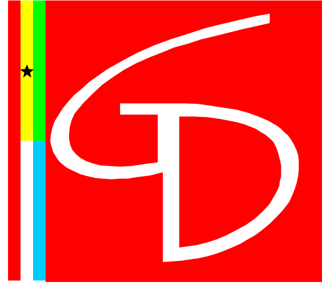

The Ghanaian-Dutch Collaboration for Health Research and Development

AN EVALUATION OF INFORMAL MUTUAL HEALTH ORGANISATIONS (MHOs) IN SOUTHERN GHANA

ERNWACA RESEARCHERS

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Project No. 2001/GD/11

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Funded by the Ghanaian-Dutch Collaboration for Health Research and Development

EXECUTIVE SUMMARY

The Government of Ghana devotes a substantial portion of its budget (8.4 per cent in 1999) to health delivery. But this has been found grossly inadequate to meet the health needs of the country. This is in spite of the introduction of a policy of cost recovery in health delivery (cash & carry system). The cash & carry system, however, has hit hard on the Ghanaian population and has denied many people access to health care.

Health Insurance Schemes, especially Mutual Health Organisations, were considered appropriate alternatives to the cash and carry system currently being implemented. Though relatively new, the health insurance concept is catching on very fast in the country. This study sought to evaluate the mutual health financing schemes that have sprung up in recent times and identify best practices, problems and policy implications of the findings.

The case study approach was used and five schemes of varying forms were selected for the study. The schemes were selected from five districts in two regions (Eastern and Ashanti regions) out of the six regions to the south of the country. The criteria for the selection of a scheme for study were basically that the scheme was in the informal sector with the primary purpose of pooling finances for health care of members. It must also be a non-profit making scheme.

The triangulation approach to data collection was employed using documentary evidence, interviews, questionnaires and focus group discussions. In all, 273 people provided information through either of the seven data collection instruments used.

The findings of the study include the following:

A total of 65 health insurance schemes were identified in the six regions with the prospects of many more district-wide schemes springing up within the next few years. Payment of premiums was by cash, was flexible and varied from scheme to scheme.

The premiums were, clearly, ridiculously low measured against cost of health delivery in Ghana. Yet they were still beyond the reach of many in the catchment areas.

Most of the schemes have passed from gestation to full operational stage because of the support they received from DANIDA and some philanthropists who initiated them. As a result of the support, some of the schemes had reserve capital.

Apart from managers appointed from within the membership of the schemes, all the schemes had Board of Directors. Even though some of them had no training to function as such, members were pleased with their leadership styles and performance.

Although structures have been put in place to manage the finances of the schemes, record keeping was a major problem for most of them. It was for instance, not possible to compute the percentage of members' contributions that went into administrative costs in some schemes. There was also problem in determining the percentage of total expenditure taken up by administrative expenditure.

Most members expressed satisfaction with the operations of the schemes.

Patronage of the schemes kept on increasing over the years but in no scheme was the entire catchment areas (potential membership) covered .

People joined the schemes on the basis of common underlying factors such as religion, school or community. There was no evidence of exclusion extended to anybody.

Benefit packages varied from scheme to scheme but there was no scheme with comprehensive benefit package. However, individual benefits were determined either at meetings or by negotiation.

Fees for services and patient visits were the major modes of paying health care providers.

Resource mobilisation was the major problem of all the schemes studied. This was particularly critical during the formative stages of the schemes.

The contributions of the schemes towards the development of health service providers were very minimal, far below the anticipation of the health-care providers.

For the schemes to be sustained there is the need for more education on the operations of the schemes and for the resources of the schemes to be properly managed.

A number of policy implications of the findings were identified. They include the following:

The policy states that contributions of self employed members (non SSNIT Contributors) shall be based primarily on household earnings and assets. This is going to be difficult to calculate as there are many in the communities who have no record of their earnings. The implication of the findings on levels of premium payment is that it is important to ensure that the premiums are truly affordable. There should be a mechanism of determining the affordability of the premiums so that the idea of Health Insurance can be embraced by all.

One of the findings of the study is that the schemes have been sustained mainly because of the support they received from DANIDA and Philanthropists. This has established that there is the need for some form of seed money for schemes, especially at their formative stages. The proposal to establish a Health Fund should, therefore, be vigorously pursued. It is important to make sure that the Fund, when established, is well managed so as to provide the needed support to the MHOs on regular basis for their sustainability.

It is important to note the increasing patronage which the schemes are enjoying. This should be seen in terms of the challenges it poses to the management of the schemes. There is the need to ensure that managers of the MHOs are well trained to manage large schemes to be able to discharge their duties effectively. Training and Monitoring should be a regular feature of the activities of the management personnel of the MHOs.

The sustainability of any organisation depends greatly on the management of their finances. The study found that proper record keeping of the finances of the MHOs was nothing to write home about. Measures should, therefore, be put in place to make sure that record-keeping of the finances of the schemes are devoid of any suspicion of malfeasance.

During the period set aside in the proposed Bill for public education, aimed at creating understanding and motivation, conscious effort should be made to encourage people to form MHOs on the basis of shared characteristics such as religion, community, profession/occupation, school, etc. This is because the study found that people joined the schemes more on the basis of these commonalties than any other consideration. Additionally, the fixing of premium for schemes with homogeneous membership is more likely to be affordable to all in the group.

The policy framework recommends the setting up of a Council to oversee the activities of MHOs countrywide. The council is expected to define the basic benefit package that must be provided by all health insurance schemes operating in Ghana. It is intended that the defined package would provide a compromise between what people would want and what they would need. This study has revealed that benefit packages varied from scheme to scheme but were related somehow to the premiums paid and that members in all cases had a say in determining the package. This was a critical factor for members identifying intimately with the schemes and accounted for the relative commitment of members to the fortunes of their schemes. A lesson needs be picked from this finding in the operational determination of the benefit packages of the schemes.

The fact that most members interviewed expressed satisfaction with the operations of the schemes does not mean they did not have grievances. It only confirms the assertion that most Ghanaians do not like complaining until things get totally out of hand. There is, therefore, the need to institute complaints units not only at the national level but also at the regional and district levels to deal with grievances of members of the MHOs.

The study has revealed that the contributions of the MHOs towards the capacity building (in terms of resource mobilisation) of health service providers was, unfortunately, very minimal. The implication of this is that with time, the facilities in the service points would deteriorate and would need replacement. Provision should necessarily be made in the policy to cater for periodic development of facilities in the health centres so that there is no break in service.

The issue of public education on what MHOs stand for should be intensified. It is the only way of getting people, especially those in the informal sector of the economy, conscientised and attracted to the scheme.

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ABBREVIATIONS

CHAG - Christian Health Association of Ghana

DANIDA - Danish International development Agency

FA - Field assistants

FGD - Focus Group Discussion

MHO - Mutual Health Organisation

MOH - Ministry of Health

NDC - National Democratic Congress

NGO - Non-governmental Organisations

NHIS - National Health Insurance scheme

PHR plus - Partners for Health Reform plus

PTA - Parent-Teacher Association

WHO - World Health Organisation

Chapter One

INTRODUCTION

RATIONALE / JUSTIFICATION

The Government of Ghana devotes quite a substantial portion of its resources to providing health care to the citizenry but this is hardly ever found to be adequate. For example, the Health of Nation Report produced by the Ministry of Health (MOH) in 1999 indicated that 8.4 per cent of government budget was spent on health. The total public expenditure was about $129 million USD and the public per capita expenditure on health was about $6.83. These amounts came mainly from the Government of Ghana (GOG), Internally Gernerated Fund (IGF) and donors. Households in Ghana spend about 4.6 per cent of their total household expenditure on health but this excludes payments in kind to traditional healers.

In order to reduce government spending, while at the same time improving resource mobilisation for the health sector, a policy of cost recovery by charging user fees was introduced by the Ghana Government (of the NDC) in 1985. Unfortunately, the policy was plagued with far more problems than was envisaged. For example, it failed to address the problem of the inability of majority of people to access health services, and could not sustain health delivery services.

Regardless of whether or not government alone can carry the burden of health delivery, there are those who argue that access to health services is a fundamental right of the citizens of any country and should be the responsibility of government. For example, Kunnes (1972) observed that the payment of hospital fees was not only a health hazard but also a psychological barrier to health care. He contended that hospital fees were roadblocks to good health and made a mockery of the idea of health care being a right, rather than a privilege. Perhaps what was conspicuously left out in the argument was a pragmatic proposal on exactly how governments, without the means, could support the provision of effective non-cost recovery health care for their people. It is needless to say that this is the situation in which many African countries, including Ghana, find themselves today.

In the Ghanaian social circumstances, the policy of health service user fee has hit hard at some categories of the population, especially the poor, the aged and children. On that account, before it could be consolidated and begin to bear fruits, if it had any at all, an alternative was already being sought to replace it even before the close of the 1980s. In the view of a school of thought, the cash and carry system, as the cost recovery policy is popularly referred to, is not only oppressive but also ultimately more expensive in its long term physical, social, economic, and political implications.

There was indeed growing public concern about the inequities inherent in the cash and carry system. There was, therefore, an urgent need to replace the system with a more humane alternative. An attempt was made within the public sector to introduce a National Health Insurance Scheme as far back as 1995. By way of experimentation with the scheme, some pilot projects were initiated in four districts in the Eastern region. The experiment in its planned form failed even to get off the ground. Thereafter, the government developed another alternative with the introduction of the User Fee Exemption Scheme that granted the following exemptions from user fee payments:

1. Exemption for disease of public health importance.
2. Exemption for antenatal services.
3. Exemption for children under five.
4. Exemption for the elderly (aged).
5. Exemption for paupers and indigents.
6. Exemption for snake bites and bites by dogs suspected or confirmed to be rabid.

The implementation of these exemptions across the regions has, however, been found to be uneven (Atim, C *et al*, 2001). Its sustainability is also considered suspect as the scheme experiences persistent shortages of funds to pay providers for the exemptions.

This scheme and the government's health care financing arrangement for public sector employees clearly did not work out as planned. The exemption scheme seemed to have failed to achieve its objectives mainly because of shortages of funds to pay service providers for the exemptions. With regard to the government health care financing arrangement for public sector employees, the process involved in reimbursing public servants for the limited health care they are entitled to is so cumbersome that it generated a great deal of dissatisfaction. This was the backdrop for the shift from concept of cost recovery based on service-point payments by individual health service users to that of community-specific-group based health insurance schemes in the country.

In a show of sensitivity to the plight of the majority of Ghanaians with regard to the cash and carry system and indeed, in fulfillment of an electioneering-campaign-promise, the NPP Government has positioned itself to completely abolish the cash and carry system and replace it with a more workable health insurance scheme. The proposed scheme, to be guided by the principles of equity and affordability, is to inform the development of a "basic benefits package" which would meet the basic health needs of the majority of Ghanaians.

For the scheme to work, there is a programme to re-organise health services in such a way that services provided at the community, sub-district and district levels will adequately meet the health needs of the people. Services at these three levels will constitute the primary health care scheme which is expected to have universal access and which will cover all residents in the country.

Even before the current efforts of government to formalise the health insurance scheme as the basis of health delivery in the country, the Christian Health Association of Ghana is known to have initiated moves to organise communities into Mutual Health Organisations (MHOs) as a possible alternative to the cash and carry system. They started the scheme as a mechanism to enable people, especially the vulnerable in the communities, to meet the cost of necessary health care (WHO, 1997). This option was being pursued in recognition of the fact that a social health insurance scheme is less repressive and more equitable in nature than the instant out of pocket payments at point of use.

Problem Statement and Policy Relevance

The medium term policy objective, as stated in the draft policy framework for the establishment of health insurance in Ghana (MOH, 2002), is that in the next 5–10 years, 50–60 per cent of the residents of Ghana will belong to health insurance schemes that cover them against the need to pay out of pocket at the point of service. It is expected that the nature of the scheme will be developed in the next five years.

In the meantime decisions need to be taken on critical issues relating to the country-wide implementation of the policy. Issues requiring decisions include the development of models for managing such schemes, benefit packages, payment levels (premium), schedules and mode of payment, rules and regulations governing membership, mechanism for winning the confidence and satisfaction of members and procedure for paying service providers.

Rather than base such decisions on mere speculations, it is more scientific and much more reliable to learn from the few schemes that are already in operation and use the lesson learnt to inform the decisions to be taken. Moreover, it is a generally believed that health insurance, if not properly designed and regulated, can create the same barriers to access to health service as has occurred under the cash and carry system. The mistakes that worked against the take off of the aborted National Health Insurance Scheme of the 1990s also need to be avoided.

Though the MOH and the Christian Health Association of Ghana (CHAG) as well as the Partners for Health Reform*plus* (PHR*plus*) have developed simple inventories of MHOs, these do not contain enough information for detailed analysis and are not up to date. Very little is, therefore, known about the form, performance and problems of the existing MHOs. It has become imperative, therefore, to conduct an evaluation of the existing schemes in order to relate performance to objectives and identify problems that they face, analyse them and propose solutions to anticipated problems that may confront new schemes. In the process, some form of guidelines for establishing new schemes could be developed.

Based on these identified needs, the Health Research Unit (HRU) of the Ghana Health Service called for letters of intent from interested teams to do research into some predetermined critical and priority areas of the Ministry of Health. The Educational Research Network for West and Central Africa (ENRWACA) and the Department of Allied Health Sciences of the School of Medicine and Health Sciences of the University for Development Studies (UDS) were selected to do research in health insurance. The two harmonised their research protocols so that they can provide information on selected schemes using the format. ENRWACA worked in the southern sector of Ghana while the UDS team worked within the northern sector.

REVIEW OF LITERATURE

General Overview

In recent years, several African governments, sometimes in collaboration with donor agencies, have proposed the adoption of insurance-based health care financing. It is argued that insurance financing does not only raise additional revenue to meet the cost of health care delivery but also diminishes the issue of finance being a barrier to obtaining health care at the time of illness. This is particularly relevant to vulnerable people such as the poor, the chronically ill, the elderly and children. Indeed, it is this aspect of health insurance that makes it a great potential for substantially improving the healthcare of people.

Available evidence, however, indicates that in the few African countries that have formal insurance schemes, only a small portion of their total populations (primarily those employed in the formal sector and/or living in urban areas) are covered.

In such countries, many of the schemes have been found to be fraught with major managerial and financial problems which work against the sustainability of the schemes. These problems have been explained by the fact that the schemes have been modeled on schemes existing in developed countries but which have proved to be unsuitable for the African socio-economic environment. For example, in Kenya, the National Hospital Insurance Fund reports a high administrative cost ratio of 14 per cent of income from contributions. This is expected not to exceed about 5 per cent. Similarly, the key problem in Zambia is that of shortage of trained staff to manage the scheme.

Currently, very little analytical information is available on community health insurance schemes, especially those in rural areas. There is lack of information on affordability of premiums, the appropriateness of payment schedules, the relationship between premiums and benefits and the resulting access to health care among the populace.

Carol Arhin (1998) proposes that in evaluating the policy relevance of health insurance to rural populations in Africa, it is essential to consider health insurance as a risk sharing mechanism employed to harness private funds for health care and to reduce the financial barriers to healthcare faced by vulnerable groups. This is in contrast to the perception that health insurance consists of those administrative and financial arrangements existing in many developed countries for pooling health care risks.

Health Financing Schemes in Ghana:

Ghana has not been left out in attempts around the continent to establish health care financing schemes in both the formal and informal sectors. The public sector attempts included the abortive National Health Insurance Scheme (NHIS) in the Eastern Region, the User Fee Exemptions Scheme which targets a large number of people and the government's health care financing arrangements for public sector employees. Though NHIS, as already noted, never really got off the ground as planned, and does not provide any opportunity for situational analysis, the circumstances leading to "its later abandonment in favour of community health insurance schemes modeled on the mutual health organisation (MHO) approach may be instructive" in any review of health financing schemes.

The private commercial sector health financing schemes have grown very rapidly in terms of members. This has happened in-spite of the fact that the first private health insurance company in the country collapsed after only a few years due, mainly, to unanticipated large number of claims, non-compliant behaviour by both users and providers

and the attendant cost escalation.' (Atim *et al*, 2001). These private commercial companies are, however, limited to only Accra and a few other urban centers. Some of these companies, having learnt from the experience of the first company, have refined their control and management systems to enhance their sustainability.

The growth of financing schemes in the community sector in recent years is rather fascinating. From an inventory of four such schemes in 1999, a survey conducted by PHR*plus* two years later had identified 47 throughout the country. By the time of this evaluation study 65 schemes had been identified in only the six regions in the south of the country. Indications are that there are as many in the regions to the north because the 2001 inventory had identified Northern and Brong-Ahafo Regions as the second and third after Eastern Region in terms of the number of schemes and membership.

In terms of design, the emerging MHOs manifest a trend towards more participatory models away from the predominantly facility-based and controlled scheme. It is expected that, with the experience of problems of earlier schemes, new ones will include fairly robust risk management features in their design to improve their viability.

The indications are that MHOs currently enjoy a lot of goodwill from the donor community and have easy access to a broad range of management and organizational tools developed exclusively for such organizations in the country. The issue, however, is the level to which the various MHOs are aware of these tools and whether they are taking full advantage of the opportunity.

RESEARCH OBJECTIVES

Mai n Objective

To evaluate existing informal mutual health financing schemes and identify best practices and nagging problems to inform policy decision on workable options for health financing in the informal sector.

Specific Objectives

- To do an inventory of MHOs in the southern part of Ghana.
- To evaluate the existing schemes in terms of performance indicators such as resource mobilization, management efficiency, sustainability, equity, consumer satisfaction and quality.
- To identify policy implications of the findings for establishing new mutual health financing schemes for the informal sector in the context of national and local socio-economic circumstances of the people.
- To identify areas for further research to support the implementation of mutual health financing schemes.

Chapter 2

METHODOLOGY

The study is basically a descriptive study: An inventory survey, followed by more detailed case studies.

DEFINITION OF SCHEMES SELECTED FOR STUDY

The qualification of schemes/organisations for selection for the study was based on the following criteria:

- The primary purpose of the scheme is the financing of health services
- It is an informal sector scheme
- It is non-profit making
- The organisation exists for pooling of finances
- It is an insurance or savings scheme

Variables measured

The first two specific objectives, as stated above, require the measurement and analysis of a number of variables. The selection of the variables was based partly on the policy framework for establishing health insurance schemes in Ghana and partly on international literature. The initial list was quite comprehensive. However, after trial testing the instruments on the health insurance scheme at Dodowa (Dangbe-West district in the Greater Accra Region), the list was pruned down, based on the realisation that data collection on some of the variables was not feasible. Variables finally used included initiation, ownership, management/administration, benefits, target group, membership, premium, performance, member satisfaction, sustainability, capitalisation, management-member relations and operational problems from the point of view of service providers.

Data collection methods

Data was collected using both qualitative and quantitative methods. Data collection was conducted in two stages.

a) Stage 1: Inventory

In a bid to identify schemes that fit the working definition of MHO adopted for this study and compile the inventory, the following methodology was employed:

- Document and literature review, including the Draf Policy Statement.
- Interview of MOH and CHAG key officials. Additionally, questionnaires were sent to all District Directors of Health, District Assemblies and known MHOs in the southern sector of the country. Retrieval of the questionnaires was very slow and sometimes very frustrating. Gradually, however, a good assemblage of relevant information was made to give a fair idea of the regional spread of the MHOs. Information supplied on some of the schemes by those in charge was, however, grossly inadequate to satisfy the demands of the format of the inventory. An important discovery at this stage was that some of the schemes which according to literature, were supposed to be in existence could either not be traced on the ground or were not operational. In contrast, many more schemes, especially some new District Assembly-initiated schemes, which had not been reported in literature were found to be operating. Information contained in the inventory include (where available) name of scheme, region and district in which it is located, current membership, target group, ownership of scheme and benefit package (*see* Appendix 1)

b) Stage 2: Case Studies

Four schemes (according to the research proposal) were proposed to be selected for detailed case study in southern Ghana. The four schemes were purposively selected from four districts in two regions with a high concentration of schemes (this was determined after the compilation of the inventory) . The criterion for stratification of the schemes to achieve a representative sample was based mainly on type of scheme with a focus on:

- Ownership (service provider / community / joint)
- Target groups (village / catchments area / district) and
- Membership (number of members)

It turned out, however, that five rather than four schemes were selected for the case studies. This was because of the curiosity and desire of the research team to seek an understanding of how the scheme operates in the school system as well, having provided for schemes based on community ownership, religious group ownership, a district-wide/diocesan-wide religious scheme and a 'susu-based' scheme. The following schemes were eventually selected: Adwumakase-kese and Manhyia Health Schemes in Ashanti Region; Koforidua Diocesan Methodist Mutual Health Insurance Scheme, Okwawuman Health Scheme at Nkwakwa and St Roses Secondary School Health Scheme, all three in the Eastern Region.

The triangulation approach to data collection was adopted to ensure comprehensive data collection and to optimise reliability in the data generated.

Data was generated using the following data collection techniques:

- **Interviews/questionnaires**: with the managers / administrators of MHOs, members of the MHOs, Health Service Managers and Providers, Religious/Traditional/Opinion Leaders and District and Regional Directors of Health.
- **Examination of documentary evidence**: including the MHO's constitution, rules and regulations, annual reports, financial statements, membership files and registration records.
- **Focus Group Discussions**: with non-members living in the catchments of the schemes.

The instruments for data collection, developed at a workshop of the research team, were subjected to content validation at a consensus building workshop of key stakeholders in Kumasi. They were reviewed taking into account the concerns of the stakeholders at the workshop and trial tested on the health scheme at Dodowa. Thereafter, the instruments were further reviewed and finalised.

The stakeholders' meeting held to validate the instruments proved to be very useful. Some wrong assumptions, held by the research team about the MHOs before the meeting, were corrected. Also at that meeting, a request was made to the stakeholders to arrange for local agents to act as guides for the research teams. It made mobilisation of respondents much easier.

The trial-testing was part of a workshop organised to train the five recruited field officers (university graduates) on the administration of the instruments. Part of the training also had to do with the translation of some of the instruments into the local languages of the areas where the selected schemes were operating. This involved initial individualised translations followed later by the harmonisation of all the versions of the translations into one version based on consensus. With both the English and local language (Twi) versions of the instruments, the field assistants were then taken to Dodowa for the pre-testing of the instruments.

Instruments eventually used for data collection were as follows:

- Interview Schedule for Traditional/Religious /Opinion Leaders (IS 01).
- Interview Schedule for Directors of Health (IS 02).
- Focus Group Discussion (FGD) schedule for Non-Members (IS 03)
- Questionnaire for MHO Managers / Administrators (IS 04).
- Questionnaire/Interview Schedule for Members of MHOs (IS 05).
  Interview Schedule for Health Care Providers (IS 06).
- Interview Schedule for District Assembly Members and Functionaries (IS 07).
- Observation Check list.

Before sending the field officers into the field, arrangements were made for the recruitment of local facilitators/ guides at each site to assist in arranging meetings and interviews. Field assistants were, however, cautioned against the guides taking advantage to influence, in particular, the focus group discussions. In order to inject a greater sense of confidence in the field officers, they were paired for the field-work instead of the original plan for each of them to take on a site/scheme. It turned out to be a very good decision for an effective coverage of the FGDs. Furthermore, for the purpose of ensuring the validity of information from the

FGDs, field officers were supplied with portable tape recorders and instructed to record the full extent of each FGD verbatim.

They were also instructed not to conduct the FGDs unless their supervisors (the Co-Researchers) were around. Thus, for every FGD, there were at least three facilitators. The Principal Researcher was also handy to participate in two FGDs.

The recordings of the FGDs provided opportunity for the Principal Researcher to re-live the sessions, review and validate the FAs' reports on the sessions.

Care was taken to ensure that the instruments were as simple as possible, given that some of the schemes evaluated were small and weak in record keeping. The translation of the instruments into the local language proved to be very useful and allowed for consistency of responses received. It also allowed for the elimination of ambiguities in responses.

Table 1 below provides details of the level of success attained in the administration of the instruments.

Field Assistants were required to hold informal interviews with members of the communities with an aim to gathering additional information which has not been provided for in the structured instruments. This has yielded fruitful results. In a way their success may be traced to the insistence of the researchers that all FAs study the research proposal thoroughly during the training session to understand exactly what they would be doing in the field.

Table 1
Administration of Instruments

Instrument Type	Code No.	No of Items	Respondent Category	Planned	Achieved
Interview Schedule	IS 01	22	Traditional/Religious Leaders	40	32
Interview Schedule	IS 02	7	Directors of Health	12	7
FGD Schedule	IS 03	11	Non-members	80	60
Questionnaire/Interview	IS 04	52	MHO Managers	20	24
Questionnaire	IS 05	26	Members of MHO	100	92
Interview Schedule	IS 06	18	Health-care Providers	15	17
Interview Schedule	IS 07	11	D.A. Functionaries	16	5
Check list		9	Observation	36	36

Data Processing and Analysis

All forms of data collected were cleaned / edited before data entry of quantitative data using SPSS was done. Qualitative items in the questionnaires as well as the report on the interviews have been summarised and collated while data from the FGDs was validated through a playback of the recorded cassettes. After the validation, they were also summarised before the analysis was done.

A data analysis workshop was organised in April 2003 at Elmina for the research teams involved in the Ghanaian-Dutch Collaboration project. It was facilitated by resource persons from HRU. The purpose was to bring all the research teams together to:

- Verify their data
- Use appropriate data analysis techniques to analyse their data
- Enable those working on similar topics to compare their data, and to
- Come out with a reporting outline.

Data analysis and presentation took the following form:

- Descriptive statistics were generally employed to analyse data.
- Some variables included in the inventory are depicted pictorially using bar and pie charts.
- The variables and the indicators were analysed qualitatively.
- Though data is based on individual cases, across-board analysis of some variables were carried out. Similarly, qualitative analysis involving comparisons between schemes was also done. This was done with a view to developing general guidelines to assist the establishment of new MHOs throughout the country.

Chapter 3

FINDINGS AND CONCLUSIONS

BACKGROUND OF SCHEMES STUDIED

Okwahuman Health Insurance Scheme

The scheme is located at Nkwakwa, the district capital whose residents are predominantly farmers. It is a district scheme and serves the people of Nkwakwa and its environs. Membership is, therefore, spread all over the district. Each community, however, has representation on the General Assembly where policies are made.

The initiator of the scheme was the Holy Family Hospital of Nkwakwa. Thereafter, the government hospital in the town teamed up with the Holy Family Hospital to serve as providers for the scheme which was officially launched in November 2000. It is the only district-wide scheme in the Eastern Region.

The scheme was established with the aim of providing access to quality health care to the people of Kwahu through affordable contributions in the spirit of everybody being his/her neighbours' keeper.

It may be explained that two main factors, both resulting from the general poverty of the people, motivated the authorities of the Holy Family Hospital to set up the scheme. These were persistent absconding of patients after treatment without paying and general inability of most people in dire need of medical attention to attend the hospital because of lack of money to pay hospital bills; sometimes with very unfortunate consequences.

Registration and renewal fees of twenty thousand cedis (¢20,000) per old member and thirty thousand cedis (¢30,000) per new member are paid annually to the Insurance Agents in every community. These agents are motivated to embark on membership drives by being paid 10 per cent of whatever funds they are able to mobilise. The benefit package available to members is as follows.

- Total admission costs in any of the two provider centers
- OPD cases above ¢200,000
- Emergency cases resulting in admissions for at least 24 hours
- Fifty per cent of cost involved in referral cases is absolved by the scheme.

Table 2 presents some information on basic financial status of the scheme.

Table 2
Income & Expenditure status of scheme

Year	Membership	Premium Yield	Expenses on Benefits	Expenses on Administration	No. of Beneficiaries
2000	-	-	-	-	-
2001	-	-	-	-	-
2002	8441	¢168,820,000	¢104,493,500 (61.9%)	¢17,409,793 (10.3%)	450 (5.3%)

Koforidua Methodist Diocesan Health Insurance Scheme

The scheme is a religious organisation based mutual health organisation and is restricted to members of the church in the diocese. It is based on the biblical principle of brotherliness among christians with each person being the neighbour's keeper. The idea for the scheme was mooted in 1999 within the Christ the King Church, by Mr. Kumi Kyeremeh and the Bishop of the diocese. The scheme eventually took off in the year 2000 with 7000 members. Currently, membership is 15000 (*see* Table 3).

The establishment of the scheme was motivated by frequent requests by church members

to the leadership for financial assistance to either seek medical attention or to pay medical bills. There were also instances when reports reached the church leadership that their members had absconded with hospital bills.

Membership is on individual basis and even children under 18 years. Premium is paid weekly (on Sundays). Thirty per cent of a person's offertory is taken as payment of premium. Consequently, people who are not able to attend service on any Sunday are expected to send their offertory for the day. Each new member serves a year's probation and must contribute ¢52,000 before being entitled to benefits. Benefit is not enjoyed at point of service but is refunded after the member has paid at service point. The scheme had 15,000 members.

Table 3
Income and Expenditure Status of Scheme

Year	Membership	Premium Yield	Expenses	Expenses on on Benefits	No. of Beneficiaries Administration
2000	-	¢78,603,825	-	37,370,300 (47.5%)	-
2001	-	¢146682559	-	1374545 (9.4%)	-
2002	15000	¢147307739	¢1,815,200 (1.2%)	17,243,500 (11.7%)	900 (5.0%)

Adwumakase-kese Community Health Insurance Scheme

This scheme serves 15 communities in the Kwabre district, Ashanti region and is based at Adwumakase-kese which is the largest of the communities in the catchments area. It is a typical farming area with very small farm holdings. As may be expected, poverty is a common problem in the area. The establishment of the scheme, initiated by a philanthropist, Mr. Joseph Obiri Yeboah, was occasioned by the following:

- Many preventable deaths were occurring as a result of poor health care.
- The Health Center at Adwumakase-kese was being very poorly patronized due to general poverty of the people.
- There were instances of people being admitted and treated on emergency but who could not settle the bills after treatment.

The scheme took off in 2002. It started with a premium of ¢1000 per month but has since been increased to ¢2000. The scheme is well organised and has an office in the premises of the health centre and is manned by two full-time officials under the coordination of a member volunteer. Table 4 gives some important information on the scheme.

The expectation of the health provider was that the scheme should help build 'drugs and non-drugs' capacity. The scheme had a membership of 1300.

Table 4
Income & Expenditure status of scheme

Year	Membership	Premium Yield	Expenses on Benefits	Expenses on Administration	No. of Beneficiaries
		2002	1248	¢6,240,000	¢21,481390
¢1409600	671				
			(344.2%)	(22.6%)	(53.8%)
2003 (Up to June)	1458	17,496,000	¢23,392,780 (133.7%)	¢1657000 (9.5%)	973 (66.7%)

Manhyia Maternity Clients 'Susu' Scheme

The scheme which targets mainly pregnant women was initiated in 2001 by the Medical Officer – in- charge of the Manhyia Polyclinic, Dr. George Aubyn, to serve the Asawansi and Manhyia communities in Kumasi. The initiation of the scheme was prompted by the following factors:

- Low attendance/delivery ratio in the catchment area.
- Frequent damping of new born babes in the bushes around.
- The frequent practice of mothers absconding from the Polyclinic either with or without the new born babies to avoid payment of bills.
- Extortion of money from pregnant women by health workers.

The scheme, in the strict sense, does not operate as an MHO and, therefore, has no fixed premium. It operates as pre-payment towards delivery charges. Members, mainly pregnant women who were predominantly petty traders, contribute as and when they have money. The health benefit is, therefore, determined by the total contribution of the individual but, generally, covers in-patient care cost of members. The scheme has a cordial non-contractual relationship with the provider with the provider being paid through the individual members at service point.

The scheme appears well organised with the health provider exercising oversight responsibility. Efforts were, however, being made for an enhanced community involvement and to open up the scheme to other health needs. The scheme had a membership of 158.

St. Roses Secondary School Health Scheme

This is a student-centred scheme established by the Parent-Teacher Association (PTA) of the school. St Roses Secondary School is a girls' school at Akwatia in the Kwabibirem district of Eastern Region and is one of the best schools in the country. The originator of the idea, a medical doctor, was an executive member of the PTA at the time (2000).

The main factor that prompted the establishment of the scheme was the realisation by parents/guardians that their wards could become ill at any time and sometimes at a time they (the wards) might not have any money to pay bills at the hospital. Though the students bear the membership cards, it is the parents/ guardians who take up membership on behalf of the wards and agree on the premium. Ten per cent of the school fee in any term was agreed upon as premium for the term. The benefit package includes full coverage of out-patient care and admission charges

The scheme is managed by a Board (made up of teachers and parents/guardians) set up by the PTA. The provider is not involved in the management of the scheme but relates well with the Board. The provider, however, negotiates for bulk payments, preferably in advance, to facilitate capacity building in drugs. All 700 students belong to the scheme because it is compulsory.

OBJECTIVE ONE: DEVELOPING AN INVENTORY OF MHOS

The concept of health insurance has, indeed, been found to be catching up very fast in Ghana. It appears to be the most attractive alternative to the cash and carry system. The increasing popularity and increasing number of the MHOs is being enhanced by the constant publicity the concept receives in the mass media coupled with the emergence of various organizations such as the Christian Health Association of Ghana (CHAG) and the PHR*plus* who have made it a business to encourage the establishment of mutual health organisations. The focused attention and campaign of the Ministry of Health itself, through its district directorates, to encourage the establishment of district-wide schemes has greatly introduced new dimensions into the emergence of MHOs.

Reports from data collection exercise in Eastern and Ashanti Regions are indicative of the fact that almost all the districts are making conscious efforts to establish district-wide-health schemes. These efforts are being spear-headed by the District Directorates of Health. Indeed, a lot of planning seems to have already gone into the planning and preparations. These efforts, unfortunately, appear, in some cases, to have swallowed up or to be gradually swallowing up or overshadowing some already existing smaller schemes such as the Maternal Mortality Prevention Scheme at Ejisu-Juaben.

The study has identified different types/forms of health insurance schemes and these are listed and described as follows:

- Community-based MHOs with ownership and management vested completely in community members.
- Community based MHOs with joint ownership and management by the community and the service provider.
- MHOs initiated by Religious Groups with ownership and management vested in the Religious Group.
- 'Susu' schemes providing coverage for health services for their members.
- Private initiative/commercial (profit-oriented) health insurance schemes.
- MHOs initiated and owned by professional groups such as the Teachers Welfare Fund.
- Student based MHOs.
- District-wide health schemes being initiated by the District Directorates of Health or the District Assemblies.

Annex A presents an inventory of Health Insurance Schemes which have been identified and their characteristics. Forty-six MHOs have been listed in the inventory. They are classified by region, district, time of establishment, target group, status, benefit package, ownership and membership. It was not easy collecting characteristics beyond what has been presented.

OBJECTIVE TWO: TO EVALUATE EXISTING SCHEMES IN TERMS OF PERFORMANCE

To achieve our second objective, the following specific research questions were formulated to assess the performance of the schemes:

1. What circumstances prompted the initiation of the various schemes/ What health problems were the schemes set up to address?
2. Who owns the various schemes?
3. How are the MHOs able to mobilise resources to run the schemes?
4. How efficient are the MHOs in meeting the needs of members?
5. How accessible and equitable are the MHOs to people?
6. What is the quality of service(s) rendered by the MHOs?
7. Are the schemes sustainable?
8. What are the operational problems being experienced by the schemes?

Circumstances which Motivated the Establishment of MHOs

The circumstances that prompted the establishment of the schemes selected for study were generally similar for all the schemes with the exception of one or two. The circumstances or problems the schemes sought to address may be listed as follows:

- Patronage of health centres was generally poor because of poverty. Many patients were unable to raise money to attend clinics/ hospitals in times of need, sometimes with very unpleasant consequences.
- Where patients had to be rushed to the health centres in emergency situations they were often unable to pay for treatment. It was common for patients after treatment to abscond without settling their bills. Reports about some of these instances of patients absconding, were received by the church leadership with heavy hearts, especially where they were known to Christians. The schemes were, therefore, meant to serve as an affordable means for inducing patients to seek proper health care and settle their bills.
- Some mothers run away from their babies in the hospitals/maternity homes to avoid the humiliation of being kept in the hospitals until bills were settled.
- Frequent damping of new born babes in the bushes. This was a common problem in the Manhyia catchment area.
- Frequent requests by church members to the leadership of the church for financial assistance to either seek medical attention or to pay medical bills. This was becoming a major drain on the resources of the church as well as becoming a major problem of equity as the church was unable to meet all requests.

Ownership of the Schemes

Except for the Manhyia and Koforidua Methodist schemes, ownership of the other schemes was vested

in the members. This is also true of the schemes at Adwumakase-kese where the scheme was initiated by a private individual (a philanthropist). Even in the school setting, ownership is not vested in the school authorities but rather in the PTA, acting on behalf of their children and wards. The Manhyia scheme is owned by the service provider which initiated it. The Koforidua Diocese of the Methodist Church owns the Koforidua Methodist scheme.

Resource Mobilisation

Mobilization of resources for the running of MHO, it is alleged, has been one of the major constraints of the schemes in the country. Against this background the following issues were outlined as indicators to assess the resource mobilization ability of the schemes:

- Flexibility of time frame for payment of premiums.
- Nature of payment.
- Average annual payment of premiums.
- Availability of reserve fund.
- Form of re-insurance available.
- Support received.
- Affordability of premiums.
- Income status and levels of members.

Table 5 provides information on the indicators listed above as was provided by managers and members. A glance at Table 5 shows that while the managers of two schemes said payment of premium was on weekly basis another two indicated that it was flexible and could be paid at anytime. In the case of the school based scheme (St Roses), premiums were paid on termly basis along side the payment of school fees. Members of two schemes, however, reported that premiums were paid on monthly basis. The rest said it was annually, weekly and termly. Furthermore, members of all the five schemes considered the time frame of payment of premiums as being sufficiently flexible.

Information in Table 5 on the nature of payment of premium indicates that all the five schemes studied accepted only cash payments which could be of two modes. While three schemes used the uniform payment mode, the remaining two schemes used differential mode of payment of premiums.

On the issue of average annual payment of premiums, only one scheme (interestingly the school scheme) has a relatively high annual premium of ¢75,000.00. All four other schemes recorded varying amounts below ¢31,000.00 per annum.

Information in Table 5 also indicates that the management of all the five schemes indicated that they had reserve funds. This is critical for the survival of the schemes and all respondents from the health provider institutions had been very blunt in making this point. One respondent had said:

There could occur serious health service emergencies at any time and there must always be some untouched fund to fall on in such situations.

Similarly, some district assembly functionaries (in four districts) had insisted that the availability of reserve fund at any given time was the only guarantee for keeping the expectations and confidence of members of the schemes afloat.

Apart from the reserve fund, four of the five schemes reported having capital reserves while two added secondary sources of funding. One scheme (Koforidua) also had treasury bill investment apart from its secondary source of funding.

There is evidence in Table 5 to show that three of the five schemes received some form of support, (cash and equipment) either occasionally, annually or as and when needed. For two of those schemes, the support came from DANIDA while the support for the third came from the initiator of the scheme. Two schemes did not receive support from anywhere. The district directors of health, however, insisted that if nothing at all, they at the district directorates provide some degree of supervision to all schemes known to them. Also, three district assembly respondents in Koforidua mentioned the formation of a Municipal Mutual Health Coordinating Team whose job it is to sensitise the public, teach them the various schemes to operate and assist schemes already in existence in their operations.

The results presented in Table 5 show that with the exception of the Manhyia scheme which was run on 'Susu' principles, members of all the other schemes (including the student members) had

Table 5

Responses on Resource Mobilisation Indicators on Performance of MHOs

Managers Of MHOs								**Members Of MHOs**		
MHO	**Time of Payment**	**Time frame of Payment**	**Nature of Payment**	**Av.Annual Payment of Premium**	**Reserve Fund**	**Form of Re-Insurance**	**Support Received**	**Time of Payment**	**Nature of Payment**	**Affordability of Premiums**
Nkawkaw	Weekly 3(100%)	Sufficiently flexible 3(100%)	Uniform cash payment 3(100%)	¢30,000 3(100%)	Yes 3(100%)	Not applicable 3(100%)	Yes 3(100%) Occasionally Cash & equipment 3(100%) Danida	Annually 20(100%)	Uniform cash payment 20(100%)	Good 20(100%)
Koforidua	Weekly 4(100%)	Flexible 4(100%)	Differential Cash payment 3(75%)	¢15,600 4(100%)	Yes 4(100%)	Secondary sources 2(50%) Treasury Bills 2(50%)	Yes 4(100%) Annually Cash & equipment 3(100%) Danida	Weekly 18(90%) Monthly 2(10%)	Differential cash payment 18(90%) Uniform cash payment 2(10%)	Good 18(100%) Average 2(10%)
Manhyia	Anytime 3(50%)	Flexible 6(100%	Cash payment According to ability to pay6(100%)	¢24,000 6(100%)	NA	Not applicable 3(100%) Part of registration 2(33%) Capital reserve 1(16.3%)	Not applicable	Monthly 9(90%) Fortnightly 1(10%)	Differential cash payment 18(90%) Uniform cash payment 2(10%) Not applicable 9(90%)	Average 1(10%) Susu scheme
Adwumakese	Anytime 5(100%)	Flexible 4(100%	Uniform cash payment 6(100%)	¢24,000 6(100%)	Yes 6(100%)	Capital reserve 1(16.3%) Sec. source, capital reserve & fund raising 5(83.3%)	Yes 3(100%) As and when needed. Logistics and allowances 3(100%) Initiator	Monthly 16(76.2%)	Not applicable 5.23.8%) Uniform cash payment 21(100%)	Good 21(100%)
St Roses'	Termly 5(100%)	Flexible 5(100%)	Uniform cash payment 5(100%)	¢75,000 5(100%)	Yes 5(100%)	Capital reserve 5(100%)	No 5(100%)	Termly	Uniform cash payment 21(100%)	Good 16(95.2%) Average 4(4.8%)

fixed premiums and rated the premiums as affordable.

It is considered important to relate the employment status and income levels of members of the schemes to the premium they are expected to pay because these have a bearing on their ability to pay. This information is presented in Table 6.
It can be discerned from Table 6 that 55 (59.1 per cent) of the respondents were income earners. Also, only 22 (23.7 per cent) respondents were earning more than ¢200,000 per month.

Focus Group Discussion (FGD) results revealed that inability to pay was the major reason for many peoples' inability to join the scheme.Participants at the FGDs generally accepted the MHO concept of solidarity and risk sharing. Many of them did understand and appreciate that joining the scheme was in their best interest but could just not afford the registration fee and the premium. Some of them admitted that, in times of crisis, they could spend far more than the level of the premium during one visit to a hospital but explained that at such times it is easier getting sympathisers to grant loans than getting loans to pay the premium. A typical response of a female participant at Nkawkaw was:
"*If I have to join the scheme then I'm to include all my siblings.Formerly, the fee was ¢20,000 but now it is ¢30,000 and I can't afford it*".

Similarly, a male participant from the catchments of the Okwahuman Health Insurance Scheme said:
"*Money is the problem; my wife ¢30,000, myself ¢30,000 and my children ¢30,000 each. It is a big problem.*"

Table 6
Income Status and Levels of Members of the MHOs

	Income Status				Income Level				
	Salary Worker	Self Employed	Unemployed skilled & Unskilled	Not Applicable	Up to ¢200,000	201,000–400,000	401,000–600,000	600,000 and more	Not applicable
Nkawkaw	6	10	2	2	14	4	-	1	1
Koforidua	11	5	2	3	7	2	4	3	4
Manhyia	2	6	-	2	7	2	-	-	1
Adwumakese	3	12	6	-	8	3	1	2	7
St. Roses'	-	-	-	21	-	-	-	-	21
Total	**22**	**33**	**10**	**28**	**36**	**11**	**5**	**6**	**34**

Efficiency

To assess the performance of the schemes in terms of efficiency, the following issues were considered and used as indicators.

- Day-to-day administration of the schemes.
- Oversight responsibility of the scheme Training and sponsorship (capacity development).
- Management of finances.
- Participatory role of members (meetings of members).
- Speed and diligence with which members receive attention.
- Satisfaction derived from being members of the schemes.

Table 7 gives a summary of responses to the listed indicators. The summary in Table 7 shows that the day-to-day administration of three of the five schemes was done by full-time managers appointed from within the membership of the MHOs. In the case of Manhyia, the Ministry of Health (MOH) and a Management Committee took charge while the school-based scheme was managed by the School Administration and the PTA of the school.

The data in Table 7 also reveals that the Board of Directors exercised oversight responsibility in four schemes while officials of MOH controlled the

Table 7

Response on Efficiency Indicators on Performance of MHOs

MHO`	**Day-To-Day Administration**	**Oversight Responsibility**	**Training & Sponsorship**	**Management of Finances**	**Speed of Attention**	**Satisfaction Derived From Scheme**
Nkawkaw	Managers appointed form members 3(100%)	Board of Directors 3(100%)	Yes 3(100%)	Statement of accounts & Keeping of proper accounts 3(100%)	Good 19(95%)	Good 20(100%)
Koforidua	Managers appointed from members 3(75%)	Board of Directors 3(100%)	Yes 3(100%)	All the variable listed 3(75%)	Good 12(60%) Average 5(20%)	Good
Manhyia	MHO and Mgt. Committee 4(66.6%)	MHO officials 4(66.6%)	No 5(83.4%) Not applicable MOH	1,2,3&4 4(100%)	Good 21(80%)	Good 8(100%)
Adwumakese	Managers appointed from members 6(100%)	Board of Directors 3(100%) Initiator of scheme 2(33.3%)	No 5(83.4%)	1,2,&3 5(83.4%)	Good 21(100%)	Good 21(100%)
St Roses' Secondary School	School Administration & PTA 4(80%)	Board of Directors 3(100%) School Administration 2(40%)	Yes 3(100%) MOH & NGOs	Keeping of proper accounts 4(80%)	Good 15(71.4%) Below Average 2(9.5%)	Good 18(85.7%)

* 1 = 2 = 3 = 4 =

fifth scheme. Figure 1 is an example of the management structure of the schemes which have Boards of Directors exercising oversight responsibility.

It is observable in Table 7 that managers and administrators in three schemes received training to enable them function effectively in their roles under the sponsorship of the Ministry of Health and some NGOs. However, managers of two schemes never received training in the management of such schemes.

**

1. Koforidua
2. Aburi
3. Mampong
4. Larteh
5. Adukrom
6. Atiebi
7. Apedwa
8. Suhum
9. Mpraeso
10. Akuse
11. Maase
12. Osiem
13. Kukurantumi
14. Nsawam
15. Afram Plains
16. Nkawkaw

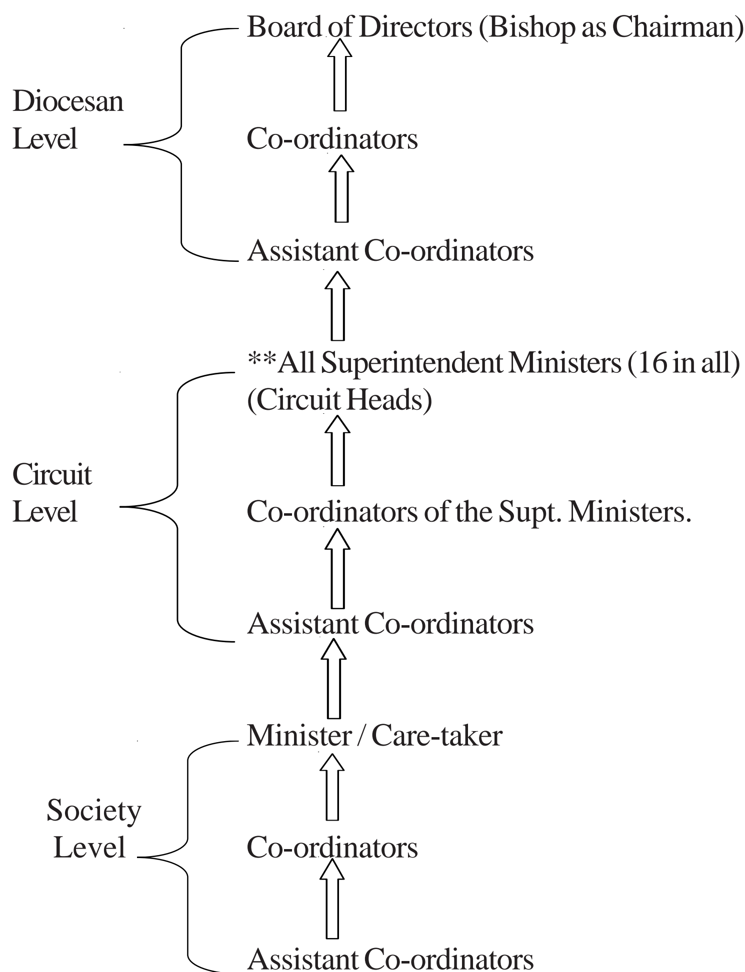

Figure 1 : Organogram of Koforidua Diocesan Mutual Health Scheme

In terms of the management of the finances of the MHOs, the results (Table 7) show that the Methodist Health Scheme, based in Koforidua, had Finance and Audit Committees which kept proper records and issued regular statement of accounts to individuals.

Similarly, Manhyia and Adwumakese also had Finance and Audit Committees and kept proper accounts and records. They were, however, unable to issue regular individual statements of accounts. The schemes at Nkwakwa and St Roses also kept proper records of accounts and presented these regularly to members at meetings.

The results also established that announcements in church and at PTA meetings were used to promote and advertise the church and school based schemes respectively while the community based schemes used a multiplicity of information dissemination techniques including traditional announcement approaches and house to house campaigns. This is corroborated by the results of FGDs. A female FGD participant in the Kwabre district was recorded to have said:

'Field co-ordinators go round to invite us personally to join the scheme'

Similarly, a male participant in the same district was reported to have said:

'Through the use of 'gong gong new members are encouraged to join'

The results of data analysis revealed that over 80 per cent of members reported that they met regularly. The remaining 20 per cent (all from the school based scheme) reported that they never met. The frequency of meetings varied from scheme to scheme. Whilst three schemes met twice in a year, one claimed to have met three times in 2002. It was only in two schemes that

minutes of general meetings held were available for inspection.

On the issue of the speed with which respondents received attention from the providers, 77 per cent reported that it was good while 13.0 per cent assessed it to be average. Only 4.3 per cent of the respondents said it was below average. Information from the health service providers appear to corroborate members assessment of the quality of service received. More than 50 per cent of the service providers contended that members of the schemes had access to 'quick, prompt and quality health care' They argued that since there were agreements between the schemes and the service providers, each party tried to fulfill its part of the agreement to maintain mutual respect and trust in promoting each others interest.

It is interesting to note that 92.5 per cent of the member respondents reported that they derived satisfaction from membership of the scheme. Only 4.3 per cent of them said the satisfaction they derived was at the average level. The most striking finding was that even non-members were aware of the satisfaction members were deriving from their membership and expressed the hope of getting maximum satisfaction from the scheme when they are able to join. A female FGD participant in Kwabre district commented with conviction: "The scheme provides security for medical care."

The area of real concern with the efficiency indicator relates to the expenditure on administration in the various schemes. Information on this was provided by three schemes and none of these was considered to be cost-effective enough. They range from 9.6–11.7 per cent of total revenue from premiums.

Accessibility to People and Equity

An evaluation of the performance of MHOs cannot be complete without looking at how accessible the schemes are to people. The following indicators were used in the assessment of this aspect.

- Trend of patronage
- Who determined benefit package?
- Who are entitled to join the scheme?
- Availability of information on the scheme to members
- Benefit packages (attractiveness)

The responses to the above issues raised in the questionnaires are reflected in Table 8.

Results reported in Table 8 indicate that majority (20 out of the 22) of managers in the sample said the trend of patronage in their schemes was increasing. This is supported by the membership figures in Table 9.

On the issue of who determined the benefit package, data in Table 8 show that three of the five schemes used negotiation and discussions at general meetings to determine the package. In the case of one scheme, (Nkawkaw) the decision was made only at general meetings. It was only at the Manhyia scheme that an indication was given that the initiator was influential in determining the benefit package. Responses from the service providers, however, gave the impression that they would prefer the determination of the package being done by the service providers since they were in the best position to know the services that were possible within the framework of the premiums that were affordable to members.

On the issue of people who are entitled to join the various schemes, Table 8 shows that, apart from the church and school-based schemes (Koforidua Methodist and St Roses) the other three schemes were open to everybody in the district or community in which they operated.

Members had opportunity to rate the level of information about the schemes available to them. Data in Table 8 shows that 80 per cent of the respondents maintained that information flow was good while about 20 per cent judged it to be only fair.

A probe into the benefit package enjoyed by members was considered important because it stands out clearly as a key variable that is indispensable. The analysis of benefits enjoyed by members is presented in Table10.

The data in Table 10 reveal that both Nkwakwa and Koforidua schemes focused mainly on admissions and sometimes on surgical operations. The benefit enjoyed by members at the Manhyia scheme was tied to childbirth only. Members of both Adwumakese and St Roses' schemes reported that they enjoyed all the benefits listed. The most baffling finding on benefit packages was the claim by

Table 8

Responses on Equity Indicators on Performance of MHOs

	Managers of MHOs		**Members of MHOs**	
MHO	Trend of Patronage	Who Determines Benefit Package	Who are Entitled to Join	Availability of Information to Members
Okwahuman Health Insurance Scheme	Increasing 3(100%)	General Meeting 3 (100%)	Everybody in the District 11(55%). Everybody in the Community 9(45%)	Good 19(95%) Average 1(5%)
Methodist Health Scheme	Increasing 4(100%)	By Negotiation 2(50%) Executive Comm. 1(25%)	Everybody in our Religion 19(95%) Everybody in the Community 1(5%)	Good 18(90%)
Manhyia Susu scheme	Increasing 4(100%)	Initiator 4(100%)	Every pregnant woman in the District 9(90%) Everybody in the Community 1(10%)	Good 6(60%) Not applicable 4 (40%)
Adwumakese Health Insurance Scheme	Increasing 6(100%)	By Negotiation beetwen Initiator and provider	Everybody in the District 18(81%) Everybody in the Community 3(9%)	Good 20(95.2%) Below Average 1 (4.8%)
St Roses' Health Scheme	Increasing 3(60%) Stable 2(40%)	By Negotiation 4(80%) General Meeting 1(20%)	Compulsory for all Students	Good 9 (42.9%) Average 6 (28.6%) Below Average 6 (28.6%

Table 9

Statistics of Membership of Schemes Studied

	2000		**2001**		**2002**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Okwawuman	-	-	-	-	4000	4441
Koforidua Methodist	2600	7400	4400	7600	5300	9700
Manhyia	-	180	-	413	-	158
Adwumankese-kase	-	-	-	-	563	745
St. Roses School	-	-	-	-	-	700

Table 10

Benefits Enjoyed by Members of MHOs

	Admissions		**Drugs**		**Childbirth**		**OPD Services**		**Credit Facilities**		**Surgical Operations**	
	Yes	**NA**	**Yes**	**NA**	**Yes**	**NA**	**Yes**	**NA**	**Yes**	**NA**	**Yes**	**NA**
Nkwakwa	14	5	4	16	3	17	1	19	-	20	10	10
Koforidua	17	3	3	17	1	19	-	20	-	20	4	16
Manhyia	-	10	-	10	10	-	-	10	-	10	-	10
Adwumakese	18	3	21	-	19	2	20	1	13	8	2	19
St Roses'	19	2	20	1	17	4	18	3	18	3	18	3
Total	**68**	**23**	**48**	**44**	**50**	**42**	**39**	**53**	**31**	**61**	**34**	**58**

members of Adwumakese and St.Roses' schemes that they enjoyed credit facilities. Members of the Manhyia scheme did not report on that at all though the background information gave the impression that they were entitled to credit facilities.

Focus Group Discussion (FGD) participants, though not members, showed awareness of the benefit packages and expressed satisfaction with them. According to a male FGD participant in the Koforidua Methodist church:

"*You enjoy benefits when you pay ¢200,000 and above.* If you fall sick and the bill is more than ¢200,000 the scheme will cater for the extra expenditure"

Another male FGD participant in the Kwabre district said:

"*A contributor who is sick is attended to without any payment at the point of service*".

Quality of Services Rendered by MHOs

Health services provided by the MHOs for their members take very different forms depending on the circumstances that prompted the establishment of the scheme. The priority concern of this study is with the quality of service(s) rendered by the schemes to their members. Quality of service in this context is restricted to only intra-scheme operations. In that respect, the issues considered in assessing the quality of services are:

- Mode of payment to health care providers.
- Benefit paid to members.
- How many members received benefits.
- Contribution to the development of the service provider facility.
- Leadership style of managers of the scheme.
- Percentage of members' contribution that go into administrative costs.
- Percentage of total expenditure taken up by administrative expenditure.

Table 11 presents the analysis of responses of both managers and members to questions on these issues.

Data in Table 11 show that three of the five schemes studied paid fees for both service and patient visit. In the case of one (St. Roses) the mode of payment was fixed while that of Koforidua was fee for service only.

On the issue of benefits paid to members, it appears that records were available only in St Roses The responses from St Roses indicate a persistent increase. While the aggregated benefits paid to members in 2000 range between 6 and 10 million cedis, it rose to between 14 and 20 million cedis in 2001 and rose beyond 25 million cedis in 2002. The trend of expenditure on benefits is presented in Table 11.

The study also established that only two of the schemes studied (Manhyia and Adwumakase-kese) were assessed to have made any contribution to the development of the service provider facility. The Adwumakase-kese scheme contributed 45.7 per cent (ie. ¢1,799,1330 out of ¢39,379,030) of the health center's total revenue from in-patients in the first half of 2003. The contribution in the remaining schemes to resources of their provider facilities was minimal. For example, in Nkawkaw, the scheme contributed only 2.8 per cent of the total revenue generated through in-patient services.

Members' perception about the leadership style of the managers of the schemes is also reflected in Table 8. The results reveal that 71per cent of members viewed the leadership style of managers of the schemes as being democratic while 8.7 per cent of them found it to be dictatorial. Again, another 40 per cent found it to be transparent. It is worth noting that those who perceived the leadership style in their scheme to be dictatorial belonged to the student-based scheme.

Available data on the percentage of membership contributions that went into administrative costs or the percentage of total expenditure which falls into the category of administrative expenses is rather worrisome. For administrative expenses to consume more than 5 per cent of total revenue from premiums is certainly unacceptable. Indeed, the proportion of premium payments that went into administration expenditure in some of the schemes is just ridiculous.

Table 11

Responses to Questions on Quality of Service

MHO	Payment to service provider	Total Benefits paid to Members	Contr. To Develop Provider Facility	Leadership style
Nkawkaw	Fee for services and patient visit (100%)	-	None (100%)	Democratic (95%)
Koforidua	Fee for service (100%)	-	N0 (100%)	Democratic (52.2%) Transparent (47.8%)
Manhyia	Fee for service and patient visit (100%)	-	Yes (25%) No (75%)	No Response (100%)
Adwumakese	Fee for service and	-	Yes (100%)	Democratic (100%)
		patient visit (100%)		Transparent (90%)
St Roses'	Fixed payment (100%)	2000: 6 – 10m 2001:14 — 20m 2002:Over 25m	No (75%)	Democratic (70%) Dictatorship(30%)

Sustainability of the MHOs

Any insurance scheme is essentially a futuristic plan making arrangement. No one wants to enter any insurance scheme that has no clear prospects for continuity. This reasoning sets the tone for the need for the MHOs to endeavour to be sustainable. The quality of services an MHO renders goes a long way in determining the sustainability of the scheme. The question "Are the schemes sustainable?" is therefore a follow–up to the question "what is the quality of service(s) rendered by the MHOs."

All categories of respondents who were confronted with this question opined that the schemes have prospects of sustainability provided the following conditions are fulfilled:

- They should have permanent secretari ats and at least some minimal full time staff.
- The management of the schemes should continue to be transparent in their dealings with the members.
- The service providers should remain committed to the schemes and render satisfactory service.
- Each party connected to the scheme should continue to fulfill its part of the agreement to ensure that mutual respect and trust between the scheme and the provider is maintained.
- The schemes should continue to cut their coats according to their sizes.
- The Government or the District Assemblies should consider lending a hand of assistance to the schemes.
- The premiums should continue to be affordable.
- Monitoring and supervising systems should be put in place to ensure efficiency.
- Serious membership drives should be undertaken since insurance is about numbers.

The FGD participants, though not members of the schemes, expressed some reservations about the moral aptitude of managers of the schemes in the face of the widespread corruption in the country. They expect members to continually demand accountability from the managers. A typical response of a female participant from the catchments of the Okwahuman scheme was:

I know some members of the scheme who are finding it extremely difficult to make ends meet and yet they are managing to contribute to the scheme. The managers should therefore take care of the scheme's money for they will account for every cedi contributed to the scheme one day."

Some participants argued that because hospital bills

are rising higher and higher, if the managers cause the collapse of the schemes they should be held responsible. They attributed the apathy on the part of non-members to lack of education on the activities of the scheme. A male participant at Nkwakwa said:

The picture of the scheme has been made to look bleak; so when you are outside the scheme one does not find it attractive. Management should be patient in educating the non-members.

This position not withstanding, FGD participants expressed some optimism in the schemes. They submitted that the future of the schemes could be bright provided everybody is faithful to them and resolute in push them. Summing up his optimism on the sustainability of the schemes, a male participant at Nkawkaw opined:

A small payment is easier than larger payment so I would prefer to pay ¢30,000 than to pay ¢500,000 when asked to pay cash down. I don't have the 30,000 now but I know I will manage to raise it and become a member.

Participants in the FGD in the Kwabre district agreed that their scheme had reached an advance stage and the chances of its collapse were slim. To them, the leaders were committed and ready to improve upon their past performance.

One disturbing factor threatening sustainability in one particular scheme is the high percentage (66.7 per cent) of sick members benefiting from the scheme while the other two on which information was available were 5.0 per cent and 5.3 per cent.

Operational Problems

Three categories of respondents (Managers, Service Providers and Members) were given the opportunity to state the problems the various schemes had encountered during the gestation periods and the period of full implementation. The following problems were mentioned:

a) Problems during Gestation Period:

Problem of effective dissemination of information about the scheme. It was not easy getting to the people initially with the concept and convincing them about the viability of the scheme. In almost every centre, there was general ignorance about the operation of mutual health insurance schemes. At that time, there were hardly any 'best practices' to cite to encourage prospective members. Worst of all, there was very little publicity on the scheme in both the print and electronic mass media.

Initial financial difficulties. This was particularly critical because funds could not be raised through premiums at this early stage. It was also not considered the type of venture that one could seek bank loans to undertake. Initiators were confronted with the difficult task of looking for some seed money to get the scheme off the drawing board.

Understanding the Probation Period. Since almost all the schemes took off with very poor financial outlays, it was necessary for the schemes to accumulate some funds to be in a position to pay the service provider when benefit demands start coming. This was something many members could not easily understand. They wanted immediate benefits and did not hide their frustrations from other members of the communities who were yet to join the scheme.

Lack of skills and experience in running such schemes. It was extremely difficult for some of the schemes to make projections about the sort of benefits that could be accommodated under the relatively low premiums the targeted members could afford.

The genuine poverty of the people which became a critical barrier for the scheme to attract sufficient members to enable them reap the benefits of numbers in such endeavours. In schemes initiated by the MOH (Manhyia) and by private philanthropist (Adwumakase) the initiators had the unpleasant duty of seeing many people not taking advantage of the opportunity created as a result of poverty.

Lack of personnel to man the scheme. There was difficulty in getting members to volunteer to provide free service for the scheme, as there

were no funds to hire people to perform various duties.

Problems during Period of Full Operation

Abuse of the scheme by both management and members. For example, the student members at the St. Roses school cultivated the habit of going to hospital, sometimes with exaggerated ailment whenever they felt like dodging classes.

Lack of office accommodation for some of the schemes to facilitate proper coordination and administration of the scheme and proper record keeping.

Failure/inability of members to meet financial obligations regularly or promptly. This, sometimes, made it difficult for the schemes to fulfill their part of the agreement with the service providers.

Respondents' Suggestions for the Formation of New Schemes:

Scheme managers, service providers, Regional/District Directors of Health and Traditional and Religious group leaders were given an opportunity to make suggestions with regard to the establishment of new schemes. Their suggestions are as follows:

1) People living in the catchment areas of the scheme should be properly educated on the scheme – that is, what it is and what it can do as well as what members are expected to do before the formal invitation to people to join the scheme.

2) There is the need to conduct feasibility study of the common health needs and the premium payment potentials of the targeted people before starting any design of the scheme.

3) Some seed money needs be made available by government to help the scheme at its take-off stage.

4) Members of the scheme should be involved in all stages of implementation.

5) Pharmacy shops from which drugs are bought should be specified.

6) There is the need for an umbrella supervisory authority to guide the establishment of all new schemes.

7) Every new scheme should start with well defined rules, regulations and responsibilities.

8) Each scheme should be managed by a Board.

Summary of findings

The findings on this objective are as follows:

- A total of … health insurance schemes were identified in the six regions with prospects of many more district-wide schemes springing up within the next few years.
- Payment of premiums was by cash, was flexible and varied from scheme to scheme.
- The premiums were, clearly, ridiculously low measured against cost of health delivery in Ghana. Yet they were still beyond the reach of some people in the catchment areas.
- Most of the schemes have passed from gestation to full and settled operational stages because of the support they received from DANIDA and some philanthropists who initiated them. As a result of the support some of the schemes had reserve capital.
- Apart from managers appointed from within the membership of the schemes, all the schemes had Board of Directors. Even though some of them had no training to function as such, members were pleased with their leadership styles.
- Although structures have been put in place to manage the finances of the schemes, record keeping was a major problem for most of them. It was not possible to compute the percentage of members' contributions that went into administrative costs. There was also problem in determining the percentage of total expenditure taken up by administrative expenditure.
- Most members expressed satisfaction with the operations of the schemes.

- Patronage of the schemes kept on increasing over the years.
- People joined the schemes on the basis of common underlying factors such as religion, school or community. There was no evidence of exclusion extended to anybody.
- Benefit packages varied from scheme to scheme. However, individual benefits were determined either at meetings or by negotiation.
- Fees for services and patient visits were the major modes of paying health care providers. Resource mobilisation was the major problem of all the schemes studied. This was particularly critical during the formative stages of the schemes.
- The contributions of the schemes towards the development of health service providers was very minimal.
- For the schemes to be sustained there is the need for more education on the operations of the schemes and for the resources of the schemes to be properly managed.

This section is devoted to discussing the findings that have been reported in chapter 3. The order of the discussion follows the same order of the presentation of the findings in the previous chapter.

Chapter 4

DISCUSSION OF FINDINGS

THE EMERGENCE OF THE MUTUAL HEALTH SCHEMES

The circumstances under which the schemes studied emerged were very similar. They all boiled down to the general difficulty and uncertainty of the people targeted by the schemes having access to affordable good quality health care. In each situation, there emerged either a concerned individual philanthropist or an organisation/agency who/which took up the challenge, initiated and championed the establishment of the an MHO to ease the difficulty of gaining easy access to health care for the majority of people in their respective areas.

On closer examination, it would appear that the establishment of the schemes sought to and did accomplish more than just creating access to health care for the vulnerable groups. The schemes became very important mechanism for implementing the cost recovery policy of government under more humane conditions and in a smoother fashion than did the cash and carry system. At least, it reduced the incidents of bad debt in the records of the service providers which resulted from patients absconding with unpaid medical bills. The schemes also became important outlet for releasing and minimising social tension for organisations like the churches that often came under pressure from their members for assistance to settle medical and some other bills.

In the light of the factors just identified, in designing the study, the assumption was made that the District Chief Executives, the District Assembly's Social Services Committee and the Assembly Members of the areas concerned would be very familiar and indeed playing active roles in the MHOs of their areas. A lot of information particularly relating to the management of the schemes is, therefore, expected from these categories of respondents. It turned out, however, that majority of the DCEs, and the Assembly Members knew very little about the schemes in their areas, irrespective of whether the schemes were community-based, religious group-based or specific group-based.

Credit needs to be given to the facilitating role of such organisations as the Christian Health Association of Ghana and the PHR*plus* (a USAID sponsored agency) in the rapid growth of the schemes within a period of barely two years. The zeal with which various District Assemblies and/or District Directorates of the Ministry of Health are approaching the initiation of new district-wide schemes represents a promising new trend for the ultimate vision of every Ghanaian having easy access to quality health care through some form of health insurance scheme.

It may be stressed, however, that the emerging district-wide schemes being championed by the Assemblies or the District Health Directorates should not be seen as substitutes for the smaller, specific need or target group schemes but rather as supplements. The fear with the district-wide schemes is that people may lose that feeling of ownership that serves as an incentive for members of existing schemes to make needed sacrifices for the success of the schemes. Such members may now begin to view the district-wide schemes as agencies of government which has the civic responsibility to provide health care to the citizenry free of charges.

OWNERSHIP OF AND PARTICIPATORY ROLES IN THE SCHEMES

The collapse of the experiment with the NHIS, unfortunate as it was, has provided a good lesson for this study and in the current wave of establishing schemes throughout the country. The failure has drawn attention to the fact that health insurance should better be approached from the level of well defined and relatively small target groups or communities where ownership and indeed, some level of control or decision making easily resides in the members. It is also a fact that the size of member-

ship should be large enough to satisfy insurance principles of numbers determining success of the scheme. However, the feeling of ownership and participatory roles of members in the scheme need to be guaranteed. These two characteristics are key to attaining a reasonable level of commitment from members and greater prospects of success. Additionally, the two characteristics create fertile grounds for mutual trust and the elimination of all forms of suspicion between the members and management and between the scheme and the service providers. This was evidenced in the Manhyia scheme where membership of the scheme is limited only to the period of pregnancy.

RESOURCE MOBILISATION

Resource mobilisation is a major factor in the implementation of a scheme of this nature. One finding from the study is the fact that none of the schemes studied found it easy to mobilise resources.

The levels of the premium paid by members were very low. The only exception was St. Roses Secondary School where the scheme was supported financially by parents/guardians who had the means to send their children and wards to such a relatively well-endowed school. This is understandable in view of the background of the people targeted to join the scheme. A high percentage of the members were found to be unemployed or workers with very low incomes. Incidentally, these are the very factors that put them into the classification of vulnerable groups that constitute the main target for the scheme. This problem of low resource mobilization was compounded by the low membership figures of the various schemes which further limited the scope of fund mobilisation. Even with the relatively well-to-do scheme at St Roses School, the aspiration of the service providers of having up-front payment to facilitate capacity building particularly in drug acquisition was never achieved.

The terms/schedules of payment of the premium were found by members in all cases to be sufficiently flexible but many of the members still defaulted in payment. Most of them were genuinely finding it difficult to fulfil their financial obligations to the scheme.

Indeed, if the basic principle of risk sharing among members underlying the MHO and self supporting stance of the scheme are strictly applied, many of the schemes would lose enthusiasm and quickly collapse..

In view of these difficulties in fund mobilisation, government assistance in providing some overhead funding to all aspiring schemes, especially at the gestation period are considered critical. Such an overhead funding would not only be assisting the schemes to take off with a stronger prospect of success but would also be ensuring the overall success of the cost recovery policy. At the same time it would create access to health care for the people. MHOs are known to enjoy a good measure of goodwill from the donor community. There should be no better time to take advantage of this goodwill than now to win some donor financial support for the schemes at these gestation stages.

EFFICIENCY OF THE SCHEMES

As many as 92.5 per cent of members of the various schemes testified that they derived satisfaction from the schemes. This could be considered as a vindication of the rationale for the establishment of the schemes and it says a lot about whether or not the schemes were achieving their objectives. It is fascinating to observe that even non-members, completely outside the scheme could also testify to the benefits and satisfaction the schemes bestowed on their members.

The appointment of full-time managers, though it increases the running costs of the schemes, should be considered necessary for the effectiveness and efficiency of the schemes. Much as the managers of the schemes have been trying to put in their best, there are still visible weaknesses in their operations that needed to be improved. Record keeping, for instance, has been so poor that the schemes can not tell how much go into administration or how much go into payments to service providers in a given year. It should, therefore, not be considered adequate merely having full time managers and other functionaries. More importantly, they should be empowered to be effective. What is required is specific training tailored to equip them with skills to effectively manage the schemes. The skills they acquire should

enable them to balance costs against revenue, relate premium to benefits, ensure good record keeping and provide professional situational analysis to assist their Boards or their General meeting in taking workable decisions. It is for this reason that one considers the role of organisations and agencies offering training in the management of health insurance schemes very critical for the survival of the MHO concept.

One other area in which the schemes seemed generally not to have fared well was in marketing the scheme. Sufficiently aggressive marketing strategies using modern advocacy techniques appeared not to have been adequately employed in the membership drives.

ACCESSIBILITY AND EQUITY

Review of literature has cautioned that in many African countries, the health insurance schemes are limited to either only public sector employees or people living in urban areas. This does not appear to true of Ghana except with the private commercial health insurance schemes. Three out of the five schemes studied were not urban-based. Moreover, majority of the members of the schemes was outside the public service.

In the areas where the schemes were located, anybody falling into the targeted membership category was free to avail himself/herself of the opportunity of benefiting from the scheme. Results from the study have indicated an increasing trend of patronage of the schemes and the service provider centres. This may be interpreted to mean that more and more people have discovered the virtues in the scheme by each passing day. This is an encouraging trend and one hopes it continues. Insurance thrives on numbers based on the principle of 'the fortunate majority absorbing the needs of the unfortunate few.

The main hindrance to membership in the Ghanaian circumstances is not that of the urban–rural divide but rather that of affordability. This situation has been aggravated by the demand of the various schemes for family heads to register each individual member of the family to entitle him/her to benefits. Ghanaians generally have large families and this has become a major obstacle against the desire of family heads to join and register all the family members. This would appear to be counter to objective of the schemes to serve as risk sharing mechanism for harnessing private funds for health care. Perhaps this may justify the need to institutionalise some support schemes (probably with some percentage of VAT or petrol tax to support such schemes) for the poor in society.

The fact that some of the schemes studied were limited to a specific category of beneficiaries gives the impression that some people may not be able to fit into any groups. The newly emerging district-wide schemes should strategise to absorb all such floating people.

QUALITY OF SERVICE

Admittedly, members generally appeared satisfied with the quality of service they received from the health service providers. It may be argued, however, that an insurance for health care serves a more useful purpose if it is comprehensive. Limited services as benefits might create a source of dissatisfaction among members when they begin to realise, with time, that the scheme is unable to grant them absolute protection in some cases of ill-health when they may have the greatest need for the scheme.

SUSTAINABILITY OF THE SCHEMES

All categories of respondents believe that the mutual health organisation concept has great potential for survival. They were, however, quick in pointing out that the sustainability of the existing schemes depended on the fulfillment of some conditions.

Three main factors may be considered critical for the survival of the schemes. The first factor relates to adequate funding of the schemes, especially with regard to the availability of reserve fund which could be used during relatively bad periods of the scheme– when demand for benefits becomes overwhelming. Experience from other countries has demonstrated the existence of many schemes that are fraught with major managerial and financial problems. It was not possible to study these problems in the schemes studied for lack of data. Indeed, the absence of up-to-date records on transactions should be viewed as weakness in the management of the schemes. The effect of these weaknesses may not show at these

early stages of the operation of the schemes. However, there is the need to take due note of them.

The extent to which the managers are able to sustain the confidence of the members and the service providers is crucial for the survival of the various schemes. Continued mutual trust will depend on the open and transparent management of the schemes and the level of participation the members are allowed by management. The participatory role of members in the management of MHOs appears to be very important. It acts as a tool for their sustainability as it helps members to associate themselves more intimately with the successes of the scheme.

The third major factor/threat for the survival of the schemes is traceable to the emergence of the district-wide schemes. Some of the earlier community-based schemes have been found to be overshadowed by the district-wide schemes being set up by some District Assemblies and or the District Health Directorates. For example, though the Ejisu-Juaben Maternal Mortality Prevention Health scheme exists on almost all inventories of MHOs, it was hard to locate it on the ground. It has become virtually unknown in the area–not even to the District Director of Health. The emerging district-wide scheme has overshadowed it completely because there appeared to be greater confidence in the district-wide schemes.

BEST PRACTICES

The study has identified some practices in one or more of the studied schemes which could serve as a model for other schemes (old or new).These are presented and discussed below.

Governance/management

The establishment and entrenchment of the concept of community ownership of the schemes served as a good motivation for loyalty and commitment of members towards their schemes. The participatory roles of members through general meetings and voluntary services to the scheme was also found to be a useful approach to confidence building in the scheme as well as encouraging transparency in the management of the scheme. The approach facilitates the building of beneficiary capacity within the scheme.

Continuing management capacity building

Health insurance is certainly a new concept in Ghana with very limited human recourse development in the area. Some of the schemes studied recognised and appreciated this weakness and made sure to avail themselves with any opportunity for training and staff development.

The District Assembly Factor (Involvement)

In almost all the areas visited during the study, the District Assemblies showed keen interest and had actually initiated moves to establish district-wide schemes. This was very encouraging and need to be sustained. It may prove more beneficial if the Assemblies do not concentrate all their energies (and perhaps recourses) on the establishment of the district-wide schemes but lend some level of support to the already existing schemes as well. Indeed, in dialoguing with the service providers, the assembly is in a better position to exert greater influence since the service providers are under the control of the assemblies.

Benefits

Most of the schemes studied were implementing specific benefit packages. But some of them had expressed the hope to provide comprehensive benefit packages some day when the scheme fully matures and can boast of a very reasonable numerical strength. Such a package is the ideal and should be encouraged since the individuals are not in control of the type of ailment that befalls them.

Premiums

All schemes studied have uniform premiums. Some member-respondents had, however, suggested the introduction of differential premiums. In their view the scheme should have a sliding scale by which infants, children, adults and the aged should not be paying the same premiums. To go a step further, it should also be possible to introduce some form of subsidy/exemptions for the very poor.

Chapter 5

CONCLUSION

OBJECTIVE THREE: IMPLICATIONS OF THE FINDINGS OF THE STUDY FOR POLICY FORMULATION

The fact that a bill is presently before parliament on National Health Insurance tells us the importance government attaches to health delivery. It is equally important at this stage to highlight some implications of the findings of a study of this nature so as to inform policy formulation. A quick look at the final draft of the 'Policy Framework' for the establishment of Health Insurance in Ghana reveals that much work has already been done. However, there are some missing links especially for the informal sector. The following are worth considering:

1. The policy states that contributions of self employed members (non SSNIT Contributors) shall be based primarily on household earnings and assets. This study has established that payment of premiums was by cash, was flexible and varied from scheme to scheme which made it affordable to members. Theimplication of this finding is that whether these modes of payment are used or not, what is important is the affordability of the premiums. There should be a mechanism of determining the affordability of the premiums so that the idea of Health Insurance can be embraced by all.

2. One of the findings of the study is that the schemes have been sustained mainly because of the support they received from DANIDA and philanthropists. This has established that there is the need for some form of seed money for schemes, especially at their formative stages. The proposal to establish a health fund is, therefore, a welcome news. It is important to make sure that the fund, when established, is well managed so as to provide the needed support to the MHOs on regular basis for their sustainability.

3. It is important to note the increasing patronage which the schemes are enjoying. This should be seen in terms of the challenges it poses to management of the schemes. To rise to the occasion, there is the need to ensure that managers of the MHOs are well trained to manage large schemes and to be able to discharge their duties effectively. Training and monitoring should be a regular feature of the activities of the management personnel of the MHOs.

4. It is an open secret that the collapse of many associations/organisations centres around mismanagement of the finances of such organisations. The study found that proper record keeping of the finances of the MHOs is nothing to write home about. Measures should, therefore, be put in place to make sure that record-keeping of the finances of the schemes are devoid of any suspicion of malfeasance.

5. During the period set aside in the proposed bill for public education aimed at creating understanding and motivation, conscious effort should be made to encourage people to form MHOs on the basis of shared characteristics such as religion, community, profession/occupation, school, etc. This is because there is evidence to suggest that people joined the schemes more on the basis of these commonalties than any other consideration. Additionally, the fixing of premium for schemes with homogeneous membership is more likely to be affordable to all in the group.

6. The policy framework recommends the setting up of a council to oversee the activities of MHOs countrywide. The council is expected to define the basic benefit package that must be provided by all health insurance schemes operating in Ghana. It is intended that the defined package would provide a compromise between what people would want and what they would need. This study has revealed that benefit packages varied from scheme to scheme but were related somehow to the premiums paid and that members in all cases had a say in determining

the package. This was a critical factor for members identifying intimately with the schemes and accounted for the relative commitment of members to the fortunes of their schemes. A lesson needs be picked from this findings in the operational determination of the benefit packages of the schemes.

7. The fact that most members studied expressed satisfaction with the operations of the schemes does not mean they do not have grievances. It only confirms the assertion that most Ghanaians do not like complaining until things get totally out of hand. There is, therefore, the need to institute complaints units not only at the national level but also at the regional and district levels to deal with grievances of members of the MHOs.

8. The study has revealed that the contributions of the MHOs towards the capacity building of health service providers was, unfortunately, very minimal. The implication of this is that with time the facilities in the service points would deteriorate and would need replacement. Provision should necessarily be made in the policy, therefore, to cater for periodic development of facilities in the health care providers so that there is no break is service.

9. The issue of public education on what MHOs are should be intensified. It is the only way of getting the people, especially those in the informal sector of the economy, conscientised and attracted to the scheme. They actually need positive attitude towards the MHOs for them to become committed members.

OBJECTIVE FOUR: RECOMMENDED AREAS FOR FURTHER RESEARCH

To further extend the descriptive literature on the performance of MHOs in the informal sector, the following recommendations for further study are presented:

1. A more comprehensive inventory of Health Insurance schemes in the country. This inventory should contain a more detailed information about all the schemes in existence.

2 A comparative study of the formal and informal MHOs. This may further elucidate discrepancies between the formal and informal MHOs with the same variables of interest.

3. A follow-up study with a more heterogeneous district sample. This is because from all indications, the national focus is now shifting to district based MHOs.

4. A nationwide survey of the schemes at the end of the fifth year after parliament succeeds in passing the National Health Insurance Act.

5. Incorporating health insurance into the operations of funeral associations/ organisations. There is no single community without a group responsible for funerals in Southern Ghana. The same, however, cannot be said of health delivery.

6. Study on the feasibility of payment of premiums in kind. (Cocoa, coffee, oil palm etc. for farmers).

7. A study into the viability of the proposed sources of contributions to the health fund (So that we do not build castles in the air).

ANNEX A

INVENTORY OF MUTUAL HEALTH ORGANISATIONS

S.N	Name Region	District/	Year	Target Group	Stage/ status	Benefit Package	Ownership	Membership (2002)
1*	St. Roses' Sec. School Health Insurance Scheme*	Kwaebibirem (Akwatia) E/R	1999	Students of St. Roses SS	Fully Operational	Inpatient and out-patient services	PTA but Co-managed PTA/Hospital	700
2	Akwatia Technical Sch. Health Scheme	Kwaebibirem E/R	2000	Students	Fully operational		Co-managed, PTA& St Dominic's Hospital	172
3	Saw-millers Health Scheme	Birim South E/R	1997	Employees of 8 sawmills	Fully Operational	OPD and Inpatients	Employers of 8 Sawmills	
4	GPRTU Mutual Health Scheme	New Juabeng E/R	2001	GPRTU members	Gestation	Inpatients members	GPRTU	44
5	Efa Emergency Health Scheme	New Juabeng E/R	2001	Community members	Gestation		Community members	
6	Nkwa Ye Health Ins. Scheme (NHIS)	Akwapim North E/R	2001	Agbenyo community members	Fully operational	Inpatient& selected OPD cases and ambulance	Community members	300
7	Asesewa Health Scheme	Manya Krobo E/R	2001	Community members	Gestation	Unspecified services	Community members	
8	Grace Presby Health Scheme		2002	Church members	Gestation	In-patients & selected out-patients	Church members	300
9	St. Mary's Voc. Training Inst. Health Scheme	West Akim (Asamankese) E/R	2001	Students of St. Mary's Voc. Institute	Fully Operational (Feb. 2002)	Inpatients & OPD	Co-managed PTA & Provider	169
10	New Abirim Susu Scheme	Birim South E/R	2001	Community members	Gestation	Sensitization	Community	
11	Okwawuman Health Scheme* E/R	Kwahu South (Nkawkaw)	2001	Community members (1-6-02)	Fully Operational OPD	Inpatients & selected Hospital	Co-managed, Community &	8441
12	Employee Credit Facility	Mampong Akwapim E/R	2001	Workers	Fully operational	Inpatients & OPD	Employer Workers &	-
13	Emergency Health Fund	Akwansram/ Abodobi E/R	-	Community members	Fully operational	In-patient & Emergencies	Community members	-
14	Awo Pa Health Scheme	Akwapim North (Adukrom) E/R	2001	Antenatal mothers	Fully operational	Deliveries, referrals & toiletry	Antenatal mothers	344
15	Dwenase Community health scheme	Kwabibrim	2001	Community members	Gestation	Inpatient & ambulance services	Community members	NA
16	Kwaebibirem District-wide Health Scheme	Kwaebibrem E/R	2001	Kade, Asoum & Dwenase Community members	Gestation	In-patients & Out-patients	Community members	
17	Methodist Mutual Health Scheme*	Koforidua Diocese E/R	2000	All church members OPD	Fully Operational	In-patients & selected	Koforidua Diocese of Methodist Church	15000

18	Mile 50 Presby Health Scheme	New Juabeng (Koforidua) E/R	2002	Church members	Gestation	In-patients &	Church	300
19	Pope John SSS Health Scheme	New Juabeng (Koforidua) E/R	2002	Students of the school	Gestation	In & Out Patients	Co-managed, Parents & Provider	-
20	Asuogyaman District Health Scheme	Asuogyaman E/R	2002	Community members	Sensitization	In & out-patients	Community members	-
21	Civil Servants Health Scheme	Regional Scheme E/R	Yet to take off	Civil servants in region	Preparatory phase	Sensitisation	Civil Servants	-
22	Rural Health Scheme	Asuom/ Dwenase E/R off	Yet to take	Community members	Preparatory phase	Sensitisation	Community members	-
23	Central Market Health Scheme	New Juabeng (Koforidu) E/R	Yet to take off	Traders	Preparatory phase	Sensitisation	Traders	-
24	Islamic Health Scheme	New Juabeng (Koforidua-Zongo) E/R	Yet to take off	Community members	Preparatory phase	Sensitisation	Community	-
25	Koforidua Dist. Presby Health	New Juabeng (Koforidua) E/R Insurance Scheme	2002	Church members	Registration in progress	Sensitisation of the church	Koforidua Presbytery Members	100
26	Lower Manya Health Scheme	(Akuse) E/R	Yet to take off	Community members	Feasibility study conducted	Sensitisation	Akuse community	-
27	Asamankese Secondary School Health Scheme	West Akim E/R	2001	Students of School	Gestation	In and out- patient	School & PTA	NA
28	New Abirim Susu Scheme	Birim North	2001	Members of community	Gestation	Selected health care services	Proprietor of the company operating scheme	NA
29	Manhyia Susu Health Insurance Scheme	Kumasi Metro A/R	2000		Fully Operational			158
30	Maternal Mortality Prevention Scheme*	Ejisu- Juabeng A/R	1996		Fully Operational			
31	As. Region Civil Servants Medical Scheme	All 18 districts (based , Kumasi) A/R	2002 (Jan.)	Civil Servants and their dependants	Fully Operational	-	Civil Servants	75000
32	Adwumakase-Kese Comm. Health Ins. Scheme*	Kwabre A/R		Community members	Fully Operational		Community members	1500
33	Micro-Care Ghana (Operates Ghana-care and Comm. HI Scheme(CHIS)	Kumasi Metro (Asokwa) A/R	1995	Community members with relations abroad & other individuals	Ghana-care fully operational; CHIS at Gestation	All inclusive health care	Managed by an NGO	200 for Ghana-care
34	Bohem Electoral Area Insurance Scheme	Kumasi Metro	2003	Community members	Formative stage	Yet to be worked out	Community	Undefined
35	Pregnant women susu scheme	Kwabre district	-	Pregnant women	Operational	Delivery services	Kwabre DHMT with private midwife	Unstable

36.	Kwabre district Health Insurance Scheme	Kwabre District	2003	Members of 97 communities	Formative Premium set and training of personnel undertaken	All inclusive healthcare	Members of the scheme	Undefined
37	Afigya Sekyere District H. Ins. Scheme	Afigya Sekyere	2003	Residents in the district	Sensitisation	Yet to be defined	District Assembly	Mem'ship drive in progress
38	St. Monica's Credit	Sekyere West	-	Women traders & artisans	Operational	Undefined	Undefined	Undefined
39	Sekyere West District H. Ins. Scheme	Sekyere West (Mampong)	2003	District wide	Feasibility studies conducted	Yet to be determined	District Assembly	Pre-mature
40	Ejisu Juaben H. Ins. Scheme	Ejisu Juaben (Ejisu)	2002	District wide	Ready for operation	Undefined	District Assembly	36,000
41	Sekyere East Dist. MHO	Sekyere East	2003	District wide	Preparatory stage	Yet to be defined	District Assembly	Pre-mature
42	Konongo-Odumase Citizens' scheme	Asante Akim North	2003	Residents at Konongo-Odumase	Sensitisation	Undefined	Residents with support of relations abroad	Pre-mature
43	Asante Akim South District H. Ins scheme	Asante Akim South	2003	District wide	Preparatory stage	Yet to be defined	District Assembly	Pre-mature
44	Bosomtwe-Atwima Kwanwoma Dist. H ins. Scheme	Bosomtwe-Atwima Kwanwoma	2003	District wide	Feasibility studies	Pre-mature	District Assembly	Pre-mature
45	Amansie East Dist. H.I.S	Amansie East	2002	District wide but community-based	Ready for operation	Undefined	District Assembly	Undefined
46	Adansi West Dist. H.I.S	Adansi West	2003	District wide	Sensitisation and preparatory stages	Yet to be defined	District Assembly	Pre-mature
47	Community Health Alliance Ins. Scheme	Adansi East	2002	District wide	Launching stage	Yet to defined	Community members	Not known
48	Antoakrom Sub-district Susu Scheme	Amansie West	2002	Pregnant women in community	Piloting	Undefined	Members	Unstable
49	District Pre-payment H.I.S	Atwima	2002	District wide	Preparatory and fund mobilisation	Undefined	District Assembly	5082
50	Community Loans Scheme	Ahafo Ano South	-	Pregnant women	Operational	Delivery services	Members of 11 communities	Unstable
51	Ahafo Ano North Dist. Ins. Scheme	Ahafo Ano North	2003	District wide	Preparatory stage	Un-defined	District Assembly	Pre-mature
52	Offinsoman H.I.S	Offinso District	2003	District wide	Feasibility studies completed	Yet to be defined	District Assembly & Traditional Council	Pre-mature
53	Integrity Associates Scheme	Accra GA/R	2001	Traders	Gestation	Selected health care	Private initiative	
54	GNTDA Health Insurance	Accra GA/R	NA		NA			
55	Dangme-West Health Scheme	Dangme-West GA/R	1998	Members of the district	Fully Operational services	OPD and inpatient initiated)	Members (though MOH	5000
56	Amenfi District Health Scheme	Amenfi W/R	2001	Members of the district	Gestation	Yet to be determined	Joint ownership-MOH and members	-

57	Juabeso Comm. W/R	Sefwi-Juabeso Health Scheme	2001	Entire members of district	Gestation	Yet to be determined	Members	-
58	Sefwi-Wiawso District Health Scheme	Sefwi- Wiawso W/R	2001	Members of the district	Gestation	Yet to be determined	Members	-
59	Organisation of Women and Development	Sekondi W/R	1999	Women	Gestation	Now being planned	-	-
60	Adausena Susu Health Scheme	Birim-North E/R	2001	Members of community	Gestation	NA members	Community	-
61	Akatsi District Health Scheme	Akatsi V/R	2001	All willing resident in the district	Gestation	Yet to be determined	Members	
62	RDHS	Ho V/R						
63	C.B Health Insurance Scheme	Nkwanta V/R						
64	DDHS	Nkwanta V/R						
65	VRHA	Ho V/R						