

The Ghanaian-Dutch Collaboration for Health Research and Development

**COMMUNITY SATISFACTION, EQUITY IN COVERAGE AND
IMPLICATIONS FOR SUSTAINABILITY OF THE DANGME WEST
HEALTH INSURANCE SCHEME**

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HEALTH INSURANCE SCHEME:**

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EXECUTIVE SUMMARY

To equitably increase financial access to health care, a District-wide Health Insurance Scheme has been in operation in the Dangme West district of the Greater Accra region of Ghana since October 2000. The per head premium was C 12,000 in the first insurance year, and C 15,000 in the second insurance year (approximately US\$ 2). To avoid adverse selection, household registration is mandatory. The benefit package consists of all ambulatory care services provided at primary care clinics in the district and referral care in hospital up to an agreed maximum ceiling that was two hundred thousand cedis (US\$ 23) in the two years under review. There is a gatekeeper system such that care provided to members in hospital will only be paid for if they first visit a primary care facility and are referred. In the first insurance year, approximately 3 per cent of the district population of about 100,000 enrolled. In the second insurance year, enrolment doubled to approximately 6 per cent of the population. Among the insured utilisation of primary care services has increased and is approximately one visit per capita per annum. This compares to a utilisation rate of 0.3 – 0.4 visits per capita per annum among the uninsured. About 2.7 per cent of scheme members are referred to hospital each year.

There has been widespread expression of dissatisfaction by some members with aspects of the scheme such as perceived poorer quality of care for insured clients. There was therefore a need to objectively assess the type and extent of problems faced by members of the scheme and their influence on registration. It was also necessary to rapidly assess whether the scheme is equitably reaching all household in the district since a major objective was to increase access especially for the poorest households who are most negatively affected by direct user fees.

The study was cross sectional, descriptive and comparative. It involved primary data collection as well as secondary data analysis in the form of retrospective routine data analysis of OPD records and the scheme's administrative data. Data was collected using Focus Group Discussions; structured

questionnaires and retrospective review of outpatient cards.

There was no difference in age, sex, or marital status between heads of ever-insured and heads of never-insured households. There was, however, a statistically significant difference in educational status and functional literacy (ability to read and write). For example, 42 percent of heads of ever-insured households had been to school as compared to 24 percent of never insured households ($p=0.000$).

It also appears that the less poor households are registering in disproportionately higher numbers than the poorest households. Proxy indicators of economic status of households based on indicators that were found to differ significantly between different income quintiles in the Ghana Living Standards Surveys and in the Ghana Core Welfare Indicators Questionnaire differed significantly between insured and uninsured households. For example 58 percent of never-insured households were using wood (which the CWIQ survey clearly showed is used by families in the poorest quintiles) as their main source of fuel as compared to 39 percent of ever-insured households. On the other hand, gas, which is used by families in the better off quintiles, was being used as the main source of fuel by 16 percent of ever-insured households as compared to 3 percent of never insured households ($p=0.000$).

Geographic access to primary care facilities also influenced the decision to enroll. Families who lived within walking distance of a primary care facility were more likely to have been ever insured as compared to families who did not (60 vs 37 percent ; $p=0.000$)

Families who had ever registered and needed medical care during the period they had coverage testified that it was a great benefit not to suddenly have to look for money to take care of illness in the family. However, some complained of being made to pay for services that were supposed to be covered at the primary care level and also at the referral hospitals. There was also a perception that insured clients were made to wait longer than uninsured clients at primary care facilities. Some members

complained that providers showed disapproval when insured clients made multiple clinic visits and made comments they found embarrassing and offensive to the effect that they were overusing the services. Some clients found the gatekeeper system inconvenient and wanted to be able to go straight to hospital especially if they lived relatively close to a hospital.

Among households who registered in the first year but did not renew in their membership in the second year, 32 percent said they did not have money or had a large household size so that the total premium was too high. Twenty percent said they were given poor reception at the health facility and 5 percent did not like the quality of drugs they were given. Fourteen percent had travelled outside the district during the registration period and missed registration

Of the households who had never registered in the scheme since its introduction, 14 percent had not heard about the scheme. Thirty-three percent had not joined because they did not have money to register and 21 percent because they did not have enough information about the scheme and did not understand it.

In conclusion, given that the less poor households are currently enrolling in disproportionately higher numbers in the scheme, there is a need to re-examine whether it is useful to have a single low premium with so much subsidy as a way of reaching the poorest households. For scheme sustainability, it may be better to have a higher premium that covers at least some if not all the administrative costs of running the scheme, and then for equity purposes, specifically identify the

poorest households and target subsidies to pay their premiums. There is also an urgent need to further address community awareness and understanding of the scheme, provider attitudes and quality of care especially at the primary care level. Lastly, improved geographic access to primary care services is likely to increase enrolment and to an extent equity given that many of the poorest households are subsistence farming households located in the most medically underserved parts of the district.

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LIST OF ABBREVIATIONS

¢	-	Cedis
CWIQ	-	Core Welfare Indicator Questionnaire
CI	-	Confidence Interval
CHPS	-	Community Health Programme Services
DHF	-	District Health Fund
DHK	-	Dangme Hewaminami Kpee
DHMT	-	District Health Management Team
FGD	-	Focus Group Discussion
GLSS	-	Ghana Living Standard Survey
OPD	-	Out Patient Department
SD	-	Standard Deviation
TBA	-	Traditional Birth Attendant

Chapter 1

INTRODUCTION

STATEMENT OF THE PROBLEM

Poor Households spend a higher proportion of their income on healthcare than wealthier households but paradoxically are less able to afford this expenditure. As a result the poor often do not visit the health facility at the onset of illness. They are managed first at home either with local herbal remedies, left-over drugs from previous health facility visits or with drugs purchased from a nearby chemical shop. These first options are tried and if they do not work, the clinic becomes the final recourse. Part of the reasons for this kind of response to illness episodes is the existence of out of pocket user fees at the point of service use. Money is not easy to come by, particularly in rural and urban poor areas. This is the situation in the Dangme West District.

In order to increase financial access to health care especially for the poor, a Community Health Insurance Scheme known as Dangme Hewaminami Kpee was developed by the DHMT in collaboration with the District Assembly of the Dangme West District. It is made up of households and individuals in the Dangme West District who have come together to contribute to a District Health Fund (DHF). Members of the scheme who have paid up fully are not expected to pay any out of pocket fee at the point of use in any of the 10 primary health care facilities in the district. They also get referral care at the hospital level to reimburse up to a maximum of ₵200,000.00.

The aim of the scheme is to make good health care accessible and affordable to every individual in the district by providing free medical care for all members. The scheme became operational in October 2000, after about four years of feasibility studies on how to implement a Community Health Insurance Scheme in the district. For the first registration period, out of a population of 96,015 in the district, 3084 people registered, representing about 3 percent of the district's

population. The registered members were from 775 households in the district. In the second year, registration doubled to a coverage of approximately 6 percent of the district population.

Unfortunately, some members of the scheme have expressed dissatisfaction with the services rendered at some of the health facilities in the district and referral hospitals within the first year of its operation. Some of the factors that had contributed to their dissatisfaction include the following:

- They are being made to pay for certain services at the primary facility.
- They are receiving poorer treatment than non- insured clients.
- They are made to pay partially or fully for services at some referral hospitals contrary to agreement.

If these problems persist it will affect the scheme since more people will not be willing to join the scheme and also create the danger of losing the existing members of the scheme. This will thus defeat the scheme's aim of making every individual of the district a member and will go a long way to affect health care in the community at large.

There is a need, therefore, to determine the magnitude of the problems and help identify the health facilities or communities where these particular problems are being encountered. This will in turn help the management of the scheme to know how, and where to direct efforts to correct the problems raised.

Another reason for the current study is that one of the objectives in setting up the scheme was to increase financial access to health services especially for the poorest households who are most negatively impacted by out of pocket fees at point of service use. It was necessary to carry out a rapid assessment of the extent to which this objective was or was not being met, in order to if necessary adjust implementation strategies.

CONCEPTUAL FRAMEWORK

The conceptual framework of this study is summarized in figure 1, and explained below.

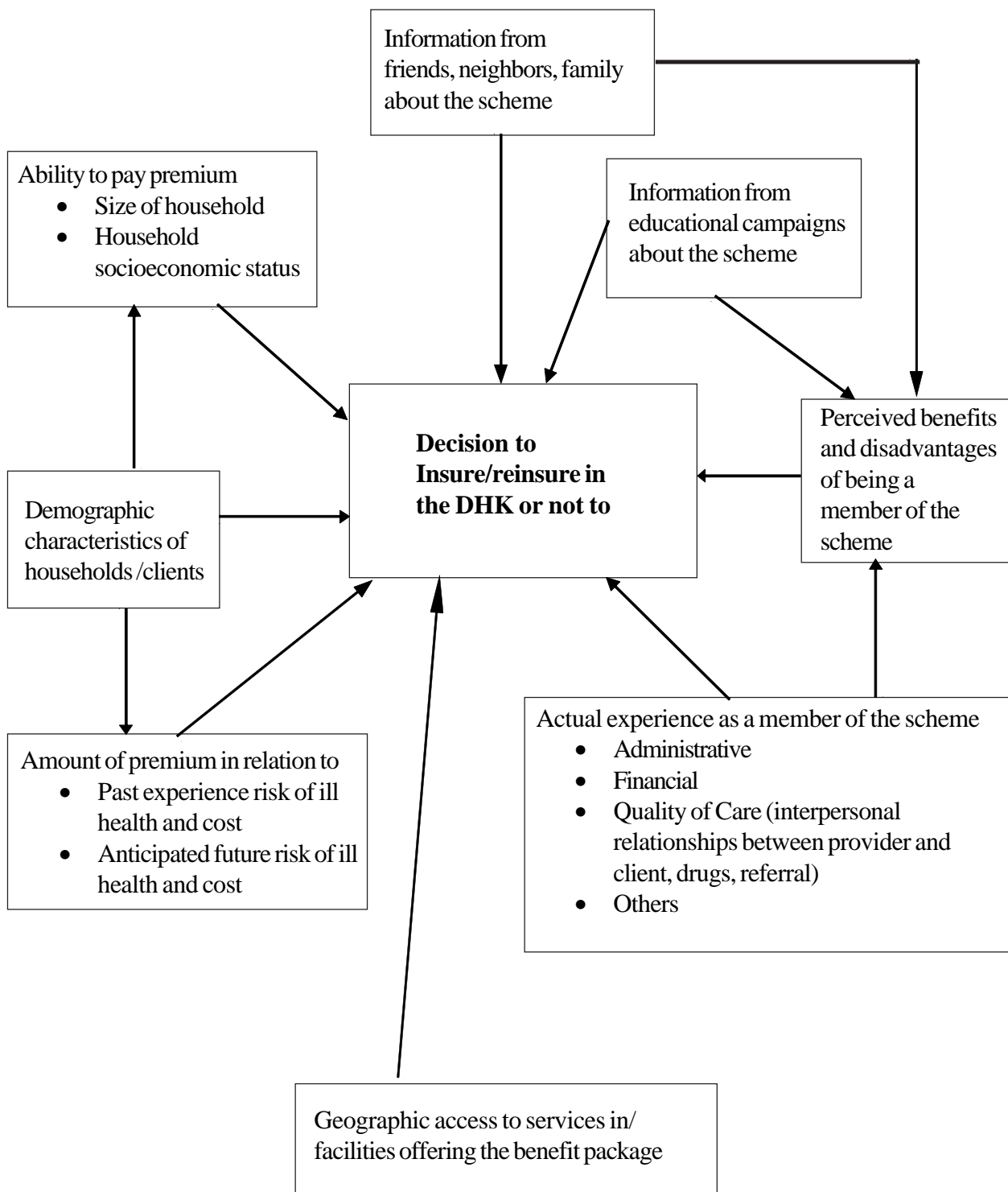


Figure 1: Conceptual framework

The conceptual model underlying the study is that the decision of a household who can afford the premium to insure in the scheme for the first time, or reinsure after the first year of participation in the scheme is related to household ability to pay the premium, household geographic access to the services offered in the schemes, benefit package, level of household risk averseness, information available and understanding of the information on the scheme and the concepts of risk sharing that underlie health insurance.

Also influencing decisions of the household to register in the scheme are their ability to afford the premium. Apart from the household's socio-economic status, since the amount of premium paid is proportional to the size of the household, the household's ability to pay the premium will be related to the size of the household. However, perhaps rather than the absolute size of the household the more important issue will be the dependency ratio of the household. A large household with most of the members in some form of employment that contributes income to the household resources may still be able to afford the premium. Thus the socio-economic status of a household is perhaps the major determining factor, and household size can affect the socio-economic status of a household, but in different directions.

RESEARCH QUESTIONS

The research questions are basically, why have some households not registered in the scheme? Is it because they have not heard about or do not under-

stand the scheme? Is it because they have had negative experiences with the scheme related to administrative or quality of care issues? Is it because in spite of the insurance, they are still being asked to pay at the facility level so that financial barriers to access still remain? Is it because geographic access to the benefit package is a problem? Or is it because the premium is unaffordable despite the fact that it is heavily subsidized?

DESCRIPTION OF THE STUDY AREA

The Dangme West district is one of the five districts in the Greater Accra region (Figure 2), and one of the two purely rural districts in the region, which have not yet been caught up by the rapid urbanization of the peripheral areas surrounding the city of Accra.

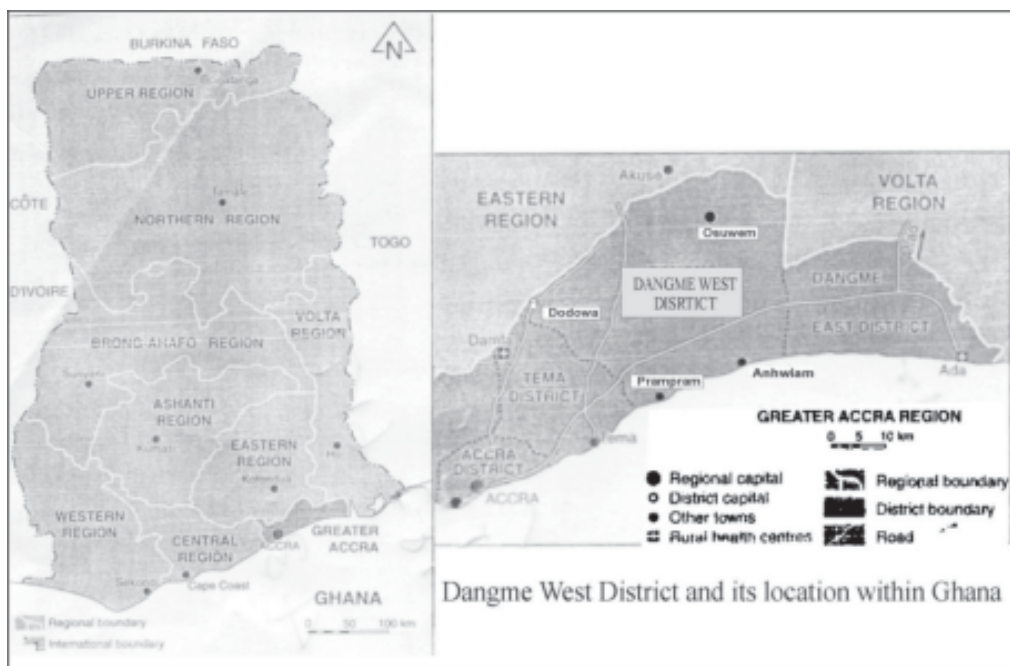


Figure 2. Dangme West District and its Location within Ghana.

Dangme West is the district with the largest land surface area (about 1,700 square kilometres) in the Greater Accra region. It is bounded on the north by the Akuapim ranges; to the south by the Gulf of Guinea, to the East by river Volta and the Dangme East district, and to the West by the Ga and Tema districts as shown in figure 2.

The land is flat and at sea level with isolated hills. Among the hills are the ancient 'Shai hills' which are a tourist attraction. The vegetation is mainly of the coastal savannah. There is a dense thicket with forest type trees in the Dodowa sub-district.

The district is divided into 7 area councils and 4 administrative sub-districts, which are:

- Dodowa (Shai) sub-district (Dodowa and Ayikuma area councils)
- Prampram sub-district (Prampram area council)
- Great Ningo sub-district (Old Ningo and Dawa area councils)
- Osudoku sub-district (Asutuare and Osuwem area councils)

The administrative sub-districts correspond to the 4 traditional areas of the district i.e the Shai, Prampram, Ningo and Osudoku traditional areas. They are also related to the District Assembly division of the district into area councils. The Dodowa sub-district corresponds to the Dodowa and Ayikuma area councils; the Prampram sub-district to the Prampram area council, the Ningo sub-district to the Old Ningo and Dawa area councils and the Osudoku sub-district to the Asutuare and Osuwem area councils. The sub-district boundaries are shown in Figure 2.

The main road networks passing through the district such as the Dodowa–Somanya road and Accra–Akosombo road are in good condition. The Accra Aflao road is in urgent need of renovation. However, most the sub-roads and the feeder roads are in very poor condition. In the rainy season there are many villages that are inaccessible except with a four-wheel drive. Sometimes at the peak of the rains, even a 4WD has difficulty accessing some of these villages. At the same time the scattered nature of the population means that a lot of effort is needed to reach a few people and good road networks are vital.

Demography

A national census conducted in the year 2000 gave the district population as 96,809. From the results of the 2000 census, Dangme West district had 3.3 per cent of the total population of the Greater Accra region. The ratio of males to females was 93:100.

Economics

The district is very poor and typical of poor disadvantaged rural districts across the country. Most of the inhabitants are subsistence farmers or fisherman. Other occupations are petty trading. There are a handful of trained artisans and craftsmen and a few civil servants mainly migrant employees of government ministries, departments and agencies.

In a study of households incomes and health expenditure in the Osudoku sub-district, Arhin (1995) found that total annual household incomes after subtracting production costs ranged from negative ¢ 1.8 million (US\$ 2,500) i.e. the household was in debt to ¢3.0 million (US\$ 4167) for 98.5 per cent of households. The mean household income was ¢ 369,800 (US\$ 513.61) and the median was ¢300,200 (US\$ 416.94). About half of the households had annual incomes after production costs of less than ¢1.0 million (US\$ 1,389). As many as 28 per cent of households were in debt after subtracting production costs.

The widespread poverty in the district affects health. Poor health status and poverty are closely interrelated in an egg and chicken fashion. Factors associated with living in poverty such as an unhealthy environment are the cause of much ill-health and are compounded by a lack of access to essential goods (e.g. nutrition), knowledge and services. The experience of ill health in turn exacerbates household poverty due to loss of income and the cost of health care. This results in a vicious cycle poverty causing poor health and poor health maintaining people in poverty.

Use of the formal health services in the district is low. In a study in the district, 50 per cent or more of cases of illness were first treated at home. The case was not taken to the formal health services. In another 20–25 per cent of cases the first thing done was consultation of a community based drug seller or non-formal sector provider. Only about 10–20 per cent of households contacted the formal sector health services as their first response to morbidity whatever the diagnosis made at the household level.

Apart from factors such as geographic access and perceived quality of care, part of the reason for the low use of formal health services in the district is the barrier posed by the cost given the widespread poverty. It is not uncommon for people referred to

hospital to delay for several hours and sometimes days because they are looking for some money to be able to go. Others may simply not go. For those who go, the health administration has received repeated complaints from some of the hospitals of clients absconding without paying their bills or lying in hospital for long periods after they have been discharged because of inability to pay.

Health Infrastructure and Providers

In the public sector, each of the 4 sub-districts that make up the district has a rural health center located in Dodowa, Prampram, Old Ningo and Asutuare towns respectively (Figure 2). In addition there are six community clinics, two in Dodowa sub-district (Doryumu and Agomeda), one in Ningo sub-district (Nyigbenya), two in Osudoku sub-district (Osuwem and Duffor) and one in Prampram sub-district (Dawhenya). These community clinics are staffed by 2 – 3 community health nurses each and currently are being used for the implementation of the CHPS programme in the district. Health services are delivered from the above-mentioned clinics as well through 103 outreach sites run by staff from the static facilities.

In the private sector, there is a private clinic in Prampram town run by a Medical Assistant (Ebenezer clinic) and another one in Afienya (Godovia clinic). There is a private midwife in Dodowa and one in Prampram.

There are 42 Chemical Sellers located in the district. These are the licensed practitioners. There is an extensive network of unlicensed practitioners and quacks in the biomedical sector located in almost every community in the district. They range from tabletop sellers of biomedical drugs such as analgesics and antibiotics to itinerant injectionsist and drug peddlers.

In the traditional sector, 106 Traditional Birth Attendants (TBAs) also provide services at the community level. There are numerous herbalists scattered all across the district.

STUDY OBJECTIVE

Main Objective

To describe community perceptions of, experience and satisfaction with the Dangme West Health Insurance Scheme (Dangme Hewaminami Kpee or DHK); ability of the scheme to equitably reach all households; and the potential influence of these on the sustainability of the scheme.

Specific Objectives

1. To compare demographic and socio-economic characteristics of ever-registered and never-registered households to assess whether the scheme is equitably reaching all households.
2. To qualitatively describe perceptions of the scheme by ever-insured households and describe benefits and problems experienced by insured clients in the first insurance year (October 2000 – September 2001) and the second insurance year (October 2001 – September 2002).
3. To quantitatively describe the extent of the problems and benefits experienced by insured clients and whether they influence the decision to renew or not.
4. To find out why some households in the district have not registered at all since the introduction of the scheme.
5. To make recommendations to the scheme administrators and executives concerning any problems identified and possible solutions.

Chapter 2

METHODOLOGY

STUDY DESIGN

This study was a cross sectional, descriptive and comparative one. It involved primary data collection as well as secondary data analysis in the form of retrospective routine data analysis of OPD records and the scheme’s administrative data.

Households in the district were divided into four groups in relation to their insurance status namely:

- Never-insured (Group 0)
- Insured in first year but not renewed in second year (Group 1)
- Insured in second year only (Group 2)
- Insured in first year and second year (Group 3)

The total numbers of households in each group are summarized as in Table 1 below.

SAMPLING

The study population was all households in the Dangme West District. Different approaches to sampling were used for the different types of data collection techniques as described below.

Focus Group Discussions (FGD)

FGDs were held with heads of households or the acting head where the head was not available. Four such discussions were held with the insured and four with the uninsured in each area council such that there was one FGD in each category per area council.

Household interviews

For the household interviews, a stratified sampling approach was used to select households. Households in the district in each of the four groups in

Table 1

Insurance Status of Households in the District

Registered Year 2 (Oct2001 – Sep 2002)	Did not register Registered	Year 1 (Oct 2000 – Sep 2001)	
		A Group 3: (431 households)	B Group 2: (1261 households)
	Did not register	C Group 1: (345 households)	D Group 0: (approximately 16,000 - 18,000 households)

DATA COLLECTION TECHNIQUES AND TOOLS

Data was collected using:

- Focus Group Discussions for insured and uninsured households.
- Structured questionnaire
- Retrospective review of outpatient cards for insured and non-insured clients

Copies of the data collection tools are attached as Appendix 2.

relation to their insurance status namely never-insured (16,000 – 18,000 households), Insured in first year but not renewed in second year (345 households), insured in second year only (1261 households) and insured in first year and second year (431 households) formed one stratum from which a random sample was taken.

The highest number of households in any of the three different groups of ever-registered households is 1261. Using StatCal in EPIINFO for a population survey or descriptive study using random (non-cluster) sampling, if the size of the population to

be sampled from is 2000 persons, the expected frequency of the event (satisfaction with the insurance scheme) is 50 per cent and the worst acceptable departure from this estimate is 40 per cent, then the minimum required sample size is 92 households at the 95 per cent Confidence Interval (CI). Based on these estimates, 100 households were selected by simple random sampling from each of the 3 groups of ever-insured. A simple random sample was possible within each group since these households are all listed in the insurance database.

Unfortunately, an up-to-date sampling frame listing each household and its location was not available for the group of the never-insured. The frame available was last updated at the beginning of 2000 and had a major error in that families are listed by the structure they are located in rather than household. This group comprised approximately 16,000–18,000 households i.e. for every household in the ever insured category, there are 8 – 9 households in the never-insured category.

A sample of this group of clients was done using cluster sampling based on the EPI cluster sampling technique i.e 7 households per cluster in 30 clusters to make 210 households total. The clusters were selected from a sampling frame comprising a list of communities /enumeration areas in the Dangme West District with their population based on the 2000 national census and obtained from the Ghana Statistical Service.

Retrospective review of outpatient records

Thirty OPD cards for insured and 30 OPD cards for the uninsured were reviewed in each of the 4 major health centres serving each sub-district for clients who used the clinic in the first insurance year (1st October 2000 – 30th September 2001); and the second insurance year (1st October 2001 – 30th September 2002). This gave a total of 240 cards of insured members and 240 cards of uninsured members.

VARIABLES

Table 2

Variables

Factor	Variable name	Variable Definition	Variable measurement
Demographic and socio-economic characteristics of clients	Age	Age in completed years as at date of interview	Years (Continuous)
	Sex		0 = Male 1 = Female
	Educational status		
	Family size	No. of members of the household where household defined as people who share economic resources i.e eat from the same pot	Discrete variable 1,2, 3, 4 etc
Geographic access to primary care clinics	Distance from nearest primary care clinic	Approximate number of kilometers travel distance by the shortest usable route to the nearest PHC clinic	Kilometers rounded off to the nearest whole number
	Travel time to nearest primary care clinic	Minutes spent by bus, taxi, bicycle or on foot	Minutes
	Mode of travel to nearest primary care clinic	Means of travel	1 = Walk 2 = Bicycle 3 = Bus /taxi
	Waiting time to get public transport to the nearest primary care clinic	Time the client must wait before a bus or taxi is available	0 = No waiting time /walk Number of minutes clients on average must wait to get a bus or taxi

Chapter 3

RESULTS

COMPARISON OF DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF INSURED AND UNINSURED HOUSEHOLDS

The first objective of the study was to compare demographic and socio-economic characteristics of ever registered (insured) and never registered (uninsured) households to assess whether the scheme is equitably reaching all households. Key background demographic and socio-economic variables that are compared between insured and uninsured households were grouped as:

- a) Variables related to demographic characteristics of head of household
 - Age
 - Sex
 - Marital status
 - Highest educational level achieved
 - Years of completed schooling
- b) Variables used as proxy indicators of economic status of the household (ability to pay premium)
 - Head of household's major source of income
 - Household assets ownership (radio, fridge, television, car/van/tractor, bicycle)
 - Fuel used for cooking
 - Housing type and quality
 - Size of household
- c) Geographic access to primary care facilities participating in the scheme
 - Nearest participating primary care facility
 - Means of getting there

Some of the tables are grouped under Appendix 1. In comparing households against these variables, households are grouped into those who have ever insured and those who have never insured for the main analysis. However, for some sub-analysis, those who have ever insured are further broken down into those who insured in the first year only, those who insured in the second year only and those

who insured in both in the second and the first year.

Demographic Characteristics of head of household and insurance status

Table 3 summarizes and compares demographic characteristics of head of household with their insurance status.

Presence of head of household in community at time of survey

Somebody other than the head of household was interviewed only if the head was unavailable in the community during the period of the survey. Where the head was temporarily out of the household, but within the community, the interviewers were requested to go back at a time when the head was back at home. In 72 per cent of all households interviewed, the head of household himself was available and was the respondent. In 21 per cent the head was not available, and the spouse was interviewed as the acting head of household. In 3 per cent of households, a child of the head was acting and was the person interviewed. In 2 households, neither the head themselves or a spouse was available and some other relative was acting.

More heads of ever-insured households were present in the community at the time of the interview than heads of never-insured households. The difference was statistically significant. Unfortunately the study did not collect data on how long the head of household had been out of the community. This would have helped to interpret the data on whether the physical presence of the head of household in the community influences whether households register in the scheme or not. Before the data was collected, it had not been anticipated that this was a variable that would make a significant difference. The observation, however, merits further investigation.

Age, Sex and Marital Status

As shown in Table 3, there was no significant difference in age, sex and marital status of heads of never-

Table 3

Demographic characteristics of head of households or their representative (where head is absent from household)

Variable	Never Insured	Ever insured (Groups 1,2 &3)	Statistical sig.of differ- ence between never in- sured and ever insured
AGE (years)			
Range	17 – 100	18 – 95	
Mean (SD)	44 (17)	42 (15)	
Median	40	39	
Mode			
SEX			
% Male	40%	47%	Chi ² =2.76
% Female	50%	53%	Pr=0.096
MARITAL STATUS			
% Married	69%	75%	Chi ² =7.72
% Single	12%	9%	Pr=0.102
% Divorced	1%	3%	
% Separated	10%	5%	
% Widowed	8%	9%	
HIGHEST EDUC. LEVEL			
Nil	42%	24%	Chi ² =38.90
Primary	18%	11%	Pr=0.000
Middle /JSS	31%	41%	
Sec. /SSS	2%	8%	
Tech./Voc./Sec.§	2%	4%	
Tertiary	4%	13%	
YEARS OF SCHOOL			
Range	0 – 22	0 – 23	
Mean (SD)	5 (5)	8 (5)	
Median	6	10	
Mode			
FUNCTIONAL LITERACY (English)			
% Able to read English	43%	66%	Chi ² =27.78
% Not Able to read English	57%	34%	Pr=0.000
FUNCTIONAL LITERACY (Local language)			
% Able to read local language	29%	55%	Chi ² =33.29
% Not Able to read local language	71%	45%	Pr=0.00
PERSON INTERVIEWED			
Head	70%	81%	Chi ² =10.43
Spouse	26%	17%	Pr=0.015
Child	4%	2%	
Others	0%	1%	

insured households as compared to heads of ever-insured households. Fifty percent of heads or acting heads of never-insured households were female and 53 percent of heads or acting heads of ever-insured households were female. Most heads of

household were married (69 percent never-insured and 75 percent ever insured).

Educational Status

There was a highly significant difference in educa-

tional status between heads of ever-insured and never-insured households with 42 percent of heads of never-insured households having no formal education as compared with 24 percent of heads of ever-insured households. Whatever way the data is analysed, there is a highly significant difference in educational level between ever-registered and never-registered households. For example comparing households whose heads have had no formal education at all with households whose heads have had some formal education, the χ^2 for comparing heads of households who have had no schooling at all and heads of households who have had some schooling whether primary or higher is 20.58 with a Pr of 0.000.

Similarly, the mean number of years of completed schooling for heads or acting heads of never-insured households is 5 years as compared to a mean of 8 years for ever-insured households. The standard deviation is the same in both groups (5 years).

If the ability to read and write whether English or the local language is analysed, the same differences are observed. 43 percent of heads of household of never insured households are able to read English as compared to 66 percent of heads of ever-insured households. Twenty-nine percent of heads of household of never insured household are able to read at least one local language as compared with 55 percent of heads of ever-insured households Fig. 3.

Proxy indicators of economic status of household and insurance status

Table 4 summarises the detail related to findings on proxy indicators of economic status of households and insurance status.

Occupation

Never-insured households had disproportionately more farmers (35 percent) as compared to the ever

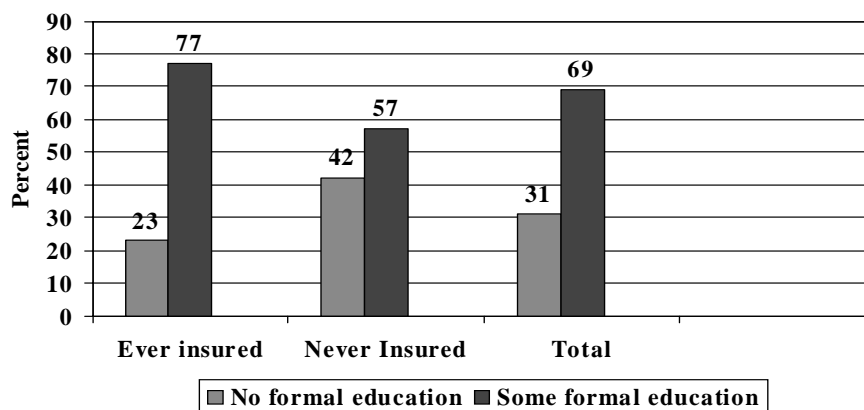


Fig. 3 Educational Status of Heads of ever-insured Households

insured (24 percent). Various living standards surveys in Ghana as well as the core welfare questionnaire indicator survey (CWIQ) have all clearly identified food crop farmers as among some of the poorest groups in Ghana. There were also disproportionately more fishermen/fishmongers (10 percent) among the never insured than among the ever insured (5 percent).

Conversely, there were more civil servants (16 percent) among the ever-insured group than the never-insured group (3 percent). Stone crackers, a group that is traditionally perceived as falling within the rural poor had a disproportionately higher number among the insured (8 percent) than among the uninsured (3 percent). The proportions of other occupational groups in the district (artisans, traders, drivers and unemployed) was similar between the insured and the uninsured.

Assets ownership

A few assets whose ownership was documented to show variation by income quintile from the various Ghana Living Standards Surveys and also from the CWIQ survey were assessed to give a rough and ready idea of household economic status. The selected assets were radio, fridge, television, car/van/tractor and bicycle ownership. Apart from bicycle ownership, and ownership of a car, van or tractor (a group that had very few households in it) assets ownership was significantly higher among the insured than among the uninsured. Conversely, there were significantly more households who owned none of these assets in the never-insured category than in the ever-insured category.

Table 4
Economic characteristics of households

Variable	Never Insured	Ever insured (Groups 1,2,3)	Statistical sig. of difference
MAJOR OCCUPATION OF HEAD			
▪ Farming	74 (35%)	72 (24%)	
▪ Fishing /fish monging	20 (10%)	15 (5%)	
▪ Civil Servant	7 (3%)	48 (16%)	
▪ Artisan	12 (6%)	28 (9%)	
▪ Trader	55 (26%)	61 (21%)	
▪ None /Unemployed	24 (11%)	22 (8%)	
▪ Driver	11 (5%)	18 (6%)	
▪ Stone cracker	6 (3%)	23 (8%)	
▪ Others	1 (0%)	7 (2%)	
ASSETS OWNERSHIP (% with)			
▪ Radio	68%	77%	Chi ² =5.56; Pr = 0.016
▪ Fridge	10%	31%	Chi ² =29.31; Pr = 0.000
▪ Television	19%	38%	Chi ² =22.01; Pr = 0.000
▪ Car /Van /Tractor	6%	10%	Chi ² =2.13; Pr = 0.144
▪ Bicycle	27%	26%	Chi ² =0.00; Pr = 0.955
▪ None of the above	29%	16%	Chi ² =11.04; Pr = 0.001
▪ Cattle	11%	5%	Chi ² =6.96; Pr = 0.008
COOKING FUEL			
▪ Wood	122 (58%)	114 (39%)	Chi ² = 34.06
▪ Gas	6 (3%)	48 (16%)	Pr = 0.000
▪ Charcoal	82 (39%)	129 (44%)	
▪ Electricity	0 (0%)	2 (1%)	
▪ Kerosene	0 (0%)	2 (1%)	
HOUSING MATERIAL			
▪ Unplastered mud walls	67 (32%)	25 (8%)	Chi ² =48.88;
▪ Plastered mud walls	30 (14%)	48 (16%)	Pr = 0.000
▪ Cement blocks /bricks	105 (50%)	215 (73%)	
▪ Aluminium	7 (3%)	5 (2%)	
▪ Wood	1 (0%)	2 (1%)	
ROOFING MATERIAL			
▪ Thatch	54 (26%)	29 (10%)	Chi ² =23.64;
▪ Zinc/Aluminium/Asbestos	153 (73%)	264 (89%)	Pr = 0.000
▪ Mixture	3 (1%)	2 (1%)	
HOUSING WITH:			
▪ Window Mosquito netting	47%	70%	Chi ² =28.33; Pr = 0.000
▪ Ceiling	29%	45%	Chi ² =13.62; Pr = 0.000
OTHERS			
▪ % who own house	66%	47%	Chi ² =17.13; Pr = 0.000
▪ % who pay rent			
HOUSEHOLD SIZE			
▪ Range			
▪ Mean (SD)			
▪ Median			

Cooking fuel

The CWIQ survey found that the type of fuel used for cooking varied significantly by income quintile with the poorest households using wood fuel and the best of households using electricity or gas.

Households in-between used charcoal.

The data from the households survey showed a significant difference in fuel use between ever-registered and never-registered households. Fifty

eight percent of never-registered households used wood for cooking as compared to 39 percent of ever-registered households. Conversely, 16 percent of ever-registered households used gas for cooking as compared to 3 percent of never-registered households. Charcoal use was similar with 39 percent of never-registered households and 44 percent of ever-registered households using charcoal for cooking.

Housing quality

Housing quality was also used as an indirect indicator of economic status. The findings were similar to the findings on the other indicators of economic status. There were significantly higher numbers of household with poorer housing quality e.g. unplastered mud walls, no ceiling or mosquito screening, thatch roofs, in the group of never insured than in the group of ever-insured.

Family size

Family size is put under proxy indicators of economic status even though it could also be put under background demographic characteristics of households because in the FGD some respondents made comments about the financial difficulties inherent in registering large households. The analysis, however, does not suggest that household size is influencing the decision to register. This may be because household size in and of itself may not make a difference. It makes a difference depending on the economic status of the large household. Perhaps those who complained about this in the FGD were people in poor large households. People in relatively well off large households may not have a problem.

Geographic access to primary care facilities and insurance status

Geographic access to primary care clinics appears to be an important factor influencing registration. Overall, 50 percent of respondents lived within walking distance of a primary care clinic, however, there were differences between the ever-insured and

the never-insured. Those who lived within walking distance of a primary care clinic were significantly more likely to have enrolled in the scheme than those who did not. Thus 60 percent of the ever registered lived within walking distance of a primary care clinic as compared to 37 percent of the never-registered, Fig. 4.

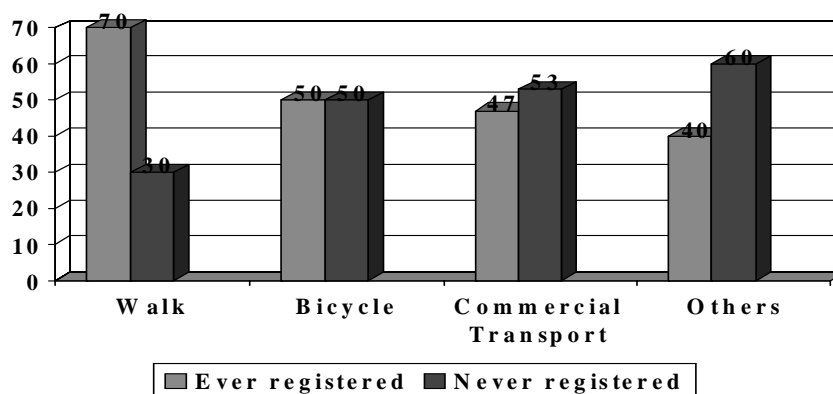


Fig. 4 Mode of Transport to the nearest Primary Clinic and Registration Scheme

QUALITATIVE ANALYSIS OF PROBLEMS AND BENEFITS OF THE SCHEME AS PERCEIVED BY COMMUNITY MEMBERS

The second objective of the study was to qualitatively describe administrative, financial, quality of care and any other problems and benefits experienced by insured as well as non-insured clients in the first insurance year (October 2000 – September 2001) and the second insurance year (October 2001–September 2002).

In order to answer this objective, focus group discussions were organised in all the four sub districts. Perceived benefits and problems with the scheme can be grouped as related to the following areas

- Financial
- Quality of Care and
- Administrative

In the presentation that follows, financial benefits and quality of care benefits are described. This is followed by a description of financial problems and quality of care problems and finally administrative problems.

Financial Benefit

From the focus group discussions for the community members, the Scheme has been helpful to them financially since they can visit the health facilities for medical treatment during emergencies even when they have no money. The problem of self-medication due to financial problems, which sometimes resulted in untimely death, has also become a thing of the past for the insured. This is a quote from a member of the focus group discussion at Dodowa New Town:

Ever since we registered I have never used my card but my household members have been visiting the clinic without paying anything, and my wife delivered a baby free of charge”.

Another member also had this to say

A relative who is a member had her child referred to Battor. When they were leaving Ningo to Battor, the mother had nothing on her but the green card. The child was treated at Battor where the scheme paid ₵200,000.00 for her and she paid about ₵50,000.00 difference. If it were not to be this scheme, we would have been in a hot soup.

Another member who was asked about her experience with the scheme had this to say

My father who was referred to Battor had both his transportation cost and Battor expenses settled without paying anything.

Quality of Care Benefits

In terms of quality of care some members of the FGD said they were taken good care of and sometimes asked to come for review. This was what one client had to say:

Personally, I don't have any problem with the use of the card. They always take very good care of me when I visit the clinic. The last time I visited the clinic they even asked me to come back for a review.

I for one when I go, they treat me and ask me to go for lab tests and after that I am given drugs

which really cures me.

The Catechist in Doryumu also went to Dodowa and came to praise the scheme. She was given enough drugs.

One member had this to say in explaining how beneficial the association (scheme) had been to them and why they felt it is good to be part of it:

We joined because, two (2) hands are better than one in raising things.

Financial Problems

In spite of the above-mentioned benefits enjoyed by insured client, there were some problems as well. Some clients said they were made to pay for some service, which according to them were supposed to be covered under the scheme such as laboratory investigations.

There were also problems related to ‘gifts’. This is what one member had to say in relation to this problem:

But recently my daughter went to deliver and the nurse took some money from her (₵15,000). My husband asked me whether we paid any money, and I told him what happened. He wanted to take the matter up, but I objected. Later, my husband mentioned it to one of the nurses when he was having a chat with her and the nurse also questioned her colleague about her conduct. I was in my shop one afternoon when the nurse came and threw the ₵15,000 and other gifts I gave to her at me. Since then, our cordial relationship has broken.

Quality of Care Problems

From the focus group discussions, most of the problems Community members had, had to do with Quality of Care. They complained of the following.

- Sitting for long periods before being treated
- Staff frowning at green card holders
- Prescription of cheaper and fewer drugs for health insurance clients

The following are some of the comments from community members related to these issues.

But other people complained to me that after the first three visits, any time the nurses see you with the green card they don't mind you. Sometimes you will all be sitting in a queue on the same bench and people who came after you and are not using the green card will be treated before you.

They sometimes frown as they see you with the green card, especially when you have been there before.

The first time I went there with my card, two nurses asked me a rhetorical question that "Green Card again?" So I thought of it and realized maybe there was something wrong somewhere. The second time I went there another patient also came with the Green Card and some of the nurses said, these people are disturbing us with their Green Card. Because they are not paying, the least thing that happens to them they pick up their cards and come.

But the next time I took the younger one there when we got to the table where temperature and weight are taken the nurse said we are disturbing them with the Green Card because we just get up and pick up our green cards and come for treatment.

I was made to wait for several hours before consultation. Meanwhile people who came after me and were not holding Green Cards were treated and sent home before me. Later I was given paracetamol syrup, chloroquine syrup, and B'co syrup. I fell sick myself and visited the clinic again, I was delayed again and was given paracetamol, chloroquine and B'co without being told what was wrong with me. Also, they did not ask me whether I was allergic to chloroquine or not. I later went to the drug store to purchase drugs. I realise that the nurses are doing these things to frustrate us because they are not getting any money directly from us.

Administrative Problems

Some of the problems insured client had with the administration of the scheme was the absence of referral letters sometimes when clients had to be re-

ferred; and the gate keeper system not being convenient. A member had this to say in an FGD organised at Dodowa New Town about inconveniences related to the need for a referral note.

My sister fell sick one night and was rushed there (clinic) and needed a drip. But after the first one was administered the nurses realised they had to refer her to a hospital, but they said they didn't know where the referral cards were. So they asked us to go to the Referral hospital and come back with the bill for refund. Later, when we brought the bill they did not refund it to us. The medical assistant later told us that we should not worry but we should be happy that our sick sister has now recovered. This is the only problem I have.

Another Community member who started but never completed registration said this in an FGD at Asutsuare about inconveniences related to the gate-keeper system.

We paid ₵40,000.00 as part payment. A sister who has the card and stays closer to Akuse (Dormeliam) than Asutsuare was sick and went to Akuse hospital but was asked by the Doctor there to come for referral card at Asutsuare because she must attend any of the health centres/clinic in the district before being referred. She complained that the way she was feeling, Akuse is closer than Asutsuare. She said a lot about the scheme which made me lose courage in registering, so my ₵40,000.00 is still with the registrar.

QUANTITATIVE ANALYSIS OF EXTENT OF PROBLEMS AND BENEFITS

To quantitatively and objectively analyse the extent of the problems and benefits identified from the qualitative work, a structured questionnaire was administered to household members. At the clinic level, a retrospective audit of OPD cards was carried out to see if there were any documented statistically significant differences between the treatment of insured and uninsured clients.

Household interview data

The third objective of the study is to quantitatively

describe the extent of the problems and benefit received by ever insured households and whether they influenced their decision to renew or not as in Table 5.

From the table above, out of 100 households who were interviewed who registered in the 1st year but did not renew their membership in the second

membership. Seven percent said they renewed because it save money. Five percent said they wanted health security. Four percent said they renewed because they had money and also 4 percent said they renewed because they fall sick and 3 percent said they renewed their membership because they understood the scheme.

Table 5

Household Interview Data

Reason	1st year but not renewed Reasons why some households renewed their membership (%)	1st year and renewed in 2nd year Reasons why you renewed your membership (%)
Wanted free medical care	27	32
Saves money	27	7
Affordable / low premium	19	21
Wanted health security	16	5
Can't tell	6	10
Scheme is good	2	14
Has money	1	4
Falls sick	1	4
Understood scheme	1	3
TOTAL	100	100

year, this is what they had to say as to why some household renewed their membership. Up to 27 percent of them said they think some households renewed because they wanted free medical care and also 27 percent said it saves money. A good 19 percent of them said they think others renewed because of affordable / low premium while 16 percent said they think it is because they wanted health security. Six percent of them could not tell why some households renewed their membership. One percent each said they think they had money, understood the scheme and falls sick and they think this is why they renewed their membership.

For those who enrolled in the first insurance year and renewed their membership in the second insurance year, these are the reason they gave.

Thirty-two percent of them renewed because they wanted free medical care. Twenty-one percent renewed because the premium was affordable / low for them. Fourteen percent said the scheme is good and this is why they renewed their membership. Ten percent said they can't tell why they renewed their

Retrospective review of OPD cards data

A retrospective analysis of OPD cards from five health facilities in the district shows that there was no difference in treatment relating to: Temperature recorded, BP recorded, Weight recorded. Client examined & results recorded, diagnosis recorded, numbers of drugs per prescription and prescriptions with antibiotics.

However, there was a significant difference in whether an injection was given. That is 14 per cent of never-insured clients were given injection as against 7 percent of ever-insured, p=0.000.

REASONS FOR NON REGISTRATION OF HOUSEHOLDS

Objective 4 of the study sought to find out why some households in the district have not registered at all since the introduction of the scheme. The issue was initially explored in the Focus Group Discussion and the extent of the documented problems assessed with a structured questionnaire.

Findings from the Focus Group Discussion (FGD)

In the Focus Group Discussion with the never-registered in the district it came to light that some households in the district did not register because of the following:

- Understanding of the scheme/Lack of information
- Financial barriers
- Quality of care for the insured
- Households not risk averse
- Have never heard about the scheme

Understanding of the scheme/lack of information

Some households have not joined the scheme at all since its introduction although they have heard about it because they do not understand what the scheme is about and how it works. Even during the FGD some discussants were seeking clarification as well as asking questions concerning how the scheme operates. Some of the clarifications and questions asked by participants who said they did not understand what the scheme was all about included questions like:

Is there no particular hospital/Doctor that works with the scheme?

Does (that means that) the scheme caters for members who have paid their contributions alone?"

Will you pay at the referral point?

Is the contribution monthly or yearly?

Financial Barriers

Some participants mentioned during the focus group discussion that they did not join the scheme because they have big household sizes and, therefore, cannot afford to pay for all their members given that household registration is mandatory. As somebody said

I have a very large household and the scheme will not allow me to register some and leave some.

Others did not register because they don't do any meaningful work that can give them money to register.

Quality of care for the insured

From the FGD, most households did not register because of reports they have received about the way members of the scheme are being treated when seeking medical care with the card especially at the primary care levels. News, both good and bad, spread very rapidly in small rural communities. People make their decisions and opinions based in part on their neighbours' experiences. People who experienced quality of care problems discussed them with their friends and neighbours who were not insured and it strongly influences community attitudes towards the scheme even among people who had never joined.

For example, a participant said among the things they had heard were that:

Some nurses also say things like "because of the green card, any common headache, then you are coming" "you people like free things" to people who are members of the scheme.

A woman who lives close to us had bodily pains (neck and waist). She attended the clinic with the (insurance) card for three times but remained the same. So I met her and I asked her why has she stopped going to the clinic. She replied that anytime she goes, she is being given the same treatment and she once told them to refer her to Akuse (hospital). They replied by asking 'does she know better than they do'. She later went to Juapong and was treated and now she is moving about strongly. So after hearing this from the woman, I changed my mind about joining (the scheme).

Not all reports from people who had not joined the scheme had received were negative, some had received positive information.

My sister's child who is a member was treated free of charge and recovered.

I saw somebody with the card who has been treated free of charge so I will join.

One of my relatives attended the clinic and was

operated at the referral hospital. The scheme paid C 200,000 for her and she paid the difference.

Household not risk averse

Some households did not join because they felt they don't fall sick and will never seek medical treatment at any health care facility.

Have never heard about the scheme

Some households said that they had never heard about the scheme.

Findings from the household interview

Out of 210 randomly selected households from the district who had never registered in the scheme since its introduction, 29 households representing 14 percent had not heard about the scheme while 181 households representing 86 percent had heard about it.

Apart from the 14 percent of households who had never heard about the scheme, other reasons why households had never joined the scheme included the following:

- Understanding of the scheme/
Lack of information

- Financial barriers
- Quality of care for the insured
- Households not risk averse

Up to 33 percent have not joined because they don't have money to register (financial barriers), 21 percent because they lack understanding of the scheme as well as enough information about the scheme. Figure 5 summarizes these reasons why some households have not joined the scheme at all since the introduction.

Table 6 summarises the sources of information through which the never-registered households who had heard about the scheme heard about it. Multiple

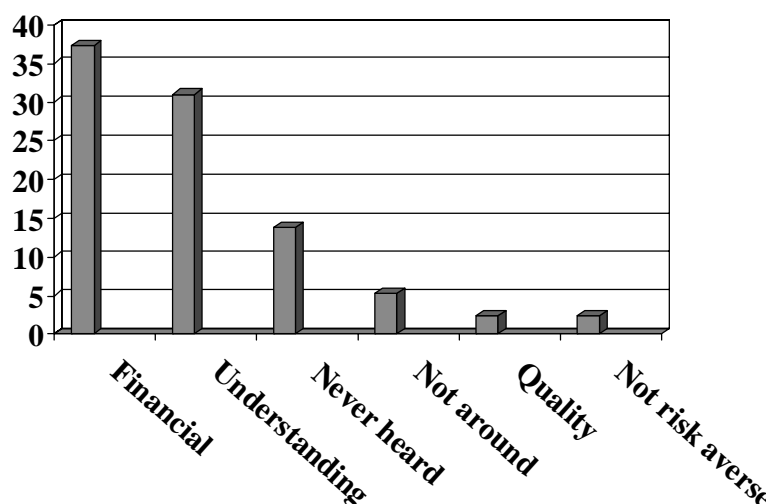


Fig. 5: Reasons for never registering

Table 6
Source of information

Source of information	Freq1 (%)	Freq2(%)	Freq3 (%)	Freq4(%)	Total Freq	Total %
Friends	14 (7.70)				14	7.70
Neighbours	27 (14.85)	1 (2.70)			28	15.40*
Household members	8 (4.40)	2 (5.41)			10	5.50
Radio	17 (9.35)	4 (10.81)			17	9.35
Leaflets/brochures	1 (0.55)	1 (2.70)			2	1.10
Health staff	60 (33.00)	6 (16.22)	4 (44.44)		70	38.50*
Area Council committee members/community educators/Drama	8 (4.40)	2 (5.41)			10	5.50
Gongon beating	1 (0.55)		1 (11.11)		2	1.10
Information Van	19 (10.45)	9 (24.32)		1 (100)	29	15.95*
Registration officers	18 (9.90)	9 (24.32)	4 (44.44)		31	17.05*
Assembly man	6 (3.30)	1 (2.70)			7	3.85
Sign board	2 (1.10)	2 (5.41)			4	2.20
Total	181 (100)	37 (100)	9 (100)	1 (100)	227	109.34

responses were allowed and the total number of responses was 281 from the 181 respondents who had heard about the scheme. The percentages in the table were calculated using as a denominator the total of 181 respondents that have heard about the scheme.

The table shows that information concerning the scheme was received mostly through the health staff (39 percent) followed by the registration officers (17 percent), then by Information Van (16 percent) and then through neighbours (15 percent).

Out of the 181 households that heard about the scheme 134 had heard from at most one source, 37 households heard it from at most two sources, 9 from at most three sources and one from at most four sources.

At the end of the interview with every respondent, through questioning and answering all the 210 respondents were now aware of the scheme and said they understood what it was all about. They were asked their opinion of the scheme now that they understood what it was all about. Eighty-four households (40 percent) of respondents felt it was a very good idea and 121 households (58 percent) felt it was good. Thus once they understood, the idea of the Dangme West Health Insurance Scheme had a 98 percent acceptability rating among households who had never heard about it. One household felt the idea of the scheme was poor/bad, two households felt it was somewhat good, and two households said they could not tell /were uncertain.

DISCUSSION, CONCLUSION AND RECOMMENDATION

DISCUSSION

Equity in Access / Coverage

The statistically significant difference in educational status and functional literacy between heads of ever-insured households and heads of never-insured households, with higher registration in household's with more literate heads is perhaps not a completely unexpected phenomenon. There is, however, generally a link between educational status and literacy of the head of the household and poverty. It is possible that the statistically significant difference in educational status and literacy of the insured and the uninsured is closely related to the other key observation that the poorest households are registering in disproportionately lower numbers than the less poor households.

A detailed assessment of household economic status using consumption, assets ownership or a combination, is time consuming, expensive and involved an undertaking that was beyond the resources of this study. The assessment of household economic status used in this study was very much a rapid appraisal using simple measurement of some key assets ownership found to be related to income quintile from the Core Welfare Indicators Questionnaire Survey (CWIQ) and the Living Standards Surveys of the Ghana Statistical Services, rather than precise grouping of households into income quintiles. The information is useful nevertheless. On virtually all the indicators of assets ownership, there is a statistically significant difference between ever insured and never insured households, with disproportionately more of the never-insured households falling into the poorer households.

The fact that the information from the analysis of assets ownership is probably valid is further supported by the information from occupational status. Never insured households had disproportionately more farmers (35 percent) as compared to the ever-insured (24 percent). Most farmers in the district are subsistence farmers

practising non-mechanized labour intensive rain fed agriculture. Various living standards surveys in Ghana as well as the core welfare questionnaire indicator survey (CWIQ) have all clearly identified food crop farmers especially in the Savanna zones as among some of the poorest groups in Ghana. Dangme West district falls within the coastal savannah zone of Southern Ghana. Even though the poverty levels in Southern Ghana overall and especially in the Greater Accra region are much better than in Northern Ghana; in micro geographic areas such as among food crop farmers in the coastal savannah observation from working among some of the communities suggests that the aggregate regional data is hiding pockets of deep poverty that approach in some cases that of the North.

The premiums in this scheme are highly subsidized and currently do not cover administrative costs. The idea was to keep them as low as possible to provide access to the poor. However, the data suggest that the poorest are not entering the scheme. It may be that the premiums are unaffordable for the poorest. However, there may be other factors. Equity of access is a complex function of many variables and not just the absolute cost of access to care. The difference in education already discussed is to an extent an equity factor since literacy increases access to information that can empower households. Education and literacy also enhance in some cases access to an income.

Another factor is geographic access to primary care services. The data clearly shows that the further off people are geographically from a primary care facility, the less likely they are to register in the scheme. The influence of geographic access to services on utilisation is not a new finding. We suspect that in Dangme West, the issue of equity of access of the poorest households to the scheme is also tied to the issue of equity of access of the poorest households to primary care services. It is the poorest and most remote rural communities who also have the least ready access to primary care facilities.

Perceptions of the scheme, problems and benefits of ever-insured clients

Despite the clearly perceived benefits of the scheme, a major finding of this study is that quality of care is proving a significant barrier to satisfaction with and registration in the scheme by community members. Major problems related to quality of care from the community perspective are interpersonal relationships with providers and perceived quality and effectiveness of drugs prescribed.

An important factor influencing the provider reactions to insured clients and their increased utilisation of primary care facilities is the issue of 'personal provider incentives' as against 'institutional incentives'. In the current public sector system in Ghana, where providers are paid a fixed salary, the personal provider incentive is similar to the incentive under a system of capitation – reduce the volume of services (frequency and quantity). Essentially a salary is a form of capitation. Extra money earned by the facility as a result of increased workloads goes into the institutional account and does not bring a proportional personal gain to providers per se. Their workload goes up for the same remuneration. In the Dangme West district OPD utilisation overall has remained constant at an extremely low level of between 0.3 and 0.4 visits per capita for several years now. This is similar to reported utilization from much of the public sector in Ghana. After the insurance scheme was introduced in 2000/2001, utilization for the insured rose to 0.9 visits/capita in year 1 and 1.35 visits per capita in year 2. The provider reactions has been "Insurance clients are overusing the facility and creating too much work for us." Essentially, they do not see any benefits from the scheme and increased utilisation is a problem rather than a blessing.

In theory when providers are paid by fee for service as is being done in the Dangme West Scheme, they have an incentive to increase amount and frequency of services provided. In practice in the public sector (Ghana Health Service), the money does not really flow to the 'provider' as an individual. It flows to the institution. There is, therefore, no real individual provider incentive to increase volume and frequency of services. Providers are paid by a monthly salary that stays the same regardless of the volume of work they carry out. What flows directly

to the provider as an individual and are related to the volume of work carried out, in the cases where providers collect them, are illegal fees. It must be mentioned that though some providers collect under-the-table fees, it is not all providers who do so. For those providers who do collect under the table fees, the current out of pocket itemized fee payment system with multiple payment points provides a cover for these illegal fees since they can be collected 'under the shadow' of the legal system. In an insurance system such as the one which has been introduced in the district, where no direct cash transactions occur at the facility level, it is much harder if not impossible, to cloak illegal fees. Thus even this 'illegal' provider incentive to increase volume of services and thus welcome increased utilisation will disappear.

Perceptions of the scheme, Reasons for never registration of some households

Information travels rapidly in small rural communities and people base their decisions on the experience and reports of their neighbours. The negative experiences with provider attitudes and quality of care of the few households who have ever-registered in the scheme seem to outweigh the positive experiences and is a source of discouragement to register for some households.

In addition, it would appear that information, education and communication about health insurance and the scheme is still very inadequate. The percentage of households who have never heard about a scheme that is in its third year of operation is high.

CONCLUSIONS

In conclusion, we briefly summarize the implications of the study findings for equity in coverage with health insurance for the non-formal sector, increase uptake (registration) in district insurance schemes and scheme sustainability.

The poor suffer most from the effects of out of pocket payments for health care at point of service use. Even in 'poor' rural areas households are not all uniformly poor, and can be stratified into the poorest and the not so poor as well as the few households who could actually be classified as

wealthy. This scheme has tried to reach all households in the district by keeping the premiums very low across and subsidizing the premiums. Given that the less poor households are currently enrolling in disproportionately higher numbers in the scheme, there is a need to re-examine whether it is useful to have a single low premium with so much subsidy as a way of reaching the poorest households. For scheme sustainability, it may be better to have a higher premium that covers at least some if not all the administrative costs of running the scheme, and then for equity purposes, specifically identify the poorest households and target subsidies to pay their premiums.

Quality of care is an issue that is of great concern to almost all community members. It appears that the financial barrier is a relative one, and the extent to which payment for services is a barrier is somewhat related to the perceived quality of the service. Part of the quality of care is a human resource as well as material resource problem. If insurance is to succeed in the study setting it is important to address quality of care. This is also another reason for raising the premium to generate more funds for quality improvement.

There is also an urgent need to further address community awareness and understanding of the scheme.

Lastly, improved geographic access to primary care services is likely to increase enrolment and to an extent equity given that many of the poorest households are subsistence farming households

located in the most medically underserved parts of the district.

RECOMMENDATIONS

- (1) Calculate and apply a more realistic premium that covers service provision as well as administrative costs to the Dangme West Health Insurance Scheme
- (2) Look for financing to improve the quality of the health services especially at the primary care level rather than financing to subsidize the administration of the insurance scheme
- (3) Look for financing to improve geographic access to services especially in the poorest parts of the district which are currently more underserved rather than financing to subsidize the administration of the scheme
- (4) Identify the poorest households and target premium subsidies to them to be able to pay the realistic premium
- (5) Develop and implement an extensive and sustained awareness raising campaign in the district to create understanding of the concepts of health insurance and risk sharing among households in the district
- (6) Dialogue with providers especially at the primary care level about their interpersonal relationships with clients and develop with them interventions to improve their interpersonal relationships with clients

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APPENDICES

APPENDIX 1

Appendix 1a Geographic Access to Primary Care Facilities

Variable	Never Insured	Ever insured (Groups 1,2 &3)	Statistical sig.of difference between never insured and ever insured
MODE OF TRAVEL TO CLINIC			
▪ Walk	77 (37%)	178 (60%)	Chi ² = 27.68 Pr = 0.000
▪ Bicycle	10 (5%)	10 (3%)	
▪ Commercial transport	120 (57%)	105 (36%)	
▪ Others ¹	3 (1%)	2 (1%)	
WAITING TIME (COMMERCIAL TRANSPORT) in minutes			
▪ Range	1 – 120	1 – 180	
▪ Mean (SD)	64 (37)	74 (39)	
▪ Median	60	99	
▪ 10 minutes or less	21 (17%)	41 (39%)	
▪ 11 – 30 minutes	52 (43%)	41 (39%)	
▪ 31 – 60 minutes	37 (31%)	16 (15%)	
▪ Over 60 minutes	10 (8%)	7 (7%)	

¹Apart from one person in the uninsured group whose mode of travel to the nearest clinic was by canoe all the rest in the ‘others’ group had a private car if they needed to go to the clinic.

Appendix 1b Reasons why some household did not renew their membership

Reason	Registered 1 st yr but did not renewed 2 nd yr	1 st yr and renewed 2 nd yr
No money	32%	27%
Poor reception	20%	19%
Poor drugs	5%	16%
Traveled outside the district	14%	2%

Appendix 1c Results of OPD card review

VARIABLE	Ever Insured	Never insured	Chi ²	Probability
Temp. Recorded	95%	92%	2.33	0.127
BP Recorded	44%	53%	4.37	0.037
Weight Recorded	66%	58%	4.09	0.043
client examined & Results Rec	48%	50%	0.376	0.539
Diagnosis Recorded	88%	83%	2.66	0.103
Injection given	7%	14%	8.05	0.005
Antibiotic given	14%	17%	0.807	0.058
Age				
Range	0 - 90	0.6 - 91		
Mean	25.63	22.7		
Median	22	20		
Mode				
Standard deviation	19.7	19.7		
Sex				
Male	50	50		
Female	50	50		

Appendix 1d

Reasons why some households have never joined the scheme

Reason	Frequency	Percentage
1. Understanding of the scheme/Lack of information		
Lack of understanding	44	20.95
Did not hear about registration period	6	2.86
Don't know registration officer/registration officer don't come to us		
2. Financial barriers	15	7.14
Poverty/Lack of money	80	33.10
Expensive premium	3	1.34
Large household size/mandatory household registration	6	2.86
3. Quality of care for the insured§		
Alleged/perceived inadequate or poor treatment for subscribers	5	2.38
4. Households not risk averse		
I don't get sick	5	2.38
5. Have never heard about the scheme	29	13.81
6. Not around	11	5.24

7. Can you read at least one of the local Languages?
0 = No 1 = Yes
8. If yes which of them?
1) Dangme 2) Ga 3) Ewe 4) Akan 5) Fante
6) others specify 99) N/A
9. Can you write at least one of the local Languages?
0 = No 1 = Yes
10. If yes which one?
1) Dangme 2) Ga 3) Ewe 4) Akan 5) Fante
6) Others specify 99) N/A
11. Can you Read English? 0 = No 1 = Yes
12. Can you Write English? 0 = No 1 = Yes
13. How many people are there in your household?

***Household is defined as people who share economic production and resources.
i.e. eat together, live together etc***

DEMOGRAPHIC AND SOCIO-ECONOMIC INFORMATION

14. What is the nearest Health Insurance Participating Clinic from where you live?
1) Dodowa Health Centre 2) Asutsuare Health Centre
3) Prampram Health Centre 4) Ningo Health Centre
5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
11) Ebenezer Clinic 12) Afiencya Clinic.
15. How do you get there? 1) Walk 2) Bicycle
3) Commercial transport 4) others (specify).....
16. If you take public transport do you have to wait by the roadside for a Car?
0 = No 1 = Yes N/A(does not take commercial transport)
17. How long on the average do you have to wait if you take commercial transport?
..... (N/A i.e. does not take commercial transport)
18. What work provides Head of Household's major source of income?
1) Farming 2) fishing/ fish monging 3) civil servant
4) Artisan 5) trader 6) none
7) Unemployed 8) Driver 9) Others (specify)...

19. Is there any other work he / she does that provide a secondary source of income?
 0 = No 1 = Yes 99) N/A
20. If Yes, what work?
21. Does your Household own any of the following Assets in working condition?
 Radio [1]
 Fridge [2]
 Television [3] NB: Circle if they have the asset(s)
 Generator [4]
 Car/Van/Tractor [5]
 Bicycle [6]
 None of the above [7]
22. What fuel do you commonly use for cooking?
 1) Wood 2) gas 3) charcoal 4) Electricity 5) kerosene
23. Does your Household own Cattle? 0 = No 1 = Yes
24. If yes how many?
25. What type of building material is your house made of?
 1) Unplastered mud walls 2) Plastered mud walls
 3) Cement blocks/ bricks 4) Others, specify
26. What type of material is used for the roofing of your house?
 1) Thatch 2) Zinc/ Aluminum/ Asbestos 3) Mixture of 1) and 2)
27. Does your house have Mosquito netting over Windows? 0 = No 1 = Yes
28. Does your house have Ceiling? 0 = No 1 = Yes
29. Does your Household own the House you live in? 0 = No 1 = Yes
30. If No, do you pay rent? 0 = No 1 = Yes
 99 = N/A (household owns the house they live in)

REGISTERED IN 1ST YEAR AND RENEWED IN 2ND YEAR
 INFORMATION ON HEALTH INSURANCE

1. How did you hear about the Dangme Hewaminami Kpe? (Select as many as possible)
- 1) Through friends 2) through neighbours
 3) Through household members 4) Through Radio
 5) Through leaflets/ brochure 6) Through Health Staff
 7) Area Council Committee members/ Community Educators/Drama

- | | |
|---------------------------|---------------------------|
| 8) Gongon beating | 9) Information Van |
| 10) Registration officers | 11) Assembly man |
| 13) Teachers | 14) Others (specify)..... |

2. Are there any **special reasons** why you renewed your Membership?
 - 1) Wanted free medical care
 - 2) Wanted Health security
 - 3) Affordable/low premium
 - 4) Scheme is good
 - 5) Save me money
 - 6) Can't tell

3. Did you also renew your membership in the third year (2002/2003)?

0 = No 1 = Yes

4. If No are there any **special reasons** why you did not renew your membership?
 - 1) No money
 - 2) Good drugs are not given
 - 3) Poor reception for those with the Green card
 - 4) Travelled outside district
 - 5) Other (specify)
 - 99) N/A

5. In your opinion, are there any **special reasons** why some households did not renew their Membership in 2001/2002 (2nd year)?
 - 1) No money
 - 2) Good drugs are not given
 - 3) Poor reception for those with the Green card
 - 4) Travelled outside district
 - 5) Can't tell
 - 6) Other (specify)

6. In your opinion are there any **special reasons** why some households have never joined the Scheme since it started?
 - 1) Poverty /lack of money
 - 2) Large households/dependants
 - 3) Not heard about the scheme
 - 4) Lack / poor understanding of scheme
 - 5) Can't tell
 - 6) Others Specify.....

INFORMATION ON HEALTH CENTRE/CLINIC USAGE AND DRUGS

7. Have you or any of your household members ever used their insurance card to seek Medical care?

0 = No, 1 = Yes

8. When was your most recent visit to the health centre / clinic?

- 1) This week 2) Last week
3) Two weeks ago 4) A month go
5) Others, specify..... 99) N/A

9. Which health facility / community clinic have you or any of your household Members ever used most recently?

- 1) Dodowa Health Centre 2) Asutsuare Health Centre
3) Prampram Health Centre 4) Ningo Health Centre
5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
11) Ebenezer Clinic 12) Afienya Clinic.
99) N/A

10. Do you know of any one who is a member of the scheme and have ever visited the Clinic with the card recently? 0 = No 1 = Yes

11. What would you say about the reception given you or any of your household members or any one who is a member during the recent visit to the health centre?

- 1) Very good 2) Good
3) Somewhat good 4) Poor / bad 99) N/A

12. What do you think about the quality of drugs? 1) Very good 2) Good
3) Somewhat good 4) Poor / bad 99) N/A

INFORMATION ON PAYMENTS AND BENEFITS RECEIVED

13. Have you ever been made to pay for some services at a primary care clinic?

0 = No 1 = Yes 99) N/A

14. If yes how much did you pay?

15. Which health facility?

- 1) Dodowa Health Centre 2) Asutsuare Health Centre
3) Prampram Health Centre 4) Ningo Health Centre
5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
11) Ebenezer Clinic 12) Afienya Clinic.
99) N/A

16. If yes which service(s) did you pay for?
 1) Lab 2) OPD 3) drugs
 4) Others specify..... 99) N/A
17. Did you pay any fees for which you demanded for a receipt and you were not given?
 0 = No 1 = Yes 99) N/A
18. If yes which Clinic?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afienya Clinic.
 99) N/A
19. When?
20. Have you been referred to a referral Hospital before?
 0 = No 1 = Yes 99) N/A
21. If Yes, which Hospital?
 1) Agomenya 2) Akuse 3) Atua Hospital 4) Tema General 5) Battor Hospital
 6) Ridge Hospital 99) N/A
22. Did the Insurance paid for your bills? 0 = No 1 = Yes 99) N/A
23. If no did you have to pay? 0 = No 1 = Yes 99) N/A
24. If Yes how much?
25. Did you get a refund from the Insurance Office? 0 = No 1 = Yes
 99) N/A(did not have to pay)
26. If no what was the reason?.....
27. Have you ever been referred from a Community Clinic to a Health Centre or from one Health Centre to another before? 0 = No 1 = Yes 99) N/A
28. If yes which Health Facility were you referred from?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afienya Clinic.
 99) N/A

29. If yes which health facility were you referred to?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre 99) N/A
30. How would you classify the benefits received by an insured Client at a health centre?
 1) Very good 2) Good 3) Somewhat good 4) Poor / bad 99) N/A
31. How would you classify the benefits received by an insured Client at a referral Hospital?
 1) Very good 2) Good 3) Somewhat good 4) Poor / bad 99) N/A
32. Does it cause you any problem to have to go to a primary Health Facility first ie. Not to be able to go straight to a Hospital? 0 = No 1= Yes
33. If Yes, what is the problem?
34. What are some of the problem you or any of your household members have encountered since joining the scheme?.....
35. What would you say about the current premium? 1) Good 2) expensive 3) Cheap
 4) too cheap 5) can't tell
36. Do you consider the payment in instalment as good? 0 = No 1 = Yes
37. Do you think registration by Household is good? 0 = No 1 = Yes
38. If No what do you suggest?
39. In general, what would you say about the scheme?
 1) Very good 2) Good 3) Somewhat good 4) Poor / bad

Do you have any general Comments about how to improve the Scheme?

.....

INFORMATION ON DRUGS

7. Have you or any of your household members ever used their insurance card to seek Medical care? 0 = No 1 = Yes
8. When was your most recent visit to the health centre / clinic with your card?
 1) This week 2) Last week
 3) Two weeks ago 4) A month ago
 5) Others, specify..... 99) N/A
9. Which health facility / community clinic have you or any of your household Members ever used most recently?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afiencya Clinic.
 13) N/A
10. Do you know of any one who is a member of the scheme and have ever visited the clinic with the card recently? 0 = No 1 = Yes
11. What would you say about the reception given you or any of your household members or any one who is a member of the scheme during the recent visit to the health centre?
 1) Very good 2) Good
 3) Somewhat good 4) Poor / bad
12. What do you think about the quality of drugs?
 1) Very good 2) Good 3) Somewhat good
 4) Poor / bad 5) Can't Tell 99) N/A

INFORMATION ON PAYMENTS AND BENEFITS RECEIVED

13. Have you ever been made to pay for some services at a primary care clinic with the card?
 0 = No 1 = Yes 99) N/A
14. If yes how much did you pay?
15. Which health facility?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afiencya Clinic. 99) N/A

16. If yes which service(s) did you pay for?
 1) Lab 2) OPD 3) Drugs
 4) Others specify..... 99) N/A
17. Did you pay any fees for which you demanded for a receipt and you were not given?
 0 = No 1 = Yes 99) N/A
18. If yes which Clinic?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afienya Clinic. 99) N/A
19. When?
- 1) This week 2) Last week
 3) Two weeks ago 4) A month ago
 5) Others, specify..... 99) N/A
20. Have you been referred to a referral Hospital before? 0 = No 1 = Yes
21. If Yes, which Hospital?
 1) Agomenya 2) Akuse 3) Atua Hospital
 4) Tema General 5) Battor Hospital 6) Ridge Hospital
 99) N/A
22. Did the Insurance pay for your bill(s)
 0 = No 1 = Yes 99) N/A(did not have to pay)
23. If No did you have to pay?
 0 = No 1 = Yes 99) N/A
24. If Yes how much?
25. Did you get a refund from the Insurance Office?
 0 = No 1 = Yes 99) N/A(did not have to pay)
26. If No what was the reason?.....
27. Have you ever been referred from a Community Clinic to a Health Centre or from one Health Centre to another before? 0 = No 1 = Yes
28. If yes which Health Facility were you referred from?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic

CENSUS FORM

NO.	NAME	RELATIONSHIP TO HEAD	AGE (IN COMPLETED YEARS)	EMPLOYMENT YES/NO	FOR CHDN UNDER 19YRS ASK WHETHER IN SCHOOLYES/NO

RELATIONSHIP TO HEAD

1 = HEAD 2 = SPOUSE 3 = CHILD 4 = PARENT
 5 = OTHERS (Brothers, Sisters, Aunties, Grand Children, etc) THANK YOU

TIME ENDED.....

REGISTERED FOR 1ST TIME IN 2ND YEAR

INFORMATION ON HEALTH INSURANCE

1. How did you hear about the Dangme Hewaminami Kpee? (Select as many as possible)

- 1) Through friends 2) through neighbours
- 3) Through household members 4) Through Radio
- 5) Through leaflets/ brochure 6) Through Health Staff
- 7) Area Council Committee members/ Community Educators/Drama
- 8) Gongon beating 9) Information Van
- 10) Registration officers 11) Assembly man
- 13) Teachers 14) Others (specify).....

2. Are there any **special reasons** why you did not join the scheme in first insurance year (2000/2001)?

- 1) Did not hear about it 2) Travelled outside district
- 3) Lack/poor understanding 4) Poverty /lack of money
- 5) Others specify..... 6) Waite and see attitude 99) N/A

INFORMATION ON PAYMENTS AND BENEFITS RECEIVED

12. Have you ever been made to pay for some services at a primary care clinic?
 0 = No 1 = Yes 99) N/A
13. If yes how much did you pay?
14. Which health facility?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afienya Clinic. 99) N/A
15. If yes which service(s) did you pay for? 1) Lab 2) OPD 3) drugs
 4) Others specify..... 99) N/A
16. Did you pay any fees for which you demanded for a receipt and you were not given?
 0 = No 1 = Yes 99) N/A
17. If yes which Clinic?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afienya Clinic. 99) N/A
18. When?
19. Have you been referred to a referral Hospital before? 0 = No 1 = Yes
20. If Yes, which Hospital? 1) Agomenya 2) Akuse 3) Atua Hospital
 4) Tema General 5) Battor Hospital 6) Ridge Hospital 99) N/A
21. Did the Insurance pay for your bill(s)? 0 = No 1 = Yes 99) N/A
22. If No did you have to pay? 0 = No 1 = Yes 99) N/A
23. If Yes how much?
24. Did you get a refund from the Insurance Office? 0 = No 1 = Yes
 99) N/A(did not have to pay)
25. If no what was the reason?.....

26. Have you ever been referred from a Community Clinic to a Health Centre or from one Health Centre to another before? 0 = No 1 = Yes
27. If yes which Health Facility were you referred from?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre
 5) Agomeda Comm. Clinic 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic 12) Afiencya Clinic. 99) N/A
28. If yes which health facility were you referred to?
 1) Dodowa Health Centre 2) Asutsuare Health Centre
 3) Prampram Health Centre 4) Ningo Health Centre 99) N/A
29. How would you classify the benefits received by an insured Client at a health centre?
 1) Very good 2) Good 3) Bad 4) Very bad
30. How would you classify the benefits received by an insured Client at a referral Hospital?
 1) Very good 2) Good 3) Bad 4) Very bad
31. Does it cause you any problem to have to go to a primary Health Facility first ie. Not to be able to go straight to a Hospital? 0 = No 1= Yes
32. If Yes, what is the problem?
-
-
33. What are some of the problem you or any of your household members have encountered since joining the scheme?.....
34. What would you say about the current premium? 1) Good 2) expensive
 3) Cheap 4) too cheap 5) can't tell
35. Do you consider the payment in instalment as good? 0 = No 1 = Yes
36. Do you think registration by Household is good? 0 = No 1 = Yes
37. If No what do you suggest?
-

CENSUS FORM

NO.	NAME	RELATIONSHIP TO HEAD	AGE (IN COMPLETED YEARS)	EMPLOYMENT YES/NO	FOR CHDN UNDER 19YRS ASK WHETHER IN SCHOOL YES/NO

RELATIONSHIP TO HEAD

1 = HEAD 2 = SPOUSE 3 = CHILD 4 = PARENT
 5 = OTHERS (Brothers, Sisters, Aunties, Grand Children, etc)

THANK YOU

TIME ENDED.....

NEVER REGISTERED

INFORMATION ON HEALTH INSURANCE

1. Have you heard about the Dangme West Health Insurance Scheme?
 0 = No 1= Yes

2. If yes, how did you hear about it? (Select as many as possible)

1) Through friends	2) through neighbours
3) Through household members	4) Through Radio
5) Through leaflets/ brochure	6) Through Health Staff
7) Area Council Committee members/ Community Educators/Drama	
8) Gongon beating	9) Information Van
10) Registration officers	11) Assembly man
12) Teachers	13) Others (specify).....

3. Why have you not joined the Scheme?
 1) Poverty / lack of money
 2) Expensive premium
 3) Lack of Understanding
 4) Alleged/perceived inadequate or poor treatment for subscribers
 5) Large household size/ mandatory household registration
 6) Lack of confidence/trust in the scheme
 7) Other, specify.....
4. In your opinion why do you think some people have joined the Scheme?
 1) Free medical care
 2) Health security
 3) No cash and carry
 4) Affordable/low premium
 5) Can't tell
 6) Others Specify..... 99) N/A
5. Do you know of any one who is a member of the scheme and have ever visited the Clinic with the card recently? 0 = No 1 = Yes
6. If yes which health facility / community clinic did the person ever visited recently.
 1) Dodowa Health Centre
 2) Asutsuare Health Centre
 3) Prampram Health Centre
 4) Ningo Health Centre
 5) Agomeda Comm. Clinic
 6) Doryumu Comm. Clinic
 7) Duffor Comm. Clinic
 8) Osuwem Comm. Clinic
 9) Dawhenya Comm. Clinic
 10) Nyigbenya Comm. Clinic
 11) Ebenezer Clinic
 12) Afiencya Clinic. 13) N/A
7. When was the visit?
 1) This week
 2) Last week
 3) Two weeks ago
 4) A month go
 5) Others, specify.....
8. Did they tell you about their experience? 0 = No 1 = Yes
9. If yes, how was the experience? 1) Good 2) Bad
 3) Somewhat good 99) N/A
10. What exactly did they tell you?.....
11. Would you register your household during next insurance period? 0 = No 1 = Yes
12. If yes, why? 1) Free medical care 2) Health security 3) No cash and carry
 4) Affordable/low premium 5) Can't tell 6) Others Specify.....
 99) N/A
13. If no, why?
 1) Poverty / lack of money 2) Expensive premium 3) Lack of Understanding
 4) Alleged/perceived inadequate or poor treatment for subscribers
 5) Large household size/ mandatory household registration

RELATIONSHIP TO HEAD

1 = HEAD 2 = SPOUSE 3 = CHILD 4 = PARENT

5 = OTHERS (Brothers, Sisters, Aunties, Grand Children, etc)

THANK YOU

TIME ENDED.....

CLINICAL CONSULTATION REVIEW – OPD CARDS

GROUP: 0 = UNINSURED 1 = INSURED

PERIOD 1 = OCTOBER 2000 – SEPTEMBER 2001
2 = OCTOBER 2001 – SEPTEMBER 2002

1. Clinic: _____

2. Name of Client (Patient) i.e., the sick person _____

3. OPD Card Number _____

4. Date of Attendance: _____

5. Age: _____

6. Sex: 0 = Male 1 = Female

7. Was the Temperature recorded? 0 = No 1 = Yes

8. Was B/P recorded? 0 = No 1 = Yes

9. Was the weight recorded? 0 = No 1 = Yes

10. Was the Client examined and results recorded?
0 = No 1 = Yes

11. Was a Diagnosis recorded? 0 = No 1 = Yes

12. If Diagnosis was recorded what was it? _____

13. Drugs prescribed (as written on the OPD card)

No.	Name of Drug	Injection, Tablets or syrup	Daily Dosage	Duration
1.				
2.				

- 3.
- 4.
- 5.
- 6.
- 7.

Name of Data Collector: _____