

The Ghanaian-Dutch Collaboration for Health Research and Development

**EVALUATION OF MUTUAL HEALTH ORGANISATIONS IN NORTHERN
GHANA**

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2006

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EXECUTIVE SUMMARY

Over the years, the cost of health care has been increasing to unaffordable levels, thus reducing access to effective health care for majority of Ghanaians.

It is the intention of government that Mutual Health Organisations replace the current cash and carry system which denies access to majority of the people. This study was commissioned to evaluate existing schemes in Northern Ghana and provide a data base for the ministry to enhance an understanding of the schemes in Northern Ghana.

The survey also covered schemes in the Brong Ahafo region. The survey has as its purpose to provide an inventory of Mutual Health Organisations/Saving Schemes. Forty five schemes were identified but of which only four completely satisfy the criteria of informal sector, primary purpose of financing health care, non-profit making and organisations that exist for the pooling of resources and are selected for case study.

The inventory consists of schemes that can be described as follows: Community based schemes, group based schemes and district wide health insurance schemes.

The four case studies are district wide schemes. They do not discriminate in terms of who joins the scheme and their primary purpose is financing of health care.

The second objective of the study was to ascertain the performance of select schemes in terms of some indicators to measure performance. Four schemes were studied using these indicators:

Governance/Management

The district wide schemes have in place structures that make transparency in management possible. Almost all leaders in the district are represented. The representations include the district assemblies, chiefs, managers and policy holders. However, the capacity of the local managers in most instances was inadequate.

Benefits

The district wide schemes offer opportunities for a person to receive benefits from a service provider. These benefits include complete payment for hospitalisation, OPD attendance for 24 hours or more or a fixed sum of money for OPD attendance, treatment for snake and dog bites as well as accidents and complicated deliveries.

Premiums

The system of paying premiums is cash. It is paid at one go per annum. The level of payments are adjusted from time to time by management. The arbitrary increases in premium rates make most members feel they are not owners of the scheme and in all cases the premiums are becoming unaffordable. This may explain why the oldest district wide scheme in the country (10 years) has only managed 30 per cent coverage.

Resource Mobilisation

The schemes are contributing substantially to the income of the service providers. Their contributions to income range between 10 per cent and a high of about 60 per cent.

Efficiency.

The schemes are spending between 20 and 50 per cent of their income from premiums on administration. It is understandable that the younger schemes have high administrative cost given the fact that most started from a zero base and need to build structures to enable an active recruitment drive.

Equity

It was realised that the very poor are not able to join the schemes. The very people for whom the schemes were intended to serve are marginalised further.

Quality.

Consumer satisfaction is an important ingredient for the growth of a Mutual Health Organisation. Most

of the schemes paid little attention to consumer satisfaction. Members complain of shuttling between the schemes and the service provider wasting precious time and energy. They also complain of inferior treatment from service providers when they are identified as policy holders.

Sustainability.

The district wide schemes when they embark on aggressive recruitment drives are capable of raising money to be sustainable. But the small size of most of the schemes examined could contribute to poor financial viability.

Adverse selection, more especially for those schemes that do individual registration, will lead to a progressively smaller risk pools and high cost.

Lastly, for purposes of sustainability, it was noted that members want to have an effective say in the management of schemes particularly in the setting of premiums. Minimal involvement could lead to minimal appreciation of the positive role of insurance.

The study makes the following recommendations which are observed best practices:

- The district assemblies be actively involved in the initiation and management of schemes.
- Building of beneficiary capacity.
- Building of management capacity.
- Include OPD attendance in benefits but put in control measures.
- Using differential premiums.
- Scientific determined and negotiated premiums.
- Subsidy and/or exemptions for the very poor.
- Improvement of quality, service/scheme.

In the districts where the schemes exist, they have deepened the concept of solidarity in the people and most members do not feel bad after paying for some years now and not “benefiting”. But to still enhance solidarity and enthusiasm further, persons who have not “benefited” could be identified and recognised publicly as such.

- Financial mobilisation to the service providers is very significant and this has improved the financial base of the service providers.

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Chapter One

INTRODUCTION

One of the medium term (5-10 years) policy objectives of the Ministry of Health, Ghana, is that within the planned period, 50-60 percent of the residents of Ghana will belong to a health insurance scheme that will guarantee their access to health services without the need to use the current cash and carry system (Ministry of Health 2002). This implies that in the next five years the scheme will have to be developed. Issues which are still to be decided include: the best way of managing such schemes; benefit packages; premium levels, frequency and methods of payment of premiums; membership recruitment; rules and regulations governing the schemes; staffing and payment of providers.

While the government's policy is yet to be implemented, there are, however, many small and medium scale informal mutual health organisations (MHOs) existing in Ghana. The MOH and Christian Health Association of Ghana (CHAG) have developed a simple inventory to collect basic data on these MHOs. The available data from this inventory neither contains enough information nor up-to-date data for analysis of the critical issues listed above. Little is, therefore, known about the form, performance and problems of these existing MHOs. This information is necessary to enable the MOH to build a suitable model based on the experiences of these informal schemes. This study is to fulfil this compelling need.

METHODOLOGY

Approach

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 Department of Allied Health Sciences of the School of Medicine and Health Sciences of the University for Development Studies (UDS) and the Educational Research Net-

work for West and Central Africa (ENRWACA) were selected to do research in health insurance. The two harmonised their research protocols so that they can provide information on schemes using the format. The UDS team worked within the northern sector of Ghana while ENRWACA worked in the southern sector.

Thereafter, UDS and ENRWACA continued to collaborate in developing instruments. A consultative meeting was organised with stakeholders in Kumasi. Stakeholders in this meeting played influential roles to reshape the instruments, which were later pre-tested in Damongo. Again a joint data analysis workshop was organised in Elmina in April 2003 to share experiences and to develop a common reporting format.

Case Selection

Prior to the selection of the actual cases for the study, there was a comprehensive inventory of existing MHOs using the following criteria:

- Informal organisation
- Primary purpose is financing health care.
- Non profit making, and
- organisation exist for pooling of finances

The inventory revealed that some of the schemes have been on the drawing boards for over three years and thus only existed on paper. Most are very rudimentary and their main purpose is not exclusively health care financing. Four schemes satisfied completely the mentioned criteria and were all selected for detailed studies. These schemes are the: West Gonja Health Insurance Scheme; Nkoranza Community Health Insurance Scheme; Jaman South District Health Scheme; and Tano District Health Insurance Scheme. It is worth noting that of all the three northern regions, it is only the Damongo scheme that satisfied the criteria for a detailed case study, while all the other three are in the Brong Ahafo Region.

DATA COLLECTION AND ANALYSIS

Both quantitative and qualitative data were collected and using a mix of tools, depending on the target respondents. This triangulatory approach to data collection was to ensure comprehensive data collection and the optimisation of reliability. The main instruments used to collect quantitative data were the five different sets of questionnaires targeting the following categories of respondents:

- Members of the Scheme
- Administrators of the Scheme
- Directors of Health Services
- District Assemblies
- Chiefs and opinion leaders

In terms of qualitative data, a Focus Group Discussion Guide (FGD) was used to collect information from non-members. The non-members were randomly sampled and formed into groups of male and female. A maximum of ten respondents were interviewed in each group.

The different data collected were entered into EPI INFO and then transported to SPSS. A sample entry was done again for purposes of cross checking.

QUALITY CONTROL

A number of measures were employed by the research partners to ensure quality research output. At the conceptual level, the stakeholder consultations/workshops and peer review sessions proved an invaluable method of defining the research problem, developing the methodology and field approaches and data collection and analysis.

At the field level, research assistants who were mostly UDS graduates, were carefully selected. This category was preferred because of their intensive training in community based development and knowledge of participatory and quantitative data collection at the community level.

A training workshop was organised for these research assistants. The first group of research assistants were twenty two (22) who were preparing to go into the field for their field practical training. They produced an inventory of Health Insurance or

saving schemes. This was followed by a more intensive training on the data collection instruments and the field procedures. The research assistants administered five sets of questionnaires and also organised focus group discussions.

At the field level, supervisors were present to oversee the data collection process. The principal researcher visited supervisors and research assistants when they were in the field to ensure that the protocols were being followed. On returning from the field, the completed questionnaires were edited before entering into the EPI INFO programme and crosschecked after entering.

A data analysis workshop was also organised from the 22 – 27th April 2003, at Elmina for the research teams. It was facilitated by three 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.

INVENTORY

About 45 saving schemes/MHO were captured in the preliminary survey (see Table 1). These were formed between 1992 and 2001. About 20 per cent of these schemes are still in their gestation period. The other 80 per cent are at various stages of formation. Out of the 45 schemes, four are directly and completely involved in health care financing and solidly doing business. This formed the basis of their selection for study.

Table 1

Inventory of Mutual Health Organisations in Brong Ahafo, Northern, Upper East and Upper West Regions

NAME AND ADDRESS	YEAR STARTED	TARGET GROUP	OWNER SHIP	MEMBER SHIP	BENEFIT PACKAGE
Dagaaba Welfare scheme Dua Yaw Nkwanta, BA	1996	Migrant Dagaaba solidarity group.	Members	213	Loans for hospitalisation
Dagaaba SongtaaHwidiem/ Kenyasi B.A	1996	Migrant Dagaaba solidarity group	Members	164	Hospital attendance
Jaman North Health Insurance Scheme	1999	North of Jaman District	The community	3,000	Hospitalization
Ward 9 Health Scheme Sene	1997	Community	Members	109	Credit for Health Care
New International Club Sene	1991	Youth	Members	76	Credit for Health Care
Donkove Junieur Squard Sene	1998	Youth	Members	54	Credit for Health Care
Kwame Danso Tailors and Dressmakers Asso.	1991	Tailors and Dressmakers	Members	86	Credit for Health Care
Dagaaba Youth Asso. Assocaition of Garages Kintampo	2002 2000	Youth Mechanics	Members The Association	Gestation 23	Credit for Health Care
Yam Sellers Association, Kintampo	1985	Yam Sellers	Members	57	Credit for Health Care.
Nandom Youth and Dev't Asso. Nkoranza	2001	Nandom youth	Members	Gestation	
Castle Base 46 Community Sene	1999	Migrant Youth	Members	34	Credit for Health Care
Sunyani District Health Insurance Scheme	2002	Entire District	Members/ Assembly	Gestation	
Nkoranza Ewe Haborbor	1996	Ewe	Members	115	Credit for Health care and other Social services
Ghana National Tailors and Dressmakers Asso	1992	Tailors and Dressmakers	Members	62	Credit for Health Care
Nkoranza Community Health Insurance, B.A.	1989	Entire district	Provider owned and co-managed	48,285	Inpatient care cost only
Tano District Health Insurance, B.A.	1999	Community initiated scheme	Members	108	Admissions
Asutifi Community Health Scheme, B.A.	2001	Community initiated	Members	Gestation	
Berekum Health Insurance Scheme	2001	Entire District	The district	Gestation	
Jaman South District Health Insurance Scheme.	1999	The assembly	Community	13,000	Admissions
Nawunzoya Health Scheme, Tamale	1992	Youth group initiated	Members	40	Admissions
Tisubin Bora SchemeEast Mamprusi	2000	Farmers	Members	18	Health care and other social events
Tisomteb Health Scheme Zone A/B	2000	Farmers	Members	2741	Credits for health care

Tisungtaaba Health Association	2001	Community Members initiated	Gestation		Admissions
Bawku East District Health Team	2001	District assembly	Community	Gestation	Hospitalisations
KANADA Community Health Scheme, Olga	2001	An individual	Members	Gestation	All cases of admissions
Damongo Health Insurance Scheme	1995	The Catholic Church	District hospital	41723	Hospitalisation.
Bunkpurugu/Tigobdia, East Manprusi	2001	Members	Members	Gestation	Admissions
Saboba/Chereponi Health Scheme,N/R	2001	Local NGO, Integrated Development Centre.	The community	3900	Admissions, complicated delivery, snake and dog bites
Tiyumtaaba Welfare Association Tamale	1998	Sagnerigu health sub-district	Members	35112	All services related to admissions
Savelugu Health Scheme	2001	Community members/DHMT	Members	Gestation	Admissions and some OPD
Vittin Health Scheme	2001	Community initiated VITTIN	Farmers	3000	admissions
Civil Servants Medical Refund Scheme U/W/R	1995	Teachers	Teachers	236	Refund of hospital bills
Funsi Communitiy Health Scheme, Wa	2000	3 Health Sub-Districts	The community	Gestation	In-patient care and ambulance services.
Poetanga Community Health Scheme, Wa	1998	Sub Districts	The community	Gestation	Admissions
Teachers Welfare Fund U/W/R	1995	Teachers	G.NAT.	Non-Functional	Admissions
Gushegu/Karaga Insurance Scheme		Farmers	Members	Gestation	Hospital attendance
Nanumba Health Scheme	2002	District	Members/Assembly	Gestation	Hospital Attendance
Salamba Women's Scheme Tamale	2002	Traders	Members	7350	Credit for medical attention.
St Charles Health Scheme	2000	Students	School	800	Health care
SDA Health Scheme	2001	Church members/others	Members	Gestation	Health Care
Tolon Health Scheme	2002	District	Community	Gestation	Health Care
Sang Health Insurance Scheme	2002	District	Members	Gestation	Health Care
Nadowli District Health Insurance Scheme	2002	The District	Members	Gestation	
Lawra District Health Scheme	2002	The District	Members	Gestation	

Source: CHAG administrative records/field survey 2003

Table 2
Matrix of selected schemes

NAME AND	TYPE OF LOCATION	INITIATOR SCHEME	MANAGER	EXTERNAL SUPPORT	PREMIUM PACKAGE	BENEFIT	POPULATION INSURED (%)
WEST GONJA HEALTH INSURANCE SCHEME, DAMONGO TANO DISTRICT HEALTH INSURANCE SCHEME, B.A	Community Health Insurance	The Catholic church through the service provider	The Church	Aktion Danida Misereor MEMISA	20,000	Admissions Snake and Dog bites	27.9
JAMAN SOUTH DISTRICT HEALTH INSURANCE SCHEME, B.A	Community Health Insurance	The District Assembly and the service provider	The assembly	Danida KIAPHRplus	20,000	Admissions Snake and Dog bites OPD bills over 200,000	
NKORANZA COMMUNITY HEALTH INSURANCE SCHEME, B.A	Community Health Insurance	The District Assembly and the service provider	The assembly	KIADanida	20,000	Admissions Snake and Dog bites	
	Community Health Insurance	The Catholic church through the service provider	The Church	CSMDanida PHRplus MEMISA W.H.O USAID	20,000	Admissions Snake and Dog bites 24 hrs stay in OPD	26

Source: Field survey - February 2003

Chapter Two

RESULTS OF THE CASES

GONJA DISTRICT HEALTH INSURANCE SCHEME

District Profile

The West Gonja District is the largest district in Ghana and it is located in the Northern Region, the largest region in the country. The total land area is 1,744,059 km. The district is bigger than four regions in the country. About a quarter of the area is occupied by the Mole National Park with only a few communities and camps.

The district is bounded on the north by the Upper West Region and the West Manprusi District. The southern sector is bounded by Brong-Ahafo Region and East Gonja District. The East of the district shares boundaries with Tolon-Kumbungu and Tamale districts while the West is bounded by Bole District.

Agriculture is the major occupation of the district. It engages over 60 per cent of the labour force. Crops cultivated include maize, sorghum, groundnuts, cassava, yam, beans and soya beans. The women in the district engage in gari and sheabutter processing (West Gonja District Medium Term Development Plan, WGDMTP 2003).

The annual average household income is estimated at about c¢550,000.00 which gives an average per capita income of about 70,000.00 per year, (WGDMTP 2003). This implies that almost 100 per cent of the population fall deeply below the lower poverty line as determined by the Ghana Living Standards Survey of 1999 to be c¢ 700,000 (\$100) per year.

The district population is 139,329 (2000 census). The population growth rate is 3.1 per cent with a sex ratio of 103 males to 100 females. The West Gonja District has a high fertility rate (8 children per woman compared to the national average of 4 to 5 children per woman). Urban population decreased from 18 per cent in 1984 to 14.5 per cent in 2000 due to ethnic conflicts in 1990 and

1994 respectively. The age structure is typical of developing countries with over 50 per cent between 15-60 years of age (WGDMTP 2003).

The Mutual Health Organisation

The scheme was inaugurated in October 1995. The idea of a community financing scheme was mooted by the Board of Directors of the West Gonja Hospital. External donors provided seed money for public education and sensitization of the scheme.

Government/Management

The scheme has a Board and a Management Team. The membership of the Board is five. They are the representatives of the Bishop, District Assembly, policy holders, service providers and staff of the scheme. The management team is made up of the Senior Medical Officer In-charge, Financial Administrator of the Diocese and the Co-ordinator of the scheme.

The day to day Management of the scheme is done by the Co-ordinator, Assistant Co-ordinator, Accountant, Office Assistant and two social Marketing officers.

The organogram, (Fig. 1) below, depicts the category of persons responsible for the day to day running of the scheme. They are all employees.

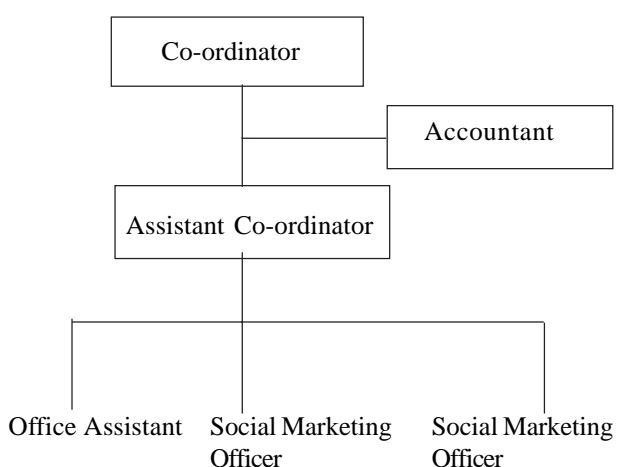


Figure 1: Organogram of WGDHIS

Benefits

The scheme offers an attractive benefits package to its members. All admission bills are taken care of (except as a result of criminal abortion). Cases of dog and snake bites, are also taken care of, even for out patients. There is no financial ceiling on levels of bills. There are also no restrictions on drugs prescribed. Where a prescribed drug is not available, the client buys from outside the hospital pharmacy and is reimbursed. To minimise the impact of adverse selection the scheme has a very long waiting period. A new member has to wait for 6 months before he can access the benefits. And where an old member delays his renewals he has to undergo a waiting period of six months. The scheme does not offer any form of credit to its clients.

Membership

The scheme has an open registration system and a person can register at any time of the year. Renewals are also done anytime of the year. Since inception the membership of the scheme has been growing as depicted in Figure 2.

The catchment area of the scheme is the whole district, a population of about 139,329. Currently the scheme, in its eight years of existence, covers 27.9 per cent of the population. The scheme does not discriminate in terms of age, sex or ethnicity. Membership is voluntary and individuals register on their own. Upon registration, a member is issued

with an identity card that bears his/her picture. Registration of new members and renewals is all year round.

Premiums

The setting of premiums is mostly done without any scientific bases. Rough estimates are made and adjusted as the years go by (see Table 3).

Payments of premiums are done at one-go in a year. A person can pay any time of the year. A policy holder has to renew his/her policy before expiration (one day grace period) or else he/she is treated as a new policy holder and will have to go through a waiting period of six months. Premiums are uniform for every body. Children, adult males and females and the aged all pay the same level of premiums. The premium is currently 20,000 cedis. The scheme pays the service provider fee for services and where the hospital pharmacy is unable to provide a prescribed drug, the client purchases the drug and is reimbursed by the scheme.

There are a number of donor organisations that support the scheme. These include Akfion Canchanaburcy, a German NGO. It donated 37,000.00 Euros in support of the payment of premiums of school children in the West Gonja District. With this package, school children paid, 5000.00 each year for 3 years and the difference was borne by the NGO.

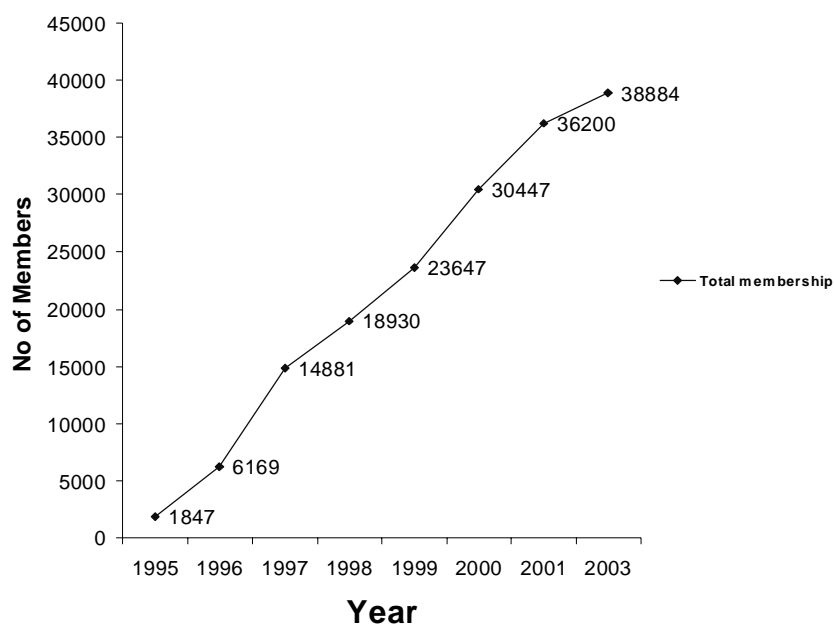


Figure 2: Trend of Growth of Membership (1995-2003)

Table 3
Changes in Premium

Year	Premium (Cedis)
1997	4,000.00
1998	5,000.00
1999	6,000.00
2000	8,000.00
2001	16,000.00
2002	16,000.00
2003	20,000.00

Source: West Gonja MHO Financial Records

Another German NGO, Misereor donated ₵59,216,887.00 in 2002. This was used to acquire a safe for the office and construction of billboards. These billboards have been mounted at strategic places within the various communities. Part of the amount was also used for recurrent expenditure and payment of responsibility allowances to staff.

Performance

Resource Mobilization

The scheme has contributed significantly to the in-patient income to the hospital. It has contributed ₵690,927,133 to the in-patient income from January 1996 – December 2002. In 2001, it contributed ₵95,000,000.00 out of an income of 195,049,469. This represents 48 per cent of inpatient bill as shown in Table 4.

Table 4
Percentage contribution of scheme to hospital income

Year	Inpatient income (₵)	Scheme contribution (₵)	% contribution
1996	70,353,126.00	6,335,220.00	9.00
1997	102,062,605.00	33,497,750.00	32.82
1998	131,290,243.00	69,848,980.00	53.20
1999	112,945,786.00	89,754,146.00	79.47
2000	216,569,238.00	132,411,706.00	61.14
2001	195,049,469.00	95,000,000.00	48.71
2002	191,073,198.00	264,079,331.00	-

SOURCE: West Gonja Hospital/Scheme Records.

* 2002 Inpatient hospital income is incomplete.

Efficiency

The total expenditure for the scheme for the year 2001 was 161,057,309. The amount that was spent on general administration or recruitment expendi-

ture was 66,057,309 (41.1 per cent). For the year 2002, the total expenditure was 500,858,067. Administration cost was 264,098,331 (52.7 per cent). On the other hand, only 47.3 per cent was spent directly on beneficiary benefits. Given the rather high percentage of administrative cost (52.7 per cent), one may conclude that the efficiency of scheme is low. However, it is important to note that the Scheme is still on a recruitment drive and is doing all that it can to reach 80 per cent coverage of its population.

Since the start of the scheme, membership has been increasing yearly. Table 5 shows total membership since 1996 and numbers that have received care and the corresponding years. From the table, the percentage utilisation of the scheme by members is between 3 and 5 per cent.

Table 5
Trends of utilization (1996-2002)

Year	Total membership	Sick	Non-sick	% of sick
1996	6,169	241	5928	3.91
1997	14,881	735	14146	4.94
1998	18,930	1,011	17919	5.34
1999	23,647	1,096	22551	4.63
2000	30,447	1,306	29,141	4.29
2001	36,200	1,522	34,678	4.20
2002	38,884	1,266	37618	3.26

Equity

Information available could not enable us make decisions on numbers of members who are poor and members who are not poor. However, given a district per capita income of ₵50,000.00 per annum, one can say that majority of the people are poor and cross subsidisation is more

meaningful for sick users versus non sick members as depicted in Table 3.

The percentage of sick members, in other words, persons who were sick, reported and

received care or received service, never exceeded six per cent. Cross subsidisation could, therefore, be seen as non-sick members subsidising the bills of the sick, the essence of insurance. Moral hazard, the tendency to over use the service because one is registered may not be an issue here. What could be an issue is that most of the insured clients come with cases of surgery and, therefore, could be persons who are adversely selected into the scheme. From the Table 4 the percentage utilization of the scheme by members is between 3 and 5 per cent.

Given the per capita annual income of ¢50,000.00 as estimated by the District Assembly one would say that a premium of ¢20,000.00 is highly unaffordable, but 94 per cent of members said that the premium was affordable; membership continues to increase. About 90 per cent non-members in a focus group discussion stated that but for lack of money they would have joined the scheme.

Box 1: An example of unaffordable Premium

“have a family of five and how to get money to register all the five is very difficult as I am not a salary worker”

Quality

In West Gonja, 60 per cent of members are satisfied with the scheme. However, about 40 percent complain that as scheme members, they are given inferior treatment. When service providers get to know that they are members of the scheme, they deny them admission even when they have very critical conditions that require admissions. When one attends hospital without receiving an injection one concludes that one is not treated well. This perception partly accounts for 40 per cent of members claim that they are not satisfied with the scheme. On the other hand, 70 per cent non-members think that they are missing a lot and members of the scheme are well treated by the service providers.

The Damongo hospital, which is the service provider, operates an essential and generic drug list system. Almost all essential drugs are always available in the hospital. Where a prescribed drug is not available in the hospital pharmacy, it is

procured from outside by the patient who is reimbursed by the scheme.

All clients to the hospital are treated on a first come first serve basis regardless of whether one is a card bearer or not.

Staff of the hospital are too nice to the clients even to the detriment of the scheme. Most of the members of the scheme when asked how they become members, they indicated that they were encouraged by the service provider.

Box 2: An Example of Adverse Selection.

‘They are cases in point where clients who came with Hydrocele were given medicine to subside the pain and then advised to join the scheme and go through the waiting period of six months and then come for surgery. This is a serious case of adverse selections given that the cost of surgery is very high.

Sustainability

Registration trends are increasing and this is one of the tools for measuring sustainability (Table 6). Apart from this, The Damongo scheme is eight years old with a growth rate of about 12 per cent and eight years of a sustained experiment could enhance survivability of that experiment (Fig 3).

**Table 6
Registration trends**

Year	Total membership	New Members	% Growth
1996	6169	4322	70.1
1997	14881	8712	58.1
1998	18930	4049	21.4
1999	23647	4717	19.9
2000	30447	6800	22.3
2001	36200	5753	15.9
2002	38884	2684	6.9

The day to day running of the Damongo scheme is done by non-graduates who have no training in insurance. They have, however, throughout the years attended workshops and seminars which have helped enhance their skills and understanding of managing an insurance scheme. They are unable to calculate cost and estimate risk. The concept of

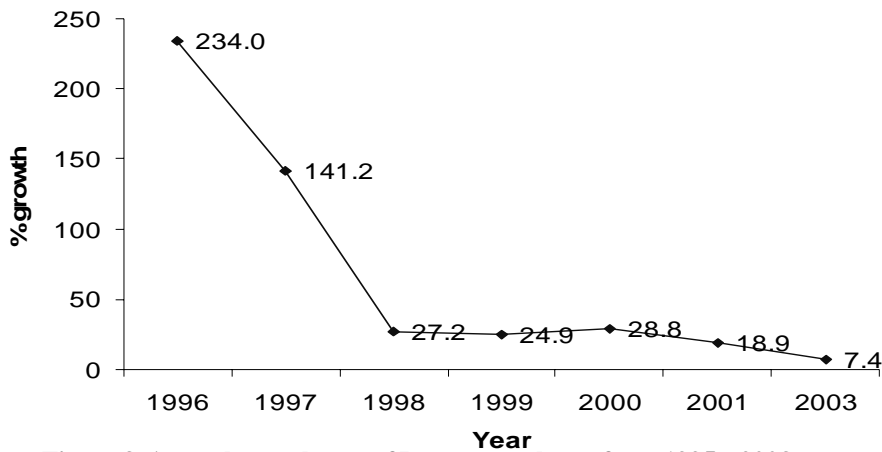


Figure 3: Annual growth rate of Damongo scheme from 1995 – 2003

community health insurance is very new in Ghana and very few persons have this skill.

The concept of solidarity, willingness to share risk is well acceptable among members as well as non-members. Eighty per cent of non members stated that they are willing to contribute to off set the bills of another person knowing very well that it could be their turn next time round.

The Damongo scheme is moving towards household registration in the coming year. This would minimise adverse selection.

NKORANZA COMMUNITY HEALTH INSURANCE SCHEME

District Profile

Nkoranza district is one of the 13 administrative districts in the Brong Ahafo Region of Ghana. It covers an area of 2,300km² and is made up of about 136 rural settlements.

The district is in the transitional zone; that is the transition between the savannah woodland of northern Ghana and the forest belt of southern Ghana.

The district has a population of about 134,236 (Ghana 2000). The population grows tremendously and has more than doubled within 14 years. The dramatic growth of the population is attributable to the inflow of settler farmers from northern Ghana. Males make up 52 per cent of the population whilst females make up 48 per cent. Children (0-17) form

39 per cent and the labour force, (18-64) 50 per cent. The aged (65+) form 5 per cent.

Nkoranza district is basically a rural population. Nkoranza Township is the dominant settlement with 17.2 per cent of the entire district population.

The predominant occupation in the district is subsistence agriculture. It engages 82 per cent of the labour force. About 25 per cent of those engaged in other occupations outside agriculture still take up agriculture as a minor activity. The average monthly income of the sampled household is ₵343,809.00. Annual Per capita income is estimated at ₵515,714.00. The highest expenditure is on food. This takes more than ten times what goes into education and nearly 20 times that of health. (Spring 1993/94 Socio-economic Survey).

Using the World Bank's approach to measuring poverty, i.e. two thirds of the average income which is ₵229,206.00 per annum, and hard core poverty one third of the average income which is ₵114,603.00, 62 per cent of the population live below the poverty line, whilst 38 per cent are the very poor.

The Mutual Health Organisation

Governance/management

The Sunyani Catholic Diocese through the St Therese's hospital was instrumental in initiating the scheme in 1992. Currently, the Scheme operates in sixty four (64) communities divided into 11 Health Zones.

The Diocesan Health Services committee is the highest decision making body of the scheme.

Below the Diocesan Health Services Committee is the General Assembly and below this are two Parallel committees, the Management Board and Oversight Committee. Below this are persons responsible for the day to day running of the scheme as depicted in the organogram in Figure 4. The Management Board comprises the Administrator of the St. Theresa’s Hospital, the District Director of Health Services, three representatives from the District Assembly, three Traditional Council members, one representative of the Diocesan Health Services, five members of the scheme, the manager of the scheme and his assistant.

The oversight committee comprises registered representatives from each of the 11 health zones in the district. The oversight committee has very important roles to play. It is its duty to quickly inform management of issues on the ground and bring to fore decisions and policies that are not well received by the members. It also explains management policies to members. It is supposed to be the investigative wing of the scheme. It receives complaints and carries out investigations for and on behalf of the scheme. Unfortunately this committee is not functioning. The reason for non-performance is financial constraints and logistics like transport to send members into the communities.

The Management organizes an annual general meeting each year where all the above groups meet to deliberate on the

achievements and failures of the scheme and the way forward.

The day-to-day running of the scheme is done by employees. These are the Manager, Assistant Manager, Accountant, District Co-ordinator, Assistant Co-ordinator and Field Workers.

The district is divided into 64 communities and each community has a field worker. The field worker does the registrations and renewals and is paid a commission. He/She also organises the community fora and brings in resource persons from the scheme to make presentations.

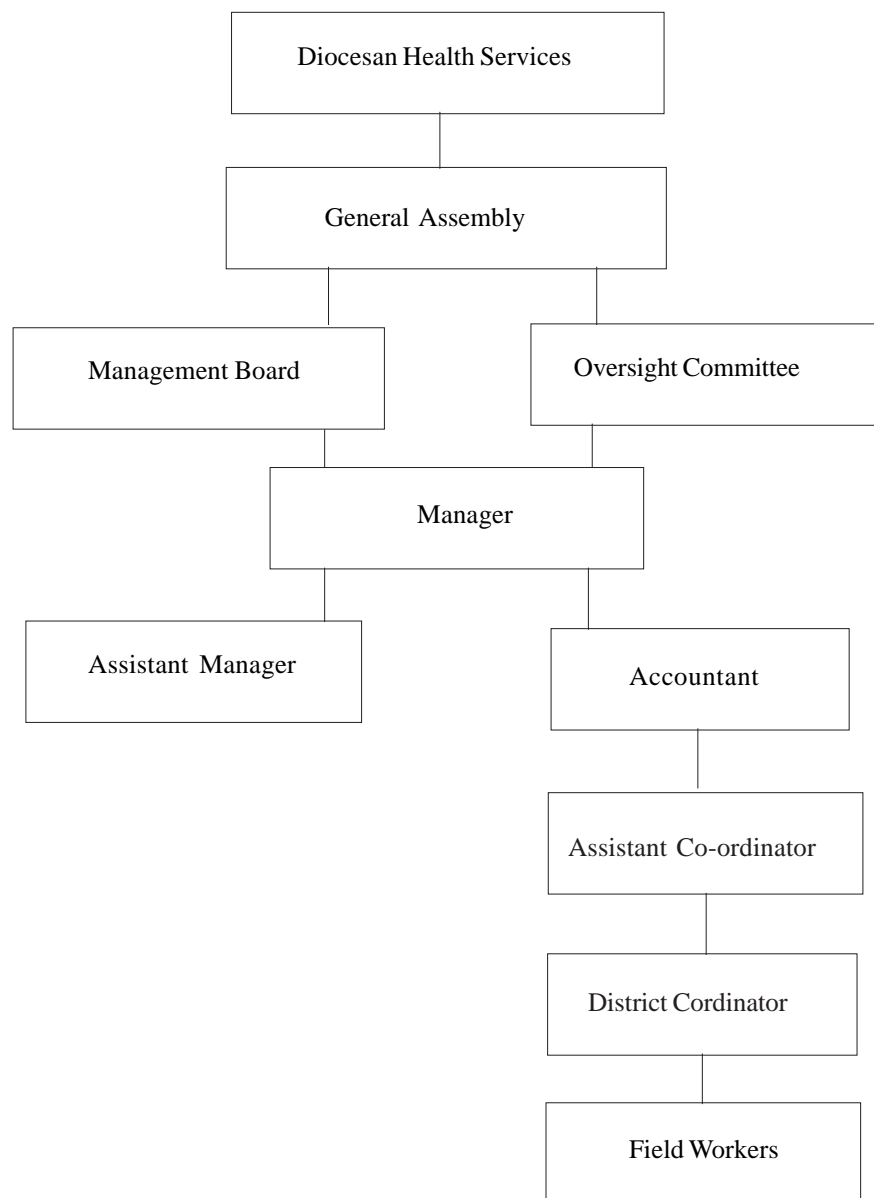


Figure 4: Organogram of the Nkoranza Community Health Insurance Scheme
 Source: Nkoranza Community Health Annual Report 2002

Benefits

The benefit package or services offered by the scheme are:

1. All medical and surgical bills of admitted insured clients in the St Theresa's hospital are paid for by the scheme.
2. Drugs in the essential drug list that are prescribed and bought outside the hospital for clients on admission are reimbursed.
3. Hospitalised clients referred to other hospitals for specialist care are paid the average in-patient bill for the month less the amount previously paid by the scheme to the service provider.

This payment is done when the following conditions are fulfilled:

Evidence of being referred by a medical officer

Evidence shown by client as having been treated at the point of referral.

Provision of receipts/OPD card indicating payments made whilst the client was on admission at the point of referral.

4. Snake and dog bites.
5. And where a client stays in the OPD for more than twenty four hours.

There are no financial ceilings on benefits and no restrictions on types of drugs; but the hospital also abides by the government policy of the use of an essential and generic drug list.

The waiting period i.e. the time it takes for a registered individual to enjoy benefits is two months. Apart from the payments of bills after hospitalisation the scheme does not provide any credit to insured clients. All residents within Nkoranza district and all indigenes residing outside the district are eligible to join the scheme.

Membership

Membership is voluntary and registration is done on household basis only. New born children are to be registered within 40 days of delivery. When this is done, they do not go through a waiting period. Proof of membership is a membership card with picture identity. The period of registration and

payment of premiums is currently between two months (September and October) but initially registration was between December and January. Members complained that it coincided with Christmas celebrations and was not favourable.

The scheme has seen a progressive increase in membership since its inception in 1992. Currently membership stands at 42,712. Over the years the scheme's coverage of the population has oscillating between 26-34 per cent. Currently the coverage is 26 per cent after a high of 37.3 per cent in 2001.

The Scheme's coverage of its catchments area is averagely 30 per cent. This implies that the scheme is yet to reach majority of the people and perhaps those who need the services more. The average growth in membership is 2,831. In 1999 and 2002 there was a reduction in membership in relation to the preceding year (see Table 7). This is depicted as negative growth in Table 8.

Table 7
Population (estimate) of catchment area of scheme and number of members (1997 – 2002)

Year	Pop (Estimate)	Membership	Percentage
1997	128,253	33,314	26.0
1998	140,000	41,342	29.5
1999	144,900	39,288	27.1
2000	127,256	43,688	34.3
2001	130,74	48,709	37.3
2002	134,236	35,064	26.1

Source: Derived from Nkoranza Health Insurance Records

Table 8
Growth of Membership (1997-2003)

Year	Total Membership	New Members	% annual Growth
1997	33314	10423	32.6
1998	41342	8028	24.1
1999	39288	-2054	-5.0
2000	43688	4400	11.2
2001	48709	5021	11.5
2002	40603	-8106	-16.6
2003	42712	2109	5.2

Source: Derived from Nkoranza Health Insurance Records

There was a short fall in registration with this new time period. At the close of 2001/2002 registration exercise, total membership was 40,603 as against 48,366 the previous year, a decrease of about 16.05

per cent. The communities were of the view that the registration would extend through December 2001. They also complained (65 per cent) that the change of the period from between December and January to September and October is a period when they spend most of their money paying school fees. Others 42 per cent said they did not hear of the change of registration period.

Premiums

Like the West Gonja Scheme, premiums are determined with non-scientific bases. The manager and the accountant are first degree holders. They have attended workshops and seminars on data management, accounting, investment, Human Resource Management and project writing. They have not had training calculating cost, risk management and setting premiums. In setting premiums, therefore, actual or cost analysis principles have not been applied. What appears to have been applied is a reasonable estimate of affordability.

In 1997 premium per head was ¢3000 and is currently ¢20,000 (see Table 9). Payments are made at one go. Currently premium is ¢20,000 flat for each household member.

There are discounts given when a household exceeds 6 members. Where a family is 7 in number, a discount of ¢2000 is given and were a family is 8 or 9 a discount of ¢3000 is given. Where a family is 10 and above a discount of ¢5000 is given. Payment is free at the point of service for a client and the scheme pays the provider for services offered.

Table 9
Changes in Premium

Year	Premium [¢]
1996	3,000
1997	5,000
1998	7,000
1999	8,500
2000	12,500
2001	18,000
2002	20,000

Source: Nkoranza Health Insurance Scheme Documents

The scheme has very supportive secondary sources of funding. These include non governmental organizations such as DANIDA, MEMISA (A Dutch Catholic Christian Organisation) WHO and USAID.

Performance

Resource Mobilisation

The scheme's financial contribution to the service provider is very encouraging. For the year 2002 total income for the scheme (premiums) was ¢729,860,102. The amount paid to the service provider was ¢572,856,145. The expenditure on Administration was ¢141,162,367. This is 19 per cent of the income and 24 per cent of expenditure on bills (see Table 10).

Table 10
Financial Contribution of Scheme to Service Provider: 1996-2002

Year	In-patient Income [¢]	Schemes Contribution [¢]	Percentage contribution
1997	182,000,000	103,000,000	56
1998	254,381,000	165,401,000	65
1999	366,581,000	247,469,000	67
2000	498,500,000	327,600,000	65
2001	560,000,000	387,000,000	69
2002	786,340,000	529,830,000	67

Source: Nkoranza Scheme Financial Records

The average in-patient bill for the non-insured this same period was ¢44,666 per month while for the insured, the average inpatient bill was ¢343,370. The question is why this big difference? If high cost is related to better health care, one may say that the insured persons are receiving better care. It may well be that the insured come with very serious problems that are often surgical in nature, whilst the non-insured come with simple cases and including normal deliveries.

Efficiency

Table 11 depicts members' contribution to the scheme and the percentage that went into administrative cost. The average administration expense of the Nkoranza Scheme is 22 per cent of income from premiums. It must be noted that donor money which is used for public sensitisation is not included in the administration cost. Also excluded are donations like computers and other office equipment. It may well

Table 11
Percentage contribution to Administration Expenses

Year	Contribution (¢)	Admin Expenses (¢)	Percentage
1997	85,933,000	18,798,172	22
1998	182,725,000	24,656,008	13
1999	206,052,000	54,792,495	27
2000	333,530,500	121,071,614	36
2001	535,343,000	92,081,678	17
2002	660,545,898	110,609,767	17

Source: Nkoranza Health Insurance Scheme Report

be that if the scheme was bearing all administrative expenses the percentage would have been higher.

The scheme does not keep data on trends in utilisation of service type. However, most of the cases were surgical, snake and dog bites and for children severe cases of malaria resulting in anaemia.

If we look at utilisation in terms of members who have benefited from services, then utilisation levels are very low; an average of 4.0 per cent (see Table 12). The low utilisation levels imply that a lot more needs to be done to maintain those

Table 12
No of Members and sick members

Year	Members	Sick members	Percentage
1997	33,314	1,687	5.0
1998	41,342	2,187	5.2
1999	39,288	2,124	5.4
2000	43,688	1,967	4.5
2001	48,709	1,691	3.0
2002	40,605	1,561	3.0

Source: Nkoranza Health Insurance Documents

who have not been accessing health care. Payment fatigue could set in for those who have over the years been consistent in paying premiums.

Equity

The Ghana living standards survey categorises almost every person living in rural Ghana as poor. There are, however, different levels of poverty and the possibility of cross subsidisation exist but certainly minimal.

Table 12 above depicts total members of the scheme and members who reported sick and received services. The percentage of members who reported sick and received services ranges between 3.0 and 5.0 per cent. There is, therefore, a lot of subsidisation between the sick and non-sick members. Since majority of the sick are normally the poor in society, there could be an element of cross subsidisation between the poor and rich. It appears that the very poor are not part of the scheme as captured in the focus group discussions.

Box 3: Perception of the Scheme and Expressing of poverty

A non-member Ajoa Boateng said: *'I feel I'm missing something but it is not also easy to be a member. At times it is very difficult to come by even thousand cedis. When you get money you want to deal with the urgent matters first'*.

Quality

The quality of services is measured in terms of client satisfaction with actual services provided and attitude of personnel of both service provider and scheme.

Ninety-five per cent of members indicated that they are happy with the scheme. Members indicate that information availability and drug availability are 95 per cent, while speed of attention and positive staff attitude are 100 per cent.

Sustainability

The percentage of members who renew their membership is a crucial indicator of the viability and sustainability of the scheme. The renewal rate for the scheme is between 82 and 86 per cent. This is very high and thus very encouraging (see Table 13 and Figure 5). From this high renewal rates, however, one cannot conclude that the scheme is very sustainable given that the scheme only covers about 30 percent of its catchment area. The scheme is now 11 years old and having survived a decade could be an indication for sustainability.

The percentage renewal for all years except 2001 has been an average of 85 per cent. The year 2001 also recorded the highest registration. In 2002,

Table 13
Number of Renewals of Nkoranza scheme from 1997–2002

Year	Total no. members	Renewals	Percentage
1997	33,314	28,360	85.1
1998	41,342	34,010	82.3
1999	39,288	34,226	87.1
2000	43,688	37,981	86.9
2001	48,709	36,854	75.0
2002	40,605	35,064	86.4

Source: Nkoranza Health Insurance Records

there was a decrease in membership and this was attributed to a change in the registration period.

The risk pooling concept of sustainability of the scheme has sunk considerably well with the people.

These statements from focus group discussions capture it all.

Box 4: Perception of importance of Scheme by Non-Members.

“It can save you from disgrace when the day you fall sick seriously and you have no money.” It is very good because one does not know when he will ever fall sick. Even if you don’t fall sick others can benefit from it”.

Source: Kweku Boateng, Boama

“I know that it is a kind of group you join so that you contribute money towards paying admission fees if admitted. The understanding is that if many people pay not many will fall at the same time. So the few who will fall sick can be treated with the money.”

Mary Owusua, Tanfaino.

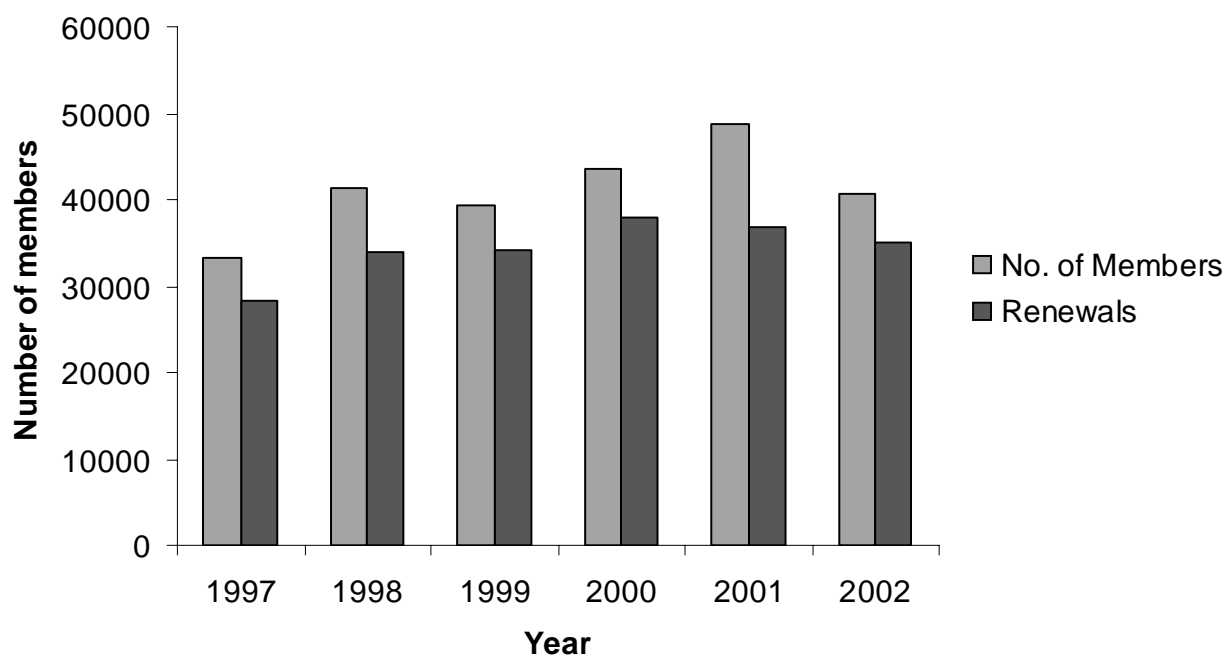


Figure 5: Number of renewals and total number of members of the Nkoranza Scheme

Source: Nkoranza Health Insurance Scheme Records. (1997-2002)

TANO DISTRICT HEALTH INSURANCE SCHEME

District Profile

Tano district is in the Brong Ahafo Region of Ghana. The district has a total land area of 1,500 square kilometres. This represents 3.79 per cent of the total land area of Brong Ahafo Region. It lies between latitudes 1°00'N and 7°25'N and between longitudes 1°45'W and 2°15'W. It is bounded on the north and east by the Offinso and Ahafo-Ano South Districts respectively, both in the Ashanti Region. In the south, it is bounded by the Ahafo-Ano North District, also in the Ashanti Region and in the West and South West by Sunyani and Asutifi Districts respectively.

The district has a population of 123,404 representing 6.8 per cent of the regions population (Tano District Assembly Three Year Medium Term Development Plan 2002-2004). The population density is 82.2 persons per square kilometre (Ghana 2000). The 2000 census indicated a rural-urban split of 56.8:43.2 per cent.

About 64 per cent of the labour force is engaged in Agriculture, Commerce 15 per cent services 13 per cent and Industry 8 per cent (Tano District Assembly Three year medium Term Development plan (2002–2004).

The district has vast fertile lands very suitable for the cultivation of cash and food crops. There are also large deposits of white and red clay at Tanoso and Atwemansu where bricks and tiles, ceramics and pottery industries are prevalent. The proportion of labour force in Agriculture has been declining with increasing activities in commerce and services.

In the 2000 Population and Housing Census, the sex ratio is 100 males to 99.5 females. The presence of migrant male farmers accounts for the slightly more males than females. The potential labour force, 15 – 64 years was 46.3 per cent of the population, indicating an age dependency ratio of 1:1.2 and economic dependency ratio of 1:1.5, implying that fewer people were working and that every worker had more mouths to feed.

The Mutual Health Organisation

Governance and Management

The scheme known as Tano District Health Insurance Scheme is owned by registered Members of the scheme who are in good standing. It was established in May 2001. The organs for the governance and management of the scheme are, the General Assembly, The Board of Directors, The Management Committee and the Internal Audit Committee. The governance of the scheme is by a Board of Trustees who are elected at an annual General Assembly. The Board elects from among its members a management committee to whom authority is given to ensure the daily management and monitoring of the scheme. The Management Committee is composed of;

- I. The Vice Chairman of the Board
- II. The Secretary General
- III. The Manager
- IV. The Accountant
- V. Two Co-ordinators

The office and day-to-day administration of the scheme is by the Manager and the Accountant and the two Co-ordinators. They are accountable to the Management Committee, who meet once a month. Figure 6 is the organogram of the scheme.

Benefits

The scheme offers the following benefits to its members.

- Payment of total cost of hospitalisation
- Payments of bills of a referred policy holder
- Snake and dog bites.
- Payment of OPD bills where cost of services provided is ₵200,000.00 or more.

In a focus group discussion, 55 per cent of the respondents feel that the benefits should not only cover admission and bills of OPD up to the tune of ₵200,000.00 or more. A participant at the forum had this to say;

The insurance scheme and the hospital can continue to refuse one admission if they think by going on admission the person will benefit so much. For example the cost of the operation can be so much high that all the communities' savings can not pay for it

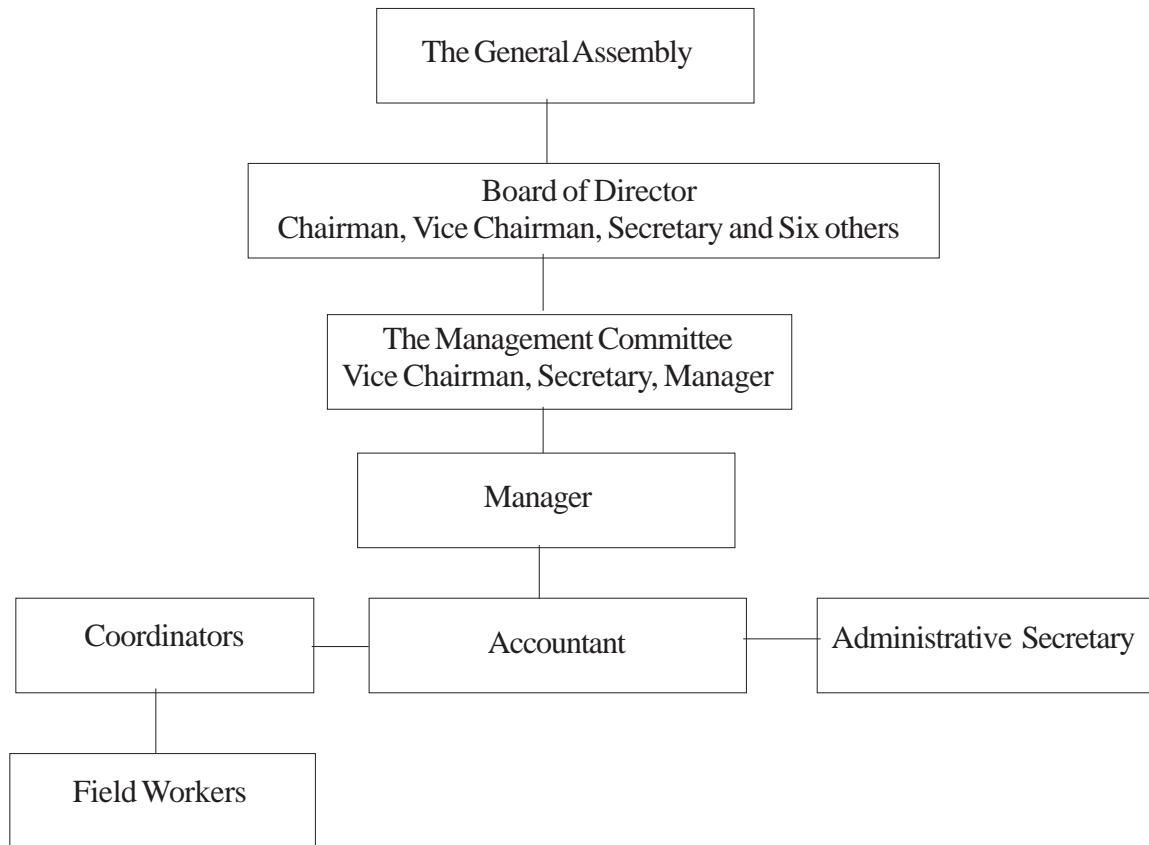


Figure 6: Organogram of the Tano District Health Insurance Scheme

Source: Tano District Health Insurance Scheme

Membership

Membership to the scheme is opened to resident and non-resident natives of Tano District and non-native resident in the Tano District.

Membership of the scheme is by household registration and is compulsory for all members in a household but not compulsory for a household. Proof of membership is an identity card with photo. A member needs to show this anytime he/she visits the hospital for any service. Registration and renewals are done between May and September each year.

In introducing the idea of insurance to the communities, the scheme’s promoters held educational fora at the community level. It was noted that the community responses were very poor. The promoters changed their strategy and visited churches instead. The responses were fantastic as pastors and church leaders introduced the essence

of community insurance in their homilies. Currently, almost 100 per cent of non-members say they have heard about the scheme and 70 per cent say they have been approached directly by promoters of the scheme encouraging them to join. As a result membership grew from 3,958 to 5,829.

Premiums

For all the schemes studied, it is only this scheme that allows payment by instalments. For the year 2001/2002, the premium per individual was ¢15,000.00 and the registration fee was ¢5,000. Currently the premium is ¢20,000 while registration fee is ¢5,000 cedis. Clients have a waiting period of 3 months after the last instalment before before they can access health care services. Each member of a household pays the same amount of premium. At the point of service, services are free and the scheme pays the service provider quarterly. There are two service providers that deal with this scheme and a client can seek care from any of these. Referrals

made by these Service Providers are also catered for. The scheme has gotten support from Danida and CHAG (Christian Hospital Association of Ghana). These are in the way of building capacity and provision of funds for sensitisation activities. The scheme has no capital reserve or seed money.

Performance

Resource Mobilisation

The scheme, in the first year of operation 2001/2002 paid a total bill of ₵68,284,776 to the service providers. A total of 206 persons (2.1 per cent) submitted these bills.

For the same year income from premium was ₵7,916,000 and administration expenditure was ₵45,598,344. This cost was covered by donations from an international charitable organisations. Six persons are responsible for the day to day running of the scheme and the sum total of their salary per annum is ₵1, 846, 000.00 (23.3 per cent)

Efficiency

The Nkoranza scheme is currently spending about 17 per cent of their income on administration. This is high in relation to accepted levels of about 7 per cent but certainly better than Damongo who are around and average of 46 per cent.

Equity

As indicated above, only 2.1 per cent of policy holders use the services. Data available was not segregated in terms of males and females, young and old and, therefore, one cannot make decisions based on the demographic characteristics of members. But in relation to the utilisation levels, the non-sick can be seen to be cross subsidising the sick in very high proportion.

Quality

Most members (70 per cent) and non-members (82 per cent) are generally happy with the scheme. However, there are a few cases or examples that members think that the discretion to admit or not to admit is used to the disadvantage of insured clients.

A case in point is where a patient attended the two hospitals but was not admitted. He went to a neutral hospital within the same period with the same complain and he was admitted. But where a client was admitted they agreed that he was given proper treatment and care.

Sustainability

As a very young scheme (one and a half years) there is no concrete data to make conclusive statement on sustainability. However, the growing members in registration and the willingness of non-members to join is a good indicator of sustainability of about 90 per cent.

So many people have talked to me about joining, friends, colleagues and even some of the insurance workers. When my wife was pregnant and was admitted she was transfused with two pints of blood and we had to pay cash down. If I had registered and had been paying we would not have paid for all these services.

We have seen a lot of people going away free from this hospital without paying anything after staying so long here.

The willingness to risk and to share group solidarity are strongly held principles and good indicators for sustainability.

Even if you pay and you don't fall sick at length you have helped others. One will never know when he will fall sick. I don't think there is any disadvantage joining. There may be disadvantages if the people at the office begin to be corrupt.

THE JAMAN SOUTH DISTRICT HEALTH INSURANCE SCHEME

District Profile

The Jaman District is also one of the districts in the Brong Ahafo region. It is in the western part of the region; very close to la Cote D'ivoire. It's district capital is Drobo. It is located between latitudes 7° 27' N and 8° 27' N and longitudes 2° 32' NW and 2° 66' W. It shares borders with the Wenchi District in the north east, Brekum in the south east, Dormaa District in the South and la Cote D'Ivoire in the West. The district has a total land area of 1,300 km² and 244 settlements. Population density is 132.4 per sq km.

The district has a population of 148,237 (2000 census). A total of 51.9 per cent are males

and 48.1 per cent females. The age distribution of the population is as follows.

0-14yrs – 43 per cent
15-64 – 52 per cent
65 – 5 per cent

Most of the people in the district are farmers, 61.7 per cent services and industry take 35.5 per cent and 2.8 per cent respectfully.

The annual income for households in Urban areas of the District is estimated at ¢1,690,810 per annum and for rural areas ¢1,167,000 per annum. With an average household of five this gives an average annual per capita income of ¢338,162.00 and ¢233,400.00 for urban and rural dwellers respectively.

The Mutual Health Organisation

The district has two health insurance schemes. One is the Jaman South District Health Insurance Scheme [JSDHIS] with its Headquarters in the district capital Drobo and the other, Jaman North District Health Insurance Scheme in the north, with the Headquarters at Sempa. Sempa is the second biggest town and it borders la Cote D'ivoire. It was initially intended that the two schemes will be one but this could not materialise. They are managed separately and independent, of each other. The two schemes however use the same modus operandi, principles and objectives. The northern scheme was the last to commence business. It works within a government-owned service provider while the JSDHIS works within a Catholic environment. The Jaman South District Health Insurance Scheme started work in earnest in November 2001. It was initiated by the service provider. It has, therefore, operated for one and a half years now.

Governance and Management of JSDHIS

The Management of the Scheme is made up of the following groups of people:

The General Assembly: This group is made up of members democratically elected and on proportionate basis of one for every five hundred members from the communities. The General Assembly is regarded as representatives of the owners of the scheme. It meets at least once a year.

Board of Directors/Trustees: This is made up of eight elected members of the General Assembly and seven automatic members. The automatic members are the Manager, the Co-ordinator, Assistant Co-ordinator and Accountant of the scheme, the Hospital Administrator, the Medical Doctor in-charge and the Hospital Matron.

There is also a Management Committee or Team which is made up of the working staff of the scheme. Figure 7 below is the organisational structure of the scheme.

Benefits

It is the policy of the scheme to treat every member equally and according to his/her needs. The benefits are as that the scheme provides is the follows:

- Total hospitalisations i.e. total cost of hospital care while on admission at St Mary's Hospital, the service provider. However, complications arising from criminal abortions and attempted suicide are exempt.
- Members referred to other hospitals are reimbursed with the average bill of member patients within that particular month. Cost of service provided by the service provider before referral shall be deducted from the average bill to be paid.
- Out-patient treatment of snake and dog bites and accidents as well as OPD stay for more than twenty four hours.
- There is no limitation as to the number of times a registered member accesses the benefits in a given period.
- There is a waiting period of three months before a member can access services after registering and paying premiums.

Membership

The scheme in its first year had a membership of 3,843. Currently membership stands at 13008.

Premiums

The scheme started with an initial premium of ¢20,000 and this is yet to be readjusted.

Performance

Resource Mobilisation

The scheme has been in operation for about one

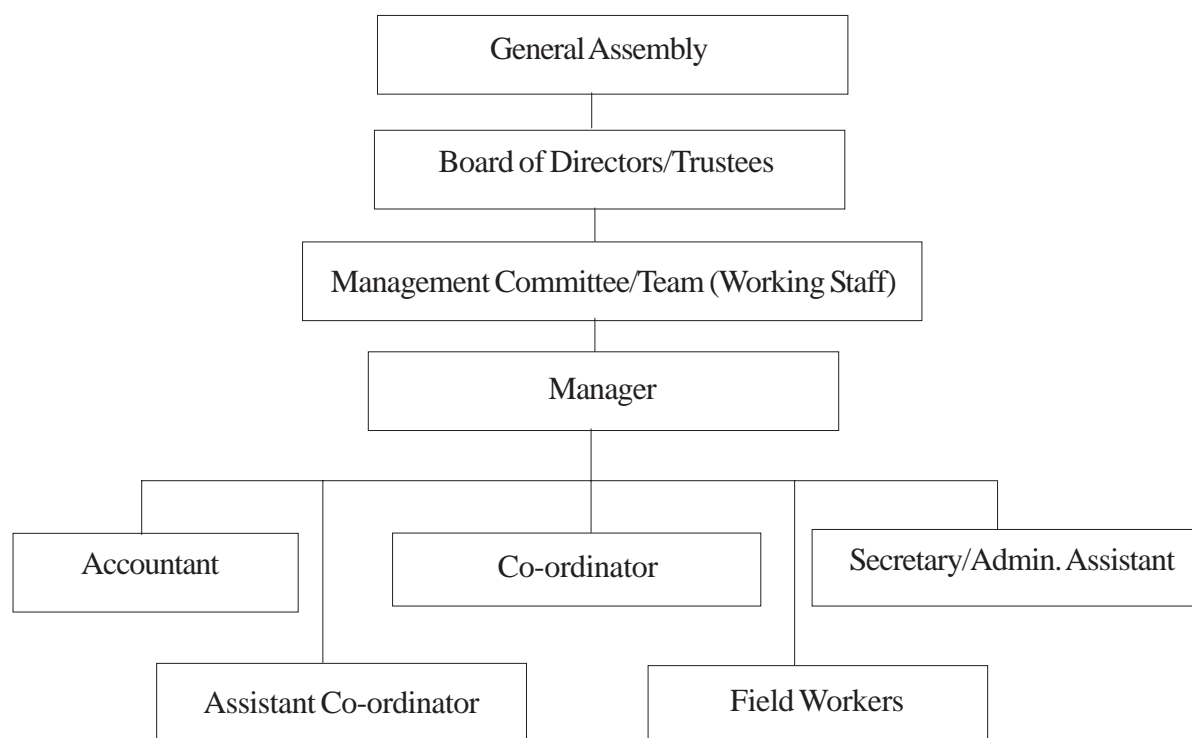


Figure 7: Organogram for the Jaman South District Health Insurance Service

and half years now. Members started receiving services in April 2002.

The catchment area of the scheme has a population of about 80,000 people. Currently the scheme has membership of 13,008 people. Total membership in the first year was 3,843. Between May and December 2002, 95 out of the 3,843 had accessed health services (see Table 14). Their total bill was ₺26,861,800. Premiums was ₺20,000 and registration was ₺5,000 given the scheme a total income of ₺96,075,000.

Efficiency

The scheme is yet to properly organise its data especially in relation to expenditure on administration.

Equity

The scheme in its first year of operation (eight months) had a total membership of 3843. Only 95 persons representing 2.4 per cent accessed the benefits. The average bill was ₺282,755,000. The sick are, there-

fore, being subsidised by the non-sick. Majority, 70 per cent of members indicated that the premiums are affordable and almost 100 per cent of both male and female non- members say the premiums are unaffordable.

Table 14

Number of people who accessed services May 2002–April 2003

MONTH '02	NO. RECIEVED SERVICES	TOTAL BILL
MAY	9	1,385,900
JUNE	9	4,361,100
JULY	7	2,618,300
AUGUST	12	3,117,500
SEPTEMBER	10	2,666,000
OCTOBER	17	3,343,000
NOVEMBER	13	3,256,000
DECEMBER	18	6,114,000
TOTAL	95	₺26,861,800
MONTH '03		
JANUARY	15	5,513,200
FEBUARY	15	2,927,400
MARCH	15	6,478,700
APRIL	11	1,428,700
TOTAL	151	₺43,209,800

Quality

Eighty per cent of members indicate that drugs are always available, and 40 per cent also indicate that most at times injections are not available. Thirty per cent also say that most of the time when they report sick they have to shuttle between the hospital and the insurance for some information and this takes a lot of their time. Almost 95 per cent said staff attitude is good and they do not have problems with waiting time.

Sixty per cent of members say they are happy with the services received. However 80 per cent are of

the view that OPD services should be included. For these people this is the only way they can also enjoy the services or else “*they will be paying for others to enjoy*”

Sustainability

Out of a total membership of 3843, 2100 renewed their policies, this represents 54 per cent. Registration trends are increasing and currently total membership stands at 13008. An increase in growth by 29 per cent. The scheme is only one and half years old.

Chapter Four

DISCUSSION OF RESULTS

INVENTORY AND CLASSIFICATION OF SCHEMES

Northern Ghana, including Brong Ahafo has about 45 schemes. Most of these schemes are very rudimentary. The fact that there is this large number of schemes indicates that most people and communities have realised that cost of health has reached levels that individuals cannot absorb on their own.

The survey reveals basically two types of schemes:

District-Wide Schemes: These are often initiated by the service providers with support from the District Assembly or vice versa.

The other type of schemes are normally society, or group based-schemes whose membership is limited to a particular class of people e.g. ethnic or religious.

Performance of Four Selected case Studies

Government/Management

All the schemes have democratic structures for running their activities. It was realised that most of the staff who run the day to day affairs of the scheme may not have the capacity to make these structures work. Apart from Nkoranza none of the schemes has employed a graduate. This could explain why apart from Nkoranza that has very complete and accurate data the rest do not have. They are unable to implement risk management properly, manage data properly, monitor cost and to report in detail to its members.

People running the scheme should be given more training. They should be able to check corruption. Anybody found to have stolen money should be sacked immediately.

However, in all schemes, 90 of members feel they own the scheme and the managers are doing well. The feeling of ownership is critical for the growth

and sustainability of the schemes. However, the arbitrary increases in premiums along side the inflationary trends or dictates of the economy without recourse to the communities is frustrating and can reduce the zeal to join a scheme.

One disadvantage is that in Ghana there is always the tendency to always increase fees and payments. When they started the premium was very small. Now we can't pay.

In setting premiums no actuarial or cost analysis are made. What is assumed to be reasonable from common sense knowledge is applied.

In all the schemes almost 100 per cent of non-members are aware of the existence of the scheme and 99 per cent had heard about the scheme over two months ago. The schemes use quite identical methods of educating the communities. These include first educating chiefs and opinion leaders including assembly men. Training of field workers and holding community fora.

"There is hardly anyone in the District who has not heard about the scheme" For the Damongo and Nkoranza Schemes 4 in 10 persons say that they have been approached directly by workers of the scheme and the scheme explained to them, apart from hearing about it in durbars. *"The chief in my village has been talking to people about it and encouraging them to join."*

The Tano Scheme went further to innovate. They used the Pastors of Churches to promote the idea of insurance. According to managers of the scheme, registration numbers increased geometrically when the Pastors got involved. It is important to note that solidarity is deep rooted in the Ghanaian society but trust in leadership is critical and that at least one can trust church leadership.

Ironically, a Pastor complained of selective admissions to the detriment of insured clients. He had evidence where one was refused admission on two occasions by the service providers and when

the one moved to a different and neutral facility the one was admitted. Some people think that the Insurance Scheme can influence the admission criteria of the service provider.

“ The insurance company should not be in the premises of the hospital and the insurance workers should not take part in determining who should be admitted.”

Benefits

All the schemes offer almost the same benefit packages to their members. The benefits include all admissions excluding admissions resulting from criminal abortions and attempted suicide, (Catholic orientation), snake and dog bites, complicated deliveries and accidents.

The Nkoranza Scheme takes care of client who stays in the Out-patient Department for more than twenty four hours while the Tano and Jaman South Schemes consider Out-patient whose bill is ₺200,000 or more. The West Gonja Scheme does not consider out-patients except for dog bites. In all the schemes, there is no financial ceiling to the benefits. The highest benefit recorded comes from Nkoranza where a cost of a client's hospitalisation was ₺8,000,000.

Non members of the schemes, 8 in 10 were of the opinion that the scheme should cover out-patients because the decision to admit is at the discretion of the scheme.

They should not only cover admissions. The Insurance Scheme and the Hospital can continue to refuse one admission if they think by going on admission the person will benefit so much. For example the cost of operation can be so high that all the communities' savings cannot pay for it. (West Gonja).

The schemes use an essential drug list and drugs are available averagely 80 per cent of the time. The schemes also have varying waiting times before clients can receive benefits. For the West Gonja Scheme the waiting period is six months. The Nkoranza Scheme is two months and the Tano and Jaman South Schemes have a waiting period of three months each.

In West Gonja where the waiting period is six months it was reported that some persons preparing for elective surgery take advantage of the scheme by registering and waiting for their policy to mature. They do the surgery and thereafter do not renew their policy. This implies that adverse selection is worst for schemes like Nkoranza, Tano and Jaman who have very short waiting periods.

Membership

All the four schemes are District-wide. All resident and non-resident natives are qualified to join as well as non natives resident in the districts. The schemes do not discriminate in terms of ethnic, religious, occupational or political affiliation. Membership in any of these schemes is voluntary. Apart from West Gonja which is doing individual registration (it is in the process of starting household registration), the other schemes do household registration. The experience for Nkoranza is that some members do not declare or register all members of the household and do not pay the premiums for all. In the case of not declaring all household members, they are using the communities' members to do the registration. In all the schemes, members are identified by the picture identity card with a pre-printed identity number embossed on the picture. Where household registration is done, a household register is kept.

The period of registration of the schemes vary. For the West Gonja Scheme, registration is all year round. In Nkoranza, registration is done during the month of September and October. For Tano, registration is done between May and September and in Jaman registration is done between November and January. Nkoranza has a two months period, Tano five months and Jaman three months. Nkoranza initially had a registration period between December and January. Members complained that the period coincided with Christmas and, therefore, was not favourable since they spend a lot of resources during Christmas. With this current period of September and October they complain that it coincides with reopening of schools and fees paid to schools take a good proportion of their incomes. It appears, therefore, that members will have an excuse to give for any month. The crucial fact to note is that premium collection should coincide with harvesting periods when food is abundant and

farmers can sell some food stuffs to pay for registration fees and premiums. Registration periods of all the schemes should coincide with this period of abundance.

Open registration system as occurs in West Gonja could be problematic in terms of data management since the schemes do not have the human capacity. It was vividly clear during the survey that West Gonja had very unorganised data. The five month period as practised in Tano could run into the same problems as West Gonja.

Currently (2003), the membership and per cent coverage of regulations of the various schemes are; West Gonja 38884 (27 per cent), Nkoranza 40,603 (30 per cent), Tano 9453 (7 per cent) and Jaman 13000 (16 per cent). The oldest scheme in Ghana, the Nkoranza Scheme has coverage of 30 per cent. The schemes still have a lot to do in getting more people to join.

Premiums

The periods of registration are also periods of payment of premiums for all schemes. All the schemes practice a flat or uniform rate system for all members. Currently premium is ₵20,000 for all individuals in all the schemes. The Tano scheme allows premiums to be paid in instalments and the last day of full payment is when the waiting period starts.

Most of the non-members of the schemes 9 out of 10, said the premiums were unaffordable and they could have joined if they had money.

I have a family of five and how to get money to register all the five is very difficult as I am not a worker (Tano).

“Sometimes when I come from my village to register I end-up returning without doing so because other pressing matters crop up so I use the money for that.” (Nkoranza)

One may conjecture that the schemes are not benefiting the majority for whom it was established. Gaining financial access is still a problem for the rural poor.

Some households are not able to renew premiums for all their members. For those who are not able to pay the premiums of all registered members, when a registered household member is

admitted, he is to pay the premiums of all the rest before he can benefit from the scheme. This is clearly not a solution to the problem. The factors leading to this situation is that the premiums are becoming unaffordable and that a flat or uniform premium for all members of a household is convenient but not appropriate. A sliding scale could be most appropriate and acceptable.

Payments are free at the point of service and the scheme reimburses the service provider thereafter. In West Gonja and in Tano the provider is reimbursed quarterly whilst in Nkoranza and Jaman South it is done monthly.

All the schemes have secondary sources of funding. Most of these sources are international Non-Governmental Organisations. Some offer to pay the salaries of the employees for the first one or two years (Nkoranza, West Gonja and Jaman South) while others provide funding for community sensitisation. Some provide capital for building offices like in Jaman and Damongo while others provide office furniture and computers as well as training. DANIDA supports in this direction. Action Medeor subsidises premiums for school children in West Gonja. Nkoranza, West Gonja and Jaman South have reserve funds they can access and this has been made available by donors.

Performance

Resource Mobilisation

The schemes have contributed significantly to the in-patient income of the service providers. The West Gonja Scheme has since its inception (January 1996 – December 2002) contributed ₵690,927,133 to the in-patient income of its service provider. In 2001, it contributed ₵95,000,000.00 out of an income of 195,049,469. This represents 48 per cent of the service provider's in-patient income. Averagely its contribution to the in-patient service provider's income is about 47 per cent.

The Nkoranza Scheme, on the other hand, in the year 2001 paid an amount of ₵387,000,000 as its expenditure on bills. The total service provider income for the same year was ₵560,000,000. The payment made by the scheme represented 69 per cent of the total in-patient income of the hospital. Averagely the scheme contributes about 64 per cent of the inpatient income of the hospital since 1997.

Both schemes, therefore, play a very critical role in the revenue mobilisation of the service providers.

The Tano and Jaman South schemes have operated a little over a year now and both have contributed significantly to their respective service providers. The Tano Scheme in the first year of operation 2001/2002 had an income of ₵79,160,000. Out of this it paid bills totalling of ₵68,284,776 (86 per cent) to its service providers. This was the bill for 206 persons. Jaman South, on the other hand, had an income of ₵96,075,000 and contributed ₵26,861,800 (27 per cent) as in-patient income to the service provider. Ninety five per cent policy holders had accessed health care.

Efficiency

Administration expenditure of the schemes have been quite reasonable in relation to the revenue collected. The West Gonja Scheme had data on expenditures for the year 2001 and 2002. Expenditure for 2001 was ₵161,057,309. The amount that went into general administration was ₵66,057,309 (41.1 per cent). For the year 2002, total expenditure was ₵500,858,067 and administration cost was 264,098,331 (52.7 per cent). The Nkoranza scheme is currently spending about 17 per cent of its income on administration. This is high in relation to accepted levels of about 7 per cent and certainly better than Damongo that has an average of 46 per cent.

The expenditure on Administration was ₵141,162,367. This is 19 per cent of the income and 24 per cent of expenditure on bills.

For the other two schemes the expenditures are financed by charitable organisations. This is because they have just begun and a lot of expenditures need to be incurred. For example, income from registration and payments of premiums for Tano in the last year was ₵7,916,000. Administration expenditure was ₵45,598,344; five times more than revenue. A total bill of ₵68,284,776 was paid to the service providers.

The Jaman South Scheme had an income of 7,686,000. Total expenditure for the scheme was 161,057,309. The amount that went into general administration expenditure was 66,057,309 (41 per cent).

All schemes have seen geometric rise in their numbers since they were established. The West Gonja Scheme started in 1996 with a membership of 6,169 and in 2002 membership is now 38,884. As the number of members increases, utilisation levels also increase. A total 241 persons in 1996 and 1266 in 2002 (see Table 5). Though there is no data on utilisation by service type, the service type most used is admission for surgery.

The Nkoranza Scheme had a membership of 33,314 in 1997 and 40,605 in 2002. Utilisation levels for Nkoranza are oscillating (Table 8). The average utilisation level is about 4.2 per cent. Up to 206 (5 per cent) members of the Tano Scheme utilised its services out of a membership of 3958 while in the Jaman Scheme 95 had received benefits out of 3,843. Currently the scheme has a membership of 13008.

Equity

Cross subsidisation, that is the situation where the rich and the poor contribute but the rich pay more or fall sick less allowing the poor who are prone to illness benefit from the pooling of resources is crucial for insurance. In Ghana it is very difficult to determine income levels. Any figures given are mere guess estimations. However, given the WHO estimate that people earning below 100 dollars fall below the poverty line, then almost three-quarters of the people living within this study area are very poor. The data available lends itself to risk equalisation than cross subsidisation. The number of persons reporting sick in all the schemes is not above 5 per cent. This implies that a great proportion of members of the schemes' areas are non-sick. It is equally important to note that the five per cent who report sick almost always erode the incomes of the schemes.

Quality

In all the schemes there is a general feeling of satisfaction by members. However, a few misunderstandings exist.

In West Gonja, most members 14 in 20 are satisfied with the scheme. However, about 10 per cent complain that as scheme members they are given inferior treatment. Drug availability is rated by members as 50 per cent. Their rating of drug availability as average is because when one attends hospital without receiving an injection one concludes

that he is not treated. Members rate waiting time as very good (70 per cent) and staff attitude as good (60 per cent).

However, non members think that they are missing a lot and members of the scheme are well treated by the service providers (80 per cent).

Ninety five per cent of members of the Nkoranza Scheme indicate that they are happy with the scheme. They indicated that information and drug availability are 95 per cent. While speed of attention and positive staff attitude are excellent (100 per cent).

For the Tano Scheme most members (70 per cent) and non members (82 per cent) are generally happy with the scheme. However, there are a few cases or examples that members think that the discretion to admit or not to admit is used to the disadvantage of insured clients.

A case in point is where a patient attended the two hospitals but was not admitted. He went to a neutral hospital within the same period with the same complain and he was admitted. But where a client was admitted they agreed that he was given proper treatment and care.

Eighty per cent of members indicate that drugs are always available, and 40 per cent also indicate that most at times injections are not available. Thirty per cent also point out that most of the time they report sick and they have to shuttle between the hospital and the insurance for some information and this takes a lot of their time. Almost 95 per cent state that staff attitude is good and they do not have problems with waiting time.

At the Jaman Scheme on the other hand, 90 per cent of members note that they are happy with the services received. However 80 per cent are of the view that OPD services should be included. For these people this is the only way they can also enjoy the services or else *“they will be paying for others to enjoy.”*

They rate drug availability, availability of information, waiting time and staff attitude very high 95 per cent, 70 per cent, 70 per cent, 90 per cent respectively.

Sustainability

Most of the schemes seem sustainable, however, sustainability depends on their ability to be relentless in their recruitment drives as well as prudent management practices and involving members at all times and making information available to all. It also involves recruiting and retaining qualified staff and giving them economic salaries.

The West Gonja Scheme has an average growth rate of about 12 per cent (Table 6). The scheme is now eight years old and eight years of a sustained experiment can enhance survivability of that experiment.

The Nkoranza Scheme has an average percentage renewal of 85 per cent. The scheme recorded the highest registration of 48,709 in 2001. In 2002, there was a decrease in membership and this was attributed to a change in the registration period (Table 8). The scheme is now eleven years old.

The Tano and the Jaman schemes are very young; (one and a half years). There is no concrete data to make a conclusive statement on sustainability. However, the growing members in registration and the willingness of non-members to join is a good indicator for sustainability. About 90 per cent of non-members said they will join.

For the Jaman Scheme, 2100 out of a total membership of 3843, renewed their policies. This represents 54 per cent. Registration trends are increasing and currently total membership stands at 13008; a growth of 29 per cent.

The day-to-day running of the schemes is being done by persons who have no formal training in insurance and community development. They are not able to calculate or estimate risk. They are also not able to draw programmes that can develop and sustain community interest in the schemes. Comparatively, Nkoranza is better placed in terms of these practices. However, all the managers have been attending workshops and seminars which have helped enhance their skills and understanding of managing an insurance scheme. It is also important to note that the concept of community health insurance is very new in Ghana and very few persons have skill to be employed in these areas. Training of the persons on the job now is what is required.

The concept of solidarity and willingness to share risk is well acceptable among members as well as non-members of all the schemes. For West Gonja, 80 per cent of non-members stated that they are willing to contribute to offset the bills of other persons knowing very well that it could be their turn next time round.

It can save you from disgrace on the day you fall sick seriously and you have no money. It is very good because one does not know when one will ever fall sick. Even if you don't fall sick others can benefit from it.

I know that it is a kind of group you join so that you contribute money towards paying admission fees if admitted. The understanding is that if many people pay not many will fall sick at the same time. So the few who will fall sick can be treated with the money (Nkoranza).

So many people have talked to me about join-

ing, friends, colleagues and even some of the insurance workers. When my wife was pregnant and was admitted she was transfused with two pints of blood and we had to pay cash down. If I had registered and paying we would not have paid for all these services (Tano).

We have seen a lot of people going away free from this hospital without paying anything after staying so long here (Jaman).

As can be determined from these statements the willingness to risk and to share-group solidarity are strongly held principles in the various communities and are good indicators for sustainability.

Even if you pay and you don't fall sick at least you have helped others. One will never know when one will fall sick. I don't think there is any disadvantage joining. There may be disadvantages if the people at the office begin to be corrupt (Damongo).

Chapter Five

BEST PRACTICES AND CONCLUSION

BEST PRACTICES

The following are observed best practices and recommendations which could be used by any district or group contemplating insurance.

Governance and Management

Most scheme members are non-literate and, therefore, do not completely understand the contemporary concepts of mutual organisations. Schemes that build beneficiary capacity, empowering members to participate in decision making processes create a better sense of “we feeling” and have great potentials for surviving.

The mushrooming of schemes all over Ghana is a realisation of the absolute fact that the Government of Ghana can no longer shoulder the financing of health care. This is evident in the shrinking government contribution in the health sector (less than \$8 Per capita) and the almost deplorable state of the hospitals and the reduced access to health care. There is, therefore, a compelling need now than ever for a total mobilisation of individuals, the family and the entire communities to ensure active and popular participation in community pooling of resources.

In other to ensure popular participation, the district should be divided into health zones and each health zone should elect an insurance representative. The representative will mobilise the zone for purposes of insurance and liaise between management and the people. He or she should also represent the zone at the management board meetings.

The building of management capacity in managing mutual organisations is very crucial. Mutual schemes are new and there is no trained pool of personnel available for one to attract. Those on the ground should be encouraged and short courses made available to them. The most successful schemes have this policy of giving opportunity to its management.

The decentralisation concept devolves power to the District Assemblies. The assemblies have the machinery for quick mobilization of the communities. Mutual organizations need to use the assemblies as a spring board to get into the communities to be recognised and accepted.

Benefits Package

In all the schemes studied, none of the schemes offer comprehensive services to its members. That is both OPD services and admissions. Where OPD services are included they have in them certain criteria that make utilisation of the services very minimal.

However, all members and non-members express the dire need of the introduction of non restrictive OPD services. The fear of this is that most persons will seek care excessively [moral hazard]. To curtail the tendency to over demand for services, the scheme should introduce co-payments [members pay a percentage of the health care bill out of pocket] and deductibles [members pay a fixed amount and the scheme pays the rest].

The ability to manage OPD Services to avoid the tendency of over-use by members is a critical issue which managers must learn to deal with.

Premiums

All the schemes studied employ a flat rate premium system, that is every member of a family pays a fixed sum of money. For most members, this is worrying since in their view the probability of illness varies in each age group and also that the productive population should not be paying the same as the non-productive.

Differential premiums are an alternative to the flat system and if this is negotiated and scientifically determined, then its acceptability will be wide.

It is also important to recognise that no matter the premium levels some people will not be able to pay. In the study, such sentiments were expressed and suggestions such as subsidies and exemptions for the very poor were made.

Quality

Issues of quality of service are noted to be motivations for persons to join a scheme. An assurance of quality service is a prime contributing factor to willingness to pay. The extent to which policy holders sustain interest in the scheme is the level of quality they perceive of the service provider. It is, therefore, imperative that schemes give equal attention to improving on their quality.

CONCLUSION

There is divided opinion about the prospects of insurance for the informal sector. Critics are of the view that the informal sector, particularly those of the rural setting, cannot participate in insurance. They argue that the income levels of rural folks are pathetically miserable and the current levels of individual health expenditure very low. This study reveals that despite the acceptable fact of low incomes of the rural folks and the inability of a good portion of the people to pay their premiums, there is a felt

need for insurance because of the ever increasing cost of medical care and their inability to pay for health care on demand.

It is an agreeable fact that voluntary insurance is highly and positively related to income. Poorer households will probably tend not to buy it. This problem can be partially offset if government subsidies for hospitals and other curative services are converted subsidised for low income households to purchase insurance.

From the study, the following conclusions could be made;

- Informal mutual health organizations are increasing community awareness of the merits of risk pooling schemes.
- The organisations are bringing about effective access to health care.
- The service providers are improving their quality of service.
- Financial mobilisation to the service providers is very significant and this has improved the financial base of the service providers.