (including resource allocation), attempt to resolve a problem and the attention given to policy formulation process. According to Winter conflicts during policy formulation stage can have an impact on implementation outcomes. Conflicts most often led to the creation of ambiguous goals. "*The*

greater the degree of conflict the more likely that implementation will be frustrated” and that “implementation is unlikely to succeed if there is not a genuine attempt to resolve a problem” (Winter 1990 cited in Ryan 1996: 738).

The second set of factors or variables focus on how implementation process affects implementation results. Thus, implementation process involves ‘organizational and inter-organizational behaviour representing different’ levels of coordination and cooperation (Peters and Pierre 2003: 209; O’Toole 2000; Pressman and Wildavsky 1984). These variables focus on reaction of organizations and inter-organizational relationships to policy directives. Degree of consistency/compatibility between policy goals and organizations interests and co-operation among institutional interests is emphasized. Organizational power, institutional relationships and ‘resource dependency’ among implementing organizations are considered (Peters and Pierre 2003).

The third variable/group in Winter’s model provides structure for the integration of street-level bureaucrats (actors) into implementation process (Lipsky 1980; Marcia Meyer and Susan Vorsnager Chapter 19 cited in Winter 2003). This variable emphasizes individual organizational actors rather than organizations and institutions. *Winter argues that “street-level bureaucrats have the capacity to systematically distort the implementation of programmes”* (Ryan 1996: 739). There is link between behaviour of street-level bureaucrats and organizational culture, to change the behaviour of street-level bureaucrats, implies a change in organizational culture (Ibid).

The fourth variable focuses on target group behaviour. According to Winter, policies and programmes should take into account the nature of target groups. For instance target groups with different socio-economic and/or educational backgrounds require different implementation strategies in order to enhance policy implementation. As it is stated: *“Target groups are more likely to co-operate with programmes when prescriptions are in accordance with existing behaviours and norms”* (Ibid). Target group of policies may be citizens of a country or firms. According to Winter in his integrated model target group *“play an important role not only on the effects of the policy, but also in affecting the performance by street-level bureaucrats through*

positive and negative actions in co-producing public services” (Winter 2003: 209). This suggests target groups can influence policy implementation process. They can influence implementers like street-level bureaucrats in achieving policy goals and objectives or failed to achieve such goals through their actions. Where target groups tend to be in favour of a policy, it is most likely for the policy to be successful and where they are in not in favour, implementation may be unsuccessful.

Skodvin et al (2010) argue that target group has the capacity to influence policies particularly when target groups control the resources decision makers’ need, where target groups set policy agenda or become veto players in making or implementing policies. Most policy implementation studies tend to neglect target groups views and responses, and their neglect tend to create some implementation difficulties. Target groups actions may bring positive or negative results on implementation. In my study target group means beneficiaries of NHIS, this includes registered members. Reference may also be made to implementing institutions staff (bureaucrats) at local level (health care facilities and service providers). These actors’ views and perspectives might easily be neglected by top managerial staffs of NHIS. My assumption is that target group active involvement and positive attitude can be an effective means of implementing NHIS at local level in Ghana.

“The more target group positive response, the better the implementation of the NHIS.”

Finally, socio-economic conditions are considered essential for policy implementation and that forms part of Winter’s integrated model. Winter (2003) indicated that socio-economic context or environment forms important conditions for policy implementation. Socio-economic context involve identifying societal or environmental factors that influence policy output and outcome (Van Meter and Van Horn 1975). The question asked is that to what extent social and economic factors affect implementation of any policy. Berman explains that the implementation of policies should consider different kinds of conditions or “context within which a policy is to be implemented” (Berman 1980: 206 cited in Buabeng 2009). Implementing policies at the local level would mean local social and economic conditions that affect the implementation process. Sabatier and Mazmanian identified socio-economic conditions as variable in their ‘non-statutory variables affecting implementation’ (Sabatier and Mazmanian 1980: 542). They agreed that

changes in socio-economic conditions could have repercussions on a program; changes due to political or social pressure may promote or hinder program or policy implementation. Agyepong and Adjei (2007) argued that societal pressures and economic conditions affect implementation of policies in Ghana. They explained further that Ghana with a Gross National Income (GNI) per capita estimated at United States Dollars-US\$ 380 (April 2006), predominantly an agricultural country, a main exporter of cocoa, timber and gold. Ghana a country where more than half of its population live in rural areas (44% in urban areas) and majority employed in non-formal sector (Agyepong and Adjei, 2007: 153). These conditions created a situation whether many of the population would not be able to pay annual premiums of NHIS, thus affecting enrolments.

An empirical study conducted in Ghana on assessing the implementation of the NHIS revealed that *“as the socio-economic status of households improves, the chance that they will register with NHIS increases”* (NDPC- Citizens’ Assessment of the NHIS 2008: 25). The study suggests that as the socio-economic conditions of the people improve; many persons will be enrolled into the NHIS. In my study, socio-economic conditions would mean increase in jobs, where people are gainfully employed be it public or private sector. My assumption is that an improved socio-economic condition enhances the implementation of NHIS.

Hypothesis 5: ***“The more improved socio-economic conditions, the better the implementation of the NHIS.”***

In examining Winter’s four sets of variables on policy implementation, it is necessary for researchers to consider the impact one set of variables has on other variables as illustrated in Figure 1 below.

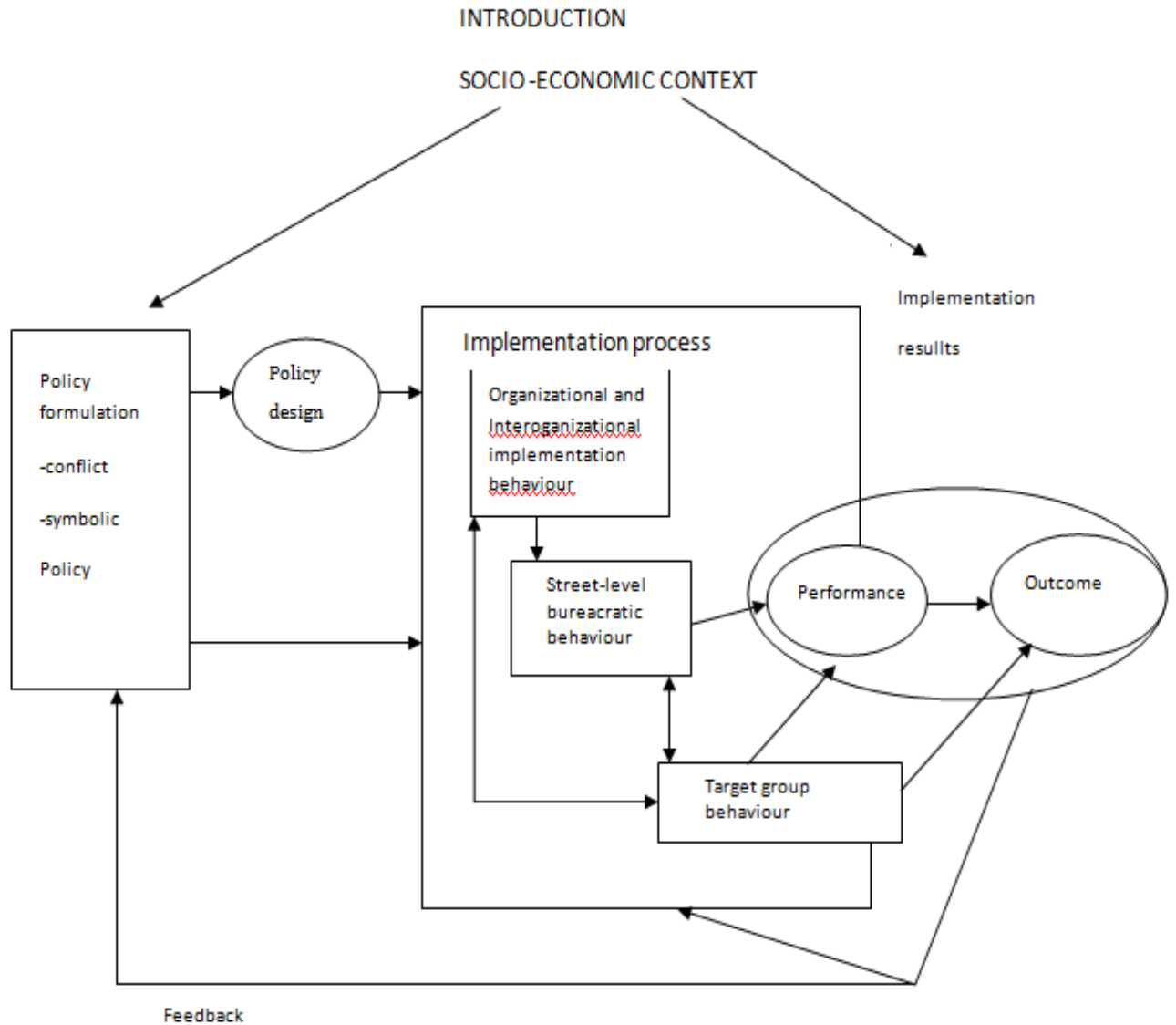


Figure 1: An Integrated Implementation Model

Source: Adopted from Winter (1990, 1994) in Winter 2003: 207.

From above figure, the arrows point forward and backward directions, from policy formulation or policy design stage to implementation results (policy performance and outcome) and that label the model as mixed (combining top-down and bottom-up perspectives). The model argues that *“The four sets of variables are interrelated. The policy formulation process influences the development of the other factors. Organizational and interorganizational behaviour is influenced by, and influences the actions of ‘street-level’ bureaucrats. These relationships also exist between target groups and ‘street-level’ bureaucrats.”* Winter (1990: 36 cited in Ryan 1996: 739).

2.2.2 Relevance of the Model and its application to the Study

One significant feature of the model is that it focuses on performance (output) and outcome (impact) in relation to official policy objectives. The model does not limit policy implementation to only performance in analyzing whether policy or programme implementation is successful or not in accordance to official goals and objectives ('top-down' perspective). The model rather broadens policy implementation perspectives as it analyzes policy or programme impact. Also, the model recognizes policy design ('top-down' perspective) and the subsequent implementation stage ('bottom-up' perspective) as crucial in the 'policy cycle' (Howlett et al 2009). Another significant feature of the model is its focus on local actors and factors ('bottom-up' perspective). The model emphasizes behaviour, action and role of street-level bureaucrats and target group in implementation process in society. The actors' action or inaction has great potential to influence the effectiveness or otherwise of the implementation of policy. The model attaches importance to policy formulation/policy design process. This deepens the understanding that successful policy implementation or otherwise is dependent on how a policy is designed. The model provided a feedback loop which is very important, as it provides mechanism in assessing the outcome of a policy or a programme (through target group behaviour).

Winter's integrated model however, does not address resources, public trust for implementing institutions and other aspects of implementation in detail. Other important literatures such as Van Meter and Van Horn (1975), Grindle and Thomas (1991), Rothstein (1998), have been used in areas which the model could not cover adequately. Allocations of resources are very crucial especially in developing countries in order to enhance and sustain implementation of public policies or reforms (Grindle and Thomas 1991). The amount of resources policy makers made available for implementation of any policy or reform can promote or hinder its implementation. According to Van Meter and Van Horn resources must be made available to facilitate the implementation of policies. Resources according to them include "*funds or other incentives in the program that might encourage or facilitate effective implementation*" (Van Meter and Van Horn 1975: 465). Inadequate resources can hinder implementation of policies. Derthick's "new towns" study indicated that the 'limited supply of federal incentives' contributed to the failure of a federal program or policy (Derthick 1972: 87 cited in Van Meter and Van Horn 1975). Availability of resources determines the extent in which policies are to be implemented. Thus, in

order to enhance implementation of policies adequate resources must be made available to the implementers (Van Meter and Van Horn 1975). Developing countries like Ghana usually find it difficult mobilizing the needed resources to implement their policies. While Van Meter and Van Horn identify resources as funds and incentives, Grindle and Thomas (1991) identify four different kinds of resources: political, financial, managerial and technical. According to Grindle and Thomas mobilizing these four resources to sustain a policy reform can be very challenging to policy makers and managers. As policy makers or policy proponents attempt to mobilized these resources, those opposing the policy may try to block access to necessary resources, thereby stalling the implementation of the policy/reform (Grindle and Thomas 1991: 126-128).

Apart from financial, human resource is also emphasized. Rothstein emphasizes that the degree of effectiveness of the implementation of a policy is dependent on the motivation and capacity of implementing staff and continual supervision and evaluation of the activities of implementing organizations (Rothstein 1998). Human resource endowment of implementing institution refers to staff professional training. The higher the training (educational qualification) the better positioned they become in executing policies (Ayisi 2009). This suggests that organizations and institutions with well trained staff; better professionals would have more advantage than those with less trained professional staffs in implementing policies. Also implementing institutions with higher remunerations and incentives would attract more qualified personnel than those with less remunerations and incentives. In this situation, the well endowed implementing organization or institution is more likely to achieve better implementation results more than its less endowed counterpart at the local level.

Applying Winter's variables to implementation of NHIS, my focus rest on linking explanatory variables to the extent of effectiveness of the implementation of the NHIS (dependent variable). It is important to note that the study focuses on implementation process and output. From Winter's analytical framework/model and literature review, I have identified five independent variables for my study. The independent variables consist of factors and actors I believe could explained the extent of effectiveness of the implementation of NHIS at the local level (Sawla-Tuna-Kalba District) in Ghana. The five independent variables include design of the policy, implementation structure, resources and target group behaviour (response) and socio-economic

conditions of beneficiaries. It is important to note that three independent variables (resources, target group behaviour and socio-economic conditions) have been discussed above while design of the policy and implementation structure is discussed below.

2.2.3. The Design of the Policy

I intend to assess the design of the policy in the implementation of NHIS in Ghana. Policy design consists of goals/objectives and instruments outlined in the policy document for achieving goals and objectives. Policy design refers to the content of public policies; include policy instruments-resources, implementation structure as well as target population (Schneider and Sidney 2009). It is argued that the more beneficial a policy is in its design, the more its acceptance. Also the extent to which a policy encourages participation of larger population or target groups the better its chances of being implemented (Grindle and Thomas 1991). Winter mentions three components that constitute well design policies, they include: setting right goals and values, mixes of policy instruments and target group and implementers access to information on how to execute policies (Winter 1990 cited in Winter 2003). May emphasizes that in order to reduce implementation difficulties, appropriate policy design should be made by building implementers' capacity and making policy intents known to them (May 1999 cited in Peters and Pierre 2003). Here policy implementers have to be knowledgeable on policy goals and the means of achieving them. For successful implementation of a policy, the clarity of the goals and objectives are prerequisite (Pressman and Wildavsky 1984; Van Meter and Van Horn 1975). The question might be on how the design of the NHIS (in terms of its goals, objectives and means) promoted or hindered the implementation of NHIS in Ghana

An empirical study conducted by Grindle in some developing countries in Africa, Asia and Latin America indicated that *“decisions made at the design or formulation stage have a considerable impact on how implementation proceeds”* (Grindle 1980: 8). Her study went further to indicate that implementation process is greatly affected by the kinds of policy objectives specified, way in which policy goals have been stated clearly or ambiguously, ‘when action programs have been designed and when funds have been allocated’ for the pursuit of the goals and objectives (Ibid: 7-8). The assumption is that the design of the NHIS has both positive and negative impact on its implementation in Ghana.

2.2.4 Implementation Structure

I intend to examine the individual actors, organizations and institutions that are to implement the NHIS at local level. According to Rothstein “...*using an inappropriate organizational structure often leads to failure in the stage of implementation- forms of organization are like tools- they are only suitable for the performance of certain definite tasks*” (Rothstein 1998: 89). Inappropriate organizational structure can impede implementation effectiveness. In this regard where there is appropriate implementation structure at the local level that can promote effective implementation of NHIS. Implementation structure consists of individual actors and organizations that are involve in the execution of public policies. Grindle provided list of possible actors that might be involved in the implementation of policies of any kind. They include national level planners (national, regional and local politicians); economic elites particularly those at the local level; recipient groups and ‘bureaucratic implementers at middle and lower levels’ (Grindle 1980: 12).

With implementation structure, the focus was on the extent of cooperation, co-ordination and commitment within and between implementing institutions. One factor that can enhance effective implementation of any policy is extent to which people (beneficiaries) have confidence in implementing institutions ability to deliver services. “*Without citizens’ trust in the institutions responsible for implementing public policies implementation is likely to fail*” (Rothstein 1998: 100). Beneficiaries would trust that they would have value for money for the services provided by the implementing institutions. Momen (2010) emphasized value for money in which public money is efficiently used in order to provide quality services. In my study, value for money would involve the use of tax payers’ money to render quality basic health care services to beneficiaries. Also make health care services much more accessible through the provision of health care facilities across Ghana to enhance the implementation of the NHIS. I intend to assess structure of each health care facility by examining the sub-units or departments responsible for the implementation of NHIS. I also intent to find out the kind of health care services health care facilities render at the local level on implementation of NHIS. Measures of appropriateness and inappropriateness of implementation structure to be examined. At the institutional level, the level of cooperation, co-ordination and commitment between and among implementing institutions or organizations can facilitate or hinder implementation of a policy. According to Winter (2003)

implementation processes are shaped by organizational and inter-organizational behaviours depending on the levels of commitment and coordination. Where actors within an implementing organization or institution have a positive attitude towards a particular policy, that can enhance its implementation and the vice versa. While O'Toole and Montjoy (1984) emphasize inter-organizational settings as influential in policy implementation, Pressman and Wildavsky (1984) rather focus on the complexity of joint action. If there is better cooperation and co-ordination between and or among implementing institutions, implementation of policies would be more enhanced. According to Pressman and Wildavsky successful implementation of policies are most likely to be affected depending on the number of actors involved, diversity of views, interests and perspectives they bring into the implementation process and multiplicity of decision and veto points (Pressman and Wildavsky 1984: 5-6). In situations where there are wide range of participants and perspectives, opportunities for blockade and delay due to many decision points can hinder the implementation process of a policy. According to Van meter and Van Horn successful implementation of policies often requires 'institutional mechanisms and procedures' whereby superiors try to exercise some kind of control over subordinates to "*act in a manner consistent with a policy's standards and objectives*" (Van Meter and Van Horn 1975: 466).

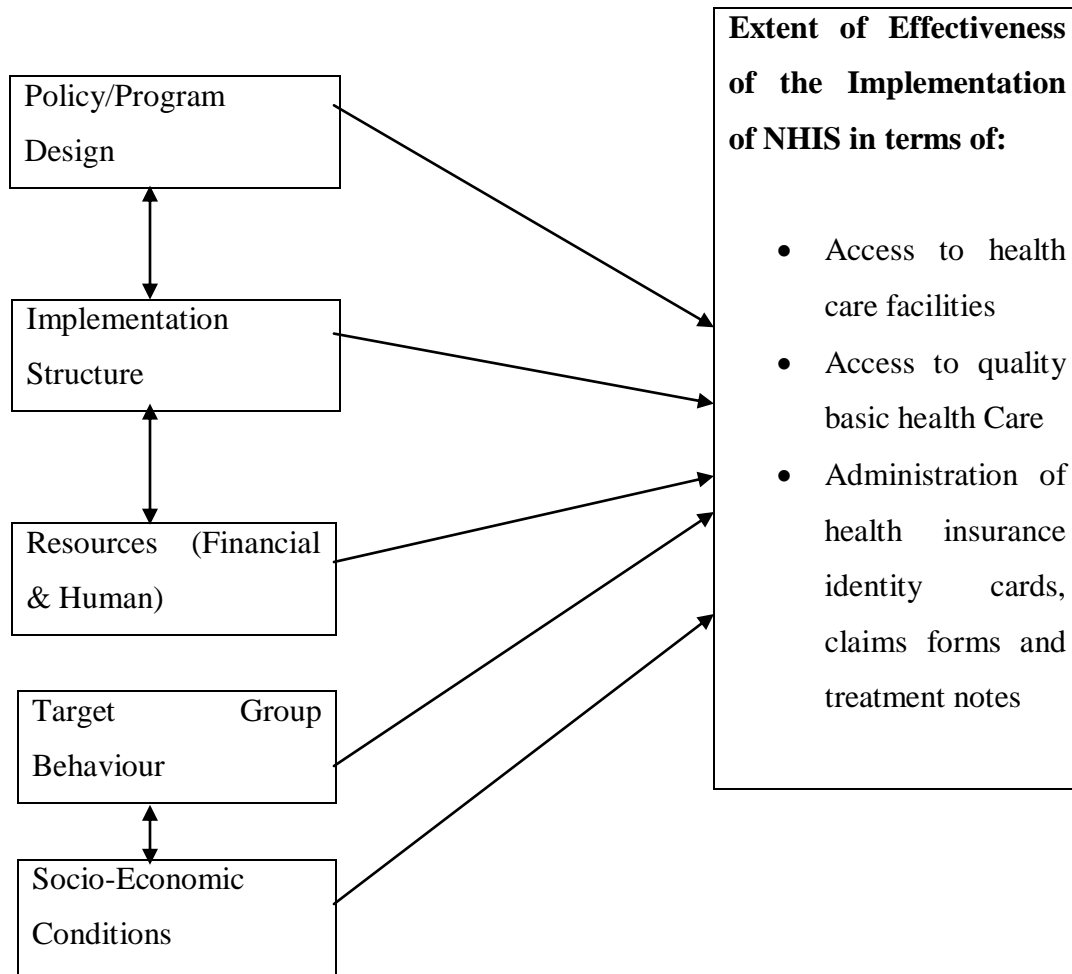
From discussions on the study five independent (explanatory) variables above, it is important to note that there exists some kind of linkage between and among the variables or factors. For this reason the five independent variables to some extent, did not exist independently in explaining the extent of effectiveness of the implementation of the NHIS at the local level in Ghana. My study's analytical framework takes into consideration policy formulation. The first variable: the design of the policy focuses on the clarity or otherwise of the goals and objectives of the NHIS policy. This variable also explains the means of executing the policy, the 'means' in this variable considers resources whether there is adequate resources at the local level for the implementation of the policy or not. The study's analytical framework as in Figure 2 below shows that there is a linkage between three variables: the design of the policy, implementation structure and resources illustrated with front and back arrows. There is a strong relationship between implementation structure and resources illustrated by front and back arrow sign in Figure 2 (more than the relationship between design of the policy and resources). The extent/degree of effectiveness of the implementation of NHIS depended on implementation structure of implementers. Adequate

resources (financial or human) or otherwise has adverse effect on the performance of NHIS implementers. Implementers need funding for the purchase of drugs, medicines, equipments and other logistics as well as funding required for motivating staff in executing policy. Though, there is linkage between target group behaviour and socio-economic conditions variables or factors yet the two variables show little linkage with other variables (design of the policy, implementation structure and resources). My study's analytical framework is illustrated in Figure 2 below.

Figure 2: Analytical Framework of the study

INDEPENDENT VARIABLES

DEPENDENT VARIABLE



Source: Developed from reviewed literature

2.3 Analytical Framework for the Implementation of NHIS

As I mentioned earlier, the main purpose of the study is to examine the implementation process of NHIS, with the view of identifying factors and actors viewed as responsible for the extent of effectiveness of the implementation of NHIS at the local level in Ghana. The main research questions are: “What factors may account for the overall policy implementation at the local level?” “What factors may account for or explain the differences between the public and private health care facilities in the implementation of NHIS.” Answers to these questions will be found through the analysis of the variables outlined in the theoretical model and other perspectives in relation to factors and actors viewed as responsible for effective implementation of NHIS.

2.4 The Dependent Variable for the Study

The dependent variable for the study was defined as “*Effectiveness of the Implementation of NHIS*” based on various research activities analyzed and organized in connection with the main research question stated above. A social science researcher’s attempt to explain the degree of effectiveness of the implementation of a policy could be challenging, because some factors might influence the process or be influenced by other factors in the implementation process. National health insurance scheme aims at increasing beneficiaries’ access to health care facilities, increase access to quality health care services and sustainability of the scheme (through regular claims payments). Thus, successful implementation of NHIS would enhance service delivery and utilization of health care facilities, finally towards the sustenance of the NHIS in Ghana.

2.5 Variables and their Operationalization in the Study

2.6 Dependent Variable

Based on research questions stated above, I operationalized the extent of effectiveness of the implementation of NHIS (dependent variable) by examining (a) the extent of beneficiaries access to health care facilities; (b) the extent of beneficiaries access to quality basic health care services; (c) the extent to which health care facilities are familiar with the administration of the following: health insurance identity cards, treatment notes, preparation of various health insurance forms: claims, prescription, diagnostic and complaints. They were drawn from the following documents:

NHI Act 2003; NHIS Medicines List (Revised) 2009¹⁰; NHI Regulations 2004 and other directives from National Health Insurance Authority (NHIA) and NHIS Secretariats.

a) Extent of beneficiaries access to health care facilities

Health care facilities are policy implementers, they carry out the ‘intent’ of the policy or programme. Equitable distribution of health care facilities across a country is challenging in most developing countries including Ghana, a situation where there are more health care facilities at urban areas than rural areas-where many have to walked long distances to attend a community health care facility (Ghana News Agency 2009).¹¹ It has been documented by Ministry of Health (MoH) and World Health Organization (WHO) that about 60% of Ghanaian population has adequate access to health care facilities (that is travelling within one hour). *“It is also clear that half of the population do not have access when the travel time is halved”* (WHO 2007b cited in Baidoo 2009). Accessibility to health care facilities sought to establish whether NHIS beneficiaries have the opportunity to consult skilled health care providers whenever they attend health care facilities (NDPC- Citizens Assessment of the NHIS 2008).

Health care facilities have the prime purpose to render quality services to their clients. Without clients visits to health care facilities the prime purpose for their establishment become useless. It is expected that clients (patients) would attend hospitals, clinics, maternity homes and other health service providers when they are ill or injured. Beneficiaries increase attendance at health care facilities¹² is very important for the utilization of health care services. According to the NHI Regulation, the first point of contact in accessing health care services is a primary health care facility (NHI Regulations 2004). Primary health care facility is any immediate health care facility. It could also be the only health care facility readily available to patients. Accessibility of health care facilities in times of referral and emergencies assumed a bottom-up hierarchy, from

¹⁰ Available at: <http://www.nhis.gov.gh/default.asp?CategoryID=158&ArticleID=1096> (Accessed 22 November, 2010).

¹¹ Ghana News Agency (GNA) is a state media house, with the publication *“NHIS Beneficiaries are Better Off- Research”*. Available at: <http://www.modernghana.com/news/225964/1/nhis-beneficiaries-are-better-off-research.html> (Accessed 10 November, 2010).

¹² SEND- A Non-governmental Organization. Research Findings on NHIS, Ghana: <http://www.ghanabusinessnews.com/2010/05/20/national-health-insurance-does-not-promote-quality-health-care-delivery-research/> (Accessed 22 November 2010).

community level health care facilities to sub-districts, districts, regional and tertiary (national) level (Agyepong et al 2007). Beneficiaries therefore will consider the distance, cost of transport (and motorability) to the facility. Access to health care facilities simply refer to the distance health insurance beneficiaries travelled in order to get health care services.

My study would refer access to health care facilities to beneficiaries' attendance at health care facilities. This being assessed on the following ways: the number of health care facilities or service providers accredited in line with NHIS accreditation rules (NHI Act 2003 and NHI Regulations 2004); proximity of health care facilities to beneficiaries and how quickly health care facilities render health care services to beneficiaries. The question posed to respondents on how they are able to attend health care facilities and utilized the health care facilities and services effectively? Health care facilities and service providers at the local level are key implementers of the NHIS and are to be well utilized in order to achieve the best possible output.

b) Extent of beneficiaries access to quality basic health care services

Access to quality basic health care services is about beneficiaries access to medical treatments, drugs, medicines and services of medical and paramedical staffs (staff attitude and waiting time) whenever they visit health care facilities. It is expected that beneficiaries accessed these services free of charge (without payments of medical bills). Beneficiaries of NHIS access to health care services refers to NHIS benefits package. This benefits package includes out-patient services, in-patient services, oral health services, maternity care services and emergencies (NHIS Benefits Package¹³). Health care facilities and service providers are expected to render high quality health services to beneficiaries. Delegation of powers, functions, responsibilities and resources have been highly decentralized, assuming a top-down perspectives to ensure that beneficiaries get good or quality health care services at health care facilities. The Government of Ghana's vision for instituting the NHIS is to assure beneficiaries quality package of basic or essential health care services (MoH 2002, 2004 cited in Agyepong et al 2007). NHI Act 2003 section 68 clearly spelt out components of basic quality health care services:

¹³ NHIS Benefits Package is type of health care services rendered free of charge to NHIS beneficiaries. Available at: <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=120> (Accessed 12 November 2010).

“The quality of healthcare services delivered are of reasonably good quality and high standard; the basic healthcare services are of standards that are uniform, throughout the country; the use of medical technology and equipments are consistent with actual need and standards of medical practice; medical procedures and the administration of drugs are appropriate, necessary and comply with accepted medical practice and ethics; and drugs and medication used for the provision of healthcare in the country are those included in the National Health Insurance Drug List of the Ministry of Health” (NHI Act 2003: 16-17).

What constitutes quality health care? Who provides quality health care? How is it provided? When should it be provided? Whom is it provided for? In my study, beneficiaries access to basic quality health care services means whether health care facilities and service providers clearly implement the NHIS according to the provisions of NHI Act 2003, NHI Regulation 2004, Drugs List (Revised) 2009 and other directives from NHIA through National Health Insurance Council (NHIC) and National Secretariat (NS). Measures, activities employed that sought to enhance implementation of NHIS at the local level include: i) health care facilities and service providers awareness of their functions and compliance with them; ii) health care facilities and service providers compliance with the Drugs List and removal of expired drugs; iii) health care facilities and service providers to render good, standard health care services; number of health personnel at health care facilities and NHIS authority and secretariat capacity to supervise, monitor and update health care facilities on new changes.

c) Extent of health care facilities being conversant with the administration of health insurance identity cards, claims, forms and treatment notes

Section 65 of NHIS Act focused on National Health Identity Card (NHIS Act 2003: 16). Regulation 18 stated that national health insurance card shall *“be issued to a member within six months of the registration of the member by the scheme”* (NHI Regulation 2004: 8). Provision was also made for replacement of identity card in case it was damaged or lost. Implementation of uniform NHIS Identity Cards facilitated the implementation of NHIS. It resolved the initial difficulties beneficiaries encountered in accessing health care services beyond their registration district. With the uniform Identity Cards beneficiaries could access health care services in every Government (public) health care facility and all accredited private health care facilities in Ghana

(Statesman Newspaper Report 2008).¹⁴ The new identity cards facilitated work of health care facilities and health care providers as they use computers in verifying members' eligibility. This has made health care facilities work faster more than the period where manuals were used (paper checking's). Health care facilities were supplied with computers and magnetic stripe readers by NHIS Secretariat. The usages of Identity cards were for membership authentication. Health care providers ensured that whenever beneficiaries attend their facilities their NHIS identity cards were swiped in which *"information about a member's eligibility will be displayed on the computer."*¹⁵ Situations where beneficiaries' identity cards were not ready, the NHIS Secretariat may issue Treatment Notes to beneficiaries to be used in place of NHIS Identity Card.

Health care facilities and service providers by law and regulations required to prepare monthly health insurance claims and submitted to NHIS Secretariat. The NHIS Secretariat was to ensure that payments were made *"within four weeks after the receipt of the claim from the health care facility"* (NHI Regulations 2004: 15). Health care facilities and service providers had to prepare these NHIS forms (prescription, diagnostic and claims) in line with rules and regulations of NHIS to facilitate the implementation of NHIS.

My study examines how health care facilities prepare and administer the various NHIS forms, monthly claims reports and treatment notes in implementing NHIS at the local level. First focus will be on whether forms, reports and notes are initiated by the health care facilities themselves (bottom –up perspective) or are initiatives from above (top-down perspective). Assessment of the effectiveness of these activities is very crucial in assessing performance of health care facilities. Beneficiaries' response on the performance of health care facilities is examined here. Measures used in the assessment of performance of health care facilities include: preparation of insurance claims should be in line to NHIS rules and regulations (timeliness); verification of beneficiaries identity cards should be well known and properly done to avoid long queues in health facilities;

¹⁴ Gilbert Boyefio, "Access Healthcare anywhere with uniform NHIS ID Card nationwide". An Article published in Statesman Newspaper on 5 January 2008. Available at: http://www.thestatesmanonline.com/pages/news_detail.php?newsid=6273§ion=1 (Accessed 25 November 2010). Statesman is a privately owned Newspaper in Ghana.

¹⁵ The New NHIS ID Card: Usage. Available at : <http://www.nhis.gov.gh/?CategoryID=162&ArticleID=106> (Accessed 25 November 2010).

filling of treatment notes should be well structured; institutional mechanisms should exist for the preparation of prescription, diagnostic and attendance forms.

2.7 Independent Variables

The next section operationalizes the factors and actors (independent variables) that explain or may influence extent of effectiveness of the implementation of NHIS (dependent variable) in the study.

2.7.1 The Design of the Policy

Operationalization is the process of defining concepts or variables into measurable terms. Operationalization is simply measurement of concepts or variables and linking these concepts or variables to their empirical determinants. The design of the policy has been operationalized by examining health care facilities understanding of objectives, goals and the means for executing the policy (NHIS). Examining health care facilities capacity, willingness to execute the goals of the policy and carry out their functions. This variable also examined beneficiaries understanding of the design of the policy and its benefits to them. Specifically on: when beneficiaries were asked whether they were treated free of charge in times of illness and injuries whenever they attend health care facilities. My study hypothesis was that **“the more clearly the goals, objectives and the means, the better the implementation of NHIS.”** But where there is lack of knowledge of goals, objectives and skills and means to execute policy, effectiveness in realizing policy output cannot be met.

2.7.2 Implementation Structure

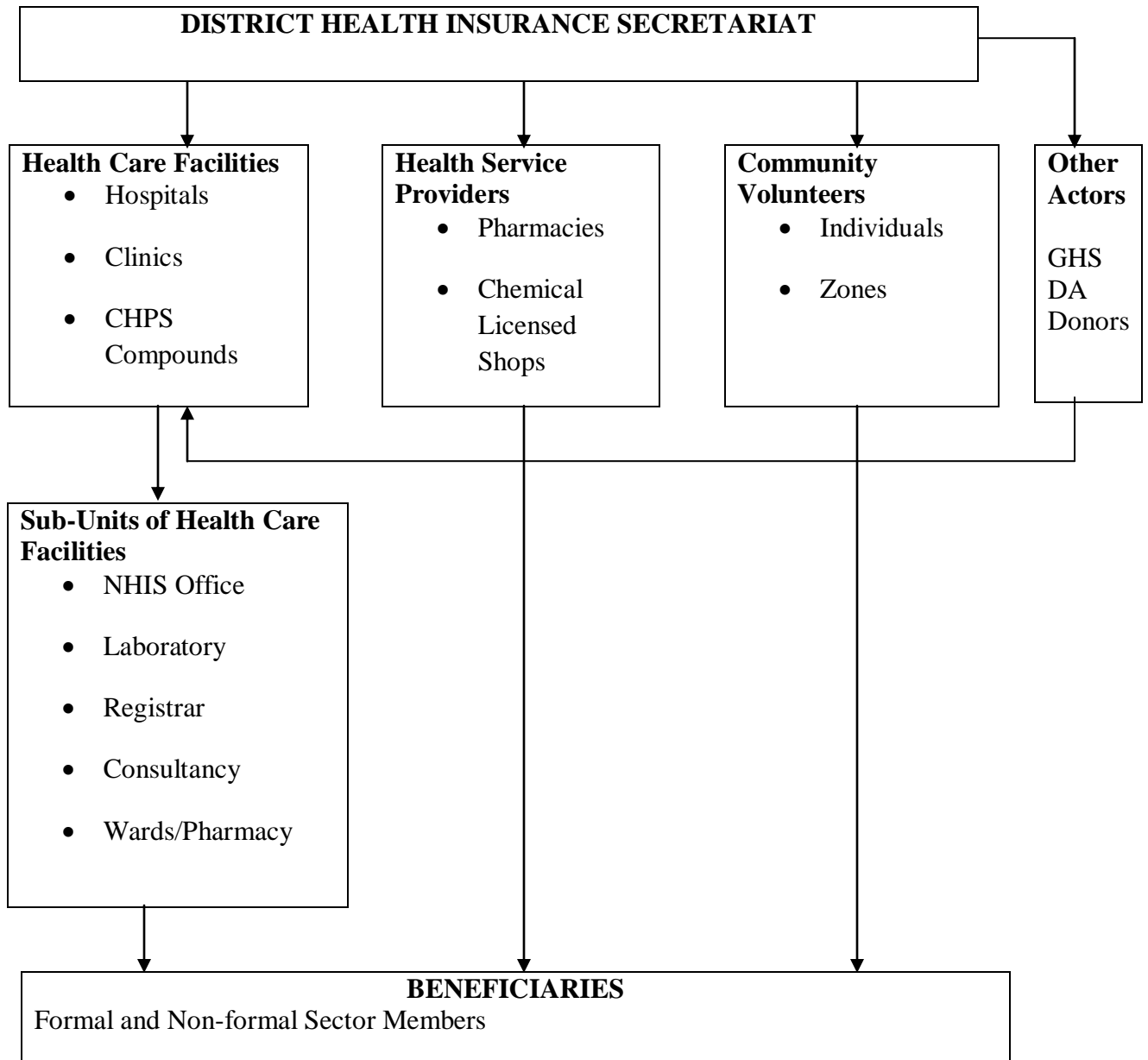
Implementation structure was operationalized by examining the institutional structure of NHIS in Ghana. At the apex are the NHIC and NS down to regional, district secretariats and health care facilities and service providers at the bottom (NHI Act 2003). At the local level in Ghana, I examined the activities and relationship between District Health Insurance Secretariat and health care facilities in the implementation of NHIS (in terms of access to facilities, quality health care and administration of various NHIS forms and cards. The individual actors are the beneficiaries (registered members of NHIS). Therefore, in my study the question was asked how health care facilities work with district health insurance secretariat, the extent of commitment, cooperation

and co-ordination among implementing institutions and how various sub-units within health care facilities have contributed to the implementation of NHIS. My assumption is that the better the cooperation, commitment and co-ordination between NHIS secretariat and health care facilities at local the better the implementation of NHIS.

Hypothesis 2: *“Degree of successful implementation of the NHIS is dependent on, the level of cooperation, commitment and co-ordination within and between implementing institutions.”*

The District Health Insurance Secretariat is the main agency responsible for the implementation of NHIS at the local level. The NHIS Secretariat has five main managers as senior staff members and other lower staff; the secretariat gives accreditation and supervises the activities of various health care facilities and service providers in each district in Ghana. Health care facilities and service providers are the principal implementers of NHIS at the local level. They provide basic health care services (medical treatments, supply of drugs and medicines among others) to beneficiaries. Health care facilities work with accredited licensed shops on supply of drugs and medicines to beneficiaries. Within health care facilities there are sub-units, their level of cooperation, co-ordination and commitment are vital for day to day implementation of NHIS. Also, community volunteers link NHIS secretariat and beneficiaries through information dissemination and registration of NHIS at various communities at local or district level. Figure 3 below illustrates Implementation Structure of NHIS at Local Level in Ghana.

Figure 3: The Implementation Structure of the NHIS at the Local Level in Ghana



Source: Researcher’s own design from field data, June-July 2010.

Keys: **GHS**- Ghana Health Service District Directorates; **DAs**-District Assemblies

2.7.3 Resources

This study focused on financial and human resources for the implementation of NHIS at the local level in Ghana. The availability or otherwise of financial and human resources determine extent

of effectiveness of the implementation of NHIS. At local level, the financial structure of NHIS sources of funding for the implementation of NHIS include annual premiums, registration fees and monthly claims payments (the main source of funding from central government transfers). Successful implementation of NHIS is dependent on the amount of money made available for implementation. Also, the timeliness of the money is very crucial.

In my study, I operationalized financial resource by examining the time district health insurance secretariat take to make claims payments to the two health care facilities, the amount of money received from the central government through secretariat, the capacity to locally generate funds called internally generated funds, raising funds from other sources like foreign donors or non-governmental organizations for effective implementation of NHIS. I also operationalized human resource by examining the number of staffs in each health care facility, their educational qualifications, professional profiles and number of staff assigned to the various sub-units in each health care facility. Therefore, I hypothesize that the well funded and the well staffed an implementing institution, the better its implementation of NHIS.

Hypothesis 3: *“the higher the resources, the better the extent of effective implementation.”*

2.7.4 Target Group Behaviour

I operationalized target group behaviour in terms of extent of cooperation and trust between health care facilities and target group, also health care facilities attitude towards target group.

2.7.5 Socio-Economic Conditions

I operationalized socio-economic conditions of beneficiaries by examining if social status of beneficiaries (their occupations and educational level) determines the kind of health care services render to them. *“The more target group positive response and improved socio-economic conditions, the better the implementation of the NHIS.”*

2.8 Conclusion

It is important to note that the purpose of this chapter was to develop an analytical framework for analyzing the extent of effectiveness of the implementation of NHIS at local level in Ghana and that depended on the five explanatory factors: policy design, implementation structure, resources target group behaviour and socio-economic conditions of beneficiaries.

CHAPTER 3

RESEARCH METHODOLOGY

3.0 Introduction

The purpose of this methodological chapter is to discuss how data was collected. This chapter focuses on the study area, research strategy, target population, methods of data collection, instruments used and methods of data analysis. This chapter also highlights some of the ethical issues I took into consideration before collecting data from respondents. The chapter discusses various activities I undertook during the period of data collection and highlights some challenges I encountered during field work.

a) Area of the Study

The study was conducted in Sawla-Tuna Kalba District of the Northern Region of Ghana. The district was created in 2004. This district is among the 170 districts¹⁶ in Ghana implementing the NHIS. The district has a total land area of about 4,601 square kilometres and the population is estimated at 84,664¹⁷. The current population is estimated to be about 94,644.¹⁸ The district capital is Sawla. The main occupation of the people in the study area is farming. Few people are also engaged in fishing along the Black Volta River. Most of the people belong to non-formal sector.¹⁹ I chose this district because of time and resource constraints for data collection. For that reason, it was not possible for me to study all the health care facilities and service providers of NHIS in the district. So, in order to minimize cost and make judicious use of the limited time for field work without affecting the quality of research work, I selected one public (government) health clinic and one private health clinic both in Sawla (where I live) for detailed comparative case study analysis. One objective for the selection was to find out differences in the extent of effectiveness of the implementation of NHIS between two health care facilities in the same district capital in Ghana.

¹⁶ All districts in Ghana. Available at: <http://www.ghanadistricts.com/districts/>

¹⁷ Sawla-Tuna-Kalba Mutual Health Insurance Scheme (STKMHIS) Business Plan (2008-2010).

¹⁸ GHS, STKD Annual Report, 2009: 1.

¹⁹ Non-Formal Sector refer to work outside formal/government employment (mostly with irregular earnings)

b) Research Strategy

The study was more qualitative with the aim of analyzing the extent/degree of effectiveness of implementation of NHIS. Qualitative approach is considered more suitable for the study rather than quantitative or mixed approaches because qualitative research approach tries to establish meaning, context as well as challenges of social phenomenon from perspectives of participants. Gray identifies types of data gathering tools and resources used in qualitative research; they include interviews, observation, focus groups, documents and others like media including print media (Gray 2009). These sources of data mentioned have been used in gathering data for my study. Miles and Huberman explains that qualitative research data normally take the ‘form of words rather than numbers’ and are ‘explanations of processes in identifiable local contexts’ (Miles and Huberman, 1994:1).

My study was more deductive than explorative as the study started with a theoretical framework. I specifically tried to look at effective implementation of NHIS (in terms of beneficiaries’ access to health care facilities, basic quality health care services and health care providers/facilities familiarity in administering NHIS cards, treatment notes and forms). Also how the design of the policy (NHIS), resources availability, implementation structure and target group behaviour and socio-economic conditions have influence the process of implementation of NHIS at local level. I used qualitative research approach and collected data from NHIS beneficiaries’ and key stakeholders in the district.

One advantage I envisage from the use of a qualitative approach in the study was that it helped my understanding of the effectiveness of the implementation process of NHIS at local level from natural ‘real-life’ setting. In a situation in which real feelings, perceptions, motivations and views of beneficiaries and key stakeholders were freely expressed to me (researcher). Also, the approach enable me to get to know the kind of relationships that exist between public and private health care facilities. Through qualitative approach triangulation of data took place. I collected data from different categories of persons such as the staff of public and private health care facilities, district health insurance secretariat and other health care providers. These persons constituted key stakeholders at the local level. Data was also collected from NHIS beneficiaries (adults, aged, indigents and children below 18 years). In addition, data was collected from

different sources like interviews (I used face to face and focus groups discussions), documentary sources (reports, acts, regulations, insurance claims sheets and circulars) and direct observations at the two health care facilities. Obtaining data from different respondents and use of multiple sources of evidence enhances both data validity and reliability. Furthermore, I was able to probe answers from key stakeholders and beneficiaries during interviews until satisfactory responses were obtained, as I followed some clues at the end of the interview period.

However, one disadvantage of qualitative approach is that it deals with single or few cases. Few which often does not offer strong grounds for empirical generalization of findings. The small groups of respondents interviewed in the study should not necessarily be taken as statistically representative.

3.1 Research design

Research design is the frame that guides a researcher in the process of data collection, analysis and interpretation of findings. Research design is a plan or procedure a researcher adopts that connects data to the 'study's initial research questions' and its conclusions (Yin 2009: 26). Yin defines a case study as an empirical inquiry in which "how" or "why" questions are posed, a study that investigates a 'contemporary phenomenon within a real-life context,' where the 'investigator has little control over events' (Ibid: 2). According to Yin multiple sources of evidence are used in case study research. This study focused on contemporary issue (implementation of NHIS) within 'a real life context' and researcher having little control over events. The study was a case study design in which two health care facilities were selected in one district. The study compared one public (government) and one private health care facility both located in the same district capital. While the public health facility was established and owned by government with the aim of providing quality and affordable health care services to the rural population, the private health care facility was established by an individual with the aim of providing quality health services and maximizes profits from the services it rendered. The motivation to carry out a comparative study of the two health facilities was to compare and contrast the process of the implementation of the NHIS between public and private health care facilities at the local level within the same rural setting or context. Also to assess if there are any significant differences between them in terms of performance or output and explain whether their differences has anything to do with one

being public or private. The two health care facilities were both implementers of NHIS. The two health care facilities were to have similar structures, particularly the creation of NHIS Office to facilitate the implementation of NHIS under the directive of NHIS secretariat and authority. The units of analysis are the two health care facilities involved in the implementation of NHIS in the Sawla-Tuna-Kalba District (STKD).

3.2 The Target Population, Selection of Respondents and Sample Size for the Study

3.2.1 Selection of Respondents

Respondents for the study were selected from the following: staff of the two health care facilities, registered members of NHIS in the district (children, aged, indigents, adults-formal sector workers and non-formal sector premium payers) and staff of District Health Insurance Secretariat. Data collected from these respondents covered the various key persons I considered as important stakeholders in the district. The study did not focus on survey of representative sample of people in the district. But the study focus was on some selected respondents for analytical purposes as in qualitative research approach rather than being used for statistical generalization as the case of quantitative research approach. Twumasi indicated that researchers must be mindful of their target population-be it urban or rural population. According to him where target population is rural *“researchers must know the characteristics and behaviour patterns of rural people”* (Twumasi 2001: 74).

In my study I used purposive selection of respondents (Twumasi 2001) in the district. Respondents were purposively selected. Also the two health care facilities were purposively selected; they were both in the district capital where I resided. This save cost of transport and time without undermining the quality of the study (data collection). The procedure for the selection of respondents was based on my research questions intended to achieve the objective or purpose of the study. Purposive sampling entails the selection of respondents based on an ‘explicitly stated criteria’ for instance selection of respondents who can answer researcher’s research questions, where a researcher picks respondents ‘he wants to be included in his sample’ and when a researcher wishes to gain an ‘insight into a social phenomenon’ (Ibid. 28). Purposive sampling to me is where researcher selects respondents that he/she considered as having relevant knowledge on the issue being studied. What I meant by purposive selection of respondents was

that my focus was on persons with relevant or needed information about the implementation of NHIS. Selection of respondents was put into two (2) main groups. The first group focused on staff of the two health care facilities (public and private clinics). They were key implementers of the NHIS. Therefore, it was useful to get their views on the effectiveness or otherwise of the implementation of NHIS. The second group focused on beneficiaries' of the NHIS (adults, aged, indigents' and children). They were asked whether they have access to treatments and drugs or not whenever they visited these health care facilities in the district. Also, accessibility to health care facilities and quality of services were crucial. The two groups were essential because they have the relevant or needed information for answering the research questions of the study.

The total number of respondents in the study was thirty four (34). I put respondents into seven categories. These categories of persons provided the needed data for the study. Below are the categories illustrated in Table 1.

Table 1: Sample Size

Sawla Health Centre (Public/Government)		Sawla Friends M. H. Clinic (Private)		
Category	Respondents	Category	Respondents	Total
1. Medical Assistants/Nurses	3	1. Medical Assistant/Nurses	3	6
2. Pharmacists/Lab. Tech.	2	2. Pharmacists/Lab. Tech.	2	4
3. NHIS Officers	1	3. NHIS Officers	1	2
4. Registrar	1	4. Registrar	1	2
5. Adults	7	5. Adults	7	14
6. Aged	1	6. Aged	1	2
7. Indigents/Children	2	7. Indigents/Children	2	4
Total	17	Total	17	34

Source: Researcher's Own Research Design, May 2010.

3.3 Interviews

I used two types of interview in the field, these are discussed below.

3.3.1 Face - Face Interview (Individuals)

I conducted an in-depth interview with staff of the two health care facilities selected, particularly registrars (patients' first point of contact), medical assistants, nurses, NHIS officials, pharmacists and laboratory technicians. I considered the vital roles these persons play concerning the implementation of NHIS. Some of them became 'informants' rather than respondents based on the level of assistance or amount of information they made available to case study investigator or researcher (Yin 2009). Another in-depth interview was conducted with NHIS beneficiaries: adults, children, indigents and the aged. I also sought the views of some officials of NHIS district secretariat. The interview was 'semi-structured' (Gray 2009: 369) and that enabled me to probe for 'comprehensive answers' (Kvale 1996 cited in Masue 2010: 63). The questions raised in the interview guide were open-ended questions (Creswell 2009) and that afforded my respondents (interviewees) to freely express their views, feelings and experiences concerning implementation of NHIS. I probed further into some answers with other respondents. Through the use of face-face interview, I was able to gather more information for the study.

3.3.2 Focus Group Discussions (FGD)

The study also obtained data through "focussed interview" (Merton, Fiske and Kendall 1990 cited in Yin 2009: 107) with beneficiaries' of NHIS. Respondents were interviewed in groups in which data was obtained, what Creswell termed 'Focus Group' discussion (Creswell 2009: 179). Yin indicates that this kind of interview (Focus Group Discussions, FGD) calls for 'probing' and by doing that researcher has to check with persons known to hold different views or perspectives (Yin 2009). According to Twumasi, focus group is a small group about 6-10 people who are brought together to 'engage them in a guided discussion' as a way of gathering information on a particular research topic (Twumasi 2001: 64). According to him, it is advisable for a researcher to have more than one focus group discussion in a given research study in order to give the researcher a 'reliable insight' into the issue being investigated- in capturing the reality from the group in their natural setting. However, Twumasi admitted that data collected from focus group discussion may be difficult to analyse.

In the study I used FGD in gathering information from the NHIS implementers and beneficiaries. For NHIS implementers (the two health care facilities staff), I used 'pair-wise ranking' method

(Rifkin and Pridmore 2001: 84). This method or technique was used to find out the functions of health care facilities in the implementation of NHIS. And for the beneficiaries, I used a different technique for ranking and scoring known as ‘preference ranking’ (Ibid: 87). This technique guided the study in knowing which health care facility beneficiaries preferred to go for treatment when they are ill. This took the form of group interviews at household levels in a manner that was convenient to the NHIS beneficiaries. The discussion took place on market day²⁰ in order to allow villagers (beneficiaries) who resided outside Sawla. I selected eight (8) respondents for easy management of the discussions. Members in the group consisted of both males and females, children, indigents and the aged. Open-ended questions were used to solicit respondents’ views on issues like access to medical assistants/doctors, nurses, drugs, any differences in treatments based on patients’ social status among others.

Other issues discussed with beneficiaries were their access to quality health care services, accessibility to health care facilities and the kind of services rendered to them. Efforts were made to make the discussions very friendly in order for beneficiaries to express their feelings, views, and challenges of the implementation of NHIS. This was a useful method of gathering data for the study. However, the aged was not able to express himself properly and that was attributed to old age. Other individuals who could not talk freely, I later contacted them after group discussions to make their views in order not to skip the information they want to offer for the study.

3.4 Direct Observation

Direct observation was used as another means of obtaining data for the study. This method helped to reveal some relevant behaviours or conditions for observation (Yin 2009: 109). Observation deals with the combination of sensation and perception and provides a researcher the opportunity to ‘get beyond people’s opinions and self interpretations of their attitude and behaviours’ (Gray 2009: 397). I observed the processes beneficiaries followed at health care facilities. I also observed how health care facilities implemented the NHIS and some activities at district NHIS secretariat. Observation for the study was among the various stakeholders involved

²⁰ Market days are the days villagers come to the market at the district capital to buy and sell goods including farm products. Sawla the district capital market days are every five days in a week.

in the implementation of NHIS. This method of obtaining data was used in situations where I could not get some information through interviews and documentary reviews.

3.5 Documentary Sources

Having discussed the primary sources of data collected for the study above, the major source of secondary data was documentary review. Gray (2009) outlined wide variety of documents such as organizational and institutional, financial, political and legal documents. According to Twumasi, documents (materials) obtained from ‘well-established institutions’ are usually reliable the reason being that they were collected with more care and patience (Twumasi 2001: 63). He mentioned official reports, census data, records, statistical data, papers, acts, agreements, and minutes of institutions among others as useful source of information for a researcher (Ibid). Documentary sources of data minimise interviews problems of bias and poor recalls. Some documentation sources include reports, records, articles and media publications like newspapers among others (Yin 2009: 103).

Secondary sources of data obtained for the study were from various reports (financial, insurance claims, statistics of patients’ attendances) from the two health care facilities. Data was also obtained from some legislation such as the NHI Act 2003 and NHI Regulations 2004 from NHIS Secretariat. Also National Health Insurance Drug Lists Review 2009 and minutes of meetings were obtained from NHIS Secretariat. In addition, newspapers were obtained from public libraries and articles from the internet. Other documents I reviewed included annual reports of Ghana Health Service (GHS) from national, regional and district (the Sawla-Tuna-Kalba reports for 2007, 2008, 2009 and half year 2010). Through the use of documentary review methods, I was able to obtain relevant data related to the roles and functions of health care facilities, responsibilities of beneficiaries, and the legal documents backing the implementation of NHIS. The documentary sources of data collected and reviewed supplemented the primary sources of data I obtained for the study.

3.6 Data Analysis

Data analysis involves making meaning out of the text and data collected, making interpretation of the meaning of data (Creswell 2009: 183). Data analysis starts after data has been collected through face-to-face interviews, focused group discussions, observations and examination of documentary sources and then making meaning out of data until the study ends. Content analysis was used to analyze both written and verbal documents in order to get interpretation of meaning of data collected. Also the study used coding for the description of findings from the categorized respondents (discussed under sample size above). In my study, data collected was analyzed through the use of explanations and narrative of what respondents said. I also presented a lot of tables, used simple percentages in order to make meaning much more clearly. Direct quotations of respondents were made to buttress some salient points as part of analysis of data. Interviews I recorded with voice recorder were transcribed and information written with hand typed for analysis. Other stages used included editing (to check accuracy and consistency of responses) and tabulation for the sake of clarity of narration and not for quantitative analysis.

3.7 Limitations of the Study

One major limitation or challenge to the study is on how issues of validity, reliability and generalizations can be address; critics argue that qualitative research approach fails to address those issues. These issues are discussed below.

3.7.1 Addressing the Issues of Validity, Reliability and Generalization

Validity refers to where a researcher checks for the accuracy of study's findings by using certain procedures (Creswell 2009). Reliability suggests that researcher's approach is 'consistent across different researchers and different projects' (Gibbs 2007 cited in Creswell 2009: 190). Reliability involves assessment of the quality of a research. Generalization in qualitative research is used in a limited way, the intent is not to 'generalize findings to individuals, sites or places outside of those under study' (Creswell 2009: 193). Critics have argued that qualitative studies' findings and conclusions cannot be generalized. However, qualitative generalization can be applied to case study research in which a researcher studies many cases (Yin 2009). According to Yin a researcher doing case studies should aim at analytical generalization rather than statistical generalization. He defines analytical generalization as a study in which "*a previously developed*

theory is used as a template with which to compare the empirical results of the case study” (Yin 2009: 38). Yin defines statistical generalization as where an inference is being made about a population on the ‘basis of empirical data collected about a sample’ from that population (Ibid). This way of generalizing is much more common in quantitative research such as surveys rather than qualitative research studies.

In order to address issues of validity and reliability, I created case study database and maintain the chain of evidence (Yin 2009: 100). This implies that the study used triangulation of methods of data collected through interviews, direct observations and review of documentary sources (reports, acts, regulations, minutes and circulars). The logic of combining documentary sources of evidence with observation and interviews was to check or compare answers obtained from one source with another source. Also, I used triangulation of persons: medical assistants, nurses, registrars, pharmacies, laboratory technicians, insurance administrators in health care facilities; officials of district health insurance secretariat and NHIS beneficiaries. These respondents were either implementers or beneficiaries’ of NHIS, getting their views and experiences enhance the quality and validity of my study. Also, the wide variety of persons interviewed was to reduce respondents’ biases. Thus, data obtained from multiple sources of evidence increases the validity of data as well as the reliability of research data in obtaining findings.

Generalization (external validity) allows findings of a case study to be generalize for other case studies. My study findings and conclusion may not reflect the real situation of implementation of NHIS in other districts with different socio-economic conditions. But the study’s findings and conclusions might provide some understanding on the extent or degree of effectiveness in the implementation of NHIS in other districts in Ghana especially those that share similar socio-economic conditions as that of Sawla-Tuna-Kalba District (study area).

3.8 Challenges Encountered During Data Collection

One challenge was the bureaucratic procedures I went through before accessing documentary information from institutions and organizations. Another challenge was on the translation of the four (4) local Ghanaian languages in the study area into English Language as most of the rural people were illiterate. As native speaker of the local languages, I consulted Ghanaian Languages-

English Grammar Versions for accurate translations. The demand for money was quite common. Some respondents complained of hunger and expected me to provide them with some food or money to buy food so as to enable them participate properly during interviews. This situation increased my expenditure and I nearly run into some financial difficulties at the study area.

3.9 Ethical Considerations in the Research

The study adhered to ethical considerations in social science research. This was done in order to safeguard the rights of respondents and to ensure that no information was taken wrongly, so as to enhance the credibility of the study's findings. According to Gray any research that deals with data gathering/collection or a research that has contact with human populations involves 'ethical considerations' (Gray 2009: 73). Some of the ethical issues considered in the study included: obtaining respondents consent, voluntary participation, respect for confidentiality, personal integrity and anonymity and informed consent (Creswell 2009). These issues were in agreement with Leiseca that "*in all research involving human participants, ethical considerations must be thoroughly discussed by the researcher before embarking on data collection and analysis*" (Leiseca 2005 cited in Buabeng 2009: 96). Furthermore, it is important for researchers to protect their participants/respondents, develop trust with participants, the need to promote the integrity of the research and 'guard against misconduct and impropriety that might reflect on their organizations or institutions' during data collection (Creswell 2009: 87).

I obtained an introduction/recommendation letter (see appendix 7) from Department of Administration and Organization Theory of the University of Bergen which was sent to my study area in Ghana in order to enable me access information needed for the study. The introduction letter was made available to all institutions, organizations visited and respondents in order to introduce myself to them. Also I sought respondents' consent on the use of voice recorder. I used voice recorder in order to avoid distortions of information and to have a better recall. All discussions between me and my respondents were treated very confidential. Respondents participation in both face to face interviews and focus group discussions were treated voluntarily, I told them the reason for their selection and reason for the conduct of the study. Respondents' personal integrity, privacy and anonymity were assured to enable them to freely express their views, opinions and perspectives.

3.10 Conclusion

As indicated earlier, the purpose of this chapter was to discuss the methods used in gathering data and the way data was analysed in the study. The chapter indicated that the study adopted mainly qualitative approach. The focus was on identifying factors and actors that may influence the degree/extent of effectiveness of the implementation of NHIS at the local level in Ghana. Primary sources of data for the study were obtained from face-to-face interviews, focus group discussions and direct observations. Open-ended questions were used in soliciting views of the respondents. The secondary sources of data were mainly obtained through documentary sources particularly NHIS act, regulations, reports, minutes of meetings, correspondences and circulars. Other secondary sources such as the use of the internet, articles, newspapers and books were also discussed. The methodology used in gathering data sought to answer the study's research questions.

Some methodological lessons were learnt during data collection and the study period. The triangulation of sources of data and persons helped in checking the accuracy of information gathered. As I tried to cross check one source with another, this increased the validity and reliability of data collected for analysis. The qualitative approach made the study much more flexible rather than rigid, as there was no strict procedure followed in gathering data. By this flexibility in approach, it created a very friendly atmosphere between me and the respondents where they freely expressed themselves in answering the study's research questions.

The next chapter focuses on health reforms initiatives in general and national health insurance in particular in Ghana. Finally discuss the institutional and financial structures of NHIS in Ghana.

CHAPTER 4

AN OVERVIEW OF GHANA'S NATIONAL HEALTH INSURANCE SCHEME

4.0 Introduction

This chapter focuses on Ghana's move towards adoption of a national health insurance scheme as a way of making quality health care services accessible and affordable in the country, with particular focus on health care services rendered by health care facilities at the local level. The chapter first examined health insurance initiatives in Ghana. Secondly, the chapter gives an overview of National Health Insurance Scheme (NHIS) particularly its institutional and financial structures. Thirdly, the chapter highlights the achievements of the NHIS in connection with the provision of health care services by health care facilities at the local level in Ghana.

4.1 Health Insurance Initiatives in Ghana

The idea of setting up a community based health insurance took place in Sunyani²¹ by Catholic Church Hospital administrators in 1989. The first community based health insurance scheme- Nkoranza Community Financing Health Insurance Scheme (CFHIS) was launched in Nkoranza in Brong Ahafo Region, with support from Dutch Christian Non-Government Organization (NGO) known as Memisa (Atim and Madjiguene 2000). The scheme aimed to “reduce the cost per individual hospital admission, thus making services accessible to all within the district” (Project Proposal 1991: 1 Ibid: 1). It was a private health insurance scheme with the goals of making health care services easily accessible and affordable to rural dwellers as future guarantee for the people in times of ill-health.

Another successful private health insurance scheme in Ghana was the West Gonja Health Insurance Scheme (WGHIS) launched in Damongo in the Northern Region in 1995. The scheme motto was “Health is Wealth” and the main objective was “to provide as well as improve financial access to health care for its members as and when required” (Sunyazi 2003: 16). Many private health insurance schemes took place at the local level in Ghana. Some of these included the Okwahuman Health Insurance Scheme (OHIS) in the Kwahu South District of the Eastern Region, initiated in 1999 and implemented or outdoor in 2001. The Holy Family Catholic

²¹ Sunyani is a city in Ghana. It is the regional capital of the Brong Ahafo Region.

Hospital established it in order to overcome the problem of patients' inability to pay cash after medical treatments (OHIS Operational Report 2004). The Tano Health Insurance Scheme (THIS) was initiated in 2000 by the Hospital Administrator of St. John of God Hospital in Duayaw Nkwanta (Brong Ahafo Region) and was implemented in 2001. The scheme aims at improving 'access to health services by the poor', particularly those living in rural communities (THIS External Evaluation 2004: 8).

Ghana's health insurance initiatives discussed above has been mainly private rather than being government initiatives. Also, the health insurance initiatives have been limited to some geographical locations and were not national in scope. Their means of funding have been mainly through donor support and contributions of members. Finally, these health insurance schemes were initiated at the local level and implemented at local levels only.

4.2 Ghana's National Health Insurance Scheme

Ghana's National health Insurance Scheme (NHIS) started in 2003. The scheme started on district basis and was later implemented across the country (nationwide) - where beneficiary could benefit from the scheme in any part of Ghana. The NHIS is one of the biggest social interventions in Ghana since independence. The NHIS covers over 95% of the most common diseases in Ghana (Health Systems 20/20 PRDD, GHS 2009). The disease conditions covered by NHIS include the following: outpatient services, in patient service, oral health, maternity care and emergencies. They constituted the NHIS benefits package for beneficiaries whenever they visit health care facilities. These health care services are rendered to NHIS beneficiaries free of charge. In addition beneficiaries of NHIS have free access to approved medicines and drugs at all accredited health care facilities across the country. To achieve this, the NHIS published the lists of all approved medicines and drugs for health care facilities and health providers to implement (NHI Medicines List 2007; 2009 (Revised)). However, NHIS has some exemptions of disease conditions that it does not cover. These exemptions are clearly stated in the policy for health providers to follow. Some exemptions include: Human Immunodeficiency Virus (HIV)

retroviral drugs, echocardiography, mortuary services and organ transplantation among others.²² Health care services rendered under the exempt disease conditions mentioned above means beneficiaries must pay for such services at accredited health care facilities across Ghana.

The NHIS policy outlined ten (10) broad objectives to achieve in Ghana. These objectives are equity, quality health care, efficiency, community/subscriber ownership, partnership, risk equalization, solidarity, reinsurance, cross- subsidization and sustainability.²³ Equity refers to the minimum benefits package for all residents of Ghana irrespective of their socio-economic status in society. Quality health care involves the delivery of high standard health care services by health care facilities and service providers (drugs, medicine and personnel endowment). In terms of efficiency, the focus is on the collection of insurance premiums from beneficiaries, timeliness in the collection of premiums and prompt re-imburement of health care facilities and service providers. Community or subscribers ownership expects all districts to take ownership of the NHIS.

Active community members' participation is essential for the implementation of NHIS at local level. Partnership is the involvement or inclusion of private sector to partner with government in order to enhance the implementation of NHIS. This objective recognizes the role private health care facilities and service providers play in the implementation of the NHIS. Risk equalization involves the allocation of financial resources based on disease burden and the country's mortality patterns. Solidarity refers to the concern for the health of every individual in society particularly the most vulnerable access to basic health care services. Re-insurance stresses the need to have a fund to recapitalize the scheme in case natural disaster or epidemic occurs. Cross- subsidization refers to the determination of annual premiums in such a way that the rich would pay more than the poor. Finally, sustainability implies the adoption of mechanisms that would help check, manage or control fraud for the sustainability of NHIS in Ghana (Afriyie 2004 cited in Wahab

²² NHIS benefits package and exemptions list. Available at: <http://www.nhis.gov.gh/?categoryid=158&articleid=120&searchparam=NHIS+BENEFITS+PACKAGE> (Accessed 3 January, 2010).

²³ Kwaku Afriyie, "National Health Insurance Framework for Ghana," (Accra: Ministry of Health, August 2004). pp. 7-8, cited in Wahab 2008.

2008). This study focuses on beneficiaries' access to quality health care services, accessibility to health care facilities and efficiency in the administration of health insurance claims, forms, cards and treatment notes.

4.3 The Institutional Structure of the NHIS

The National Health Insurance Authority (NHIA) has been vested with the power to implement the NHIS in Ghana. The NHIA worked through a governing body known as the National Health Insurance Council (NHIC) and National Secretariat (NS). Three (3) secretariats and many service providers are involved in the implementation of NHIS. Functions of each secretariat at different levels are clearly stated in the NHI Act 2003 and NHI Regulations 2004 as well as the functions, roles and responsibilities of service providers. The functions of NHIA, secretariats and service providers are discussed as follows:

4.3.1 The National Health Insurance Authority (NHIA)

The object or mandate of NHIA is to “secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents” (NHI Act 2003: 4). The NHI Act established a governing body of NHIA known as the NHIC. The council has 16 members and all the members including the chairperson are appointed by the president of Ghana under Section 3 (2) of NHI Act 2003. The NHIC and NS of the NHIS are based in Accra (Ghana's capital). They are implementers of NHIS at national level- macro-implementation, Berman (1978). They exercise the powers and functions of the authority. The NHIA has been empowered under Section 2 of NHI Act to perform the following functions with regard to the implementation of NHIS, summarized in Box 1 below.

Box 1: Summary of the functions of the NHIA (NHIC & National Secretariat)

1. To register, licence, regulate and supervise the operations of health insurance scheme
2. To grant accreditation and monitor the performance of health care providers.
3. To ensure that health care services rendered to beneficiaries are of good quality.
4. To manage the National Health Insurance Fund and perform any other function conferred on it by Act 650.

Source: National Health Insurance Act 2003.

4.3.2 Regional Secretariats of NHIS

Each of the ten (10) regions of Ghana has offices for the implementation of NHIS. The regional health insurance manager and the other managerial officers including claims, accounts, public relations, management information system, monitoring, they constitute the regional secretariat. The regional offices of NHIS receive subsidy, reinsurance and technical support from national secretariat and NHIC to be directed to the satellite units (districts). Functions of the Regional Secretariat with regards to the implementation of NHIS are summarized in Box 2 below.

Box 2: Summary of the functions of the Regional Secretariats

1. To monitor, guide and supervise the operations of the district health insurance schemes
2. To carry out periodic audit of accounts of the district health insurance schemes.
3. To give directives and circulars on changes on the implementation of the NHIS.

Source: Author's review of literature at Regional Secretariat, Tamale (July 2010).

4.3.3 The District Health Insurance Secretariats

Below the Regional Secretariats are the District Health Insurance Secretariats which manage the District Mutual Health Insurance Schemes (DMHIS).²⁴ Section 29 (1) stated that “There shall be established in every district in the country a mutual health insurance scheme for the residents of the district” (NHI Act 2003: 10). Each of the 170 Districts in Ghana has the DMHIS for the implementation of NHIS. The DMHIS are managed by a Board known as the General Assembly (GA). Members of the GA are made up of Community Health Insurance Committee (CHIC)²⁵ representatives in each district. These CHIC members represent ‘geographically determined Health Insurance Communities’ within each district (Grub 2007 cited in Health Systems 20/20 PRDD GHS 2009). CHIC representatives are officially to collect insurance premiums from their respective communities and deposit them into the District Health Insurance Fund (DHIF). CHIC

²⁴ District Mutual Health Insurance Schemes (DMHIS) are sometimes used inter-changeably with District secretariats but it is rather district secretariats that manage the DMHIS in Ghana.

²⁵ Community Health Insurance Committees (CHIC) are key actors (mostly adults) formed from Health Insurance Community (HIC)- a particular geographical area where NHIS beneficiaries lived.

representatives link the views and interests of their community members on NHIS to DMHIS offices at various districts in Ghana. Below is a summary of the functions of District Secretariats with regards to the implementation of NHIS in Box 3.

Box 3: Summary of the functions of District Secretariats

1. To register and collect premium from beneficiaries of NHIS.
2. To educate persons resident in the district the benefits of the NHIS.
3. To vet claims submitted by health facilities and health providers.
4. To pay monthly claims to accredited health providers and health facilities within four (4) weeks after their submission of claims to the scheme.
5. To give directives and information to service providers in the district.

Source: NHI Act 2003; NHI Regulations 2004; Author's reviewed literature

The DMHIS serves the various Service Providers at district level. Service Providers (health care facilities) role in the implementation of NHIS at the local level in Ghana is vital for this study.

4.3.4 Service Providers

Service providers²⁶ render health care services to NHIS beneficiaries in Ghana. They actually convert policy into reality at local level- micro implementation (Berman 1978). Beneficiaries' visit health care facilities for health care services when they are ill. Regulation 22 (1) clearly outlined service providers that may be accredited²⁷ to implement NHIS as: teaching hospitals; regional hospitals; district hospitals; quasi public hospitals, (like the Military, Police, University, and Social Security and National Insurance Trust hospitals); health centres; dental clinics; private hospitals and health clinics; maternity homes; mission hospitals; pharmacies and licensed chemical sellers facilities; private medical diagnostic facilities and such other facilities as the Council may determine (NHI Regulation 2004: 9). Functions of service providers with regards to the implementation of NHIS are summarized in Box 4 below.

²⁶ Service providers are used interchangeably with health care facilities and health care providers.

²⁷ Accredited refers to acceptance for health care facilities to implement NHIS by NHIA through secretariats.

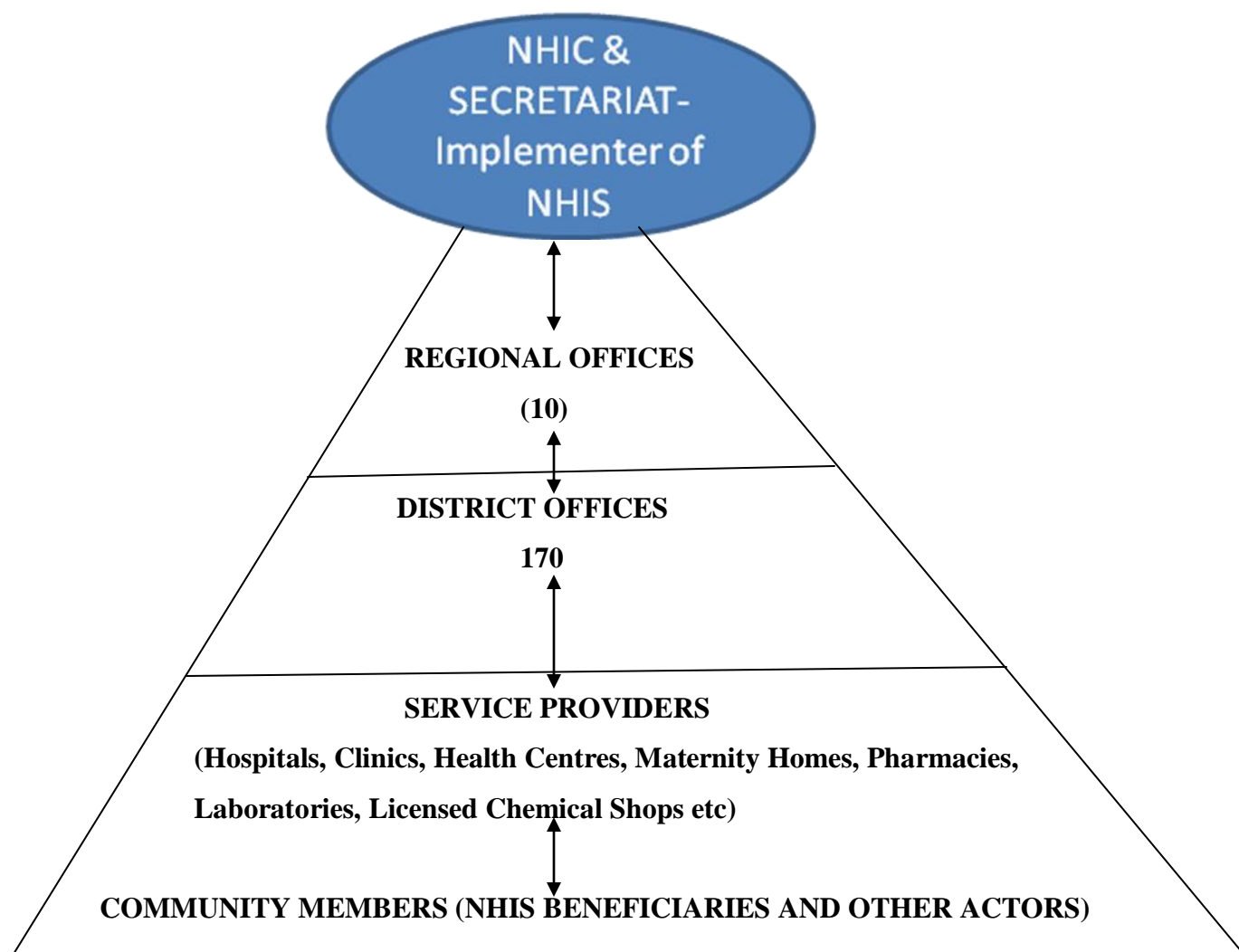
Box 4: Summary of the functions of Service Providers

1. To render quality health care services to NHIS beneficiaries.
2. To prepare monthly claims reports and submit reports regularly to health insurance schemes.
3. To render approved treatments, drugs and medicine free of charge to beneficiaries.

Source: Author's reviewed literature; NHI Act 2003; NHI Regulation 2004.

From the discussions on the institutional structure of the NHIS above, it is important to note that authority, functions, responsibilities have been highly decentralized from the top (national level) to those at the bottom (local or district level). The institutional setting is that policy directives, circulars, regulations flows from the NHIS national secretariat and NHIC to regional secretariats and finally to the district secretariats. The district secretariats of NHIS work hand-in-hand with health care facilities and health care service providers. These health care facilities and health care service providers are the actual implementers of NHIS at local level as they render health care services to NHIS beneficiaries. Berman (1978) made distinction between macro-implementation and micro-implementation institutional settings. While the institutional setting for the macro-implementation covers the whole policy sector spanning from national level to local level, the institutional setting for micro-implementation involves a local delivery organization (for example hospital or clinic). Figure 4 below illustrates the institutional structure of the NHIS in Ghana.

Figure 4: NHIS Institutional Framework



Source: Modified from NHIS document (Boateng, R. 2007. NHIS Presentation, Health Summit, Accra).

4.4 The Financial Structure of the NHIS

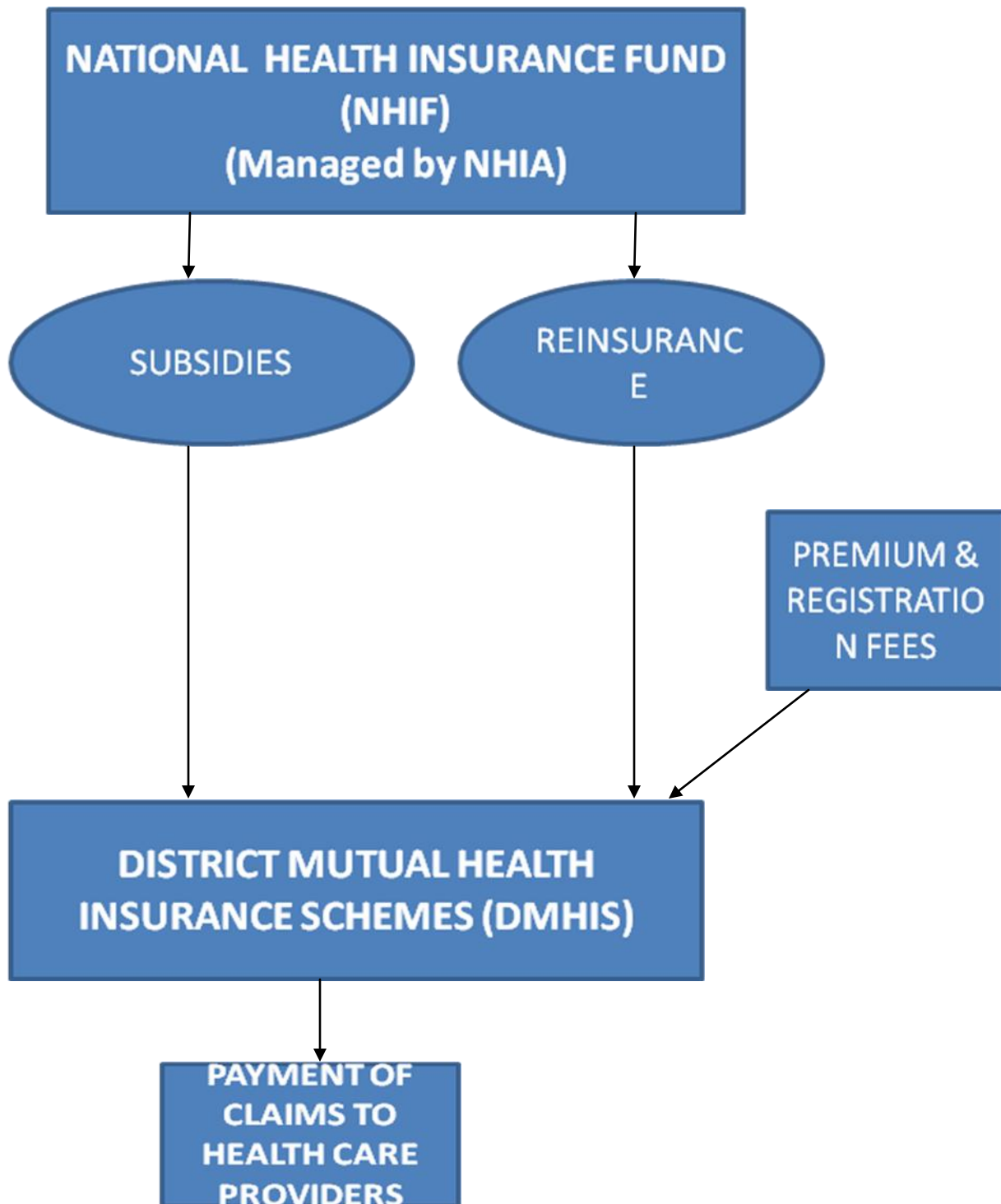
The NHI Act established a fund known as National Health Insurance Fund (NHIF). The purpose of the fund is “to provide finance to subsidise the cost of provision of healthcare services to members of district mutual health insurances schemes licensed by the Authority” (NHI Act 2003: 18). The Act identified sources of money for the NHIF. These include health insurance levy, 2.5% of Social Security and National Investment Trust (SSNIT) and pensions scheme contributions, money allocated by Parliament, money accrue from the fund investment, gifts,

donations, grants and other voluntary contributions made to the NHIF (Ibid). Statistics in 2008 on the in-flow of income for the NHIS indicated that 69.5% income came from health insurance levy, followed with SSNIT (formal workers) members' contributions of 23.2%, next 5.1% insurance premium collected by DMHIS and 2.2 investment income.²⁸ In 2009 in-flow of funds were insurance levy (61.0%), followed by investment income (17.0%), next SSNIT contribution (15.6%), insurance premium (3.8%), sector budget support (2.3%) and other income (0.2%) (NHIA Annual Report 2009: 34). These are means by which funds are generated into the NHIF for the implementation of NHIS at the national level.

At the local (district) level, the DMHIS are mandated by NHI Act to collect annual premiums from persons seeking to benefit from the NHIS, except the exempt groups. The premiums are determined by schemes in accordance to the directives of the NHIC. Another source of funding for DMHIS is registration fees; the Act has mandated DMHIS to collect registration fees in addition to premiums (NHI Act 2003). The DMHIS are to make payments of claims to health care providers. Monthly claims payments to health care facilities by DMHIS at the local level are essential for this study. According to Regulation 38, the time for payment of healthcare claims to health care facilities and providers should be “*within four weeks after the receipt of the claim from the health care facility*” (NHI Regulation 2004: 18). Timely payment of claims to health care facilities is necessary in order for them to render quality healthcare services to NHIS beneficiaries. The sources of cash flow for the implementation of NHIS are illustrated in Figure 5 which depicts the financial structure of NHIS in Ghana.

²⁸ Moving Toward Universal Health Coverage, Ghana Case Study. Available at: http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Ghana_Case_Study_2-24-10%20FINAL.pdf (Accessed 5 January 2010).

Figure 5: The financial structure of NHIS



Source: Modified from NHIS document (Health Systems 20/20 PRDD GHS 2009).

Discussions on the financial structure of NHIS above suggest that in the design of the policy (NHIS) adequate provisions were made on the sources of funding. Two categories of funds were clearly stated in NHI Act 2003. They include in- flows of money into NHIF at the national level and local sources of funding through annual premiums, registration fees of new members. The NHIF is the main source of funding for the implementation of NHIS and it is administered by the NHIA. The NHIF is used to subsidize and provide re-insurance for DMHIS and DMHIS makes payments of claims to health care facilities and health care providers after their submission of monthly insurance claims.

4.5 Provision of Health Care Services at the Local Level

Since 2003 a number of efforts were made by government with respect to the provision of health care services at the local level. The move of government was to provide more health care facilities across the country especially rural areas (local level). The private sector was also encouraged to partner government's efforts. In pursuit of this goal, the Government of Ghana through GHS adopted Community based Health Planning and Services (CHPS)²⁹ strategy to increase persons living in rural communities access to basic health care services.

The CHPS strategy first started in Nkwanta Volta Region of Ghana in 2001. The strategy was also part of efforts towards the implementation of the NHIS at the local level. Various District Directorates of the GHS were urged to make the CHPS zones functional (by offering health care services). In that regards, provision of CHPS compounds (buildings) were carried out across the country. It was reported that in 2002, 36 functional CHPS zones were created in Ghana; 2003 they increased to 55; 2004 recorded 84; in 2005 they increased more than double to 190; 2006 increased to 270; 2007 (345); 2008 the number increased to 409; 2009 recorded 868; and the rural population CHPS zones covered increased from 7.2% in 2008 to 15.3% in 2009 (GHS Annual Report 2009: 31). The CHPS strategy had boasted NHIS beneficiaries' access to health care facilities at the local level. However, the state of physical infrastructure deteriorated at some rural areas and getting requisite health personnel to offer quality health care services at health care facilities in rural areas remain a challenge at the local level in Ghana.

²⁹ Community based Health Planning and Services (CHPS) is as a strategy of dividing districts into zones (sub-districts) for the provision of health care services.

The Ghana Health Service (GHS) reported an increase in accreditation of health care facilities in Ghana as a way of making health care services accessible or available to the entire population. Public health care facilities in the country were given provisional accreditation and as many as 800 private health care providers have been accredited by the NHIA (GHS Annual Report 2007). By December 2009, the number of private health care facilities accredited was 863; Mission-Christian Health Association of Ghana (CHAG) was 119; Government was 948; with the total of 1,930 health care facilities and health care providers accredited in Ghana to implement the NHIS (NHIA Annual Report 2009: 33). The NHIS Act 2003 empowered NHIA to grant accreditation to health care facilities and health care providers to implement the NHIS. The goal is to ensure that health care services rendered to beneficiaries are of good quality. The increase in number of health care facilities accreditation could be partly associated with the increased collaboration between government and private sector (individuals, missions and NGOs). The change in policy direction of NHIA in which private health care facilities have been granted accreditation against earlier decision where implementation of NHIS was limited to only public health care facilities was very helpful.

The rate of enrolment of persons into NHIS improved greatly from 2005- 2009 as illustrated in Table 2 below.

Table 2: Some Achievements of the NHIS from 2005-2009 (in terms of enrolments)

Year	2005	2006	2007	2008	2009
Number Enrolled (millions)	1,348,160	3,867,862	8,184,294	12,518,560	14,511,777

Source: NHIA Annual Report, 2009: 26

Table 2 above, indicates that as at December 31, 2009 a total of 14,511,777 subscribers (NHIS beneficiaries) had registered with the NHIS, representing 62% of the estimated population (over 20 million) against the 2008 enrolment rate (coverage) of 55% for the same period. The general trend indicates continuous increase in membership of the scheme over the five-year period (2005

-2009) (NHIA Annual Report 2009: 26). NHIS currently has a total of 15,555,816 persons registered in Ghana as at 30th June 2010 (Joy FM News).³⁰

In terms of resources distribution, NHIA has decentralized funds from national level to district level for the implementation of NHIS. According to the NHI Act health care facilities are obliged to submit their monthly claims to DMHIS secretariats for payments. Due to increased enrolment of beneficiaries into the scheme, claims payments to health care facilities and health care providers have also increased tremendously from 2005-2009. In 2005 the NHIA disbursement of claims (subsidies and reinsurance) was GH¢ 7.60 million (Ghana Cedis). In 2006, the amount paid on claims increased to GH¢35.48 million indicating an increase of 367%.

Moreover, payments of claims increased in 2007 from GH¢79.26 million to GH¢ 198.11 million in 2008 and increased greatly to GH¢308.15 in 2009 (NHIA Annual Report 2009: 32). The data show that the amount NHIA paid for subsidies were far more than amount paid for reinsurance to health care facilities. Each health care facility receives claims³¹ from district health insurance office (DMHIS) after submission of monthly claims. The DMHIS pays health care facilities based on the number of beneficiaries who have visited health care facilities in times of ill-health. However, there have been some delays in the payments of insurance claims to health care facilities, posing threat to operations of health care facilities and the quality of services offered to beneficiaries. Insurance claims submitted are usually vetted³² by DMHIS before payments are made to health care facilities. As indicated under the financial structure of NHIS, less than 10% revenue is generated at the local level mostly from premium payments. About 90% of revenue for the implementation of the NHIS comes from the central government through NHIA and this makes health care facilities heavily dependent on central government.

Despite this shortcoming at the local level, the NHIA has put in place proper financial control mechanisms to ensure that funds transferred from the authority gets to health care facilities. To

³⁰ Joy FM is a local private radio station in Accra, Ghana. Figures given by Ametor-Quarmyne, Deputy Director, Strategy and Corporate Affairs (NHIS Headquarters). Available at: <http://69-64-75-206.dedicated.abac.net/health/201011/55426.asp> (Accessed on 5 November 2010).

³¹ Claims are the money paid to health care facilities and health care providers by DMHIS for rendering health care services to NHIS beneficiaries.

³² Vetting of insurance claims refers to the process of verifying the amounts stated by health care facilities in order to check fraud.

this effect, every health care facility has a bank account where insurance claims are directly deposited by the DMHIS officials. Only authorized persons of health care facilities can withdraw the insurance claims for the provision of health care services to beneficiaries. Also, all money deposited into the accounts of the DMHIS are audited (NHI Regulations 2004).

At the local level, the DMHIS initiated treatment notes for NHIS beneficiaries whose health insurance identity cards were not ready. Health insurance identity cards are issued to new members of the NHIS with six month after registration (NHI Act 2003; NHI Regulation 2004). In situations where there are delays in issuing health insurance identity cards, the DMHIS has to design temporary forms (treatment notes) to enable beneficiaries to access health care services at health care facilities at the local level. Health care facilities are responsible for preparing prescription, diagnostic and attendance forms and monthly claims reports. In addition, health care facilities have to generate funds locally to enable them solve local problems (Berman 1978). However, there are still challenges among health care facilities in terms of capacity, competence in executing their functions effectively at the local level in Ghana.

4.6 Conclusion

Ghana has made a remarkable achievement in her move towards the adoption of national health insurance scheme. Local based health insurance schemes paved the way to a national health insurance scheme. Appropriate institutional and financial structures were designed in such a way that responsibilities, roles functions and resources were transferred from the ‘top’ (national level) to the ‘bottom’ (local level) to enhance the work of health care facilities in rendering health care services. Though Ghana had made a lot of efforts in improving the welfare (health care) of the rural population, however not much has been achieved in the areas of human resource development (capacity building) and financial autonomy of local institutions. Many local institutions still rely heavily on central government funds to enable them execute policies. This is also the challenge of inadequate personnel at local level and should be address properly.

CHAPTER 5

FINDINGS AND DISCUSSIONS

5.0 Introduction

This chapter discusses findings on two variables of the study (policy design and implementation structure) on the implementation of NHIS. The chapter attempts to answer the two operational research questions of the study as mentioned earlier. Next is the presentation of a brief profile of the two selected health care facilities in the district.

5.1 Brief Profile of Selected Health Care Facilities

The Sawla Health Centre (SHC) was established in August 2005. It was established a year after the creation of the Sawla-Tuna-Kalba District (STKD) out of Bole District of Northern Region of Ghana. The SHC was established by government of Ghana through Ministry of Health (MoH)/GHS to provide health care services to people in the community. It is the oldest and biggest government health care facility in STKD. All permanent staffs of SHC are paid by central government, its drugs and medicines are supplied by government through MoH/GHS Regional Medical Store in Tamale. Its infrastructure and other logistics are supplied by government. The SHC is located outside Sawla Township; it is about one mile from Sawla, the district capital.

The Sawla Friends Maternity Home Clinic (SFMHC) was established in November 1987. The SFMHC was established by a private individual, a midwife and a native daughter of the area. Thus, the SFMHC is a private health care facility. It is the oldest and biggest privately-owned health care facility in the district. Provision of infrastructures, logistics, supply of drugs and medicines and salaries of staff are funded by the health care facility. The SFMHC is located in the town centre of Sawla.

5.2 Accreditation of Health Care Facilities

The STKD has 14 health care facilities. Nine (9) owned by government of Ghana through Ghana Health Service (GHS), three (3) owned by Christian Health Association of Ghana (CHAG) and two (2) privately owned (STKD GHS Half-Year Report 2010). A documentary review indicated

all the 14 health care facilities have been accredited towards increasing beneficiaries' access to health care facilities in the district. Also one private chemical licensed shop was accredited in order to increase beneficiaries' access to medicines and drugs (STKMHIS Accreditation Report 2010).

5.2.1 Health Care Facilities and Accreditation Qualifications

Accreditation of health care facilities is stated under section 70 of the NHI Act 2003. The NHI Act stated that every health care facility needs the approval of NHIA before it can implement the NHIS. The NHI Act stipulates that *“a scheme shall not use the services of a healthcare provider or a health facility in the operation of the scheme unless the healthcare provider or the health facility has been approved and accredited to the scheme by the Authority”* (NHI Act 2003: 17). Also, the NHI Regulations 2004 stipulate qualifications health care facilities have to fulfil before they are given accreditation (approval to implement NHIS). The NHI Regulation stipulate that a health care facility must be in operation for at least six months before applying for accreditation, a health care facility must have good record of offering quality health care services. Also, health care facility must have adequate human resource, physical structures and standard equipment.

Moreover, health facility must: respect rights of patients (NHIS beneficiaries) and treat them with care, keep accurate records of health care services rendered, expenditure on beneficiaries and 'comply with the information system' established by NHIC (NHI Regulation 2004: 9). The two health care facilities visited during field work confirmed their compliance with the above mentioned accreditation qualifications. The two health care facilities for the study indicated that without their compliance to those accreditation qualifications, their accreditation contracts would have been terminated or suspended by NHIC. However, the two health care facilities accepted, in reality strict compliance on physical structures has been very challenging to them.

5.2.2 Health Care Facilities and Accreditation Requirements

On accreditation requirements, health care facilities are granted an initial accreditation of five (5) and are subject for renewal every two (2) years. Also, the NHIC considers every health care facility ‘capacity in terms of equipment and services’ and “*may impose limitations on the services to be provided by the facility*” (NHI Regulations 2004: 11). The study assessed the requirements for granting accreditations in general and specifically made a comparison between the two health care facilities, examine to what extent they have complied with the accreditation requirements at the local level. Also, the study examine to what extent, granting accreditation has been decentralized from national, regional to district level. A documentary review revealed that both health care facilities were accredited before implementation of NHIS commenced in January 2008 (STKD GHS Annual Report 2008).

The medical assistant at SHC (public) has this to say on accreditation requirements:

“As soon as the clinic was established, it was granted accreditation because it is a government health care facility, you know government clinics and hospitals usually are given accreditation to implement the NHIS. Officials of the District Mutual Health Insurance Scheme (DMHIS) inspected our equipment, physical structures and that was all and we started taken care of patients. I speak on authority that our health care facility met the requirements for accreditation though we lack laboratory. We are fully aware accreditation is subject to renewal”

Health care facilities after accreditation ensured that they render quality health care services to beneficiaries (NHI Act 2003; NHI Regulations 2004). The Proprietor (a midwife) of SFMHC (private) on accreditation requirements explained that:

“Our health care facility has been rendering health care services to the community for about two decades before government introduced the NHIS. Initially we could not apply for accreditation because only public health institutions were allowed to implement the NHIS in Ghana. Later when private health institutions were given the nod, we applied for accreditation. We paid the accreditation fees, the district insurance scheme authorities came and inspected our facility’s equipment, buildings, services, staff capacity and granted us an accreditation to implement the NHIS. We must deliver in order to pave way for renewal. The problem we had was that we used to have a medical doctor here to do surgical operations but we were asked to stop and close the surgery theatre because our facility lacks capacity to render such services to beneficiaries.”

The study findings confirmed that the two health care facilities were granted accreditation before they started the implementation of NHIS in the district in January 2008. Also, the power to grant accreditation to health care facilities was decentralized from NHIC to the DMHIS. The DMHIS

Secretariat was identified as a key facilitator of the accreditation process. Face to face interview at both health care facilities confirmed the practice of periodic inspection of health care facilities. The DMHIS carried out periodic inspection of health care facilities to ensure that quality health care services are rendered to beneficiaries. This was in conformity with NHI Act 2003 and NHI Regulation 2004 requirements. In addition, the accreditation process was a little flexible and that allow local level health care facilities to operate. The flexibility gave room for local conditions (factors) to prevail, where health care facilities with less physical structures were allowed to implement NHIS. This was contrary to the laid down accreditation requirements. Furthermore, findings revealed that health care facilities were not allowed to render health care services beyond their capacity. After five years, health care facilities could renew their contract for two years based on good performance. In that regard, both health care facilities confirmed that accreditation was not permanent. One significant difference between the two health care facilities was that, while SHC (public) health care facility was granted accreditation soon after establishment, the SFMHC (private) had to apply, pay accreditation fees before it was granted accreditation to implement the NHIS.

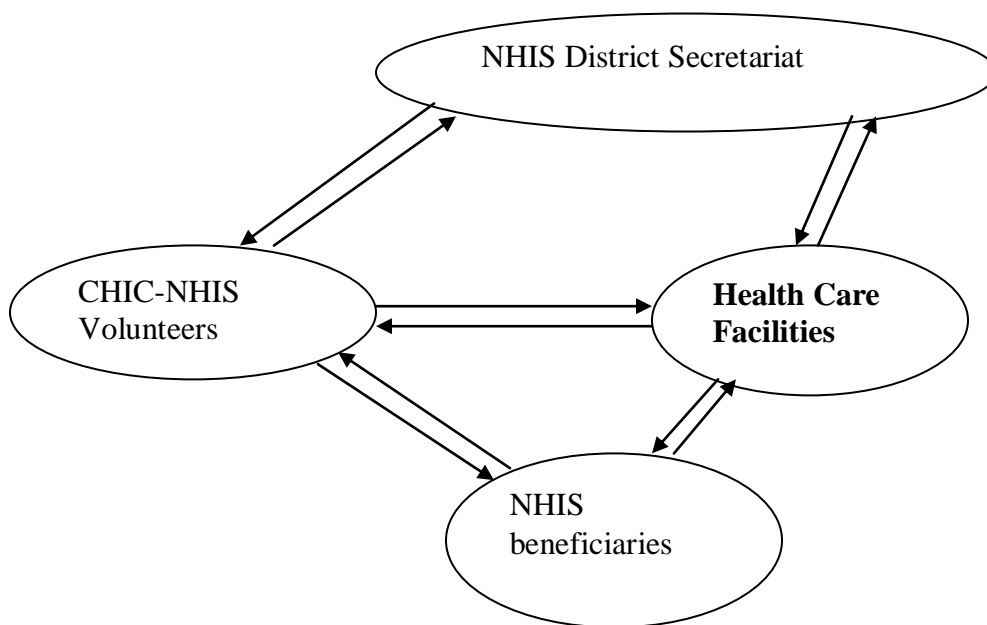
5.3 The Design of the Policy (NHIS)

During data collection (fieldwork), the study examined the understanding of NHIS objectives, benefits package and participation (interaction) between health care facilities and other actors at the local level. The study's aim was to assess the clarity or otherwise of the objectives, adequate access to NHIS benefits package and extent of interaction among actors. The methodological approach used to obtain information from staff of the two health care facilities and other actors included Focus Group Discussions (FGD), documentary review and individual interviews (face-face interview).

As I indicated in the NHIS institutional framework (see figure 4), health care facilities provided direct link between district health insurance secretariat and community members (which include NHIS beneficiaries and other actors). Health care facilities are key implementing institutions of the NHIS, where many functions and responsibilities have been decentralized in order to enable them to effectively implement the NHIS at local level. Health care facilities receive information, complains and other issues from beneficiaries and re-direct such information/issues to NHIS

authority (district secretariat) for redress (bottom-up interaction). On the other hand, the district secretariat gives information and other issues to health care facilities and is delivered to community members -NHIS beneficiaries and other actors (top-down interaction). Another kind of interaction noted in the study area took place between health care facilities and Community Health Insurance Committee (CHIC). The CHIC members were popularly known as NHIS Community Volunteers. These NHIS community volunteers link beneficiaries and district health insurance secretariat. The implementation of NHIS at local level as designed in the institutional framework represents both top-down and bottom-up interactions and these kinds of interactions provided useful insight for the study. The kinds of interactions that take place between the two selected health care facilities and other actors at the local level are illustrated in figure 6 below.

Figure 6: Kinds of interactions between health facilities and other actors at the local level



Source: Designed from field work data June-July 2010

5.3.1 Health Care Facilities and NHIS Beneficiaries

Health care facilities are responsible for the implementation of NHIS at the local level. Health care facilities are to ensure that beneficiaries have access to quality health care services, standard medical health care services throughout Ghana through use of appropriate medical technology and equipments, proper administration of drugs on NHIS approved drug lists (NHI Act 2003). To

enhance effectiveness of the implementation of the NHIS, health facilities are to comply with NHIS benefits package for beneficiaries, this include beneficiaries adequate access to drugs in the following service areas: in-and-out-patient services, emergency services, oral health services, maternity care and emergencies (see appendix 3).

During data collection, I realized that health care facilities were provided with the NHIS Benefits Package List. In addition, I observed that the two health care facilities have NHIS Medical Lists. The Medical Lists serve to check over-or under-utilization of health services, wrong medication and prescriptions, unnecessary diagnostic and irrational referral systems (referring beneficiaries from clinics to hospitals). As captured in the NHIS institutional framework, health care facilities are service providers and are expected to provide NHIS benefits package to beneficiaries. Interviews with some of the beneficiaries on the adequacy of their access to benefits package and extent of interactions, made me aware of issues of inadequate drugs supply, few diagnostic tests, and lack of interest in referrals had existed between health care facilities and beneficiaries. A beneficiary at the public health care facility (SHC) responded that:

“My son, I must be frank with you, the NHIS is good. I get free medical treatment whenever I visit this clinic, unlike some years ago when I used to fear because of lack of money to pay medical bills. I talk freely with the doctors and the nurses, in fact they are kind. But, one thing I do not like about the clinic is that, they like given me prescription forms too much to go and buy drugs in town and doing referral tests outside the clinic.”

At the private health care facility (SFMHC), another beneficiary gave a different thought on adequate access to the benefits package, supply of drugs and extent of interaction among key actors. According to him, such issues were about beneficiaries mind set. He explained ‘mind set’ as beneficiaries who do not want to hear issues like pay for drugs, go to Bole Hospital (different district) as referral, when they visit health care facilities for treatment. He recommended the need to educate beneficiaries more on the operations of the NHIS by key actors. This was his remark:

“This clinic has experienced staff, I have confidence in them. They have adequate wards to admit patients; they have a good laboratory for most tests without going to other hospitals. Most of the time I get all the drugs from the pharmacy unit, I do not waste so much time when I enter their NHIS Office to verify my card. I remember last year when my card was not ready and I brought a treatment note from the district secretariat they filed the note so quick. As for Madam Vero and her staff they are so friendly to me all the time. All actors responsible must do more to educate us on NHIS operations.”

The responses above, implies some challenging issues of benefits package, supply of drugs and participation between health care facilities and beneficiaries, even though health care facilities are to provide health care services to beneficiaries. Findings revealed that health care facilities have not been able to provide adequate education on operations of NHIS to beneficiaries particularly those on excluded services/benefits (see appendix 4). Focus Groups Discussions (FGD) took place with staff of the two health care facilities and beneficiaries. The findings revealed mix feelings among beneficiaries, where beneficiaries appeared frustrated, disappointed in situations where they expect health care facilities to supply them with drugs, medical officials rather give them prescription forms. Also, instead of beneficiaries accessing diagnostic services within health care facility, health service providers rather refer beneficiaries' diagnostic tests to other facilities and the challenging issue of demand for payment for some drugs.

A preference ranking technique was used to find out beneficiaries choice of health care facility for treatment in times of illness based on NHIS benefits package. Each group consist of 8 beneficiaries. Beneficiaries ranked the two health care facilities with 2 or 1 stripes/stripe of papers, in which 2 stripes represented the most preferred choice and 1 stripe on paper represented least preferred choice of health care facility respectively. In one of the FGD SFMHC (private) got total score of 14 and was ranked 1 against SHC (public) with total score of 10 and ranked 2, an indication that the private health care facility (SFMHC) was their most preferred choice for treatment as shown in appendix 2 (d). In another FGD with beneficiaries, 5 out of 8 (62%) preferred SFMHC (private) more than SHC (public) based on their views on service delivery by the two health care facilities through use of preference ranking technique (see appendix 2 c) probing questions facilitated FGD with beneficiaries. Thus, significant number of beneficiaries during FGDs preferred SFMHC (private) than SHC (public), this was attributed to beneficiaries more access to drugs, diagnostic services, in-patient services (benefits package/service delivery).

5.3.2 Health Care Facilities and District Health Insurance Secretariat

The District Health Insurance Secretariat plays a very useful role in the implementation of NHIS at the local level. The district secretariat works hand-in-hand with health care facilities as design in the policy. The district secretariat is meant to coordinate and monitor performance of health care facilities accredited for implementation of NHIS. The secretariat performs other functions

(see Box 3). I examined how district secretariat works with the two selected health care facilities on the implementation of NHIS during field work. I reviewed documents such as reports, minutes of meetings, circulars, payments of tariffs and claims reports. Findings from documents revealed the existence of cordial relationships between the secretariat and health care facilities and periodic exchange of information. During the field work period, I noted that the district secretariat serves as a facilitating agency on the implementation of NHIS. The district claims manager (and a beneficiary) was the official I interviewed on how the district secretariat interacts with the two health care facilities on the implementation of NHIS. This was his response:

“We facilitate the implementation process in the district, what I mean by this is that we register people, determine premium, deposit premium into district scheme account. We also receive money from NHIC based in Accra and disburse it to health care facilities. Also, we receive monthly claims, vet them where they are problems we invite health care facilities for corrections. On daily basis we move to health care facilities to resolve problems they encounter with beneficiaries. Where there are operational changes, we send circulars to keep them abreast.”

An NHIS official who doubles as pharmacist technologist at SHC (public) has this to say on the kind of interaction that takes place between their health care facility and the district secretariat:

“The district secretariat usually invites us for meetings, sometimes they send circulars. Our facility ensures that only registered members’ benefits from the NHIS benefits. What we do is to swipe registered members cards to authenticate their membership. However, we often run into problems, some members cards appear invalid or expire yet the members will insist their cards are valid, in situations like this we have to either ask members to go back to the secretariat or we invite secretariat officials to intervene.”

A senior NHIS official from the private health care facility (SFMHC) remarked that:

“Our office is in-charge of filling or filing of members’ insurance forms in line with regulation 62 of NHI Regulation 2004. We fill kinds of services rendered to members and submit monthly claims to district secretariat. Whenever we have problems with members, we try to contact the secretariat, some registered members come to our facility with treatment notes without official stamps, in such circumstances we have to seek the consent of the secretariat before we render services to such members, usually the secretariat respond positively to our call for help.”

The responses above suggest that there is some kind of cordial interactions between the two health care facilities and the district secretariat. Also, the responses implies the district secretariat interactions with the selected health care facilities took the form of circulars, reports, meetings among others as established in the institutional framework for the implementation of NHIS.

5.3.3 Health Care Facilities and CHIC (NHIS Volunteers)

To enhance the effective implementation of the NHIS, functions and responsibilities have been decentralized from the national level (NHIC, NS) through regional secretariats to district secretariats. Each district scheme is sub-divided into health insurance community in order to bring NHIS to doorsteps of all persons resident in Ghana. Health Insurance Community (HIC) refers to “any group of adults who live in the same geographical area” (NHIS: What You Must Know 2004: 3)³³ and registered for the scheme. Community Health Insurance Committees (CHIC) are key actors formed from each HIC. The committee has five (5) members including a Collector. The collector collects insurance premium from residents in HIC and deposit money into District Health Insurance Fund (DHIF). Such locally generated funds are used to facilitate contributors’ (beneficiaries) access to quality health care at the local level.

During the field work, I reviewed a report at the Public Relations Office, which revealed that 27 Health Insurance Communities were created and that indicated the existence of NHIC (NHIS Volunteers) in STKD. The NHIC (NHIS Volunteers) worked hand-in-hand with the two selected health care facilities at local level on increasing beneficiaries’ access to quality health care. One Collector at Sawla East HIC confirmed to me that since the creation of CHIC in the district, contributors’ access to quality health care services have improved tremendously more than 2008. In addition, contributors (beneficiaries) were educated on the benefits of NHIS and what they have to do whenever they visit health care facilities. This was what one NHIS collector said:

“Karachi (in local Gonja-Vagla language meaning officer), I feel good and great whenever my people call me Insurance Collector, I am not paid by government but I get my share from amount of premium collected as commission. I educate contributors to always go to ‘asibiti’ (local language word for hospitals and clinics) with their insurance cards to avoid unattended to by ‘asibiti’ staff. Sometime I explain to contributors that, not all the time that they will get drugs, they may be ask to pay or buy drugs outside.”

The Proprietor of FMHC (private) confirmed the existence of CHIC in the district and how the CHIC interact with health care facilities, this was her remark:

³³ “NHIS: What You Must Know” is a leaflet publication of the National Health Insurance Scheme (NHIS) in collaboration with Ministry of Health (MoH), Ghana.

“The community volunteers are our key partners; they link our facility to beneficiaries as well as the district secretariat.”

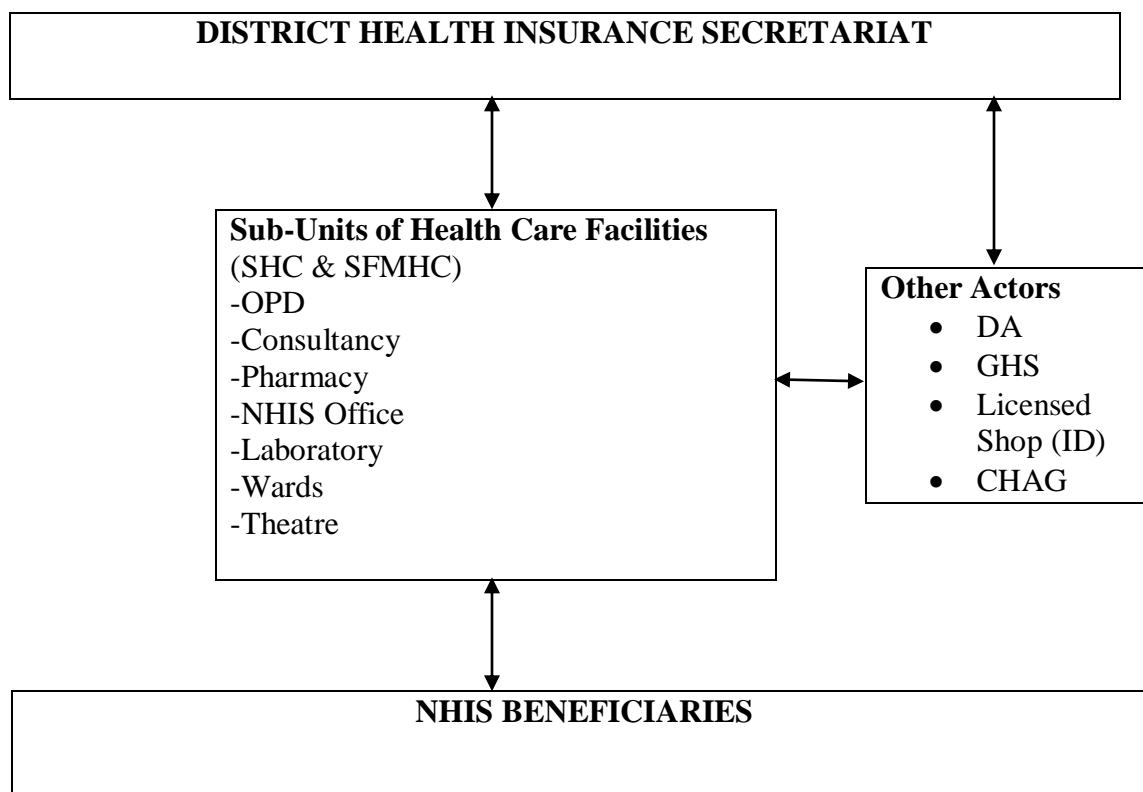
From the quotes above, implies there is close interaction between CHIC and health care facilities and other actors. A more strengthen institutional framework provides a sure way of enhancing the implementation of NHIS among key actors at the local level.

5.4 Implementation Structure

The extent of effectiveness of the implementation of the NHIS at the local level is dependent on implementation structure of implementing institution(s). Thus, implementation structure is one of the five independent variables for the study. As indicated in the theoretical chapter, appropriate implementation structure plays an important role in the execution of a policy. Appropriate implementation structure promotes successful implementation of policy or program. On the other hand ‘using inappropriate organizational structure’ may hinder successful execution of a policy or program (Rothstein 1998). The institutional framework for implementation of NHIS in Ghana (figure 4) illustrates implementation structure from national, regional, districts, service providers to beneficiaries.

On implementation structure at local level, the study focuses on implementation structure as found in STKD and how the structure influences effectiveness of the implementation of NHIS. Discussions on the implementation structure was divided into four (4) sections namely district health insurance secretariat, sub-units of health care facilities, other actors and beneficiaries perspectives. The kind of cooperation, co-ordination and commitment between the two health care facilities and district NHIS secretariat and other actors were examined. The implementation structure of NHIS in STKD is illustrated in figure 7 below.

Figure 7: The Implementation Structure of NHIS in STKD



Source: Designed from field data (June-July 2010); Simplified from Figure 2

Keys: **DA**-District Assembly; **GHS**-Ghana Health Service; **ID**-Isaac Dramani

5.4.1 The Administrative Structure of District Health Insurance Secretariat

The secretariat was managed by a management team consisted of scheme manager, accountant, management information system manager, claims manager, publicity and marketing manager and data entry clerks, each manager occupied a unit in the secretariat. The secretariat was headed by scheme manager. However, during field work I was informed there was no scheme manager, the information was that the scheme manager was transferred to regional secretariat in Tamale. The Public Relation Unit was in-charge of information dissemination. The unit ensured that changes on policy (NHIS) got to health care facilities. According to the Public Relation Officer (PRO) a beneficiary, the secretariat coordinates the activities of service providers and cooperates with health care facilities for the successful implementation of NHIS. However, the secretariat faced many logistical challenges, the secretariat has no information van or vehicle and that has

negatively affected dissemination of information to health care facilities in the district. This was PRO's remark:

“Our information dissemination work has been hindered by our lack of vehicle and our only motorbike has always been used by other officials making movements very difficult. Sometime I want to visit a health facility but no means to move there.”

The management and information unit was in charge of issuing of health insurance identification (ID) cards to beneficiaries. According to section 65 of NHI Act 2003 and NHI Regulation 2004 regulation 18, ID Cards are issued to members within six (6) months of registration. But this was not the situation in the secretariat. I observed the decentralized unit (district secretariat) lack of capacity to issue ID Cards at the local level. My observation in the secretariat was that only pictures of registered members were taken while ID cards were to be issued at national level and that has been a major setback to the implementation process at the local level. The Management Information System (MIS) Official at the secretariat confirmed this, he remarked that:

“Our unit has always been congested with registered members seeking for their ID Cards to enable them access health care services at health care facilities. I tell you Gentleman, some registered members really become so angry for my failure to produce them ID card for more than six months after registration.”

Such delays contradict the intent of the policy where beneficiaries are supposed to be issued ID within six (6) months after registration. The study's findings have shown that issuing of ID cards has not been decentralized at the local level and that has negatively affected the implementation process at local level.

Fortunately, the district secretariat supplied health care facilities with computers for verification of ID cards against fraud. There has been so much inter-organizational cooperation between secretariat and health care facilities. MIS unit of the district secretariat educate NHIS officials at health care facilities on the need to verify beneficiaries ID cards before rendering health care services to them. The secretariat co-ordinate the operations of health care facilities with regards to implementation of NHIS. In response to local factors and conditions (what Berman termed 'local micro-implementation problem' (Berman 1978:157), the secretariat adopted a strategy of issuing Treatment Notes in place of ID Cards to beneficiaries after three months of registration in order to enable beneficiaries have access to health care services at health care facilities. The

design of the Treatment Notes (see appendix 5) created some sense of ownership of the policy (NHIS) and that was a local initiative rather than always waiting or receiving instructions from national level. In this regard, bottom-up perspective on policy implementation gain prominence at the secretariat. On inter-organizational cooperation, both PRO and MIS confirmed that the secretariat co-ordinate health care facilities activities in order to ensure that quality health care services were not compromised. Also, both officials (PRO and MIS) confirmed the secretariat cooperate with the two health care facilities in resolving implementation difficulties.

5.4.2 Sub-Units of Health Care Facilities

As indicated (in figure 7), sub-units of the two health care facilities are expected to provide the framework for bottom-up perspective on the implementation of NHIS. I interviewed officials of the two health care facilities on the following issues: establishment of sub-units within health care facilities, procedures followed in rendering health care services and administration of various health insurance forms and cards. In addition to individual interviews, the study used focus group discussion on the functional areas of the established sub-units. The rationale was to find out actual functions of each sub-unit. The two methodological approaches used were to examine extent to which health facilities operations at local level have conformed to NHI Act 2003 and NHI Regulations 2004.

During the field work, I visited the two health care facilities; the first was SHC (public) on how its sub-units were formed or established. Findings revealed five (5) sub-units were established. They include NHIS Office, Pharmacy Unit, Out-Patient Department (OPD), Wards (maternity and children) and Consultation Unit. However, there was no structure for Laboratory Unit. In SFMHC (private) its conformity to establishment of sub-units that enhance implementation of NHIS, I noted that seven (7) sub-units were established. They include NHIS Office, OPD, Pharmacy Unit, Wards (children, maternity and emergency), Consultations Unit, Laboratory and Theatre. Findings revealed that both health care facilities have conformed to NHIS procedural requirements for establishment of sub-units. The establishment of sub-units was to enable health care facilities to provide health care services effectively on the five thematic areas (oral health, inpatient services, maternity care, outpatient services, and emergencies) under NHIS benefits

package (details, see appendix 3). Table 3 illustrates the sub-units established by the two selected health care facilities.

Table 3: The Established Sub-Units of the two Health Care Facilities

Sub-Units	Health Care Facilities	
	SHC	SFMHC
1. NHIS Office	✓	✓
2. Out-Patient Department (OPD)	✓	✓
3. Wards	✓	✓
4. Consultations Unit	✓	✓
5. Pharmacy Unit	✓	✓
6. Laboratory		✓
7. Theatre		✓

Source: Constructed from field data from SHC and SFMHC, June 2010.

From Table 3 above, five (5) sub-units were established by both health care facilities, while the remaining two (2) sub-units (laboratory and theatre) were established by only SFMHC (private). Though SHC (public) has not established laboratory unit due to lack of physical structure, they have some laboratory equipments that were used to conduct tests in areas such as HIV/AIDS, malaria and pregnancy. In that regard, while SHC (public) had to refer many beneficiaries' tests to Bole District Hospital for diagnostics services, SFMHC (private) had established a laboratory unit in which various kinds of diagnostic services were rendered to beneficiaries, with only few referral cases made to Bole District Hospital. Findings indicated that both health care facilities recognized the importance for establishing laboratory unit in order to help beneficiaries have more access to NHIS benefits package at health care facilities. However, the main difference

between the two health care facilities was in the last sub-unit (Theatre). While SHC (public) could not establish theatre for the conduct of surgical operations due to staff, equipment and other logistical constraints, SFHMC (private) had established theatre unit (though short-lived, for lack of ‘authorized capacity’).³⁴ The establishment of theatre unit was to enable health care facilities carry out various forms of surgical operations in conformity with NHI Act 2003 and NHI Regulations 2004 (increasing beneficiaries’ access to quality health care services). Study findings have clearly indicated that the two health care facilities had adequate knowledge on the categories of sub-units to be established in order to improve the quality of health care services rendered to NHIS beneficiaries at the local level.

5.4.3 The Role of Sub-Units in the Implementation Structure

Discussions focused mainly on four sub-units namely out-patient department, consultation unit, pharmacy unit and the NHIS Office. Both FGDs and individuals interviews considered them as much more crucial for the implementation of NHIS at the local level.

Do the Sub-Units influence the Effectiveness of the Implementation of NHIS?

a) The Out Patient Department (OPD)

The OPD is a very important unit; it is the first point of contact to a health care facility. The unit keeps records of attendance at a health care facility. As part of the implementation process, the unit is expected to cooperate with other units and relate well with beneficiaries. From the bottom-up approach on policy implementation actors are to initiate procedures and practices that would enhance service delivery at the local level based on local conditions. The concern of the study was to examine the procedures that were followed by actors (staff) at the two health care facilities that sought to promote the effectiveness of the implementation of NHIS. This was the remark made by a registrar of SHC (public) on effectiveness of the implementation process:

“Our unit plays very useful role in the implementation of NHIS, we keep attendance books, we prepare reports on common causes of OPD attendance, we refer patients to other units based on their health conditions, we also keep patients folders concerning their medical history. In fact, since the implementation of NHIS we have recorded high attendances at our facility and we have to work for extra hours.”

³⁴ According to the NHI Regulation 39 (5) any health care facility that performs operations beyond its authorized capacity (limitations on kinds of services) is considered a violation and such services will not be paid by authority.

Another OPD attendance at SFMHC (private) commented that:

“In order to encourage patients to attend our facility we always give them warm reception, we try to fasten our procedures and practices. We ask of their names, write in attendance book, pick up their files/folders, direct them to the next unit in order not to waste their time, we always maintain that human life is precious and must be preserved. I must confess to you that, in this unit we are committed to our work. But sometime we are overwhelmed by the numbers of beneficiaries and then fatigue sets in.”

The quotes above, with regards to effectiveness of the implementation process, officials from the two health care facilities indicated that they keep attendance records, prepare records on common illnesses, cooperation with other units by directing beneficiaries where to go next to fasten their procedures and practices. Both health care facilities have recorded increased attendances at their OPD units. The two officials interviewed however accepted that their main challenge was on how to deal with increasing attendances by beneficiaries and suggested that the way out was to recruit more officials into the unit. Study findings from implementers (staff) at the grassroots revealed that there has been an increased in attendance in the two health care facilities. The study reviewed attendances recorded by the two health care facilities to find out if there exist any significant differences. Table 4 illustrates attendances at the OPD of the two health care facilities.

Table 4: OPD Attendance of SHC and SFMHC

Health Care Facility	Attendance by Years		Total
	2009	2010 (Jan-July)	
SHC (Public)	3,987	3,648	7,635
SFMHC (Private)	8,952	6,838	15,790

Source: Attendance Record Books from SHC and SFMHC, August 2010

Table 4 above shows that the total number of clients who visited SHC (public) from 2009-June 2010 was 7,635 while SFMHC (private) recorded 15,790, an indication that more beneficiaries attended SFMHC (private) more than SHC (public). The study noted that, there was significant difference between the two health care facilities in terms of OPD attendances in which SFMHC (private) attendance far out-numbered SHC (public). The study identified some factors viewed as responsible for the difference in attendance between the two health care facilities including the

kind of health care services rendered in terms of quality, attitude of staff, distance, and timeliness in service delivery.

Also, study findings indicated there were disparities between insured (NHIS registered members) and non-insured (non-registered members) in terms of attendance at the two health care facilities. A documentary review of reports of STKD confirmed the interview responses that there was a tremendous increase in attendance at health care facilities. The number of NHIS beneficiaries who attended all the 14 health care facilities in the district as at June 2010 was three times more than non-beneficiaries (STKD GHS Half Year Report 2010: 46). The two officials of the OPD unit of the two health care facilities explained reasons behind the increasing trend. Since the implementation of NHIS registered members do not fear visiting health care facilities because of free treatment, unlike the previous cash and carry policy where patients have to pay before they are treated, payment of medical bills used to scare sick persons from attending health care facilities. This point was over-emphasized by the two OPD officials: *“The fear for medical bills is gone under NHIS.”*

b) Consultations Unit

Consultations Unit in health care facilities help beneficiaries access the services of medical assistants, midwives and nurses. The unit created an opportunity for beneficiaries to talk directly to medical personnel on their illnesses, injuries and other diseases. The unit was expected to operate within acceptable medical practices in conformity with NHI Act 2003 and NHI Regulations 2004. Also, adopt Standard Treatment Guidelines 2004 (a MoH document) that serves as both clinical guide and education tool to medical professionals and means of providing standard quality health care services to beneficiaries (see box 4). My concern in the study was to find answer (s) to kind of co-operation, co-ordination and commitment that takes place between consultations unit and other sub-units in health care facilities (as in appendix 1 Q. 5) concerning effectiveness of implementation of NHIS at the local level. A medical assistant at SHC (public) commented that:

“Our unit is very sensitive because it is the engine of the facility. We ask patients why in the clinic and they tell us their health conditions, after listening we prescribe the kind of drugs or medicine that could cure their illness. We also advice patients to take preventive measures on the slogan of prevention is better than cure. The unit does not work in isolation; we cooperate with

the pharmacy unit as we refer beneficiaries there. Upon examination of the health conditions we decide whether to admit to a Ward or not. We also refer patients to laboratories for diagnostic services. Mr Student, all medical practitioners in this unit are hard working and are committed to their work.”

Another medical assistant at the SFMHC (private) remarked as follows:

“As far as implementation of the NHIS is concern, this unit plays a very crucial role in ensuring that patients get the right treatment. By my medical profession I must give right prescriptions, cooperate and collaborate with the other units in order to ensure that registered members get value for their money paid that is quality health care service. Any time patients call on me in the unit I respond promptly, though sometimes very tired but I must work hard to safe lives of customers at the facility. Our unit cooperate with other units, but does not co-ordinate the implementation of NHIS in the clinic.”

From the two responses of the officials above, it is clear that consultation units play an important role in the implementation of NHIS. It is also obvious in the two health care facilities that consultations units cooperate with other units in providing health care services (prescriptions, diagnosis and preventive measures) to beneficiaries. The unit ensure that beneficiaries have adequate access to quality health care. Their responses confirmed that effective implementation of the NHIS dependent on better cooperation among sub-units of health care facilities.

c) Pharmacy Unit

Pharmacy units established at health care facilities in Ghana ensures that beneficiaries have adequate access to drugs and medicines under approved Medicines List.³⁵ The 2007 approved list and 2009 reviewed list of medicines are key documents for health care facilities to implement. With regards to implementation of NHIS, pharmacy units are the principal units charged with the responsibility of supplying drugs and medicines to NHIS beneficiaries at health care facilities to improve quality of health care services. Beneficiaries are not supposed to pay for drugs and medicines on the approved list. Within each health care facility, pharmacy units provide direct link with beneficiaries through the supply of drugs and medicines, thus linking beneficiaries to health care facilities. My study’s concern was to examine the adequacy of supply of approved

³⁵ Medicines List consist of drugs and medicines approved by NHIS. The list contains names of drugs and medicines, unit of pricing and proposed prices to be administered.

Available at: <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=1096> (Accessed 06 January 2011)

medicines to beneficiaries, also examine the extent of cooperation and co-ordination between pharmacy unit and other sub-units in the two health care facilities. On supply of drugs and medicines, a pharmacy technologist at SHC (public) reported that:

“We get our supplies from regional medical store in the capital (Tamale). Both NHIS approved and unapproved drugs and medicines are in our store. The reason for both is that there are some drugs and medicines that are helpful for treating some kinds of illnesses that may not found in the NHIS Medicines List. However, drugs and medicines that are not approved, NHIS registered members must pay cash for them while approved medicines are free of charge.”

A pharmacist at SFMHC (private) has this to say:

“Our pharmacy is well stocked with drugs and medicines. We get our supplies from our partners -leading pharmacies in Wa, Tamale and beyond. As you can see, all drugs and medicines are approved. We do not have drugs and medicines beside those approved by NHIS. The reason is that we do not want to operate outside the policy directives. We do not want to continue the practice of cash and carry any more. The NHIS Medicines list is wide and covered most of the common diseases in our community.”

On intra-organizational cooperation and co-ordination, the two pharmacists agreed that they cooperated well with other sub-units and indicated that only pharmacy unit co-ordinate activities involving purchase and supply of drugs and medicines to beneficiaries. At inter-organizational level, findings revealed that SHC (public) cooperated with regional medical store for supply of drugs and medicines while the SFMHC (private) cooperated with other private pharmacies for supplies. From the two quotes above it is clear that drugs and medicines were supplied to beneficiaries free of charge (no payments). However, drugs and medicines outside NHIS approved Medicines List; beneficiaries had to pay cash for them. A review of receipt booklets, reports confirmed linkage between the two health care facilities pharmacy units and their supply partners. Such intra-organizational and inter-organizational cooperation between health care facilities and partners have contributed positively towards effective implementation of NHIS.

d) The NHIS Office

The NHIS Office is expected to create sense of ownership of the policy at health care facilities. The unit serves as the epicentre of the implementation of NHIS in health care facilities across Ghana. The unit allow health care facilities initiate measures on their own (bottom-up approach) rather than merely receiving policy directives from higher authority, in order to facilitate the implementation process. During my visit to the two health care facilities, I observed that the

NHIS Officials at the two health care facilities were busy receiving and filling health insurance forms, treatment notes from beneficiaries. I noted that beneficiaries presented their insurance ID cards to officials in NHIS Office to be swiped through magnetic readers to validate ID cards or to authenticate beneficiaries' membership before treatment at the two health care facilities. I however observed that two beneficiaries were turned away from medical treatment at SFMHC (private) because their ID cards had expired, according to officials in NHIS Office. Later, the NHIS officials made the affected beneficiaries to fill complaint forms (form 10) in line with regulation 43 (3) of NHI Regulations 2004, in which complaint form would be submitted to the district secretariat or scheme complaint committee for re-dress. The observation revealed that beneficiaries who could not renew their ID cards could not access health care services at health care facilities.

During the focus group discussions with the two health facilities revealed that officials of NHIS Office identified their functional areas on service delivery shown in appendix 2 (a), (b). For instance, administration of health insurance form 8 (claims) by Regulation 62; preparation of monthly claims reports (see box 4); verification of ID cards and treatment notes. The NHIS officials (through FGDs) indicated that such activities were carried out in conformity with NHI Act, 2003; NHI Regulations, 2004. When I had an interview with one official in NHIS Office (SFMHC-private) on how unit cooperate with other sub-units in increasing beneficiaries' access to health care services. This was his response:

“The NHIS office co-ordinates most activities involving the implementation of NHIS in this facility, we are in charge of verifying members ID cards, we fill claims forms, prepare claims reports, we receive treatments notes from members who do not have ID cards, after we have work on them we direct members to other units. We attend meetings with district secretariat and inform other units on policy changes. However, we do not issue ID cards, treatment notes, complaint and claims forms, we receive all from the secretariat. Mr student, I tell you that there is division of labour in this our unit; one officer is dealing with all forms, another officer deal with computers/magnetic readers and the third officer deals with money that is preparation of monthly claims reports and submission to secretariat for re-imburement. The divisions are useful not to waste members' time in order to promote and increase attendance at our facility.”

The implementation structure in STKD (figure 7) provided framework of interaction among key actors in enhancing effectiveness of the implementation of NHIS. Through the structure, health care facilities are to cooperate with district secretariat, district assemblies and other decentralized

units in fostering inter-organizational relations in order to effectively implement NHIS. Another official in the NHIS Office (SFMHC-private) explained that:

“Our office deals mostly with the district secretariat particularly on claims re-imburements. Sometimes GHS through district health directorate invite us to seminars and conferences on ways of improving health care services to our clients. Our office also collaborates with Isaac Dramani Chemical licensed shop to supply registered members with drugs and medicines that we do not have in stock.”

An NHIS official from SHC (public), who doubles as pharmacy technologist indicated that NHIS Office coordinates activities concerning implementation of NHIS. The official however lamented over queues of beneficiaries at their health care facility. The official attributed the problem to lack of permanent official in the unit. He commented that:

“Mr student the truth of the matter is that, I work as a pharmacist and I have to come back to attend to registered members at the NHIS Office, this situation has affected the operations of the unit. However, I try to work on all forms, treatment notes and claims reports for re-imburement from secretariat.”

From the three responses above, it is obvious that NHIS Office is the main unit that coordinate implementation of NHIS within the two health care facilities. It is also evident that NHIS Office cooperates with other organizations in improving quality of services rendered to beneficiaries. The responses confirmed that health care facilities lack the capacity to initiate the various health insurance forms and treatment notes on their own. The reason was that health care facilities were not empowered by the NHI Act 2003 and Regulations 2004 to do so. Other implementation challenges identified by the study include time of renewals, activations of cards after renewals, quick ways of resolving beneficiaries' complaints within health care facilities and between health care facilities and scheme/secretariat complaint committee in times of invalid or expired cards.

5.4.4 Other Actors in the Implementation Structure at the Local Level

The implementation of NHIS at local level involved other key actors such as District Assemblies (DAs), decentralized department like Ghana Health Service (GHS) district directorate, Non-Governmental Organizations (NGOs) and private chemical shop owners. DAs have oversight responsibility on ensuring public policies (including health reforms) are effectively implemented within their jurisdiction to promote socio-economic development. Decentralized departments within each district link up with DAs in promoting the welfare community members. My study's

concern was to examine the extent of involvement of these key actors in the implementation process of NHIS. Also, my concern during the study was to assess how these actors cooperate or coordinate implementation process as well as their commitments.

I noted that STKD Assembly's contribution was in the area of provision of infrastructure for district health insurance secretariat and public health care facilities in the district capital (Sawla) and villages outside the capital. The provision of infrastructure helped in reducing distance beneficiaries have to travel to attend to health care facility, thus making health care services more accessible to beneficiaries. Findings revealed that the STKD Assembly was committed toward the provision of infrastructure. For instance, the DA established four (4) health care facilities out of nine (9) in the district (STKD GHS Annual Report 2008: 2); the DA added two more in 2009 and by June 2010, '11CHPS compounds' have been demarcated and established in increasing beneficiaries access to health care facilities (STKD GHS Half Year Report 2010:2). However, the DA was not directly involved in day-to-day implementation of NHIS at local level; this was confirmed during FGD with staff of two health care facilities and interviews with secretariat officials.

On cooperation and co-ordination, District Co-ordinating Director, who doubles as a beneficiary in an interview explained that:

“The STKD-Assembly cooperates very well with insurance secretariat, district health directorate in provision of health care facilities in communities including the biggest SHC as recommended by our decentralized department GHS District Directorate.”

The study realised the involvement of GHS district directorate and one accredited Licensed Chemical Shop. GHS district directorate cooperated with the two health care facilities through the form of seminars, conferences on how to deliver quality health care service to beneficiaries. Another actor identified in the study was Isaac Dramani's Licensed Chemical Shop (the only NHIS accredited licensed chemical shop in the STKD). The shop served as a linkage between the two selected health care facilities and beneficiaries on supply of drugs and medicines. The licensed shop complements the two health care facilities in situations where they experience shortage of drugs and medicines. Findings shown that beneficiaries could only access (receive)

drugs/medicines from accredited Licensed Chemical Shop when they come with a prescription form issued and signed by a medical practitioner.

On the involvement of NGOs in the implementation of NHIS, few respondents (both staff of the two health care facilities and beneficiaries) indicated the existence of NGOs in the area, they mentioned IBIS/PAPADEV. Four (4) out of 12 staffs mentioned IBI/PAPADEV involvement in the area of educating public on the importance of the NHIS and six (6) out of 22 beneficiaries confirmed having benefited from those NGO's education on enrolment into NHIS. Another prominent NGO involved in the implementation of NHIS is the Christian Health Association of Ghana (CHAG). Most respondents have knowledge on CHAG and its health care facilities. A review of 2008 Annual Report and 2010 Half-Year Report of GHS-STKD revealed that CHAG established three (3) out of 14 health care facilities in the district. Findings indicated that CHAG health care facilities were located outside district capital and have contributed greatly, increasing beneficiaries' access to health care facilities in rural areas. Findings from both interviews and FGD clearly revealed NGOs involvement in the implementation of NHIS at local level. Other studies also indicated involvement of NGOs in community based projects (Buabeng 2009) and involvement of NGOs in education development at local level (Orest 2010).

5.4.5 Beneficiaries Perspectives on the Implementation Structure

NHIS beneficiaries are the individual actors in the implementation of NHIS at the local level in Ghana. The study examined beneficiaries' perspectives (feelings, views) on implementation structure in STKD. As indicated in the theoretical chapter, beneficiaries trust for implementing institutions or organizations is important in assessing extent of effectiveness of implementation of NHIS. In the institutional framework for implementation of NHIS (figure 4), beneficiaries were identified as key actors and their perspectives considered crucial in assessing the extent of effectiveness of the implementation of NHIS at the local level. My concern during the study was to examine extent of beneficiaries trust on the organizational structure of the two health care facilities and other actors.

On beneficiaries trust on intra-organizational structure of health care facilities, most beneficiaries I interviewed indicated their trust for health care facilities have increased since implementation of NHIS, an adult beneficiary at SHC (public) commented:

“Actually I believe in this clinic because any time I come here, they take good care of me. I am free to talk to doctors and nurses, they will give me some ‘para’ (local word for paracetamol tablet) and other drugs free, and if my sickness is serious they will admit me. Where they do not have drugs, they give me form to go to Dramani ‘dru store’ (Local Akan word Meaning drugs store).”

Another adult beneficiary at SFMHC (private) responded that:

“Mr Abroad Man, anywhere you go in the clinic, the clinic workers will ask you to go to the insurance office with your ID card. From there, I went to see a doctor, who then refers me to take a laboratory test, after which I was given a lot of drugs to go home and take some twice and others thrice a day. I can assure you that there is no waste of time in this clinic starting from the insurance office to other units. I have much confidence in the staff of the clinic, they cooperate so nice and are so nice to me whenever I visit the clinic.”

On kind of cooperation that exists between health care facilities and the other actors, there were mixed responses from respondents (beneficiaries). While some beneficiaries stated that relations between health care facilities and other key actors are cordial, others argued contrary. One child beneficiary from SHC (public) explained that:

“Anytime I send prescription form to ‘dru store’ (local word for drugs store, meaning licensed chemical shop), they do not always give me drugs. It happened about three times. But I do not know why the sellers always refused to give me drugs.”

An indigent beneficiary at SFMHC (private) confirmed that he was also once turned away from supply of drugs at the accredited licensed shop. According to him:

“The sellers refused to supply me drugs because my prescription form was not signed by medical assistant who issued the prescription form.”

An adult beneficiary from SFMHC (private) reported that she always receive drugs from Isaac Dramani’s Licensed Chemical shop whenever she presents a prescription form. She further indicated that she had presented prescription forms from both SHC (public) and SFMHC (private) and has never been refused drugs. This was her remark from SFMHC (private):

“Just last week I came to this clinic and the doctor gave me drugs and ask me to take this form to Dramani shop for more drugs. I am telling you the truth; I went there and was given a lot of drugs. So I can say that clinics and the drug store work as one for NHIS.”

One aged beneficiary expressed disappointment when he was denied health care services at a health care facility (SHC-public) on grounds of holding registration receipt instead of NHIS ID card or treatment note. According to him, the health care facility should have made direct contact with district secretariat rather than to ask him go to secretariat for an ID card or treatment note. This was what he said:

“Mr Student, it is wrong to ask me go back to the secretariat, the clinic should have a telephone to call the secretariat directly and resolve the differences at organizational level rather than involving me.”

From the quotes above, regarding beneficiaries’ trust for implementation structure, beneficiaries indicated that their trust for the two health care facilities in rendering quality health care services have improved particularly in increasing their access to drugs, medical assistants, diagnostic services. And relations have also improved between health care facilities and other key actors in rendering health care services to beneficiaries. However, communication barrier was identified as still a challenge to beneficiaries in accessing health care services within sub-units of health care facilities and between the health care facilities and other key actors in STKD.

CHAPTER 6

FINDINGS AND DISCUSSIONS

On How Resources, Target Group Behaviour and Socio-Economic Conditions Affect Effective Implementation of NHIS

6.0 Introduction

This chapter analyses how three variables of the study (resources, target group behaviour and socio-economic conditions) affect effective implementation of NHIS at local level in Ghana. The first section focuses on how resources (financial and human) affect effective implementation of NHIS at local level. The second section focuses on how target group behaviour and socio-economic conditions of beneficiaries affect the extent of effectiveness of the implementation of NHIS at local level. The findings aim to answer the main research questions mentioned earlier.

6.1 Resources

As mentioned earlier resources in the study consist of both financial and human resources needed for effective implementation of NHIS in Ghana. Adequate resources must be made available to facilitate implementation of policies (Van Meter Van Horn 1975). The study focuses on extent of availability of financial and human resources in the two health care facilities for implementation of NHIS in STKD. Thus, the extent of effectiveness of the implementation of NHIS is dependent on availability of resources (independent variable). The study first examined financial resources, followed with human resource endowment in the two health care facilities.

6.2 Financial Resources

Girndle and Thomas (1991) identified financial resource as one resource required to sustain a policy reform (a case of NHIS). Three (3) main sources of financial resources were identified in the two health care facilities in STKD namely National Health Insurance Fund (NHIF) - central government, Internally Generated Fund (IGF) and External sources for implementation of NHIS. The three main sources of financial resources were in conformity to the NHI Act 2003.

6.2.1 National Health Insurance Fund (NHIF)

The NHIF was established by NHI Act 2003 to subsidize cost of health care services provided by health care facilities to beneficiaries in Ghana. More than 80% of health care facilities in Ghana relied on the NHIF as source of funding (‘to procure drugs and supplies’) for health care services rendered to NHIS beneficiaries (GHS Annual Report 2009: 3). The NHIF was expected to be transferred from national level to local level (district secretariats³⁶) in the form of subsidies and reinsurance and disbursed to health care facilities as claims towards effective implementation of NHIS (see figure 5). My concern during the field work was to examine the disbursement process of the fund to health care facilities at the local level in terms of adequacy and duration. Officials of the district health insurance secretariat reported that since the implementation of NHIS in the district, the NHIF had been the main source of funding. Officials of the secretariat accepted that money from NHIF was based on monthly claims reports submitted by health care facilities. On process of disbursement of monthly claims to health care facilities, the claims manager explained that health care facilities prepare monthly claims reports and submit them to district secretariat, secretariat vets the claims (NHIA approval) and make payments to health care facilities.

I visited the two health care facilities to assess the adequacy or otherwise of NHIF for effective implementation of NHIS. Staff of the two health care facilities indicated that they were aware of the NHIF and confirmed at FGD that it was the main source of funding for the implementation of NHIS. Also, the staff of the two health care facilities accepted that NHIF was made available to them by the district health insurance secretariat. Both health facilities indicated that accessing the fund was easy for the years 2008 and 2009. According to them they usually submit their monthly claims and within four weeks they were paid. The study found that purchase and supply of drugs, medicines, and medical equipment were acquired from the fund for the provision of health care services to beneficiaries. This was what a senior nurse in-charge of SHC (public) said on NHIF:

“Our clinic relies so much on central government fund; we use the money to improve services we render to our dear clients. Government, I mean health insurance authority has not disappointed us at all, we send our claims and within a month we are reimbursed and that make us happy as implementers as well as our clients. But we do not use fund to buy medical equipment because government supply us with equipment.”

The Proprietor (head) of SFMHC (private) has this to say on access to NHIF:

³⁶ District Secretariats refer to District Mutual Health Insurance Schemes (DMHIS).

“Mr Student, in fact the NHIF has been useful to our facility, for example money from the fund is used to buy drugs, repair broker equipment or buy new ones. I tell you since 2008 in-flow of money from secretariat have been encouraging and that help in improving the quality of health care services to members of the scheme.”

The two quotes above confirmed what the study found in FGD with staff of the two health care facilities that their claims were paid early between 2008 and 2009 and has improved health care services offered to NHIS beneficiaries. While SFMHC (private) use part of the fund to provide medical equipment, SHC (public) received equipment from government and does not use fund on equipment. I noted in the study that from 2008 to 2009 payment of claims complied with NHI Act 2003. A review of the two health care facilities monthly claims reports and secretariat claims verification reports confirmed early payments of claims as stipulated in the act (payments within four weeks after submission).

However, two main problems were identified with management of NHIF at district secretariat. The first was what the two health care facilities termed “deductions of claims” from the district secretariat. All four officials in NHIS Offices indicated that the total monthly claims submitted to secretariat, they usually get less than the amount submitted. NHIS officer in-charge of claims at SFMHC (private) commented that:

“We have always been careful in filling our NHIS Claims Forms and make accurate calculations on cost of health care services and cost of drugs and medicines. Yet whenever it is time for us to go our monthly claims, we get lower than the amount submitted to the district secretariat.”

Another NHIS Officer (a care taker) at SHC (public) has this to say on claims deductions:

“Mr Researcher, I can count number of months that our facility experienced a marginal increase or received same amount submitted, we really do not understand how the claims officials at the secretariat do their calculations on our monthly claims. We often experience deductions on our monthly claims by secretariat.”

It is evidence from the two responses above, the two health care facilities experienced deductions on their monthly claims paid from NHIF. The only difference noted between the two health care facilities in terms of claims deductions was that while SHC (public) once experienced negligible increase and having received the same amount twice in 2009, the SFMHC (private) experienced deductions every month in 2009. Similarly, documentary review of the monthly claims reports of the two health care facilities revealed the regular deductions by secretariat on behalf of NHIA.

Annual summary of the two health care facilities total amount submitted, amount received and amount deducted are illustrated in Table 5 below.

Table 5: Claims Payments from NHIF for the two health care facilities for 2009

Name of Health Care Facility	Amount Submitted GH¢ (US Dollars \$)	Amount Received GH¢ (\$)	Amount Deducted GH¢ (\$)
SHC (Public)	30,306.36 (20,090.39)	29,694.98 (19,685.10)	676.84 (448.684)
SFMHC (Private)	72,697.15 (48,191.68)	69,626.10 (46,155.85)	3,071.05 (2,035.83)

Source: Constructed from field data from SHC, SFMHC and STKD MHS June-July 2010.

As indicated in table 5, the two health care facilities have shown similar trend, both experienced deductions on claims received from NHIF. In 2009, the SFMHC (private) incurred more losses from cost of health care services and drugs provided to beneficiaries more than SHC (public). Out of the total amount SFMHC (private) submitted (72,697.15 Ghana cedis), district health insurance secretariat after vetting of claims paid 69,626.10 Ghana cedis leaving a deficit of 3,071.05 Ghana cedis representing 4.2% claims deductions. SHC (public) submitted 30,306.36 Ghana cedis claims for health care services rendered to beneficiaries, it was paid 29,694.98, and incurred deficit of 676.84 Ghana cedis representing 2.2% claims deductions. The study findings show that private health care facility experienced more deductions and received highest financial assistance than public health care facility, an indication that private health care facility (SFMHC) rendered more health care services to beneficiaries in 2009 more than public health care facility (SHC).

An official circular from district health insurance secretariat provided justification for claims deductions. The vetting of claims was aimed to check fraud and for the sustainability of the scheme. The circular revealed that deductions were done where: *“service charges do not agree with tariff, pharmacy charges do not agree with tariff, prescriptions do not agree with diagnosis,*

over-servicing, wrong calculations and expired cards” (STKMHIS Circular 2010).³⁷ It is important to note that deductions of claims were not meant to punish health care facilities but to check fraud and avoid abuses. Similarly, it was reported in *Daily Graphic* newspaper that NHIA was able to “*recover a huge amount of 7 million Ghana cedis (GH¢)*”³⁸ (\$4,640,371.29) as fraudulent claims submitted by health care providers from January 2009 to June 2010 in Ghana. The NHIA was reported to have recovered GH¢ 982,000 as illegal claims from Ketu District Scheme and have “*suspended two hospitals from rendering services to policy holders.*”³⁹. These two newspapers publications have clearly demonstrated how some health care facilities/providers have resorted to the use of fraud which has negative effect on the implementation of NHIS at local level in Ghana. The study findings revealed that STKMHIS took pragmatic measures to check fraud through vigorous vetting of claims submitted by health care facilities in STKD.

Apart from deductions on claims, the second problem identified is delays in payments of claims from NHIF in 2010 on the part of district secretariat for cost of health care services rendered to beneficiaries. The study examined how regular or otherwise the in-flow of the NHIF has been to the two health care facilities. The rationale was to find out extent of compliance of secretariat (NHIA) to the provisions of the act to health care facilities. It is stated in NHI Act section 71 that tariffs (claims) payable to health care facilities/providers “*shall be paid within four weeks by schemes to the health care providers directly*” after submission (NHI Act 2003: 17). The study found that district secretariat could not pay monthly claims submitted by the two health care facilities from April to July 2010. Study findings revealed lack of fiscal decentralization as district secretariat relied absolutely on central government transfer of fund; this indeed hinders the effectiveness of the implementation of NHIS within these periods of indebtedness to health care facilities. An NHIS official at SFMHC (private) commented on delays in claims payments:

“We received our claims payments for January and February and some part of March and have since not been paid up to this July 2010. This has affected our supplies of drugs and medicines and purchase of other medical equipments, we really do not know why this indebtedness?”

The Claims Manager of STKMHIS confirmed NHIA through secretariat indebtedness to health care facilities in STKD. He emphasized that the delays were not due to change of government in

³⁷ A circular issued by Claims Officer captioned: “*Adjustment of Claims Amount*” from Claims Department, STKMHIS 2010.

³⁸ *Daily Graphic* is national (state) newspaper in Ghana. Published on Monday, June 7, 2010, p. 7.

³⁹ *Ibid.* Saturday, May 8, 2010, p.19.

Ghana in 2009, thus not politically motivated but were due to administrative arrangements within the scheme including setting up of clinical audits. Clinical audits were carried out in Ghana to ensure that health care facilities and health providers do not over-charge the scheme and to check other fraudulent practices. Table 6 below illustrates date of submission of claims and date of payments of claims for the two selected health care facilities in 2010.

Table 6: Date of Submission and Payment of Monthly Claims for SHC and SFMHC (2010)

H.C. Facility	Month	Date of submission	Date of Payment	Duration
SHC (Public)	JAN.	February 1	March 12	39 Days
	FEB.	March 1	June 7	98 Days
SFMHC (Private)	JAN.	February 1	May 17	77 Days
	FEB.	March 3	June 15	106 Days

Source: Constructed from field data from STKDMHIS June-July 2010. Key: **HC**-Health Care

As indicated in table 6, each health care facility submitted their monthly claims on time, that suggest that the two health care facilities were working in line with district secretariat directives on early submission of claims (by 5th of each month). However the district secretariat failed to disburse claims to the two health care facilities within four weeks of submission in accordance to NHI Act 2003. For instance in January 2010, it took 39 days for SHC (public) to be paid and it took more than two months (77 days) for SFMHC (private) to be paid its claims. In February each health care facility received their claims after three months. Claims Payments records in STKMHIS have shown that the rest of the months particularly (April-July) were in arrears. This increased indebtedness of the two health care facilities has affected the implementation process negatively. Findings indicated that implementation of NHIS in 2010 was not as effective as in 2008 and 2009 in STKD due to delays in accessing the NHIF by the two health care facilities.

It was also reported in Daily Graphic captioned “*Hospitals Collapsing from unpaid Insurance Claims*”⁴⁰ in Ghana. A situation in which health care providers were becoming reluctant in rendering health care services to beneficiaries because their cost of services were not paid by NHIA. The newspaper publication confirmed how the two health care facilities claims had not been paid for four to six months in 2010 and that affected the implementation of NHIS in STKD.

6.2.2 Internally Generated Fund (IGF)

Data provided by district secretariat (accountant) show that revenue was generated internally mainly through premiums and registration fees. The secretariat had other sources of income internally but was quite insignificant. However, revenue obtained from Internally Generated Funds (IGF) generally was insignificant to settle indebtedness of health care facilities in STKD.

During the field work, I visited the two health care facilities and explored the means or ways the two health care facilities adopted in mobilising financial resources internally for implementation of NHIS. I interviewed heads of the two health care facilities for key information on IGF at local level to supplement central government efforts (NHIF) towards improving the implementation of NHIS. The senior nurse in-charge of SHC (public) commented on the mobilization of financial resources internally towards effective implementation of NHIS:

“Mr Researcher, our facility generates funds internally from district directorate of GHS to pay our casual workers, use some to motivate staff to continue hard work towards the provision of quality health care services to beneficiaries. We use some of these funds for provision of chairs for our dear clients at the OPD. But I must say these funds are not enough so we are still trying to diversify our means of generating more funds within our facility.”

This is what the Proprietor of SFMHC (private) has to say concerning IGF:

“Gentleman, we have a number of ways of mobilizing funds on our own towards improved health care service delivery in the district. One, we have an outlet in Kui (a galamsey mining village) and I tell you we make reasonable amount of money there. Second, the use of gift box serves dual purposes. Third, a laboratory fee charge is another source but we do so in line with secretariat directives. We also established our own small ‘susu’ (staff voluntary contributions). Money from these sources keeps our facility in operation.”

From the two quotes above, it is evident that the private health care facility (SFMHC) has more sources of generating funds more than the public health care facility (SHC) in improving health

⁴⁰ *Daily Graphic*, Tuesday, June 1, 2010, p. 10.

care service delivery to beneficiaries. Also, both health care facilities have identified key role IGF played in the implementation of NHIS in their facilities. However, I noted that the two health care facilities means of generating internal funds for the implementation of NHIS has not been so effective. One reason identified for this ineffective IGF was due to the district secretariat interferences through directives in the form of circulars and their close monitoring of health care facilities charges on health care services rendered to NHIS beneficiaries.

6.2.3 External Sources

On external sources, the study focused on funds received from donors (local and foreign) and NGOs. The study found that the private health care facility has strong ties with foreign donors based in Netherlands. According to the Proprietor her health care facility has benefited greatly in areas of provision of medical equipment for laboratory, theatre, beds for wards, wheel chairs for the sick persons among others including cash for staff motivations and remunerations. This was what she said on foreign donations with regards to improvement of quality health care services:

“I am just preparing to visit Netherlands next week. I have very helpful partners there, they do send us money and medical equipment and that help us to deliver quality health care services in the district. Today as we talk if not because of these foreign sources of donations health care services would have deteriorated because secretariat owed us four months claims.”

The study had little information on external sources of funding for the public health care facility (SHC). On local donations and NGOs both health care facilities received little. Study findings shown that SFMHC (private) received more financial resources (NHIF, IGF, Foreign Donors) than SHC (public) in the implementation of NHIS. Also, staffs of SFMHC (private) were highly motivated, received more incentives and remunerations through external support and that promoted more staff hard work in SFMHC (private) than in SHC (public).

6.3 Human Resources

As indicated in the theoretical chapter effectiveness of the implementation of policy is dependent on better motivation, capacity and training of staff of implementing institution/ organization. The study assessed number of health personnel at post in the district (STK). In 2007 the entire health personnel in STKD were 31, same 31 in 2008, increased to 39 in 2009, dropped to 37 as at June 2010. The shortfall of health personnel in the district was very serious. The records indicated that more shortfall of health personnel were recorded for the same period, for instance 2007 (73

shortfall), 2008 (81), 2009 (92) and 95 shortfall as at June 2010 (STKD GHS Annual Reports, 2007, 2008, 2009 and Half Year 2010). It is important to note that the shortfall refers to number of health personnel needed in various health care facilities in the district. These records have shown inadequate number of health personnel at local levels in Ghana and that has serious implication on effective implementation of NHIS in STKD. Findings revealed unwillingness of trained health personnel at national and regional levels to accept postings and transfers to rural districts (this was attributed to weak decentralized system). This is an indication that devolution of responsibilities and personnel from the 'top' to implement policies at local level in Ghana has not been effective.

The study then assessed the human resource endowment of the two health care facilities in terms of total number of staffs assigned to sub-units; level of education (educational qualifications); professional training/supervision; and knowledge/skills and capacity on their functional areas. The rationale was to see how these indicators affected the implementation process and then try to examine if there is any difference between staff of the two health care facilities in carrying out their functions.

6.3.1 Number of Staff in Sub-Units

During the study, I assessed total number of staff in each health care facility and assessed the number of staff assigned to sub-units in the two health care facilities. The rationale was to try to match the number of personnel in each sub-unit to their functional areas. Also to ascertain if there is any difference between the two health care facilities with regard to adequacy of staff in making quality health care services easily accessible/available to beneficiaries.

Table 7: Number of Staffs in each Sub-unit

Name of Facility	Sub-Units (Functional Areas)					Total
	OPD	Wards	NHIS Office	Consulting Rooms	Pharmacy	
SHC (Public)	1	5	-	2	2	10
SFMHC(Private)	2	6	3	2	2	15
Total	3	11	3	4	4	25

Source: Constructed from field data from SHC and SFMHC June-July, 2010

As shown in table 7, there is significant difference in the total number of staff in the two health care facilities, out of total 25 staff, 15 are from private health care facility (SFMHC) representing 60% while the remaining 10 (40%) are from SHC (public), an indication that that the SFMHC (private) was able to attract more health personnel in STKD more than SHC (public). There were more nurses and Ward AIDs (Assistants) to take care of sick persons (beneficiaries) at wards of SFMHC (private) more than SHC (public), an indication that patients admitted had access to more nurses than in SHC (public). In addition, table 6 have shown that the private health care facility (SFMHC) had three officials in the NHIS Office but the public health care facility (SHC) does not have a permanent officer to take charge of the administration of health insurance forms, treatments notes and ID cards. This was an indication that beneficiaries had to wait for some time before being attended to by an officer from different sub-unit in SHC (public). This was confirmed in FGDs with beneficiaries and interview with official of SHC. Thus, beneficiaries spent less time in SFMHC (private) as compared to SHC (public), an indication that beneficiaries have better access to health care services in the private health care facility in terms of quick services more than the public health care facility.

However, both health care facilities have shown similar trend in two units (pharmacy and consultations rooms). Each health care facility has two consulting rooms manned by two officials (medical assistants and midwives). Also each health care facility has two officials in pharmacy unit which is responsible for supply of drugs and medicines to beneficiaries. This is an indication

that in terms of consultations and pharmacy services rendered to beneficiaries, there was no significant difference between the two health care facilities.

6.3.2 Staff Educational Qualifications

The study assessed the profiles of staff of the two health care facilities in terms of educational qualifications. The rationale was to match level of education attained by staff to their functional areas (assigned roles) between the two health care facilities and assessed whether their level of education affects the effectiveness of the implementation of NHIS.

Table 8: Educational qualifications of staff of the two health facilities

Name of Health Care Facility	Level of Education			Total
	Basic Education	Secondary Education	Tertiary/College Education	
SHC (Public)	-	2	8	10
SFMHC(Private)	-	7	8	15
Total	-	9	16	25
Percentage (%)	-	36	64	100

Source: Records from SHC and SFMHC, August 2010

From table 8 above, no member of staff of the two health care facilities had basic education (primary and Junior high schools). The dominant level of education was tertiary (diploma/degree awarding institutions) and college education, 16 (64%) out of 25 and that indicated that staff of the two health care facilities had attained higher education. The remaining 9 (36%) out of 25 staff members had attained secondary education, an indication that the lowest level of education attained in both facilities was secondary education. About two thirds (2/3) of the staff attained tertiary/college education while one third (1/3) attained secondary education in both health care facilities. Each sub-unit in the two health care facilities was headed by officers whose level of education was up to tertiary/college education and assisted with lower level officers (secondary) though there were some units without assistants.

The study found officials with higher level of education (tertiary/college) were more involved in the implementation process (prescriptions, diagnosis, drugs, claims reports, consultations) within the sub-units of the two health care facilities than those with lower level of education (secondary

education). The study found that the two health care facilities had equal number of staff who attained tertiary/college education. However, the study found some difference between staff that attained secondary education, in which the private health care facility (SFMHC) had more staff (7) with secondary education than the public health facility (SHC) with only 2 staff members. Thus, the private health care facility (SFMHC) had assistants in all sub-units in implementing NHIS but not in SHC (public), an indication that implementation might have been more effective in the private health (SFMHC) with more requisite staff more public health care facility (SHC).

In conformity with provisions of NHI Act 2003 which stipulate that health care facilities must have medical personnel with requisite knowledge to deliver quality health care services to beneficiaries. Also, the act stipulates health care facilities medical personnel must have adequate education to follow “medical procedures” and appropriate administration of drugs to maintain “quality assurance” to beneficiaries (NHI Act, 2003: 16). The study has found that both health care facilities have met human resource requirement on medical personnel. This supports the argument that well-educated medical personnel of health care facilities enhance effectiveness of the implementation of NHIS.

6.3.3 Staff Professional Training and Supervision

The study assessed professional profiles of staff of the two health care facilities and how their training has contributed to effective implementation of NHIS. The study attempt to match their professional training to their functional areas (roles); and also assessed non-professional staff profiles and their roles in the implementation of NHIS between the two health care facilities. The study noted the public health care facility (SHC) had more professional staff than private health care facility (SFMHC) as in table 8. This was attributed to the process of recruitment of staff. A senior nurse at SHC (public) explained the process:

“You see, our health care facility belong to government of Ghana, so government supply us with health personnel. Students are trained in public health institutions and after completion; they are posted to public clinics and hospitals across Ghana. In our clinic we do not look for staff ourselves, the district health directorate of GHS post medical personnel to us. We do not pay professionally trained personnel; it is government that pays them.”

This was how the Proprietor of the SFMHC (private) commented on staff recruitment:

“We recruit medical personnel ourselves, in doing so; we have to offer good, attractive salaries, allowances and housing packages in order to attract well-trained and qualified health personnel to our facility. At the back of the clinic is staff accommodation, this make us offer 24 hour health care services to our clients.”

From the two responses above, it is evident that professionally trained medical personnel in SHC (public) were recruited by government through GHS and were more than those professionals in private health care (SFMHC), yet accommodation and other improved working conditions were better in SFMHC than SHC. It was noted in the study that improved service conditions at health care facility and the provision of accommodation for staff contributed positively towards the implementation of NHIS in SFMHC (private) where professional staff was readily contacted to offer health care services to beneficiaries more than SHC (public). Table 9 below summarizes the professional profiles of the two health care facilities.

Table 9: Staff Professional Profiles

Professional Category	Name of Health Care Facility		Functional Areas
	SHC (Public)	SFMHC (Private)	
Medical Assistants	1	1	Consultations
Nurse General (GRN)	1	2	OPD/Admissions
Midwife	1	1	Consultations
Specialist (Eye)	1	-	Eye Consultancy
Dispensing Technician	1	1	Pharmacy Serv.
Laboratory Technician	-	1	Laboratory Serv.
Community Health Nurses	3	-	OPD/Admissions
Total Professionals	8	6	

Source: Records of Staff, SHC and SFMHC, June 2010. **Key:** Serv.-Services

From table 9, the study found that both health care facilities had the requisite medical personnel (medical assistants and senior and experienced midwives) in charge of consultations where beneficiaries discuss their ill-health conditions with professionals. After which diagnosis were carried out by laboratory technicians. Also both health care facilities had qualified personnel in-charge of dispensaries, where right drugs, medicines and appropriate dosages were administered to beneficiaries. Furthermore, both health care facilities had at least one Ghana Registered Nurse

(GRN) in charge of wards (where sick persons were admitted). However, the study observed there were few nurses in the two health care facilities than what was expected. When staff of the two health facilities were asked on “any suggestions on improving....human resources at the local level for the implementation of the NHIS” (see, Appendix 1 (I) Financial and Human Resources Q. 5). A professional at SHC (public) commented that:

“Since the implementation of the NHIS, DAs have been urged to sponsor their own personnel so that after completion of their studies, they will return to their sponsored districts to serve in both public and private health facilities. So that is the best solution and any DA that fails to pursue the policy will run short of professional staff at clinics and hospitals.”

On non-professional staff of the two health care facilities, I noted there were more non-professionals at SFMHC (private) than in SHC (public). The non-professional staff members referred to personnel who were not trained from any GHS approved health training institutions in Ghana. Findings revealed that most of the non-professionals had secondary education and did not head most of the sub-units in the two health care facilities. Also, the study found that the non-professionals mostly assisted the professional staff in the sub-units in the provision of health care services to beneficiaries; their assistance enhanced the effectiveness of the implementation of NHIS in terms of timeliness (less time) and proper care for patients. Sub-units where the non-professionals provided assistance, health services were faster, quicker than sub-units where there was no assistance to medical professionals.

However, two exceptions were observed on the non-professionals. One was that the NHIS Office was headed by a non-professional staff in SFMHC (private) but with higher education. The other exception was that the medical records offices in both health care facilities were headed by non-professional staff. Table 10 below summarizes the profiles and roles performed by the non-professional staff of the two health care facilities.

Table 10: Non-Professional Staff Profiles

Non-Professional Category	Name of Health Care Facility		Functional Areas
	SHC (Public)	SFMHC(Private)	
Ward AIDs	-	4	Admissions
NIS Officials	-	3	cards/forms
Laboratory Assistants	1	-	Laboratory Ser
Dispensing Assistants	-	1	Pharmacy Serv
Medical Records Assistants	1	1	Attendance
Total Non-Professionals	2	9	-

Source: Records of Staff from SHC and SFMHC, June 2010. **Key:** Ser/Serv-Services

Table 10 above indicated that there was more non-professional staff in the private health care facility (SFMHC) than in the public health care facility (SHC). An implication that health care services were made more accessible and available to beneficiaries in SFMHC (private) than in SHC (public) at various functional areas (admissions, administration of NHIS cards, treatment notes and forms, pharmacy services, attendance records and laboratory services).

On supervision of staff of the two health care facilities, the study assessed who supervises and how often or regular the supervision has been in the implementation of NHIS. I noted that the Proprietor of SFMHC (private) played supervisory role across all the sub-units. While in SHC (public) the Medical Assistant in-charge has oversight responsibility over all sub-units. My observation during the study was that the Proprietor was always visible and was more active in monitoring services rendered by staff to beneficiaries. This was what the Proprietor of the private health care facility said: *“My aim is to see to it that we do not compromise our quality health care services to beneficiaries.”*

A member of staff at SFMHC (private) explained that:

“Our Proprietor has always been active supervising our work; she is very humane, sociable and approachable during her supervision. Every day you see her moving from one unit to another encouraging staff to be more patient and deliver good quality and high standard health services to our dear beneficiaries.”

This was confirmed during FGD with staff of the two health care facilities, in which most staff members accepted the Proprietor has always been active in her clinic.

However, one staff member at SHC (public) had a different opinion on how their health care facility was supervised by their head. This was what she said: *“Our in-charge does supervise work in the clinic but it is not regular, he does so once a while may be because he knows most of us are professionals and we know our work.”*

The quotes above indicates there is more supervision in the private health care facility (SFMHC) led by the Proprietor than in the Public health facility (SHC) led by Medical Assistant in-charge.

6.3.4 Staff Knowledge/Skills and Capacity

The study assessed the knowledge of staff on their functional areas and how they carried out their functional roles. The study found that staff had adequate knowledge in accomplishing their roles in the following areas: issuing prescriptions, patients’ diagnosis, administration of drugs, administration of NHIS forms, monthly claims reports, consultations services, admissions of patients. This was attributed to their level of education, professional training and experience and that enhanced the effectiveness of the implementation of NHIS in both health care facilities.

Also, it was found during the study that officials at the two health care facilities have adequate knowledge and skills in operating the computers supplied by NHIS secretariat on verification of beneficiaries ID cards to ascertain whether the ID cards were valid or not. However, the study found both health care facilities had difficulty on activation of invalid ID cards of beneficiaries before treatment, unless they had to contact district secretariat MIS official. This situation was seen as a set-back to NHIS implementation process in STKD. The difficulty of ID card activation was confirmed during FGDs with staff of the two health facilities and interviews with NHIS Officials. This was what an NHIS official at SFMHC (private) said:

“The problem is that we the health care facilities do not have the power to activate beneficiaries ID cards only the secretariat MIS officer, this becomes more serious when a beneficiary comes from a different district or region. We do not have telephones to make calls and if you use your mobile phone, who bears the cost of calls? This is a real challenge to the implementation of NHIS in making health care services accessible and available everywhere in Ghana.”

The quote is an indication that health care facilities do not have power to activate ID cards of beneficiaries, so that health care services can be rendered without delays. The response above shows that knowledge and power on activation of beneficiaries ID cards appeared a prerogative

of NHIS secretariats. This was confirmed by another NHIS official at SHC (public) on their inability to activate beneficiaries ID cards:

“I am always wondering if the secretariat is deliberately refusing to teach us on the activation of ID cards or it is because we the officials at health care facilities are really not computer literates to be able to access beneficiaries’ data from the various insurance secretariats across Ghana.”

On staff capacity building, the Proprietor of SFMHC (private) and Medical Assistant in-charge of SHC (public) confirmed having received training from STKMHS officials on how to prepare and submit quarterly report to NHIC on the following: number of patients attended to both in-patient and out-patient, bed occupancy, mortality rate, five/ten most common causes of admissions/OPD attendance and minor and major operations done in conformity with Section 36 of NHI Regulation, 2004. Also both heads of health care facilities confirmed they received NHIS approved Medical Lists and were trained on how to use lists to avoid over or under servicing of beneficiaries by health care facilities. The secretariat training sessions aim to develop staff capacity towards effective implementation of NHIS at local level with regards to administration of reports and NHIS medicines lists. The Proprietor of SFMHC (private) remarked that:

“Since 2008 we have received a number of training from officials of the district secretariat and we also carry out our duty of submitting quarterly claims on health care services rendered to beneficiaries. There were series of courses organized by secretariat for our pharmacists on the usage of the NHIS medicines Lists; we have been complying with the list. Within our facility, we also organize number of in-service trainings for our staff, four times every year as we carry out routine quarterly review of our health care services.”

The head of SHC (public) has this to say on staff trainings:

“Mr Student, the secretariat has not relented on its efforts of training our staff, the trainings are useful and they guide us against abuses, but for 2010 the trainings have not been regular as the years before. Besides secretariat, we receive trainings on service delivery from GHS to boost the capacity of our staff members in order to make implementation of NHIS more effectively.”

The two quotes above show that capacity building of staff was identified by government as a key tool in enhancing implementation of NHIS at local level. As such trainings were organized for health care facilities by district secretariat towards development of staff capacity. The main difference noted between the two health care facilities with regards to staff training was that the private health care facility (SFMHC) had its own in-service trainings (which was quarterly) while SHC (public) relied more on GHS district directorate (which had no regular pattern, but was done based on availability of funds).

An official of STKMHS accepted having trained staff of health care facilities on number of issues including preparation of quarter reports, claims reports, administration of NHIS forms and ID cards. However, the official indicated that the secretariat relied more on central government funds and admitted that administrative budget alone was quite inadequate for them to continue their regular training sessions particularly in 2010, thus inadequate funds hindered the every four months training of health care providers in the STKD. This was the response of the official:

“As soon as we receive more funds from national level through regional secretariat training of health care providers will continue to boost their capacity.”

The District health directorate of GHS also embarked on capacity building of health staff ‘on the importance of NHIS as the surest way to improving the health status of the people of STKD and Ghana as a whole.’ (STKD GHS Annual Report 2008: 39). In addition, capacity building course was carried out in the district in which 166 health staff and other volunteers participated within Jan-March (STKD GHS Half Year Report 2010: 30).

6.4 Key Functions of Health Care facilities

The study examined the functions of health care facilities. Focus Group Discussion (FGD) was used through the use of pair-wise ranking method (see appendix 2 (a) and (b)). This method was adopted in order to find out policy implementers understanding of their functions as stipulated in Act 2003 and NHI Regulation 2004. Also, the outcome of the FGD helped the study to identify key functions of implementers at the local level in rendering health care services to beneficiaries. Each health care facility (one public and one private) represented a group. Each group consisted of six (6) persons (85%) out of seven (7) respondents selected for the study. As mentioned in the methodological chapter probing questions were used in the discussions. During the discussions members were asked to mention some of their functions in connection to the implementation of NHIS irrespective of their positions or status at work place. Seven (7) functions were mentioned, these were written with a marker pen on a pair-wise ranking grid on cardboard paper on both vertical and horizontal axes, placed on a tripod wooden board (designed like flip chart). The pair-wise ranking grid used for the FGD is shown in appendix 2 (a) and (b). On the usage of the pair-wise ranking grid, respondents after listing of the functions on the grid, they were asked to start with each pair of functions written on the right-hand corner (horizontal axis) and compare them with their corresponding pair of functions on the left-hand corner (vertical axis). Based on these

comparisons, ranking is based on which pair of function occurred more than the other functions. For instance if respondents agreed that their health care facility rendered consultation services more than supply of drugs to beneficiaries, then consultation services had to be ticked more on the pair-ranking grid on both axis.

However, where two pair of functions was the same and met on a common box/square on both axes, those pair of functions cannot be compared, as such the box or square had to be left blank. After filling of boxes on the grid has ended counting start. Counting was done based on the number of times a pair of function occurred on the pair-wise ranking grid and the number written on the total column. Ranking was done starting with the highest number and written in the rank column.

Findings from the two FGDs, seven (7) key functions were identified by staff of the two health care facilities and those functions mentioned in the FGD were in line with provisions of NHI Act 2003 and NHI Regulations 2004. This suggests that policy implementers had in depth knowledge of their functions at local level. This helps them to execute their functions judiciously without deviating from policy documents in rendering quality health care services to NHIS beneficiaries. Both groups identified five (5) related functions which were considered very important. They included consultation Services, preparation of monthly claims, supply of drugs, admission of patients and verification of health insurance identification (ID) cards (see appendix 2 a, b).

Two significant differences were noted between the two health care facilities on their functional areas/roles. One was that while one focus group SHC (public) saw the provision of infrastructure more a function of government than the health care facility, the other group SFMHC (private) saw provision of infrastructure such as staff accommodation, toilets, wards, halls as a function of health care facility. The second difference was that while SFMHC (private) paid attention and rendered diagnostic services to beneficiaries, SHC (public) gave prominence to prescription of drugs and medicines to beneficiaries as a crucial function of health care facility.

6.5 Target Group Behaviour and Socio-Economic Conditions

As explained earlier in the theoretical chapter target group play vital role in the implementation of policies and their actions and inactions affect performance of implementers. This section focuses on two variables or factors. One variable focuses on target group (beneficiaries) and their responses to NHIS. The other variable focuses on socio-economic conditions of beneficiaries and how those conditions affect the effectiveness of the implementation of NHIS in STKD.

6.6 Target Group Behaviour

As explained earlier in theoretical chapter target groups tend to influence policy formulation and implementation when they control resources needed (Skodvin et al 2010). I noted in the study that most target group (beneficiaries) had little influence over the formulation of NHIS. Out of the 22 beneficiaries interviewed, none of them was consulted during formulation and did not set agenda. But on implementation of NHIS, target group members indicated they were involved through their participation. Their responses indicated target group members were very positive on the implementation of NHIS. Target group involvement in the implementation of NHIS confirmed that their views were not neglected at the grassroots level. The study assessed extent of cooperation between target group and the two health care facilities (implementers of NHIS).

This was how an adult beneficiary at SHC (public) responded:

“I tell you that we the registered members work well with health care providers, for example sometime you come and they ask you do sit here, go there, bring your card...all these instructions we follow because we like the policy and try to relate well with doctors, nurses and other staff members.”

Another adult beneficiary at the private health care facility (SFMHC) explained that:

“If we the beneficiaries fail to cooperate with medical personnel then we are simply rejecting the policy, I tell you this policy is the best health policy in Ghana and we registered members will not frustrate the efforts of health care providers in our district.”

This was what an adult indigent said:

“We the sick registered members need clinics and health centres more than they need us, so I tell you that I have to give them maximum cooperation, as many other registered members do.”

From the three quotes above, it is evident that target group cooperate with health care facilities in the implementation of NHIS at the local level. Study findings revealed that target group were in

favour of the policy (NHIS) and have worked hand-in hand with health care facilities to ensure that NHIS was successfully executed. The findings also indicated that target group has a positive attitude towards health care facilities. The two health care facilities also cooperated well with target group. These interviews results were confirmed in FGDs with beneficiaries and staff of the two health care facilities.

The study also assessed the attitude of staff of the two health care facilities. Positive or negative attitude of health care facilities towards target group could promote or inhibit the effectiveness of the implementation of NHIS. Out of 22 target group interviewed, 14 (64%) among staff at SFMHC (private) were more friendly, had superb human relation more than SHC (public) with 8 (36%), an indication that staff at private health care facility has exhibited a more positive attitude towards target group and could promote effective implementation of NHIS than those in public health facility. This was how one target group member (an indigent) commented on the question: “How would you describe the attitude of staff of the two health care facilities?” (See appendix 1(II) a. Q. 7)

“My son, I really do not know why the nurses in their white dresses and sometime the man who gives drugs shout at us so much. The clinic at the top on the Damongo-Tamale road, they do not even know elders and needy persons, they show little courtesy. The man who gives drugs can shout and shout and something use our local language to insult us for not doing what he has instructed. But whenever I go to Ajara clinic, I mean the one in town, the nurses; doctors are all cool, nice and sociable.”

From the quote above, clinic at the top refers to SHC (public) and Ajara clinic refers to SFMHC (private), the quote confirmed that the attitude of staff at the private health care facility was more positive than the public health care facility.

The study assessed target group trust for implementing institutions of NHIS at local level. The rationale was to try to find out if target group has trust in health care facilities to get value for their money on implementation of NHIS with regard to basic quality health care services. Target group members were to base their responses on More-Average-Less scale, as the study attempt to answer the question: “Do you trust health care facilities for quality health care services? (See Appendix 1 (II) a. Q. 6). Out of the 20 target group members interviewed, 15 (75%) of them indicated that they have more trust in the health care facilities abilities on rendering them quality

health care services, 4 (20%) indicated average trust and only 1 (5%) indicated less trust. Comparing their responses between the two health care facilities, the study found that there was no significant difference between the two health care facilities with regards to target group trust for provision of basic health care services. To avoid bias responses of target groups, interviews were done outside the premises of the two health care facilities, educated interviewees used percentages (Less Trust = less than 50%; Average Trust = between 50-70% and More Trust = above 70% and illiterates interviewees used strokes/stripes on pieces of papers designed with 1,2,3,4 stripes; 5,6,7 stripes and 8,9,10 stripes representing Less, Average and More Trust respectively). This method of obtaining information was used in another study where 'school committee members were asked to assess themselves' on roles they perform based on Low-Moderate-High scale (Orest 2010: 85).

6.7 Socio-Economic Conditions

The study assessed socio-economic conditions of target group and how these conditions might have promoted or hindered effectiveness of the implementation of NHIS in STKD. As explained earlier in the theoretical chapter, target group with different socio-economic background needs different implementation strategies to promote policy implementation. The study took into consideration social status, educational, occupational backgrounds of target group and attempt to find out if these backgrounds have affected the implementation of NHIS in terms of enrolments, access to health care facilities and equal access to quality health care services in the two selected health care facilities.

The study assessed enrolment of target group in the STKD along target group backgrounds to ascertain if there are differences in their payments of NHIS annual premiums. The study found that exempt groups (children under 18 years, indigents-very poor), Social Security and National Investment Trust (SSNIT) pensioners and pregnant women) did not pay for the annual premium (8 Ghana Cedis (\$5.3). This was in conformity with NHI Act 2003 and NHI Regulation 2004 which excluded exempt groups from payment of NHIS premium. Study findings indicated that majority of target group belong to the exempt groups. Enrolment figures for 2009 shown that 93.1% of persons enrolled in the NHIS in STKD belong to the exempt groups while 6.9% paid for premium. It is important to note that the provision for exempt groups was to help enrol many

persons who may not be able to pay annual premium, thus government efforts in increasing more beneficiaries' access to health care facilities for quality health care services. The study has found that formal sector workers paid premium from their monthly salaries while informal sector workers paid premium directly to NHIS officials. Table 11 below illustrates 2009 enrolments.

Table 11: NHIS Enrolment for 2009

Target Group	Informal Workers	Formal Workers	Indigents (Poor)	Under 18 Yrs	70 Yrs Above	Pensioners SSNIT	Pregnant Women	Grand Total
Total	2,470	103	117	26,132	648	17	7484	36,971
P (%)	6.7	0.2	0.3	70.7	1.8	0.1	20.2	100

Source: STKMHIS District Secretariat June-July 2010 **Key: P-** Percentage

From Table 11 above shows the number of informal sector workers who registered for NHIS in 2009 was more than those in the formal sector. This was because there were few formal sector workers in the district. Both FGDs and interviews with target groups found that that target group members were prepared to renew their membership. Study findings revealed that beneficiaries with improved socio-economic conditions (those gainfully employed, higher education, formal sector workers) easily renew more than unemployed ones. Yao-Dablau (2000) findings on socio-economic characteristics of rural people on access to health care found that persons with higher education in Nkoranza district were more likely to join the community based insurance scheme and his finding concurs with this study on socio-economic conditions of beneficiaries in STKD. Target group members particularly informal sector workers indicated that premium was quite high and has affected their enrolments. 15 (68%) out of 22 target group/beneficiaries' indicated they were always willing and ready to renew their insurance but sometimes financial difficulties set in. Thus, lack of money/poverty was identified as a challenge to enrolment into NHIS.

On target group access to health care facilities, the study found that most target group members indicated that their means of transport to health care facilities was by either walking or riding of bicycles. Out of the 22 target group members interviewed, only three had motor bikes. Between men and women, it was found that most men used bicycles while most women walk. The study

also found that none of the two health care facilities had a vehicle (ambulance) to transport target group to hospitals in other districts in times of emergency. The study found that there was no ambulance in STKD for emergency health care services to target group members.

The study then assessed target group equal access to quality health care services. The rationale was to find out if target group social status, occupation and educational backgrounds affect implementation of NHIS with regards to quality health care. This was an attempt to answer the question: “Does socio-economic conditions of target group affect health care services? In your opinion, does socio-economic status of target group determine the kind of medical treatment rendered?”

A child at SHC (public) explained that:

“Brother, there is some kind of discrimination when it comes to treatment, the staff will say they are following first come first serve but they do not follow it well. I sat here and three people have jumped the queue and they are inside, all that the nurse said was that they are workers and you are a child so wait for your turn.”

Another child at SFMHC (private) commented that:

“Adults are more respected than children in the clinic but they follow our sitting arrangements, our names are arranged in the way we sit, when nurse call your name, you go in for treatment. The nurses treat us the same, I get drugs and sometime they let me sleep here, last month my malaria was serious so I slept in the clinic for two days.”

This was how an adult formal sector worker commented:

“Mr Student, I do not see any discrimination in treatment in any clinic in Sawla here. The nurses and doctors listen to my narration of illness and make their prescriptions or sometime ask me to go for lab test, I think all registered members are the same and they treat us the same, it does not matter what education or position one has in society.”

But an informal sector adult disagreed:

“The nurses and doctors do not treat us the same, the highly educated and respected ones are better treated more than the less privilege in society in both clinics.”

The quotes above represented mixed responses, while some target group members indicated that socio-economic backgrounds affect the effectiveness of the implementation of NHIS in terms of access to quality health care services, others responded otherwise. My observation in the two health care facilities during field work was that members were not discriminated but it appeared that some preferential treatments were given out to members due to their background. The study

noted that socio-economic conditions affect enrolment more than kind of treatments rendered to target group at the two health care facilities. A Medical Assistant at SFMHC (private) retorted that:

“No beneficiary is given better treatment than the other; one aim of NHIS is to ensure equitable treatment for all. And that is what we the medical personnel are doing in this clinic.”

6.8 Beneficiaries Choice of Health Care Facility for Treatment

The study was concerned with seeking views of beneficiaries on health care facilities. As indicated in the theoretical chapter target group behaviour may have an effect on policy implementation. In doing so the study explored the preferences of beneficiaries on their preferred choice of health care facility for medical treatments. Preference ranking technique was used to explore ways in which local people (NHIS beneficiaries) rank health care facilities, based on how these health care facilities rendered health care services to them. This was done through FGD using ‘preference ranking’ (Rifkin and Pridmore 2001) method.

The study compared the various categories of NHIS beneficiaries (adults-males and females, the aged, indigents and children) and their corresponding choice of health care facility for treatment in the study area as shown in appendix 2 (d). Each of the categories of beneficiaries was represented by one person. Eight (8) beneficiaries (72%) out of eleven (11) took part in the FGD. Pen marker was used to make marks (one and two) on pieces of papers. Those pieces of papers with one mark represented the most preferred choice of health care facility for treatment while the other pieces of papers with two marks represented the least preferred choice of health care facility visited for treatment. Friends Maternity Home Clinic (SFMHC) - private had a total of 14 and Sawla Health Centre (SHC)- public got 10 after counting and ranking, as shown in appendix 2 (d). It was interesting that the discussion almost took the form of voting, counting and ranking of health care facilities by beneficiaries. Findings from the study showed that most beneficiaries preferred visiting SFMHC (private) more than SHC (public) in times of ill health.

During the FGD, beneficiaries were asked to express freely their views on key areas of services delivery that they expected from health facilities. Eight (8) out of the eleven (11) beneficiaries selected for the study took part in the FGD and that represented 72% of beneficiaries. Each of the

beneficiaries was asked through probe questions to mention key areas that enhance the implementation of NHIS at local level. Answers were written on card board papers with a pen marker on the vertical axis. And on the horizontal axis, categories of beneficiaries, total score and ranking were written. Each beneficiary was asked to tick (for the literate) or show by piece of paper marks (non-literates) health care facilities service delivery area they either preferred most (2 marked dots) or least preferred (with 1 marked dots/block). After that total score of beneficiaries based on service delivery areas were worked out and ranked as illustrated in appendix 2 (c).

Findings eight (8) service delivery areas were identified by the NHIS beneficiaries. Interestingly some of the service delivery areas identified by beneficiaries were also identified by staff of the two health care facilities (implementers) as their functional areas. This confirmed that both implementers and beneficiaries have a good knowledge on the policy (what implementers are to do and what beneficiaries expect from them).

CHAPTER 7

SUMMARY, IMPLICATIONS OF THE FINDINGS AND CONCLUSION

7.0 Introduction

This chapter is the final chapter of the thesis. The chapter is divided into three (3) main sections namely summary of key findings, implications of the findings and conclusion to the entire study. The first section focuses on the main findings of the five explanatory/independent variables of the study. The second section focuses on implications of the findings by examining theoretical relevance of the study, emerging issues, limitations of the study and suggestions for future research and contribution of the study. The final section is conclusion.

7.1 Summary of Main Findings

The study used five explanatory/independent variables in assessing extent of effectiveness of the implementation of NHIS. The main research findings are linked to the study research questions: What factors may account for the overall policy implementation at the local level? What factors may account for or explain the differences between the public and private health care facilities in the implementation of NHIS?

7.1.1 The Design of the Policy (NHIS)

Policy design refers to content of the policy. Policy design consists of policy goals to be pursued, implementation structure/plan, policy tools (resources/incentives) as well as target population-‘players’ (Schneider and Sidney 2009). The performance of the two health care facilities on quality health care services to beneficiaries has been very impressive. The two health care facilities have adequate knowledge of the goals and objectives of NHIS devoid of ambiguity, show competence in administration of NHIS forms, cards and treatment notes. Findings indicated that three channels of communication existed among district secretariat, health care facilities and NHIS Volunteers. These channels were used to provide information to NHIS beneficiaries in STKD. Findings show a tremendous increase in attendances at the two health care facilities as beneficiaries do not ‘fear’ to visit health care facilities because of free medical treatments. It was found that beneficiaries and other actors (particularly NHIS Volunteers) actively participated in the implementation process and that enhances the implementation of

NHIS. This study finding concurs with Grindle and Thomas (1991) that policy that is design to encourage participation of larger population enhances chances of the policy being implemented. Another study conducted in Ghana on the implementation of pro-poor programmes revealed that programmes that involve community members' active participation were more effective than those programmes with less involvement of community members. The study noted that districts in which beneficiaries were deeply involved in planning and implementation of pro-poor projects and programmes implementation were more effective than districts with less involvement of beneficiaries. Study indicated Bawku West DA engages more beneficiaries in implementation of pro-poor programmes and had "performed relatively better than Bongo DA in their efforts at implementing the GPRS"- Ghana Poverty Reduction Strategy (Buabeng 2009: 262).

A few hypothesized factors in my theoretical model may have accounted for the successful implementation of NHIS at the local level. One perceived factor was design of the policy particularly its broad objectives, elaborate benefits package that covered about 95% of common diseases in Ghana in which beneficiaries had adequate access to the benefits package. In addition the study noted that there were many sources of funding for the policy. Three main sources were identified in the study namely the NHIF, IGF and external sources. It was also noted that requisite medical personnel were available at health care facilities, 64% of the personnel had attained higher education and most sub-units were headed by professionally trained personnel. As part of the design, implementation was not limited to only public institutions and agencies but private institutions were allowed to implement the policy. This brought about some kind of competition between public and private health care facilities on health care service delivery.

The study also found that target group were very positive toward the policy and cooperated well with implementers (health care facilities). Implementers also tried their best to cooperate with target group members. On socio-economic conditions of beneficiaries, it was noted socio-economic status of beneficiaries did not influence kind of health care services rendered to them. That has probably encouraged beneficiaries to attend/visit health care facilities in times of illness. This may account for the increase in attendance at the two health care facilities at the local level, an indication of successful implementation of the policy (NHIS) in general.

Despite these developments, some differences/variations were observed between the two health care facilities. The private health care facility had more sources of funding, more staff, more accommodation for staff, more positive relations with beneficiaries more than the public health care facility. On the other hand the public health care facility had little more professional staff than the private health care facility.

Findings from the study indicated the two health care facilities were accredited in accordance to section 70 of the NHI Act 2003 before they started implementation of NHIS in the district. The main significant difference noted between the two health care facilities was that the public health care facility (SHC) was granted more or less automatic accreditation to implement NHIS while the private health care facility (SFMHC) had to apply, pay accreditation fees and prove its capability to deliver quality health care services before it was granted accreditation.

Another significant difference noted between the two health care facilities on beneficiaries adequate access to NHIS benefits package particularly supply of drugs and diagnostic services, the study found that beneficiaries had more access to drugs and diagnostic services (laboratory tests) in the private health care facility (SFMHC) than in SHC (public). This was attributed to perceived understanding of NHIS benefits package by officials of the two health care facilities whether to have only approved drugs at dispensary or not. It was noted that beneficiaries at the private health care facility were given more drugs because all drugs at dispensary were on approved medical lists rather than issuing them with prescription forms. The well-established laboratory in the private health care facility contributed to its less referral of beneficiaries to other health care facilities for diagnostic services. Thus, the study noted beneficiaries were more satisfied with health care services rendered at SFMHC (private) than in SHC (public). However, the study identified one inhibiting factor on the implementation of NHIS and that was inadequate education on NHIS excluded services/benefits (appendix 4) to beneficiaries. This made some beneficiaries disappointed over payments for drugs outside approved lists, issuing of prescription forms instead of supply of drugs/medicines and referrals to other hospitals outside the district. From this, it can be argued that though three channels of communication existed, they needed more strengthening at the local level.

7.1.2 Implementation Structure

The study found that the two health care facilities had established sub-units in line with NHI Act 2003 and NHI Regulations 2004 toward effective implementation of NHIS. It was noted that there was cooperation among various sub-units established in the two health care facilities. The NHIS Office was responsible for co-ordination of activities concerning the implementation of NHIS in each health care facility and they link up with district secretariat.

There were a number of differences between the two health care facilities with regard to implementation structure. First, the study noted the private health care facility (SFMHC) had established seven (7) sub-units while the public health care facility (SHC) established five (5) sub-units. The study found that the private health care facility had a laboratory for diagnostic services and a theatre for surgical operations in increasing beneficiaries access to quality health care services but these two units were absent in the public health care facility an indication that beneficiaries there had to seek such health care services in other health care facilities. Secondly, the study shown that there were more attendances in the OPD sub-unit in SFMHC (private) than SHC (public). This was attributed to some factors including quality health care service, attitude of staff, distance and time beneficiaries spend to receive health care services.

The study identified other actors in the implementation structure at local level (STKD); they include DA, one decentralized unit (GHS) NGOs and one private Chemical Licensed Shop. Each actor plays key roles in the implementation of NHIS. I noted each actor cooperated with the two health care facilities and that contributed positively towards effective implementation of NHIS. Also the study found the involvement of NGOs in the implementation of NHIS in STKD as other studies indicated involvement of NGOs in community based projects (Buabeng 2009) and involvement of NGOs in education development at local level (Orest 2010).

7.1.3 Resources

The study noted that the main source of funding for implementation of NHIS for the two health care facilities was central government transfers (NHIF). The inflow of the NHIF was regular for 2008 and 2009 and payments were made within stipulated time (four weeks) after submission of monthly claims in accordance to section 71 of NHI Act 2003. The study found that regular

payments of claims enhanced the effectiveness of the implementation of NHIS in terms of supply of drugs, purchase of medical equipment in rendering quality health care services to beneficiaries in both health care facilities. IGF is another source of funding for implementation of NHIS, where the two health care facilities generated money on their own. This fund contributed positively toward effective implementation of NHIS in rendering quality health care services to beneficiaries. The study identified external source of funding as facilitating factor that enhanced implementation of NHIS. Also human resource endowment of two health care facilities in terms of number of staff members, educational qualifications, professional training/supervision, staff knowledge/skills and capacity on their functional areas contributed positively towards effective implementation of NHIS. However, two factors were viewed as challenging to implementation process of NHIS particularly in 2010. One was on deductions of monthly claims of health care facilities and the other factor was delays in disbursement of NHIF to health care facilities.

There were significant differences between the two health care facilities in terms of their ability to generate funds outside central government transfers (NHIF). The private health care facility (SFMHC) had many sources of generating funds internally for the implementation of NHIS more than the public health care facility (SHC). Also it was found that SFMHC (private) had a foreign donor partner (Netherlands) that boosted their revenue mobilization compared to SHC (public). This external source of fund was used as an incentive in motivating staff to deliver good and standard health care services to beneficiaries. There were more members of staff in SFMHC (private) than in SHC (public), an indication that beneficiaries admitted in wards had more access to nurses and health aids taken care of sick persons in the private health care facility more than the public health care facility. The two health care facilities efforts in the acquisition of both financial and human resources for the implementation of NHIS confirms Scott (1981) study that organizations must have the ability to organize resources (including financial and human) needed from its environment in order to perform better. The study observed there was more regular supervision of staff in private health care facility (SFMHC) than in SHC (public) on health care services rendered to beneficiaries. This may have made staff more caring towards beneficiaries in the private health care facility than in the public health care facility. There were no significant differences in terms of staff understanding of their functional areas/roles. Also on administration of NHIS forms, cards and treatment notes, there was no significant difference in terms of

competence of staff. This was attributed to their higher level of education as many staff members of the two health care facilities had tertiary/college education. But in terms of in-service training to boost staff capacity, study found that private health care facility (SFMHC) organizes quarterly in-service training to its staff. The public health care facility (SHC) however, relied more on district health directorate in-services trainings which the study noted was not 'fixed' or regular. Both health care facilities recognized the importance of in-service training of staff. These in-service training findings in this study are in line with Attafuaah (2001) findings in which staff of Ministry of Finance (MOF) and other Ministries, Departments and Agencies (MDAs) in Ghana "acquired their skills on the job" without organizing further in-service training for their staff to develop capacity beyond "what they had acquired through experience" (Attafuaah 2001: 81).

7.1.4 Target Group Behaviour

The study findings shown that target group were not involved in the agenda setting of the policy (NHIS). The study also observed target group had no influence over resources needed for implementation of NHIS. This is a different finding compared to arguments by Skodvin et al 2010 that target groups tend to influence policy formulation as well as its implementation when they control resources needed. Though target group had no influence over the formulation of the NHIS, it was noted in the study that target group were involved in implementation of NHIS. The study found target group were positive to the policy (NHIS) and they cooperated with the two health care facilities on the implementation of NHIS at local level. One significant difference noted between the two health care facilities was the attitude of their staff. The study revealed that out of 22 target group interviewed, 14 (64%) of them indicated that staff of the private health care facility (SFMHC) have exhibited positive attitude towards beneficiaries in terms of giving of instructions more than staff at SHC (public) with 8 (36%) in favour. The study shown that many professional staffs in the public health care facility were perceived as more 'arrogant and impolite' than their counterparts in the private health care facility. It was observed in the study that some staff members in SHC (public) often shouted at beneficiaries. These remarks from staff of SHC (public) make some beneficiaries feel uncomfortable whenever they visited the clinic for treatment. There was no significant difference between the two health care facilities with regards to target group trust for the provision of basic health care services. Thus target group had trust for both health care facilities on health care service delivery. This confirms

Rothstein (1978) argument that citizens (beneficiaries) should have trust in institutions responsible for executing public policies. Without such trust ‘implementation is likely to fail’ (Rothstein 1998: 100).

7.1.5 Socio-Economic Conditions

There were no significant differences between the two selected health care facilities in terms of beneficiaries’ access to health care facilities and equal access to quality health care services based on their socio-economic conditions. Rather the study found that there is strong relationship between socio-economic status of beneficiaries and enrolment into NHIS. The study noted that beneficiaries with privileged social status, educational and occupational backgrounds were able to register more and renew their membership cards more regularly than those with less beneficial socio-economic conditions. For instance, the study observed that two-thirds of beneficiaries who were gainfully employed, more easily renewed their membership than the unemployed ones. This explains why the study found over 90% of beneficiaries in 2009 enrolment belonging to exempt groups (those who do not pay annual insurance premium) in the district. This finding confirms what was found in another study on NDPC- citizens’ assessment of the NHIS in Ghana (2008) that where the socio-economic conditions/status of households improves, the chances that many household members will register/join NHIS increases. The study noted that as people’s social status, educational and occupations improves, more persons will get enrolled in NHIS. The study revealed mixed responses on beneficiaries’ equal access to medical treatment. While some beneficiaries argued they were subjected to discrimination in terms of quality health care services based on their socio-economic status, other beneficiaries disagreed.

7.2 Implications of the Findings

7.2.1 Theoretical relevance of the study

This study was conducted within the framework of Winter’s integrated model. Winter’s heuristic model integrate most relevant features of the various perspectives and ‘promising variables’ in implementation research into a single model known as “Integrated Implementation Model” (Winter 1990 in Winter 2003). Winter’s model is a ‘framework of analysis’ that presents key clusters of factors and mechanisms which supposedly affect implementation outputs and outcomes (Winter 2003). The four factors identified in the model as required for effective

implementation of policy are (i) the character of the policy formation process prior to the law (decision) to be implemented; (ii) organizational and inter-organizational implementation behaviour; (iii) street-level bureaucratic behaviour and (iv) response by target groups and other changes in society and socio-economic context/conditions (Winter 1990: 20-1 cited in Ryan 1996; Winter 2003). These factors/variables appeared relevant in analyzing the implementation of NHIS. This study identified program design, implementation structure, resources target group behaviour and socio-economic conditions as explanatory variables.

From Winter's integrated model, policy formulation or design has impact on implementation. One component of program design the model identified is policy goals and objectives. This study established that, the more clearly the NHIS goals, objectives and perceived means, the better the implementation. The extent/degree of effectiveness or otherwise of the implementation of NHIS is dependent on implementers perceived understanding of objectives and level of beneficiaries participation. Thus the study argues that implementation of NHIS is likely to be more effective in health care facility which has better understanding of the benefits package, medicines lists, accreditation and encourages beneficiaries participation.

The second indicator/variable used in the theoretical chapter is implementation structure (which focuses on individual actors, organizations and institutions responsible for executing public policies). In line with Winter's integrated model, the level of cooperation, co-ordination and commitment between/among implementing institutions could facilitate or hinder implementation of a policy. This study has established that extent of effective implementation of NHIS is dependent on the level of cooperation, commitment and co-ordination within and between implementing institutions. From the study findings health care facility that has better cooperation with other actors, implementation of the NHIS would be more effective than the health care facility with less cooperation. The study noted sub-administrative structures were established in the two health care facilities to enhance implementation process.

The third variables or factors are availability of financial and human resources for the execution of public policies. Winter's model emphasizes means in carrying out policy goals and objectives, the means include resources. Financial and human resources played key role in the findings of

this study in terms of the ability of the two health care facilities to generate financial resources on their own and attract requisite medical personnel to their health facility. Thus there is a strong relationship between availability of financial and human resources and ability of the two health care facilities to implement NHIS effectively at the local level in Ghana. The study hypothesize that, the higher the resources, the greater the degree of effective implementation of NHIS. The study findings are consistent with Van Meter and Van Horn (1975) and Grindle and Thomas (1991) argument that an implementing institution/organization with adequate funds, incentives, motivations for its staff could lead to implementation effectiveness more than less endowed one.

Target group behaviour and socio-economic conditions of beneficiaries are the fourth and fifth variables/indicators established in the theoretical chapter. The assumption is that the more target group positive responses, the better the implementation of the NHIS. As explained in Winter's integrated model, target group actions and inactions (positive and negative actions) affect performance of implementers. The extent to which target group cooperate with implementers, exhibit trust and develop positive attitude towards implementers or otherwise may facilitate or hinder effective implementation of NHIS. The study found that target group cooperated well and had trust in the two health care facilities on provision of health care services. Winter's model considered socio-economic context an important condition for policy implementation. The assumption here is that the better socio-economic conditions are the better implementation of NHIS.

7.2.2 Emerging Issues

At the onset of the study, the assumption was that since public health care facilities were the first to implement NHIS in Ghana, they would have been more effective in the implementation of NHIS than private health care facilities. For that reason five factors were used in assessing extent of effectiveness of NHIS at local level in Ghana between one public health care facility (SHC) and one private health care facility (SFMHC) in the same district capital. The study started with assumption that since the public health care facility was owned by government it would have easy access to financial and human resources, have well-established implementation structure and have better understanding of the goals and objectives of NHIS due to implementation experience. However, findings indicate the opposite despite public health care facilities lead in

the implementation of NHIS. This study has brought in a new dimension from the traditional pattern where most implementation of public policies was confined to public institutions or organizations thus, the study introduced public-private sector divide into implementation study.

Major findings on three factors or variables (program/policy design, implementation structure and resources) indicated that the private health care facility (SFMHC) performed better than the public health care facility (SHC). Another revelation found in the study was that relationship between professional staff at SHC (public) and beneficiaries was not as friendly as in SFMHC (private). The assumption was that professional staff would have handle patients much more professionally. That was not so. The unexpected findings between the public and private health care facility may be attributed to other factors/conditions, probably due to better remunerations, more supervision, rigorous recruitment process, access to foreign donors, more serious and motivated staff to deliver quality health care services in order to gain accreditation renewal contract at the private health care facility whereby some kind of complacency on the side of public health care facility. The reason may be that since these public health care facilities' survival depended mostly on government for salaries and other issues and they do not struggle to gain accreditation renewal contract. The study found these differences/variations between public and private health care facilities as important emerging issues that needed further exploration. With respect to the other two variables/factors (target group behaviour and socio-economic conditions) there were no significant differences between the two health care facilities with regards to extent of effectiveness of the implementation of NHIS. The two health care facilities exhibited similar trends with regards to beneficiaries trust, cooperation, access to health care facilities and access to equal treatments.

7.2.3 Limitations of the Study and Future Research

Qualitative studies' findings and conclusions often face the challenge of empirical generalization. This study is not an exception since it had a limited geographical area focus (one rural district). Despite these limitations, the study brought some insights into how government owned institutions 'compete' with privately own institutions on the implementation of NHIS in Ghana- a break in public health care facilities monopoly over NHIS implementation. It would be helpful if future empirical studies are to build on the findings of this study to explore reasons

why private health care facility probably may perform more effectively in the implementation of NHIS at local level in Ghana than public health care facility.

7.2.4 Contribution of the Study

This study has added a contribution to existing literature on policy implementation in general and implementation of Ghana's NHIS at local level in particular. Unlike many other previous studies which focus on public institutions/sectors for instance (Attafuah 2001; Buabeng 2009; Aysis 2009; Sunyehzi 2003; Mruma 2005). This study has brought in new dimension on policy implementation at local level in developing countries including Ghana on how public policy is implemented by government/public institution and private institution and uncovers reasons why one of the institutions performed better than the other. This study may have contributed some kind of scholarly understanding of this 'under-researched implementation setting'-refers to private sector participation in public policies like wastewater treatment privatization (O'Toole 1989). Privatization of public policies may ease implementation difficulties without affecting quality of services rendered. Though O'Toole study was conducted in developed world settings (America), conducting similar studies in developing world settings like my study adds diversity to implementation research (comparisons of public and private sectors). Despite perceived risk of private sector involvement of public policies, study findings suggest privatized arrangements (private health care facility) performed quite well than public sector counterpart (public health care facility) in the policy sector (NHIS).

7.3 Conclusion

The study concludes adequacy of resources, implementers perceived understanding of program design, well organized implementation structure, target group trust in implementing institutions and socio-economic conditions of beneficiaries accounted for effective implementation of the policy (NHIS) at local level in Ghana. Also three of the factors (resources, implementation structure, program design) provided a higher explanatory power that is explained implementation differences between the two health care facilities more than target group behaviour and socio-economic conditions of beneficiaries in the study. Despite impressive implementation process of the policy delays in disbursement of central government transfers (NHIF) to health care facilities needed to be tackled seriously towards effective implementation of NHIS at local level in Ghana.

REFERENCES

- Agyepong, I. A. and Adjei S. (2007). "Public social policy development and implementation: a case study of the national health insurance scheme". *Health Policy and Planning*. 23 (2): 150-160.
- Atim, C. and Madjiguene S. (2000). "An external evaluation of the Nkoranza community financing health insurance scheme, Ghana." *Technical Report*, No. 50. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- Attafuah, J. (2001). "The implementation of public financial management reform program in Ghana: revenue management (VAT) and budgetary process (BPEMS)." Department of Administration and Organization Theory, University of Bergen, Bergen.
- Ayee, J. R. A. (2000). *Saints Wizards Demons and Systems: Explaining the Success or Failure of Public policies and Programmes*. Accra: Ghana Universities Press.
- Ayisi, E. K. (2009). "Challenges of implementing public policy in developing countries: the case of Ghana national health insurance scheme." Department of Administration and Organization Theory, University of Bergen, Bergen.
- Baidoo, R. (2009). "Toward a comprehensive healthcare system in Ghana." Faculty of the Center for International Studies, Ohio University, Ohio.
- Berman, P. (1978). "The study of macro-and micro-implementation." *Public Policy*, 26 (2): 157-184.
- Boateng, R. (2007). National Health Insurance Scheme Presentation, Health Summit, Accra, Ghana.
- Buabeng, T. (2009). "Implementation of public policy at the local level in Ghana: the experience of Ghana poverty reduction strategy." Department of Administration and Organization Theory, University of Bergen, Bergen.
- Clarke, M. (1992). 'Implementation' in Harrop. (ed). *Power and Policy in Liberal Democracies*. Cambridge: Cambridge University Press.

Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 3rd ed. Sage Publications, Inc.

Daily Graphic (National Newspaper in Ghana), published on Monday, June 7, 2010, p. 7.

Daily Graphic (National Newspaper in Ghana), published on Saturday, May 8, 2010, p. 19

Daily Graphic (National Newspaper in Ghana), published on Tuesday, June 1, 2010, p. 10

Dye, T. R. (2001). *Top-Down Policymaking*. New York: Chatham House.

Elmore, R. F. (1985). "Forward and backward mapping: reversible logic in the analysis of public policy," in Hanf K. and Toonen, T. A. J. (eds), *Policy Implementation in Federal and Unitary Systems*. Dordrecht: Martinus Nijhoff.

GHS- Ghana Health Service (2007). *Annual report*. Accra: Government of Ghana.

GHS- Ghana Health Service (2009). *Annual report*. Accra: Government of Ghana.

Ghana, Republic of. *1992 Constitution of the Republic of Ghana* (Abridged 2005). Accra: Ministry of Justice/Allshore Co.

Gray, D. E. (2009). *Doing Research in the Real World*. 2nd ed. London: SAGE Publications Ltd.

Grindle, M. S. (1980). *Politics and Policy Implementation in the Third World*. Princeton-New Jersey: Princeton University Press.

Grindle, M. S. and Thomas, J. W. (1991). *Public Choice and Policy Change: The Political Economy of Reform in Developing Countries*. Baltimore and London: The Johns Hopkins University Press.

Gyapong, J., Garshong B., Akazili J., Aikins M., Agyepong I., Nyongator F. (2007). "Critical analysis of Ghana's health system with a focus on equity challenges and the national health insurance." (SHIELD Workpackage 1 Report) [online]. Available at:

<http://web.uct.ac.za/depts/heu//SHIELD/reports/Ghana1.pdf> (Assessed 10 October 2010).

Hargrove, E.C. (1975). *The Missing Link: The Study of the Implementation of Social Policy*. Washington, DC: Urban Institute.

Health Systems 20/20 Project and Research and Development Division of the Ghana Health Service (2009). *An Evaluation of the Effects of the National Health Insurance Scheme in Ghana*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Hill, M. and Hupe, P. (2009). *Implementing Public Policy*. 2nd ed. London: SAGE Publications Ltd.

Hjern, B. and Hull, C. (1982). "Implementation research as empirical constitutionalism," *European Journal of Political Research*, 10 (2): 105-115.

Hogwood, B. W. and Gunn, L. (1984). *Policy Analysis for the Real World*. Oxford: Oxford University Press.

Howlett, M., Ramesh M. and Perl A. (2009). *Studying Public Policy: Policy Cycles & Policy Subsystems*. Oxford: Oxford University Press.

Kerlinger, F. N. (1979). *Behavioural Research: A Conceptual Approach*. New York: Holt, Rinehart & Winston.

King, G., Keohane, R. O. and Verba, S. (1994). *Designing Social Inquiry: Scientific Inference in Qualitative Research*. Princeton New Jersey: Princeton University Press.

Kuo, D. (2006). *Tempting Faith: An inside Story of Political Seduction*. New York: Free Press.

Lipsky, M. (1980). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York : Russell Sage Foundation.

Masue O. S. (2010). "Empowerment and effectiveness of school committees in Tanzania." Department of Administration and Organization Theory, University of Bergen, Bergen.

Matland, R. E. (1995). "Synthesizing the implementation literature: the ambiguity-conflict model of policy implementation." *Journal of Public Administration and Theory*. 5(2):145-174.

May, J. M. (1999). "Policy Design and Implementation." In Peters, B. G. and Pierre, J. (eds.), *Handbook of Public Administration*. London: Sage.

Miles, M. B. and Huberman, A. M. (1994). *Qualitative data analysis*. 2nd ed. Thousand Oaks, CA: Sage.

Ministry of Health/Ghana Health Service (2004). *Standard Treatment Guidelines*. Accra, Ghana.

Momen, N. MD. (2010). "Challenges of Implementing Public Procurement Reform Initiatives in Bangladesh: The Case of Local Government Engineering Department (LGED)." Department of Administration and Organization Theory, University of Bergen, Bergen.

Mruma. R. O. (2005). "Implementation of the National Environment Policy: A Case of the Local Government Authorities in Da Res Salaam City- Tanzania." Department of Administration and Organization Theory, University of Bergen, Bergen.

National Development Planning Commission, Ghana (2008). "Citizens' Assessment of National Health Insurance Scheme." Available at:
(<http://www.ndpc.gov.gh/GPRS/Citizens'%20Assessment%20of%20NHIS%202008.pdf>
Accessed 02/05/2010).

National Health Insurance Act, Act 650 (2003). Consolidated Statutes of Ghana. Available at:
(<http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/Act650original2.pdf> (Accessed 2 February 2010).

NHIA- National Health Insurance Authority (2009). *Annual Report 2009*. Republic of Ghana..

National Health Insurance Regulations (2004). Legislative Instrument (LI) LI1809: Republic of Ghana. Available at: <http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/LI18091.pdf> (Accessed 3 February 2010).

Nkrumah, K. (1967). *Axioms of Kwame Nkrumah*. London: Panaf Books Ltd. Oxford University Press.

OHIS-Okwahan Health Insurance Scheme (2004). *Operational Report*. May 2001- August 2003. Accra: DANIDA HSSO.

O'Toole, L. J. Jr. (2000). "Research on policy implementation: assessment and prospects," *Journal of Public Administration Research and Theory*, 10: 263-88.

O'Toole, L. J. Jr. (1989). "Goal multiplicity in the implementation setting: subtle impacts and the case of wastewater treatment privatization." *Policy Studies Journal*, 18 (1): 1-20.

O'Toole, L. J., Jr and Montjoy, R. S. (1984). "Inter-organizational Policy Implementation: A Theoretical Perspective," *Public Administration Review*, 10 (6): 491-503.

Peters, B. G. and Pierre, J. (eds.) (2003). *Handbook of Public Administration*. London: Sage.

- Preker, A. S., Scheffler, R. M. and Bassett, M. C. (eds.) (2007). *Private Voluntary Health Insurance in Development: Friend or Foe?* Washington D.C: World Bank.
- Pressman, J. L. and Wildavsky, A. (1984). *Implementation*. 3rd ed. Berkeley, CA: University of California Press (1st edn, 1973; 2nd edn, 1979).
- Rifkin, S. B. and Pridmore, P. (2001). *Partners in Planning: Information, Participation and Empowerment*. 1st ed. London and Oxford: Macmillan Education Ltd.
- Rothstein B. (1998). *Just Institutions Matter: The Moral and Political Logic of Universal Welfare State*. Cambridge University Press.
- Ryan, N. (1996). "Some advantages of an integrated approach to implementation analysis: a study of Australian industry policy." *Public Administration*, 74 (4): 737-753).
- Sabatier, P. A. (1986). "Top-down and bottom-up approaches to implementation research: a critical analysis and suggested synthesis." *Journal of Public Policy*, 6 (1): 21-48.
- Sabatier, P. A. and Mazmanian, D. A. (1980). "The implementation of public policy: a framework of analysis," *Policy Studies Journal*, 8 (special issue): 538-60.
- Sawla-Tuna-Kalba District, Ghana Health Service (2007). *Annual report*. District Directorate.
- Sawla-Tuna-Kalba District, Ghana Health Service (2008). *Annual report*. District Directorate.
- Sawla-Tuna-Kalba District, Ghana Health Service (2009). *Annual report*. District Directorate.
- Sawla-Tuna-Kalba District, Ghana Health Service (2010). *Half year report*. District Directorate.
- Schneider, A. and Sidney, M. (2009). "What is next for policy design and social construction theory?" *The Policy Studies Journal*, 37 (1): 103-119.
- Scott, R. W. (1981). *Organizations, Rational, Natural and Open Systems*. Prentice Hall, New Jersey.
- Senah, K. A. (2001). "In sickness and in health: globalization and health care delivery in Ghana." *Research Review, New Series*, 17 (1): 83-89.

Shaw, R. P. and Griffin, C. C. (1995). "Financing health care in Sub-Saharan Africa through user-fees and insurance." *Direction in Development*. Washington D.C: World Bank.

Skodvin, T., Gullberg, A. T., and Aakre, S. (2010). "Target-group influence and political feasibility: the case of climate policy design in Europe." *Journal of European Public Policy*, 17 (6): 854-873.

Smith, T. B. (1973). "The policy implementation process", *Policy Sciences*. 4 (2): 197-209.

Standard Treatment Guidelines (2004). Ministry of Health/Ghana Health Service Document for Health care Professionals in Treatment Choices, Accra Ghana.

Sunyazi, J. K. A. (2003): "The impact of community based-health insurance schemes on financial access to health care: the case of the West Gonja District health insurance scheme." School of Administration, University of Ghana (Unpublished).

THIS-Tano Health Insurance Scheme (2004). "*External Evaluation*." Accra: JSA Consultants Ltd, DANIDA HSSO.

Twumasi, P. A. (2001). *Social Science Research: In Rural Communities*. 2nd ed. Accra: Ghana Universities Press.

Van Meter, D. and Van Horn, C. E. (1975). "The policy implementation process: a conceptual framework," *Administration and Society*, 6 (4): 445-88.

Wahab, H. (2008). "Universal healthcare coverage: assessing the implementation of Ghana's NHIS Law." Paper Prepared for the Workshop in Political Theory and Policy Analysis Mini Conference, Indiana University, Bloomington, April 26-28.

Winter, S. (2003). "Implementation." In Peters, B. G. and Pierre, J. (eds.), *Handbook of Public Administration*. New York/London: Sage Publications. Pp. 205-222.

Yao-Dablu, K. K. (2000). "The Effect of the Nkoranza Community Health Insurance Scheme on Access to Health Care." School of Administration, University of Ghana (Unpublished).

Yin, R. K. (2009). *Case Study Research: Design and Methods*. 3rd ed. London: SAGE Publication Inc.

Appendix 1: Interview Questions

D) Questions for NHIS Implementers

Accreditation

1. When was your health care facility accredited? Who did the accreditation? Did your facility meet the accreditation qualifications and requirements?
2. How long has your health care facility been accredited for the implementation of the NHIS?

Policy Design

1. Do you have any idea about the NHIS?
2. What in your view, are the main objectives of the NHIS?
3. Are the objectives of the NHIS clear?
4. What are some of the benefits of the NHIS to health care providers-a case of your health care facility?
5. Does the NHIS has any benefits to persons who join the scheme-beneficiaries?
6. What are the functions of health care facilities in implementing NHIS?
7. By the design of the policy (NHIS), who are the main persons, actors or agencies responsible for its implementation? Could you explain the role of each actor or agency?
8. What legal documents (Acts, Laws, Regulations and Instruments) establish the NHIS? Do you have access to any one or all of them?

Implementation Structure

3. How long have you been in your current position, what functions do you perform in relation to the implementation of the NHIS?
4. How does your health care facility relate with the District Secretariat of the NHIS and other relevant actors?
5. What kind of co-operation, co-ordination and commitment take place between/among the various sub-units in the health care facility?
6. Explain the strengths of the sub-units within your health care facility?
7. Any weaknesses of the sub-units within your health care facility in carrying out the NHIS? If any, please mention.

8. Explain the formal procedures that are followed in the health care facility in executing the NHIS?
9. Do you see any difference (s) in the implementation structure between public and health care facilities in the district in relation to the the implementation of the NHIS? If yes, why?

Financial and Human Resources

1. Please what are the sources of financial resources for the implementation of NHIS? How adequate or otherwise are the sources and how does that affect quality of health care services?
2. How long does it take you get your monthly claims from the District Secretariat of the NHIS? Are the claims repayments in compliance to the NHI Act and the NHI Regulation?
3. How would you comment on human resource (staff) capacity in terms of training, experience, number and performance for the implementation of the NHIS?
4. In your view, do you think there are differences between financial and human resources between public and private health care facilities at the local level? If yes, could you give reasons.
5. Any suggestions on improving both financial and human resources at the local level for the implementation of the NHIS.

Target Group Behaviour and Socio-Economic Conditions

1. With regards to the implementation of the NHIS, who would you refer to as the target group?
2. Does target group utilize health care services: under-utilization or over-utilization? Do they pay for the services rendered to them?
3. Has target group utilization of health care services improve quality or not?
4. Do socio-economic conditions of target group affect health care services? In your opinion, does socio-economic status of target group determine the kind of medical treatment rendered?

II) Questions for NHIS Beneficiaries

a) Adults (18-69 years)

1. How much is the premium of NHIS? In your view, is the amount affordable or not?

2. How long does it take to get the identification (ID) card from the secretariat? How long does it take for health care facilities to verify your ID card before treatment?
3. How long does it take to access health care services at health care facilities?
4. In your view, do you get quality medical treatment at health care facilities in terms of supply of drugs and medicine, access to doctors/medical assistants/nurses, laboratory services?
5. Are there differences in access to quality health care services (as stated in Q.4 above) between public and private health care facilities?
6. Do you trust health care facilities for quality health care services?
7. How would you describe the attitude of staff of the two health care facilities?

b) Aged (SSNIT Pensioners and 70 years and above)

1. How were you registered for the NHIS?
2. How would you describe the quality of health care services at health care facilities?
3. Do you pay for health care services any time you visit health care facilities?
4. Do staffs of health care facilities discriminate between you and other younger beneficiaries of NHIS? Are staff friendly or hostile at health care facilities?
5. Are there differences in service delivery between public and private health care facilities?

c) Children (Below 18 years)

1. How were you registered for the NHIS?
2. How much did you pay for the NHIS?
3. Do you like the way the NHIS is implemented at health care facilities?
4. Are there differences in health care services between public and private clinics?

d) Indigents (the poorest of the poor)

1. How were you registered for the NHIS? Was it free? Did you pay? If yes, who paid?
2. Are you discriminated any time you visit health care facilities?
3. Do you get good quality health care services?
4. Which areas of health care services do you like, and which areas you do not like?
5. Do you see any difference (s) in services rendered by public and private clinics?

Appendix 2: Data on Focus Group Discussion (FGD)

a) A Pair-wise Ranking of Health Care Facility Functions by staff of Sawla Health Centre (SHC)-Public

FUNCTIONAL AREAS	MC	CS	SD	AP	VHC	P	BA	No. of Times	Ranking
Preparation of Monthly Claims (MC)		MC	MC	MC	VHC	MC		4	2
Consultation Services (CS)			CS	CS	CS	CS	CS	5	1
Supply of Drugs (SD)				SD	VHC	SD	SD	3	3
Admission of Patients (AP)					AP	AP		2	5
Verification of Health Insurance ID Cards (VHC)						VHC		3	3
Prescriptions (p)								0	-
Buildings/Accommodation (BA)								0	-

Source: Focus Group Discussion, July 2010.

**b) A Pair-wise Ranking of Health Care Facility Functions by Staff of Sawla Friends
Maternity Home Clinic (SFMHC)-Private**

FUNCTIONAL AREAS	CS	MC	SD	DS	VHC	AP	BA	No. of Times	Ranking
Consultation Services (CS)		CS	CS	CS	CS	CS	CS	6	1
Preparation of Monthly Claims (MC)			MC	MC	MC	MC	MC	5	2
Supply of Drugs (SD)				SD	VHC	SD	SD	3	4
Diagnostic Services (DS)					VHC	AP		0	-
Verification of Health Insurance Cards (VHC)						VHC	VHC	4	3
Admission of Patients (AP)							AP	1	5
Buildings/Accommodation (BA)								0	-

Source: Focus Group Discussion, July 2010.

c) A Preference Ranking of Beneficiaries Views on Service Delivery by Health Care Facilities

SERVICE DELIVERY AREAS	Categories of Beneficiaries								Total	Rank
	M	F	M	F	F	AG	IND	CHN		
Consultations	2	2	2	1	2	2	2	2	15	1
Supply of Drugs	1	2	2	1	2	2	1	2	13	3
ID Card Processing	1	1	1	1	1	1	2	2	10	6
Admissions	2	2	1	2	2	2	1	2	14	2
Staff Attitude	1	1	1	1	1	2	1	1	9	7
Distance (emergencies)	2	1	1	1	1	1	1	2	10	6
Prescriptions	2	2	1	2	1	1	1	1	11	5
Laboratory Services	2	2	1	1	2	1	1	2	12	4

Source: Focus Group Discussion, July 2010.

Note: 2=The Most Important, 1=The Least Important

d) A Preference Ranking of Beneficiaries Choice of Health Care Facility for Treatment

HEALTH CARE FACILITY	Respondents								Total	Rank
	Adults					Children	Aged	Indigents		
	M	F	M	F	F					
SHC (Public)	1	1	1	2	1	2	1	1	10	2
SFMHC (Private)	2	2	2	1	2	1	2	2	14	1

Source: Focus Group Discussion, July 2010. **Keys:** **SHC**- Sawla Health Centre; **SFMHC**- Sawla Friends Maternity Home Clinic.

Note: 2=The Most Preferred Choice, 1=The Least Preferred Choice

Appendix 3: Ghana NHIS - Benefits Package

Over 95% of disease conditions that afflict us are covered by the NHIS

o Out Patient Services

- o General and specialist Consultations reviews
- o General and specialist diagnostic testing including, laboratory investigation, X-rays, Ultrasound scanning
- o Medicines on the NHIS Medicines list
- o Surgical Operation such as Hernia repair
- o Physiotherapy

o In Patient Service

- o General and specialist in patient care
- o Diagnostic tests
- o Medication-prescribed medicines on the NHIS medicines list, blood and blood products
- o Surgical operations
- o In patient physiotherapy
- o Accommodation in the general ward
- o Feeding (where available)

o Oral Health

- o Pain relief (tooth extraction, temporary incision and drainage)
- o Dental restoration (simple amalgam filling, temporary dressing)

o Maternity Care

- o Antenatal care
- o Deliveries (normal and assisted)
- o Caesarean session
- o Post-natal care

o Emergencies

These refer to crises in health situations that demand urgent attention such as:

- o Medical emergencies
- o Surgical emergencies
- o Pediatric emergencies
- o Obstetric and gynecological emergencies
- o Road traffic accident

Source: Available at:

<http://www.nhis.gov.gh/?categoryid=158&articleid=120&searchparam=NHIS+BENEFITS+PA+CKAGE> (Accessed 15 February 2011).

Appendix 4: Ghana NHIS – Excluded Services/Benefits

EXCLUSION LIST

The following health procedures are excluded from the NHIS Benefits

- o Appliance and Prostheses including Optical aids, Heart aids, Orthopaedic aids, dentures etc.
- o Cosmetic surgeries and aesthetic treatment
- o HIV Retroviral drugs
- o Assisted Reproduction (e.g. Artificial Insemination) and gynecological hormone replacement therapy.
- o Echocardiography
- o Photography
- o Angiography
- o Dialysis for chronic renal failure
- o Organ transplantation
- o All drugs that are not listed on the NHIS list
- o Heart and Brain Surgery other than those resulting from accidents
- o Cancer treatment other than breast and cervical
- o Mortuary Services
- o Diagnosis and treatment abroad
- o Medical examinations for purposes other than treatment in accredited health facilities (e.g. Visa application, Education, Institutional, Driving license etc)
- o VIP ward (Accommodation)

Source: Available at:

<http://www.nhis.gov.gh/?categoryid=158&articleid=120&searchparam=NHIS+BENEFITS+PA+CKAGE> (Accessed 15 February 2011).

Appendix 5: Sample of Treatment Note

**SAWLA- TUNA- KALBA MUTUAL HEALTH INSURANCE SCHEME
TEMPORARY TREATMENT NOTE**



Post Office Box 3,
Sawla, N/R
E-Mailstkmhis@yahoo.com

VALID UP TO:

AGE: **SEX:**

STKMHS

Tel: 0243253302, 0275704674, 0275759212, 0206687773, 0209282843, 0207881118

**THE OFFICER IN-CHARGE/SCHEME MANAGER
NATIONAL HEALTH INSURANCE ACCREDITED FACILITY/
NATIONAL HEALTH INSURANCE SCHEME**

The bearer of this note is a registered member of the
Mutual Health Insurance Scheme in the Region
and qualified to enjoy health care benefits under the scheme pending the issuance of his/her
membership ID card.

NAME

IDENTIFICATION NUMBER

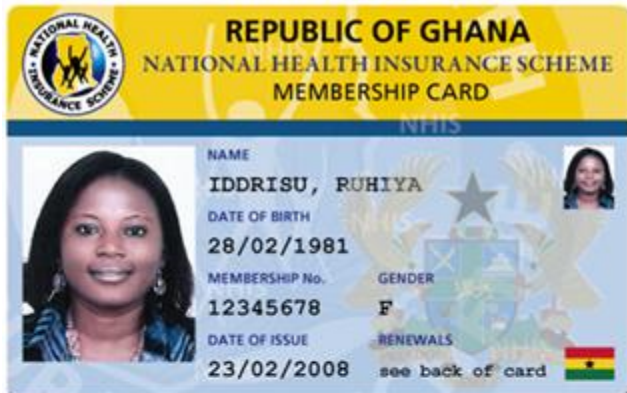
.....
Kindly attend to him/her to access health care at your facility and attach this note to the patient's
claims form and submit the bill to the scheme for prompt reimbursement.

**SCHEME'S STAMP/SIGNATURE
ORIGINAL COPY**

PS: ACCEPT ONLY

Source: STKMHS Secretariat August 2010.

Appendix 6: National Health Insurance Identity Card (ID Card)



Front →



Back →

Source: Available at:

<http://www.nhis.gov.gh/?categoryid=162&articleid=106&searchparam=card>

(Accessed 13 March 2011).

Appendix 7: Introduction/Recommendation Letter



UNIVERSITY OF BERGEN

Department of Administration and Organization Theory

LETTER OF RECOMMENDATION

To Whom It May Concern

This is to introduce Mr. Daniel Donwazum Kipo who is a student of mine. He is pursuing an MPhil degree in Public Administration at the Department of Administration and Organisation Theory, University of Bergen, Norway.

Mr. Daniel Donwazum Kipo has completed one year of course work and is now doing research for his thesis on the topic:

“Analysis of Public Policy Implementation at the Local Level in Ghana: A Case of the National Health Insurance Scheme in Sawla-Tuna-Kalba District”

He is conducting the research on this topic in his home country Ghana. As an important part of this exercise he has to interview various persons and collect relevant documents. I hope you may assist him in the research. The information provided to him is for academic purposes only. Any assistance given to him is highly appreciated.

Yours sincerely,

Professor Harald Sætren
Supervisor

Postaddress: Christiesgt. 17 Officeaddress: Christiesgt. 17
www.svf.uib.no/admorg/welcome.html
N-5007 Bergen 5007 Bergen

Phone: 47 55 58 2190

Telefax: 47 55 58 9890

e-mail: post@aorg.uib.no