The Economy of Ghana Network (EGN)
Institute of Statistical Social and Economic Research (ISSER)

Policy Brief

August 2014, No. 16

BARRIERS TO ENROLMENT AND RETENTION IN GHANA'S NATIONAL HEALTH INSURANCE SCHEME

Introduction

The government's vision for introducing the National Health Insurance Scheme (NHIS) in 2004 was to provide a more equitable quality healthcare to all residents in Ghana without the need of out-of-pocket payment at the point of service utilisation. The premium is heavily subsidised with the subsidy financed by a 2.5% value added tax and formal sector workers' Social Security and National Insurance Trust (SSNIT) contributions. The cost of premium for non-SSNIT contributors is GH₵18.00-GH₵48.00 per annum and GH₵4.00 as registration fee and GH₵1.00 administrative fee to renew membership. Exemptions are provided for vulnerable groups (children below 18 years, those aged 70 years and above, SSNIT pensioners, indigents and pregnant women). Except pregnant women, all exempt categories pay registration and administrative fees. The NHIS was thus expected to reach the poor first and achieve universal coverage within five years. However, alongside NHIS' success story of improving healthcare access, enrolment is low and dropout high (National Health Insurance Authority, 2011) and the poor, the target of the policy enrol less (Asante and Aikins 2008, Sarpong, 2010) making the dream of achieving universal coverage a mirage.

Methods

This policy brief is based on an anthropological component of a multidisciplinary study which identified barriers to enrolment in the NHIS in the Central and Eastern regions of Ghana. The study used data from household survey in 15 districts in the two regions (7 in Central Region and 8 in Eastern Region) and anthropological approaches used to identify barriers to enrolment and retention of members in the NHIS. The sample was randomly selected using a three-stage procedure: (1) One census enumeration area (EA) referred to as community in this paper was randomly selected from each of the 30 districts with DHIS offices using computer generated random numbers. (2) All structures were mapped and households listed. (3) 110 households randomly selected using the lottery method. The survey was conducted after each problem-solving group (which consist of representatives of community

members, health providers and District Health Insurance Scheme staff) in each community carried out 20-months educational and promotional activities to ensure all community members understood NHIS' operational principles and benefits package.

Qualitative information was obtained from two case study communities using observation, in-depth interviews and informal conversations. In all, 40 key informants; 20 from each study site (11 community members, 7 health providers and 2 DHIS staff) were purposely selected. The community members were selected based on their representativeness of the target population: currently insured, previously insured and never insured and being above eighteen years of age, gender, education, socio-economic status and perceived health status. Key informants who were health providers or DHIS staff were purposely selected before going to the field based on their work schedule and insight in the NHIS' operations.

The results provide in-depth information on individual NHIS status and among five socio-economic categories, barriers to enrolment and retention in the NHIS. The NHIS status was grouped into three: currently insured (those who have valid NHIS cards), previously insured (those who did not renew their membership) and never insured.

Results and discussion

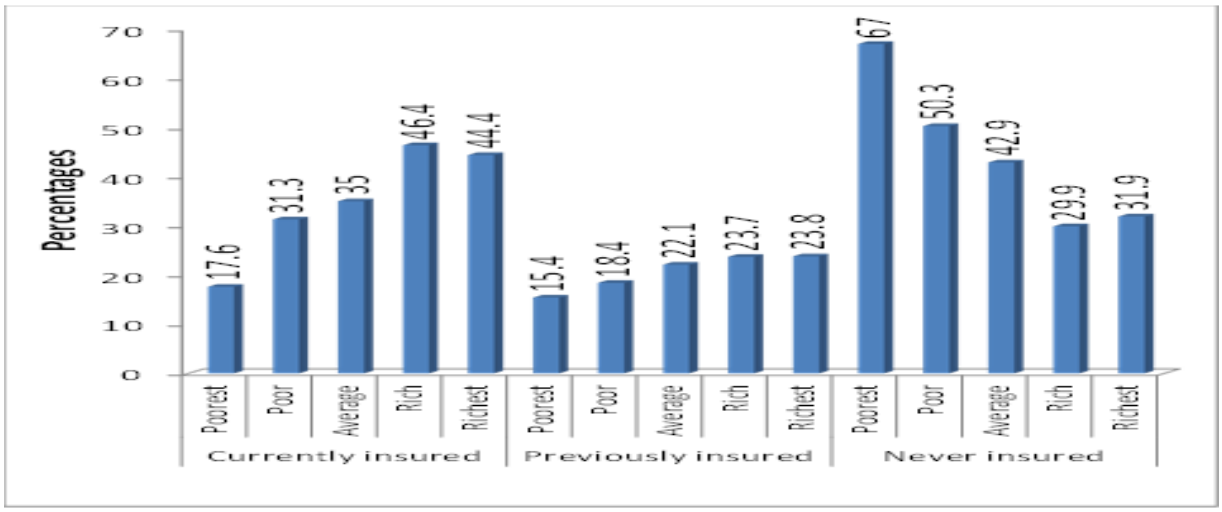
Barriers to enrolment in the NHIS and retention of members

The overwhelming endorsement of the NHIS as providing financial relief from catastrophic healthcare payments did not translate into high enrolment and regular renewal of membership. The survey results show that many people who enrolled in the NHIS did not renew their membership regularly. Less than half (40.3%) of the population surveyed were currently insured, 22.4% were previously insured and 37.3% never insured. Three main factors that respondents believed eroded confidence in the NHIS and contributed to low enrolment and retention were: poverty, healthcare delivery challenges, policy makers' and implementers' lack of commitment to include the core poor in the scheme.

Poverty and low uptake of health insurance

Figure 1 shows that poor quintiles enrol less: poorest 17.6%, poor 28.6%, the rich 46.4% and richest 44.4%. Membership non-renewal rate was higher among the richest (23.7%) and rich (23.8%) than poorest (15.4%) and poor (18.4%). Figure 2 show that many people did not renew their membership because they did not have money to pay the premium. This statistics indicates poverty contributes to enrolment but less significant in renewal of membership.

Figure 1: NHIS status by socio-economic groups



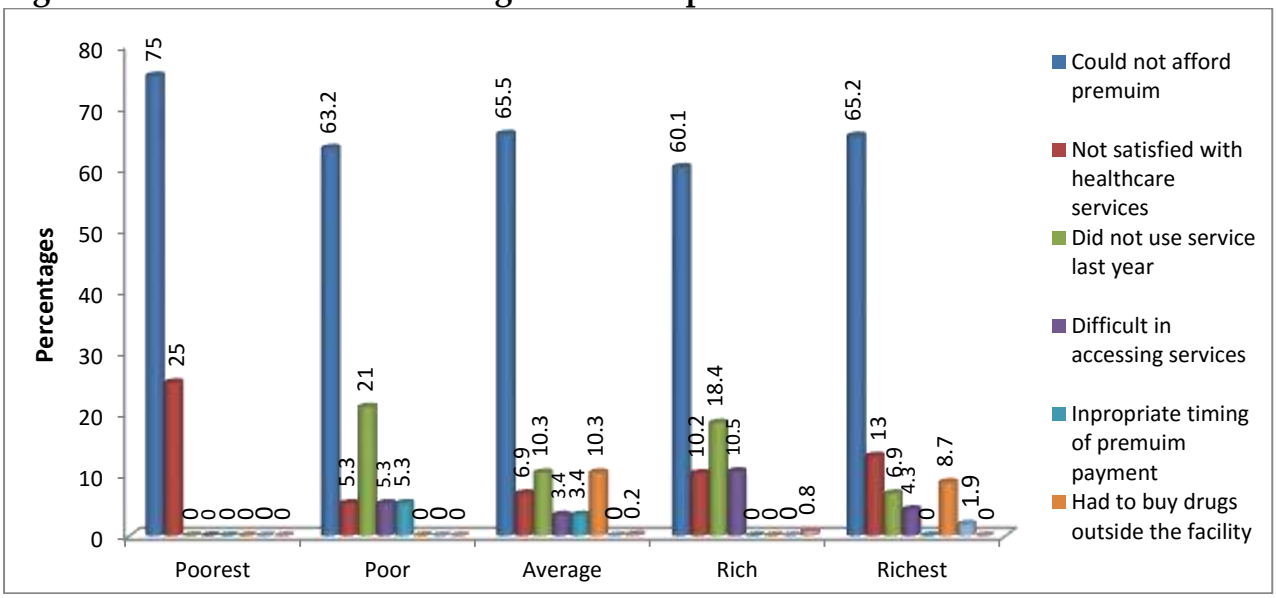
The result indicates that poverty was the reason for not renewing membership in the NHIS and never enrolling. The core poor, the poorest quintile, were the least enrolled because they did not have money to pay the premium as shown in Figure 2.

A core poor woman explained their situation as follows:

"I have five children. I want to enrol them because the cost of premium is cheaper than the cost of healthcare, but I don't have money.... I do menial jobs… one of my daughters died because I had no money to take her to the hospital when she was sick."

Meanwhile the exemption provided to ensure the core poor's inclusion in the NHIS is not reaching them. This situation thus defeats the purpose of the NHIS as a safety net, which is expected to provide the poor with access to healthcare when ill.

Figure 2: Reasons for not renewing membership in the NHIS



A community leader explained the actual situation as follows:
"Health insurance means little to us. It is a pity that most of us have not enrolled when in fact we can … during harvest time. We, Ghanaians don't think about securing ourselves against ill health until we are sick."

Getting our priorities right!
The more than 60% of average, rich and richest respondents who did not renew their membership or never enrolled because they could not genuinely pay the heavily subsidised premium of GH₵18.00 raises the question about priorities in household spending. Analysis of the comments shows that poverty in many cases was not the main reason for not enrolling in the NHIS or enrollees renewing their membership. People saw health insurance as a less pressing issue when healthy. They used the "*No money to pay premium*" as a more rational answer and convenient excuse to avoid blame. This clearly indicates that the minimum solidarity values that were expected to inspire people to accept the cost-and risk-sharing embedded in social health insurance was absent.

Many key informants explained the behaviour as follows:
"*Many people were influenced by nnoboa (traditional risk-sharing groups) where every member is certain to benefit according to his or her contribution, while an insured person has largely unlimited access to healthcare when sick but receives nothing if they are well."*

Thus though solidarity and reciprocity are predominant features of both traditional mutual risk-sharing arrangements and health insurance, the respondents' reaction to the latter is influenced by the principles of the former.

Negative experiences with health professionals
The study revealed that the NHIS was implemented within an overburdened health system without providing adequate resources to health facilities' capacities to cope with the increase in service utilisation. Though the increase in utilisation is desirable, it increased health providers' clinical and administrative workload. Generally, clinicians are used to hurriedly writing a few words and not spending time filling out long and complicated forms. The additional task of completing the two page NHIS form psychologically drew a negative reaction towards insured patients. Some health workers were hostile to insured patients, demanded cash payments from them to avoid filling the NHIS forms and gave preference to uninsured patients.

Insured patients' complaints are summarised as follows:

"Health workers don't respect us. They often use derogatory language such as 'NHIS card holders disturb us'. They give priority to uninsured patients. They make us wait longer than cash-paying patients. Above all, some of them collect illegal fees".

A health worker's reaction to insured patients' complaints was:
"*These are genuine complaints …. Some of us see insured patients as giving us extra work so we are hostile towards them, collect money from them, and give preference to uninsured patients.*"

However, health workers were not a homogenous category in the way they treated insured patients. Some of them persuaded their patients to enrol.

An insured patient shared his experience in the following statement:
"*I registered because of the Medical Assistant's persuasion. She always convinces her patients to register. … They ask patients whether they have insurance card.*"

Shortage of drugs on Health Insurance Drug List at health facilities
There was "missing links" among stakeholders about the care that insured patients expect and what policy makers' thought would satisfy them and stimulate enrolment and retain members. Insured patients anticipated to receive all their prescribed drugs from the health facilities. Policy makers on the other hand, felt that accredited pharmacies and chemist shops could augment drug shortages at health facilities and satisfy insured patients' needs. Insured patients complained about the inconvenience of looking for accredited pharmacies and chemist shops to get their prescribed drugs.

The following description by a community member shows insured patients' dissatisfaction:

"We don't have an NHIS accredited pharmacy here so if all they give us at the hospital is a prescription to go and look for drugs we could as well go to the store, describe our condition and buy the drug. The last time, I ended up paying for a drug covered by health insurance in an accredited pharmacy. Sometimes that is what happens and we don't feel like renewing our cards."

The survey results corroborate these findings and show that 64% of insured respondents still have to buy drugs. An overwhelming majority (83.7%) insured respondents and (90.3%) previously insured respondents indicated that: "*Availability of drugs at health facilities should be improved*". Insured patients mentioned that these payments make the NHIS expensive and does not provide the expected relief from out-of-pocket payment. These experiences discouraged many people from enrolling or enrolees form renewing their membership since the idea of enrolling in the NHIS was not to pay money when accessing healthcare. For many people, enrolling and

remaining in the NHIS is determined by whether they were given drugs at health facilities or not.
These incidents make insured patients feel disappointed about the quality of service at health facilities. This illustrates a significant misunderstanding about what insured patients considered crucial to quality services and what policy makers considered reasonable and will encourage people to enrol and enrolees renew their membership.

Conclusions and implications for policy

The multiple and often conflicting interests of stakeholders (both potential subscribers and service providers) converged to undermine enrolment in the NHIS. It appears neither poverty nor cost of premium was a major constraint for not enrolling and remaining in the NHIS. Rather, traditional mutual-aid principles and practices that rested on immediate reciprocity influenced many people not to see health insurance based solidarity and delayed rewards, as a pressing need when healthy. More education is needed to improve Ghanaians' understanding and appreciation of the cost- and risk-sharing embedded in the NHIS so they do not consider the operational principles of the NHIS as the same as traditional mutual support groups. Moreover, since the cost of prolonged illness does not only hinder an individual's wellbeing, but the country's development as well, it makes economic sense to use some form of incentive such as making health insurance a requirement for obtaining voter identity cards, driving licenses, passports, marriage certificates and admission to educational institutions to ensure that all citizens have access to healthcare and remain healthy.

The deteriorating quality of care has been raised as one of the barriers to enrolment and utilisation of healthcare services. The underpinning question is how can the health facilities be better resourced? Does the country have the resources to do that? Is there a need to reflect some more on the subsidies so that we find a better premium that reflect the actuarially fair price of the insurance? This is the real challenge for policy and this must be addressed to bring back confidence in the scheme and ensure its sustainability in the long term.

Acknowledgement

This research was supported by the Netherlands Organisation for Scientific Research (NWO) through the SHINE Ghana Project: 'Reaching the poor with Ghana's National Health Insurance Scheme.

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Published by

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This brief is based on a workshop organized by the EGN.
Publication of this brief is funded by the ACBF