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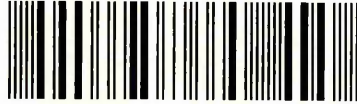
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**Health Sector Reforms: A Study of Mutual Health
Organisations in Ghana**

Augustine Afari-Adomah

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Sheffield Hallam University
for the degree of Doctor of Philosophy**

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Abstract

This thesis examines the problems of health financing and the emergence of Mutual Health Organisations under the health sector reforms in Ghana. Governments of sub-Saharan Africa region have embraced the Community-based health insurance schemes concept under the health sector reforms, with momentous enthusiasm. They believe that these newly emerging health financing arrangements could easily be utilised as platforms for initiating Social Health Insurance strategies to reach the economically deprived people. Without such schemes, citizens would become poorer because they would have had to dispose of their family's wealth in order to treat a member who falls sick. Ghana, a developing country in West Africa has introduced a National Health Insurance Scheme, which is fused with Social health insurance and Community-based health insurance schemes. This study examines pro-active plans to address the financial viability of the schemes, to prevent them from going insolvent.

The study generally, investigates health sector reforms in the context of Ghana. Four operating District Mutual Health Insurance Schemes (MHOs) were selected using geographical locations, among other criteria, as case studies. Data was gathered through interviews. The findings of the empirical study were analysed and interpreted using social policy and community field theories with the support of available documents. The evidence from the study concludes that government's intervention (implementation of NHI Act 650) has increased and expanded the membership base of the schemes: from small group-based to district-wide schemes under the ambit of the District Assemblies. However, such intervention has equally led to diminished community initiatives in establishing, and the complete collapse of the original small group-based schemes. The study also finds among other things that:

1. The financial viability of the schemes depends on the provision of long-term government subsidy. However, they may not be financially viable beyond subsidy-funding due to uncontrollable high utilisation rate, occurrence of health insurance fraud, moral hazard and associated exorbitant claims made on them by health care providers.
2. There are problems with late release of reimbursement funds for discharging with claims by the central government. This has impacted heavily on the financial and strategic management and decision making processes of health institutions in the operating districts.
3. Health managers are unable to fulfil their contractual obligations to their suppliers as their capital funds are locked up with the Mutual Health Organisations that are also unable to provide front loading for the health providers even up to a period of three (3) months of their financial operational requirements.
4. There is therefore, a perceived tension between the schemes and the health institutions as the health institutions prefer to treat clients who come under the 'cash and carry' group since they provide prompt payment; to the detriment of insured clients whose reimbursement is delayed causing the institutions to be cash-trapped. This is recommended for immediate attention.

Declaration

I declare that this thesis titled 'Health Sector Reforms: A Study of Mutual Health Organisations in Ghana' has never been presented anywhere for an academic award. All cited works have been acknowledged in the references accordingly. I may however, be pardoned for any unacknowledged work which might have been caused by oversight.

Signature.....

Augustine Afari-Adomah

(Student)

Signature.....

Prof. J.A. Chandler

(Supervisor)

Signature.....

Prof. G.A. Mountain

(Supervisor)

Dedication

This piece of academic work is dedicated to the memory of two most important people who provided the fundamental challenge and motivation for my academic pursuits. They are: the late Pastor Mary Adarkwa Yeboah-Afari, who is represented by Miss Valentia Maame Adarkwa-Afari (my daughter) and the late Bishop (Dr) Paul Owusu-Tabiri, who is represented by Mr Eric Papa Owusu-Afari (my son).

“But when you humble yourself like a lamb before the LORD, He will lift you up and you will work miracles and God will do wonders in your life” (Owusu-Tabiri, P., 2004:99).

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Abbreviations

ACOPAM	Appui Associatif et Coopératif aux initiatives de Développement à la base (programme du BIT)
ADHA	Additional Duty Hours Allowance
ADMHO-M	Aduana Mutual Health Organisation-Member
ADMHO-NM	Aduana Mutual Health Organisation-Non-Member
AGMs	Annual General Assembly Meetings
ANMC	Alliance National Mutuelles Chrétiennes Belge
ASKMHO-M	Asakyiri Mutual Health Organisation-Member
ASKMHO-NM	Asakyiri Mutual Health Organisation-Non-Member
ASNMHO-M	Asona Mutual Health Organisation-Member
ASNMHO-NM	Asona Mutual Health Organisation-Non-Member
AU	African Union
BIT	Bureau International de Travail
BP	Blood Pressure
BRMHO-M	Biretuo Mutual Health Organisation-Member
BRMHO-NM	Biretuo Mutual Health Organisation-Non-Member
BSc.	Bachelor of Science
CAGD	Controller and Accountant General's Department
CBHIS	Community-Based Health Insurance Schemes
CHAG	Christian Health Association of Ghana
CHI	Community Health Insurance
CHIC	Community Health Insurance Committees
CHPS	Community Based Health Planning Services
CM	Claims Manager(s)
CPP	Convention People's Party
CRMS	Central and Regional Medical Stores
CS	Civil Servants / Civil Service
DANIDA	Danish International Development Agency
DCEs	District Chief Executives
DDHS	District Director of Health Service
Dfid	Department for International Development
DMHIS	District Mutual Health Insurance Schemes
DMMHIS	District and Municipal Mutual Health Insurance Schemes
DPF	Donor Pool Fund
EC	Electoral Commission
Ed	Education
EDL	Essential Drugs List
ERP	Economic Recovery Programme
FCO	Foreign and Commonwealth Office
FE	Financial Encumbrance
FM	Frequency Modulation
FoN	Federation of Nigeria
GCE O'Level	General Certificate of Education (Ordinary Level)
GCS	Ghana Civil Service
GD	Ghana Districts
GDP	Gross Domestic Product
GHS	Ghana Health Service

GMC	Ghana Muslim Council
GNA	Ghana News Agency
GNeMHO	Ghana Network of Mutual Health Organisations
GNHIS	Ghana National Health Insurance Scheme
GNP	Gross National Product
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
GPRS	Growth and Poverty Reduction Strategy
GSS	Ghana Statistical Service
HIPC	Heavily Indebted Poor Country (ies)
HMP	Health Managers and other Personnel
HND	Higher National Diploma
HR	Human Resources
ICT	Information, Communication and Technology
ICU	Intensive Care Unit
ID	Identification (ID) cards
IGF	Internally Generated Fund
ILO	International Labour Organisation
IMF	International Monetary Fund
ISSER	Institute of Statistical, Social and Economic Research
L.I.	Legislative Instrument
LLB	Bachelor of Legal Laws
LR	Liquidity Ratio
MCEs	Municipal Chief Executives
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MDHS	Municipal Director of Health Service
MHI	Mutual Health Insurance
MHO	Mutual Health Organisation
MHOs	Mutual Health Organisations
MMHIS	Municipal Mutual Health Insurance Schemes
MMHIS	Municipal-wide Mutual Health Insurance Scheme
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOHCW	Ministry of Health and Child Welfare
MPS	Marginal Propensity to Save or Spend
MTEF	Medium Term Expenditure Framework
NCHIS	Nkoranza Community Health Insurance Scheme
NDC	National Democratic Congress
NDPC	National Development Planning Commission
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organisations
NHI	National Health Insurance
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIDL	National Health Insurance Drugs List
NHIDL	National Health Insurance Levy
NHIF	National Health Insurance Fund
NHIP	National Health Insurance Programme
NHIS	National Health Insurance Scheme

NIC	National Insurance Commission
NMC	Nurses and Midwifery Council
NPP	New Patriotic Party
NSS	National Service Scheme
NVQ	National Vocational Qualification
OECD	Organisation for Economic Co-operation and Development
OI	Other Income
OPD	Out Patient Department
PAS	Public Address System
PHC	Primary Health Care
PHI	Private Health Insurance
PHR	Partners for Health Reform
PHRplus	Partners for Health Reformplus
PIS	Paying Informal Sector
PMS	Policy Makers and Stakeholders
PMHIS	Private Mutual Health Insurance Schemes
PNDC	Provisional National Defence Council
POW	Programme of Work
Post-NHI	Post-National Health Insurance Act 650 (2003)
Pre-NHI	Pre-National Health Insurance Act 650 (2003)
PSU	Pennsylvania State University
QA	Quality Assurance
RCE	Ratio of Coverage of Expenses
RECD	Ratio of Efficiency in Collecting Dues
ROCI	Ratio of Operating Costs to Income
RSE	Ratio of Subscription to Expenditure
SAPs	Structural Adjustment Programmes
SBS	Sheffield Business School
SDC	Swiss Agency for Development and Cooperation
SHI	Social Health Insurance
SHU	Sheffield Hallam University
SMMHO	Scheme Manager – Mutual Health Organisation
SSNIT	Social Security and National Insurance Trust
SR	Solvability Ratio
SSS	Senior Secondary School
SWAP	Sector-Wide Approach to Programme
UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USD	United States Dollar
VRHA	Volta Regional Health Administration
WB	World Bank
WCA	West and Central Africa
WHO	World Health Organisation
WHO/SEA	World Health Organisation / South East Asia
WSM	Solidarité Mondiale

Table of Contents

Health Sector Reforms: A Study of Mutual Health Organisations in Ghana

Abstract	i
Declaration	ii
Dedication	iii
Acknowledgements	iv
Abbreviations	v
Table of Contents	
List of Figures	
List of Tables	
Appendices	

Chapter	Heading	Page
Chapter 1:	Introduction	
1.0.	Background to the Study	1
1.1.	Statement of the Research Problem	1
1.2.	Rationale of the Study	2
1.3.	Aims of the Study	5
1.3.1.	Objectives	5
1.3.2.	Research Questions	5
1.4.	Outline of the Thesis	6
Chapter 2:	Health Sector Reforms in Developing Countries: A Review of Related Literature	
2.0.	Introduction	9
2.1.	Terminologies	9
2.1.1.	Health	9
2.1.2.	Health Insurance	10
2.1.3.	Health Financing and Expenditure	11
2.2.	Problems of Health Financing	11
2.2.1.	Problems of Health Care Delivery	14
2.3.	Economic Reforms	16
2.3.1.	Health Sector Reforms	17
2.3.2.	Justification for Health Sector Reforms	17
2.3.3.	Health Financing Reform in Sub-Saharan Africa	21
2.3.3.1.	Cost Sharing (User Fees) Policy	22
2.3.3.1.1.	Weaknesses in User Fees Policy	22
2.3.3.2.	Risk Sharing (Health Insurance) Policy	23
2.3.4.	Constraints to Implementing Health Insurance Schemes	24
2.3.4.1.	Weak Administrative Structures	24
2.3.4.2.	Economic Disparities	25

2.3.4.3. Lack of Trust in the Public System	25
2.3.4.4. Neglect of the Informal Sector Economy	26
2.4. Summary of the Chapter	27

Chapter 3: Sustainability of Mutual Health Organisations: A Review of Related Literature

3.0. Introduction	28
3.1. Mutual Health Organisations	28
3.1.1. Sustainability of Mutual Health Organisations	29
3.2. Financial Viability of Mutual Health Organisations	31
3.2.1. Interplay between Financial Viability, Institutional Viability and Social Viability	33
3.2.2. Institutional Viability	35
3.2.2.1. The Role of Government	36
3.2.2.1.1. The Provision of Regulation	36
3.2.2.1.2. The Provision of Subsidy	37
3.2.3. Social Viability	38
3.2.3.1. Relationship between MHOs and Stakeholder Organisations	39
3.2.3.1.1. Health Care Institutions	40
3.2.3.1.2. International Donors and Non-Governmental Organisations (NGOs)	41
3.3. Managing Mutual Health Organisations' Risks Factors (Technical Viability)	43
3.3.1. Adverse Selection	44
3.3.2. Moral Hazard	44
3.3.3. Cost Escalation	45
3.3.4. Fraud and Abuse	45
3.4. Summary of the Chapter	46

Chapter 4: Theoretical Framework

4.0. Introduction	47
4.1. Neo-Classical Economics Theory	47
4.1.1. New Institutional Economics	49
4.1.2. Transaction Costs and Reform	51
4.1.3. New Institutional Sociology	51
4.1.4. Private Finance Initiatives	52
4.1.5. Justification for the Choice of Social Policy and Community Field Theories	52
4.2. Social Policy Theory	55
4.2.1. The Residual Welfare Model of Social Policy	57
4.2.2. The Industrial Achievement -Performance Model of Social Policy	57
4.2.3. The Institutional Redistributive Model of Social Policy	57
4.2.4. The Rationale of Government Involvement	58

4.2.4.1. Undeveloped Private Health Sector	59
4.2.4.2. Fairness in Health Financing	60
4.2.4.3. Social Security System	61
4.2.4.4. Poverty Alleviation	61
4.2.4.5. Equity Implications	62
4.2.4.6. Enhancing Altruism	64
4.2.5. Process of Setting Standards and Regulation	67
4.2.6. Weaknesses in Social Policy Theory	67
4.3. Community Field Theory	68
4.3.1. The Interactional Community	69
4.3.1.1. Local Ecology	70
4.3.1.2. Social Organisation	70
4.3.1.3. Community Action	70
4.3.2. Social and Human Capital	71
4.3.2.1. Community Solidarity	72
4.3.2.2. Community Leadership	73
4.3.2.3. Community Cohesion	73
4.4. Harmonisation between Social Policy and Community Field Theories	74
4.5. Summary of the Chapter	75

Chapter 5: Ghanaian Environment

5.0. Introduction	76
5.1. Ecological Framework	77
5.2. Political Framework	78
5.2.1. Modern Government System: Local Government Administration	79
5.2.2. Traditional Governance System: Chieftaincy	80
5.3. Economic Environment	80
5.3.1. Economically Active Population	81
5.3.2. Economic Reform	82
5.3.3. Economic Reform and the Private Sector	83
5.3.4. The HIPC Initiative	84
5.3.5. Debt Status	84
5.4. Social Environment	86
5.4.1. Traditional Social Welfare System	87
5.4.2. Formal Social Security System	87
5.4.3. Weaknesses in the Social Security System	89
5.5. Summary of the Chapter	90

Chapter 6: Ghana's Health Sector Reform

6.0. Introduction	91
6.1. Problems of Health Financing and Delivery	91
6.2. Health Sector Reform	93
6.3. Health Institutional Reform	94

6.3.1. Ministry of Health	95
6.3.2. Ghana Health Service	96
6.3.3. Teaching Hospitals Board	97
6.3.4. Private Health Sector	97
6.4. Health Human Resources Reform	98
6.4.1. Challenges of the Exodus of Health Personnel to the Diasporas	99
6.4.2. Effect of Incentivisation	100
6.5. Health Financing Reform	101
6.5.1. Government of Ghana Funding via Taxation	101
6.5.2. Donor Funding	102
6.5.3. Cost Recovery or User Fees – ‘Little R’ Reform	104
6.5.3.1. The Bamako Initiative and Cash and Carry	105
6.5.3.2. The Effect of Cost Recovery Policy (Cash and Carry)	105
6.5.4. Risk Sharing: Health Insurance Scheme – ‘Big R’ Reform	106
6.5.4.1. The Pilot National Health Insurance Scheme: 1997	107
6.5.4.2. The National Health Insurance Scheme 2003 (Act 650):2004	107
6.5.4.3. The Model of the National Health Insurance Scheme	108
6.5.4.4. National Health Insurance Council & Authority (NHIC & NHIA)	109
6.5.4.5. Private Health Insurance Sector	110
6.6. Summary of the Chapter	110

Chapter 7: The Emergence of Mutual Health Organisations

7.0. Introduction	112
7.1. Stimulus for the interest in the Mutual Health Organisations	112
7.2. Pre-NHI 2003 Mutual Health Organisations Era	113
7.2.1. Community-Based Health Insurance Era: 1850 – 1998	113
7.2.2. Mutual Health Organisations Era: 1999 – 2004	115
7.3. The NHI Act 650 and the Challenges for the Mutual Health Organisations	117
7.4. Summary of the Chapter	117

Chapter 8: Research Methodology

8.0. Introduction	118
8.1. Philosophical Paradigm	118
8.1.1. Researcher’s Perspective: Interpretivist	120
8.1.2. Justification for the Researcher’s Perspective	120
8.2. Research Methodology: Debate between Quantitative and Qualitative	121
8.2.1. Qualitative Research Methodology	123
8.3. Research Design and Strategy	125
8.3.1. Sampling Strategies	125
8.3.2. Case Study	126
8.3.3. Selection of Studied Organisations	127
8.3.3.1. Regional Consideration	127
8.3.3.2. Geographic Location	127

8.3.3.3. Duration of Establishment	128
8.3.3.4. Size of the Mutual Health Organisation (s)	128
8.3.3.5. Founders' Background: Pre and Post NHI 2003 MHOs	128
8.3.4. Selection of Research Participants	129
8.3.4.1. Policy Makers and Stakeholders	129
8.3.4.2. Health Managers and Personnel	130
8.3.4.3. Staff of the Mutual Health Organisations	130
8.3.4.4. Contributors of the Mutual Health Organisations	130
8.3.4.5. Non-contributors of the Mutual Health Organisations	131
8.3.5. Negotiating Access to Studied Organisations and Research Participants	131
8.4. Data Collection: Field Study	133
8.4.1. Research Method(s)	134
8.4.2. Interviews	134
8.4.2.1. Hospital Exit Interviews	136
8.4.2.2. Snowball Sampling Method	137
8.4.2.3. Office Situation	137
8.4.3. Participant Observation	137
8.4.4. Audio Recording	138
8.4.5. Documentary Analysis	138
8.4.6. Analysing and Interpreting the Interview Data	139
8.4.6.1. Codes for the Research Participants	140
8.5. Quantitative Research Methodology	142
8.5.1. Measuring the Key Viability Indicators	142
8.5.1.1. Measuring Financial Viability	143
8.5.1.1.1. Access to the MHOs' Financial Statements	143
8.5.1.1.2. Limitations in the MHOs' Financial Statements	144
8.5.1.1.3. Formula for Calculating Financial Viability Ratios	145
8.5.1.1.4. Calculating the MHOs' Financial Viability Ratios: 2005 and 2006	147
8.5.1.1.5. Additional Financial Analysis	149
8.5.1.2. Measuring Institutional Viability	151
8.5.1.3. Measuring Social Viability	152
8.6. Summary of the Chapter	154

Chapter 9: Case Results: The Performance of the Mutual Health Organisations

9.0. Introduction	155
9.1. Operations of the Four Mutual Health Organisations	157
9.1.1. Description of the Case Study Mutual Health Organisations	157
9.1.1.1. Aduana Mutual Health Organisation	157
9.1.1.2. Asakyiri Mutual Health Organisation	158
9.1.1.3. Asona Mutual Health Organisation	158
9.1.1.4. Biretuo Mutual Health Organisation	159
9.1.2. Management of the Post-NHI 2003 MHOs (DMMHIS)	159
9.1.2.1. General Assembly	161
9.1.2.2. The Governing Body (Board of Directors)	162
9.1.2.3. The Scheme Manager and Management	164
9.1.3. Membership Categorisations and Eligibility	166

9.1.3.1. Formal Sector Membership: Social Health Insurance Contributors	166
9.1.3.2. Informal Sector Membership: Community-Based Health Insurance Contributors	167
9.1.3.3. Exempted Members or Social Group Elements	167
9.1.3.4. Non-Members and Ineligibility under NHI Act 650	167
9.2. Financial Performance and Viability of the Mutual Health Organisations	171
9.2.1. Funding Streams of the four Mutual Health Organisations	171
9.2.2. The Cost of Health Insurance Policy of the MHOs: 2005-2006	172
9.2.3. Financial Viability Indicators	174
9.2.3.1. Liquidity Ratio of the MHOs: 2005-2006	174
9.2.3.2. Solvability Ratio of the MHOs: 2005-2006	176
9.2.3.3. Ratio of Coverage of Expenses of the MHOs: 2005-2006	178
9.2.3.4. Ratio of Subscriptions to Expenditure of the MHOs: 2005-2006	181
9.2.3.5. Ratio of Operating Costs to Income of the MHOs: 2005-2006	184
9.2.3.6. Ratio of Efficiency in Collecting Dues of the MHOs: 2005-2006	187
9.2.4. Additional Financial Analysis	189
9.2.4.1. Source of Income as a Percentage of Total Income of the MHOs: 2005-2006	189
9.2.4.2. Expenditure as a Percentage of Total Income of the MHOs: 2005-2006	191
9.2.4.3. NHIF Claims as a Percentage of Total Health Care Claims of the MHOs: 2005-2006	193
9.2.4.4. Paying Informal Sector (PIS) Income as a Percentage of Total Income of the MHO: 2005-2006	196
9.2.4.5. Reserve Funds of the MHOs: 2005-2006	198
9.3. Perceived Benefits of the Mutual Health Organisations	202
9.3.1. Understanding and Reasons for Joining the MHOs	202
9.3.2. Institutional Viability Indicators	206
9.3.2.1. Rate of Membership Coverage of the Catchment Population of the MHOs: 2005-2006	206
9.3.2.2. Rate of New Adherents or Penetration into the Target (Formal and Informal Sectors) Population of the MHOs: 2005-2006	207
9.3.2.3. Rate of New Adherents or Penetration into the Formal Sector (SSNIT Contributors) Population of the MHOs: 2005-2006	209
9.3.2.4. Rate of New Adherents or Penetration into the Paying Informal Sector Population of the MHOs: 2005-2006	210
9.3.2.5. Rate of New Adherents or Penetration into the Social Group Membership of the MHOs: 2005-2006	211
9.3.3. Enhanced Universality in Health Financial Protection	213
9.3.4. Advertising the Benefits of Membership	214
9.3.4.1. Financial Peace of Mind and Renewed Confidence	215
9.3.4.2. Collective Bargain of Health Care Costs	217
9.3.4.3. Reduced Costs of Transportation to the Health Care Facilities	217
9.4. Perceived Problems of the Mutual Health Organisations	220
9.4.1. Insufficient Education on the Concept of Health Insurance	220
9.4.2. Low Enrolment amongst the Paying Informal Sector Members	226
9.4.2.1. The Effect of Premium on Membership Enrolment	227
9.4.2.2. Seasonality of Income	230
9.4.2.3. Timing of Registration	232

9.4.2.4. Prioritising Social Commitments over Health Care	234
9.4.2.5. Unfulfilled Expectations and Reduced Levels of Motivation	237
9.5. Summary of the Chapter	239

Chapter 10: Case Results: External Influences on the Performance of the Mutual Health Organisations

10.0. Introduction	241
10.1. Contribution of Community Leadership upon the Performance of the Mutual Health Organisations	242
10.1.1. District and Municipal Chief Executives	242
10.1.2. The Role of Assemblmen and Assemblywomen	243
10.1.3. The Role of District Directorate (Director) of Health Service	245
10.1.4. The Role of Religious or Faith Leadership	246
10.1.5. The Role of Traditional Leadership	248
10.1.6. The Role of Community Members	251
10.1.6.1. Sense of Mutuality	251
10.1.6.2. Sense of Solidarity	253
10.1.6.3. Sense of Ownership	255
10.2. Efficiency and Effectiveness of Health Care Services on the Performance of the Mutual Health Organisations	257
10.2.1. Social Viability Indicators	257
10.2.1.1. Rate of Access to Medical Care (Eligible Members and Health Care Benefits of the MHOs): 2005-2006	257
10.2.1.2. Rate of Access to Medical Care (OPD Attendance): 2005 -2006	259
10.2.1.3. Health Risk Factors of Rural Dwellers	261
10.2.1.4. Joining Based on Selective Health Status	262
10.2.1.5. Non-Adherence to Gate Keeping System	263
10.2.1.6. Lack of Knowledge of the Costs of Health Care	265
10.2.1.7. Abuse of Privileges by Insured Members	266
10.2.2. Provision of Orthodox Health Care by MHOs' Contracted Health Care Institutions	268
10.2.2.1. Dwindling Funding Inflows of the Health Care Institutions	268
10.2.2.2. Health Treatment Protocols (Availability of Drugs)	271
10.2.2.3. Waiting Time	276
10.2.2.4. Relationship between Health Personnel and MHO Members	276
10.3. Implications of Regulatory Changes for the Mutual Health Organisations	280
10.3.1. Regularised Management System for the MHOs	280
10.3.2. Competition between the MHOs and the Private Commercial Health Insurance Schemes	282
10.3.3. Pluralistic Health Sector Approach through the MHOs	283
10.3.4. Private Health Sector Conundrum	285
10.3.5. Collapse of Pre-NHI MHOs and Non-Establishment of PMHIS	288
10.3.5.1. Policy Minutiae and Funding Uncertainties of the PMHIS	289
10.3.5.2. Non-State Actors	292
10.4. Summary of the Chapter	294

Chapter 11: Analysis and Discussion of Empirical Findings

11.0. Introduction	295
11.1. Social Policy Theory	296
11.1.1. Financial Performance and Viability of the MHOs	296
11.1.1.1. Liquidity Ratio	297
11.1.1.2. Solvability Ratio	297
11.1.1.3. Ratio of Coverage of Expenses	298
11.1.1.4. Ratio of Subscriptions to Expenditure	299
11.1.1.5. Ratio of Operating Costs to Income	299
11.1.1.6. Ratio of Efficiency in Collecting Dues	300
11.1.1.7. The Effect of Excessive Healthcare Utilisation Rate on the MHOs' Income and Expenditure	301
11.1.1.7. The Effect of NHI Act 650 Tariff Structure on PIS Income	306
11.1.1.8. Reserve Funds of the MHOs	309
11.1.1.9. Uses of the Financial Information by the MHOs	310
11.1.2. Financing and Improved Financial Access	315
11.1.3. Social Health Insurance	318
11.1.4. Regulation of Mutual Health Organisations	319
11.1.5. Setting up and Subsidy for Mutual Health Organisations	321
11.1.6. Social Group Members	323
11.1.6.1. Inadequate Public Administration System and Oversight	325
11.1.7. Health Benefits and Utilisation	328
11.1.8. Developing Local Initiatives	330
11.2. Community Field Theory	332
11.2.1. Community Wealth	333
11.2.2. Members and Non-Members of the MHOs	335
11.2.3. Traditional Leadership	339
11.3. Complementarity between Social Policy and Community Field Theories	347
11.3.1. Inter-Organisational Consensus	348
11.3.2. Traditional and Modern Management Systems	350
11.3.3. Community Sense of Initiative in Health Financing Schemes	353
11.3.4. Membership Involvement in the Management of MHOs	355
11.3.5. Enhancing Complementarity between Social Policy and Community Field Theories	359
11.4. Summary of the Chapter	360

Chapter 12: Conclusion of the Study

12.0. Introduction	361
12.1. Summary of the study	361
12.1.1. Financial Viability of the Mutual Health Organisations	361
12.1.1.1. Reserve Funds of the MHOs	362
12.1.1.2. Ratio of Coverage of Expenses of the MHOs	363
12.1.1.3. Ratio of Operating Costs to Income of the MHOs	364
12.1.1.4. The Effect of Excessive Healthcare Utilisation Rate on the MHOs' Finances	364

12.1.1.5. The Effect of NHI Act 650 Tariff Structure on PIS Income of the MHOs	365
12.1.2. Influence of Government Regulation on the MHOs	366
12.1.3. Influence of Government Participation on Health Financing	367
12.1.4. Influence of Community Wealth (Social & Human Capital) on the MHOs-	368
12.1.5. Problems facing the Mutual Health Organisations	368
12.1.6. Improving Financial Viability of the Mutual Health Organisations	369
12.1.6.1. Prudent Financial Management System for MHOs	370
12.1.6.2. Flexible Tariff Structure for MHOs	370
12.1.6.3. Government Subsidy to Enhance Financial Viability of MHOs	371
12.1.6.4. Portability of MHOs' Services	372
12.1.6.5. Non-Politicisation of MHOs	372
12.1.6.6. Replication of MHOs' Model of Health Financing	373
12.2. Potential Contributions to Knowledge	374
12.2.1. Contribution to Theory	374
12.2.2. Contribution to Policy	375
12.2.3. Interplay between Financial, Institutional and Social Viability Models	377
12.3. Limitations of the Study	380
12.4. Directions for Future Research	381
12.5. Concluding Statement	382

References	383-435
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List of Figures

Figure 1.1: Structure of the Study	8
Figure 2.1: Characteristics of Health Sector Reform	20
Figure 3.1: MHO Sustainability Framework	34
Figure 4.1: Elements of Social Policy and Community Field Theories	54
Figure 5.1: Relationship between the Health Sector and National Framework	76
Figure 6.1: Structural Relationship and Key Functions in the Health Sector	95
Figure 6.2: Service Delivery Levels in the Health System	97
Figure 9.1: Organogram of the Post-NHI 2003 MHOs (DMMHIS)	160

List of Tables

Table 2.1: Health Financing Schemes	12
Table 3.1: Types of Voluntary, Non-Profit Health Insurance Schemes	29
Table 5.1: Percentage Distribution of Urban and Rural Population by Sex: 1960, 1970, 1984 & 2000 (per cent)	78

Table 5.2: Economically Active Persons as Proportion of Population (15 years and older) by Region (per cent)	81
Table 5.3: SSNIT Benefits Statistics: July 2009 (thousand old cedis, ¢)	88
Table 5.4: Distribution of Pensioners by Area of Operation: July, 2009	89
Table 5.5: Age Distribution of Pensioners: 72-90+ (July, 2009)	90
Table 6.1: Countries Hosting Ghanaian Doctors: 2002	99
Table 6.2: Ghana Nurses Verification: Country Verified for and Year	100
Table 6.3: Budget Ceiling by Item (million old cedis, ¢):2007	102
Table 6.4: Donor's Expected Contribution to Health Account: 2003 (in USD)	103
Table 6.5: Donor Component: Budget Execution – Spending Against Budget by Selected Categories: 2008 (million old cedis, ¢)	104
Table 6.6: Informal Sector Categorisation: Ghana	108
Table 8.1: Different Methods used by Quantitative and Qualitative Research Methodologies	122
Table 8.2: Codes for the Research Participants	142
Table 8.3: Financial Viability Framework	146
Table 8.4: Analysis of Aduana MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)	147
Table 8.5: Analysis of Asakyiri MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)	147
Table 8.6: Analysis of Asona MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)	148
Table 8.7: Analysis of Biretuo MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)	148
Table 8.8: Institutional Viability Framework	152
Table 8.9: Social Viability Framework	153
Table 9.1: Rate of New Adherents or Penetration into the Target (Formal and Informal Sectors) Population of the MHOs: 2005-2006	208
Table 9.2: Rate of New Adherents or Penetration into the Formal Sector (SSNIT Contributors) Population of the MHOs: 2005-2006	209
Table 9.3: Rate of New Adherents or Penetration into the Paying Informal Sector Population of the MHOs: 2005-2006	210
Table 9.4: Rate of New Adherents or Penetration into the Social Group Membership of the MHOs: 2005-2006	211

Table 9.5: Rate of Coverage of Membership (Paying Informal Sector Members) of the Total MHO memberships: 2005 – 2006	226
Table 9.6: Premium Rates of the Aduana MHO: 2002 to 2003; and 2005 to 2006 (old cedis, ‘¢’)	229
Table 9.7: Premium Rates of the Biretuo MHO: 2002 to 2003 and 2005 to 2006 (old cedis, ¢)	230
Table 10.1: Rate of Access to Medical Care (Eligible Members and Health Care Benefits of the MHOs): 2005–2006	258
Table 10.2: Rate of Access to Medical Care (OPD Attendance of the MHOs): 2005 -2006	260
Table 10.3: Outstanding Health Care Claims owed ‘Biako Ye Hospital’ by MHOs: January to December 2006 (old cedis, ¢)	271
Table 10.4: Evolution of MHOs in Ghana: 1990 – 2007	282

Appendices

Appendix A: Administrative Structure of Pre-NHI 2003 MHOs	
Appendix B: Characteristics of Case Study Mutual Health Organisations	
Appendix C: Research Participant’s Consent Form	
Appendix D1: Rate of Membership Coverage of the Catchment Population of the Aduana MHO: 2005-2006	
Appendix D2: Rate of Membership Coverage of the Catchment Population of the Asakyiri MHO: 2005 - 2006	
Appendix D3: Rate of Membership Coverage of the Catchment Population of the Asona MHO: 2005 - 2006	
Appendix D4: Rate of Membership Coverage of the Catchment Population of the Biretuo MHO: 2005 - 2006	
Appendix E: Health Care Benefits of Members – Post-NHI 2003 MHOs	
Appendix F: Professional Background of Staff of the four MHOs	
Appendix G: Cost of Health Insurance Policy of the MHOs: 2005-2006 (old cedis, ¢)	
Appendix H: Summary of Financial Performance & Viability Ratios of the MHOs: 2005 – 2006 (old cedis, ¢)	

Appendix I: Source of Income as a Percentage of Total Income of the MHOs: 2005 – 2006 (old cedis, ¢)

Appendix J: Expenditure as a Percentage of Total Income of the MHOs: 2005 – 2006 (old cedis, ¢)

Appendix K: NHIF Claims as a Percentage of Total Health Care Claims of the MHOs: 2005 – 2006 (old cedis, ¢)

Appendix L: Paying Informal Sector (PIS) Income as a Percentage of Total Income of the MHO: 2005–2006 (old cedis, ¢)

Appendix M: Reserve Funds of the MHOs: 2005–2006 (old cedis, ¢)

Appendix N: List of Research Participants

Appendix O: Interview Schedule for Policy Makers and Stakeholders

Appendix P: Interview Schedule for Health Managers and Personnel

Appendix Q: Interview Schedule for Scheme Managers-MHOs

Appendix R: Interview Schedule for Contributors of the MHOs

Appendix S: Interview Schedule for Non-Contributors of the MHOs

Appendix T: Research Framework: Health Sector Reforms: A Study of Mutual Health Organisations in Ghana. Analytical and Data Collection Plan- November, 2006-January, 2007-Sheffield Hallam University-
– United Kingdom

CHAPTER 1

INTRODUCTION

1.0. Background to the Study

This chapter introduces the study under consideration. It begins with the background to the study, which is followed by the statement of the problem. These are followed by the rationale, aims, objectives and research questions. The outline of the entire study is also presented diagrammatically.

The mutual health organisations phenomenon emerged in Africa in the latter part of 1980s and early 1990s; as a rapid response strategy to ameliorating the health financing crisis. The enthusiasm with which developing countries, especially, those in sub-Saharan Africa have embraced this concept as a newly emerging institutional arrangement for financing and increasing access to quality and modern health care services has been momentous. This has been boosted by the fact that governments believe that the schemes could easily be utilised as platforms for initiating social health insurance strategies to reach economically deprived people (Carrin *et al.*, 2001; Poletti *et al.*, 2007). Without such schemes, citizens would become poorer because they would have had to dispose of their family's wealth in order to treat a member who falls sick (Medici Con L'Africa, 2001; Criel, 2001). Ghana, a developing country in West Africa, has introduced a National Health Insurance Scheme (NHIS), which is fused with social health insurance and community-based health insurance schemes (MOH, 2003d, 2004b). This study examines pro-active plans to address the financial viability of the schemes, to prevent them from going insolvent.

1.1. Statement of the Research Problem

As governments seek to provide equitable health to their people, it is obvious that there are major difficulties, especially, as there are no strongly developed social and public administration structures in place (Carrin *et al.*, 2005; Criel *et al.*, 2005). Therefore, lack of access to reasonable and efficient health care is a major problem (Meessen *et al.*, 2003; Frenk *et al.*, 2006; McIntyre *et al.*, 2006; van Doorslaer *et al.*, 2006; Jacobs *et al.*, 2008). In the light of the above, McIntyre and Gilson(2005), suggests that it would be best to devise an equitable health financing strategy that takes into account the background of a continent crippled by poverty like Africa.

However, Mills *et al.* (2001), argue that it is difficult to understand the way bureaucracies work without relating them to the wider societal relations and the institutional conditions within which they are implanted. Particularly, in most developing countries, the role of the state in the health sector has normally sought to weaken civil society and subdue private and community initiatives (Mills *et al.*, 2001).

The problems of health financing led to the implementation of health sector reforms in the 1980s in most sub-Saharan Africa countries, including Ghana. Under the health financing reforms, cost sharing and risk sharing were recommended as alternatives (Frenk, 1994; Berman, 1995; Collins *et al.*, 1999). The implementation of cost sharing or user fees policy has caused a lot of anxiety amongst governments and policy makers. However, there are inadequacies in implementing system-wide risk sharing or formalised social health insurance (Arhinful, 2000).

There have been considerable discussions on the way forward. One of the options put forward under the reforms which aims to ameliorate the problem is community health insurance schemes or mutual health organisations strategy, which is largely, inspired by the European experience with social health insurance (Brouillet *et al.*, 1997; Dror and Jacquier, 1999; Ndiaye *et al.*, 2007). Nevertheless, the greatest challenge faced by these mutual health organisations is how to ensure their financial viability. Since financial viability is also influenced by other factors such as the institutional framework and social dynamics of the communities within which they operate, these are examined empirically in this thesis to demonstrate how there could be a successful interplay between them in order to guarantee the overall sustainability of the mutual health organisations.

1.2. Rationale of the Study

This study is undertaken for a number of reasons. To start with, the area of finance and financial viability of the mutual health organisations have been minimally explored. As these are important issues, it is undeniable that they impact upon decision-making processes. Similarly, although there are a number of studies of mutual health organisations in Ghana, these had only minimally explored the financial issues in the context of their viability (Atim *et al.*, 1998; Atim, 1999; Arhinful, 2000;

Atim and Sock 2000; Atim *et al.*, 2001a, 2001b, 2001c; Anie *et al.*, 2001; Dablu, 2001; Aikins, 2003; Arhinful, 2005). The studies do not also consider the professional expertise available to the organisations to manage funding or their capacity to raise sufficient funds from members as well as making prudent financial decisions, in an economic environment of considerable uncertainty like Ghana's.

The mutual health organisations are not health care providers *per se*. They are considered as financing mechanisms that can enhance health care delivery by providing financial access to their members (Atim, 1998, 2000). With the exception of a few studies, the area is not widely explored and they have not been developed even though the Ghana National Health Insurance Scheme (GNHIS) has established District and Municipal Mutual Health Insurance Schemes (MOH, 2003d, 2004b). Therefore, the value of mutual and social health financing needs to be analysed to reduce the health financing burden. The predominant issue is to assess the contributions that the emerging mutual health organisations could make and are making to address the health financing crisis crippling the health sectors of most developing countries based on Ghana's experience (Atim, 1999; Jakab and Krishnan, 2001; van Ginneken, 2002; Carrin *et al.*, 2005; Franco *et al.*, 2006).

In addition, it was envisaged that exploring such schemes would bring out advantages and disadvantages of use considering the fact that such schemes are very informal in nature (Jacobs *et al.*, 2008). They can attract people mostly in the informal sectors of the economy (Musau, 1999; Bennett *et al.*, 2004; Chankova *et al.*, 2008). Exploration also involved identifying regulatory framework that would enhance their sustainability as well as safeguard investment (Kutzin and Barnum, 1992; Barnum and Kutzin, 1993). Since the debate about health financing has always been centred on the need to ensure equity in health care delivery, it was anticipated that the mutual health organisations could contribute to achieving such a realisation (Atim *et al.*, 1998; Ranson, 2002).

The earlier studies on Ghana were conducted at a time when the government played a limited role in the management of mutual health organisations (Foster, 2007; Jacobs *et al.*, 2008). Since the introduction of the National Health Insurance Act 650 in March, 2004 with the Legislative Instrument (L.I. 1809) the government of Ghana has

played an active role. It was important therefore, to examine what impact this has had on health financing, financial viability and the operations of the mutual health organisations. Even though the running of some of the schemes somehow remains voluntary, the mutual health organisations are now part of the wider system of governance and must respond to the demands of the new National Health Insurance Act 650 (MOH, 2003d, 2004b). The study, therefore, examines how the mutual health organisations had managed to react to the influence brought to bear upon them by the new regulatory framework in Ghana (Ron, 1999; Basu *et al.*, 2005).

Furthermore, the studies conducted in Ghana had not considered the authentic influence of social dynamics in the development, promotion and sustainability of the mutual health organisations. The implications of the role of traditional leadership, effective community dynamics and their consequential influence on policy implementation had not been explored. Consequently, the study builds on earlier work. It refines the ideas in the previous studies in the light of these underplayed factors. The current study aims to contribute to the literature on health sector reforms in general and health financing strategies in particular. It was also needed to assess the contribution of the emerging mutual health organisations to address these health financing problems in Ghana in particular, and in Africa in general (Develtere, 1993; Atim, 1999; Atim *et al.*, 2001a).

Additionally, my personal interest and experience in health financing and health administration were motivating factors for this study. I had worked in the Ghana health sector and had established a useful relationship with the mutual health organisations in Ghana. Therefore, the insight gained into the ever increasing problems of health administration and health financing facing developing countries especially, Ghana, provided the impetus needed for such a study. Reflections on my experience helped to bring greater understandings to the discussions on the way forward in identifying a viable health financing mechanism as well as providing suggestions for sustaining the emerging mutual health organisations (Johnson and Duberley, 2000).

1.3. Aims of the Study

The study aims to review the health sector reforms in the context of developing countries. More specifically, it analyses the problems of financial access to health in sub-Saharan Africa and the financial, institutional and social dynamics of mutual health organisations as innovative and newly emerging mechanisms seeking to help resolve these problems in Ghana.

1.3.1. Objectives

In order to achieve the above aims, a number of objectives are pursued. These are to:

1. Describe and analyse problems of financial access to health in developing countries, especially, sub-Saharan Africa.
2. Evaluate the reforms in the health sector and the emergence of health financing schemes, especially, mutual health organisations, as innovative new mechanisms seeking to help solve the above problems.
3. Critically evaluate the financial viability and performance of mutual health organisations as mechanisms to enhance access to quality health care.
4. Investigate the impact of institutional framework such as the National Health Insurance Act 650 (MOH, 2003d) on the operations of mutual health organisations to assess the evolution of the system within an institutionalised context.
5. Investigate the effect of social dynamics on the performance of mutual health organisations to show the influence of community wealth (social and human capital) and community leadership on policy implementation.

1.3.2. Research Questions

Specifically, the following questions are examined through empirical research:

1. Are the mutual health organisations financially viable?

2. How does the institutional framework influence the financial viability and performance of the mutual health organisations?
3. To what extent is the participation of government affecting health financing?
4. How do the role of community leadership and social dynamics improve the performance of the mutual health organisations as well as enhance the acceptance of government policy?
5. What are the problems faced by the mutual health organisations or health financing?
6. How can the financial viability of the mutual health organisations be improved?

These are important issues that form the basis of this research.

1.4. Outline of the Thesis

The entire study is presented pictorially in figure 1.1. This chapter is an introduction to the study. Chapter two (2) presents an analysis of the problems of health financing in sub-Saharan Africa within which Ghana is located. The chapter also reviews the literature on the theory and delivery of the health sector reforms adopted in sub-Saharan Africa. The problems associated with the implementation of user fees and the constraints to adopting social health insurance on a wider scale have been enumerated. Chapter three (3) is a review of literature on theory and delivery of the mutual health organisations. The issues impeding their sustainability are identified through previous studies.

Chapter four (4) discusses the theoretical framework used to interpret the findings of the empirical study. The neo-classical economics and new institutional economics theories are first and foremost discussed but rejected as basis for the interpretation of the empirical findings of this study. Since one particular theory cannot explain the health sector reform, reference is made to both social policy and community field

theories. In chapter five (5) the background to the general issues of the Ghanaian environment: ecological, political, economic and social are enumerated.

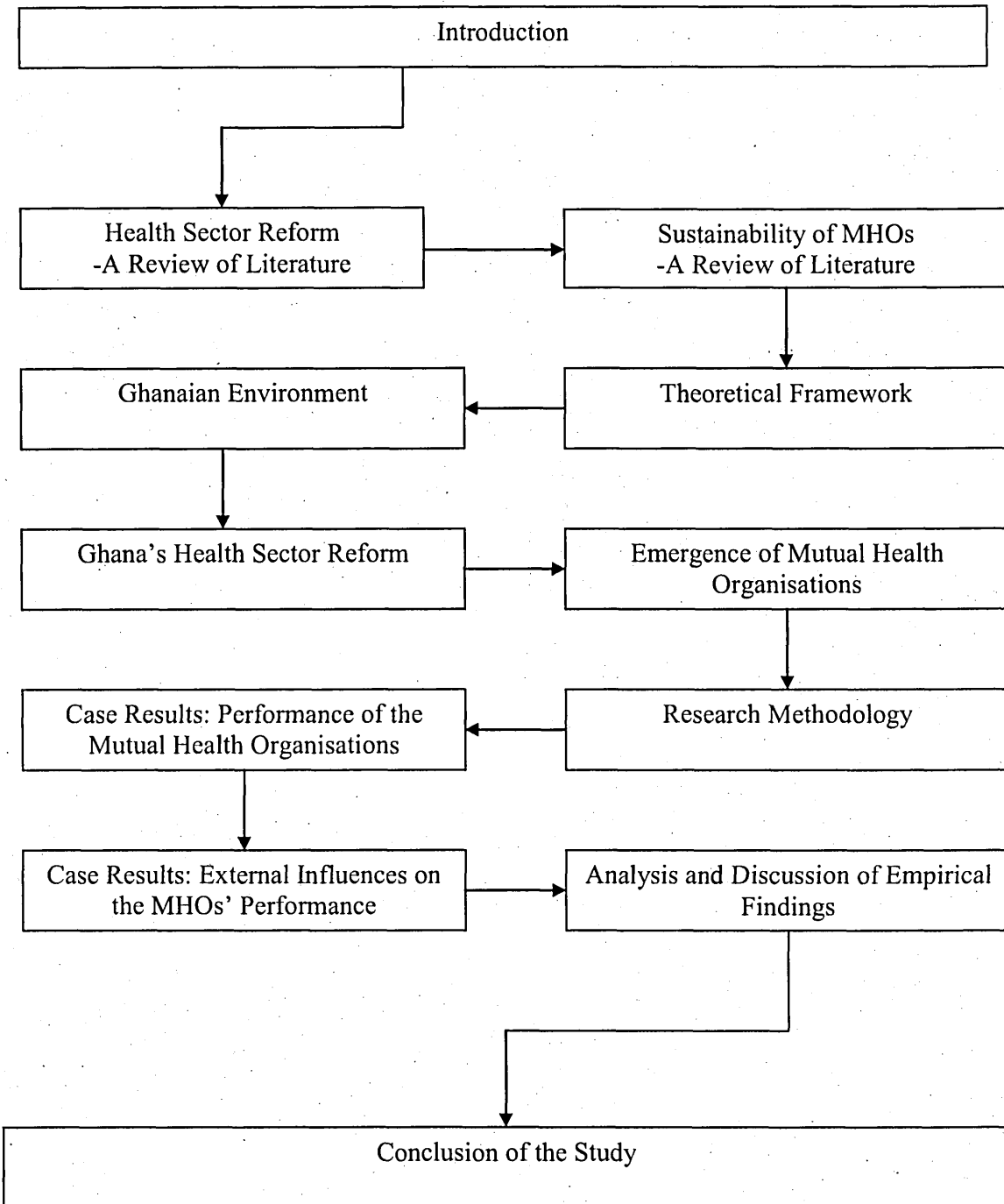
Chapter six (6) discusses the health sector reforms in the context of Ghana. Here, an attempt has been made to review the institutional, human resources and financial reforms in the Ghana health sector. A brief discussion is given of the Ghana National Health Insurance Scheme under Act 650 implemented in 2004, which has facilitated greater government involvement in the operations of the mutual health organisations. Chapter seven (7) discusses the emergence of mutual health organisations with particular reference to Ghana. Here, the stimulus and different stages of their evolution have been explained. Chapter eight (8) presents the research methodology. Thus, it provides an insight into the philosophical paradigm underlying the research, which led to the choice of the qualitative research methodology, case studies method and interview approach for the empirical study carried out in Ghana. This is supported by quantitative research methodology.

Chapter nine (9) is a discussion of the first part of the case results of the empirical study conducted on the four mutual health organisations in Ghana. This part examines the performance of the mutual health organisations on the basis of their operations. There is a brief description of the mutual health organisations used for the in-depth case studies and how they are operating under the National Health Insurance Act 650 (MOH, 2003d). Chapter ten (10) examines the second part of the case results of the empirical study. Here, the influence of external agencies on the performance of the four mutual health organisations is explored.

Chapter eleven (11) is the analysis and discussion of the empirical findings as interpreted within the theoretical models of social policy and community field theories, underpinning the entire study. Here, the successes and the challenges of the mutual health organisations are critically discussed on the basis of these theories. Finally, chapter twelve (12) is a conclusion of the entire study. Here, the summary of the study, recommendations, contributions to knowledge, limitations to the study and directions for future research are espoused. There is also a concluding statement.

Structure of the Study

Figure 1.1: Pictorial Outline of the Study



CHAPTER 2

HEALTH SECTOR REFORMS IN DEVELOPING COUNTRIES: A REVIEW OF RELATED LITERATURE

2.0. Introduction

This chapter presents a review of related literature on the problems of health financing and health sector reforms. There are four (4) sections. Section one (1) discusses the terminologies of some words which are used frequently in this study. Section two (2) analyses the problems of health financing and its effect on health care delivery in sub-Saharan Africa. Section three (3) is the introduction of economic reforms within which the health sector reforms were embedded. Section four (4) is a brief summary of the entire chapter.

2.1. Terminologies

Silverman (2006), explains that concepts are visibly precise facts based on a meticulous model, which 'offer ways of looking at the world which are essential in defining a research problem' (p.3). Some researchers point out that a definition is just a definition, but when the *definiendum* is a word already in common use with highly favourable connotations, it is clear that we are trying to be persuasive (Stevenson, 1945; Little, 1950; Arrow, 1963).

2.1.1. Health

The World Health Organisation (WHO) provides a universal definition: 'health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity; is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors, in addition to the health sector' (WHO/UNICEF, 1978:1; see Frenk, 1994:27). Health encompasses a broad range of issues; importantly, the political, economic, social and epidemiological together with community dimensions to work together in a well-coordinated manner. All these factors need to be harmonised in order to achieve a sustained programme of health financing and service provision. It was in the light of the above aim of achieving global development goals that this comprehensive definition of 'health' was arrived at.

2.1.2. Health Insurance

The term 'insurance' has been defined in different ways because there are various things that can be covered by insurance schemes such as: property, motor, equipment and many more. Even when the term is applied to health, there are varied explanations that can be given. Therefore, for the purposes of health and healthcare, the term 'health insurance' is used to describe an insurance against expenses that are incurred through illness of someone who is insured under an insurance scheme. This is a pre-payment plan that can help to provide services or cash indemnities for medical care. The money may be put together in a fund called an insurance pool. When members of the fund fall sick or are injured and incur any medical costs, the costs may be paid for them by using money from this insurance pool either in part or full (PSU, 2004). Hurley (2001), argues that unpredictability in the need for health care and the high costs of health care have created an imperative role for insurance in health care financing. Thus, under health insurance, individuals' financial risks that are connected with health care are pooled. This helps to reduce the full amount of risk in society as well as it allows those members who fall ill to acquire the health care they need (see also Carrin *et al.*, 2005; Jacobs *et al.*, 2008).

Some economists explain that because people lack information about the form, the amount and the cost of their future health care needs, they are encouraged to require quality health cover in the form of insurance so as to be able to make a claim since the insurance company is another commodity that has been bought in the market place and is subject to the standard result of neoclassical price theory (Arrow, 1963; McGuire *et al.*, 1989). Using an ethical perspective, Hurley (2001), posits that unlike most goods and services, insurance is a collective activity, which an individual can only produce by joining together with others to form a risk pool. However, Evans (1987), argues that health insurance does not insure health; rather it reimburses the costs of health care and enables potential users of care to pool their risks. Donaldson and Gerard (2005), support this assertion and observe that people cannot insure against ill-health itself but rather the financial costs of ill-health and as a result, health care insurance embodies the wider concept of income maintenance.

2.1.3. Health Financing and Expenditure

The World Health Organisation (WHO) explains that health financing is the collection of funds from various sources, pooling of funds and spreading of risks across larger population groups and allocation or use of funds to purchase services from public and private providers of health care. The rationale of health financing schemes is to make funding available, as well as setting the right financial enticement for providers. This is also to make sure that all persons gain right of entry to valuable public health and personal health care (WHO, 2000, 2006).

Government health expenditure is the expenditure on health by all government units and includes social insurance schemes and extra-budgetary spending on autonomous health institutions. The autonomous health institutions may include quasi-government hospitals such as university hospitals, among others (see WHO, 2003a, 2003b). Moreover, the government health expenditure includes donor funding that is channelled through the government but excludes off-budget donor funding for prudent projects (WHO, 2003b; Kruk *et al.*, 2007). Culyer (1983), observes that the amount of health care expenditure in any country seems to be unrelated to the degree of governmental involvement in the financing or delivery of health services, instead, it can almost entirely be accounted for by differences in the various countries' national income (Culyer, 1983; Leu, 1986; Di Matteo, 2009).

2.2. Problems of Health Financing

Developing countries have adopted different ways of collecting revenue for financing health similar to those existing in the developed countries with slight variations in approach (Mwabu, 1990; Sein, 2002). Maeda (1998), categorises countries into three levels of development as low-income, middle-income and high-income: each level has a different health care financing system. Whilst low-income and middle-income countries generate a lot of their health funds from patient out of pocket, high-income countries generate their health funds through National Health Service (Maeda, 1998; Schieber *et al.*, 2006). In summary, the basic sources and mechanisms of financing health are shown in table 2.1 (SDC, 2003).

Table 2.1: Health Financing Schemes

Type of Scheme	Sources of Funds
Government Expenditure	Variety of tax instruments
Private Health Insurance	Individual premiums to health insurance companies
Social Health Insurance	Percentage contribution from employers and employees
Out of Pocket Payment	Payment of services at point of service use
Community Health Insurance	Percentage contribution by community members to a non-profit organisation
Donor Organisations	Grants from international financial and aid institutions via Government or specific organisations
Loans	Funding of health care investment items by external organisations

Health care is a 'commodity' that is seldom left for the unregulated market to decide the price, location, type and volume of services to be provided because of its relevance to governments the world over. The only difference is that the proportion of finance from the different financing sources varies greatly, from country to country. Typically, health systems, in developing countries, depend on a mix of financing mechanisms (WHO, 1993; Noterman *et al.*, 1995; Bennett *et al.*, 1996, 1998; Bossert *et al.*, 1998; Bennett and Gilson, 2001; Donaldson and Gerard 2005). However, majority of governments in sub-Saharan Africa, rely heavily on taxes to provide health care, because there is no proper health insurance system in place (Carrin and James, 2005).

There are concerns regarding how to identify a viable health financing strategy, as there are still problems with how to finance health. Unlike their counterparts in the developed economies like the United Kingdom (see Culyer, 1989a, 1989b; McGuire *et al.*, 1989), the United States of America and Canada (Evans, 1986, 1987), who have achieved equitable and universal health coverage as well as ensured financial

protection for their people (Bärnighausen and Sauerborn, 2002; Jacobs *et al.*, 2008), health financing and delivery in sub-Saharan Africa, including Ghana, have been constrained by a lot of factors (Mwabu, 1990).

According to the World Health Report 2005, about forty-four (44) countries of the WHO African Region, spent less than 15 per cent of their national annual budget on health; 29 national governments spent less than US\$10 per person per year; 50 per cent of the total expenditure on health in 24 countries was from government sources; and prepaid health financing mechanisms covered only a small proportion of populations in the region. Again, private spending constituted over 40 per cent of the total expenditure on health in 31 countries, whilst direct out-of-pocket expenditures constituted over 50 per cent of the private health expenditure in 38 countries (WHO, 2005, 2006).

Why this is the case requires an imperative review of health financing strategies in sub-Saharan Africa, which must necessarily take into account certain factors, which are peculiar to the continent (McIntyre and Gilson, 2005; Criel *et al.*, 2005). Mwabu (1990), outlines some of the issues including, the fact that African economies, like economies of other continents are linked to the international economy. Therefore, health financing strategy in each country has to take into consideration both the external and the domestic factors that affect health budgets. The poor economic performance make it increasingly difficult for governments to finance the health sector by increasing tax revenues or take additional loans from international sources (Mills *et al.*, 2001; Carrin, 2003; Carrin *et al.*, 2005).

It would appear as unlucky rather than a case of inefficiency that in spite of numerous attempts and strategies to prevent the occurrence of the problems confronting the health systems, there still seems to be a constant decline of Africa's health systems (Criel, 2001; Medici Con L'Africa, 2001). The causes of the problems can be related to certain fiscal policies of both the internal and external stakeholders in Africa's health care environment. These include:

1. The insignificant resources allocated to the health sectors of most developing countries in Africa, south of the Sahara; estimated to be on average less than USD5 per capita per year;
2. The introduction of user fees in public health services in the 1980s;
3. The reduction of international aid; and
4. The rapid spread of market systems and privatisation (Medici Con L’Africa, 2001).

Hoare (1987), discusses the conventional mechanisms for financing health from either public or private sources and notes the problems facing developing countries.

2.2.1. Problems of Health Care Delivery

The problems enumerated above have created conditions whereby there seems to be serious inequity in the redistribution of resources devoted to the health sectors of the economies of sub-Saharan Africa countries. There is increasing number of people in the population who have either little or no access to orthodox health care services when they are most in need of it (Medici Con L’Africa, 2001; McIntyre *et al.*, 2006; van Doorslaer *et al.*, 2006; Jacobs *et al.*, 2008). To reduce poverty and ensure sustainable economic development (Berman, 1995), low-income countries have been urged to address issues of health and poverty concurrently, as health care development is a key ingredient for human capital formation and sustainable economic development (Asfaw, 2003). If people are healthy and can work, they can contribute economically to their country (Criel, 2001; Skinner and Staiger, 2007; Skinner *et al.*, 2008).

The World Health Organisation Report 2000 notes in part that in the world’s poorest countries, particularly the longstanding poor have to pay for health care from their own pockets at the very time they are sick and most in need of it. Most of these people may not be in any gainful employment and are also unlikely to be members of employment-oriented or job-based pre-payment schemes. They have less access than

better-off groups to subsidised services from their employers (WHO, 2000; Nancy, 2000). The World Bank Report (2008), observes that health care provision is the largest private health care segment in sub-Saharan Africa. This holds significant potential for financial returns and development impact since the:

...private sector share of provision varies significantly by country, and this variation is primarily driven by individual government perspectives on the role that should be played by paid health care services...the majority of private health care provision is for-profit...(WB, 2008:40)

Unfortunately, there is no longer universal free health care at the point of service use. This was a policy option adopted in most of these countries immediately after independence. This has proved inapplicable in the current health care context due to economic policy reforms (Frenk, 1994). Since there are no alternative arrangements to access formalised health care, people in desperate attempt are compelled to resort to all different means possible to attend to the health care needs of a sick family member. One of the humane methods may be to utilise the family's savings, which is referred to as family capital fund. The economic repercussions on the family's capital can be a situation where the family's financial resource base becomes unsustainable because of constant depletion. This leads to a vicious cycle of poverty-illness-poverty. When people are poor they fall ill easily; spend their accumulated capital in treating their illness; cannot work during that period to raise money; and find themselves back in the clutches of poverty (Criel, 2001; Medici Con L'Africa, 2001; Jacobs *et al.*, 2008).

Additionally, in sub-Saharan Africa, at times, communities have to contend with natural disasters like floods and bushfires, civil conflicts and national economic depression, which are beyond the control of ordinary people (Criel and Kegels, 1997; Criel, 2001; Medici Con L'Africa, 2001). As the majority of the people in the rural communities are peasant farmers, it becomes economically, disastrous with health consequences when rural households experience crop failures. Due to their locations, jobs are not available and unemployment is high amongst even the youth. The lack of governments' ability to deliver universal health care means that an entire household

may sink deeper into poverty (Schneider *et al.*, 2001a, 2001b; Carrin *et al.*, 2005; Basaza *et al.*, 2007).

2.3. Economic Reforms

In the 1990s, most governments changed their health financing strategies and systems either through political ideology or economic and international pressures under the public sector reforms. Thus, the inadequacies in funding coupled with the economic recession in the 1980s created unbearable problems for governments in developing countries in the areas of health financing and delivery. The World Bank (WB) and the International Monetary Fund (IMF) bailed them out with loans, which had stringent conditions: the major one was the introduction of economic reforms. The loans granted were implemented under a policy of Economic Recovery Programme (ERP), which had sub-programmes. Prominent among them was the Structural Adjustment Programmes (SAPs). These were the standard WB and IMF policy packages which stipulated the slashing of government spending, privatisation and opening up of these countries to foreign investment, among other measures. It is observed that the general outcome of these programmes is deepened poverty around the world, due to implementation difficulties peculiar to these countries (Double Standards, 2005).

The economic reform had implications for the health sector as well. There are aims contained in the World Development Report 1993 to assist governments of developing countries to improve the health of their populations. The suggested policies to improve the system include fostering an environment that enables households to improve health; promote diversity and competition in the provision of healthcare services; and improve government spending on health. Thus, the Report's prescriptive advice is that governments should ensure universal access of at least a minimum package of health services, especially, for the poor (see World Bank, 1993; Paalman *et al.*, 1998). However, Paalman and a team of analysts (1998), argue that there cannot be one universally applicable set of priorities because the political, physical, social, environmental and behavioural affects on health are specific to different cultures and different economic circumstances. These must be fully taken into account (Paalman *et al.*, 1998).

2.3.1. Health Sector Reforms

Different definitions have been given by different authors of health sector reform, but they seem to lack details of the actual institutional arrangements needed to achieve health sector goals (Frenk and Gonzalez-Block, 1992; Cassells, 1993, 1995; Frenk 1994; Gwatkin, 2001; Roberts *et al.*, 2004; Huntington, 2004). It is argued that health sector reform is not a concept on its own, it only became necessary to introduce a change process that would be sustained, purposeful and fundamental (Cassells and Janovsky, 1996; Berman and Bossert, 2000). The argument is that there is no consistently-applied, universal package of measures that constitute health sector reform (Cassells, 1995). However, most reform initiators would indicate their overall goals as improving health sector efficiency, equity and sustainability (Mills *et al.*, 2001).

In this study, health sector reform is defined as a rapid response to the discrepancies in the health sector in general, which aims at finding workable solutions to promote viable institutional and financial mechanisms that can enhance the efficient and equitable delivery of health care for the population. This agrees with the often used definition of health sector reform as 'sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector' (Berman, 1995:15). Thus, health sector means the entirety of strategies, programs, institutions and actors who provide health care. These are organised efforts to treat and prevent disease in a holistic manner. Berman (1995), argues that in general terms, reform entails altering both policies and institutions in the health sector. Therefore, the goals of efficiency, equity, and effectiveness of the health sector require the translation of these into explicit ideas such as increasing productivity levels, giving the underprivileged population additional benefits and developing plans to amend mortality and disability patterns in the population (Berman, 1995).

2.3.2. Justification for Health Sector Reforms

Different stages of health sector reforms have been implemented by governments of sub-Saharan Africa countries since the late 1970s and early 1980s (Gilson and Mills, 1995; Leighton, 1996; Russell *et al.*, 1999; UNICEF, 1999; WHO, 1978; Mills *et al.*, 2001). The first global ideal of health sector reform was initiated in 1978 when a World Health Summit was held in Alma Ata in Russia. The outcome of the

conference was the birth of Primary Health Care (PHC) as a model that could be used to deliver equitable health care to the people. The conference proposed among other things that governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures based on the active involvement of the community (WHO, 1978; Frenk 1994). The recommendations also expected governments and the international community to ensure that people attained a level of health that would permit them to lead a socially and economically productive life by the turn of the millennium through a popular slogan dubbed: 'Health for All by the Year 2000' (WHO, 1978:2).

Developing countries earnestly ratified the declaration of the Primary Health Care (PHC) concept. However, the objectives of this campaign could not be realised by many countries, mostly, in sub-Saharan Africa, at the turn of the century in the year 2000 (Berman and Bossert, 2000). Before this could happen a new health sector reform directive had been suggested, to kick-start another change in the way health was financed and delivered (Mohindra, 2001). This was because the health sectors of these countries were suffering from grossly inefficient and inequitable resource allocation, declining quality, and demoralised work forces (Berman and Bossert, 2000; Russell *et al.*, 1999).

Different perspectives have been expressed by different researchers regarding the reasons why health sector reform has become widespread (Frenk, 1994; Berman, 1995; Collins *et al.*, 1999). What is clearly common is that all the factors are interrelated. For instance, Berman (1995), and Collins *et al.* (1999), have utilised many ideas from Frenk's conceptual framework (Frenk, 1994). Berman (1995), uses a development context to discuss the objectives of health sector reform and explains that there has been global interest because health is a central goal of national development as it makes development more sustainable.

The gaps in Berman's justification are filled by Collins *et al.* (1999), who use the political context. They identify six factors generating the need for health sector reform as: demographic and epidemiological change; processes of social and economic change and conflict; economic and financial policy; politics and the political regime; ideology, public policy and the public sector; and external factors,

especially in developing countries (Collins *et al.*, 1999). Even though, they observe that any refusal to recognise the policy context and how it is implemented can lead to principal unhelpful outcomes for the improvement of the health sector, their analysis did not touch on the lack of institutional capacity and the political and individual motivations of the citizens that are crucial to reforms.

The most appropriate approaches to analysing how developing countries embarked on health sector reform are given in Frenk's (1994), systems concept. This identifies four main attributes as: economic, political, ideological and epidemiological. These take into account organising and financing health care, promotion of goals of equity, effectiveness and efficiency in the health sector. This also shows the interplay between the stakeholders and the economic, social, political, ideological and epidemiological elements. Frenk argues that the changes are subject to the collective will of societies and therefore, offer opportunities for decision (Frenk, 1994).

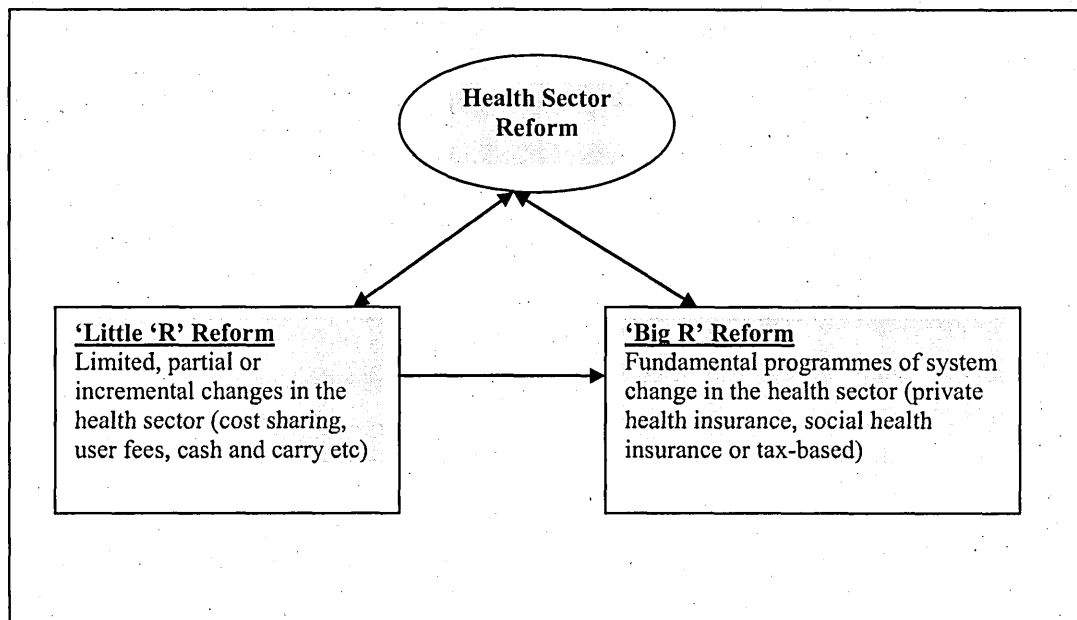
However, the economic reason necessitating the health sector reform is that the position of a country's economy has an overall effect on the subsequent relationship with all other sectors including, health. The intensity of the economic status of a country depends on whether it is developed or underdeveloped. Whereas in the developed economies, health sector reform was initiated to contain the escalating costs and to enhance value for money this was also partially forced on developing economies by the vagaries of the world economic order and the economic crisis of the 1980s (Frenk, 1994). A study of twenty-six (26) member states of the Organisation for Economic Commission and Development (OECD) found that 16 out of the 26 had reformed the way they financed health and health care. There are attempts geared toward reducing the total contribution of funding from the public coffers while increasing the role of the private health sector and private insurance. Therefore, between 1990 and 1998, government funding in sixteen (16) out of the 26 countries dwindled in relationship to other funding methods such as private insurance or user fees (Donaldson and Gerard, 2005).

The world's health sector has been engulfed by change that is impacting upon social, economic and political environments with improved health status being one of the measuring rods of progress that countries aspire to (Frenk, 1994; Berman, 1995).

Frenk (1994), observes that all countries are adhering to the changes that take place in the health sector because health is seen as an essential field in human life and development of countries' economy. Hsiao (2000), identifies a set of control knobs that can help establish the key routes and effects of health care systems and can be used for assessing the success or otherwise of health sector reform. Thus, the main focus of health sector reform attempts: 'to establish, set, or adjust these control knobs of financing, payment, organisation, regulation, and consumer behaviour' (Berman and Bossert, 2000:2).

Using this framework, Berman and Bossert (2000), characterise the actions taken in the health sector under the reforms into 'fundamental programmes of system change', which they call the 'big R' reforms (p.2). These are reforms that engage at least two or more of Hsiao's (2000), control knobs as they change a considerable part of the health care system. The second characteristic deals with actions taken in the health sector, which are 'more limited, partial, or incremental', which they call the 'little R' reforms. These are reforms that seek to address only one control knob with a more limited scope of change. They however, observe that the 'big R' reform may involve the implementation of many 'little R' activities (Berman and Bossert, 2000:3). These two characteristics have been illustrated in figure 2.1 below.

Figure 2.1: Characteristics of Health Sector Reform



Reforms in sub-Saharan Africa countries as a whole can be grouped under three main themes:

1. Diversification of funding patterns away from tax revenues to fund public health services. Thus, there is the need to explore other sources of financing in addition to the traditional tax-based funding by the central government;
2. The formalisation of relationships between public and private health sectors. Thus, there is the need to ensure collaboration between both the public and private health sectors in health financing and delivery; and
3. Reforming the role of consumers and citizens in the financing and planning of health services. Thus, there is the need to ensure greater community involvement and participation in addressing the problems affecting the health sector (Mills, 2000, Mills *et al.*, 2001; Donaldson and Gerard 2005).

It is obvious that governments and policymakers in the developing world have undertaken reforms due to poor economic performance (Frenk, 1994; Berman, 1995; Collins *et al.*, 1999; Bro, 2007). Some researchers have found that the implementation of health sector (Berman, 1995), and public sector (Russell *et al.*, 1999), reforms in developing countries had been difficult.

2.3.3. Health Financing Reforms in Sub-Saharan Africa

As a result of the perceived tension between the different stakeholders in the health environment: the presence of multi-faceted groups of professionals, politicians, international financial institutions, and the community at large, two alternatives of how to mobilise funding for health care were suggested to policy makers in sub-Saharan Africa, under the health financing reform. These focus on:

1. Allowing service users to pay for services they use, which is also known as fee for service payment or payment per episode of sickness or risk.
2. A payment based on risk sharing schemes through the contributions of potential users (Noterman *et al.*, 1995; Donaldson and Gerard 2005).

These two alternatives have since been implemented in some sub-Saharan Africa countries as discussed below.

2.3.3.1. Cost Sharing (User Fees) Policy

The first option under health financing reform is user fees. This was initially, adopted and has become widespread in sub-Saharan Africa. Two broad models of user fees systems adopted are the standard model and the Bamako initiative model (Nolan and Turbat, 1995; Gilson, 1997). In addition, there is wide range of user fees payment systems: flat fee or differentiated fee; fee per episode or fee per item of service; prepayment or payment at time of use (Price, 2002).

2.3.3.1.1. Weaknesses in User Fees Policy

There are several problems associated with the implementation of user fees. Firstly, it fails to completely address the equity and welfare goals in these countries (Diop *et al.*, 1995; Gilson and Mills, 1995; Mills, 2000; Mills *et al.*, 2001). In addition to the formal fee charges introduced in government health facilities, informal charges are also common practice (Stekelenburg *et al.*, 2005). Moreover, there has been a total change in the attitude of both health care personnel and consumers, leading to a sharp reduction in attendance rate at orthodox public health facilities and the longstanding poor households are massively, affected because they cannot access health care (McPake, 1993; Carrin, 2003).

The problems have been compounded by the fact that people in communities of most sub-Saharan Africa countries are exposed to a lot of risks basically due to their disadvantaged locations. A proper transportation system linking the towns and villages to ensure easy access to health care facilities is often lacking. Therefore, many people in the remotest parts of the communities tend to consult traditional healers for treatment for common ailments. This is considered as an inexpensive substitute (Stekelenburg *et al.*, 2005). Green (1997), found that more than 80 per cent of the people still use the services of traditional healers because of the escalating premium of Westernised health care and medicine (Green, 1997; Stekelenburg *et al.*, 2005). People only report to the modern health care facility as a last resort when their health conditions had deteriorated, because of the high costs of drugs (Short & Tsey, 1995; Tsey, 1997).

Chan (2009), argues that user fees for health care were put forward as a way to recover costs and discourage the excessive use of health services: this did not happen. As a substitute user fees punished the poor: this is a bitter irony at a time when the international community is committed to poverty reduction (Chan, 2009; Marriot *et al.*, 2009). Therefore, Stocking (2009), cautions that lives will be needlessly lost before leaders act as poor people simply cannot afford fees and inaction will continue to deny access to life-saving healthcare for millions (Stocking, 2009; Marriot *et al.*, 2009). Due to the problems associated with policy implementation, governments and policy makers have been anxious about the severe consequences of people's inability to access orthodox health care and are sourcing for alternative mechanisms (McIntyre *et al.*, 2006; van Doorslaer *et al.*, 2006; Jacobs *et al.*, 2008). This led to suggestions that the second alternative, risk sharing policy could be tested.

2.3.3.2. Risk Sharing (Health Insurance) Policy

The second health financing reform strategy emphasises the need to involve the private sector and private health financiers as well as encouraging prospective users to share risk in the delivery of health care in developing economies (Frenk, 1994; Berman, 1995). This requires the setting up of a new extended system of national health insurance which needs to include extensive adjustment in financing, regulation, and delivery (Noterman *et al.*, 1995; Donaldson and Gerard 2005). Thus, this approach uses health insurance, especially, social health insurance, which is the dominant method in industrialised economies. This is expected to enhance the chances of achieving universal health coverage; provide financial security for all against exorbitant health care costs; and provide fairness in financing for health care (Sauerborn *et al.*, 1996; Carrin *et al.*, 2005). Health care risk pooling is central feature of health insurance arrangements. This facilitates health care services to be delivered in line with people's need rather than their individual capacity to pay (Lautier, 2003).

A few countries in the African sub-region have been considering the possibility of introducing national or social health insurance schemes. For instance, Nigeria has introduced a Federal Health Insurance Policy (FoN, 1999); and Zambia has adopted a comprehensive health sector reform including the introduction of health insurance schemes (Mills *et al.*, 2001). Zimbabwe is considering a national health insurance or

social health insurance scheme (MOHCW, 2001; Badasu, 2004; *The Herald*, June, 2004; McIntyre and Gilson, 2005).

2.3.4. Constraints to Implementing Health Insurance Schemes

However, the majority of the countries have yet to embark on any serious programme of health financing reform because implementation is anticipated to fall short of expectations. National or social health insurance provides cover for people in the formal employment sector such as public and civil servants, raising questions about population coverage (Carrin *et al.*, 2005). Some researchers even question whether the health insurance idea was deeply rooted in the African society (Vogel, 1990a, 1990b; ILO, 1993; Shaw and Griffin, 1995; Dablu, 2001). For instance, the World Bank Report 2008 argues that microinsurance is still rare across sub-Saharan Africa (WB, 2008). However, studies have found that health insurance in developing countries dates as far back as the years preceding the Second World War (Zschock, 1982; ILO, 1993; Arhin, 1995; VRHA, 1998; Dablu, 2001).

Although, the Philippines, a low to middle-income country in South-East Asia, has had more than thirty-five (35) years experience of implementing social health insurance, the scheme still has problems (Obermann *et al.*, 2006). Attempts by sub-Saharan Africa to model their health insurance schemes on the basis of schemes that exist in high-income countries had led to serious financial, managerial and equity problems because of the socio-cultural variations within Africa compared with the developed world (Barnard, 2000; Criel *et al.*, 2005). Therefore, any attempt to move swiftly into health insurance will create as many difficulties as well as anticipated benefits (van Ginneken, 1999a; Carrin, 2003; Carrin *et al.*, 2005; Obermann *et al.*, 2006). There are many constraints to implementing comprehensive health insurance in sub-Saharan Africa (Sekhri and Savedoff, 2005). Some of these have been discussed below.

2.3.4.1. Weak Administrative Structures

Any country proposing to implement a national or social health insurance scheme needs to assess its administrative capacity and capability. Where there are weak administrative systems coupled with an undeveloped private sector, there are difficulties in setting up and assuring the running of a low-cost and competent

management; problems in calculating the capability of households to pay premiums; and complications in determining reasonable premiums and collecting them (Carrin, 1986, 2002, 2003). Governments in sub-Saharan Africa lack the required managerial tools because of problems with systems of communication due to absence of information, communication and technology (ICT), for example, telephone facilities are inadequate (Arhinful, 2000; Carrin, 2003; Carrin *et al.*, 2005). Governments have to contend with the absence of banking facilities in most communities where people live thereby impeding inter-bank networking to facilitate smooth transfer of financial transactions. There is a lack of reliable computerised database on the population (see GSS, 2005; NDPC, 2005a, 2005b).

2.3.4.2. Economic Disparities

Governments are also confronted with how to achieve consensus nationwide on the policy direction of social health insurance. This requires the pooling of all available resources so that financial resources are transferred from the well-to-do individuals to the needy and poor (Carrin *et al.*, 2005). The healthy and strong need to see to the weaker ones in their midst and those in active employment need to be able to transfer something to those who are unemployed. These are rather problematic issues for sub-Saharan Africa countries, where people have significant disparities of incomes and resources (Preker *et al.*, 2002). The economic disparity gaps are very wide to the extent that majority of the population are unemployed or have incomes below the poverty line. For that reason, raising significant revenue through taxation is a herculean task for governments (Carrin, 2002, 2003; Mariam, 2003). The UNDP Report 2005 is clear on the income differentials of populations in developing countries (UNDP, 2005b; Asante *et al.*, 2006). The difficult socio-economic web that has entangled sub-Saharan Africa countries has yet to be disentangled.

2.3.4.3. Lack of Trust in the Public System

The problem with the seeming absence of political stability in some of the sub-Saharan Africa countries either as a result of civil conflict or intermittent military intervention on the political scene has also been observed (Criel and Kegels, 1997; Preker *et al.*, 2002; Schneider, 2005a, 2005b). The true costs of civil conflict apart from the human loss of life have been the destruction of a country's infrastructure as well as mistrust and the lack of confidence of the people in the political system (Criel

and Waelkens, 2003; Schneider, 2005a, 2005b; Jacobs *et al.*, 2008). This will not encourage people to contribute effectively, to health care system fashioned on a health insurance model. They need systems that can reinvigorate their confidence (Carrin *et al.*, 2005; Schneider, 2005a, 2005b; Basaza *et al.*, 2007). Even though, governments have gone to enormous efforts to reinforce the need for equity and solidarity in access to health care; this cannot be guaranteed under a health insurance plan (Khetrapal, 2004). Thus, equity and solidarity are not only indispensable for the implementation and effectiveness of health care systems; they are important for social cohesion (Abdeljalil, 2003).

2.3.4.4. Neglect of the Informal Sector Economy

The adoption of health care insurance appears to have neglected people in the informal sector of the economy. The way forward to addressing the problem of health financing in sub-Saharan Africa is that different mechanisms need to be tested. This has necessitated the need for the health sector reform to be re-focused on other context specific mechanisms of health financing (Bärnighausen and Sauerborn, 2002; Criel *et al.*, 2005). For this reason, Saltman (1997b), suggests that any decision to adopt competitive incentives should reflect the rational calculated judgment tied to the organisational characteristics of each particular sub-sector as hospitals, general practitioners and home care insurance are influenced by their national, cultural and institutional contexts (see Saltman, 1997a, 1997b).

Jacobs *et al.* (2008), argue that in low and middle-income countries, majority of people are either self-employed or work in the informal sector: mostly small scale entrepreneurs, peasant farmers and artisans. This makes expansion of formal health insurance, if available, difficult. This creates difficulty in achieving equity and universal coverage in health care financial protection. Comprehensive health insurance arrangements are difficult to apply in countries where there is large informal population and poverty is part of the national economic life of the people. Majority of the populace in sub-Saharan Africa live in rural areas: they are mostly in the non-formal employment sectors. Therefore, it is anticipated that improved equity in health will require greater investment in those factors which are outside the formal health system, not just increased access to illness-oriented services (Saltman, 1997a, 1997b; Brownell *et al.*, 2001; Mahnken, 2001).

Hence, alternative mechanisms that might address the needs of the people in the informal sector of societies as well as enhance community participation, equity, equality and solidarity amongst the people constitute the current direction of the evolving health sector reform (Jakab and Krishnan, 2001; van Ginneken, 2002; Carrin *et al.*, 2005; Jacobs *et al.*, 2008). Mutual health organisations are being tested accordingly as discussed in chapters 3 and 7.

2.4. Summary of the Chapter

This chapter has analysed the problems of health financing and delivery in sub-Saharan Africa and reviewed the economic and health sector reforms. Problems caused by the introduction of cost recovery policy and the constraints to implementing system-wide social health insurance have been discussed. The need to explore other context-specific health financing mechanisms to address problems of inequity confronting the informal sector population has been emphasised. The next chapter discusses the concept of mutual health organisations.

CHAPTER 3

SUSTAINABILITY OF MUTUAL HEALTH ORGANISATIONS: A REVIEW OF RELATED LITERATURE

3.0. Introduction

This chapter presents the first part of the review of related literature on the concept of mutual health organisations (see chapter 7 for the second part). The evaluation in this chapter provides a basis upon which the empirical study of the mutual health organisations in Ghana was conducted. The chapter is divided into four (4) sections. Section one (1) introduces the concept of mutual health organisations and arguments relating to their overall sustainability. Section two (2) examines arguments in respect of financial viability of mutual health organisations. The need to ensure interplay between financial viability, institutional viability and social viability has been espoused. Section three (3) discusses some risk factors that are likely to affect the financial viability of mutual health organisations. This is discussed by Cripps *et al.*, (2003), as technical viability. Section four (4) is a summary of the chapter.

3.1. Mutual Health Organisations

The concept and the development of community-based health insurance schemes (CBHIS), otherwise known as mutual health organisations (MHOs), which are organised by communities to finance their health care have been discussed by different researchers (Criel and Waelkens, 2000; Jakab and Krishnan, 2001; Jütting, 2001; Schneider *et al.*, 2001a, 2001b; Mariam, 2003; Carrin *et al.*, 2005; Jacobs *et al.*, 2008). Mutual health organisations (MHOs) are known as 'mutuelles' in French, and are not-for-profit, autonomous, member-based organisations that aim to improve their members' access to health care. They do this by a variety of financing arrangements, crucially, using insurance and sometimes simple pre-payments, savings schemes (Atim, 1998).

Atim (2000), defines a mutual health organisation (MHO) as a group of people coming together to contribute towards meeting the costs of their health care needs. The members contribute an agreed sum into a common pot and each time a member falls sick, the cost of treatment is paid from the common pot. At least five types of

voluntary, non-profit health insurance schemes have been identified in Africa from literature and observation (Atim, 1999), as described in table 3.1 below.

Table 3.1: Types of Voluntary, Non-Profit Health Insurance Schemes

Type of Scheme and Characteristics	
<p>1. <u>Traditional Social Solidarity Networks:</u> These types are based on a narrow (clan or ethnic) definition of the target group but there can be, and are often based in urban areas. For instance, members of a particular town or village who reside in a different town or city can form a group and as part of their numerous benefits, include health care financial assistance for their members.</p>	<p>2. <u>More Inclusive Mutual Health Associations or Movements:</u> These are based on rural or urban communities, enterprises, trade unions, and professional associations, among others. They have a mass base, which is unrestricted by ethnicity or similar factors. These are normally professional groups like teachers union or members of any identifiable group who have come together.</p>
<p>3. <u>Simple or Low Participation Model of Community Financing:</u> This is usually organised by a health care provider in the context of Cost Recovery in which participation by the insured in the running of the scheme is low or sometimes non-existent.</p>	<p>4. <u>Complex or High Participation Financing Model:</u> This is the one in which the community participates in managing, at least, at the first level of health care (health centres), usually in partnership with the health providers, through participatory structures.</p>
<p>5. <u>Medical Aid Societies:</u> These are the most advanced and highly developed modification of the mutual aid social movement, organised on a big scale, in terms of members. They usually involve professional staff and some techniques of management borrowed from private commercial insurance to run it.</p>	

3.1.1. Sustainability of Mutual Health Organisations

Despite the optimistic view that mutual health organisations can help people in the communities in times of sickness to manage their health care costs (Jakab and Krishnan, 2001; Jütting, 2001; Schneider *et al.*, 2001a, 2001b; Mariam, 2003; Carrin *et al.*, 2005; Jacobs *et al.*, 2008), findings of some studies have been sceptical about their financial viability and overall sustainability. A review shows that these non-profit insurance schemes have limited coverage, low cost recovery rates and little aptitude for safeguarding the poorest in society (Creese and Bennett, 1997; Atim, 1999; Criel and Waelkens, 2003; Carrin *et al.*, 2005; Ndiaye *et al.*, 2007; Jacobs *et al.*,

2008). The writers explain this unenthusiastic observation by highlighting that many of the schemes studied were poorly designed (Creese and Bennett, 1997; Atim, 1999).

Another point for debate is that even as there is a growing tendency amongst international donor agencies to promote these schemes as part of a system-wide resolution to improving 'access to health care services in low-income countries' (Ranson, 2002:613), the existing evidence suggests that they fail to reach or impact on utilisation among the poorest of the poor (Ndiaye *et al.*, 2007; Franco *et al.*, 2008; Jacobs *et al.*, 2008). Ranson (2002), asserts that these might be due to the fact that most appraisals focus on mainly instrumental goals: scheme design and management, per centage coverage of target populations and levels of cost recovery as benchmarks for evaluating their significance and sustainability. Using this approach, the International Labour Organisation (ILO) reviewed 258 schemes and found that 50 per cent had less than 500 members (ILO, 2002; Criel and Waelkens, 2003; Carrin *et al.*, 2005; Jacobs *et al.*, 2008). However, such statements and findings cast doubts about the potential of mutual health organisations to promote health care access to the poor who are located in the remotest communities of most developing countries (Jakab and Krishnan, 2001; Jacobs *et al.*, 2008).

In contrast, some studies have found that mutual health organisations can increase the use of health care and also reduce costs directly to the consumer (Bogg *et al.*, 1996; Criel and Kegels, 1997; Atim, 1999; Musau, 1999; Ranson, 2002). Subsequently, Atim (1999), reacted to Creese and Bennett's (1997), observation and notes that it is promising that with better design and widespread dissemination of knowledge, many of the difficulties may possibly be assuaged. Due to their flexibility, even policy-makers hope that mutual health organisations will add to World Health Organisation's (WHO) goals of 'better health, fair financing and responsiveness' (WHO, 2000:35. See also Ranson, 2002; Kirigia *et al.*, 2006). Mutual health organisations have the potential for raising additional and stable revenue to fund the cost of health care provision. They have the capacity to reduce financial barriers to health care utilisation and have greater redistributive effects (Preker, 2002, 2004a). Mutual health organisations are found to provide financial power to their 'administrators with a leverage to obtain-better quality services and have more accountable health-care providers' (Jacobs *et al.*, 2008:140).

Optimism about the survival of the mutual health organisations is boosted by other studies that suggest efficacy in promoting financial access to the poor in the communities (De Ferranti, 1985; Abel-Smith, 1993; Wiesmann and Jütting, 2000; Jakab and Krishnan, 2001; Jacobs *et al.*, 2008). These researchers urge that with the distinctive ethnic, language and cultural mix of African nations, this approach to health financing may be beneficial because it permits variations to suit local circumstances. Supporting this view, Atim argues that mutual health organisations have the potential to bestow more to the health care sector in West and Central Africa. Mutual health organisations have the possibility to attract more people (Atim, 1998, Atim *et al.*, 1998; Atim, 2001). Mutual health organisations can be combined effectively with social security arrangements in countries that are searching for equitable health financing strategies (Zschock, 1982; Hoare, 1987). Jacobs *et al.*, (2008), suggest the need to bridge mutual health organisations and social protection programmes so as to assist households and communities to better manage risks; and provide support to the critical poor (see Holzmann and Jorgensen, 2000). The World Bank Report 2008 suggests:

...creating incentives for customers to buy health insurance packaged with traditional microfinance products could spur the growth of this market and extend health care coverage within poorer segments of society and rural populations... (WB, 2008:43)

Notably, evidence from other studies has shown ambiguity about the potential of mutual health organisations to support the poor in accessing health care. While the researchers have been largely questioning they have also been recommending a revamp of mutual health organisations (Atim *et al.*, 1998; Arhinful, 2000; Atim and Sock, 2000; Dablu, 2001; Aikins, 2003; Baku *et al.*, 2006; Baltussen *et al.*, 2006). Thus, as they are emerging, mutual health organisations are confronted with challenges that threaten their financial and overall sustainability (Fairbank, 2003; Fairbank and Diop, 2003).

3.2. Financial Viability of Mutual Health Organisations

There are different sources of financing available for health in general and the mutual health organisations in particular. Some researchers observe that mutual health

organisations need to guard against financial insolvency (Fairbank, 2003). Fairbank and Diop (2003), observe that while mutual health organisations may offer the benefits of risk-spreading (health-risk) they themselves may be at risk of insolvency in the early days of development. Obviously, the sustainability of mutual health organisations depends on financial viability, which is an overall indication of their financial health and how they can be sustained financially (Atim, 1999; Cripps *et al.*, 2003). Financial viability of organisations has been discussed by different disciplines such as agriculture (Gabriel and Baker, 1980; Johnson and Durham, 1999), hospital services (Altman *et al.*, 1998; Matherlee, 1999), microfinance (Blundell, 1998), and mutual health organisations (Atim, 1999; Cripps *et al.*, 2003; Fairbank and Diop, 2003; Franco *et al.*, 2006).

Odhiambo-Otieno (2005), suggests that the evaluation criteria for district health management information system (MIS) should include: policy and objectives; technical feasibility; political viability; administrative operatibility; and financial viability. The financial viability criterion measures what the system will cost and what it will produce for benefits. Three categories are suggested for consideration when examining measures for hospitals' financial viability in the United States of America:

1. The first is net income: this is revenue minus expense.
2. The second is liquidity and cash flow: this gives providers enough liquid assets to meet near term obligations to employees, vendors and creditors, and to move on community needs and opportunities.
3. The third is debt burden: this should be controlled because if they are too high, they can limit flexibility and pose undue risks of default or insolvency (Altman *et al.*, 1998; Matherlee, 1999).

Other researchers observe that any estimation of sustainable financing of mutual health organisations must be considered in respect of how progressive subsidies could be obtained from whatever source available (Fairbank, 2003; Fairbank and Diop, 2003). This is because most community health insurance schemes (CHIS) enjoy a lot

of goodwill in the form of either cash or kind from donor sources (Atim, 2001; Carrin, 2003). In a World Health Organisation (WHO) study, community health insurance schemes (CHIS) were assessed on both financial and administrative terms. A number of reasons for poor financial viability are identified, including the small scale of community health insurance schemes (CHIS); the occurrence of adverse selection leading to progressively smaller risk pools and higher costs and important administrative costs (Bennett *et al.*, 1998; Carrin, 2003, Carrin *et al.*, 2005).

Two caveats are identified. For instance, financial viability is not necessarily equal to self-financing. Since several partners may contribute to health financing within the context of community health insurance schemes (CHIS), it is important to identify enterprises and international donors who have a role to play. Additionally, it is necessary to compare financial viability of community health insurance schemes in the context of similar benefits packages. This is due to the fact that community health insurance schemes may exclude a number of health services from the benefits packages and therefore show a high per centage of cost recovery (Carrin, 2003; Carrin *et al.*, 2005).

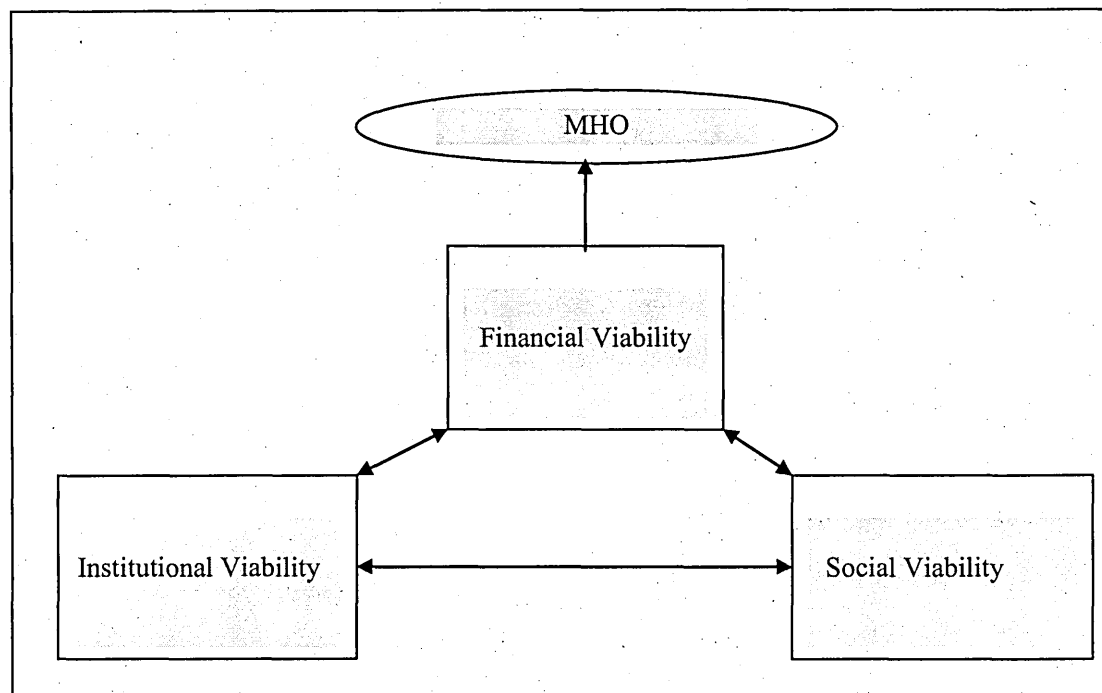
Similarly, an International Labour Organisation (ILO) study found that for 69 out of 85 community health insurance schemes, central and local government cover the larger part of the cost of health services, whilst the central government together with other organisations are found to be important financiers in seven cases (ILO, 1999; Carrin *et al.*, 2005). Consequently, all sources of financing available to mutual health organisations must be considered when calculating their financial viability (Baeza *et al.* 2002; Carrin *et al.*, 2005). What is common in all the measurements used is that financial viability is examined in both financial and non-financial terms. The indicators used for measuring financial viability in this study are shown on table 8.3.

3.2.1. Interplay between Financial Viability, Institutional Viability and Social Viability

Unquestionably, the long term survival of mutual health organisations depends on their financial viability. However, financial viability cannot be achieved without enabling institutional environment and the support of social networks in the communities in which they are located. Therefore, a successful interplay between

these three factors: financial viability; institutional framework; and social dynamics, will help to ensure the overall sustainability of mutual health organisations as depicted in figure 3.1 below. The figure shows that the sustainability of mutual health organisations depends on financial viability. Financial viability is also influenced by both institutional viability and social viability. Thus, there is the need to examine these factors together so as to ensure harmonisation between them. This will ensure the financial as well as overall sustainability of mutual health organisations.

Figure 3.1: MHO Sustainability Framework



Cripps *et al.* (2003), have provided analysis of the overall sustainability of mutual health organisations using two main dimensions: financial viability and non-financial viability. The non-financial viability dimension is further categorised into three areas: institutional, social and technical. However, the technical viability is discussed in relation to the management of health insurance risk factors in this chapter (see 3.3). Thus, the measurement criteria suggested by Cripps *et al.* (2003), are used to assess the financial performance of the mutual health organisations in this study. These are suitable because they indicate the elements and the sources of data from which to conduct an analysis of the financial viability and over all sustainability of mutual health organisations (Cripps *et al.*, 2003).

3.2.2. Institutional Viability

The institutional environment within which mutual health organisations operate also has immense influence on their financial viability as well as factors leading to their success or failure. The institutional viability is a non-financial indicator and looks at how they can be promulgated by increasing membership, they are socially accepted, they conduct elections, and how legality and legitimacy issues are dealt with (Musau, 1999; Atim, 2000). Consideration regarding how to finance mutual health organisations must take account of important factors such as organisational capacity. This is a frequent cause of preventable costs. Other areas of preventable costs are low enrolment and high utilization rate. Wasteful use of resources leads to collapse and a lot of financial waste can be saved if administrative systems are well structured like any other business entity (Fairbank and Diop, 2003; Jacobs *et al.*, 2008).

It is also important to address shortage of skills that are common in community health insurance (CHI) in most sub-Saharan Africa countries. Some researchers found that areas where the lack of skills are evident are the setting of contributions, collection and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems and accounting (Atim *et al.*, 1998, Atim and Sock, 2000; Carrin, 2003; Carrin *et al.*, 2005). There are some confident arguments made to the direction that with appropriate instruments designed for mutual health organisations even the poor in rural and informal sector settings are insurable (Kutzin, 1995; Atim, 1999).

Some researchers also argue that if the full potential of the mutual health organisations is to be realised, there was the need to reinforce their institutional, managerial and administrative capacities. Experience has shown that they are likely to enhance performance when they are linked to an organisation, which already has experience in financial services and social protection (Ron *et al.*, 1990; Atim, 1998; Ron, 1999; Atim and Sock, 2000; Jacobs *et al.*, 2008). However, it was found that the introduction of professional management may well require external subsidy as the mutual health organisations on their own cannot mobilise funding to train their management personnel (Bennett, 2004; Carrin *et al.*, 2005).

Most of the mutual health organisations are vulnerable to mismanagement, technical errors and political interference (Abel-Smith & Dua, 1988; Moens, 1990; Ron, 1999; Atampugre, 2003). In sub-Saharan Africa, the role of government in providing health care services is seen as paramount. Whilst it is considered that governments' role in providing a tax funded health system as a regulatory mechanism is not efficient, other reviews of rural risk-sharing schemes show that governments and other stakeholders will have to play a major role if mutual health organisations are to be scaled up as part of a national strategy (Musgrove, 1996; Bloom and Shenglan, 1999; Desmet *et al.*, 1999; Tabor, 2005; Poletti *et al.*, 2007). The role of government in enhancing the institutional viability of mutual health organisations is explained below.

3.2.2.1. The Role of Government

Ron (1999), argues that governments need to play significant roles as initiator and enabler in the development and sustainability of mutual health organisations. The management and administrative dimensions of mutual health organisations are also examined in light of other influential factors including, the role of government in the areas of regulation and subsidy as discussed below.

3.2.2.1.1. The Provision of Regulation

Different ideas with mixed convictions abound regarding the kind of regulatory framework necessary to promote mutual health organisations. Desmet *et al.* (1999), argue that the seeming lack of lucid national government health policy leads to overlapping of responsibilities and duplication of resource use where there are one or more mutual health organisations. Liu *et al.* (1995), recommend that governments could set up a national agency with the responsibility of providing assistance including, accreditation for mutual health organisations. Atim (1998), suggests the need for governments' legislation to enable mutual health organisations to acquire legal and corporate status through registration, so as to offer protection for members who subscribe and pay dues as well as regulating their financial management and administration systems. Some researchers also suggest that the role of governments is to provide stewardship, an enabling conducive environment in the form of effective decentralisation, tax regulation, a better health care delivery system and an appropriate legislative framework for mutual health organisations (Carrin, 2003; Carrin and James, 2004; Carrin *et al.*, 2005).

Despite these suggestions, caution is raised by some researchers that governments should not create and manage mutuals as excessive local political interference could affect registration and growth (Huber *et al.*, 2002). Ron (1999), notes that it is important to involve neutral agencies to supervise and provide direction for mutual health organisations, when regulations are developed instead of using government machinery directly. Others question whether excessive governments' control could cripple the movement (Atim, 1998).

3.2.2.1.2. The Provision of Subsidy

There is general consensus regarding the need for subsidies in the financing of health care in developing countries in general and in Ghana in particular. However, researchers and policy makers are not sure of the type of subsidy that governments might provide to support the financial viability of mutual health organisations, which were set up as voluntary schemes. The suspicion is that if the arrangements are not balanced, it could lead to tension between the government, health providers and the promoters of mutual health organisations (Atim, 1998; Ron, 1999).

It is also observed that in compulsory health insurance systems in Europe, the premiums of the poor or unemployed are subsidised or even directly paid by the government as social assistance or in-built in the countries' social security systems (Eisenblaetter *et al.*, 2001). A similar thing could be done for mutual health organisations. Researchers who support this view also suggest that in order to ensure that subsidy achieves its full impact on health care in developing economies, there should be a strategy to clarify that it is to cover expenses at hospital level and management of the health care system as a whole (Desmet *et al.*, 1999).

Marcadent (1999), argues that subsidies can be a strong incentive for people to join mutual health organisations. Similarly, Ron (1999), reveals that the mechanism of subsidised contributions may encourage as well as sustain membership and supports the view that this should be accessible to specific very low and unstable income families over a limited period. Bennett (2004), also concurs to this view noting that government subsidies to mutual health organisations should aim at the poor, particularly those who cannot afford to pay a premium. This would enable them to access quality health care (Bennett, 2004; Jacobs *et al.*, 2008).

In contrast to the above views, Atim (1998), cautions against subsidising the premiums because in a World Bank project in Tanzania this proved discouraging. Ron (1999), expresses the notion that if this was to continue for a very long time, it might discourage some members from making individual efforts to pay their own dues and they also might drop out from mutual health organisations as soon as such a subsidy was discontinued. Huber *et al.* (2002), agree with this view noting that it is unwise to subsidise the premium level because mutual health organisations cannot count on significant budgetary support by the governments of the Africa sub-region.

Derriennic *et al.* (2005), found that this approach was unsustainable in Uganda where the majority of the health facility-based mutual health organisations were being subsidised. There was the fear that this might have had to discontinue at some point. Premium payments through group-level mechanisms are proposed as plausible option to ensure the longevity and sustainability of mutual health organisations instead of total reliance on subsidy. The indicators used for measuring the institutional viability of mutual health organisations are shown on table 8.8.

3.2.3. Social Viability

Social dynamics is another important factor that has an effect upon the financial viability as well as the overall sustainability of mutual health organisations. This is described by some researchers as social viability (Atim, 1999, 2000; Cripps *et al.*, 2003). This is a non-financial indicator and measures how the community participates in the management of mutual health organisations as well as how mutual health organisations are accountable to their members as autonomous organisations (Atim, 1999, 2000; Cripps *et al.*, 2003; Franco *et al.*, 2004, 2006, 2008). It is this dynamic relationship between mutual health organisations and the communities, which has attracted interest (Atim, 1998, Atim *et al.*, 1998).

Mutual health organisations are considered as a form of community participation in health care delivery. They make it possible for community members to contribute to discussions regarding how health issues in their communities are structured (Abel-Smith & Dua, 1988). A community participation approach affords members of mutual health organisations the opportunity to make suggestions about their health

priority needs, discuss how to design benefit packages, assess the performance of health care providers and enable them to contribute to health financing (Atim *et al.*, 2001a, 2001b, 2001c; Poletti *et al.*, 2007). Jakab and Krishnan (2001), argue that this gives the impression that through mutual health organisations the community can play a major role in mobilising, pooling, allocating, managing and or supervising health care resources (Jakab and Krishnan, 2001; see Jacobs *et al.*, 2008:140).

Some empirical evidence shows that community participation is usually greater if mutual health organisations are owned and managed by members themselves than health providers (Mathiyazhagan, 1998). The usefulness of community participation and how it can be encouraged has been observed. This can be enhanced through increased community representation on the management boards of mutual health organisations. Through this, members can exhibit responsible behaviour and take up ownership (Griffin, 1989; Upton, 1991; Ensor, 1995; Eyre & Gauld, 2003; Franco *et al.*, 2004).

Other reviews of community participation have looked at the influence of local hierarchies and geographical constraints. Local hierarchies can preclude local committees from successfully representing the interest of community members because of the presence of male domination within these committees (McPake *et al.*, 1993). Community participation is sometimes impeded because of the use of technical language during discussions at meetings, which deprives most members of the freedom to exercise their right of contribution due to lack of understanding of the main issues (Atim, 1998; Desmet *et al.*, 1999; Eyre and Gauld, 2003). Thus, the absence of community participation in the development and management of the mutual health organisations will lead to low participation (Musau, 1999; Atim, 2001). The relationship between mutual health organisations and stakeholder organisations is discussed below.

3.2.3.1. Relationship between MHOs and Stakeholder Organisations

It is argued that in business, behaviours that have economic motives are implanted in interpersonal associations, which take place between participants (Sonnemans *et al.*, 2006). The socialising activities in such groups or networks (social ties) also forcefully impact on how organisations perform economically as well as in other areas

or take advantage of their share of the allotted markets. Organisational theorists argue that the social structure and the culture of an organisation affect the eagerness, with which its members decide to support, cooperate, organise and harmonise information they share and how trust for one another is nurtured. Therefore, there is the need to pay attention to both economic and social contexts (Coleman, 1984; Scott, 1981; Forsyth, 1990; Turner, 1999; Schneider, 2005a, 2005b; Sonnemans *et al.*, 2006).

Waelkens and Criel, (2004), suggest that small-scale networks can be formed to enhance membership and financial power of mutual health organisations (Waelkens and Criel, 2004; Jacobs *et al.*, 2008). Jacobs *et al.* (2008), suggest the need for 'local and national solidarity arrangements to enhance fair cross-subsidies'. However, they argue that 'solidarity mechanisms are socially and politically' more suitable and can be sustained where there is 'one single fund rather than different funds catering for different population groups' (p.142). Mutual health organisations have relationships with stakeholder organisations in the communities. Two organisations are discussed below.

3.2.3.1.1. Health Care Institutions

The provision of acceptable health care to clients has been found to encourage the survival of mutual health organisations (Ensor, 1995; Leighton, 1995). While there are many views regarding what constitutes quality health care, Donabedian (1988), has developed a framework for defining and measuring quality of care and differentiates between observed quality of care and perceived quality of care. The observed quality of care focuses merely on the structure, the process and the outcome. The structure refers to facilities, personnel and organisation. The process refers to the interaction between the provider and the consumer. The outcome also measures the extent to which the service meets the consumers' expectations. The difference between observed quality of care and perceived quality of care is that whilst the observed quality of care relates to professionally defined standards of care, the perceived quality of care reflects the views of the patients (Donabedian, 1988).

Under the Ghanaian health care delivery system, quality of care indicators have been considered to include: waiting time, availability of drugs and availability of health personnel (Agyepong, 1999; Atim *et al.*, 2001a, 2001b, 2001c; JAHSAG, 2001;

Adjei, 2005), and good customer relationships exhibited by health care professionals (Afari-Adomah, 2000). Atim (2001), recommends that the Ministry of Health (MOH) in Ghana could assist health facilities to institutionalise Quality Assurance (QA) programmes and a system of facility accreditation to improve quality. Despite Atim's recommendations, Anie and a team of researchers found that none of the mutual health organisations in Ghana had policies on quality of care or quality assurance (Anie *et al.*, 2001).

Criel *et al.* (2002), found in an evaluation of the Maliando scheme in Guinea-Conakry that quality of care was mentioned 383 times by participants as an important factor in the population's attitude towards the mutual health organisation. Equally, the lack of quality of care is cited as the most important cause of non-enrolment (Criel *et al.*, 2002; Carrin, 2003). Different studies have found that quality health care provided by health institutions is an important factor which encourages community members' participation in mutual health organisations (Offei *et al.*, 1995; Atim and Sock, 2000; Akua-Agyepong *et al.*, 2001; Chee *et al.*, 2002; Criel and Waelkens, 2003; Jacobs *et al.*, 2008). In order to enhance the satisfaction of insured clients and all patients alike, Ensor (1995), suggests that governments should adequately invest in health care to improve both availability and quality of services.

3.2.3.1.2. International Donors and Non-Governmental Organisations (NGOs)

Most developing countries often rely on the international donor community (financial aid organisations) to develop the social services sectors including health. The World Bank Report 2008 argues that the huge variety of financial and developmental prospects that the health sector presents in sub-Saharan Africa will necessitate significant participation by all fragments of the investor community (WB, 2008). These investors include:

1. Financially driven private investors: will find sustained industry growth combined with opportunities for consolidation;

2. Angel investors: can engage with innovative social enterprises to deliver great returns while addressing some of the most pressing health care challenges facing the region;
3. Double-bottom line investors: such as development finance institutions and foundations, can collaborate to provide 'patient capital' to achieve financial returns over the longer term while delivering significant development impact; and
4. Donors: can play a key role by financing those enterprises that are not financially viable, but have the promise to play a crucial role in the development of high-quality private sector health care (WB, 2008).

Preker (2004a), contends that in sub-Saharan Africa and other low income regions, due to the absence of adequate funding for health, there is poor access to even the under-financed and low quality publicly financed health services. The consequence of this is that the health sector is left highly dependent on donor assistance. Due to poverty many people are being deprived of access to health care at orthodox facilities. Therefore, a group of non-governmental organisations led by Oxfam is calling on world leaders to provide free health care to vulnerable groups in developing countries:

...I am writing on behalf of over 60 organisations who today have launched a report calling on world leaders to act ahead of the high level event on health on 23rd September [2009] at the UN General Assembly to make health care free and save lives. User fees for health care are a life or death issue for millions of people in poor countries. Too poor to pay, women and children are paying with their lives. For those who do pay, over 100 million are pushed into poverty each year... (Stocking, 2009)

Atim (2000), found that mutual health organisations enjoy a lot of goodwill from the donor community, which has translated into the availability of a broad range of management and organisational tools developed exclusively for such organisations (Atim, 2000, 2001). A survey of eighty-two schemes also confirms that mutual health organisations usually survive only for as long as transfer payments from an external source can be secured (Bennett *et al.*, 1998; Dror and Duru, 2000). Thus, most mutual health organisations in West and Central Africa (WCA) owe their existence to

the technical and financial assistance from both international donors and local non-governmental organisations (NGOs) and religious groups (Atim, 1998; Atim and Sock, 2000).

In general terms, overdependence on international organisations can create funding gaps if they withdraw their support. Huber *et al.* (2002), contend that health system and health financing reforms in sub-Saharan Africa promoted by international donors since the 1970s have not resolved the problem of reduced access to health care. The question is whether this donor support can continue ad-infinitum and what would happen to the funding gap if they withdraw? (Evlo and Carrin, 1992; Gutman, 2009). On the basis of the fact that international donor support, though necessary, cannot be relied upon forever, the issue which needs to be addressed is whether the sustainability and the value of mutual health organisations are in the communities that are very poor with no resources including, social capital to fall back on or very rich communities where state or private wealth can be mobilised to sustain health financing and health care. The elements used for measuring the social viability of mutual health organisations are outlined on table 8.9.

3.3. Managing Mutual Health Organisations' Risks Factors (Technical Viability)

Cripps *et al.* (2003), describe the major health insurance risk factors, which can cause mutual health organisations' collapse as technical viability. Some researchers and authors include community health insurance schemes (CHIS) as private health insurance plans and others also make a clear distinction between the variety of private insurance forms based on the different roles in the health care financing structure (see Cutler and Zeckhauser, 2000; Colombo and Tapay, 2004; Sekhri and Savedoff, 2005). However, critics of private health insurance point out two most important problems as moral hazards and adverse selection (see Pauly, 1968, 1986; Evans, 1987; Besley, 1989; Culyer, 1989a, 1989b; McGuire *et al.*, 1989; Culyer and Simpson, 1980; Donaldson and Gerard, 2005). Therefore, it is important for managers of mutual health organisations to be up to date with techniques of dealing with risks associated with insurance operations (Atim, 1999, 2000). Some of the major health insurance risk factors are described below (Cripps *et al.*, 2003).

3.3.1. Adverse Selection

This part also explains adverse selection, which is a health insurance risk factor. That is to say that adverse selection may be described as a scenario where prospective insurance clients are discriminated against due to factors beyond their control, importantly, on the basis of health risks or their financial inability to meet the costs of subscription to an insurance scheme. When this happens, certain groups of people in the society, who are mostly: poor, medically indigent, and those with chronic sickness, will not usually be covered by the agencies and will have to depend on charity care, if available (Pauly, 1968, 1986; Evans, 1987; Donaldson and Gerard, 2005). On the other hand, adverse selection may occur in a situation where people who are at greater risk of falling ill (high risk) or who are already ill, subscribe to an insurance scheme in greater numbers than those who are less at risk (low risk). If the actual subscribers are people who use the services more extensively, than the average predicted, then the mutual health organisation is prone to insolvency (Culyer, 1989a, 1989b; McGuire *et al.*, 1989; Cripps *et al.*, 2003).

In a World Health Organisation (WHO) review of 44 community-based health insurance schemes, adverse selection was found to be affecting the schemes that insured against high-cost low frequency events compared to schemes that covered low-cost high-frequency events. This was attributed to the fact that many people might have enrolled with the schemes, at the time of illness. Therefore, people with high risks are more inclined to be over-represented in mutual health organisations (Desmet *et al.*, 1999; Carrin, 2003). This can also affect the financial viability of the mutual health organisations because premiums are calculated on the basis of the average risk of illness of the whole community or target group. A community health fund in the Boyeboye District of Niger instituted compulsory subscription as a measure to control adverse selection (Kyeremeh, 2001).

3.3.2. Moral Hazard

This part explains moral hazard as a health insurance risk factor. That is, moral hazard may be explained as a situation where there is misuse of available health care on the part of insured clients on one hand and misapplication of health care resources by health providers. The conviction is that there is insurance money that can be used to offset the bills (Pauly, 1968, 1986; Evans, 1987; Besley, 1989). Moral hazard occurs

when the insured members have a tendency to use the services more intensively than if they were not insured. Moral hazard is different from fraudulent use of the services because it relates mainly to the fact that the cost associated with the use of the service to the insured person may be much lower than the actual cost of the service (McGuire *et al.*, 1989; Cripps *et al.*, 2003). Culyer (1989a), argues that moral hazard arises with some forms of insurance since the consumer of medical care is confronted with a marginal cost at the point of receiving care that is less than the true marginal social cost of provision, consequently, leading to some loss of welfare (see Culyer, 1989a,1989b). This over-consumption jeopardises the financial viability of mutual health organisations. Kyeremeh (2001), observes: 'cases of moral hazard have been reported at the Nkoranza Scheme, Masis etc' (p15).

3.3.3. Cost Escalation

Another health insurance risk factor that managers of mutual health organisations will be confronted with is cost escalation, which results from some actions and inactions of both the members and health care providers. Some researchers explain that cost escalation is the danger that an insurance scheme will face rapidly rising cost for a variety of reasons; related to the behaviour of both providers and subscribers once such a scheme is implemented (see Kyeremeh, 2001). Culyer (1989a), supports this view and observes that cost escalation occurs where there is the danger of rapidly rising costs due to an assortment of reasons related to the behaviour of providers and patients (Culyer, 1989a,1989b). In some instances, the providers with the complicity of patients (members) may have incentives to use costly, treatment protocols or provide excess services in the knowledge that the mutual health organisation will pay the bill. That is: 'the prescribers in order to please the patients may yield to these demands as reported at Nkoranza' (Kyeremeh, 2001:15). This can drive up the costs to the mutual health organisations (see McGuire *et al.*, 1989; Cripps *et al.*, 2003).

3.3.4. Fraud and Abuse

Other health insurance risk factors are fraud and abuse which occur where unregistered individuals who are not entitled to the benefits packages may use the identities of registered members to enjoy the services or benefits without paying for them. This occurs where there are no systems in place to check the identity of the insured clients (McGuire *et al.*, 1989; Cripps *et al.*, 2003). Kyeremeh (2001),

suggests that this could be prevented if mutual health organisations institute: 'social control systems, use photo ID cards or MHO member authenticate' (p.15).

3.4. Summary of the Chapter

This chapter has introduced the concept as well as analysed the debates about the sustainability of mutual health organisations. It has argued that the sustainability of mutual health organisations depends on financial viability. However, financial viability also depends on, and is influenced by both institutional viability and social viability. Therefore, there is the need for interplay between these three key elements, which this study seeks to explore. The next chapter discusses the theoretical framework for the interpretation of the findings of this study.

CHAPTER 4

THEORETICAL FRAMEWORK

4.0. Introduction

This chapter presents a review of the theories that are relevant for explaining the findings of the empirical study. The chapter is divided into five (5) sections. Section one (1) is a review of neo-classical economics theory together with related concepts. However, this theory is rejected as basis for the interpretation of the findings of this study. While section two (2) discusses social policy theory, section three (3) also discusses community field theory. Section four (4) presents a brief discussion of the harmonisation between these two theories: social policy and community field. Section five (5) is a brief summary of the entire chapter.

The role of theory in research has been discussed by researchers like Silverman (2006), who observes that:

...theories arrange sets of concepts to define and explain some phenomenon...without a theory there is nothing to research (Silverman, 2006:3)

The theoretical literature underlying health sector reform can be explained from three different perspectives: private sector involvement, public sector involvement and community sector involvement. These have been discussed below.

4.1. Neo-Classical Economics Theory

There have been arguments that there should be private sector participation in the financing and delivery of health care. These are based on the philosophy of neo-classical economics theory (see Lees, 1961, 1962; Culyer, 1989a, 1989b, McGuire *et al.*, 1989; Frenk, 1994; Berman, 1995). Henry (1990), argues that influenced by classical economic theory, neo-classical theory developed after World War II focuses on micro-economic theory by exploring the conditions of static equilibrium. It is concerned with the problems of an economy enjoying equilibrium at full employment and with savings-determined investment, marginal utility and marginal rates of substitution (Henry, 1990). The protagonists of neo-classical economics theory argue that there was the need to apply market approaches in the social sectors

of the economy: health, education, and social protection, even in countries that are practising the welfare system (Titmuss, 1974, 1987).

Neo-classical economic theorists favour the introduction of health insurance, particularly, private health insurance schemes in the health sector as practised in the United States of America (Evans, 1986, 1987). Steinbrook (2006), explains that privatisation transfers ownership of resources or enterprise from a collective, public basis to an individual private one. The balance is embedded in the property rights over the resource allocation decision (Steinbrook, 2006; Di Matteo, 2009). In most developed countries, private health insurance is more often than not raised by insurance premiums and or out of pocket payments (Propper and Green, 1999). In the United Kingdom, there was debate as to whether there should be a move from the National Health Service system to private insurance or completely, to the private provision of health care itself (Lees 1961, 1962; Arrow, 1962, 1963, 1972; Buchanan, 1965; Klarman, 1962, 1963, 1965a, 1965b; Culyer, 1989a, McGuire *et al.*, 1989).

This theory is also encrypted in the assumption that public sector or government intervention in the economy could lead to failure due to inefficiency and lack of accountability (Preker and Harding, 2000). Whilst advocates for a greater market role in health care argue that privatisation will foster greater efficiency, the opponents counter-argue this by noting that one of the main reasons for the observed differences is that governments tend to supply goods and services that are inherently more difficult to produce than those supplied by the private sector leading to greater inefficiency (Stoddart and Labelle, 1985; Di Matteo, 2009).

The proponents of private sector involvement argue that health care is a private good because individuals can be excluded from consumption for non-payment (Di Matteo, 2009). Williams (1988), argues that while the proponents of private health care view health care as part of society's reward system, public health advocates argue that such access is every citizen's right (Williams, 1988; Di Matteo, 2009). Hurley (2001), notes that the defect in the operations of a system of private health insurance markets alone is that it will not be able to provide the expanded access required by the entire people in the society, as the low-income members would not be able to procure health care insurance policies in view of unaffordable premiums.

4.1.1. New Institutional Economics

The new institutional economics is a concept which provides a justification for organisational activities to facilitate and widen the neoclassical optimising descriptions to include costs of contracting. This gives a basis for the degree to which organisations choose 'trade or hierarchy as the appropriate form for components of their business' (Roberts *et al.*, 1998:278). Rafferty *et al.* (1994), based their analysis of quasi-market on transaction costs theories. These theories have similarities with the subjective cost theories since it is the awareness of costs instead of estimated costs with the intention of motivating entrepreneurs (Rafferty *et al.*, 1994; Roberts *et al.*, 1998). Buckley and Chapman (1997), argue that:

transaction costs are funny things: the most important of them exist not in reality, but in realities that have been avoided, in worlds that have not come to be (Buckley and Chapman, 1997:136).

Roberts *et al.* (1998), postulate that transaction cost economics surrenders to 'a *modus vivendi* for decision making yet has potentially tautological outcome as survivors are by definition those that choose the optimising strategies' (p.279). Appleby (1994b), argues that transaction costs in the quasi-market field have focused not on expectation of the costs that could arise from agreeing to a meticulous organisational form but on the time spent by the workforce on the contracting process (see Appleby, 1994a; Appleby, 1994b; Roberts *et al.*, 1998). Roberts *et al.* (1998), observe that:

proposals for the reform of the health system in the UK, to reduce the management costs of transactions in a quasi-market, while rightly concerned with reducing costs of billing, neglect the much more important aspects of transaction costs that require more insightful management (Roberts *et al.*, 1998:279).

Barrowclough, (1998), shows a different view that although proficient organisational forms may emerge and managed by knowledgeable manager entrepreneurs which could help to minimise production and transaction costs, these might still be unproductive social organisations except those discussing the contracts take steps to 'internalise these external effects and manage any public good aspects of services in the contracting process' (see Roberts *et al.*, 1998:280).

Trust is essential in building relationships to enhance the contracting process. Roberts *et al.* (1998), inform that straightforward contracting is uncommon in areas of welfare since enclosed logic and doubts triumph, which present a scope for opportunism. However, they emphasise that it is the relationships that build up among the business parties that afford the best guard against opportunism. The belief is that such relationships complement contracts and may increase cross organisational forms, networks, neither market nor hierarchy but some mix that is more collaborative and trusting than combative and competitive (see Allen, 1995; Hughes *et al.*, 1997; Bartlett, 1991; Roberts, 1997; Maher, 1997; Olsen, 1997a; Roberts *et al.*, 1998).

McMaster (1998), studied the movement away from the strict behavioural assumption of individual self-interest in neoclassical economics. This was a response to the fact that agency relationship is rooted in cultural norms and customs. These norms and routines give direction for satisfactory conduct in standard business interactions and provide the goodwill trust that exists between the parties (Sako, 1992; McMaster, 1998; Roberts *et al.*, 1998). Other analysts also argue that trust is seen as an externality that lessens behavioural vagueness and so increases efficiency (Arrow, 1974; Roberts *et al.*, 1998). The assumption is that trust enables governance costs to reduce, takes time to build up but can be destroyed instantly and may be impracticable to restore (Dasgupta, 1988; Le Grand, 1997a, 1997b; Roberts *et al.*, 1998).

Lyons and Mehta (1997), distinguish between self-interested trust and social oriented trust and point out that there is danger of economists and sociologists adopting polar locations regarding trust. While the economists perceive trust as instrumental and its benefits quantifiable; sociologists and anthropologists observe trust as set in social engagements. Whilst these perspectives are valid in transaction costs, trust must necessarily involve mutual value system (Roberts *et al.*, 1998). Bhasker (1994), argues that these mutual social and group value sets both shape and are shaped by the relations between structures and individual agents (Bhasker, 1994; Roberts *et al.*, 1998). While Lyons and Mehta (1997), recognise that there is an interplay between structures and agents (see Lyons and Mehta, 1997; Roberts *et al.*, 1998). As a result, in 'formulating policy' it is important to be aware of the 'dynamics of these interactions' since policy may 'impose pressures that can undermine traditional patterns' and 'disrupt functioning long-term relationships' (Roberts *et al.*, 1998:282).

4.1.2. Transaction Costs and Reform

Organisations are subject to change caused by both internal and external factors. Discussing transaction costs and change, Hughes *et al.* (1997), question the autonomy of executives in the quasi-markets and their competence to assume optimising plans and suggest that quasi-markets are under government control because they are formed by the government and as a result could be transformed by the same government decree which established them (see Hughes *et al.*, 1997; Roberts *et al.*, 1998). This debate is succinctly discussed by new institutional sociologists, as explained below.

4.1.3. New Institutional Sociology

Institutional sociologists have faced up to the opinion that survival of an organisation depends on it being efficient (Perrow, 1981a; Roberts *et al.*, 1998). Some researchers show that reforms in organisations are caused by three forces namely: coercive forces, normative pressures or imitative processes (Di Maggio and Powell, 1991; Hughes *et al.*, 1997; Roberts *et al.*, 1998). Coercive forces are the prevailing approach adopted in the health sector where the sector is subject to:

annual revenue allocations, annual contracting timetables, cost improvement per centages, pricing rules, standardised returns, conciliation procedures, charter standards and long-term strategic targets (see Roberts *et al.*, 1998:281).

Normative reforms in organisations are caused by the kind of pressure normally exerted on management by professional groups over issues of common standards of conduct. The imitative pressures are also orchestrated by apparent need for the development of administrative procedures and the form which contracts should be undertaken (Hughes *et al.*, 1997; Roberts *et al.*, 1998).

Some economic and policy analysts argue that it is ambiguous how far organisational forms will congregate as suggested by some of the isomorphic theories (Roberts *et al.*, 1998). They wonder whether diversity will continue because diversity may arise either as an adaptive reaction to dissimilar circumstances or as meaningless change in undeveloped systems that may be unsuccessful because of organisational reservations, recurrent interference by governments and absence of financial or cultural property rights of the contributors (Di Maggio and Powell, 1991; Roberts *et al.*, 1998).

4.1.4. Private Finance Initiatives

In the health sector, the current trend of reform is aimed at using the Private Finance Initiatives (PFIs). Under this initiative, the private sector is contracted to provide some or all of the capital funds to ensure the construction or provision of a particular service in the health sector. This is paid back through a system where the hospitals provide some services and charge for them so that they can recoup such investments made from the public sector and to a lesser extent, the private purchasers (US Congress, Office of Technology Assessment, 1995; Donaldson and Gerard, 2005).

4.1.5. Justification for the Choice of Social Policy and Community Field Theories

However, the above theories are not applicable to this study because currently, in Ghana, like most other sub-Saharan Africa countries, the role of the private sector and contracting in the financing and delivery of health is negligible, although there are attempts to integrate private providers into the mainstream health care provision (Sekhri and Savedoff, 2005). Moreover, the changes in the health sector are also necessitated by government regulation since the health sector depends on government funding (see Di Maggio and Powell, 1991; Hughes *et al.*, 1997; Roberts *et al.*, 1998). Therefore, social policy and community field theories are being applied. In Ghana, health financing and delivery necessitate concerted efforts between the government and all stakeholders including, the community. Current health care dispensation is a pluralistic system whereby the public health sector, private health sector and traditional medicine practitioners are encouraged to pool resources together to ensure that health care is easily accessed by the population (WHO, 1978; MOH, 2003c, 2005). Most of health care providers are located in the communities and require cooperation of the people to ensure their effective functioning.

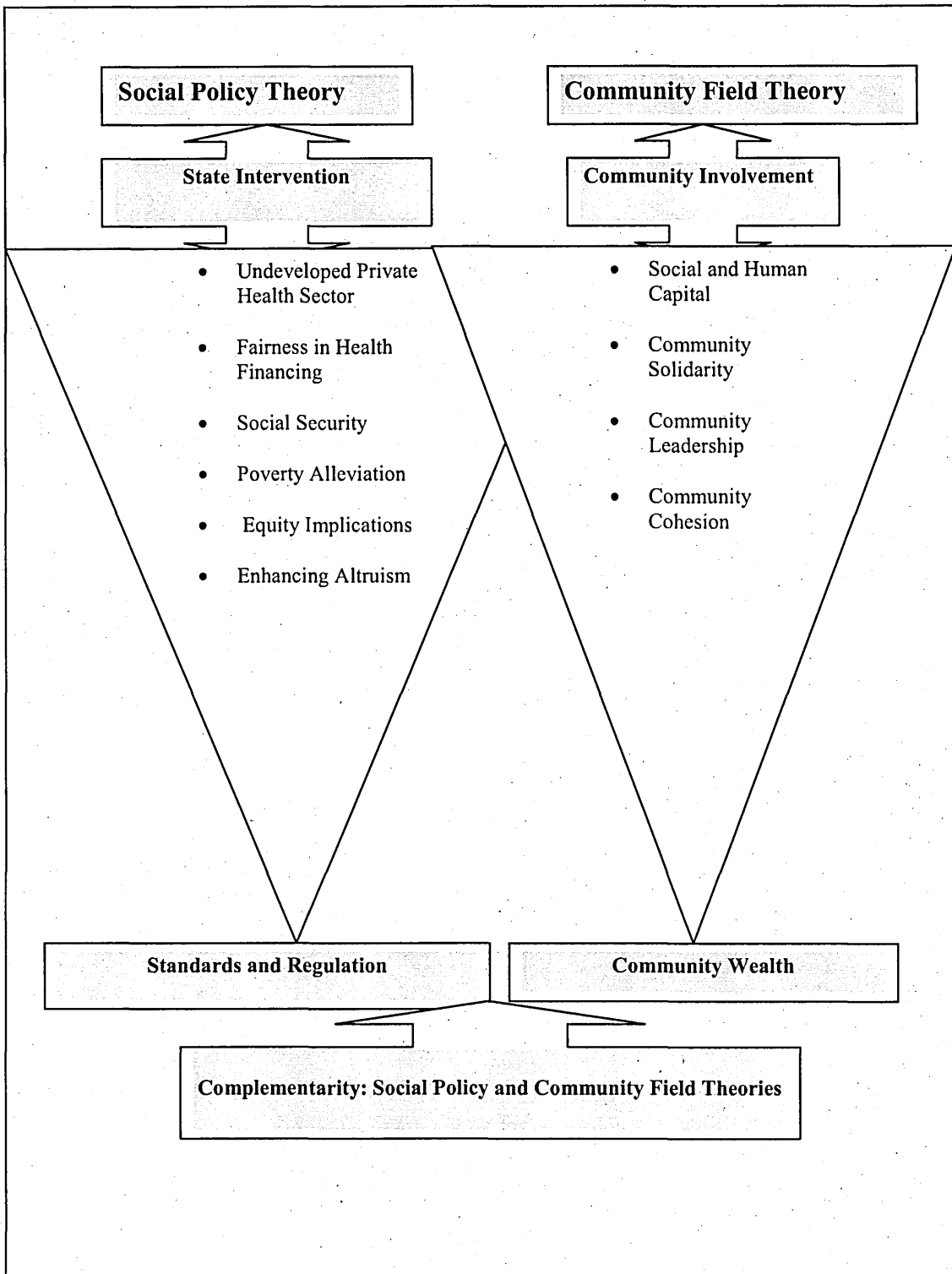
While social policy theory explains the influence of governments' intervention in ensuring equity of health financing and delivery, community field theory helps in construing the role that the community itself plays in sustaining community development programmes such as health financing and delivery and in the achievement of equity goals. This strategy helps to integrate both community and social participation mechanisms to ensure implementation of programmes (Mills *et al.*, 2004). Epple and Romano (1996b), show that under a dual public-private system

of health care provision, an equilibrium exists whereby the rich and poor together prefer reduced public provision while the middle class prefers more (see Epple and Romano, 1996a; Epple and Romano, 1996b; Di Matteo, 2009). In addition, economic theory suggests that mixed systems of health care provision are a likely outcome, which is much like other publicly provided goods with privately available counterparts. Marchand and Schroyen (2005), also observe that a mixed health care system may improve on a pure public system if earnings dispersion is large enough (Marchand and Schroyen, 2005; Di Matteo, 2009).

Key elements of social policy and community field theories are summarised as depicted in figure 4.1. The diagram shows how social policy theory (state intervention) and community field theory (community involvement) can be combined to explain health sector reforms. The rationale of state intervention results from the fact that governments want to ensure that certain objectives are achieved through a process of implementing certain policies, standards and regulation in the health sector. Community field theory also explains community involvement in health sector reforms. This is achieved by explaining how social and human capital or community wealth are utilised by the community members to achieve desired results.

All the activities performed by the government and the community are harmonised. Since the community complements the efforts and policies of the government in the health sector, social policy and community field theories are harmonised to explain the findings of this study. It argues that there is the need to enhance complementarity between the government and the community. This ensures that triangulation, which involves the ability to compare 'different kinds of data, for example, quantitative and qualitative and different methods' such as 'observation and interview to see whether they corroborate one another' (Silverman, 2006:307), is enhanced.

Figure 4.1: Elements of Social Policy and Community Field Theories



4.2. Social Policy Theory

This part explains the concept of social policy. On one hand of the debate regarding state versus private sector participation in the economy is the social policy and welfare philosophers such as Marshall (1965), and Titmuss (1974, 1987), whose perspective is that the state should control market forces; in this case, public financing and delivery of health and health care. Marshall (1965), saw the market economy and inequality of rewards, as important reasons to sustain a productive and good organisation that could help ensure that civil and political liberties in the society were maintained (Marshall, 1965; Titmuss, 1974, 1987). Although, Titmuss' work is said to lack a theoretical basis (Fontaine, 2004), Marshall is said to maintain a normative theoretical constituent and is criticised for been idealistic in his approach (Mishra, 1982). Hence, Titmuss' position has been adopted for the interpretation of this study (Titmuss, 1974, 1987).

Discussions abound on what constitutes social policy. One view expressed by Goffman (1963), is that social policy is that which is centred in those institutions that create integration and discourage alienation (Goffman, 1963; Caplow, 1954; Titmuss, 1974, 1987). Marshall (1965), observes that 'social policy is not a technical term with an exact meaning. It is taken to refer to the policy of governments with regards to action having a direct impact on the welfare of the citizens, by providing them with services or income. The central core consists of 'social insurance, public or national assistance, the health and welfare services, housing policy' (Marshall, 1965:7; Titmuss, 1974:30).

Titmuss (1974), suggests that the word 'policy' attached to 'social' should be understood as 'the principles that govern action directed towards given ends; which implies change: changing situations, systems, practices, behaviour' (p.23). The word 'social' seeks to position man in society and his association with non-economic factors such as human interactions. Therefore, social policy is part of the 'self-regulatory mechanisms built into a 'natural' social system' (p.24). Change is a dynamic process and anything that is subject to change can be considered as social policy or welfare theory. Perhaps this explains why Titmuss is accused of lacking theoretical aptitude in his analysis of social policy (Fontaine, 2004).

Titmuss (1974), argues that the term 'policy' or social policy is used in an 'action-oriented and problem-oriented sense' with the collective 'we' used to refer to the performance of state machinery and how it expresses the 'general will' of the people it governs (p.24). It is this view of collective 'action-oriented' and 'problem-oriented' programmes that makes it imperative for governments, all over the world irrespective of location, economic ranking or political orientation to demonstrate commitment in leadership. In addition, social policy is expected to be 'beneficent, redistributive and concerned with economic as well as non-economic objectives' and 'involved in choices in the ordering of social change' (p.30).

Le Grand (1997), argues that there are two main changes taking place in welfare-oriented states like Britain and other developed economies. The first one is the replacement of the state provision of services by 'quasi-market' provision. This involves the introduction of competition into the delivery of social services such as education, health care and social care. This is 'pro-market in nature' and has relationship with the neo-classical economics theory discussed earlier (refer to 4.1). The second change concerns the other side of the welfare state. This deals with social security or the redistribution of income. This may be illustrated as the supplementation of 'fiscal' by 'legal' welfare. Legal welfare involves the use of regulation or legislation to intervene in market outcome and could be interpreted in part as 'anti-market'. These developments pose interesting questions for social policy analysts.

Roberts *et al.* (1998), posit that the quasi-market revolution had been a defining characteristic of social policy in the 1990s and explain that quasi-market resolution is predisposed to address issues that the 'markets fail to accommodate and locate bureaucratic failures in provider units and to rely on purchasers to deal with matters that the markets fail to accommodate' (p.276). Le Grand (1997), further observes that 'quasi-market and legal changes in welfare systems' are based on a particular view of 'human motivation and behaviour' (Le Grand, 1997:149). Di Matteo (2009), supports this view and argues that the public-private debate in health care has two aspects. Thus, it is a discussion in public economics and it is also an ideological debate between the proponents of a libertarian or market view versus an egalitarian or non-market view of health care provision. Giaimo and Manow (1999), also argue that

social health insurance schemes in some countries are provided as part of the collective social provision and protection based on a political ideology of a welfare state (Esping-Anderson, 1990; Giaimo and Manow, 1999). According to Titmuss (1974:30-31), there are three different models of social policy, which can be used as framework for redistribution in the state as discussed below.

4.2.1. The Residual Welfare Model of Social Policy

This model subsists on the assumption that there are situations that are natural for mankind, which help to fulfil the basic needs of an individual, irrespective of their status, and is universally enjoyed by all. Two cornerstones of this are the family and the private market. The individual is born into a family, which has the responsibility to provide for their basic requirements. The private market provides another avenue through which individuals can meet their necessities of life. In the event that the basic means of fulfilment are unrealisable, another alternative system must be available that can provide support. This is where the intervention of government or social welfare becomes relevant. Titmuss (1974), criticises this model of redistribution and income maintenance on the basis that it assumes that 'the true objective of the welfare state is to teach people how to do without it' (see Peacock, 1960:11; Titmuss, 1974:31).

4.2.2. The Industrial Achievement-Performance Model of Social Policy

This model is based on the premise that government machinery itself cannot perform all functions for the population. This calls for institutions like social services or welfare to be a system-wide organisation of the national economy. However, people in need would have to fulfil certain eligibility criteria: 'of merit, work performance and productivity' (Titmuss, 1974:31). The root of this postulation is linked to 'economic and psychological theories' concerned with certain elements such as 'incentives, effort and reward and the formation of class and group loyalties' (p.31).

4.2.3. The Institutional Redistributive Model of Social Policy

This model posits that if collective 'action-oriented' and 'problem-solving' programmes are to be manifested in a country, a national institution such as social welfare or social security scheme should be established and operated without the defining wall of the private market. The state must focus attention on the 'principle of need' by redistributing national wealth through such an institution. This would

contribute to realising 'multiple effects of social change and the economic system...principle of social equality' (Titmuss, 1974:31). Titmuss' (1974, 1987), perspective against capitalist-economic system provides the theoretical framework for studying social policy and social welfare provisions introduced by states and governments.

Titmuss (1987), suggests that the institutional redistribution model of social policy would ensure that the citizens demonstrate altruism, which would ensure reciprocal acts of giving (Rapport and Maggs, 2002). The gift exchange process may be of forms such as economic, religious, social and moral (Titmuss, 1943; Reisman, 2004). Titmuss (1987), views institutional redistribution under social policy in the sense that it is an instrument that could be used to uplift economic flexibility. The marketisation of the economic system would lead to social disruption and retard social growth, as gain-seeking market in general is hostile to social unity (Titmuss, 1987; Reisman, 2004; Fontaine, 2004).

4.2.4. The Rationale of Government Involvement

This part explicates the rationale of governments' involvement in health sector reforms. Social policy theory demonstrates the need for governments to have maximum control of the market forces, especially, social sectors of the economy: health, education and social protection. This ensures that better care and services are provided for deprived people in society who would otherwise not be able to access them. Some people would not be able to access quality health care, if it was left to the private sector and private health insurance schemes to manage. Titmuss (1974, 1987), suggests a different view to the private market concept of the economy on grounds that it is a deviation from what the bona fide role of the state should be in managing economic and social change processes in any country. The role of government (welfare state) in the provision of essential services must be sustained even if there was economic growth and development. The rationale behind the total involvement of government in health financing reform is based on many factors, with the need to enhance national cohesion amongst the people being prominent. The government envisages that its involvement in health financing and medical care provision could assist in reducing the disparities amongst families and households in their access to

and utilisation of this important service (Titmuss, 1987). Some of the reasons why governments intervene in health sector reforms are discussed below.

4.2.4.1. Undeveloped Private Health Sector

While Barr (1988), argues that the most suitable premise for the delivery of health care is held by efficiency and social justice, Helm (1986), observes that the perfect competition in the market is one of the many institutional approaches to obtaining optimal allocation of resources. However, failures of the market economy in the health sector are many (Culyer, 1988, 1989a, 1989b; McGuire *et al.*, 1989; Preker and Harding, 2000; Donaldson and Gerard, 2005). For instance, there is asymmetry of information in the health care market. The availability of information will aid the prospective clients to make an informed decision regarding what benefits they want from their interactions with the health insurance organisations. However, in the health sector, sometimes the prospective clients may lack the ability to search for the information and have had to depend on the insurance providers at the same time to provide such information. When this happens, it is termed information asymmetry (Culyer, 1989a; McGuire *et al.*, 1989; Donaldson and Gerard, 2005).

Again, there is the absence of consumer confidence in the health care market. Consumer confidence assumes that consumers are fully informed, knowledgeable and possess the ability to search for producers with the lowest prices. However, in the health care market, there is the lack of fully informed and knowledgeable patients or clients who have the ability to weigh up the costs and benefits of health care so that they can make a choice which can lead to the maximisation of their well-being (Olsen *et al.*, 1999; Donaldson and Gerard, 2005). Moreover, there is the presence of positive and negative externalities. The perception of externalities means that there are spillovers from other people's use or consumption of commodities, which can equally affect other individuals in either a negative or a positive way without any necessary compensation for them in the market. Thus, it is anticipated that individuals care about the health of their fellow beings and wish that they are well. However, there is the presence of both positive and negative externalities in the health care market (McGuire *et al.*, 1989).

Additionally, an economy of scale is a comparison of the relationship between fixed cost and output. The assumption is that the larger the organisation, the easier it becomes normally for that organisation to distribute a fixed cost across its products. This helps to reduce both the fixed cost and total cost per unit produced. The opposite of economies of scale is diseconomies of scale. This occurs in situations where because an organisation is too small, its unit costs may also begin to rise (Culyer, 1988, 1989a, 1989b; McGuire *et al.*, 1989; Preker and Harding, 2000; Donaldson and Gerard, 2005).

Due to these problems, social policy analysts argue that despite the promising objectives of marketisation of health care there is market failure since not all the goods are marketable (Evans, 1986, 1987). Even the goods that are available in the health market may not be offered in the socially optimal quantities (McGuire *et al.*, 1989; Olsen *et al.*, 1999). This explains why the perfect market is infrequently applied to the health sector and almost all health care systems the world over operate with governments playing leading roles in providing financing and regulation, in either regulated or unregulated forms (Olsen *et al.*, 1999).

In most African countries including Ghana, private health sector is not sufficiently resourced to deliver health. Therefore, governments following social democratic ideology believe that if health financing and delivery are handed over exclusively, to private financiers, they would fail to make the expected impact as people would fail to use them (Evans, 1986, 1987; MOH, 2002, 2003b, 2003c, 2005). Therefore, Titmuss, (1974), suggests that state intervention is needed because of the failures caused by perfect markets (Titmuss, 1974, 1987; Preker and Harding, 2000). Other economists and social policy analysts also believe that the provision of centralised government health insurance creates expenditure controls that can reduce over-prescription of treatments and internalise positive externalities that would be foregone if provided solely through private arrangements (Steinbrook, 2006; Di Matteo, 2009).

4.2.4.2. Fairness in Health Financing

Social policy analysts postulate that governments' involvement in the implementation of a national health financing strategy under health sector reform necessitates an efficient tax system in the country. Titmuss' (1987), conviction is that a truly

progressive tax system would ensure that funds are available to provide the needed health service expenditures. The effect of this is that health care expenditures would genuinely, be redistributive. Thus, it is the public health services provision which would ensure that everyone is treated as equal citizen. This would also ensure that the disparities in the treatment meted out by institutions and poverty would be eradicated from society (Miller, 1987; Titmuss, 1987; Le Grand, 1997).

4.2.4.3. Social Security System

The formation of social health insurance scheme depends on the availability of social organisations in the country and how these can be grouped together to achieve a common goal. Social policy analysts suggest that to organise all these social movements under one umbrella, government intervention is required, for example, to encourage them to provide pension cover for employed citizens as well as devise systems to support the needy in society (Titmuss, 1987; Le Grand, 1997). The greater involvement of the state in the provision of health financing under health sector reform serves to enhance and help to introduce a social security system. Social health insurance schemes in most developed economies have evolved overtime with historical and ideological underpinnings (Esping-Anderson, 1990; Giaimo and Manow, 1999; Bärnighausen and Sauerborn, 2002; Carrin and James, 2005).

4.2.4.4. Poverty Alleviation

A state which adopts social policy, also implements welfare provisions for its citizens. Social policy analysts assume that no matter how rich or developed a country might be; some people will still be poor. For instance, Titmuss (1987), observes: ‘...we overestimated the potentialities of economic growth by itself alone to solve the problems of poverty, economic, educational and social...’ (Titmuss, 1987:203). Thus, poverty and inequality are conditions that can never be eliminated from human existence. Titmuss (1943), speaks against absolute deprivation, which he anticipates could kill more people and shrink the nation and reveals that wealth opens the door of opportunity while poverty keeps it closed from the cradle to the grave and perceives poverty-relief as an investment in all citizens, not just in the poor (Titmuss and Titmuss, 1942; Titmuss, 1943; Reisman, 2004).

Titmuss and Grundy (1945), implore the state to spend freely in order to transform the market's failure into a de facto citizenship right, where policy should not be determined mainly according to money resources (Titmuss and Grundy 1945; Reisman, 2004). Implementing state welfare provision demands huge financial commitment. Therefore, it is the state apparatus which must be able to make a commitment to such services considered as social (Titmuss, 1987). The state must constrain the budget for other sectors of the economy by setting its objectives, which must be in agreement with what the society wishes to see expressed. Additionally, Titmuss argues that there is unfairness in the daily lives of the citizens even to the point of selection and reiterates the need for the government to provide facilities for the universal enjoyment of all. This would tone down the effect of poverty even in the midst of economic growth:

...the future distribution of social costs and the future of social policy lies the problem of stigma, of felt and experienced discrimination and disapproval on grounds of moral behaviour...measured intelligence...or other criteria of selection-rejection... (Titmuss, 1987:198)

Governments need to assist the poor to access basic health care services.

4.2.4.5. Equity Implications

A state provided health service is to ensure equity and eradicate inequities. Equity may be described as a situation where no individual is deprived of the use of health care because of their inability to financially access it (Arrow, 1963, Pauly, 1986, Culyer, 1989a, McGuire *et al.*, 1989). Hauck *et al.* (2004), identify seven concepts of equity as:

1. Egalitarianism: which implies that everybody should have identical health status;
2. Allocation according to need: which relies on an adequate definition of 'need';

3. The concept of rule of rescue: which demands that it is an ethical duty to do everything possible to help individuals in immediate life-threatening situations;
4. Equality of access: which is often used to operationalise the concept of equity but itself requires a definition of 'access' as well as 'need';
5. The notion of providing a decent minimum: which involves definition of an essential package of health services;
6. Rawls' 'maximin' principle: which demands that social policy should seek to maximise the position of the worst-off; and
7. Libertarianism: which favours a distribution of resources according to entitlement (Hauck *et al.*, 2004: x).

In any society where inequities dominate, the extent to which people can interact and support each other in times of need and deprivation is limited. For instance, people who are in positions of trust and authority can behave in a manner that will create a gap between themselves and those they are supposed to serve. This will achieve nothing except to weaken an otherwise unstable society. The government should ensure equity by making services available for the communities like health centres and assist with the establishment of community health groups (Miller, 1987; Titmuss, 1987).

Titmuss (1968, 1970), believes in welfare and the welfare state and centralisation instead of devolution of certain operations of the government machinery and points out that socialism is about community as well as equality. It is about what individuals contribute without price to the community and how they act and live as socialists. Social equity is paramount to assure the maelstrom of market failure and therefore the state should take charge of the affairs because state-pooled welfare alone has an explicit contract to bring about redistribution from the rich to the poor. The state is in the circumstances the better way to institutionalise the collective commitment to mutual aid without fault or guilt (Titmuss, 1968; Titmuss, 1970; Reisman, 2004).

Hauck *et al.* (2004), argue that most equity considerations can be captured in two broad headings: equity related to some concept of need and equity related to access to services. In principle equity issues can be integrated into an economic approach to priority setting. However, they found that many contributions to the debate on equity concepts are speculative and secluded from practical performance issues. For instance, the conventional cost-effectiveness method usually ignores the various practical limitations that emanate from the political, institutional, and environmental context in which priority setting occurs. These comprise the influence of interest groups, the transaction costs associated with policy changes, and the exchanges between the provision and financing of health services (Hauck *et al.*, 2004).

4.2.4.6. Enhancing Altruism

Social policy analysts believe that governments have the responsibility to encourage altruistic behaviour in the society. Thus, reciprocity binds the giver and the receiver together in an often complex relationship, that ensures that giving and counter-giving are woven into the fabric of being (Malinowski, 1922; Mauss, 1954; Levi-Strauss, 1969; Titmuss, 1970; Rapport and Maggs, 2002). Reisman (2004), notes that communitarian socialism is entrenched in the rights in the matrix of duties and disapproves of the condition of a materialistic society. For instance, on the issue of commercialisation of the UK health system, Titmuss used: 'The Gift Relationship' to draw attention to his abhorrence of this philosophy as he saw it as the possible corruption of British society's values (Titmuss and Titmuss, 1942, Reisman, 2004). Tawney (1937; 1953), deplores the sickness of a marketing culture in which the economic selfishness, which seizes private gains at the cost of the community was leaving little room for the higher moral worth of cohesion, commitment and the bond of service to a common purpose.

Rapport and Maggs (2002), observe that 'The Gift Relationship' was meant to distinguish between the 'social' and 'economic' in both public policy and institutions concerned with welfare goals. Le Grand (1997b), suggests that there are four fundamental arguments incorporated in: 'The Gift Relationship' meant to denounce a market-driven system in blood donation. These are: the wasteful market in blood, which created shortages and surpluses; a bureaucratic and inefficient donation system; the exploitative redistribution of blood products from the poor to the rich; and a

market in blood which is degrading for society replacing altruistic motivations for donation with self-interest and personal gain (see Titmuss, 1970; Le Grand, 1997b; Rapport and Maggs, 2002).

Different arguments have been advanced as to whether there is anything such as altruism or creative altruism: genuine selflessness (Nagel 1970; Trivers, 1971; Krasner & Ullmann, 1973; Arrow, 1974; Badcock, 1986; Titmuss, 1987; Batson *et al.*, 1991; Rapport and Maggs, 2002). Some researchers argue in favour of altruism noting that what people do is motivated by egoism, which can also be of benefit to other people (Krasner and Ullmann, 1973; Rapport and Maggs, 2002). Trivers (1971), observes that reciprocal altruism is the altruistic form, which is most relevant to human activity which manifests in sharing of food, implantation and knowledge (Trivers, 1971; Rapport and Maggs, 2002). The positive attributes of reciprocal altruism include benefit to both giver and receiver, which is a more balanced relationship between giver and receiver, and can heighten the sense of communal sharing (Trivers, 1971; Badcock, 1986; Batson *et al.*, 1991; Rapport and Maggs, 2002).

There are other researchers who also use socio-psychological model to view 'pure' altruism and note that it is possible in the sense that it can only happen in small discrete groups such as family groups and only over a short period of time (Batson & Shaw, 1991; Rapport and Maggs, 2002). This is based on a belief that an altruistic act can occur if someone feels empathy towards someone else. This emanates from a perceived attachment to the other person based on kinship, friendship, familiarity or similarity (Rapport & Maggs, 2002). Badcock (1986), identifies other forms of altruism such as kin altruism and induced altruism. The kin altruism is a situation where an individual is more predisposed to act altruistically when they can identify with the people they are assisting. In contrast, induced altruism is a form of self-sacrificing act, where the giver may not gain any benefit from the act of giving; such acts are ethical, spiritual and moral in nature. Self-sacrifice enhances the position of the recipient to the detriment of the giver (Badcock, 1986; Rapport and Maggs, 2002).

Smith (1995), relates altruism to the community and the individual by using a concept analysis to display four attributes. These are: a sense of personal responsibility for

another's well-being; a sense of compassion for another; a sense of empathy; and an uncalculated selfless commitment to the needs of others (Smith, 1995; Rapport and Maggs, 2002). Dworkin (1992), constructs a mechanism for incorporating the individual into the community and calls it 'integration'. Thus, like other liberal communitarians, Dworkin argues that altruism that emerges from individualised empathy comes from a particular connection with another and not from participation in any act (Dworkin, 1992; Keown, 1997; Rapport and Maggs, 2002).

Some researchers who hold postmodernist's perspective criticise social policy on the grounds that particularism, diversity and difference should not be formulated within a guiding framework that is universalist in character. They question the desirability of incorporating any significant element of universalism into social policy (Thompson and Hoggett, 1996). This would imply a rejection of a theory which posits the existence of a set of basic, culturally universal needs based on an account of an intrinsic human nature (Doyal and Gough, 1991; Thompson and Hoggett, 1996). In addition, Titmuss' (1974, 1987), economic analysis of a voluntary versus a market led system is criticised by economists such as Cooper and Culyer (1968). Rapport and Maggs (2002), also conclude that Titmuss' model on: 'The Gift Relationship' is methodologically flawed and based on assertion that does not stand up to scrutiny (see Titmuss, 1970; Rapport and Maggs, 2002).

However, Fontaine (2004), notes that Titmuss' worldview is mostly ethically inspired and that his exposition of intellectualism serves to remind the economists that in society, the idea of excellent behaviour becoming an obligation for the general population should be considered as essential as much as the market devices aim to assure social cohesion. This contributed to the creation and development of the field of research that has come to be called social policy (Fontaine, 2004; Reisman, 2004).

The African Union (AU), outlines its social policy performance and explains that it is measured by the level of human and social development. Social development can be determined by the income, education and life expectancy of the population (AU, 2005b). Hence, employment, education and health constitute the pillars of the social policy framework. Therefore, human and social development evaluation in some contexts is supplemented by 'social integration related indicators, which are pertinent

to people's degree of freedom to undertake economic, social, political and cultural activities' (AU, 2005b:10).

4.2.5. Process of Setting Standards and Regulation

Social policy analysts assume that the government has command over the economic framework and can set the necessary standards and regulation using its infrastructure to supervise all allied institutions as they carry out their activities (Titmuss, 1974, 1987). Social policy analysts believe that without the government involvement, the necessary institutional and administrative mechanisms and the change process can never be initiated and implemented (Titmuss, 1974, 1987). Although the aim of government in the context of healthcare is to ensure that communities take total control over their own health financing and related affairs in the long run, it also recognises that it has to imbue in the people a sense of responsibility, thereby empowering them. This will help boost their confidence and trust levels which can help the delivery of equity goals (Titmuss, 1987; Hauck *et al.*, 2004).

4.2.6. Weaknesses in Social Policy Theory

However, it is argued that complete state intervention in the economies of developing countries has caused public sector failure due to problems of poor public accountability, information asymmetry, abuse of monopoly power, failure to provide public goods, and loss of strategic policy formulation that have parallels in market failure (Preker and Harding, 2000). The failure of government to solely provide the required funding for the delivery of health care has led to calls that other stakeholders should be involved, especially, in developing countries, including Ghana (WHO, 1978; World Bank, 1993; Paalman *et al.*, 1998; Mills *et al.*, 2004). Instead of leaving responsibility to the private sector it is recommended that governments provide a mix of funding and provision streams (Carrin and James, 2005). Against this background, it is central to use an alternative theory as social policy alone cannot explain the findings of this study.

4.3. Community Field Theory

This part of the chapter discusses community involvement in health sector reforms through an evaluation of community field theory (compare with discussions on social viability: 3.2.3). Many communities in Africa are set within environments, which are very close to each other where there is community sharing and people know each other. Thus, people relate to the dynamics of the communities within which they are located. The word community means different things to different people. An important element is to ascertain how the sense of community is felt by the people living in it in order to obtain their support for policies and programmes that are initiated within their communities as well as encouraging the policies from external agencies. The experience of a community can occur as the individuals involved play a part in an assortment of extraordinary interest fields through horizontal associations within the community and vertical relationships outside the community (Wilkinson, 1991). With this notion, organisations in the community create the collective demand for existing community resources like health care. The changes in the health sector and the potential impacts on community members can provide an opportunity for the various interest fields that come together for purposive collective action to develop and support the community health system (Martin, 2003).

Etzioni (2009), uses communitarian and neo-communitarian approaches to discuss the concept of community. From the communitarian perspective, community is defined as: 'a group of individuals that possesses two characteristics'. This is more than just 'one-on-one relationships'. The second characteristic is where there is 'some commitment to a core of shared values, norms, and meanings, as well as collective history and identity'. This is 'a particularistic moral culture' (p.115). On the other hand, neo-communitarians assume that community is fundamentally 'a major common good in itself as well as a major source of other common goods'. Neo-communitarians argue that similar to all goods, community can take on 'dysfunctional forms, especially when its social bonds, culture or political structure are oppressive'. As a result, there was the need to balance the 'community as a value with commitments to rights' (Etzioni, 2009:115).

Etzioni (2009), identifies certain disadvantages from the lack of sense of community in the society. In the first place, the absence of adequate communal acquaintances

could cause a person to feel detached and alienated (Putnam, 2000; Etzioni, 2009). The second is that the lack of community feeling also could cause loneliness amongst certain individuals leading to social vices in the society (Lasch, 1979; Etzioni, 2009). However, the most important aspect of communities is their capacity to provide informal social controls that strengthen the moral commitments of their members. This leads to voluntary social order. The neo-communitarians view is that since people need encouragement and approval from others, this sense of community has the 'persuasive power as a key function of communities' (Etzioni, 2009:115). This tries to curtail the role of the state and its coercive actions which could be replaced by the endorsement of common good based on informal social controls that communities provide (Wrong, 1994; Etzioni, 2009).

To understand collective action, Kaufman (1959), proposed the community field theory, where the impetus for action within a community evolves from the relationships between individuals within a geographic setting. Community is seen as a field of social interaction, which when strengthened and focused creates public good and better organisation to manage resources (Kaufman and Wilkinson, 1967). Wilkinson (1970), who was a student of Kauffman, continued to develop the concept of community as an interactional field. In his book 'the rural community in America', Wilkinson defines the community field as a process of interrelated actions through, which residents express their common interest in the local society (Wilkinson, 1991; Martin, 2003). The notion of interactional community is explained below.

4.3.1. The Interactional Community

Wilkinson (1991), talks about the interactional community, which is relevant to the study of community organisations. This has three properties and provides criteria for assessing the extent of the feeling of community in a population settlement. These are: ecology, social organisation, and community action, the amalgamation of which produces a social bond that is natural and ever-present. When the bond of the community is experienced intentionally, it can engender feeling. There are cognitive and emotional responses to the experience of the community. This is what Wilkinson describes as 'communion', which celebrates 'community' (Wilkinson, 1970, 1991). The three properties of the interactional community, which are relevant to the study of

community organisations, to determine the extent of the feeling of community in a population, have been expounded below (Wilkinson, 1991).

4.3.1.1. Local Ecology

The first property of the interactional community is local ecology (Wilkinson, 1991). Local ecology can be explained using the conservative approach, which presumes that the community is an organisation of social life used for meeting the daily needs of the people as well as help them adapt to the changes in a particular territorial and social environment (Wilkinson, 1991). The community health system can be part of the organised social life for meeting individual needs and responding to change. Groups of people and identifiable organisations who are interested in health financing and provision can utilise this to collaborate with health care providers in the communities in an attempt to take a pro-active role in responding to the changes that are taking place in the health market. They can also facilitate initiatives such as urban-based networks to move into rural areas and communities (Martin, 2003).

4.3.1.2. Social Organisation

The second property of the interactional community is social organisation (Wilkinson, 1991). As a social organisation, the community can be equated to an organisation of social life, which makes it a complete interactional structure. This also makes the community a social whole, which provides a common life used to express the full range of common needs and interests of the local residents. However, it should also be noted that the lives of the people need not be entirely enclosed within its boundaries (Wilkinson, 1991).

4.3.1.3. Community Action

The third property of the interactional community is community action (Wilkinson, 1991). Using the idea of community action, the community can be seen as a bond of local solidarity, which is articulated in the way the community members act. The inhabitants of a community live together whilst sharing a common life and also act together when solving common problems. They try to take full advantage of the available opportunities that can help them improve their common life and devise solutions to local problems (Wilkinson, 1991). Community members use social and

human capital instincts in order to utilise available community wealth and resources to achieve developmental objectives, as discussed below.

4.3.2. Social and Human Capital

The progress of the community in meeting its needs depends on how the elements of social and human capital can be utilised to facilitate development programmes. Mladovsky and Mossialos (2008), argue that even as social capital has been the subject of vigorous academic debate for almost two decades, its definition remains a source of disagreement. For instance, while trust, which is an important component of social capital, is occasionally discussed in the community-based health insurance (CBHI) literature, CBHI has not frequently engaged with social capital theories as it is either mentioned only in passing or its wealth and intricacy are overlooked.

Whilst the relationship between social capital and human capital is unclear, Burchardt (2008), explains that human capital is a concept used by economists and often measured by duration of schooling and labour market experience or by educational qualifications, where the benefits accrue largely, to the individual. In contrast, social capital is a public or collective good, which is an attribute of a group. The conflict is resolved by Burchardt because the two forms of capital are complementary. The high levels of human capital generate social capital and social capital promotes acquisition of human capital (Burchardt, 2008). Coleman (1990), uses a sociological perspective and argues that social capital is defined by its function, it is not a single entity, but a variety of different entities, which have characteristics in common. From an economic perspective, Fukuyama's concept of social capital places emphasises on the integration of social capital and trust, and how it works within an economic framework (Fukuyama, 1995).

Woolcock (1998), developed a framework for social capital and defines it as: 'the information, trust and norms of reciprocity inhering in one's social network' (p.153). This framework joins together a number of theories of social capital using both quantitative and qualitative evidence and focuses on community level economic development projects in low-income countries, which are comparable to community-based health insurance (Woolcock, 2001; Woolcock and Narayan, 2006; Mladovsky

and Mossialos, 2008). Among other things, this framework can be observed as an effort to practically examine the need for an alternative, or complement, to income-based and purely economic approaches to development (Bebbington, 2004; Mladovsky and Mossialos, 2008). Thus, it incorporates both economic and social theory by trying to resolve the dispute over whether humans are realistic mediators or directed by norms and culture. Garson (2006), refers to the norms of social capital and observes that a norm of a culture high in social capital is reciprocity, which encourages bargaining, compromise, and pluralistic politics. Theories of social capital have also been applied widely in public health policy (Moore *et al.*, 2006).

4.3.2.1. Community Solidarity

Community action arises out of the bond of local solidarity. The absence of solidarity can even endanger the very fabric of community cohesion (Wilkinson, 1991). Solidarity may be affected by peculiar social or cultural factors. For instance, in communities where there is high emphasis on moral values, solidarity is encouraged. However, in communities where crime is high, scepticism supersedes solidarity: acts of generosity may even be miscomprehended as mere pretences. Freudenburg (1986), argues that the decline in the solidarity of the associations in quickly developing communities could result in victimisation and increased fear of crime (Freudenburg, 1986; Allen, 1998). Extrapolating from Freudenburg's (1986), argument, Allen (1998), notes that increasing the density of acquaintanceship will add to local community cohesion. Krannich and his associates (1989), also observe that decreasing density of acquaintanceship, contributes to the reduced feeling of security, due to declining mutual familiarity and reduced effectiveness of informal deviance control mechanisms (Krannich *et al.*, 1989; Allen, 1998). Wilkinson (1991), concedes that although the homogeneity of community residents may enhance community fields; the negative factor is that it has a potential obstacle, which is the heterogeneity of community residents.

Martin (2003), postulates that in the health care environment, clients including, employees and employers are interested as purchasers of health. They want to have access to local health providers who can meet their individual and family health care needs. This creates some kind of interaction between the residents and the providers. Thus, the interactional structure that emerges through the relationships between

community-based organisations can provide insights into the importance of solidarity aspect of the community field theory. This provides the basis for how community members adapt to changes that take place and helps to know how they accept institutions as mechanisms for enhancing this interaction (Wilkinson, 1991; Martin, 2003).

4.3.2.2. Community Leadership

Leadership in a community field theory is considered an interactional role that consists of the acts which contribute to the accomplishment of the tasks and or the preservation of structure. It emphasises the way interactions take place while recognising elements in the community such as: cultural, personal and other context specific factors (Cartwright and Zander, 1968; Wilkinson, 1970). What is relevant is not who occupies what position in a community organisation but who can ensure that the objectives are achieved. According to Wilkinson the generalised leadership roles can be treated as developing out of the roles that are being played by individuals in the various programmes and fields in the community (Wilkinson, 1965, 1970). Leadership in the community field theory is different from a leadership based on reputation, office, and prestige. However, these are recognised as important correlates. Thus, in community field theory, leadership may be distinguished from power in at least two ways: in action and behaviour (French and Raven, 1968; Wilkinson, 1965, 1970).

4.3.2.3. Community Cohesion

Community field theory as applied to community development projects ensures that all internal and external interest stakeholders are united towards a common goal (Wilkinson, 1991). The community can ensure cohesion, which Wilkinson, describes as homogeneity among community members (Wilkinson, 1991). Allen and Dillman (1994), support the need for homogeneity by illustrating that a homogenous community can boost its community field by linking the social fields in an action that can benefit the community as a whole. Relationships go beyond connecting organisational structures to personalisation of the exchanges increasing the extent of friendship amongst the community affiliates (Allen and Dillman, 1994; Allen, 1998).

There are various groups and associations that may be outside the health sector and yet have influence on how health is financed and delivered. Their relationship with the main decision makers in the health sector need to be studied as well. Martin (2003), presents a vivid analysis of how the changes in the health care system are being driven by cost, efficiency, and quality concerns. The decisions behind these changes may be made by interest groups, insurance companies and other stakeholders outside the community. Therefore, the sense of community enhances the ability of all these interest groups in the community and the health sector to resolve problems and express their locality-based interest in a unified way (Wilkinson, 1972; Martin, 2003).

4.4. Harmonisation between Social Policy and Community Field Theories

This section illustrates the interplay between social policy and community field theories. Whilst social policy theory on its own cannot help explain all the findings of this study, community field theory cannot unilaterally, explain the findings either. Thus, while social policy can only explain the findings relating to governments' intervention, community field theory can also only explain the findings relating to the community's involvement in the health sector reforms. This warrants the combination of the two theories in the interpretation of the findings of this study (see chapter 11).

Crucially, both social policy and community field theories are used together because of the elements that emerged from the empirical study conducted in Ghana. Mutual health organisations are influenced and supported by both the government and the community. There is also an interrelationship between the government and the community in the governance system of Ghana (see 5.2). Therefore, the successful interplay between government action and community receptiveness to a greater extent will guarantee the financial viability in particular and the overall sustainability of the mutual health organisations. The analysis of the results will show both the government and the community's response to the changes occurring in the health financing environment (see chapter 11). Furthermore, the two theories have been combined to give the multiple effects, as they fulfil triangulation. This means, more than one theoretical approach has been used to analyse the findings of the empirical study to ensure that the data is enhanced (Denzin, 1970, 1978; Bowling, 2000).

4.5. Summary of the Chapter

This chapter has extensively discussed the three theoretical models or perspectives useful for explaining health sector reforms. First and foremost, neo-classical economics theory has been discussed but dismissed. Thus, as a result of the empirical findings of this study, social policy and community field theories have been adopted as appropriate for explaining health sector reform (s) in the context of Ghana (see chapter 11). The next chapter discusses the Ghanaian environment.

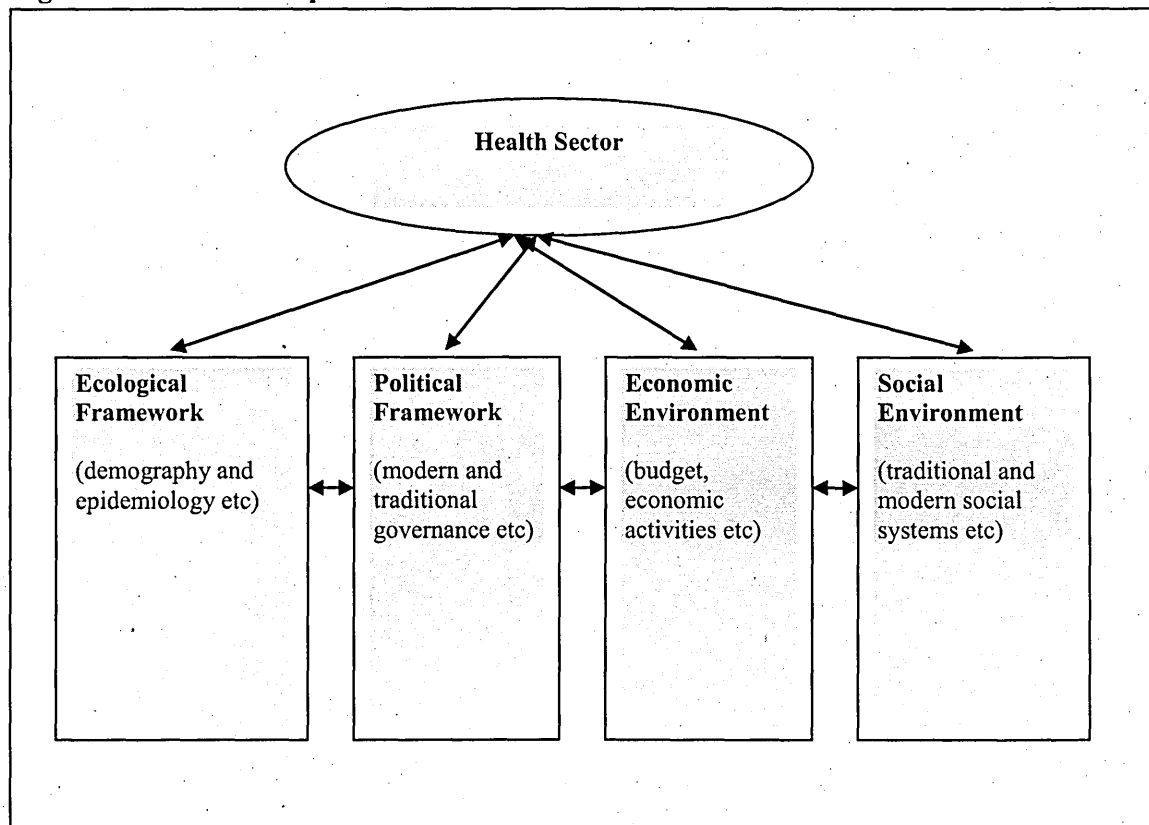
CHAPTER 5

GHANAIAN ENVIRONMENT

5.0. Introduction

This chapter discusses the Ghanaian environment. That is, the ecological, political, economic and social background of Ghana within which health care is financed and delivered. There are five (5) sections constituting this chapter. Section one (1) is an analysis of the ecological framework. Section two (2) examines the political framework. Section three (3) is a review of the economic environment. Section four (4) is also an analysis of the social environment. Section five (5) is a brief summary of the chapter. Figure 5.1 below depicts the sustenance of the health sector within these four important elements in Ghana. The figure shows that the health sector is embedded within the ecological, political, economic and social networks and is a collaborative activity between the government and all stakeholders in Ghana (Republic of Ghana, 1992; MOH, 2005). There is also interrelationship between these elements as each complements the other.

Figure 5.1: Relationship between the Health Sector and National Framework



Therefore, any attempt to detach political developments from merely economic dynamics would not provide the basis upon, which to explain all tendencies in the context of Ghana (Abdul-Nashiru, 2001).

5.1. Ecological Framework

Ghana is a tropical country located on the West coast of Africa, with a national population density estimated to be 78.9 persons per square kilometres. The land area is 238,537 sq. km (92, 100 sq. miles). The population, according to 2000 census was 18.8 million with a growth rate of 2.4 per cent. This was estimated to have reached 22.5 million based on a population growth rate of 1.9 per cent by 2006 (GSS, 2005; World Bank, 2007). The life expectancy of the Ghanaian population is 56 years for men and 57 years for women (GSS, 2005, MOH, 2005). The 15 to 64 years age group represents 55.33 per cent of the total population. The 65 years and over age range represents 3.4 per cent of the total population (GSS, 2005). In 2002, the population under 15 years was estimated to be around 40 per cent of the total population. This compared with sub-Saharan Africa's 44 per cent and the world's 29 per cent. The population over the age of 65 years was estimated to be 3 per cent compared with sub-Saharan Africa's 3 per cent and the world's 7 per cent (Earth Trends, 2003). Hence, old age is not a major problem for the country in terms of provision of social services.

Between 2000 and 2004, adult males' literacy rate for those 15 years and above was 62.9 per cent and of the females in the same range was 45.7 per cent (WHO, 2006). Ghana is a heterogeneous society with diverse ethnic and dialectical groupings. About 49.1 per cent of the population belong to the ethnic group known as Akan. Others are: Mole-Dagomba (16.5 per cent); Ewe (12.7 per cent); and Ga-Dangme (8 per cent) [(GSS, 2005)]. The population distribution contributes to economic disparities between different regions as shown on table 5.1. The data shown on table 5.1 are the current and most reliable from the Ghana Statistical Service since the last population census was conducted in Ghana in 2000 (GSS, 2005).

The statistics shown in table 5.1 indicate that for any given period, the population of both males and females residing in the rural areas had far exceeded that of the urban

dwellers: 76.9 per cent against 23.1 per cent in 1960; 71.1 per cent against 28.9 per cent in 1970; 68.0 per cent against 32.0 per cent in 1984; and 56.2 per cent against 43.8 per cent in 2000. Thus, poverty has affected rural dwellers more than the urban dwellers, even though, there is urban poverty (GSS, 2005).

Table 5.1: Percentage Distribution of Urban and Rural Population by Sex: 1960, 1970, 1984 & 2000 (per cent)

Year	1960		1970		1984		2000	
Sex	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Male	11.9	38.7	14.4	35.2	15.6	33.7	21.4	28.1
Female	11.2	38.2	14.5	35.9	16.4	34.3	22.4	28.1
Total	23.1	76.9	28.9	71.1	32.0	68.0	43.8	56.2

Source: GSS, 2005, 2008

There are different religious groups, which cherish and propagate their respective faith. Religious belief can be a determining factor governing choice of a particular health care intervention. The main religious groups include: Christianity (69 per cent), Islam or Muslim (15.6 per cent), African Traditional Religion (8.5 per cent) and Others (6.9 per cent) [(GSS, 2005, 2008)].

5.2. Political Framework

The political environment within which Ghana functions is a product of both the modern and traditional systems of governance. These work hand in hand to promote national cohesion and development. This is characterised by what Whitefield and Jones, describe as neo-patrimonial political system, which indicates a mix of the legal-rational state and the traditional-patrimonial state. This refers to personalisation of power; political competition based on traditional forms of mobilisation such as ethnicity and kinship; and the construction of political authority through the extension of patronage (Whitefield and Jones, 2007).

Ghana has had about six separate constitutionally elected governments with four Republican constitutions written and adopted for state governance. In between democratically elected governments there have been intermittent military

interventions. The military leaders have given general dissatisfaction and economic recession as their motive for take over (MOH, 1996; Adedeji, 2001). However, overall democracy has been the hallmark of modern government administration since 1992 (Higazi, 2004). The 1992 constitution of the Republic of Ghana promotes freedom of expression and association (Republic of Ghana, 1992). The modern political administration is headed by a parliamentary democracy with an elected President assisted by a Vice-President, an elected Parliament (Legislature) and an independent Judiciary. The current Parliament has two hundred and thirty (230) elected members representing their respective constituencies (Republic of Ghana, 1992).

5.2.1. Modern Governance System: Local Government Administration

The administration of the country is centralised with enormous power residing in the President. Constitutional developments from 1980's onwards have attempted to decentralise affirming the role of Local Government Administration (Boafo-Arthur, 2001; Higazi, 2004). For reasons of national political administration, the country is divided into ten (10) administrative regions, which are managed on behalf of the President by appointed Regional Ministers and Deputy Regional Ministers. The President is represented at the district and municipal levels by District and Municipal Chief Executives (DCEs and MCEs), who are appointed by the President. The process is that the President submits the nominated candidates to the respective municipal and district Assemblies where the Assemblymen and Assemblywomen vote to either accept or reject them. These are the elected representatives of the people in the communities on political party lines. There were 138 district and municipal assemblies in 2006 (Ghana Districts, 2008), which was likely to increase to 165 in 2008 (Adjei-Darko, 2007). By March, 2010, these had increased to 170 (Ghana Districts, 2010).

The local government decentralisation policy entrusts the development of the districts, municipalities and sub-districts in the country into the hands of the district and municipal Assemblies. The objective of the framers of the Local Government Act 1988, PNDC Law 207 and National Decentralisation Action Plan 2004 was that decentralisation has got a lot of benefits, including, positive outcomes in both democratic and developmental terms (Crawford, 2004; Kantatiето, 2008). The government through

this structure delegates some of its powers to the local people in the communities to administer and ensure grass root participation in the governance of the country.

5.2.2. Traditional Governance System: Chieftaincy

The governance of the country is a shared action between the modern system of government and traditional system. Thus, the socio-cultural and political milieu of Ghana is firmly founded on one principal traditional institution known as Chieftaincy. This consists of the Chiefs, Queenmothers, sub-chiefs and family heads. All these leaders play vital roles in ensuring that local projects and government policies are implemented. These leaders help to mobilise the people in the communities for development (Boafo-Arthur, 2001; Awumah, 2007). The common practice over the years in the Ghanaian democratic dispensation and governance arrangement is that politicians usually seek to align themselves with the Chiefs so as to attract their subjects to vote for them. It is an accepted fact that any programme that revolves around the Chieftaincy institution is assumed to be credible because of the unique position of Chiefs. This is why the lack of clearly defined boundaries and roles between the traditional rulers and the District and Municipal Chief Executives who are political appointees of the various officially demarcated locales, under the 1992 Republican constitution has resulted in occasional misunderstanding between these two important players in the communities (Republic of Ghana, 1992; Boafo-Arthur, 2001; Adjei-Darko, 2007).

5.3. Economic Environment

A country's economic situation impacts heavily on all essential services, including, health care. Ghana enjoyed relative peace and economic prosperity immediately after independence in 1957. With the booming economy, the first President of the Republic of Ghana, Dr Kwame Nkrumah, bought into the prevailing political ideology and advocated for 'African Socialism'; to be modelled on systems existing in European countries (FCO, 2004). This interventionist orientation gave the government a major role to play in the setting up of industries and other commercial ventures without much emphasis on the private sector (Abdul-Nashiru, 2001). This policy direction did not seem to change much until the 1980s (MOH, 2000).

5.3.1. Economically Active Population

Ghana is a country where there are vast economic disparities between and among geographic regions. The economically active population groups and their relationship to wealth creation and distribution of wealth within the various regions are discussed in the Ghana Statistical Services Report 2005 (GSS, 2005). The 2000 Census recorded an economically active population of 8,292,114, representing 43.8 per cent of the total population, which showed an increase of 48.6 per cent compared with the 1984 census as shown on table 5.2. However, the International Labour Organisation (ILO) estimates show that the economically active population of Ghana as at 22 May 2008 for men in the 15 to 65 and over age group was totalled 5,667 and that of women in the same age group was 5,182. The total for both sexes in the same age group was 10,849 (ILO, 2008). The regional distribution shows that 47.4 per cent of the population in Greater Accra was economically active, followed by Brong Ahafo (45.1 per cent), Ashanti (44.6 per cent) and Western (44.5 per cent) in 2000. This was explained by the fact that they had gained in the share of national population. The increased shares might not be labour migrating into these regions rather than the national increase (GSS, 2005).

The statistics shown on table 5.2 are the current and most reliable from the Ghana Statistical Service since the last population census was conducted in Ghana in 2000 (GSS, 2005).

Table 5.2: Economically Active Persons as Proportion of Population (15 years and older) by Region (per cent)

Region	1960	1970	1984	2000
Western	74.9	74.3	47.1	44.5
Central	Included in Western figure	75.5	45.5	42.1
Greater Accra	66.8	67.0	45.3	47.4
Volta	73.3	73.3	46.1	42.7
Eastern	74.2	71.9	46.5	44.0
Ashanti	74.3	72.3	45.6	44.6
Brong Ahafo	68.0	76.8	45.2	45.1
Northern	50.9	57.6	40.4	40.0
Upper East	Included in Northern	48.9	46.3	39.2
Upper West	Included in Northern	Included in Upper East	45.7	41.8
Total	68.6	69.0	45.4	43.8

Source: GSS, 2005:332.

About half (50.7 per cent) of the working population was engaged in agriculture, hunting, forestry and fishing activities. These occupations are predominant in Ashanti, Brong Ahafo, Northern, Eastern and Western regions. The proportion of the population engaged in manufacturing, including, mining and construction activities is highest in Greater Accra, followed by Ashanti and Western regions. In addition, wholesale and retail trading activities, as well as restaurant and hotels, engage a higher proportion of people in Greater Accra and Ashanti regions (GSS, 2005).

5.3.2. Economic Reform

Ghana, like most countries in sub-Saharan Africa, experienced economic turmoil, which necessitated the review of its initial policies adopted after independence in 1957. The country was hit by the global economic recession in the late 1970s and early 1980s. This was made worse by the rampant bushfires that engulfed the length and breadth of the country in 1983. Cocoa trees, the cash crop that earned the country its foreign exchange, were ravaged in the bushfires. The government was compelled to seek financial assistance from the World Bank (WB) and the International Monetary Fund (IMF), which imposed conditions when the loan was granted. Under the banner of the Economic Recovery Programme (ERP), Structural Adjustment Programmes (SAPs) were introduced in 1983. The government was coerced to relinquish its total funding of some essential services including, health care (MOH, 1996; WB, 1998; Colgan, 2002). The anticipation was that the ERP and SAPs would overturn a prolonged period of grave economic downturn, which was characterised by a seeming careless financial management which led to the inflation rate exceeding the 100 per cent mark. Based on a capitalist-focused ideology, a case was made by the International Monetary Fund and the World Bank to the effect that there was excessive government participation in the Ghanaian economy (Abdul-Nashiru, 2001).

The rating of the Economic Recovery Programme (ERP) as a 'success' or 'failure' depends on who is making the assessment. While the government, the International Monetary Fund (IMF) and the World Bank (WB) estimate that it has made substantial improvements in tumbling macro-economic discrepancies and liberalised the external sector of the economy (IMF, 1998; 2002), others observe that its effect on the population has been negative, especially, with regards to employment creation and well-being of the people (Jonah, 1989; Panford, 1997; Boafo-Arthur, 1999). A

neutral opinion can be drawn from the evidence from the International Monetary Fund (IMF) assessment which shows that by the year 2001, poverty was still a systemic problem in Ghana. The per capita Gross Domestic Product (GDP) was about US\$300 in 2001, placing Ghana's income level below the average for sub-Saharan Africa countries (IMF, 2002).

5.3.3. Economic Reform and the Private Sector

The 'market-oriented' economic policy being pursued by the government and the slogan of private sector as engine of growth reflects in the support for the private sector. The banks have been encouraged to support the private sector with credit facilities. The year 2006 saw a strong growth in bank credit to the private sector: from ₵1,234m to ₵3,298m, representing 59.8 per cent growth in 2007. This was an increase on the figure of ₵618m, which represented 42.8 per cent growth recorded for the same period in 2006. This was made possible due to rapid expansion in the credit portfolio of the banks. The credit distribution increased for the following sectors of the economy: Services (27.5 per cent); Commerce (22.3 per cent); Miscellaneous (18.1 per cent); Construction (9.5 per cent) and Manufacturing (6.2 per cent) [(Acquah, 2008; 'Ghanaweb', 29th January, 2008)].

However, for a country to be economically strong, it should be able to engage in export of finished goods and try to reduce import of goods that can be produced from within. This does not appear to be the case in Ghana, even though, it is endowed with untapped natural resources like gold, diamond, bauxite and manganese, in addition to the traditional export products like cocoa and recently discovered oil deposits (Tawiah, 2007, 2008). Whereas the country's export of goods and services was 49.1 per cent of its GDP, its corresponding imports stood at 69.7 per cent in 2000. In 2005, exports accounted for 36.1 per cent of GDP but imports accounted for 61.7 per cent of GDP. In the same way, while exports stood at 39.2 per cent, imports also stood at 63.8 per cent of GDP in 2006.

Recent evidence indicates that while imports between June and August, 2009 shot up to US\$5,268.58 million, exports on the other hand lagged behind reaching US\$3,829.13 million. Exports of cocoa beans and products from January to August, 2009 amounted to \$1,023.85 million; an annual growth of 7.4 per cent compared with

\$953.06 million for the same period in 2008 having an annual growth of 21.3 per cent (Acquah, 2009; 'GNA' Wednesday, 23 September, 2009e; 'Ghanaweb', Wednesday, 23 September, 2009f). Therefore, the country was spending higher percentage of its resources on imports than it was gaining from exports. This had a corresponding effect on prices of goods and services (see World Bank, 2003a, 2003b, 2003c, 2007: GSS, 2005).

5.3.4. The HIPC Initiative

Due to the economic crisis, the total external debts of Ghana rose from \$1407 million in 1980 to \$4209 million in 1991. By 1996 the total debt of the country had increased to \$6.2 billion; becoming one of the highly indebted poor countries (World Bank, 1993; 'The Guardian', May 15, 1998; Brobbey-Mpiani, 1998). The popular Ghanaian proverb that encapsulates the subsequent economic reform agenda is: '*obi a ose wayera no nko ara na onim baabi a ohye*' translated as 'it is only the person who pretends to be lost, who knows his or her hide-out'. Therefore, the International Monetary Fund (IMF) and the World Bank (WB) after almost two decades of implementing the ERP and SAPs had to agree to support an all-inclusive debt reduction package for Ghana under the enhanced Heavily Indebted Poor Countries (HIPC) initiative in 2002 (IMF, 2002; Oduro, 2002).

This was to see a total debt relief from all of Ghana's creditors worth approximately US\$3.7 billion. This is an equivalent of US\$2.186 billion in Net Present Value (NPV). This is the same as a 56 per cent of total outstanding debt after the full use of traditional debt relief mechanisms. Ghana was plunged into extreme poverty and is now a Highly Indebted Poor Country (HIPC) in sub-Saharan Africa: 'from the frying pan into the fire' kind of scenario (IMF, 2002; Oduro, 2002). The failure of the Economic Recovery Programme (ERP) could be explained by the neglect of the overall context of the country. Some researchers argue that some interventions can fail due to the specific context within which they are implemented (Criel *et al.*, 2005; Adjei and Agyepong, 2007).

5.3.5. Debt Status

Important economic indicators, which show a country's economic progress, include Gross Domestic Product (GDP) and Gross National Income (GNI). Initially, there

seemed to be a steady growth in the Gross National Income per capita from US\$320 in 2000, increasing to US\$450 in 2005 and US\$520 in 2006. The Gross Domestic Product also showed some improvements in growth since the year 2000 figure of 3.7 per cent rising to 6.2 per cent in 2006 (WB, 2007). However, the economy was still unstable as the country's total debt stock remained at US\$7.1 billion as of December 2007 and nothing noteworthy was realised from the private sector to contribute to employment creation. By the end of June, 2008, total public debt had increased from the January 2008 figure of US\$7.3 billion to US\$7.8 billion, representing an increase of 7.1 per cent within a period of six months (Acquah, 2008; 'Ghanaweb', 29th January, 2008).

Recent evidence shows that Ghana's trade deficit rose from \$954.4 million as at June to US\$1,439.45 million at the end of August 2009, mainly on account of the widening gap between exports and imports (Acquah, 2009; 'GNA', Wednesday, 23 September 2009e; 'Ghanaweb', Wednesday, 23 September 2009f). Due to these developments, decision makers have redesigned the policy of Ghana's Poverty Reduction Strategy I (Fayemi *et al.*, 2004), to one focused on Growth and Poverty Reduction Strategy II (GPRS II) 2006-2009. The GPRS II has objectives to improve human resource development, modernisation of agriculture and strengthening of infrastructure. The attainment of these objectives will help move Ghana towards reaching the middle-income country status: a country located between the lower limits of an average income of \$750 per capita per annum (NDPC, 2005a 2005b, 2006; WB, 2006).

The implementation of the Economic Recovery Programme (ERP) has had some impact on the economy as a whole and the people. For instance, it has had consequences for state financing of health care in the country as the government continues to slash out budgets to the health sector. Consequently, a prosperous economy has implications for the health status of the people. Undoubtedly, this economic situation has also had implications for marginal propensity to save or spend (MPS): how much the people can save to be able to purchase goods and services including access to health care. Therefore, efforts to restrict public funding of health by the International Monetary Fund (IMF) in the case of Ghana, has repercussions for public health financing and policy. This also has implications for the mutual health organisations which are supposed to be financed by the people in the community.

5.4. Social Environment

Social policy and social services in Ghana include: health, education, social security, social work and housing (Streeten, 1979; Spicker, 1995; Aryeetey and Goldstein, 1999). Social service provision is always influenced by the system of government in power (GSS, 2005; 2008). The United Nations Children's Fund Report 1986 summed up the critical issues of social policy deficiencies and observed that there was increasing poverty, inadequate nutrition and ineffective social services between the late 1970s and early 1980s (UNICEF, 1986; UNDP, 2004; Laid, 2006). These problems still persist in recent times with rural poverty being a major issue (GSS, 2005, 2008).

Different governments since independence have outlined developmental programmes aimed at alleviating poverty, as there is no clearly defined overall social policy programme (ISSER, 1996; Aryeetey and Goldstein, 1999; NDPC, 2005a, 2005b; GSS, 2005, 2008). Aryeetey and Goldstein (1999), argue that the implications of the Economic Recovery Programme (ERP) for social policy were two-fold:

1. That macro-economic aspirations took precedence over pledges to social-development targets.
2. That continuous growth would lead to equitable social distribution.

Aryeetey and Goldstein (1999), note that the Economic Recovery Programme (ERP) had accounted for the decline in social welfare for a greater number of the population. Therefore, social policy in Ghana has been subjected to the dictates of economic reform and has been disjointed and residual (Aryeetey and Goldstein, 1999). Unemployment remains very high and the government recognises that despite the progress made, including the decline in the level of poverty the numbers in the poverty category are still too high (Agyekum, 2007).

It is apparent that social policy framework for education is not well structured. However, in recent times, institutions or departments with a focus on social policy related disciplines are being established. Laid (2006), argues that the curriculum at the University of Ghana Social Work Department is based on both the British and

American texts and models with psycho-social approach to interventions. Therefore, there is the need to reform the curriculum in order to reflect the knowledge base and skills base training in order to address issues of the structural causes of poverty. Laid (2006), suggests that there is the need to develop social work based on African paradigms instead of over-relying on Anglo-American models.

5.4.1. Traditional Social Welfare System

The traditional social welfare idea in Ghana is located in the socio-cultural understanding of how the family and other social relationships operate. The extended family provides a social and psychological support in times of economic and social crisis. The training and upbringing of a child is not the sole responsibility of the biological parents but that of the entire extended family and the community. There are two kinds of family inheritance in Ghana: paternal and maternal. Some communities and tribes follow what is termed the paternal form of inheritance where the offspring have according to customs and traditions, the right to inherit their father's estate in the event of his death. This suggests that the children of a family owe more allegiance to their father's side than to their mother's side.

The maternal concept of inheritance on the other hand gives children the sense of belonging to their mother's side more than to their father's side. The children can inherit the estate of their uncles who are mostly the brothers of their mothers. Due to occasional misunderstanding as a result of the absence of 'written wills' the family Intestate Succession Law (PNDC Law 111 and 264) was formulated to guide family inheritance (Republic of Ghana, 1985, 1991; Photius, 2004; Global Property Guide, 2007).

5.4.2. Formal Social Security System

During the colonial administration, a pension scheme was instituted in 1940 to cater for the needs of a categorised group of employees known as 'Pensionable Staff'. This legacy was very limited in coverage and little was done immediately, after independence to overhaul its remit. However, an Act of Parliament was passed in 1965 for the institution of a statutory scheme, which was to cover all categories of workers. From 1965, it operated a Provident Fund and then in 1991 it was converted into a Pension Scheme to cover all formal sector employees. It had defined benefits

and was partially funded (Osei, 2003). This led to a nationwide social security scheme within an institutional arrangement known as the Social Security and National Insurance Trust (SSNIT). This was established in 1972 by a decree to administer Ghana's National Pension Scheme. Its primary responsibility is to replace part of lost income due to old age, invalidity or loss of life.

The Social Security and National Insurance Trust (SSNIT) is operating different schemes at the moment and it is the largest non-bank financial institution in the country (Osei, 2003; SSNIT, 2008a, 2008b). In addition, there are other social security provisions, which include civil service pensions, which are paid out of the general taxes to some civil servants. There is also another scheme known as superannuation scheme for staff of the universities: lecturers, senior members of other research institutions and other staff with analogous qualifications. The Pension Fund that SSNIT administers is a social insurance scheme under which members contribute during their working life and receive benefits in the event of old age and invalidity. In case of death, members' dependants receive a survivors' benefit. The benefits statistics as at July 2009 are shown in table 5.3. The table indicates that the Social Security and National Insurance Trust (SSNIT) paid the highest pension or benefits of ₵17,442,200 in July, 2009. However, the highest pension paid since the inception of the pension fund amounted to ₵109,655,500 as at July, 2009 (SSNIT, 2009).

Table 5.3: SSNIT Benefits Statistics: July 2009 (thousand old cedis, ₵)

Benefits	Current Month (₵)	Since Inception (₵)
Highest Pension	17,442,200	109,655,500
Lowest Pension	260,000	5,000
Average Pension	2,187,300	-
Highest 25% Lump sum	498,734,200	1,898,258,900
Lowest 25% Lump sum	18,900	1,000
Highest Survivor's	3,502,599,100	1,665,690,100
Lowest Survivor's	3,192,500	11,900

Source: SSNIT, 2009

NB: The original SSNIT figures were converted from 'thousand new Ghana cedi-GH₵' to 'thousand old cedis-₵'.

As stakeholders of the scheme, contributors are covered under three main contingencies, when benefits are paid to them as and when they occur (Osei, 2003). The total number of SSNIT Pensioners on the pension payroll for the month of February, 2008 was 80,733 (SSNIT, 2008a, 2008b). This had increased to 94, 598 as at July, 2009 as shown on table 5.4 (SSNIT, 2009). The table shows that majority of SSNIT pensioners were in the Accra area in the Greater Accra region: 26,527. This is because Accra is the national capital town with large formal sector employee pool. The least number of SSNIT pensioners was recorded in Tamale area in the Northern region: 4,655. Northern region is one of the three most deprived regions. The other two are the Upper East and Upper West regions (GSS, 2005).

Table 5.4: Distribution of Pensioners by Area of Operation: July, 2009

Area	Number
Accra Area	26,527
Tema Area	6,952
Kumasi Area	16,928
Sunyani Area	13,389
Takoradi Area	19,025
Tamale Area	4,655
Koforidua Area	7,122
TOTAL	94,598

Source: SSNIT, 2009

5.4.3. Weaknesses in the Social Security System

Even though provisions have been made under the pension plan for the formal sector employees; it is evident that the informal sector is always neglected (GSS, 2005, 2008). The age distribution of SSNIT Pensioners in the country as at July, 2009 is depicted in table 5.5 (SSNIT, 2009). The table demonstrates that majority of SSNIT pensioners were within the 72 to 89 years age group: male: 14, 370 and female: 1,105. Whilst the total number of male pensioners was 14, 395, the total number of female pensioners was 1, 106, showing a gender variation in the employment of people in the formal sector of the economy. The overall total number of SSNIT pensioners was 15,501 in an estimated population of 22.5m (World Bank, 2007).

Table 5.5: Age Distribution of Pensioners: 72-90+ (July, 2009)

Age	Male	Female	Total
72 - 89	14,370	1,105	15,475
90	7	0	7
90+	18	1	19
TOTAL	14,395	1,106	15, 501

Source: SSNIT, 2009

NB: The table shows the number of pensioners within the defined age groups only.

The above problems and statistics highlight the difficulties brought about by the seeming absence of a structured social policy and social services framework in the country (Aryeetey and Goldstein, 1999). It was believed that this challenge could be resolved if a number of strategies were identified and implemented (Osei, 2003; SSNIT, 2008a, 2008b; Yaron, 2005; Boatın & Nyarko, 2006). The question that remains to be answered is: what happens to those who are not covered by the SSNIT Pension Scheme? To address the problems SSNIT devised a new strategy, which was aimed at encouraging people in the informal sector to join and contribute to the Pension Scheme (Osei, 2006; SSNIT, 2008a, 2008b). However, until these become mature, it can only be deduced that the majority of Ghanaians who are mostly, in the informal sector are neglected and have had to still seek assistance from the traditional social welfare system.

5.5. Summary of the Chapter

This chapter has evaluated the ecological, political, economic and social environments within which health is financed and delivered in Ghana. It has argued that the lack of economic growth and other uncontrollable circumstances compelled Ghana to solicit financial assistance from the World Bank and International Monetary Fund in the 1980s. The associated conditionalities have had negative effects on the social and economic sectors including, health in the country rather than the anticipated benefits. The next chapter reviews how economic reforms led to health sector reform in Ghana.

CHAPTER 6

GHANA'S HEALTH SECTOR REFORM

6.0. Introduction

This chapter presents Ghana's health sector reform and is divided into six (6) sections. Section one (1) is a brief overview of the problems of health financing and delivery. Section two (2) is a discussion on the health sector reform in general. Section three (3) discusses the health institutional reform. Section four (4) examines the health human resources reform. Section five (5) is an analysis of the health financing reform. Section six (6) is a brief summary of the entire chapter.

Initially, as a result of the post independence socialist system adopted in the 1960s, health service provision was focused on public delivery to the disadvantage of the private sector, particularly, self-financing health care providers (MOH, 2003c). Therefore, there is the need to relate policy reforms in Ghana's health sector to:

the complex historical, social, cultural, economic, political, organisational and institutional context; actors interests, experiences, positions and agendas; and policy development processes that influence policy programme choices (Agyepong and Adjei, 2007:150).

The government of Ghana through the sector Ministry of Health (MOH) ratified the Alma Ata Declaration on Primary Health Care in 1978 (WHO, 1978; Country Studies, 1994). As a result, health financing and delivery is a combined effort between the government, the private sector and the community (MOH, 2005).

6.1. Problems of Health Financing and Delivery

This part explains the problems of health financing and delivery. That is the economic circumstances under which Ghana was operating in the 1990s, had an impact on health financing and delivery, impeding equity to the limit so that:

1. The cumulative effect of the global economic recession led to shrinking public finance and mounting external debts. For example, in 1993 sub-Saharan Africa countries including Ghana spent 50 per cent more on servicing their

debt than on health and education (Logie and Woodroffe, 1993).

2. The World Development Report 1993 indicates that spending for health by developing countries like Ghana was disproportionately skewed to benefit the rich in the form of below-cost care provided through sophisticated tertiary care hospitals, whilst the poor lacked access to basic health services and received low quality care (World Bank, 1993; MOH, 1996a; Brobbey-Mpiani, 1998).

Health provision in Ghana was considered to be the lawful and indispensable responsibility of the government. However, since the implementation of the Economic Recovery Programme, the idea that healthcare was a collective right, which government must fulfil changed (Smithson *et al.*, 1997, Brobbey-Mpiani, 1998; MOH, 2003c). This led to a myriad of problems regarding health care financing and provision. A Ministry of Health (MOH) document sums up the challenges in Ghana's health delivery as:

the economic decline in the late 1960s and the 1970s slowed down the expansion and growth of the public sector. In spite of this, constant efforts were made towards providing primary health services for all. Nevertheless, accessibility, quality and utilisation of services have been low due to a dwindled health budget to as low as US\$6 per capita. It has been estimated that less than 60 per cent of Ghanaians have had regular access to health services (MOH, 2003c: V)

Despite policy implementation in the health sector, there is still a problem of inequity in terms of geographical access to health facilities (MOH, 1996; Brobbey-Mpiani, 1998; Agyepong, 1999). About 40 per cent of the Ghanaian population is defined as poor and 27 per cent as extremely poor: those who cannot meet their basic nutritional requirements (MOH, 2003c). The UNDP Human Development Report on Ghana for 2007 notes: 'life expectancy in the country increased from 55 years in 2003 to 57.9 in 2006 compared to a world average of 64.3 years in 2006' (UNDP, 2007:34). Thus, poverty has a consequential effect on health outcome, at least in Ghana as: 'ill health is both a cause and a consequence of poverty' (MOH, 2005:5). Although, the Ghana Living Standards Survey of 1999 showed decline in poverty levels from 51.7 per cent in 1992 to 39.5 per cent in 1999, this did not reflect in the provision of health care (GSS, 1999; Adams *et al.*, 2004).

6.2. Health Sector Reform

This section discusses health sector reform in Ghana. Current health sector reform has to be viewed in relation to its effect on institutional arrangements instituted in 1988, when the aim was to halt the sliding drift of performance caused by the economic recession of the country (MOH, 1996; Dovlo, 1998). Reforms were part of the general measures taken to strengthen the monitoring and control of public expenditure (Russell *et al.*, 1999; IMF, 2002). The implementation of the Sector-Wide Approach (SWAP); Ghana Vision 2020; and the Second Health Sector Programme of Work (2002-2006), were all aimed at ensuring equal access; improve quality; efficiency; and financing (WHO, 2006). In 1995 the government of Ghana launched a development policy known as Vision 2020. Based on this, the Ministry of Health also developed and introduced health sector reform as a measure to solve some of the problems associated with health service delivery. The objectives of the first phase of the Medium Term Health Strategy (1996-2000) corresponded with the VISION 2020, and had five basic themes that focused on ensuring:

1. Increased geographical and financial access to basic health services.
2. Better quality of care in all health facilities and in outreach services.
3. Improved efficiency in the health sector.
4. Increased overall resources in the health sector to be equitably and efficiently distributed.
5. Closer collaboration and partnership between the health sector and communities, other sectors and private providers: both allopathic and traditional (Republic of Ghana, 1995; MOH, 1996b; Dovlo, 1998).

The health sector reform was legally implemented within the Ghana Health Service and Teaching Hospitals Act 525. The aim was to improve accessibility and quality of health services in Ghana. The health sector itself was divided into the Ministry of Health, the Ghana Health Service and the Teaching Hospitals Board, with respective management structures and functions (Republic of Ghana, 1996; MOH, 1996a, 2000).

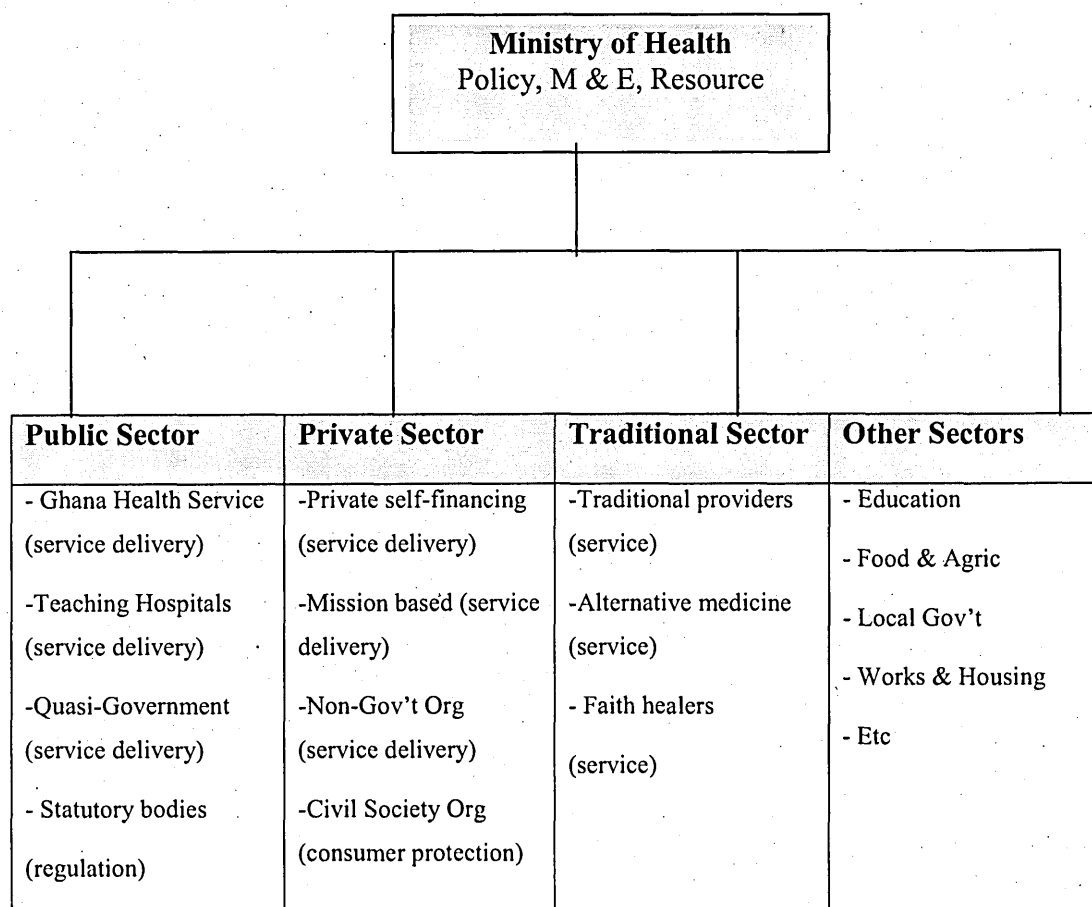
6.3. Health Institutional Reform

The health sector in Ghana has been decentralised. The structure consists of national, regional, district, sub-district and community health systems (GSS, 2005). These systems are part of the context of health financing and delivery in Ghana as illustrated in figure 6.1.

The figure shows that health service delivery in Ghana is a concerted effort between the Ministry of Health and other stakeholder organisations. Thus, the health sector is divided into: the public sector, private sector, traditional sector and other sectors. The public health sector consists of institutions, which provide health service as well as institutions, which perform regulatory functions. The private health sector consists of private self-financing, mission based (Christian Health Association of Ghana-CHAG) and non-governmental organisations, which provide health service as well as civil society organisations, which provide consumer protection.

The traditional health sector also consists of traditional providers, alternative medicine and faith healers who provide health service. Finally, the other sectors consist of relevant ministries such as Ministry of Education; Ministry of Food and Agriculture; Ministry of Local Government; Ministry of Works and Housing and other departments. There are inter-organisational working relationships between these ministries and the Ministry of Health since their activities have influence on the health of the people and the health sector (GSS, 2005).

Figure 6.1: Structural Relationship and Key Functions in the Health Sector



Source: GSS, 2005:72

The main institutional arrangements in the health sector have been explained below.

6.3.1. Ministry of Health

The Ministry of Health, headed by the Minister of Health (a politician) is entrusted with the responsibility of focusing on: policy formulation, regulation, target setting, monitoring and evaluation, provision of information and resource mobilisation for the health sector as well as health budgeting (MOH, 2003b, 2003c). The mission of the Ministry of Health is:

to work in collaboration with all parties in the health sector to ensure good health and vitality and equitable access to quality health for all people living anywhere in Ghana (MOH, 2005:6)

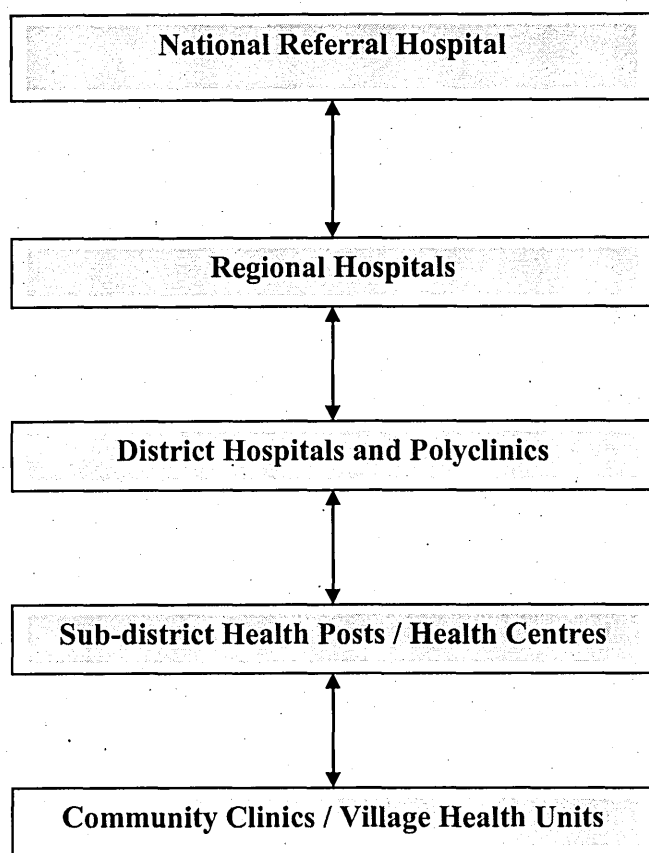
The attainment of this aim depends on how realistic, innovative and resourceful the health sector is in its bid to achieve certain objectives. These include national objectives, the New Partnership for Africa's Development (NEPAD) and the Millennium Development Goals (MDGs). It is estimated that the Millennium Development Goals (MDGs) will require a per capita health expenditure of US\$40 million to bring about the necessary scaling up of priority health interventions. However, the potential resources available to the health sector for the same period are estimated to be around US\$16.5 million (Amofa, 2008).

6.3.2. Ghana Health Service

The Ghana Health Service is responsible for the delivery of health sector policies developed by the Ministry of Health through the provision of health care in the country (MOH, 1996a). The national budget allocated to the health sector is shared between the Ministry of Health (MOH) and the Ghana Health Service (GHS). The Ghana Health Service's component of the budget is also allocated to the directorates, units and health institutions. The decision making process in the health sector has almost always adopted a top-down approach (Agyepong, 1999). Therefore, the policies developed at the national level are transmitted either vertically or horizontally by the chain of command to the Regional hospitals, District hospitals and the Health Centre facilities (GSS, 2005).

The structure of public health service delivery is shown in figure 6.2. The figure shows that health service in the country is provided at the community health clinics or units through the sub-district health centres; district hospitals and polyclinics; regional hospitals to the national referral hospitals or teaching hospitals. There are interrelationships between these levels through monitoring and supervision. This structure provides a gatekeeper system where people's first point of contact with the health system should be at the community clinics or units. Depending on their conditions, they would be referred to the next level on the health system (MOH, 2004d). However, there are problems with the implementation of the gatekeeper system due to inadequate number of health personnel, facilities and medical equipment at the lower levels (MOH, 2003e).

Figure 6.2: Service Delivery Levels in the Health System



Source: GSS, 2005:73

6.3.3. Teaching Hospitals Board

There are two established national teaching hospitals: Korle-Bu Teaching Hospital and Komfo Anokye Teaching Hospital (GSS, 2005). The third teaching hospital: Tamale Teaching Hospital is still being upgraded. They have their separate Boards and organisational structures according to the specifications of the Ghana Health Service and Teaching Hospitals Act 525. The Chief Executives are in the helm of administration supported by heads of other directorates (MOH, 1996a).

6.3.4. Private Health Sector

The private health sector refers to all organisations and individuals that work outside the control of the state in the health sector. Among the criteria used to identify the private health sector are profit motives, sources of financing and who owns the health

facility. Private health organisations have the primary aim of making profit but some may not be fully motivated by profit making. Some are 'for-profit' and others are 'not-for-profit' (Bennett and Ngalande-Banda, 1994, Brobbey-Mpiani, 1998). However, Ghana's private health sector is inhibited by several factors (MOH, 2000, 2003c). A new vision had to be identified under health sector reform where the approach was to free government of its total control of the health sector funding and provision (MOH, 2003c; CHAG, 2006; MOH/CHAG, 2006).

6.4. Health Human Resources Reform

The health sector in Ghana needs trained and motivated staff who will work in areas where their services are needed because health service delivery is labour intensive and as a result, requires numbers and mix of staff to achieve efficiency (MOH, 2005; Di Matteo, 2009). The availability of skilled and adequate health human resources contributes to the quality of care provided at health care institutions. The reform of health care human resources had to take into account the situation preceding 1996, which militated against health care delivery. Shortage of human resources led to health facilities being unevenly distributed with more access toward the south and in the cities. On average, about 40 per cent of Ghanaians were living more than 15 kilometres away from even the most basic health services (MOH, 1995; Dovlo, 1998).

A number of strategies were introduced with the expectation that they would help develop skilled based health personnel which would improve health service delivery (MOH, 1996b, 1997; Dovlo, 1998). Even though efforts are made to train all categories of health staff, the sector still faces a lot of challenges in developing and retaining a workforce (WB, 1994; Dovlo, 1998, MOH, 2004c). The ratio of doctors to the population had increased from 16,759 in 2003 to 17,615 in 2004. The ratio of nurse to patient in the population was reduced from 2,254 in 2003 to 1,513 in 2004. Although, the net ratio of nurses and doctors to the population was considered as positive (GHS, 2004a), by the year 2008, the doctor to patient ratio was 1 doctor to 9,090 patients; the nurse to patient ratio was 1 nurse to 1,538 patients; and the pharmacist to patient ratio was 1 pharmacist to 13,373 patients in the population (Amofa, 2008).

6.4.1. Challenges of the Exodus of Health Personnel to the Diasporas

Apart from retirement and other reasons for attrition, the health sector was hit by what was termed the 'brain drain' of health staff in the latter part of the 1990s. By 2008, the problem of an ageing workforce combined with the 'brain drain' resulted in inadequacy in numbers, skill mix and distribution (Amofa, 2008). Table 6.1 shows the receiving countries of these health personnel who left the country. It shows that as many as 1200 doctors travelled to the United States of America while only 50 doctors travelled to Canada. Thus, a total of 1700 doctors left Ghana in 2002 (Buchan and Dovlo, 2004).

Table 6.1: Countries Hosting Ghanaian Doctors: 2002

Country	Number of Ghanaian Doctors
USA	1200
UK	300
South Africa	150
Canada	50

Source: Buchan and Dovlo, 2004

Similarly, within a six year period, a total of 3,087 nurses left the country for the assumed greener pastures in the developed economies as shown on table 6.2. It shows that between 1998 and May, 2003, the United Kingdom received the highest number of 2,468 nurses and South Africa received the least number of 24 nurses (Buchan and Dovlo, 2004).

The root of the problem was that a shortage of health staff in the developed economies opened up avenues for some of the workforce to emigrate from Ghana to countries like the United States of America, United Kingdom and Canada among others (Buchan, 2001; Chanda, 2002; Martineau *et al.*, 2002; OECD, 2002; Pearce, 2002; Buchan and Dovlo, 2004; Dovlo, 2005). The high quality of training offered to health professionals in Ghana, led to the high international recognition and made these staff desirable elsewhere. The demand saw health staff leave the country to foreign countries by either private arrangement or active recruitment processes

(MOH, 2002; Buchan and Dovlo, 2004). The data available for May, 2003 had not changed.

Table 6.2: Ghana Nurses Verification: Country Verified for and Year

Country of Destination	Number of Nurses & Year of Seeking Verification						
	1998	1999	2000	2001	2002	2003 (up to May)	Total
USA	50	42	44	129	81	80	426
UK	97	265	646	738	405	317	2,468
Canada	12	13	26	46	33	10	140
South Africa	9	4	3	2	6	-	24
Others	4	4	8	8	5	-	29
Total	172	328	727	923	530	407	3,087

Source: Buchan and Dovlo, 2004

The poor remuneration and unfavourable conditions of service in Ghana and the apparently lucrative salaries offered in foreign countries was the common reason for desertion. Due to economic reform in Ghana (MOH, 1996b), the Ghanaian currency, the cedi (¢) has devalued and currencies like the US dollar (\$) and UK pound sterling (£) gained high values in tender. Whilst the salaries received made little difference to the lives of the immigrant health workers, including Ghanaians in the diasporas, it was somehow assumed that the devaluation of Ghanaian currency made all the difference when they were able to make remittances home (Dogbevi, 2009). Ironically, contemporaneous evidence tends to rather pose a question that still remains unanswered: how much could they save at the end of the month while in the diasporas, to be able to make the remittances back home?

6.4.2. Effect of Incentivisation

The government instituted the Additional Duty Hours Allowance (ADHA) as an incentive to stem the 'brain-drain' in 2001/2002 fiscal year. This was non-taxable allowance, which was given separately, from staff salaries at the end of the month for

working extra hours. Cash was paid to staff at the accounts or finance department of the health institutions. Until then, overtime allowance was not a common feature of public health service financial management structure (Buchan and Dovlo, 2004). Paradoxically, this incentive package rather served as the 'push factor' for health personnel who were willing to leave the country to confirm their determination to do so because they could accumulate money to pay for their travel expenses. To reverse the trend, the ADHA was mechanised into the overall salary structure for health staff in 2004 under expenditure item 1 (Personal Emoluments) [(GHS, 2004a)].

The two key issues facing health policy makers are work load and the staff mix in the context of a limited supply of health staff. There is pressure on the staff at the health facilities. Therefore: 'health workers continued to work under very difficult circumstances to ensure that services are delivered in all parts of the country' and 'it is the extra hard work by the ever-dwindling numbers that have kept the current levels of service delivery from total collapse' (GHS, 2004a:2).

6.5. Health Financing Reform

Different health financing models have been implemented since independence in 1957. These always took into account the prevailing ideology such as the socialist and the market-driven economic approaches. Ghana adopted health financing policies with the view to improving financial access and ensuring equity in health care for the population. Traditionally, there are three main sources of funding for the health sector (MOH, 2007b, 2007c). These are explained below.

6.5.1. Government of Ghana Funding via Taxation

During the colonial era, patients to public health facilities were paying about 20 pence per each patient in fees. This continued immediately after independence in 1957. During President Nkrumah's rule with his Convention People's Party (CPP), there was some token payment for services at hospitals, but much of the funding came from the government. The health sector's financing policy was fashioned along the social system of health care delivery where everyone was treated free of charge in the public health institutions and the cost absorbed by the government (MOH, 2003b, 2003c; Osei *et al.*, 2007). This strategy corresponded with the prevailing political ideology which was interventionist in orientation (FCO, 2004).

Table 6.3 shows how the health budget was used on various expenditure items for the 2007 fiscal year. It shows that the government of Ghana (GoG) component of the health budget, finances certain expenditure such as: item 1: personal emoluments; item 2: administration; item 3: service delivery; and item 4: investments (MOH, 2007b). This constituted an amount of ₵2,481,904 in 2007 (MOH, 2007b).

Table 6.3: Budget Ceiling by Item: 2007 (million old cedis, ₵)

Item	GOG	DHF	Donor earmarked	IGF	NHIF	HIPC	Total
1	2,175,550	-	-	-	72,530	-	2,248,080
2	102,676	18,000	-	169,153	60,647	-	350,476
3	100,389	171,000	365,565	318,909	1,252,550	80,000	2,288,413
4	103,289	-	312,225	32,938	373,370	15,000	836,822
Total	2,481,904	189,000	677,790	521,000	1,759,097	95,000	5,723,791

Source: MOH, 2007b

Taxation was the main source of financing the health sector (Kwegyir-Aggrey, 1998, Atampugri, 2003). The Ministry of Health was allocated sufficient funds in national budgets to meet the cost of drugs, medical equipment and staff remuneration. The population of the country at the time was less than six million (6m). The government was the main financier of the health sector until events in the 1980s brought a dramatic change in funding. A number of events took place, which made it extremely difficult for the government to single-handedly finance health care (see MOH, 1985, 1996b, 2000, 2002, 2003a, 2003b, 2003c, 2004a, 2005).

6.5.2. Donor Funding

The presence and contribution of the international donor community for Ghana's health financing was introduced: a new development model called 'Millennium Development Goals' raised the level of consciousness about the severe under-funding of health care services and other necessary services in low-income countries. Consequently, donor countries expressed interest in spending more on health and other specific projects they wanted to support (Mayhew, 2002; Mayhew *et al.*, 2003). Table 6.4 shows the estimated contributions from the donor organisations into Ghana's Health Account in 2003 (Danida, 2002a, 2002b). The World Bank contributed the highest amount of \$22,500,00 while the European Union contributed

the least amount of \$4,900,000 into the health account in 2003 (see also Danida, 2002a, 2002b; WB, 2003a, 2003b, 2003c, 2004a, 2004b).

Table 6.4: Donor's Expected Contribution to Health Account: 2003 (in USD)

Donor Organisation / Country	Projected Contribution (USD)
World Bank	22,500,00
Danida	8,800,000
DfID	12,400,000
Netherlands Government	14,470,000
European Union	4,900,000

Sources: MOH, 2002; Danida, 2002a.

Initially, these organisations provided their support separately. Eventually, a partnership was fostered where all such contributions were put together in a common fund called the Donor Pool Fund (DPF). The Ministry of Health benefited from these funds, which were provided through grants, loans and indirectly, through projects, constituting between 40 and 60 per cent of the health sector budgets for Ghana (see MOH, 2000, 2002). The problem with Ghana's economy is its over-reliance on external aid, which has made it an aid dependent country (Whitefield, 2005; Chisala, 2006; Whitefield and Jones, 2007). Therefore, it became an issue of concern for health policy makers and administrators when the Donor Pool Fund began to dwindle in 2006 as part of the transfer to Multi-Donor Budget Support under the supervision of the Ministry of Finance and Economic Planning (see MOH, 2003a, 2003b, 2003c, 2004a, 2004c). This has implications for resource inflows into the health sector.

However, as can be seen from table 6.5, donor organisations contributed to the health sector budget for 2008 financial year (MOH, 2009). It shows the donor component of a budget summary by the Ministry of Health, which used 'provisional data from the Draft 2008 Financial Statements and allocating against the approved budget from the Annual Estimates...' (MOH, 2009:43). It also shows that donor organisations do not contribute to expenditure item 1: personal emoluments. The Ministry of Health document observes: 'the amount at the foot of the budget column is the total of the Approved Estimate' (MOH, 2009:43). Thus, the approved budget expenditure was ₵1,414,192,790.000.

Table 6.5: Donor Component: Budget Execution – Spending Against Budget by Selected Categories: 2008 (million old cedis, ₵)

Item	Description	Investment Expenses	Expenditure	Variance	%
1	Personal Emoluments	-	-	-	-
2	Administration Expenses	5,000,000,000	6,686,540,000	(1,686,540,000)	(33.73)
3	Service Expenses	397,000,000,000	1,088,166,490,000	(691,166,490,000)	(174.10)
4	Investment Expenses	865,312,190,000	319,339,760,000	545,972,430,000	63.10
Approved Budget		1,267,312,190,000	1,414,192,790,000	(146,880,600,000)	(11.59)

Source: MOH, 2009.

NB: The original figures were converted from 'million new Ghana cedi (GH₵)' to 'million old cedis (₵)'.

6.5.3. Cost Recovery or User Fees – 'Little R' Reform

Historically, user fees were re-introduced in public health facilities in 1969. In the 1970s, the Hospital Fees Act (No. 387) of 1971 was introduced where minimal charges were allowed for some of the services provided at public health facilities (Atim *et al.*, 2001a, 2001b, 2001c). The government's responsibility for solely financing health changed where some aspects of the cost of health care were passed onto the patient (MOH, 1985). Ghana adopted the first financing reform alternative under the health sector reform classified as 'little R' reform (Hsiao, 2000; Berman and Bossert, 2000).

Ghana started to look at other sources of financing health services particularly in the early 1980s with the coming into political power of Flt. Lt J.J. Rawlings and the Provisional National Defence Council. In 1981 the public hospitals were in a very poor state. The health workers out of frustration due to their inability to attend effectively to the patients unilaterally began charging money just to raise some internal funds to procure basic health care consumables. The Ministry of Health through the Policy Planning, Monitoring and Evaluation Directorate (known by then as Planning Unit) argued why it was necessary to charge fees. The government somehow saw reason and around 1983, token fees were implemented officially. In 1985 the new Hospital Fees regulation was introduced under Legislative Instrument

(L.I. 1313), which introduced significant increase in fee payment for services (MOH, 1985).

6.5.3.1. The Bamako Initiative and Cash and Carry

The actual cost recovery programme for essential drugs was implemented after the Bamako Initiative in 1987 (AU, 2005a; Kasilo, 2005). This policy aimed to grant public health facilities seeded capital in the form of drug supplies from which they were to sell at a 15 per cent mark up on cost after buying the drugs from the Central and Regional Medical Stores (CRMS). The regulation permitted public health institutions and patients to procure drugs from the open market: licensed chemists and pharmaceutical companies in the event of the unavailability of any particular drug. The Essential Drugs List (EDL) guided drug purchases for the public health institutions.

A pilot implementation of the drugs policy was conducted at Ridge Hospital in the Greater Accra region in 1992. The success of this led to a nationwide roll out of the programme in all public health facilities in the same year (MOH, 1985; Afari-Adomah, 1996). Other hospital services such as laboratory, radiology, x-ray, among others, were included in a policy, which later became known as 'Cash and Carry' system. The government also defined entitlements to full or partial exemption from payment for paupers, health workers, patients with tuberculosis and leprosy and psychiatric patients among others (MOH, 1985). Four categories of user fees for public health facilities were identified (Adams, 1996; Nyonator and Kutzin, 1999).

6.5.3.2. The Effect of Cost Recovery Policy (Cash and Carry)

The implementation of this policy was problematic. Despite the assumed growth in expenditure by the Ministry of Health by 12 per cent in real terms from 1986 to 1990, it only led to a 2.3 per cent real per capita increase due to the population growth rate of over 3 per cent per annum (Asenso-Okyere, 1995; Nyonator and Kutzin, 1999). Even though it was envisaged that the Ministry of Health could raise at least 15 per cent of its recurrent expenditure through user fees, it did only raise an average of 10 per cent from 1985 to 1993 (Atim *et al.*, 2001a, 2001b, 2001c). The negative effect of this health financing mechanism began to have a toll on the citizens and different

descriptions of people's disenchantment were circulated. Asenso-Okyere (1995), describes it as a comprehensive scheme notoriously referred to as Cash-and-Carry.

Asenso-Okyere *et al.* (1998), investigated the effect of the cost recovery policy on health care seeking behaviour of the patient and found that there was an increase in self-medication and other behaviours aimed at cost-saving. In a related study, Asenso-Okyere *et al.* (1999), studied the behaviour of health workers and found that while the availability of safe and effective drugs had improved, most prescribers took economic limitations into account before issuing prescriptions with far reaching implications for people's health (Asenso-Okyere *et al.*, 1999).

Many people began to seek health care away from public health facilities. They sought it from private medical practitioners, mission health institutions, herbalists, and fetish priests (Waddington & Enyimayew, 1989, 1990; Asenso-Okyere *et al.*, 1998; Van den Boom *et al.*, 2004). Again, the introduction of this policy in the public health facilities encouraged near 'corrupt attitude' amongst health personnel. Adams, (1996), observes that there are widespread local charging practices by health facilities and under-the-table payments to health service providers: its equity ramifications are doubtful (Adams, 1996; Nyonator and Kutzin, 1999). The rural areas are the most badly hit and its contribution to health sector funding is not significant. Obviously, the entire population, including the health workers do not like the policy.

6.5.4. Risk Sharing: Health Insurance Scheme – 'Big R' Reform

As the health sector financing reform continued to evolve, a stage was set for implementing a health insurance scheme. This qualifies as the 'big R' reform. The government's reliance on tax-based and donor aid financing was no longer realistic and health insurance was seen as an alternative source of financing the badly required improvement and delivery of health care as well as managing the sufferings that households face in paying for medical costs under the user fees (Nolan and Turbat, 1995, Dablu, 2001).

6.5.4.1. The Pilot National Health Insurance Scheme: 1997

The implementation of the National Health Insurance Scheme (NHIS) as a new and supplementary health financing strategy went through several processes. A pilot project was launched in 1997 in four administrative districts in the Eastern region by the then Government under the National Democratic Congress (NDC). As it was going to be the first of its kind in the country, there was the need to ascertain the willingness to participate on the part of the people. A survey found that there was a high degree of acceptance in all communities. Over 90 per cent of respondents agreed to participate in the scheme and up to 63.6 per cent were willing to pay a premium of ₵5,000.00 (5000 cents or \$3.03) a month for a household of five persons (Asenso-Okyere *et al.* 1997). However, it was suspended for many reasons. There was lack of adequate debate amongst stakeholders in the country. The need for a general overhaul of the health financing policy was recognised (Atim *et al.*, 2001a, 2001b, 2001c).

6.5.4.2. The National Health Insurance Scheme 2003 (Act 650): 2004

The Government under the New Patriotic Party (NPP) included in its manifesto for election 2000: a promise to introduce health insurance into the Ghana health financing stream. They assumed power in 2001 and an Act of Parliament titled: National Health Insurance Scheme 2003, Act 650 was subsequently launched in March, 2004 (MOH, 2003d; Abbey, 2003). Among other things, it is to: ‘...establish a National Health Insurance Fund that will provide subsidy to licensed district mutual health insurance schemes...’ (MOH, 2003d:5). Again, ‘the aim of the health insurance is to enable the government achieve its set health goal within the context of the GPRS and the health sector’s Five-Year Programme of Work: 2002-2006’ (MOH, 2004d:5).

The long-term vision is that health insurance would become mandatory for every Ghanaian and residents in Ghana (Apoya, 2002; Danida, 2002a, 2002b). The fundamental principle is that inability to pay at the point of service use should not prevent access to essential services (MOH, 2003d; Atim, 2003). Objectives are identified for the first ten years of the implementation of the National Health Insurance Programme (NHIP). The penultimate objective is to achieve an insurance coverage of between 30-40 per cent of the population within the short to medium term and between 50-60 per cent within the medium to long term (Atim, 2003).

6.5.4.3. The Model of the National Health Insurance Scheme

When introducing the National Health Insurance policy, the question that remained to be answered was how to deal with the large informal sector population. For the purposes of the National Health Insurance Scheme's healthcare benefits, the Ministry of Health has categorised the population on the basis of socio-economic status, as explained in table 6.6 below. The core poor people in the population are exempted from payment of premiums under the National Health Insurance Scheme (MOH, 2003d, 2004b, 2004d).

Table 6.6: Informal Sector Categorisation: Ghana

Social Group	Class	Definition
Core Poor	A	Adults who are unemployed and receive no identifiable income and therefore unable to support themselves financially
Very Poor	B	Adults who are unemployed but receive identifiable and consistent financial support from the source of low income
Poor	C	Adults who are employed but receive low returns for their efforts and are unable to meet basic needs
Middle Income	D	Adults who are employed and receive incomes which are just enough to meet their basic needs
Rich	E	Adults who are able to meet their basic needs and some of their wants
Very Rich	F	Adults who are able to meet their basic needs and most of their wants

Source: MOH, 2004d: 14

As indicated earlier, from 1985, Ghana started seeking different methods to finance its health care delivery (MOH, 1985). These included different kinds of geographically based mutual health organisations for the informal sector; social health insurance for the formal sector and private health insurance for the affluent and those who could pay extra. Within these three types as the government estimated, the private health insurance (PHI) and social health insurance (SHI) could cater for a proportion of the formal sector of the economy estimated to be around 15 per cent of the population (GSS, 2005). The government was of the view that if mutual health organisations (see chapter 7) were to be sustained or new ones established, they could also cover an estimated 85 per cent of the informal sector population (Apoya, 2002; Danida, 2002a, 2002b).

Therefore, the model of the National Health Insurance Scheme was designed as a mandatory social health insurance. An Act of Parliament: NHI 2003, Act 650 (MOH, 2003d), makes it compulsory for all or some citizens, especially, those in formal employment to become members of a health insurance scheme with its community health insurance dimension (McIntyre and Gilson, 2005). The Legislative Instrument 1809 was introduced to affirm its establishment (MOH, 2004b). Three main types of health insurance schemes are specified under the NHI Act 650:

1. District Mutual Health Insurance Schemes;
2. Private Commercial Health Insurance Schemes; and
3. Private Mutual Health Insurance Schemes (MOH, 2003d).

The district mutual health insurance schemes and private mutual health insurance schemes are targeted at almost the same population groups. The socialised health insurance approach is incorporated into the district mutual health insurance schemes (DMHIS) where the formal sector employees are covered by social health insurance system. The informal sector population is also covered by the district mutual health insurance schemes modelled after the mutual health organisations approach (Atim, 2003). The private mutual health insurance schemes (PMHIS) are supposed to be established and managed by independent groups and associations that are outside the management control of the district and municipal Assemblies (MOH, 2003d). Thus, the Ministry of Health policy document makes it clear that:

any group of persons in Ghana may establish and operate a Private Mutual Health Insurance Scheme which shall not necessarily have a district focus. It may either be community-based or occupational or faith-based. It is also social in character but this type will not receive subsidy from government (MOH, 2004d: 11)

6.5.4.4. National Health Insurance Council and Authority (NHIC & NHIA)

The NHI Act 650 provides a strong regulatory framework for the management of the National Health Insurance Scheme. At the national level, institutions have been established, which include the National Health Insurance Council (NHIC) and

Authority (NHIA), which are entrusted with the responsibility for formulating and providing policy guidance and overseeing the implementation of the National Health Insurance Programme (NHIP). Other functions are: the collection, deposit, investment, administration and disbursement of the funds that come into the National Health Insurance Fund (NHIF); supervision and licensing of prospective health insurance schemes; regulating as well as accrediting health care providers (DFID, 2002; MOH, 2003d, 2004b; Atim, 2003).

6.5.4.5. Private Health Insurance Sector

By 2001, there seemed to be no specific legal framework for the private health insurance sector in Ghana (Atim *et al.*, 2001a, 2001b, 2001c). The reason was that the private health insurance market is not well developed. The World Bank Report 2008 argues:

Regardless of the social and political context, over time the limited capability of the public sector to fully satisfy the anticipated continued rapid increase in demand is expected to drive an increase in the private sector's share in most countries (WB, 2008:40)

This is why the National Health Insurance Act 650 under section 39 states that: 'a body corporate registered as a limited liability company under the Companies Code 1973 (Act 179) may operate as a Private Commercial Health Insurance Scheme' (MOH, 2003d:16). Preker (2004b), observes that even in countries with a tax funded National Health Service, there is a role for insurance to: mobilize additional money, protect against financial risk and secure access to better care. The challenge is to explore the extent to which private sector participation is encouraged within the implementation of the National Health Insurance Scheme (NHIS).

6.6. Summary of the Chapter

This chapter has analysed Ghana's health sector reform. It has been shown that the reform in the health sector has had effect in the areas of health institutional, health human resources and health financing. The inability of central government to single-handedly provide funding for the health sector led to the implementation of the user fees policy or 'cash and carry' system in public health facilities. This brought in its

wake myriad of problems including, reduced access to orthodox health care by the people. That is, the problem of inequity is pronounced amongst the informal sector population. Therefore, different funding mechanisms were experimented, leading to the introduction of risk-sharing or health insurance in March, 2004 (MOH, 2003d, 2004b). The next chapter examines the emergence and development of mutual health organisations.

CHAPTER 7

THE EMERGENCE OF MUTUAL HEALTH ORGANISATIONS

7.0. Introduction

This chapter is a follow up to the discussions in chapter three (3) on the emergence of mutual health organisations in sub-Saharan Africa and Ghana. Specifically, it describes how mutual health organisations have evolved in Ghana. The chapter is divided into four (4) sections. Section one (1) discusses the stimulus for the interest in the mutual health organisations. Section two (2) presents the Pre-NHI 2003 MHOs era. Here, there is a review of the community-based health insurance era spanning between 1850 and 1998. There is also a discussion of the mutual health organisations era, which spans between 1999 and 2004. Section three (3) is a brief account of the National Health Insurance Act 650 (MOH, 2003d), and the challenges for the mutual health organisations. Section four (4) is a summary of the chapter.

7.1. Stimulus for the interest in the Mutual Health Organisations

Mutual health organisations have distinct characteristics (see Atim, 1999; Criel and Waelkens, 2000; Mariam, 2003). They differ from all other types of health insurance and financing schemes that use risk-sharing and risk-pooling approaches (Atim, 2000). The reasons for the establishment of mutual health organisations in sub-Saharan Africa vary, depending on the specific community context (Gibson, 1988; De Bethune *et al.*, 1989; Arhin, 1995; Sikosana *et al.*, 1997; Atim, 1998, 1999; Dablu, 2001; Criel *et al.*, 2005; McIntyre and Gilson, 2005). Some policy and economic analysts assert that community-based health insurance schemes in developing countries were initiated as a response to severe economic constraints, political instability and the absence of good governance (Preker *et al.*, 2002), but Ghana's case was propelled by economic need rather than political instability or lack of good governance (Obama, 2009a, 2009b).

In the year 2000, taxation and external sources constituted 53.5 per cent of the total public health expenditure and private health expenditure in Ghana. This included insurance, out-of-pocket payments, non-governmental organisations (NGOs) and private investment was 46.5 per cent. However, the expenditure of community-based

health insurance schemes alone as a percentage of total health expenditure is not available, because about 80 per cent of all schemes were formed between 1999 and 2000 (WHO, 2000; Atim *et al.*, 2001a, 2001b, 2001c; Atampugri, 2003). Arhinful (2000), describes the complications and inconveniences of implementing health insurance schemes in Ghana which include Ghana's low economic base, a relatively poor population with unplanned spending on health care, and lack of expertise on socialised health insurance.

The public and private 'not-for-profit' health care providers, especially, the Mission health institutions view mutual health organisations as a way of controlling unpaid bills left by patients who abscond after treatment (Musau, 1999), and a method of helping relatively poor communities to manage health risks (Criel, 1998, 2001; Preker *et al.*, 2002; Preker, 2005; Tabor, 2005). The user fees policy has not able to totally ensure the provision of universal health coverage and financial protection to the people of Ghana, especially, those in the remotest parts of the country. Therefore, the need arose for the communities to find a way to address their own health financing needs without relying on resources in the public health sector (Arhinful, 2000; Atim *et al.*, 2001a, 2001b, 2001c; Dablu, 2001; Atampugri, 2003).

7.2. Pre-NHI 2003 Mutual Health Organisations Era

Mutual health organisations in Ghana have a distinctive history of development. Specific periods have sought to give them an identity and this explains the enthusiasm with which the communities have embraced the concept. Two different phases of how they have evolved and operated in Ghana can be identified. The first covers two periods that preceded the implementation of the National Health Insurance Act 650 in 2004 (MOH, 2003d), which is termed the pre-NHI 2003 MHOs era. The second phase covers their current operations under the National Health Insurance Act 650 (MOH, 2003d). This period is termed post-NHI 2003 MHOs era (see chapter 9).

7.2.1. Community-Based Health Insurance Era: 1850 - 1998

This period covers the operations of community health insurance between 1850 and 1998. Even though, Ghana embraced the community-based health insurance ideology, which became well established in the late 1990s and early 2000, there were

already some saving groups and social movements in the communities (VHRA, 1998). There are good interpersonal relationships amongst people and between the communities in Ghana. The extended family system encourages long-lasting relationships between families and communities. There are also intra and inter community networks brought about by inter-tribal marriages. All these provide the basis for solidarity between and amongst the stakeholders in such unions (Arhinful, 2000; Jacobs *et al.*, 2008).

In the Volta region alone, about 3000 social financing (saving) schemes ((Develtere, 1993; Atim, 1999), could be identified, some of them established as far back as the 1850s (VRHA, 1998; Atim, 1999, 2000; Dablu, 2001). They are generally formed on a small to medium scale in terms of their membership (Atim, 1998, 1999, 2000; Musau, 1999; Criel and Waelkens, 2000, 2003; Mariam, 2003; Carrin *et al.*, 2005; Jacobs *et al.*, 2008). They operate on the basis of traditional financial solidarity networks using resource mobilisation efforts in the form of family contributions: 'abusua dwatire' and 'abusua fotoo' (family capital). Family members have to contribute to be able to benefit when one has needs (Atim & Sock, 2000; Dablu, 2001). The 'Susu' or the credit union types are formed on the basis that members contribute an agreed amount of money into a common fund. At the end of any agreed period, a member is given the opportunity to take out the amount contributed or a greater percentage of it. This can be used for any purpose when the member is in need of money. This is done on rotational basis, the basic principles being mutuality and trust (Atim, 1999, 2000; Schneider, 2005a, 2005b).

In the 1990s, there was formal recognition of this effort by the communities. In 1992, the management of St Theresa's Hospital collaborated with the Chiefs and people of the Nkoranza District in the Brong Ahafo region, to establish the first community health insurance scheme (Atim and Sock, 2000). This was under the direction of the Catholic Diocese of Sunyani, and it was supported by Memisa, a Non-Governmental Organisation (NGO). This was informed by the experience of the Bwamanda Scheme in former Zaire, now People's Democratic Republic of Congo (Criel and Kegels, 1997). The Nkoranza Community Health Insurance Scheme (NCHIS) partially solved the health care financing problems facing the people in the farming communities of the Nkoranza District. It helped to reduce the rate at which patients

abscond after treatment. It also helped to reduce mortality rates at the St Theresa's Hospital, which is the only hospital in the entire district and owned by the Catholic Diocese of Sunyani (Atim and Sock, 2000).

This success encouraged other rural communities to establish their own schemes. In 1995, the West Gonja Hospital Health Insurance Scheme in Damongo in the Northern region, was established (Kipo and Marx, 2001; Osei-Akoto, 2003). This was a replica of the Nkoranza Scheme in design and management structure. It was also initiated by the Catholic Diocese in the district. These schemes relied on the support of the opinion leaders like the Bishops, who adopted special roles in the promotion and sustenance of community development projects in Ghana. The first health sector-initiated community health insurance scheme was piloted in the Dangme West District in the Greater Accra region. It started in 1996 and became operational in the year 2000, as a partnership between the Ministry of Health and the Chiefs and people of the district (Agyepong *et al.*, 2006).

7.2.2. Mutual Health Organisations Era: 1999 – 2004

The overwhelming success of these pilot schemes prompted health policy makers and international experts to find ways of encouraging their spread in the country (Atim, 1998, 1999). Thus, the orientation of the community-based health insurance schemes in Ghana was streamlined when international donor organisations, 'Partners for Health Reform' (PHR) and its sister organisation, 'Partnership for Health Reformplus' (PHRplus) joined efforts to promote these schemes from the latter part of 1990s to early 2000s. These organisations were under the financial sponsorship of United States Agency for International Development (USAID) and the 'Danish International Development Agency' (DANIDA). Their involvement contributed to a systematic study on these local initiatives in Ghana, which led to the first published documents on the concept of the mutual health organisations. This also led to a nationwide dissemination of their effectiveness and hidden potential in increasing access to health care by poor people (Atim, 2000; Apoya, 2002, 2003).

The involvement of other organisations using the Nkoranza Community Health Insurance Scheme as a template drew attention from international actors like the World Health Organisation (Atim, 1998, 1999; Atim *et al.*, 1998; Atim and Sock,

2000). The word 'mutual', which is the English version of the French word, 'mutuelle' was coined for the schemes in Ghana around 1999. The name, identity and operational remits of the schemes have changed from this time onwards. The phenomenon was adopted in most communities and the schemes started springing up in greater numbers. In the Ashanti region of Ghana, 'Partnerships for Health Reformplus' (PHRplus) helped mutual health organisations get started and they also worked with the Ashanti King to design a Regional Fund to provide technical assistance with a view to potentially subsidising membership for the poorest to increase their access to tertiary care (Apoya, 2002). This shows the role of Chiefs and traditional leadership in the promotion of the mutual health organisations (MHOs) in Ghana.

A nationwide survey conducted in 2001 identified and recorded 47 mutual health organisations (Kankye *et al.*, 2001; Atim *et al.* 2001a, 2001b, 2001c). By the year 2004, the number had increased to as many as between 160 and 170 (Apoya, 2003; Bennett, 2004). The number of people who were accessing health care through mutual health organisations ranged from 400,000 to 500,000, which represents 59 per cent of the membership in the informal sector population of Ghana (Apoya, 2003). They have their own constitutions and have the ability to decide which health providers they would like to deal with. It was this unique feature that enabled them to grow within a short time (Apoya, 2003). Basically, two types of community health insurance schemes (CHIS) or mutual health organisations (MHOs) could be identified during this time in Ghana:

1. Schemes owned and managed by health providers,
2. Schemes organised and managed by the communities themselves who then contracted the service providers for a fee (Atim, 1998, 2001; Atim *et al.*, 2001a, 2001b, 2001c).

This success led to the proposal that the solution, in the short to medium term, in financing a sustainable health care system for Ghanaians, especially the rural population, lay in decentralised community-based health insurance schemes (Apoya,

2002; Danida, 2002a, 2002b). The administrative structure, roles and responsibilities of management of the pre-NHI 2003 MHOs are described in appendix A.

7.3. The NHI Act 650 and the Challenges for the Mutual Health Organisations

It would be recalled from chapter 6 that mutual health organisations were being explored to recreate the health financing system in order to meet the needs of the people in the informal sector economy before the Ghana National Health Insurance Scheme was introduced in 2004. Meanwhile, the National Health Insurance Act 650 (MOH, 2003d), specifies that district and municipal mutual health insurance schemes (DMMHIS) are to be established in all the political administrative districts and municipalities. They will operate as health insurance management groups and serve as third party health care purchasers for the respective communities. The financial management component of their roles is to serve as a conduit through which funds accumulated are to be used to pay for community-based health services on behalf of the population in their area of operation (MOH, 2003d, 2004b). With this development, it is imperative that the influence of the NHI Act 650 on the operations of mutual health organisations in Ghana is critically examined vis-à-vis the institutional framework, financial viability and social dynamics (see chapters 9, 10 and 11).

7.4. Summary of the Chapter

This chapter has appraised the emergence and evolution of mutual health organisations, especially, before the National Health Insurance Act 650 was introduced with legislative instrument L.I. 1809 in Ghana in 2004 (MOH, 2003d, 2004b). It has been shown that the mutual health organisations phenomenon emerged when some international donor organisations collaborated with some communities to reveal the potential of these schemes to increase health care financial access to people in the informal sector of the economy. The next chapter presents the research methodology.

CHAPTER 8

RESEARCH METHODOLOGY

8.0. Introduction

This chapter presents a comprehensive account of the processes undertaken to collect empirical data to address the objectives of the study. Thus, the field study was designed to solicit information from certain individuals, groups of people and organisations in Ghana (see appendix T). The chapter is divided into six (6) sections. Section one (1) presents a brief argument about the use of philosophical paradigm in management research and justifies the researcher's position. Section two (2) also analyses the differences between quantitative and qualitative research methodologies. The premise is that both qualitative and quantitative research methodologies have been combined in the study. The qualitative research methodology aspect of the study has been explained and justified as well. Section three (3) discusses and justifies the research design and strategy used in this study. Here, the sampling strategies, case study, selection of studied organisations and research participants, and how access was negotiated have been explained. Section four (4) discusses the field study and data collection strategies. Here, the methods used for gathering and analysing empirical data for this study have been explained and justified. Section five (5) presents the quantitative research methodology aspect of the study. This explains how the financial, institutional and social viability indicators were measured to support the qualitative analysis. Section six (6) is a brief summary of the chapter.

8.1. Philosophical Paradigm

The discussion in this section informs the researcher's sense of awareness of the different perspectives in social science research, especially, in business and management research disciplines. The statement of the researcher's philosophical assumption as interpretivist is to aid the reader or the assessor to understand and use the appropriate criteria to examine the arguments in this study (see Johnson *et al.*, 2003). Some researchers suggest that it is unwise to conduct research without an awareness of the philosophical and political issues that lie in the background (Easterby-Smith *et al.*, 2002). Johnson *et al.* (2003), argue that there is diversity amongst the schools of thought, which has come about as a result of competition. This has produced distinctive research assumptions, which have equally sought to

legitimise as well as appropriate different sets of evaluation criteria. These have their attendant methodological commitments and key research questions, which portray them as engaged in philosophical struggles on the basis of ontological status of human behaviour and epistemology (Johnson *et al.*, 2003; Clark, 2004).

Some researchers have deliberated on three broad research paradigms: positivist, ~~interpretivist~~, and critical (see Orlikowski and Baroudi, 1991; Mingers, 2001). Silverman (2006), describes positivism as: 'a model of the research process which treats 'social facts' as existing independently of the activities of both participants and researchers' (p.306). To the positivist, truth in business and management research is based on three basic roots. The positivist rationalists believe that truth about knowledge may be available to the contemplative mind. The positivist empiricists assume that truth is based on observation as knowledge could only be established by accessing the world through our senses. They are not concerned with measuring the meaning of situations to people because they cannot be measured in a scientific and objective manner. Thus, the empiricist tradition aims to make truth- which is claims about reality - objectively assessable (Johnson and Duberley, 2000).

Alvesson and Deetz (2000), use the term neo-empiricist for those management researchers who place reliance upon qualitative empirical data as capable of ensuring objective truth in a correspondence sense, yet who simultaneously reject falsificationism (see Putnam *et al.*, 1993; Denzin and Lincoln, 1994; Johnson *et al.*, 2003). Silverman (2006), explains that post-modernism is: 'a contemporary approach which questions or seeks to deconstruct both accepted concepts such as the 'subject' and the 'field' and scientific method' (p.306). Recently, postmodernism has attracted the interest of management researchers and a new form of qualitative management research has emerged where suitably reformulated ethnographies have become the language of postmodernism. This perspective is accused of criticising the basic tenets of truth without necessarily providing any alternatives (see Kondo, 1990; Giroux, 1992; Linstead, 1993a, 1993b; Ely, 1995; Johnson *et al.*, 2003). Thus, 'postmodernism is both an analytical model and a way of describing contemporary society as a pastiche of insecure and changing elements' (Silverman, 2006:306).

Relating their study to information systems, Orlikowski and Baroudi (1991), found that between 1983 and 1988, about 97 per cent of research articles applied a positivist framework. However, they argue that there has been increasing interest in, and commitment to, a range of nonpositivist approaches. The nonpositivist approach is sometimes called post-empiricist, which focuses on interpretivism (Orlikowski and Baroudi, 1991; Mingers, 2001). The philosophical assumption of this researcher is explained below.

8.1.1. Researcher's Perspective: Interpretivist

Johnson and Duberley (2000), assert that the method of investigation used depends on the investigator's assumptions about society. Hence, this researcher's philosophical assumption is based on the interpretivist perspective. Silverman (2006), uses the word constructionist in place of interpretivist. Interpretivists consider that reality is not objectively determined, but it is socially constructed (see Husserl, 1965; Kelliher, 2005). The fundamental postulation is that when people are placed in their social contexts, it would provide a greater possibility to appreciate the insights they have of their own actions (see Hussey and Hussey, 1997; Kelliher, 2005).

In essence, interpretivism encourages the worth of qualitative data in search of knowledge (Kaplan and Maxwell, 1994; Kelliher, 2005). This is a research concept which is concerned with the distinctiveness of a meticulous condition, which also contributes to the original exploration of appropriate understanding (Myers, 1997; Kelliher, 2005). Mingers (2001), observes that the interpretive analysis imposes no external categories, but aims to surface and understand the meaning of the various interactions to the individual participants themselves within their particular organizational context. This tries to 'establish an insider's rather than outsider's view' (Mingers, 2001: 255). Some interpretive methods that were applied by Mingers include: ethnography, hermeneutics, participant observation, and grounded theory (Mingers, 2001).

8.1.2. Justification for the Researcher's Perspective

The interpretivists' approach was chosen since it assisted with the choice of method for the investigations in this research. This perspective assumes that:

...the socially situated researcher creates, through interaction, the realities that constitute the places where empirical materials are collected and analysed, where the interpretive practices of qualitative research are implemented...these practices are methods and techniques for producing empirical materials as well as theoretical interpretations of the world...(Denzin and Lincoln, 1998:35)

This perspective also takes into account the importance of language in discussions. In Ghana, language plays a significant part in day-to-day discourse. Certain words are usually used with peculiar historical or proverbial meaning, which can only be understood by people with 'proverbial minds'. It is only through the use of hermeneutics that meaning could be derived from or attributed to such spoken words. Traditional rulers always use proverbs and figurative speeches, which are then translated by linguists to the audience. 'Truth' is derived from such spoken words without questioning.

Moreover, folktales or storytelling, popularly termed 'anansesem', which literary means 'spider's story', play a remarkable role in discourse and this had to be culturally understood by the researcher. This perspective fulfils the idea that the hermeneutic route to understanding is through the iterative use of patterns, metaphors, stories, and models to amplify understanding. Thus, people actually dialogue with the phenomenon to be understood, by asking what it means to those who create it (Bentz and Shapiro, 1998; Ezzy 2002). As a Ghanaian employed in healthcare administration, the researcher had had a substantial understanding of the political, economic, social and value systems of different groups in Ghana and is able to appreciate the different views and perceptions held by people in the communities. This ensures that wrong perceptions and biases are minimised. A brief explanation of quantitative and qualitative research methodologies is given below.

8.2. Research Methodology: Debate between Quantitative and Qualitative

This part explains why both qualitative and quantitative research methodologies were combined in this study. Silverman (2006), describes research methodology as the choices researchers make about the cases to be studied, methods of data gathering and forms of data analysis, in planning and executing a research study. There appears to be an argument regarding the choice of research methodology when conducting any

research. It is generally between the qualitative and quantitative methods (Silverman, 2006). Their differences could be seen in the methods applied to gather empirical data as shown in table 8.1. However, these can be combined in undertaking a research because:

...there is no reason why qualitative researchers should not, where appropriate, use quantitative measures. Simple counting techniques, theoretically, derived and ideally based on participant's own categories, can offer a means to survey the whole corpus of data ordinarily lost in intensive, qualitative research (Silverman, 2006:37)

Table 8.1 shows how the different methods are applied by both quantitative and qualitative researchers.

Table 8.1: Different Methods used by Quantitative and Qualitative Research Methodologies

Methodology		
Method	Quantitative Research	Qualitative Research
Observation	Preliminary work, e.g. prior to framing questionnaire	Fundamental to understanding another culture
Textual Analysis	Content analysis, i.e. counting in terms of researchers' categories	Understanding participants' categories
Interviews	Survey research: mainly fixed-choice questions to random samples	Open-ended questions to small samples
Audio and video recording	Used infrequently to check the accuracy of interview records	Used to understand how participants organise their talk and body movements

Source: Silverman, 2006:12

Importantly, using the interpretivists' paradigm, different methodologies can be employed in any particular study: it provides flexibility for the researcher. Silverman suggests: 'the choice between different research methods should depend upon what you are trying to find out' (Silverman, 2006:25). This is why the study engages both qualitative and quantitative methodological approaches. While the qualitative research methodology aspect of the data collection and analysis in this study is discussed below (8.2.1 to 8.4.6), the quantitative research methodology aspect of the data collection and analysis is discussed later (see 8.5 to 8.5.3).

8.2.1. Qualitative Research Methodology

This part explains and justifies qualitative research methodology, including its limitations. Qualitative research is defined by Denzin and Lincoln (1998), as multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This methodology was adopted in this study because it is partly descriptive and seeks to document the phenomena of interest: mutual health organisations. This research methodology gives researchers the opportunity to study the research participants in their natural environments and allows research participants to actively create meaning based on the accounts of the world they are a part of (see Holstein and Gubrium, 1997; Silverman, 2006).

The qualitative research methodology helped this researcher in gaining much understanding of the phenomenon under study, as the mutual health organisations are located in the communities where there is little dilution of their cultural protocols in terms of exposure to modern cultural adulteration. Hence, the researcher was able to locate in the case study setting, which helped to make useful sense of, as well as enabled an interpretation of the mutual health organisations phenomenon with regard to its meaning to the people who patronise it (Denzin and Lincoln, 1998).

Nevertheless, whilst interpretive or qualitative research is acknowledged for its significance in providing context-specific insight, outcomes are frequently criticised in respect of issues such as: 'validity, reliability and the ability to generalise, referred to collectively as research legitimisation' (Kelliher, 2005:123). These issues are augmented in the single case situation by some researchers (see Eisenhardt, 1989; Perry, 1998; Kelliher, 2005). One basis upon which qualitative research is usually criticised is reliability. Reliability refers to the consistency or stability of a measure (Kelliher, 2005). Denzin (1970), argues that multiple and independent methods have to, if arriving at the same conclusions, have greater reliability than a single methodological approach to a problem. That is, the amalgamation of methodologies in the study of the same phenomenon is known as triangulation (Denzin, 1970; Kelliher, 2005).

Using an interpretive perspective, some researchers recommend that the researcher needs to begin with a general research question, create systematic data collection and

ensure case access to create strong triangulated measures (Eisenhardt, 1989; Kelliher, 2005). Other researchers also argue that qualitative research conclusions can be reinforced through this approach by interviews and documentary sources in a single case (see Hammersley and Atkinson, 1983; Kelliher, 2005).

Moreover, qualitative research is criticised for its lack of validity. Some researchers explain that qualitative research depends on the production of concrete descriptive data, so that the researcher guides the reader to an understanding of the meaning of the experience under study (Stake, 1995; Kelliher, 2005). Other researchers also argue that validation is an interpretive understanding of truth (Angen, 2000; Kelliher, 2005). Therefore, Denzin and Lincoln (2003), argue that triangulation is not a strategy of validation, however, it is a substitute to validation (see Denzin & Lincoln, 2003; Kelliher, 2005). Other researchers also suggest that by using multiple data sources, researchers can establish identifiable chain of evidence, and ensure that the draft is reviewed by the research participants in order to strengthen validity (Remenyi *et al.*, 1998; Kelliher, 2005).

Another criticism of qualitative research is based on the issue of generalisability, which refers to the extent to which the conclusions of the enquiry are more generally applicable outside the whole story of the situation studied (see Robson, 2004; Kelliher, 2005). In terms of qualitative research, the research goal is to provide a case description; including data collection procedures that would allow the reader to repeat the research process in another case (see Kidder and Judd, 1986; Vaughan, 1992; Kelliher, 2005). Other researchers are of the view that even though a single case may not be able to provide adequate proof to make strong generalisations, it can help to establish the existence of a phenomenon, which will be adequate for the purposes of exploratory research (see van Maanen, 1988; Remenyi *et al.*, 1998). In consequence, this study may be generalisable to theoretical propositions, which will help create a distinction between analytical and statistical generalisability (see Yin, 1984; Yin, 2003; Kelliher, 2005). Thus, theory triangulation will help to enhance the validity of the empirical data collected (see Denzin, 1970). Further justification of the validity and reliability of the entire study has been discussed in chapter 12 under limitations to the study. The research design and strategy is explained below.

8.3. Research Design and Strategy

This part explains the research design and strategy used to collect empirical data for the study. The empirical research was designed based on the philosophical assumption underlying the study. Some researchers explain that qualitative research design is a rough sketch to be filled in by the researcher as the study proceeds (Frankel and Devers, 2000a, 2000b; Devers and Frankel, 2000). Devers and Frankel (2000), explain that this can take place after the research questions have been formulated and resources secured. In this study, this was considered necessary because the researcher had to understand and consider the distinctive characteristics of the research participants and settings in which they are located so as to be able to solicit the needed perceptions to understand the phenomenon underlying the mutual health organisations in Ghana (see appendix T).

8.3.1. Sampling Strategies

Some researchers describe three of the most common sampling methods used in qualitative research to include: purposive sampling, quota sampling, and snowball sampling (Mack *et al.*, 2005). However, the purposive sampling method was used for selecting sites and the subjects (research participants) for this study. This was used to enhance this researcher's understanding of selected individuals or groups' experience (s) so as to develop theories and concepts (Devers and Frankel, 2000). Purposive sampling strategies were considered appropriate to this study instead of random sampling method usually applied in quantitative research (Devers and Frankel, 2000), or quota sampling method (Mack *et al.*, 2005). However, during the field study, it became necessary to adopt snowball sampling method (see Yin, 1984). The justification is that the researcher needed to ensure that organisations, groups and individuals who could provide the greatest insight into the mutual health organisations phenomenon were selected so as to answer the research questions (see Miles and Huberman, 1994; Devers and Frankel, 2000).

The research framework developed to aid the researcher in identifying the research participants and sources of data is shown in appendix T. While the rationale for selecting the study organisations (see 8.3.3 to 8.3.3.5 and research participants (see 8.3.4 to 8.3.4.5) has been discussed under each sub-title respectively, detailed questions used during the data collection stage based on the semi-structured interview

format have been outlined in the interview schedules (see appendices O-S). The case study approach is discussed below.

8.3.2. Case Study

This part describes and justifies why the case study or multiple case studies approach was adopted; selection of studied organisations; research participants; and how access was negotiated. A case study has been defined by different researchers (see Mitchell, 1983; Stoecker, 1991; Gomm *et al.*, 2000; Stake, 2000; Yin, 1983, 1994; Rhee, 2004). Yin (1994), defines it as an empirical inquiry, which examines a current phenomenon within its 'real-life context', principally, when the boundaries between phenomenon and context are not clearly evident. This relies on multiple sources of evidence (Yin, 1994:13). Other researchers also explain that a case study refers to research that investigates a few cases in considerable depth (see Gomm *et al.*, 2000; Rhee, 2004).

It is agreed among some researchers that a case study is not a particular method but a strategy (Stoecker, 1991, Yin, 1994; Rhee, 2004). Whereas Stake (2000), shows the view that a case study is not so much a methodological choice but a choice of what is to be studied, Yin (1994), also explains that a case study should not be confused with qualitative research (see Yin, 1994; Stake, 2004; Rhee, 2004). Even as Gomm *et al.* (2000), contend that a case study implies collection of unstructured data and qualitative analysis of data, other researchers, also imply that a case study can employ the best of both quantitative and qualitative methods (Yin, 1994; Stake, 2000; Stoecker, 1991; Rhee, 2004). Stoecker (1991), also indicate that case studies allow researchers to explore different outcomes of general processes suggested by theories depending on different contexts (see Stoecker, 1991; Rhee, 2004).

Marshall and Rossman (2006), explain that case studies are often used in studies focusing on society and culture in a group, a program, or an organization and involve engagement in the group. Case studies may require multiple methods like interviews, observations, document analysis and survey. Therefore, the case study strategy was adopted in this study since it has the strength and the ability to deal with a range of evidence collected from documents, interviews, and observations (see Walton, 1992; Rhee, 2004). Specifically, multiple case studies strategy was used to gather primary data as it was the best option to help the researcher to produce the best concepts from

different settings and population groups to explain the findings of the study (see Yin, 1984, 1994). Moreover, this research strategy is considered appropriate as it allows for in-depth learning of the mutual health organisations, which are developed out of community initiatives. This also provides grounds for developing new knowledge about how local and community initiatives could be harnessed to support formalised structures by revealing their applicability in health financing. How the purposive sampling strategies were applied to select the four mutual health organisations for in-depth case study in this research have been explained below.

8.3.3. Selection of Studied Organisations

This part explains and justifies the criteria used for selecting the four mutual health organisations used for the case study in Ghana. There were one hundred and thirty-four (134) district-wide and municipal-wide mutual health insurance schemes established under the National Health Insurance Act 650 (MOH, 2003d, 2004b), at the time of the empirical study between November, 2006 and January, 2007. Therefore, defined criteria were adopted in selecting four operating mutual health organisations for case studies as explained below (see also appendix B).

8.3.3.1. Regional Consideration

Ghana has ten (10) political administrative regions. There were one hundred and thirty-eight (138) district and municipal Assemblies established nationwide at the time of the study (refer to chapter 5). These were to increase to 165 in 2008 (Adjei-Darko, 2007). There were 170 district and municipal Assemblies established by March, 2010 (Ghana Districts, 2010). Therefore, one criterion was to consider mutual health organisations in relation to how they are located regionally. The four mutual health organisations are located in four (4) out of the ten (10) administrative regions.

8.3.3.2. Geographic Location

Due to logistics constraints, attempts were also made to consider mutual health organisations that were accessible. All the four mutual health organisations are easily accessible by means of transportation available and in terms of geographical proximity to each other. Whilst two (2) of the mutual health organisations are located in the northern sector, the other two (2) are also located in the southern sector of Ghana (see Asante and Gyimah-Boadi, 2004).

8.3.3.3. Duration of Establishment

The selected mutual health organisations would have been in operation for two to five years. All the four mutual health organisations have been in operation between two (2) and fifteen (15) years in terms of existence, as indicated in appendix B.

8.3.3.4. Size of the Mutual Health Organisation (s)

Selection was based on the size of membership of the mutual health organisations using urban and rural criteria. All the four mutual health organisations have more than ten thousand (10,000) members and are either urban or rural based, as shown in appendices D1 to D4.

8.3.3.5. Founders' Background: Pre and Post NHI 2003 MHOs

Another criterion adopted was that for purposes of clarity, the mutual health organisation(s) should have been established and operated before the coming into force of the National Health Insurance Act 650 in March 2004 (MOH, 2003d; Abbey, 2003). This is described as a 'pre-NHI 2003 MHO era' (refer to chapter 7). Again, they should have been established and operated upon the implementation of the National Health Insurance Act 650 since March, 2004 (MOH, 2003d; Abbey, 2003). This is also described as a 'post-NHI 2003 MHO era' (see chapter 9). That is, selection was based on the background of the initiators, founders or promoters of the mutual health organisations.

Some of the mutual health organisations in Ghana were set up initially by individual health care entrepreneurs, health institutions, religious institutions led by the Diocesan Bishops and traditional rulers of the communities (refer to chapter 7). Thus, two (2) mutual health organisations in this study were set up initially by their respective communities in collaboration with the health institutions and the Diocesan Health Committees but were handed over to the district Assemblies when the NHI Act 650 was introduced in 2004. Other mutual health organisations were established by their respective district and municipal Assemblies (see chapter 9).

Thus, two (2) of the mutual health organisations in this study were established by their respective district and municipal Assemblies when the NHI Act 650 was introduced in 2004. Attempts are made to identify the sources of motivation from the

patrons, sponsors, and promoters and how these influence their desire and decision to change. Kyeremeh (2001), suggests one of the pre-requisites of a viable mutual health organisation to be: 'people's confidence in the scheme' and 'in the initiators' (p.16). How the purposive sampling strategies were applied to select the research participants in this study have been explained below.

8.3.4. Selection of Research Participants

This part also explains and justifies how the interviewees or research participants were selected in Ghana for this study. The following research participants were selected from within the localities of the four (4) mutual health organisations in the case study regions as well as stakeholders within and outside these locations for some specific reasons, as explained below.

8.3.4.1. Policy Makers and Stakeholders

In order to gain a better understanding of the mechanisms of health financing in Ghana and also to investigate the level of understanding of policy makers regarding health insurance in general and mutual health organisations in particular, interviews were conducted with officials of the Ministry of Health, Ghana Health Service, National Health Insurance Council and Authority, international donor organisations, local non-governmental organisations (NGOs), traditional rulers, opinion leaders, bishops, politicians, technocrats and other stakeholders in the mutual health organisations and health insurance environment.

This provided the background knowledge about the motivation for the introduction of the National Health Insurance Act 650 and related matters (MOH, 2003d). This supports Kyeremeh's (2001), argument that enabling factors for a successful mutual health organisation are: 'a favourable government policy and cooperation of key stakeholders' (p.16). Twenty-two (22) officials from such identifiable organisations were interviewed. Different strategies were applied to select these policy makers as well as to obtain access [(see 8.3.5: negotiating access and appendix O for the interview schedule)].

8.3.4.2. Health Managers and Personnel

Originally, most of the mutual health organisations did not have any contractual arrangements with health care institutions. However, the National Health Insurance Act 650 makes it imperative for all health insurance schemes in the country to sign contracts with the health care providers they work with (MOH, 2003d, 2004b). Interviews were conducted with directors, managers, administrators and personnel of some healthcare institutions within the proximity of the four selected mutual health organisations. The focus was on their perception of the potential contribution of mutual health organisations to enhancing efficiency, utilisation, quality health care delivery and related matters. A total of twelve (12) officials from these institutions were interviewed [(see 8.3.5: negotiating access and appendix P for the interview schedule)].

8.3.4.3. Staff of the Mutual Health Organisations

In each of the four case study mutual health organisations, the core members of the management teams and Board of Directors were interviewed. The focus was on their knowledge, awareness, familiarity as well as the influence of the National Health Insurance Act 650 (MOH, 2003d), on their operations, including assessment of how they were responding to the changes in their environment. It was also meant to examine the administrative and existing financial management practices. A total of four (4) from all the four (4) mutual health organisations were interviewed [(see 8.3.5: negotiating access and appendix Q for the interview schedule)].

8.3.4.4. Contributors of the Mutual Health Organisations

Contributors or the insured members of the mutual health organisations were interviewed. The focus was on their perception of the performance and the effectiveness of the mutual health organisations to meeting their health care financing needs. Participants were identified using different strategies, including the registers of the mutual health organisations. Ten (10) contributors of each of the four selected mutual health organisations were interviewed and the total number was forty (40) [(see 8.3.5: negotiating access and appendix R for the interview schedule)].

8.3.4.5. Non-contributors of the Mutual Health Organisations

Some non-contributors or uninsured members in the communities were interviewed. These are people who have not been able to register with the mutual health organisations for different reasons. The focus was on their perception of the viability of mutual health organisations as a mechanism to increasing their financial access to health care. It was also to unearth the reasons for their non-enrolment and to find out how they intend to register. Five (5) non-contributors from each of the vicinity of the four mutual health organisations brought the total number to twenty (20) [(see 8.3.5: negotiating access and appendix S for the interview schedule)].

Approximately, ninety-eight (98) participants contributed to the entire study as detailed in appendix N. How access was negotiated is explained below.

8.3.5. Negotiating Access to Studied Organisations and Research Participants

This part explains and justifies how access to the case study mutual health organisations, stakeholder organisations and the research participants was negotiated. Some researchers argue that the researcher is the research instrument and almost all qualitative research approaches require the development, maintenance and eventual closure of relationships with research subjects and sites (Frankel and Devers, 2000a; Devers and Frankel, 2000). That is, there is the need to develop and maintain good relationships, which are important for effective sampling and for the credibility of the research (Devers and Frankel, 2000).

A number of steps were taken regarding access. The research proposal was submitted to the Sheffield Business School's (SBS) Research Ethics Committee before the commencement of field work in Ghana. A formal letter of introduction from the Director of Studies (supervisor) was posted to the selected organisations. Copies were taken along to be tendered in as evidence in cases where they might have been misplaced or could not reach on time due to postal uncertainties.

Devers and Frankel (2000), explain that accessing existing social networks can be useful for obtaining basic information and facilitating entrée: this ensures that a high level of trust is maintained during the study. Informal access to some of the

organisations and the case study mutual health organisations in Ghana had already been arranged due to the researcher's previous working relationships with them. However, it is a practice under the Ghana Civil Service (GCS) procedural code of practice for Civil Servants (CS) to observe confidentiality of vital information. Staff will only be prepared to speak to a researcher who has been introduced by someone higher in the organisational hierarchy. This culture has been inculcated into the emerging mutual health organisations (see Analoui, 1998). Consequently, attempts were also made to ensure that the top echelon of the organisations was aware and assurance was given to the prospective participants concerning confidentiality and anonymity. Financial statements of the organisations were released for analysis subject to agreement to maintain confidentiality (see 8.5.1.1.1).

Since the researcher had worked at the headquarters of the Ministry of Health and Ghana Health Service, it was easy to identify policy makers in charge of the key directorates and divisions. However, the procedure is that a letter had to be sent to the Director General of the Ghana Health Service to seek access and permission to interview these officials. In this case, permission was granted. The Ministry of Health and Ghana Health Service have instituted Local Research Ethics Review Committee to screen researchers who use health facilities and institutions for research of any kind. An application was made to this committee for consideration and approval accordingly. Research participants who willingly agreed to participate in the study were asked to sign a respondent's consent form, which had been approved by this committee as shown in appendix C. However, those who did not have time to contribute were not coerced into participating in the study.

Moreover, the researcher had had previous working relationships with officials of the international donor organisations and the non-governmental organisations (NGOs) in the mutual health organisations environment in Ghana. Telephone conversations as well as email correspondences were made to seek their consent to participate in the research before the letters were posted to them. Letters were also posted to all the District Directors of Health Services, District and Municipal Chief Executives, District and Municipal Co-ordinating Directors as well as the managers and administrators of the health institutions that participated in this study. The researcher was also introduced to the traditional rulers, opinion leaders, bishops and political

activists in the communities by either the scheme managers or selected agents of the mutual health organisations.

It is important to note that usually, researchers have to negotiate access by securing permission from 'gatekeepers' as the understanding of gatekeepers' views is critical for 'negotiating and maintaining access; and maintaining the integrity and credibility of the research' (Devers and Frankel, 2000:266). Ghana is a heterogeneous country with distinct tribal categories. There are various languages and dialects spoken by its people, although English language is accepted as the official language (see Kuyini, 2010; Khalid, 2010; 'GNA', Monday, 5 April, 2010).

Therefore, in some of the communities where the spoken language was a barrier between the researcher and some of the research participants, it was essential that a member of the community, mostly an agent of the mutual health organisation, was identified by the scheme manager to accompany the researcher to visit and speak to the research participants. Fifteen (15) research participants were interviewed by this method. In as much as this strategy was effective, it had its own limitations. The agent had to translate the questions from English language to the local dialect of research participants and vice versa. Not only was this time consuming, a lot of substance in the message relayed was lost in-between the communication channel or translation. A similar approach was adopted by other researchers (Musau, 1999; Poletti *et al.*, 2007).

8.4. Data Collection: Field Study

This section explains how the field study was conducted in Ghana between the months of November, 2006 and January, 2007. The methods of data collection within the qualitative research methodology have been explained. Some researchers argue that the choice of methods for a study is based on the purpose of the study, research questions and resources available to the researcher (see Frankel and Devers, 2000a; Devers and Frankel, 2000). The research framework: analytical and data collection plan in appendix T, outlines the processes and sources of data. The research method is explained below.

8.4.1. Research Method(s)

This part describes and justifies the appropriate research methods applied in the data collection based on the outline within the qualitative research methodology as shown on table 8.1 (refer to p.122). Research method may be defined as specific techniques used by researchers to gather empirical data. These include quantitative techniques like statistical correlations, observation, interviewing and audio recording (Silverman, 2006). Silverman (2006), identifies four major methods used by qualitative researchers as: 'observation, analysing texts and documents, interviews and recording and transcribing,' and notes that these are often combined (p.11). Each of these four domains of qualitative research has distinct advantages and disadvantages (see Frankel and Devers, 2000a; Devers and Frankel, 2000).

Mack *et al.* (2005), argue that the three most common qualitative methods are participant observation, in-depth interviews, and focus groups. They explain that participant observation is appropriate for collecting data on naturally occurring behaviours in their usual contexts; in-depth interviews are best for collecting data on individuals' personal histories, perspectives, and experiences; and focus groups are useful in obtaining data on the cultural norms of a group and in generating general ideas about issues of concern to the cultural groups or subgroups represented (Mack *et al.*, 2005). Primary data was gathered through interviews, as explained below.

8.4.2. Interviews

This part describes how interviews were used to gather primary data for this study. It justifies why in-depth and semi-structured types were used, instead of administration of questionnaire, as in quantitative research methodology (Silverman, 2006). Berry (1999), explains that interviewing is a key method of data collection. Kvale (1996), argues that even as the research interview may not lead to objective information, it can help capture many of the subjects' views on something and explains why the basic subject matter consists of meaningful relations to be interpreted. Kvale further argues that the interview is neither an objective nor a subjective method since its core is intersubjective interaction (Kvale, 1996).

There are different approaches to using interviews to collect primary data, including 'an open-ended interview study' (Silverman, 2006:17). While some researchers

identify nine types as structured interview, survey interview, counselling interview, diary interview, life history interview, ethnographic interview, informal or unstructured interview, and conversations (see Hitchcock, 1989; Berry, 1999), others group interviews into four types: structured interview, unstructured interview, non-directive interview, and focused interview (see Cohen and Manion, 1994; Berry, 1999). Other researchers also suggest different approaches to conducting qualitative interviews, which include informal conversational interview, general interview guide and standardised open-ended interview (see Patton, 1987; Kvale, 1996; Berry, 1999).

This study adopted a personal or face to face in-depth interviews approach with the research participants in collecting empirical data, instead of focus group discussion (Mack *et al.*, 2005). Berry (1999), explains that in-depth interviewing is a type of interview which researchers use to obtain information so as to achieve a holistic understanding of the interviewee's point of view or situation. The interviews were also semi-structured. This strategy was appropriate because it offered the participants the opportunity to explain their views on important issues as well as describe reality as they deemed fit while the researcher provided the necessary promptings.

The choice of face to face in-depth interviews and the semi-structured interview approaches also correspond with the researcher's philosophical assumption as interpretivist (Kaplan and Maxwell, 1994; Kelliher, 2005). This permitted the researcher to derive understanding from the perspective of the respondents, as the researcher actively engaged the interviewees in the construction of meaning. The focus was particularly on how the interviewees constructed their narrative of events, people using their own dialects and turn-by-turn constructed meaning (Silverman, 2006). A similar approach had been applied in studies of community health insurance schemes (see De Allegri *et al.*, 2006; Poletti *et al.*, 2007).

The semi-structured interview schedules are shown in appendices O-S. Generally, based on the aims, objectives and questions of this study (refer to chapter 1), the semi-structured interview schedules were designed within a framework, which sought to find answers to specific questions regarding the financial, institutional and social viability of the mutual health organisations and how these could be harnessed to ensure their overall sustainability in the long term (refer to 8.3.4 to 8.3.4.5 for specific

reasons why the research participants were selected). The overall framework within which the interview schedules were developed was to find answers to these questions:

1. Who are the key stakeholders in the formulation and implementation of policies, including health financing (NHI Act 650) from the national through to the community levels of governance?
2. What is the influence of the NHI Act 650 on the mutual health organisations with regards to their operations, improving financial access to healthcare and enhancing equity for their members in the communities as well as the entire country?
3. How are the mutual health organisations operating to ensure their own financial viability vis-à-vis the effect of institutional and social viability issues on their performances, from the national through to the community levels?
4. What are the perceptions, understandings and aspirations of the entire population of the MHOs/NHIS and how they are getting involved in these programmes?

In Ghana, different locations present different opportunities such that one particular method of data collection cannot be applicable to all settings. Therefore, suitable locations were adopted and techniques were applied in gathering the empirical data (see Denzin and Lincoln, 1998), as described below.

8.4.2.1. Hospital Exit Interviews

The study assessed the perception and satisfaction of contributors or insured members about the services they receive from the mutual health organisations through the health care facilities as well as ascertain their willingness to continue their membership. Additionally, the perceived financial burden faced by the non-contributors or uninsured due to their inability to join the mutual health organisations

was also assessed. These were done through hospital exit interview technique, which was applied in similar studies (Mariam, 2003). Permission was sought from the hospital authorities before the researcher was located at vantage points within the hospitals. Contributors (insured) and non-contributors (uninsured) of the mutual health organisations were identified by the type or colour of their hospital attendance cards. Clients' consent to participating in the study was first and foremost sought after they had received their health care services.

8.4.2.2. Snowball Sampling Method

Another relevant technique was the use of snowball sampling method (see Yin, 1984). This may be explained as a research strategy where prospective research participants are identified and introduced to the researcher by previous participants who already know them. This was applied in the communities where interview participants willingly gave names and contact house addresses of other contributing or non-contributing members for the researcher to follow up on them.

8.4.2.3. Office Situation

The interviews with the officials of the stakeholder organisations and policy makers, managers of the mutual health organisations, health directors, managers and administrators of the health institutions, District and Municipal Co-ordinating Directors and Chief Executives of the district and municipal Assemblies were held at their respective offices. Organising the interviews outside official hours was not possible. However, there were interruptions by other members of staff and visitors. There were also intermittent telephone calls, which caused a lot of pausing in-between discussions.

8.4.3. Participant Observation

This part also explains how participant observation, as another method of qualitative research methodology, was applied (Silverman, 2006). The researcher had the opportunity to join a congregation of a religious denomination, which was operating a faith-based mutual health organisation, to observe how the congregants contributed towards the mutual health organisation during Church service. Access was granted by the Lay Chairman of the Church who was the Administrator to the Bishop of the

Diocese. This provided first hand learning experience regarding how information about the mutual health organisation and the National Health Insurance Scheme was disseminated. The researcher participated in the Church service and made a financial contribution to the annual harvest in aid of the construction of a Church building. A similar method was also applied by other researchers (Musau, 1999).

8.4.4. Audio Recording

Audio recording is another method used in qualitative research methodology (Silverman, 2006). A digital voice recorder, which groups recorded voices into folders, was used in the data collection. This enabled the interviews to be tape-recorded. The interviews lasted between ten (10) minutes and two (2) hours depending on the contributions by the participant and emerging issues. The recorded voices were played back immediately to the research participants for the necessary clarifications. Transcription was done with Microsoft word application, which provided a protocol for the detailed analysis. The local dialects spoken by some of the research participants were translated into English language. The interview transcripts were emailed to some of the policy makers and managers who gave their emails addresses. A note was made to the effect that non-response meant acceptance or confirmation. All the transcripts emailed were confirmed by the recipients accordingly.

8.4.5. Documentary Analysis

This section explains how secondary data or documentary analysis as a method was conducted as part of the qualitative research methodology (Silverman, 2006). Silverman (1993), reveals that records are a potential goldmine for sociological investigation. Secondary data was gathered through documentary analysis for certain reasons. To be able to answer some of the questions and investigate the financial management and health insurance knowledge of the managers of the mutual health organisations, available records were reviewed to assess their educational backgrounds as shown in appendix F. The economic disparities of the regions relating to the capacity of the consumers to meet the costs required by a viable mutual health organisation, was reviewed. This was to get some idea of the income levels and

the economically active population (see appendix B). This revealed their capacity to contribute to a health insurance scheme. Furthermore, much of the information gathered through the interviews had to be validated to be able to draw a balanced opinion. Government statistics based on the Ghana Standard Survey prepared by the Ghana Statistical Service was reviewed (GSS, 2005, 2008).

In addition, previous studies conducted on mutual health organisations accessed through journals and the internet, were critically reviewed to draw inferences and references to support the analysis of this study. Other sources of data were relevant government publications, policy documents from the Ministry of Health, Ghana Health Service, international donor organisations and non-governmental organisations (NGOs). Moreover, key documents obtained from the mutual health organisations were studied. These included annual reports, minutes of meetings of board of directors, administrative documents on membership trends, membership cards and registers or database. Where authority was granted, the accounting and book-keeping records, financial statements or reports of the mutual health organisations were provided to the researcher, which were reviewed to observe the cash inflows and outflows. How these were accessed have been described later (see 8.5.1.1.1). This approach was similar to what earlier researchers used (Atim, 1999; Hussain and Hoque, 2002). The data collection was also aided by notes taking, printing and photocopying of reports.

8.4.6. Analysing and Interpreting the Interview Data

This part explains how the interview data was analysed. Some researchers have argued that one major problem confronting researchers in the qualitative divide is what to do with vast volumes of data gathered through interviews. At some point the researcher must stop exploring and write, fixing her or his interpretations in ink with all the inherent political implications (Risser, 1997; Ezzy, 2002). Even though, there is no single set of rules for the analysis of data from qualitative research interviews (Hycner, 1985; King, 1995), there was the need to adhere to a set of principles. The interviews were analysed using suitable theories and techniques. For instance, Miller and Crabtree's four main approaches to data analysis categorised as: quasi-statistical, templates, editing and immersion or crystallisation (Miller and Crabtree, 1992; King,

1995), were applied. These were similar to the analytic techniques: pattern-matching, explanation-building, and time-series analysis suggested by Yin (1994).

This means that the interview transcripts were read over and over again where patterns and themes were developed based on frequently occurring issues raised by the interviewees. These were grouped and matched to draw the needed conclusions. On the basis of the interpretivists' or constructionists' paradigm, Silverman (2006), describes three ways in which social scientists interpret interview data using philosophical thoughts as positivism, emotionalism, and constructionism. The interpretative perspective was used in the data analysis because there was the need for thematic emphasis on understanding and interpretation (Bernstein, 1983; Lincoln, 1990). This was important as the ultimate aim was not to find out the 'truth' but rather look for meaning from the point of view of those who had access to information (Schwandt, 1998).

The researcher also reflected on his experiences, which conformed to the suggestion on reflexivity in management research by Johnson and Duberley (2000). All these techniques were applied so as to help identify the relevance of the themes and patterns which emerged from the interview data, as well as to build a robust story. This way, the bulk of evidence might show that contradictory evidence might not be valid (Denzin, 1970). Thus, the patterns and themes were allowed to emerge from the interview data / transcripts (see chapters 9, 10 and 11).

8.4.6.1. Codes for the Research Participants

The research participants are given some codes in the analysis as part of the anonymity and confidentiality requirements. The codes which are used to describe them in the analysis whenever they are quoted are shown in table 8.2. Thus, the table shows the abbreviations used for the research participants when they are quoted in the analysis (see chapters 9, 10 and 11). These have been explained below.

PMS: means an interviewee who is a policy maker, a politician, a chief, a community leader, an opinion leader, a clergy or a stakeholder.

HMP: means a health manager, health administrator or health personnel.

SMMHO: indicates a scheme manager, a member of the board of directors, or a staff of a mutual health organisation.

ADMHO-M: means a contributor or an insured member of the Aduana Mutual Health Organisation.

ADMHO-NM: denotes a non-contributor or uninsured person in the vicinity of the Aduana Mutual Health Organisation.

ASKMHO-M: means a contributor or an insured member of the Asakyiri Mutual Health Organisation.

ASKMHO-NM: means a non-contributor or uninsured person in the vicinity of the Asakyiri Mutual Health Organisation.

ASNMHO-M: indicates a contributor or an insured member of the Asona Mutual Health Organisation.

ASNMHO-NM: indicates a non-contributor or uninsured person in the vicinity of the Asona Mutual Health Organisation.

BRMHO-M: refers to a contributor or an insured member of the Biretuo Mutual Health Organisation.

BRMHO-NM: means a non-contributor or uninsured person in the vicinity of the Biretuo Mutual Health Organisation.

Table 8.2: Codes for the Research Participants

Participant	Code
Policy makers, politicians, community leaders, opinion leaders, clergy, stakeholders	PMS
Health Administrators and Health Personnel	HMP
Scheme Managers, Board of Directors and Staff of the Mutual Health Organisations	SMMHO
Members and non-members of Aduana Mutual Health Organisation	ADMHO-M ADMHO-NM
Members and non-members of Asakyiri Mutual Health Organisation	ASKMHO-M ASKMHO-NM
Members and non-members of Asona Mutual Health Organisation	ASNMHO-M ASNMHO-NM
Members and non-members of Biretuo Mutual Health Organisation	BRMHO-M BRMHO-NM

8.5. Quantitative Research Methodology

This section explains quantitative research methodology and justifies why it was used to support the qualitative analysis. Quantitative research may be explained as a research methodology which relies less on interviews, observations, small numbers of questionnaires, focus groups, subjective reports and case studies. This is much more focused on the collection and analysis of numerical data and statistics (Paranormality, 2009). Some researchers also explain that quantitative research is a type which uses a special language, which is similar to the ways in which scientists speak about how they explore the natural order: variables, control, measurement and experiment (see Bryman, 1988; Silverman, 2006). Thus, the quantitative aspect of this study involves how the financial, institutional and social viability indicators were calculated to support the qualitative analysis, as clarified below.

8.5.1. Measuring the Key Viability Indicators

This section explains how the key indicators used were measured. That is, some methods were used to calculate financial viability; institutional viability; and social viability to support the qualitative analysis (refer to chapter 3). The indicators suggested for measuring the viability of mutual health insurance schemes by the ANMC/BIT-ACOPAM/WSM (1996), which was considered to be the best practice in the evaluation of community financing and mutual aid movements in West and Central Africa were applied (Atim, 1999). These were similar to the indicators

proposed for East and Southern Africa by Cripps and a team of researchers (Cripps *et al.*, 2003).

8.5.1.1. Measuring Financial Viability

This part explains how financial viability is measured. As discussed earlier (refer to 3.2) the mutual health organisations have the responsibility to ensure that they achieve financial viability by undertaking assessment of their financial performances. There are ratios, which attempt to compare the various items on an organisation's balance sheet or receipts and payments also referred to as income and expenditure (Cripps *et al.*, 2003). They show its financial position in relation to its associated expenditure and can be used to project its future viability. Knowledge about these ratios enables the management to plan and prepare prudent budgets (Altman *et al.*, 1998; Matherlee, 1999; Wipf and Garand, 2008).

8.5.1.1.1. Access to the MHOs' Financial Statements

As indicated earlier, the financial statements used for the quantitative analysis were obtained from the four mutual health organisations as part of the documentary analysis method of data collection in Ghana between November 2006 and January, 2007 (refer to 8.4.5). It must be emphasised that these financial statements titled: 'income and expenditure' were printed off the computer system and issued to the researcher under an agreement to maintain anonymity and confidentiality.

Thus, the financial management or accounting system these mutual health organisations operate is based on income and expenditure. This is because the mutual health organisations are 'not-for-profit' organisations. They are intermediaries between their members and the health care providers contracted to deliver health care to their members (refer to chapter 3). Their sources of income are mainly from premiums and administration fees; National Health Insurance Fund (NHIF) and/or accrued interests on deposits and donations (see 9.2). Their expenditures cover mainly payment of health care claims to contracted health providers, administrative expenses among other incidental costs.

The financial statements or accounts of the four mutual health organisations had been approved by the board of directors as well as the general assembly. Whereas the 2005

financial statements (income and expenditure) were presented and approved by their respective boards and general assemblies in March, 2006, the 2006 financial statements were to be presented for approval in March, 2007. In this case, they were presented and approved. The financial statements are presented by the Scheme Managers as part of the MHOs' Annual Report during the Annual General Meetings (AGMs). This is not very detailed because the financial part of the report only indicates how much was accrued under 'income' and how much was expended under 'expenditure'. These were analysed using the financial viability model explained by Cripps *et al.* (2003), and the results shown in tables 8.4 to 8.7 and summarised in appendix H.

8.5.1.1.2. Limitations in the MHOs' Financial Statements

Whereas there was no problem with accessing these financial statements, there were few problems with the analysis or calculation of the financial viability ratios as presented in tables 8.4 to 8.7 and summarized in appendix H. Thus, the financial analyses in chapters 9, 11 and 12 were made against the background of certain limitations in the financial statements used. Although the income and expenditure statements were printed and issued to the researcher, these financial statements had not been audited at the time of the study, which was conducted between November, 2006 and January, 2007. The reason is that the four mutual health organisations are operating as central government institutions and are required to audit their accounts by the Ghana Audit Service staff (see MOH, 2003d, MOH, 2004b).

Although the Asakyiri MHO and Asona MHO were in the process of contracting private auditors or firms to audit their accounts for 2005/2006 financial periods, the Aduana MHO and Biretuo MHO saw this attempt as a drain on their resources due to high fees charged by private or chartered accountants. It must also be noted that these are community-based organisations which have been transformed into formalised organisations upon the implementation of the NHI Act 650 since 2004 (MOH, 2003d). They were still undergoing transition at the time of the study. They are operating within communities where there are problems with electricity supply, pipe-borne water, road networks and telephone communication networks: they lack basic social amenities (see GSS, 2005).

These explain why some of the ratios such as liquidity ratio and solvability ratio could not be calculated (due to non-availability of data, especially, balance sheets). Therefore, these together with other ratios such as ratio of subscriptions to expenditure and ratio of efficiency in collecting dues or rate of payment of dues, are analysed to explain the model or methodological limitations in their application in this study because of the lack of, or inadequate data as explained under the sub-titles in chapter 9. Consequently, the applicable ratios to this study are the ratio of coverage of expenses and ratio of operating costs to income. These have been used for the analysis in regards to the financial perspective on the performances of the four mutual health organisations (see chapters 9, 11 and 12).

8.5.1.1.3. Formula for Calculating Financial Viability Ratios

The financial ratios suggested by Cripps *et al.* (2003), have been explained in table 8.3 similar to what was used in earlier studies (Atim, 1999; Musau, 1999). The principal sources of data to be used include statement of income and expenditure or receipts and payments and balance sheet (where accounts audited) for the period (s) under consideration (Cripps *et al.*, 2003). The formula used for calculating the financial ratios shown in table 8.3 have been explained below (Cripps *et al.*, 2003).

Liquidity Ratio

The formula is current assets or short-term assets divided by current liabilities:

$$\frac{\text{Current Assets (or short-term assets)}}{\text{Current Liabilities}}$$

Solvability Ratio

The formula is assets divided by liabilities: $\frac{\text{Assets}}{\text{Liabilities}}$

Ratio of Coverage of Expenses

The formula is reserves or reserve fund divided by monthly expenses. The monthly expenses are derived by dividing the total expenditure by 12 months, which is one financial year or period under consideration:

$$\frac{\text{Reserves}}{\text{Monthly Expenses (total expenditure divided by 12)}}$$

Ratio of Subscription(s) to Expenditure

The formula is total amount of dues collected divided by the total annual expenditure:

$$\frac{\text{Total amount of Dues}}{\text{Annual Expenditure}}$$

Ratio of Operating Costs to Income

The formula is operating costs divided by total income:

$$\frac{\text{Operating Cost}}{\text{Income}} \text{ or } \frac{\text{Operating Cost}}{\text{Income}} \times 100$$

Ratio of Efficiency in Collecting Dues

This measured the rate of payment of dues. Here, we divide the total dues or subscriptions collected by dues or subscriptions expected or budgeted for in the previous year: $\frac{\text{Dues Collected}}{\text{Dues Expected}}$ or $\frac{\text{Dues Collected}}{\text{Dues Expected}} \times 100$

$$\frac{\text{Dues Collected}}{\text{Dues Expected}} \text{ or } \frac{\text{Dues Collected}}{\text{Dues Expected}} \times 100$$

Table 8.3: Financial Viability Framework

Indicator	Measurement	Remark
Liquidity Ratio (LR)	This compares the MHO's current assets with its current liabilities	The ratio must be higher than 1. This will signify that it will be in a position to defray its debts to the health providers immediately, when members access healthcare and claims are made
Solvability Ratio (SR)	This indicates the ability of a MHO to honour its debts to third party organisations through redeeming or selling its assets, without resorting to borrowing	This must be equal to or higher than 1. This will also provide the basis for a sound financial management. However, if the solvability ratio is less than 1, then the organisation will be termed 'insolvent'
Ratio of Coverage of Expenses (RCE)	This gives an idea that the accrued reserves must correspond to the average expenses for three to six months	The objective is to ensure sufficient stability to be able to meet exceptional expenditures
Ratio of Subscription to Expenditure (RSE)	Accounts for the need to maintain sufficient subscriptions to cover the expenditures as they arise	This ratio must necessarily be equal to or higher than 1
Ratio of Operating Costs to Income (ROCI)	All the costs related to the administration and management of the scheme	This ratio should not exceed 5 per cent of overall income
Ratio of Efficiency in Collecting Dues (RECD)	Rate of payment of dues or the amount of dues actually collected to the amount expected during a given period	A rate nearer 100 per cent indicates active participation and enhances the MHO's ability to pay for the services it offers

This model was used to calculate the financial viability ratios of the four mutual health organisations in this study, as shown below.

8.5.1.1.4. Calculating the MHOs' Financial Viability Ratios: 2005 and 2006

The financial viability ratios of the four mutual health organisations in this study have been calculated and the results shown in tables 8.4 to 8.7 below. Moreover, these ratios have been summarised and shown in appendix H.

Table 8.4 shows how the financial viability ratios of the Aduana MHO were calculated and summarised in appendix H (see 9.2.3 for detailed analysis).

Table 8.4: Analysis of Aduana MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)

2005	2006
LR = N/A	N/A
SR = N/A	N/A
RCE = $\frac{97,000,000.00}{1,776,000,000.00/12} = 0.65$	$\frac{985,254,000.00}{997,746,000.00/12} = 11.85$
RSE = $\frac{652,773,000.00}{1,776,000,000.00} = 0.36$	$\frac{294,430,000.00}{997,746,000.00} = 0.29$
ROCI = $\frac{341,855,117.00}{1,873,000,000.00} = 1.8$	$\frac{281,553,789.00}{1,983,000,000.00} = 1.4$
RECD = $\frac{652,773,000.00}{N/A}$	$\frac{294,430,000.00}{652,773,000.00} = 0.45$

NB: Monthly Expenses: =148,000,000.00

=83,145,500.00

NA: Data not available.

Table 8.5 shows how the financial viability ratios of the Asakyiri MHO were calculated and summarised in appendix H (see 9.2.3 for detailed analysis).

Table 8.5: Analysis of Asakyiri MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)

2005	2006
LR = N/A	N/A
SR = N/A	N/A
RCE = $\frac{609,258,000.00}{864,742,000.00/12} = 8.45$	$\frac{261,000,000.00}{1,327,000,000.00/12} = 2.36$
RSE = $\frac{439,595,000.00}{864,742,000.00} = 0.50$	$\frac{274,352,000.00}{1,327,000,000.00} = 0.20$
ROCI = $\frac{238,678,919.00}{1,474,000,000.00} = 0.16$	$\frac{189,801,889.00}{1,588,000,000.00} = 0.11$
RECD = $\frac{439,595,000.00}{N/A}$	$\frac{274,352,000.00}{439,595,000.00} = 0.62$

NB: Monthly Expenses: =72,061,833.33

=110,583,333.33

NA: Data not available.

Table 8.6 shows how the financial viability ratios of the Asona MHO were calculated and summarised in appendix H (see 9.2.3 for detailed analysis).

Table 8.6: Analysis of Asona MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)

2005	2006
LR = N/A	N/A
SR = N/A	N/A
RCE = $\frac{418,000,000.00}{2,340,000,000.00/12} = 2.14$	$\frac{530,000,000.00}{7,874,000,000.00/12} = 0.80$
RSE = $\frac{842,289,000.00}{2,340,000,000.00} = 0.35$	$\frac{1,769,000,000.00}{7,874,000,000.00} = 0.22$
ROCI = $\frac{102,451,325.00}{2,758,000,000.00} = 0.03$	$\frac{92,403,318.00}{8,404,000,000.00} = 0.01$
RECD = $\frac{842,289,000.00}{N/A}$	$\frac{1,769,000,000.00}{842,289,000.00} = 2.1$

NB: Monthly Expenses: =195,000,000.00

=656,166,666.66

NA: Data not available.

Table 8.7 shows how the financial viability ratios of the Biretuo MHO were calculated and summarised in appendix H (see 9.2.3 for detailed analysis).

Table 8.7: Analysis of Biretuo MHO's Financial Statements (Financial Viability Indicators): 2005-2006 (old cedis, ¢)

2005	2006
LR = N/A	N/A
SR = N/A	N/A
RCE = $\frac{2,220,000,000.00}{2,656,000,000.00/12} = 10.03$	$\frac{1,284,000,000.00}{7,972,000,000.00/12} = 1.93$
RSE = $\frac{1,993,000,000.00}{2,656,000,000.00} = 0.75$	$\frac{3,472,000,000.00}{7,972,000,000.00} = 0.43$
ROCI = $\frac{262,851,500.00}{4,876,000,000.00} = 0.05$	$\frac{2,137,920,735.00}{9,256,000,000.00} = 0.23$
RECD = $\frac{1,993,000,000.00}{N/A}$	$\frac{3,472,000,000.00}{1,993,000,000.00} = 1.74$

NB: Monthly Expenses: =221,333,333.33

=664,333,333.33

NA: Data not available.

The results of most of the ratios in tables 8.4 to 8.7 did not show any significant impact on the financial performances and viability of the four mutual health organisations due to limitations in the financial statements obtained. Thus, additional financial analyses were done to support the arguments made (see chapters 9, 11 and 12). These have been explained below.

8.5.1.1.5. Additional Financial Analysis

Based on this premise, some of the analyses were based on the assessment of the percentage contributions of: the sources of income to total income; income and expenditure levels; and net income to find out whether there was any excess of income over expenditure (surplus) or excess of expenditure over income (deficit); and an analysis of the cash balances or reserve funds (Foster and Kettler, 2008). The formula used to calculate these rates (percentages) have been detailed below.

Source of Income as a Percentage of Total Income

The percentage contribution of the sources of income to total income is calculated based on the formulae where the source of income being analysed is divided by the base year or the source and multiplied by 100 to derive the percentage (Cripps *et al.*, 2003). For example:

The calculation is based on the formula: source of income divided by total income and multiplied by 100:
$$\frac{\text{Source of income}}{\text{Total income}} \times 100$$

Expenditure as a Percentage of Total Income

The method used for the calculation is expenditure divided by total income and multiplied by 100:
$$\frac{\text{Expenditure}}{\text{Total Income}} \times 100$$

NHIF Claims as a Percentage of Total Health Care Claims

The method used for the calculation is NHIF claims divided by total health care claims and multiplied by 100:
$$\frac{\text{NHIF Claim}}{\text{Total Health Care Claims}} \times 100$$

Paying Informal Sector (PIS) Income as a Percentage of Total Income

The formula used for the calculation is paying informal sector income divided by total income and multiplied by 100:
$$\frac{\text{PIS Income}}{\text{Total Income}} \times 100$$

Reserve Fund

Reserve fund may be defined as the own capital accumulated by the health micro-insurance scheme to meet future expenses, particularly, those arising from unforeseen circumstances: reserves implies reserve fund (ILO, 2005). Surplus has also been explained as the difference between income and expenditure for a particular accounting period when income exceeds expenditure. Other expressions, such as 'profit' or 'earnings', may be used (ILO, 2005).

However, in this study, reserve fund is defined as total income minus total expenditure. The formula for this is:

Total Income – Total Expenditure

This is to explain that reserve fund is the surplus of the financial year. The main reason for using this approach is due to the fact that the financial statements obtained from the four mutual health organisations had no balance sheets to be able to deduce the actual reserves for analysis (refer to 8.5.1.1.2). In reality, other researchers have used this approach in their studies due to lack of data or balance sheet: a similar approach was adopted in USAID projects in other parts of Western and Central Africa, including, Ghana (see Atim, 1998, 2001; Atim *et al.*, 1998, 2001a). The authors argue that:

Strictly speaking, the actual reserves of the scheme are the subsidy from Misereor, which is being held in a special account on behalf of the scheme, but it was judged more prudent to base the calculations on the details presented in the scheme's financial statement, which are the result of the operations for the year and therefore a better gauge of management performance (see Atim, 2001:32)

Thus, 'surplus' is used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year. This supports the authors' suggestion that: '...the surplus at the end of the year is assumed to constitute the scheme's reserves...' (see Atim, 2001:32). Consequently, the analyses and discussions relating to reserves or reserve fund in this study are based on this assumption (see chapters 9, 11, 12; and appendix M).

The financial performances of the four mutual health organisations have been analysed (see 9.2, 11.1.1, 12.1.1 and 12.2.3) and outlined in appendices: G, H, I, J, K, L, and M.

8.5.1.2. Measuring Institutional Viability

This part explains how institutional viability is measured. As indicated earlier (refer to 3.2.2) the outcomes of the institutional viability of the mutual health organisations were measured using certain indicators with respect to their operations (Cripps *et al.*, 2003). These provided information for assessing their strength and impact on health delivery. These are calculated in rates or percentages as explained in table 8.8 as discussed by Cripps *et al.* (2003). Applicable rates regarding membership trends of the four mutual health organisations have been analysed. For example,

Rate of Membership Coverage of the Catchment Population

This is calculated by using the total membership divided by the catchment population and multiplied by 100: $\frac{\text{Total Membership}}{\text{Population}} \times 100$

Population

Rate of Coverage of Membership (category of membership) of the Total Membership

To calculate this, the category of membership registered is divided by the total membership and multiplied by 100: $\frac{\text{Category of Membership}}{\text{Total membership}} \times 100$

Total membership

Rate of New Adherents (Rate of New Registration) or Penetration into the Catchment Population

The formula for the calculation is the number of new adherents in 2006 divided by the number of members for base year 2005 and multiplied by 100: $\frac{\text{New members}}{\text{2005 members}} \times 100$

2005 members

Table 8.8: Institutional Viability Framework

Indicator	Measurement	Remark
Rate of Membership Coverage	This estimates how the overall membership of the scheme is calculated over a period of time	The scheme should be able to increase rather than decrease membership
Rate of New registration	This identifies how many new members it is able to attract over a period of time	The difference is shown in the number of new people who join the scheme and the total number of old members
Rate of Enrolment into the Target Population	This measures the trend of enrolment into the target population	The difference is shown in the number of members and the total population- across some years of the scheme's operations
Rate of Members' Involvement	This shows active involvement of members in the operations of the scheme	How members attend meetings and voting rights
Rate of Drop-out of Membership	This shows how many members fail to renew their subscription over the course of the years	The scheme must make efforts to entice old members to commit themselves to their membership on a regular basis

However, some of the rates like the rate of members' involvement could not be deduced due to lack of adequate data. Additionally, the rate of drop-out of membership was not significant in the overall membership of the mutual health organisations. That is, apart from one mutual health organisation, all the other three mutual health organisations increased their membership in their population coverage for 2005 and 2006 registration periods. Therefore, applicable rates regarding membership trends of the four mutual health organisations have been analysed and shown in appendix D1 to D4 and tables 9.1 to 9.4.

8.5.1.3. Measuring Social Viability

This part also enlightens how social viability is measured. As discussed earlier (refer to 3.2.3) social viability is examined using indicators such as the members' rate of participation in meetings, elections, payment of dues; the kinds of solidarity bonds linking the members; and the ratio of volunteers to paid staff (Atim, 1999; Cripps *et al.*, 2003). Some of the indicators explained in table 8.9 are used to measure how members of the four mutual health organisations utilise health facilities (Atim, 1999; Cripps *et al.*, 2003). For example,

Rate of Access to Medical Care (Eligible Members and Health Care Benefits)

The formula used is the number of eligible members divided by the total membership for the base year and multiplied by 100: $\frac{\text{Eligible Members}}{\text{Total membership}} \times 100$

Total membership

Rate of Access to Medical Care (OPD Attendance of the MHOs)

The formula used is the number of members who attended health facility divided by the total membership for the base year and multiplied by 100:

$\frac{\text{Members' Attendance}}{\text{Total membership}} \times 100$

Total membership

Table 8.9: Social Viability Framework

Indicator	Measurement	Remark
Efficiency and Effectiveness of Service Delivery	The MHO negotiates on behalf of members for health care provision	Evidence is shown by analysing the clinical and other services rendered to the members
Rate of Access to Medical Care	Measures the performance of the scheme on members' access of health care	Rising rate of attendance must be investigated
Beneficiary per health care expenses	Assesses the trend of health care expenses per member per health care category	Enables the MHO to identify increasing expenditure items to aid the preparation of budgets
Rate of Morbidity Patterns of Members	Measures the number of cases of a particular illness in a given population against the total size of the population	Declining morbidity rate among MHO members signifies an improvement of the health care cover
Rate of Mortality Patterns of Members	Assesses how often members die in the population.	Need to know the impact of membership on health in general
Health Treatment Protocols	Measures how health institutions comply with treatment protocols	Providers must demonstrate a professional attitude towards members

However, some of these indicators could not be verified due to lack of data. This is because the General Assembly or Annual General Meetings (AGMs) are conducted on representative basis (see 9.1.2.1). Moreover, the membership of the mutual health organisations include indigents, children under 18 years and the aged (70 years and over). They do not participate actively in these meetings. Furthermore, some of the rates in the table such as beneficiary per health care expenses, rate of morbidity patterns of members, and rate of mortality patterns of members could not be

calculated in numerical terms due to lack of data. Consequently, applicable rates regarding membership attendance at the health facilities have been analysed and shown in tables 10.1 and 10.2.

8.6. Summary of the Chapter

This chapter has discussed the research methodology used for this study, taking cognisance of the philosophical perspectives adopted in conducting research in the business and management disciplines. It has also explained the research design and strategies based on the qualitative research methodology used in gathering empirical data in Ghana. Quantitative research methodology, including how financial, institutional and social viability indicators are analysed has been explained. Thus, it has established that both qualitative and quantitative research methodologies were adopted in the study in view of the researcher's philosophical assumption as an interpretivist. The next chapter presents the first part of the case results of the empirical study.

CHAPTER 9

CASE RESULTS: THE PERFORMANCE OF THE MUTUAL HEALTH ORGANISATIONS

9.0. Introduction

This chapter describes the first part of the case results of the empirical study conducted of the four mutual health organisations in Ghana. The main theme is the performance of the mutual health organisations. However, four sub-themes are also identified and discussed. The first sub-theme is the management and administrative performance of the mutual health organisations. The second sub-theme is the financial performance of the mutual health organisations. The third sub-theme is the perceived benefits of the mutual health organisations while the fourth examines the perceived problems of the mutual health organisations. The chapter ends with a summary.

As mentioned in chapter 8, these themes emerged from the interview data and are supported with available documents. Mutual health organisations are required to provide an easy financial access to orthodox health care for their members. There is a relationship between how insured members perceive the performance of the health care providers and the mutual health organisations as the former have been contracted to provide services on behalf of the latter. This is the reason why section 68 (1a) of the National Health Insurance Act 650 insists: 'the quality of health care services delivered are of reasonably good quality and high standard' (MHO, 2003d:23).

The analyses in chapters 9, 10, 11 and 12 must be read with the framework in figure 3.1 (MHO Sustainability Framework) in mind. There is a pattern running through to establish the fact that financial performance and viability of the mutual health organisations in this study is influenced by both institutional viability and social viability. That is, the context of the study is that mutual health organisations (MHOs) are emerging as a health financing strategy in sub-Saharan Africa. Most of them are located in villages or communities, where there is lack of basic social amenities: e.g. electricity supply and pipe borne water (refer to chapters 3 and 7).

In Ghana, the mutual health organisations (MHOs) had just been metamorphosed into formalised institutions upon implementation of the NHI Act 650 in March, 2004

(Abbey, 2003; MHO, 2003d). They were still in transition at the time of the study. Some of them were compiling data manually, until computers were donated to them. Therefore, both positive and negative implications of the titles/sub-titles as analysed in chapters 9 and 10 have been discussed in conjunction with other themes/sub-themes in chapters 11 and 12 to reflect the process of change. The thesis is arranged and presented to suit a certain pattern: the link between financial, institutional and social viability issues.

9.1. Operations of the four Mutual Health Organisations

This section describes the second phase of mutual health organisations development, which was discussed in relation to the health financing reform under the National Health Insurance Scheme (Act 650), which is termed post-NHI 2003 MHOs era (refer to 6.5.4.2 and 7.2). It also describes the background characteristics of the four mutual health organisations used for the empirical study and how they are operating under the National Health Insurance Scheme Act 650 (MOH, 2003d, 2004b).

9.1.1. Description of the Case Study Mutual Health Organisations

Pseudonyms have been used to disguise the identity of the mutual health organisations used for the case studies as a fulfilment of the promise of confidentiality (refer to chapter 8). The Aduana, Asakyiri, Asona, and Biretuo are terms used in place of the real names for the district-wide and municipal-wide mutual health insurance schemes, which are referred to as mutual health organisations (MHOs) in this study. All the four mutual health organisations are being supervised by their respective district and municipal Assemblies. The government provided a start-up capital fund of ₵150m old cedis towards their re-formation (in the case of the pre-NHI 2003 MHOs): Aduana MHO and Biretuo MHO or establishment (in the case of post NHI 2003 MHOs): Asakyiri MHO and Asona MHO.

9.1.1.1. Aduana Mutual Health Organisation

The Aduana Mutual Health Organisation was a pre-NHI 2003 MHO, which transformed into district-wide mutual health insurance scheme, when the National Health Insurance Act 650 was implemented in 2004. It had been in existence for about seven (7) years at the time of the study. It is located in a district in the Greater Accra region of Ghana. The regional population labour force for Greater Accra region in 2000 was 15.3 per cent for males and 15.4 per cent for females, with an economically active population rate of 88.3 per cent for urban areas and 11.7 per cent in the rural areas (GSS, 2005).

However, the district within which the Aduana MHO is located is described as an Ordinary District (Ghana Districts, 2008). The population of the district, according to the 2000 census, was around 98,000. This is currently estimated to be around 121,000 based on a growth rate of 2.6 per cent. Workers are in occupations such as:

agriculture, animal husbandry, fishing and hunting in the district. This represents 50.2 per cent, revealing a high proportion of males engaged in agriculture and related work. The district has the lowest unemployment rate of 8.9 per cent in the Greater Accra region. About a third of the 'not economically active' persons in the district are homemakers. As a result, poverty is widespread. Health care is only provided by health centres with no hospital provision (GSS, 2000, 2005). In 2005, the Aduana MHO registered approximately 14,000 people within its catchment population of 98,000, which represented 14.3 per cent. In 2006, it also registered approximately 21,000 members, which represented 17.4 per cent of an estimated population of 121,000. Membership statistics are shown in appendix D1.

9.1.1.2. Asakyiri Mutual Health Organisation

The Asakyiri Mutual Health Organisation is a post-NHI 2003 MHO, which started as one of the pilot district mutual health insurance schemes in the country in 2001. An interim management was put in place in May 2004 to establish the current scheme, which started operating in 2005. The district in which the Asakyiri MHO is located is in the Ashanti region of Ghana (Ghana Districts, 2008). The regional population labour force in 2000 was 19.4 per cent for males and 18.8 per cent for females. The economically active population was 50.7 per cent for males and 49.3 per cent for females. The district in which Asakyiri MHO is located is described as a rural district with a population of approximately 125,000, according to 2000 census (GSS, 2005), which increased to 146,000 in 2006 (Ghana Districts, 2008). Health care delivery in the district is provided by a district hospital, private 'for-profit' and private 'not-for-profit' hospitals and health centres. People in the district also visit the nearby Komfo Anokye Teaching Hospital (GSS, 2005). The Asakyiri MHO in 2005 registered approximately 18,000 members, which represented 14.3 per cent of a population of 126,000. In 2006, approximately 42,000 members were registered, which represented 28.8 per cent of an estimated population of 146,000. The statistics of membership are shown in appendix D2.

9.1.1.3. Asona Mutual Health Organisation

The Asona Mutual Health Organisation was established in 2004 and became operational in 2005 as a post-NHI 2003 MHO. It is a municipal-wide mutual health insurance scheme (MMHIS) in the Eastern region of Ghana. The Eastern regional

population labour force in 2000 was 11.1 per cent for males and 11.2 per cent for females. The economically active population was 33.4 per cent urban and 66.6 per cent rural. The municipality in which the Asona Mutual Health Organisations is located is described as an urban district (Ghana Districts, 2008), with a population of 137,768 according to 2000 census (GSS, 2005). This is currently, 147,000, with a growth rate of 2.6 per cent (Ghana Districts, 2008). Health care is served by a regional hospital and a private specialist hospital with no polyclinic or health centres. The Asona MHO registered approximately 87,000 members, which represented 63 per cent of the population of 138,000 in 2005. In the year 2006, it attracted a total membership of approximately 88,000, which represented 59.9 per cent of an estimated population of 147,000. The statistics of membership are shown in appendix D3.

9.1.1.4. Biretuo Mutual Health Organisation

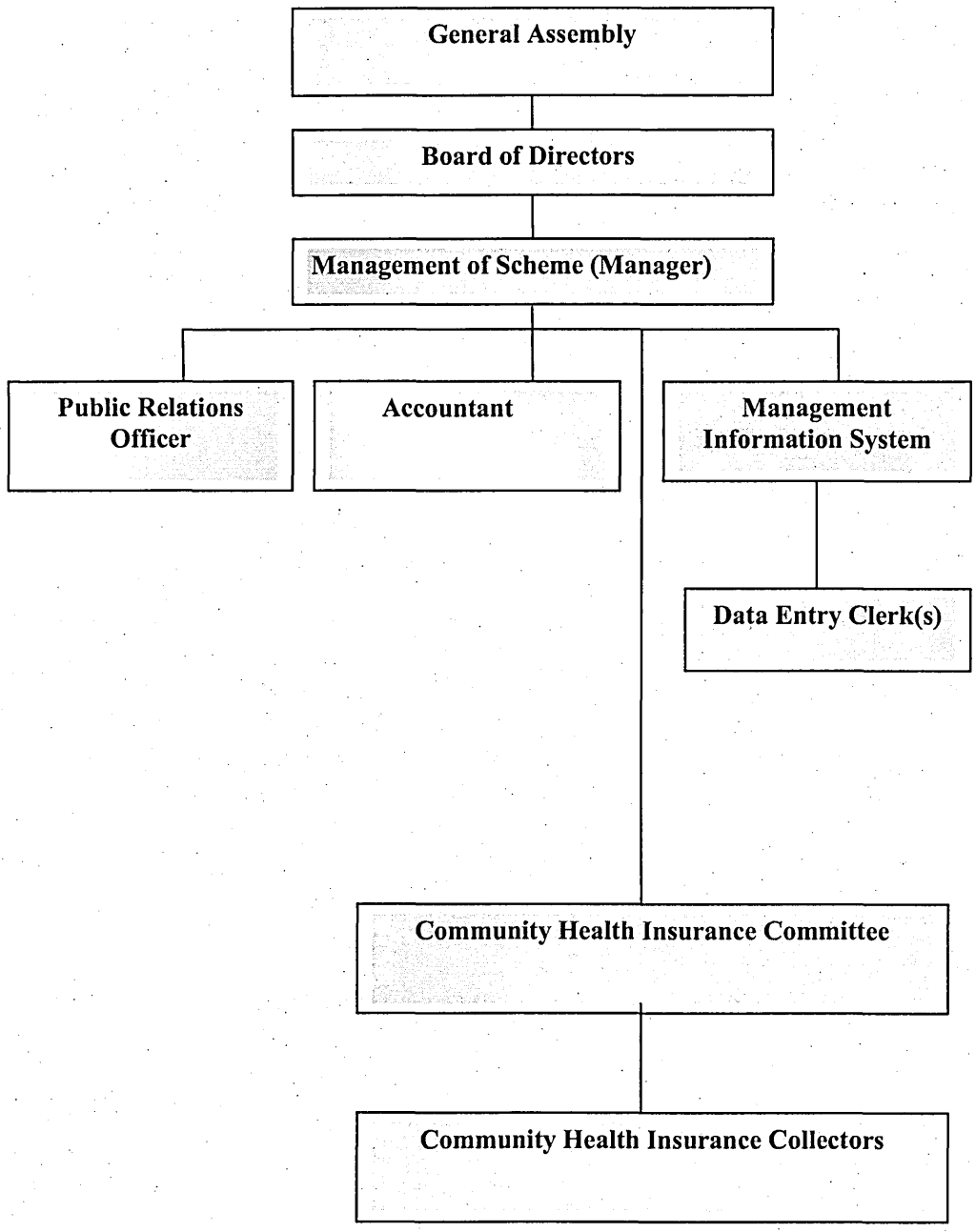
The Biretuo Mutual Health Organisation was also a pre-NHI 2003 MHO, which reformed into a district-wide mutual health insurance scheme under the NHI Act 650 in 2004. It had been in existence for about 15 years in an administrative district capital under the Local Government territorial demarcation in the Brong Ahafo region of Ghana. The regional population labour force for Brong Ahafo in 2000 was 9.7 per cent for males and 9.5 per cent for females. The economically active population of the Brong Ahafo region was 36.3 per cent urban and 63.7 per cent rural in 2000 (GSS, 2005). The population of the district in which the Biretuo MHO is located according to the 2006 estimate was 150,000 with a growth rate of 2.3 per cent. It is predominantly a farming community served by a district hospital and health centres (GSS, 2005, Ghana Districts, 2008). The Biretuo MHO in 2005 registered approximately 69,000 members, which represented 49.6 per cent of a population of 139,000. In 2006, it registered approximately 65,000 members, which represented 43.3 per cent of an estimated population of 150,000. The statistics of membership are shown in appendix D4.

9.1.2. Management of the Post-NHI 2003 MHOs (DMMHIS)

All the mutual health organisations in this study are being managed according to the management structure proposed by the National Health Insurance Act 650 (MOH, 2003d, 2004b), which is described in figure 9.1. This is not very much different from

what already existed before the NHI Act 650 was introduced as described by Kankye (2001), and shown in appendix A. The figure shows a top-down management system where decisions of the district and municipal mutual health organisations are taken at the general assembly level and passed on to the board of directors. The respective boards of directors are to liaise with the management of the schemes or the manager to ensure that the decisions are implemented (see 9.1.2.1 to 9.1.2.3).

Figure 9.1: Organogram of the Post-NHI 2003 MHOs (DMMHIS)



Some pre-NHI 2003 MHOs (Biretuo MHO) have not seen much structural changes as the communities kept the old management structure. Some members of the management team who worked with the schemes under their pre-NHI 2003 MHO era were recommended for appointment by the district Assemblies to administer their current schemes under their post-NHI 2003 MHO era:

...I will say nothing has changed in our case...Our structures are okay...it is a continuation of the old system. The current management hasn't changed much from the previous one. The man who was managing affairs in the old scheme is still the manager... (BRMHO-M-10)

However, a pre-NHI 2003 MHO like the Aduana MHO has maintained its management structures but reshuffled some of its personnel. A health manager who has been associated with the Aduana MHO observes that:

...we had inexperienced scheme management initially which was also a problem because the former management members of the community health insurance scheme [pre-NHI 2003 MHO] were re-shuffled. The structure of the scheme is almost the same but as I said there is a change in staffing and the NHI Act 650 has made the scheme more formal... (HMP-6)

On the other hand, a post-NHI 2003 MHO like the Asakyiri MHO adopted the NHI Act 650 management structures but reshuffled its personnel altogether after it operated as a pilot scheme in 2001:

...we were not there but from the records, they tried to mobilise the community...everything was done together with the chiefs, opinion leaders and identifiable groups like women's groups, religious bodies, muslims and market women. Several of the groups were organised to sell the idea to them and also to mobilise their members. That was exactly what they did...(SMMHO-4)

9.1.2.1. General Assembly

Each of the General Assembly of the four mutual health organisations consists of registered and fully paid up members, who take major decisions. However, members are being represented at the Annual General Meetings (AGMs) by the leadership of the community health insurance committees (CHIC), which are formed in the

remotest localities. These comprise of a chairman, a vice-chairman, a treasurer and a secretary (MOH, 2003d; GHS, 2004b). This management system seeks to use the Local Government administrative structure of decentralisation and rule by representation:

...we decided that we wanted to maintain the ideals of decentralisation while at the same time, making sure that there is access to health care for everybody... the schemes are semi-autonomous, have their own boards, they can set their own policies, to a limited extent, and deal with residents of their respective districts... (PMS-13)

The aim is to enhance community participation through a bottom-up approach whereby ideas and decisions are generated from the community members and then forwarded to the General Assembly via these representatives:

...there has not been much change in members' participation at meetings... We have stakeholders meeting, we have the AGM and we have now established Health Insurance Committees in all the surrounding villages and communities who report to us of all the problems the community members want solutions to, for our attention. That is to say that we have now decentralised decision making... (BRMHO-M-10)

Thus, this management style is working for some of the mutual health organisations.

9.1.2.2. The Governing Body (Board of Directors)

The Board of Directors follows the General Assembly, being a top-down pyramidal structure. Section 54 (1) of the National Health Insurance Act 650 stipulates that:

Every scheme shall have a governing body which shall be responsible for the direction of the policies of the scheme and appointment of employees (MOH, 2003d:19)

Thus, the appointment process follows the content of the National Health Insurance Act 650, in that it includes members of identifiable community groups. These include: the District Assembly, the District Health Directorate, the Christian Council, the Muslim Council, the Community or Traditional Council and the Scheme Manager

(MOH, 2003d). The District Co-ordinating Directors (DCDs) of the Assemblies are being nominated by the District and Municipal Chief Executives to serve on the board of the mutual health organisations on the virtue of their positions as technocrats of the district and municipal Assemblies. A health manager who is familiar with the operations of the Aduana MHO explains the changes in the composition of the board of directors:

...Board of Directors consists of some community members and the institutional management committees are involved in the management of the scheme at the local levels. Thus the structure involves more community members than the previous system...(HMP-6)

The membership of the governing body of the four mutual health organisations range between seven (7) and fifteen (15) people. Thus, the composition of the Board of Directors has been expanded and improved through implementation of the National Health Insurance Act 650 (compare this with appendix A). Some policy makers also perceive that there are more formal sector representatives on the Board of Directors than community members in some of the communities dependent on their interpretation of the NHI Act 650:

...now you have District Chief Executives appointing people to form the Board, but there is some guideline(s) in the law that you should have: a religious person, traditional person, muslim person, and so forth...so you have some places that you have quite a number of the formal sector people on the Board and few community people on the Board...they are not actually elected...So that is the change you know, from the people themselves... (PMS-16)

The Chairmen of this body are elected from amongst the entire membership of the Board of Directors. The responsibility of the governing body (the board) is to direct the effective and efficient policies and appoint the staff of the mutual health organisations (see 9.1.2.3). This is being done in conjunction with the district and municipal Assemblies. The scheme managers are serving as the secretaries to their Governing Boards (MOH, 2003d; GHS, 2004b).

9.1.2.3. The Scheme Manager and Management

The implementation of the NHI Act 650 has made it possible to define criteria for human resources for the mutual health organisations. It states that at least six minimum core number of staff are required to operate any sustainable mutual health organisation, and they must have required levels of professional and occupational qualifications. The criteria set down ensure an easy method of short-listing prospective applicants for subsequent interviews and appointment (MOH, 2003d, 2004b). In practice, number of staff vary from community to community, due to the varying size of different localities. The day-to-day administration of the mutual health organisations in this research lay with the scheme manager and five other core appointed staff. They all have qualifications deserving of their careers.

Outline of the management staff employed is shown in appendix F. It would be seen that all the four Scheme Managers are graduates or have first degree. The accountants have either Higher National Diploma (HND) or BSc. Administration (Accounting Option). The Management Information Systems (MIS) managers have Higher National Diploma (HND) or appropriate qualifications. The Claims Managers also have either Higher National Diploma (HND) or General Certificate of Education Ordinary level (GCE O-Level) qualifications. The Data Entry Clerks also have National Vocational Qualifications (NVQs).

Another set of employees of pre-NHI 2003 MHOs, which has been regularised under the NHI Act 650, is field workers, who have been replaced by community health insurance collectors (CHIC). Their employment is by recommendations from guarantors from amongst their community members, who witness a bond upon their selection and engagement. These staff are located within the heart of the communities as shown in figure 9.1. Their main task is to register and collect the premiums from community members and forward the money with details to the secretariat of the mutual health organisations.

During the pre-NHI 2003 MHOs era, the field workers were remunerated on the basis of a percentage of the number of people they register and the amount of money collected. However, the community health insurance collectors who are working with the mutual health organisations are paid allowances and are also considered as

supporting the core staff of their mutual health organisations. Administratively, all the staff of the mutual health organisations including field workers are appointed as part of the human resources component of their district and municipal Assemblies. This is an improved way of maintaining staff on full time contract basis as they are on the Assemblies' payrolls.

Due to the regulatory endorsement, all the key management staff of the mutual health organisations are very confident about performing their respective duties (see 10.3.1.1):

...then we also have the authority and the backing to be confident that whatever we want to do is backed by the law in which case we may not be afraid, but are covered. Then we also know the direction we are going and what to do... (SMMHO-4)

The management staff are regularised under the Civil Service (CS) staff codes, reflecting how the mutual health organisations are operating as business entities. They need to exhibit a sense of responsibility in spending health insurance funds. This was necessary for their sustainability, as the efficiency with which they organised and managed the affairs would help boost confidence and trust in members. Mismanagement or misappropriation of funds could discourage members from participating. For this purpose, section 59 (1) of the Act 650 notes:

A scheme shall have at all times high calibre directors, principal officers and expert technical and professional staff and shall maintain such standards as may from time to time be prescribed or as may be directed by the Council (MOH, 2003d:21)

Theoretically, the suitable qualification for the key personnel of the mutual health organisations as shown in appendix F should have been people with insurance specific knowledge and qualifications. However, it is difficult to identify many such people:

...You will not get it, you won't get. We haven't produced enough people to occupy 130 districts, you can't get that number of people with insurance background...they cannot be found... (PMS-16)

Meanwhile, by the standard of formal educational attainment in Ghana, these are some of the highest qualifications. These people are broadminded with general understanding of management principles to deal with related matters. Nonetheless, the Business School of the University of Ghana, Legon, Accra, is training graduates with insurance speciality, to fill this skills gap. As they do not possess background in insurance, the core staff needed orientation in health insurance and community-based health insurance operations. The Danish International Development Agency (DANIDA) through its collaboration with the health sector had helped to provide technical assistance for the scheme managers:

*...I attended an orientation workshop organised by Danida upon my appointment...Here is my certificate of participation...
(SMMHO-4)*

The only constraint to their career progression is the absence of a ladder for career promotion. Some respondents suggest that the Ministry of Health (MOH) as the sectoral ministry should employ these staff instead of the district and municipal Assemblies. This would ensure that a well-categorised salary structure and better conditions of service, which are lacking would be developed for all the staff of the mutual health organisations in the country.

9.1.3. Membership Categorisations and Eligibility

The mutual health organisations are recruiting their members. For the purposes of easy classification, the members have been categorised as described below.

9.1.3.1. Formal Sector Membership: Social Health Insurance Contributors

Formal sector members are people who are employed or working and contributing to the Social Security and National Insurance Trust (SSNIT) Pension Scheme, as well as retired formal sector employees who have opted for the SSNIT Pension Scheme (refer to 5.4.2). Retired formal sector employees who have opted out of the SSNIT Pension Scheme by collecting their entitlements in bulk are referred to as 'Cap 30' members and are considered to be informal sector members by the mutual health organisations. These SSNIT contributors and Pensioners represent the social health insurance component of the fused National Health Insurance Scheme (MOH, 2003d, 2004b;

Osei, 2003). The formal sector membership of the four mutual health organisations is analysed in appendix D1 to D4.

9.1.3.2. Informal Sector Membership: Community-Based Health Insurance

Contributors

The informal sector members are people who are not working in any formal establishment or earning their wages by any codified remuneration packages and are not contributing to the Social Security and National Insurance Trust (SSNIT) Pension Scheme. They are mostly artisans, farmers, and fishermen, petty traders, among others (refer to table 6.6). The 'Cap 30' pensioners are also considered to be informal sector members. The informal sector members are within the age range of 18 to 69 years and are also classified as 'paying informal sector' members. They constitute the community-based health insurance scheme component of the combined National Health Insurance Scheme (MOH, 2003d, 2004b). The paying informal sector (PIS) membership of the four mutual health organisations is analysed in appendix D1 to D4.

9.1.3.3. Exempted Members or Social Group Elements

In theory, the National Health Insurance Act 650 and Legislative Instrument 1809 categorise the exempt group members who could access free medical care from the mutual health organisations. These are the indigents: people belonging to the 'core poor' category on the socio-economic ladder; children under the age of 18 years: from birth to 18 years; and the aged: 70 years and over (MOH, 2003d, 2004b; GHS, 2004b). The health care benefits of members of the post-NHI 2003 MHOs, which the mutual health organisations in this study are providing for their members are explained in appendix E. The social group membership of the four mutual health organisations is analysed in appendix D1 to D4.

9.1.3.4. Non-Members and Ineligibility under NHI Act 650

There are some categories of people in the communities who cannot enrol due to either the high premium rates or exemptions within the NHI Act 650 (MOH, 2003d, 2004b). The mutual health organisations are providing all children under the age of 18 years with free health care access under an exemption package. However, the management are at the same time expecting both parents, whether married or not, to necessarily register before the children could be considered for the exemption (MOH,

2003d, 2004b). Even children of single parentage are being refused access because either the mother or father cannot get the 'second partner' to register with. It is difficult for couples to register their children separately, when they cannot raise the premiums to register themselves:

*...those who are not married are not allowed to register...
(ADMHO-NM-4)*

In Ghana, the responsibility for ensuring that children are sent to the hospital for orthodox health care usually falls on the woman. When the household is headed by men or where there are couples involved, the man is expected to provide the funds to meet the costs incurred. Where the woman is unemployed, she becomes economically, dependent on the financial provisions of the man (husband) and needs his support to join a health insurance scheme even if she has good reasons to enrol. In cases where the men cannot provide the funds for the registration, the entire household cannot participate in the mutual health organisations:

...my brother, it is my husband oh. I am really sick and I need to go to the hospital, but my husband has failed to pay the premium to enable us enrol with the scheme so that I can get some treatment. Even the children's own is another problem because the scheme will not register them until we the parents have registered... (ADMHO-NM-1)

Another group of non-members within the communities are those between the ages of 19 and 30. They are outside the exemption criteria and are still pursuing either formal or informal education, apprenticeship or peasant farming. Due to lack of employment avenues, youth unemployment is increasing (refer to chapter 5). Whilst they have the urge to register, they cannot raise the premiums to actualise it by enrolling with the mutual health organisations. Majority of the people in this age group are still depending on their parents for their livelihoods. This is also creating problems for relatively poor parents:

...we have the responsibility to register for our children who are not working and are above 18years...there is not enough money to register every family member at the moment so others are not yet registered...(ASKMHO-M-6)

Ghana is a nation where the extended family system encourages solidarity of all kinds including, financial solidarity. Even though, the eagerness to express this solidarity is present, it cannot be seen to be demonstrated amongst some people in the communities where the mutual health organisations are located because of lack of funds. There is another group of uninsured members who are in the age range of 31 to 69 years who are also not in any gainful employment. While they cannot register on their own, some of them do not also have any benefactors to support them. For those people between the range of 50 and 69 years, the ideal situation would have been to rely on their children, where available, for financial support. There are other inhibiting factors involved here: some of them are childless and even those who have children cannot depend on them where the children themselves are not working or have no means of gaining regular incomes:

...currently, my mother and my auntie are not registered because of lack of funds and they are not yet 70 years old. I should have been assisting them but I do not have it... (ADMHO-M-10)

In order for these relatively poor people between the range of 50 and 69 years who cannot register to enjoy free comprehensive health care benefits at the point of service use by membership of the mutual health organisations, they would have to count on some benevolent financial assistance, from whichever sources possible: ‘...gyese obi pia won akyi...’ (ADMHO-M-3), translated as: they need financial push from someone. An international financial aid organisation was supporting some poor members in some of the communities within the district where the Aduana MHO is operating. The project was dubbed ‘Premium Subsidy Project’. The eligible members were to part-pay 25 per cent of their subscriptions while the organisation was to subsidise the 75 per cent. This project was failing to encourage beneficiaries as they did not simply have the resources to even pay 25 per cent:

...initially, they were supposed to pay 75 per cent but the people were not bringing their 25 per cent, so along the line, they were paying 100 per cent for them... (SMMHO-1)

This case demonstrates that when some people in the communities in Ghana are classified as 'relatively poor' or 'core poor', it really means, they are 'poor'. The financial viability of the mutual health organisations also depends on the ability of the members in the communities to register and sustain the payment of their contributions on regular basis.

9.2. Financial Performance and Viability of the Mutual Health Organisations

This sub-theme evaluates the financial performance of the mutual health organisations in their efforts to mobilise revenue and make prudent financial decisions. It has been observed in chapter 3 that just as mutual health organisations may offer the benefits of risk-spreading (health-risk), they themselves may be at risk of insolvency in their development. As indicated in chapter 8, there are limitations in using the financial statements of the four mutual health organisations to establish their financial viability based on their actual reserved funds in this study due to unavailability of balance sheets. Moreover, the financial issues in this study are set within certain limitations particularly, against the background of complicated actuarial difficulties: the statistical calculation of risk or life expectancy for insurance purposes. The analysis under the above theme is based on the assessment of several intermediate factors and the figures are quoted in old cedis (¢). The exchange rate was one pound sterling (£1), an equivalent of eighteen thousand (¢18,000.00) old cedis as at November 2006. See discussions below.

9.2.1. Funding Streams of the four Mutual Health Organisations

There are three main sources of income available to the mutual health organisations. The first is premiums. This is accrued from the 'Paying Informal Sector' (PIS) members who pay direct cash for their premiums and administration fees to obtain membership. The administration fee is charged to meet current costs of stationery and printing of membership photo identification cards.

The second source of income is from the National Health Insurance Fund (NHIF), which is a government subsidy. This constitutes incomes from two sources. The first one is the 2.5 percent National Health Insurance Levy (NHIL) on selected goods and services. The second is 2.5 percent deducted from the 17.5 percent monthly contributions of formal sector employees' Social Security and National Insurance Trust (SSNIT) Pension Scheme. Hence, formal sector members of the mutual health organisations are not paying direct cash towards their premiums as their subscriptions are deducted at source from their monthly salaries. There are no uniform premiums paid as the 2.5 percent is dependent on each worker's salary level and annual income.

Thus, the 'formal sector' members and the 'exempted' members are only paying direct cash for the administration fees.

The third source of income is from the 'Other Income' (OI). These are financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits.

9.2.2. The Cost of Health Insurance Policy of the MHOs: 2005-2006

Notably, all the mutual health organisations did not decide their own premiums. They are using graduated premiums set by the National Health Insurance Act 650 (MOH, 2004d, 2004b). These range from ₦72,000.00 to ₦480,000.00. The expectation of policy makers, when deciding on the graduated premiums was that the rich people in society should volunteer to pay higher premiums so that the financial base of the mutual health organisations would increase. This would have a 'knock on effect' on the 'financially less endowed' members in the communities:

...one thing we also took into account is relative paying ability of those who were in a position to make a contribution. There are the rich people, the middle class, the lower middle class, and the blue collar people...So depending on your economic circumstances, you could be paying three hundred thousand old cedis (₦300,000.00), the poor person or the blue collar guy is paying seventy-two thousand old cedis (₦72,000.00)... (PMS-13)

In practice, all the mutual health organisations in this study are applying the minimum premium of ₦72,000.00. A breakdown of how the mutual health organisations are charging their members is shown in appendix G and discussed below.

Aduana MHO

It would be seen that in 2005, the Aduana MHO charged a premium of ₦72,000.00 and administration fees of ₦10,000.00. This brought the total cost of registration to ₦82,000.00. In 2006, it charged a premium of ₦72,000.00 and administration fees of ₦28,000.00. The total cost of registration was ₦100,000.00 (health insurance policy for paying informal sector members).

Asakyiri MHO

In 2005, the Asakyiri MHO charged a premium of ₦72,000.00 and administration fees of ₦28,000.00. The total cost of registration was ₦100,000.00. In 2006, it charged a premium of ₦72,000.00 and the same administration fees of ₦28,000.00. The total cost of registration was the same ₦100,000.00 (health insurance policy for paying informal sector members).

Asona MHO

In the case of Asona MHO, in 2005, it charged a premium of ₦72,000.00 and administration fees of ₦28,000.00. The total cost of registration was ₦100,000.00. In 2006, it charged a premium of ₦72,000.00 and administration fees of ₦48,000.00. The total cost of registration was ₦120,000.00 (health insurance policy for paying informal sector members).

Biretuo MHO

In 2005, the Biretuo MHO charged a premium of ₦72,000.00 and administration fees of ₦28,000.00. The total cost of registration was ₦100,000.00. In 2006, it maintained the same premium ₦72,000.00 and the same administration fees of ₦28,000.00. The total cost of registration was the same ₦100,000.00 (health insurance policy for paying informal sector members).

From the above, it would be seen that the cost of the premium to the paying informal sector (PIS) members ranged from ₦82,000.00 to ₦120,000.00 during the 2005 and 2006 registration periods:

...at the implementation level, the various schemes have decided to charge a minimum of hundred thousand old cedis (₦100, 000.00). This is beside the ₦72, 000.00 as there is a processing fee for card issuance to cover the cost of printing and so forth. But that is not for everybody, it is the minimum, okay. So technically, even the hundred thousand old cedis (₦100, 000.00) is only US\$10 for the whole year... (PMS-13)

This was due to the differences in administration fees paid by the different membership groups. The difference between the mutual health organisations was ₦10,000.00 and ₦48,000.00 for the periods: 2005 and 2006. Therefore, the total cost

of health insurance policy constitutes premiums and administration fees in respect of the paying informal sector members. This is what is creating problems for large families (refer to 9.1.3.4 and see 9.4).

9.2.3. Financial Viability Indicators

The indicators outlined in the financial model shown in table 8.3, were examined. The results are shown on tables 8.4 to 8.7 and summarised in appendix H. It is important to observe that the financial analyses in this section are set within the limitations in the financial statements obtained from the four mutual health organisations (refer to chapter 8). In view of this, it is difficult to assess the financial viability of the mutual health organisations on the basis of their actual reserves (see ILO, 2005). Therefore, a different approach (refer to p.150), which was used by other researchers (see Atim, 1998, 2001; Atim *et al.*, 1998, 2001a), was applied to analyse the financial performance and viability of the four mutual health organisations in this study.

9.2.3.1. Liquidity Ratio of the MHOs: 2005-2006

The liquidity ratio shows the ability of the mutual health organisation to pay its liabilities as they fall due. This compares its current assets such as cash, short-term investments, inventories or stock, accounts receivable, which are debtors and other assets that management intends to convert into cash within a year with its current liabilities. Current liabilities are those debts that must be paid off within a year, for example, payments to suppliers of goods and services. These are also known as creditors or accounts payable. The financial analysts assumption is that if the ratio is higher than 1, it will signify that the mutual health organisation would be in a position to defray its debts to healthcare providers immediately, if need be (see Cripps *et al.*, 2003).

Aduana MHO

As can be seen from table 8.4 and appendix H, it is obvious that there were no data or balance sheets from the Aduana MHO's financial statements for years 2005 and 2006 from which to determine and project its financial viability based on liquidity ratios.

The problem is that the accounts of the Aduana MHO had not been audited by the Ghana Audit Service as required (see MOH, 2003d, 2004b), at the time of the study. Although they could contract private or chartered accountants to audit the accounts, the management team saw this as a drain on the insufficient revenue. The limitation is that due to unavailability of data, it is not possible to establish the long term viability of the Aduana MHO on the basis of this indicator. It is recommended that the management team should liaise with the Ghana Audit Service to ensure timely auditing of the accounts (see MOH, 2003d, 2004b).

Asakyiri MHO

As can be seen from table 8.5 and appendix H, there was a limitation in the Asakyiri MHO's financial statement since there were no data with respect to the balance sheets for 2005 and 2006. The accounts had not been audited by the Ghana Audit Service (see MOH, 2003d, 2004b). This made it difficult to calculate its liquidity ratios for the periods 2005 and 2006. Therefore, it is difficult to determine the long term financial viability of the Asakyiri MHO on the basis of this measure. Even though the management team was in the process of contracting private or chartered accountants to audit these accounts, this would have implications for the already over-stretched funds. It is recommended that the management team should liaise with the Ghana Audit Service to ensure that the accounts are timely audited (see MOH, 2003d, 2004b).

Asona MHO

As can be seen from table 8.6 and appendix H, the analysis of the Asona MHO's financial viability with respect to liquidity ratio based on its financial statements provided for years 2005 and 2006 faced problems of inadequate data. This was due to lack of balance sheets since the accounts had not been audited. Even though the management team was willing to contract private or chartered accountants to audit the accounts, the financial implications were also considered. The limitation is that due to lack of balance sheets, it is not possible to establish the long term viability of the Asona MHO on the basis of this financial indicator. It is important for the management team to liaise effectively with the Ghana Audit Service to ensure that the accounts are audited on timely basis (see MOH, 2003d, 2004b).

Biretuo MHO

From table 8.7 and appendix H, the financial viability of the Biretuo MHO could not be assessed using the indicator: liquidity ratio. The reason is that there were no balance sheets in the financial statements provided for 2005 and 2006 from which to deduce the figures to determine the liquidity ratios, as the accounts had not been audited. The management team was not keen to contract private or chartered accountants to perform the auditing of the accounts since they are struggling with huge debts to the contracted health care providers. The limitations caused by the absence of suitable data in the financial statements provided made it impossible to establish the long term viability of the Biretuo MHO on the basis of this financial ratio. This issue could be resolved if the management team is able to liaise with the Ghana Audit Service to ensure that the accounts are audited promptly as required (see MOH, 2003d, 2004b).

9.2.3.2. Solvability Ratio of the MHOs: 2005-2006

Solvability ratio shows the capacity of the mutual health organisation to honour its debts to third parties through redeeming or selling its assets, without recourse to borrowing. The assumption is that the ratio should be equal to or higher than 1, to ensure a sound financial management. However, when the ratio is less than 1, then the mutual health organisation could be termed 'insolvent' (Cripps *et al.*, 2003).

Aduana MHO

As can be seen from table 8.4 and appendix H, there were no balance sheets from the Aduana MHO's financial statements provided for years 2005 and 2006. This made it impossible to establish its financial viability based on solvability ratio. This is due to the fact that the accounts had not been audited (see MOH, 2003d, 2004b). Although it is difficult to determine the Aduana MHO's solvability ratio, it could be argued that it is not insolvent since its reserve funds show that it accrued surpluses instead of deficits for 2005 and 2006 (refer to p.150; and see 9.2.4.1, 9.2.4.5; and appendices I and M). However, management should ensure that the accounts are audited on regular basis so that the solvability ratio could be used to establish whether it can honour its debts (if any) by redeeming or selling its assets without recourse to borrowing (see MOH, 2003d, 2004b).

Asakyiri MHO

As can be seen from table 8.5 and appendix H, the Asakyiri MHO's financial statements had some data limitations since there were no balance sheets for 2005 and 2006 financial periods: the accounts had not been audited (see MOH, 2003d, 2004b). Although it is complex to estimate its solvability ratio for the periods 2005 and 2006, it can be argued that the Asakyiri MHO is not insolvent using the reserve funds, which indicate surpluses instead of deficits for 2005 and 2006 (refer to p.150; and see 9.2.4.1, 9.2.4.5; and appendices I and M). Nonetheless, it is not clear whether it can pay off its future debts without recourse to borrowing. Therefore, it is recommended that the accounts should be audited so that the Asakyiri MHO can firmly convince itself that it has assets with which it can use to pay off its future debts (if any) as and when they occur without recourse to borrowing (see MOH, 2003d, 2004b).

Asona MHO

Table 8.6 and appendix H show the analysis of the Asona MHO's financial viability using the solvability ratio for financial periods 2005 and 2006 based on its financial statements provided. However, there were some deficiencies in the data and the solvability ratio could not be determined as the accounts had not been audited to provide balance sheets for 2005 and 2006. This notwithstanding it can be assumed that the Asona MHO is not facing problems of insolvency considering that its reserve funds are showing surpluses and not deficits (refer to p.150; and see 9.2.4.1, 9.2.4.5; and appendices I and M). In order for the management team to be certain that it can redeem its debts (if any) without recourse to borrowing, it is recommended that the accounts are audited in line with regulations so as to determine the exact assets available (see MOH, 2003d, 2004b).

Biretuo MHO

The analysis of the Biretuo MHO's solvability ratios for financial periods 2005 and 2006 are shown on table 8.7 and appendix H. It would be seen that there were limitations in calculating the solvability ratios for 2005 and 2006 due to the inability of the Biretuo MHO to audit its accounts to provide balance sheets from which to extract the needed figures for computation. Therefore, it is complicated to establish its financial viability on the basis of this financial indicator. However, it could be

assumed that the Biretuo MHO is not on the verge of insolvency looking at its reserve funds for 2005 and 2006, which show surpluses instead of deficits (refer to p.150; and see 9.2.4.1, 9.2.4.5; and appendices I and M). For a solid projection of long term financial stability, which would help it defray any outstanding debts (if any) without recourse to borrowing, it is recommended that the management team should make it a habit to ensure that the accounts are audited on regular basis (see MOH, 2003d, 2004b).

9.2.3.3. Ratio of Coverage of Expenses of the MHOs: 2005-2006

This ratio assumes that the accumulated reserves of the mutual health organisations must correspond to the average expenses for at least three to six months. The objective is to ensure sufficient stability to be able to meet exceptional expenditures (Cripps *et al.*, 2003). As explained in chapter 8, 'surplus' is used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150; and see 9.2.4.5; and appendix M). This approach is used to analyse the ratio of coverage of expenses in respect of the four mutual health organisations in this study. The results are outlined in tables 8.4 to 8.7 and appendix H.

Aduana MHO

Although it could be argued that the Aduana MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to confirm this assumption (refer to chapter 8). Therefore, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Aduana MHO at the end of the financial year (refer to p.150; and see 9.2.4.5; and appendix M). As shown on table 8.4 and appendix H, in 2005, the Aduana MHO had reserves of ₦97m. (refer to p.150; and see 9.2.4.5; and appendix M). Meanwhile, when this was divided by its monthly expenses of ₦148m, it showed a ratio of coverage of expenses of 0.65, which is less than 1. This means it cannot meet average expenses for at least six months. However, its performance in 2006 was relatively good. When its reserves of ₦985m was matched against its corresponding monthly

expenses of ₵83m, it showed a ratio of coverage of expenses of 11.85. This means it can meet average expenses for at least six months. However, the overall assessment of the performance of this scheme on the basis of this indicator shows that the results are mixed because it is not certain whether it has sufficient funds to meet incidental expenses within six months. The Aduana MHO is located in one of the deprived districts in the Greater Accra region and has serious problems with human resources coupled with lack of adequate health facilities. The district has no hospital and members either over-utilise the few services provided by the health centres or often times report directly to the nearby health facilities for secondary or tertiary care (compare this with 10.2). It is recommended that the management team institute measures to ensure that the gate keeping system is adequately followed (refer to chapter 6).

Asakyiri MHO

Even though it could be argued that the Asakyiri MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to confirm this assumption (refer to chapter 8). Therefore, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Asakyiri MHO at the end of the financial year (refer to p.150; and see 9.2.4.5; and appendix M). The results are shown on table 8.5 and appendix H. In 2005, the Asakyiri MHO accumulated reserves of ₵609m (refer to p.150; and see 9.2.4.5; and appendix M). This was matched against its monthly expenses of ₵72m. The corresponding ratio of coverage of expenses was 8.45, which is encouraging because it means that it can meet average expenses for at least six months. In 2006, when its reserves of ₵261m, was matched against its monthly expenses of ₵110m, it indicated a ratio of coverage of expenses of 2.36. The ratio is higher than 1 and shows that the scheme is doing well on the basis of this indicator. Even though the overall financial performance of the Asakyiri MHO on the basis of this measure seems promising, it is still not certain whether it can meet its expenses within a period of six months. Members tend to report frequently to the tertiary health facility in Kumasi the regional capital town of the Ashanti region for healthcare rather

than adhering to the gate keeping system at the district and sub-district levels (refer to chapter 6). Therefore, the management will have to institute measures to boost its capacity to ensure that members adhere to the gate keeping system and try to subdue other incidental expenses (compare this with 10.2).

Asona MHO

While it could be argued that the Asona MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to confirm this assumption (refer to chapter 8). Therefore, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Asona MHO at the end of the financial year (refer to p.150; and see 9.2.4.5; and appendix M). The results are shown on table 8.6 and appendix H. In 2005, the Asona MHO posted reserves of ₦418m (refer to p.150; and see 9.2.4.5; and appendix M), which was set against its monthly expenses of ₦195m. This showed a ratio of coverage of expenses of 2.14 which is higher than 1. This means that it is performing well and may be able to meet average expenses for at least six months. In 2006, it posted reserves of ₦530m, which was matched against its monthly expenses of ₦656m. The resulting ratio of coverage of expenses was 0.80. Since this ratio is less than 1, it is clear that it has not got enough reserves to meet incidental expenses within a period of six months: its performance on this measure is questionable. Hence, the overall assessment of the performance of this scheme for 2005 and 2006 is mixed. The health care benefits packages provided under the NHI Act 650 for members is militating against the financial performance of this scheme. However, the management of the scheme has little control to regulate how often members can access available health care services (see MOH, 2003d, 2004b). Nevertheless, it is important for the management of the Asona MHO to strengthen its risk management techniques to be able to deal with health insurance risks (refer to 3.3) and minimise other expenses (compare this with 10.2).

Biretuo MHO

Although it could be argued that the Biretuo MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions

from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to confirm this assumption (refer to chapter 8). Therefore, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Biretuo MHO at the end of the financial year (refer to p.150; and see 9.2.4.5; and appendix M). It can be seen from table 8.7 and appendix H that in 2005, the Biretuo MHO accumulated reserves of ¢2,220m (refer to p.150; and see 9.2.4.5; and appendix M), which was matched against its monthly expenses of ¢221m. This showed a ratio of coverage of expenses of 10.03, which is encouraging since the assumption is that it can meet average expenses for at least six months. However, its performance in 2006 was not very encouraging because when the accumulated reserves of ¢1,284m, was matched against the corresponding monthly expenses of ¢664m, it showed a ratio of coverage of expenses of 1.93. This is higher than 1 and shows that its overall performance is good. However, there are still concerns with the rate at which members utilise health services and management also incur certain expenses. It is assumed that the Biretuo MHO might not be able to meet its expenses within six months without recourse to borrowing. The management is limited in its capacity to handle health insurance risk challenges. Meanwhile there are regulatory limitations on the part of the management to put a cap on how often members can utilise health services (MOH, 2003d, 2004b). Even so, there is still the need to introduce measures to reduce excessive spending resulting from over-utilisation of health services by its members (compare this with 10.2).

9.2.3.4. Ratio of Subscriptions to Expenditure of the MHOs: 2005-2006

The ratio of subscriptions to expenditure shows the sufficiency of subscriptions to cover the expenditures incurred. The financial assumption is that this should be equal to or higher than 1 to ensure financial vibrancy (Cripps *et al.*, 2003). This ratio was also analysed to see how the four mutual health organisations were able to raise sufficient subscriptions from their members and the results are shown in tables 8.4 to 8.7 and appendix H.

Aduana MHO

It would be seen from table 8.4 and appendix H, that in 2005, the Aduana MHO raised a total amount of ₵652m from subscriptions, which was matched against its annual expenditure of ₵1,776m. This showed a ratio of subscription to expenditure of 0.36. This ratio is less than 1 and does not show a good sign: it could not ensure financial vibrancy. In 2006, it raised a total amount of ₵294m from subscriptions, which was set against its annual expenditure of ₵997m. This represents a ratio of subscriptions to expenditure of 0.29, which is less than 1. This is also not a good sign because the Aduana MHO is not able to raise enough subscriptions from its members. Since this MHO is located in one of the most deprived districts in the Greater Accra region (GSS, 2005), it is important for the management to review the premium and the administration fees so that prospective paying informal sector members with large families can register so as to boost its income from premiums. This must have recourse to the tariff structure provided under the NHI Act 650 (see MOH, 2003d, 2004b). This notwithstanding, there were limitations in the financial data provided. The formal sector members' subscriptions are not paid directly to the Aduana MHO and also the social group members do not pay premiums at all: these could not be computed together with the paying informal sector members' subscriptions in this study (refer to 9.2.1).

Asakyiri MHO

It could be seen from table 8.5 and appendix H that in 2005, the Asakyiri MHO accrued a total amount of ₵439m from subscriptions. When this was matched against its annual expenditure of ₵864m, it showed a ratio of subscriptions to expenditure of 0.50. This is less than 1 and it is not a good sign that the scheme is showing that it is financially vibrant to meet its expenditures as they occur. In 2006, the total subscriptions raised was ₵274m. This was set against the annual expenditure of ₵1,327m, which showed a ratio of subscriptions to expenditure of 0.20. This is less than 1 and does not show a good sign that it is financially vibrant to cover future expenditures. It is obvious that the Asakyiri MHO is not able to design a suitable premium for the people in the district to be able to raise enough subscriptions from the paying informal sector membership. There is the need to set premiums based on statistical analysis so that a lot more people may be able to sign up to the scheme.

This must be considered in tandem with the rigidities in the NHI Act 650 tariff structure (MOH, 2003d, 2004d). The Asakyiri MHO like its counterpart- Aduana MHO, there were limitations in the financial data provided. The formal sector members' subscriptions are not paid directly to the Asakyiri MHO and also the social group members do not pay premiums at all: these could not be computed together with the paying informal sector members' subscriptions in this study (refer to 9.2.1).

Asona MHO

It could be seen from table 8.6 and appendix H that, in 2005, the Asona MHO accumulated an amount of ₦842m from subscriptions. When this was set against its annual expenditure of ₦2,340m, it showed a ratio of subscriptions to expenditure of 0.35, which is less than 1. This is not a good sign that the scheme has enough funds to pay off its expenditures. In 2006, subscriptions amounted to ₦1,769m, which was set against the annual expenditure of ₦7,874m. This indicated a ratio of subscriptions to expenditure of 0.22. Since this is less than 1, it does not show a good sign that it can meet expenditures as and when they occur. The assumption is that the Asona MHO is not able to devise strategies to attract paying informal sector members in the communities to enrol and pay premiums. There is the need to review the premium and the administration fees for its paying informal sector membership against the background of the rigidity in the NHI Act 650 tariff structure (MOH, 2003d, 2004b). This will help to attract many people who are currently missing out to enrol with the Asona MHO so that its subscriptions can increase to meet expenditures as they occur. However, the Asona MHO like its counterparts- Aduana MHO and Asakyiri MHO, there were limitations in the financial data provided. The formal sector members' subscriptions are not paid directly to the Asona MHO and also the social group members do not pay premiums at all: these could not be computed together with the paying informal sector members' subscriptions in this study (refer to 9.2.1).

Biretuo MHO

As seen from table 8.7 and appendix H, in 2005, the Biretuo MHO collected a total amount of ₦1,993m in subscriptions. This was matched against the annual expenditure of ₦2,656m. This represents a ratio of subscriptions to expenditure of

0.75. This is less than 1 and therefore, it does not show a good sign that the scheme has enough subscriptions to meet expenditures as they occur. In 2006, the accrued subscriptions was totalled ₦3,472m, which was matched against the annual expenditure of ₦7,972m. This signified a ratio of subscriptions to expenditure of 0.43. This is less than 1 and does not show a good sign that there is financial vibrancy on the part of the Biretuo MHO. This means that the Biretuo MHO is not likely to meet its expenditures based on accrued subscriptions since it cannot set suitable premiums. There is the need for the management to review the premium and the administration fees taking cognisance of the provisions of the NHI Act 650 tariff structure (MOH, 2003d, 2004b), so that peasant farmers in the district who have large family sizes can enrol. On the other hand, the Biretuo MHO like its counterparts- Aduana MHO, Asakyiri MHO and Asona MHO, there were limitations in the financial data used. The formal sector members' subscriptions are not paid directly to the Biretuo MHO and also the social group members do not pay premiums at all: these could not be computed together with the paying informal sector members' subscriptions in this study (refer to 9.2.1).

9.2.3.5. Ratio of Operating Costs to Income of the MHOs: 2005-2006

The ratio of operating costs to income includes all the costs related to the administration and management of the mutual health organisation. The general rule is that this ratio should not exceed 5 percent of the income generated (Cripps *et al.*, 2003). This was also explored to find out if the management of the four mutual health organisations are ensuring judicious use of financial resources and the results are indicated in tables 8.4 to 8.7 and appendix H.

Aduana MHO

The results are shown in table 8.4 and appendix H. In 2005, the Aduana MHO incurred operating costs of ₦341m. This was matched against the annual income of ₦1,873m and showed a ratio of operating costs to income of 0.18 (18 percent). Since this is more than 5 percent, it shows that it is not doing well in curtailing costs. Similarly, in 2006, it paid an amount of ₦281m towards operating costs. This was matched against its annual income of ₦1,983m. It showed a corresponding ratio of

operating costs to income of 0.14 (14 percent). Since this is more than 5 percent, it shows that the MHO is not doing well in controlling operating costs. Therefore, its performance on the basis of this ratio is poor. The Aduana MHO has a problem with how to reach out to its communities. The main channels of communication are FM radio and mobile van: to sensitise the people on the need to enrol. These have high cost implications (see 9.4). It is important for the management team to reduce costs in areas such as regular use of FM radio advertisement, which might not reach majority of the catchment population due to its geographical location (GSS, 2005). The management team should liaise effectively with the leadership of the various social groups in the district.

Asakyiri MHO

It can be seen from table 8.5 and appendix H, that in 2005, the Asakyiri MHO accrued annual income of ₦1,474m. The operating costs of ₦238m was matched against this annual income and showed a ratio of operating costs to income of 0.16 (16 percent). This is more than the 5 percent mark and shows a poor performance on the part of management to control operating costs. In 2006, it accrued a total income of ₦1,588m. When the operating costs of ₦189m was matched against the annual income, it showed a ratio of operating costs to income of 0.11 (11 percent). This is more than 5 percent and shows a poor performance on the part of management to reduce operating costs. The operating costs of the Asakyiri MHO are increasing because its offices are in a rented premise, among other factors. This problem can be resolved if the management team can liaise with the District Assembly to find office accommodation within the premises of the Assembly or a separate building is constructed and dedicated to the scheme. This will reduce the huge costs incurred in renting of office accommodation.

Asona MHO

As shown in table 8.6 and appendix H, in 2005, the Asona MHO's operating costs was ₦102m, which was matched against its annual income of ₦2,758m. This represents a ratio of operating costs to income of 0.03 (3 percent). Since this is lower than the stipulated 5 percent mark, it shows a good sign that management is somewhat

prudent in managing costs. In 2006, its operating costs consisted of ₦92m, which was set against an annual income of ₦8,404m. The ratio of operating costs to income showed 0.01 (1 percent), which is less than 5 percent. This shows a good sign that management is not incurring much in operating costs. Therefore, its performance on the basis of this ratio is good. The Asona MHO is located in an urban township where its catchment population can be reached easily by both radio and television (national) advertisements. Moreover, it is accommodated in a building, which was renovated by the Municipal Assembly and located at the heart of the municipality: it is closer to the market, private businesses and other Local Government decentralised departments. Accessibility is helping to reduce running costs relating to vehicles and other mobility issues.

Biretuo MHO

As can be seen from table 8.7 and appendix H, in 2005, the Biretuo MHO spent an amount of ₦262m in operating costs, which was matched against an annual income of ₦4,876m. The ratio of operating costs to income represents 0.05 (5 percent), which is the same as the stipulated 5 percent and shows that the management is able to break-even in incidental costs. In 2006, an amount of ₦2,137m was spent in operating costs, which was set against an annual income of ₦9,256m. This showed a ratio of operating costs to income of 0.23 (23 percent), which is more than 5 percent and shows that the management is not doing well in managing costs. The operating costs of the Biretuo MHO increased in 2006, due to multiplicity of factors. Importantly, the Biretuo MHO is located in a district where many of its adjoining communities cannot be reached easily by radio and television advertisements. Since these communities are also not accessible during the wet season, the management team spends considerable amount of financial resources in vehicle running costs and human resources during the dry or harmattan season to sensitise people in the district. This cost can be brought under control if the management team can effectively utilise the community leadership to carry out health insurance education and mobilisation campaigns.

9.2.3.6. Ratio of Efficiency in Collecting Dues of the MHOs: 2005-2006

This measured the rate of payment of dues, which is the ratio between the amount of dues actually collected to the total amount expected during a given period. A rate nearer 100 percent indicates active participation and enhances the scheme's ability to pay for the services it offers. It may also signify the attainment of the objectives of a campaign of sensitisation and promotion (Cripps *et al.*, 2003). Thus, the rate of payment of dues was examined to see how the four mutual health organisations are upbeat in the collection of subscriptions. The results are shown in tables 8.4 to 8.7 and appendix H.

Aduana MHO

It would be seen from table 8.4 and appendix H, that in 2005, the subscriptions collected by the Aduana MHO totalled ₦652m. However, the expected dues for this period had not been projected by management. In 2006, it raised a total amount of ₦294m from subscriptions. The expected subscriptions for 2006 was deduced from the 2005 subscriptions collected, which was ₦652m. The rate of payment of dues or efficiency in collecting dues represents 0.45 (45 percent). This shows a very low participation because it could not reach even 50 percent. This problem could be attributed to the inability of the Aduana MHO to determine and devise suitable premiums to attract more members in the communities to enrol rather than their physical inability to collect the premiums. A review of the premium is recommended for consideration by the management team. This must be considered in respect of the government tariff structure set under the NHI Act 650 (see MOH, 2003d, 2004b). It must be remembered that there were limitations in the financial data provided to determine the projected subscriptions by the Aduana MHO for 2005 and 2006 financial periods (refer chapter 8). Only the PIS members' subscriptions were used since both the formal sector and social group members do not pay premiums directly to the scheme (refer to 9.2.1).

Asakyiri MHO

From table 8.5 and appendix H, in 2005, the Asakyiri MHO accrued a total amount of ₦439m from subscriptions. However, the expected dues for 2005 had not been

projected by management. In 2006, the scheme raised a total amount of ₦274m from subscriptions. The 2005 subscriptions of ₦439m was used as expected dues for 2006. The rate of payment of dues or ratio of efficiency in collecting dues represents 0.62 (62 percent). Even though the ratio is more than 50 percent, it is still considered as a low participation. There are problems with technological and administrative systems on the part of the management team to determine the eligible population and premiums: this is recommended for rectification. However, there were limitations in the financial data provided to determine the projected subscriptions by the Asakyiri MHO for 2005 and 2006 financial periods (refer chapter 8). Only the PIS members' subscriptions were used since both the formal sector and social group members do not pay premiums directly to the scheme (refer to 9.2.1).

Asona MHO

As seen from table 8.6 and appendix H, in 2005, the Asona MHO accumulated an amount of ₦842m from subscriptions. However, the expected subscriptions for 2005 had not been projected by management. In 2006, it raised an amount of ₦1,769m from subscriptions. The 2005 actual subscriptions collected, which was ₦842m was used as the 2006 expected dues. The rate of payment of dues or ratio of efficiency in collecting dues represents 2.1 (210 percent). This shows that there is high participation since the ratio exceeded the stipulated 100 percent mark. However, there are still problems with technological and administrative capacity of the Asona MHO to determine the eligible population to be able to project and calculate the expected subscriptions. The management team should undergo refresher courses on how to undertake actuarial and risk management techniques in health insurance. Nonetheless, there were limitations in the financial data provided to determine the projected subscriptions by the Asona MHO for 2005 and 2006 financial periods (refer chapter 8). Only the PIS members' subscriptions were used since both the formal sector and social group members do not pay premiums directly to the scheme (refer to 9.2.1).

Biretuo MHO

From table 8.7 and appendix H, in 2005, the Biretuo MHO collected an amount of ₦1,993m as subscriptions. However, the expected dues for 2005 had not been estimated by management. In 2006, it accrued an amount of ₦3,472m in subscriptions. The 2005 subscriptions of ₦1,993m was used as the 2006 estimated dues. The rate of payment of dues represents 1.74 (174 percent). This is encouraging as it indicates a very high participation since it exceeded the stipulated 100 percent mark. However, the Biretuo MHO is facing problems with how to determine the eligible population as well as how to statistically determine suitable premiums for its prospective paying informal sector members. This is caused by the fact that it is not able to calculate how many people in the population would register due to the rigidity in the NHI Act 650 tariff structure (see MOH, 2003d, 2004b). There is the need for Parliamentary review of the NHI Act 650 (MOH, 2003d, 2004b), to enable the Biretuo MHO decide suitable premiums for its large informal sector population who are mostly peasant farmers. Yet, there were limitations in the financial data provided to determine the projected subscriptions by the Biretuo MHO for 2005 and 2006 financial periods (refer chapter 8). Only the PIS members' subscriptions were used since both the formal sector and social group members do not pay premiums directly to the scheme (refer to 9.2.1).

9.2.4. Additional Financial Analysis

The above financial viability indicators used could not help to give a much clearer picture of the financial performance and viability of the four mutual health organisations in this study; there is either lack of, or inadequate data. As a result, other financial analyses were made to measure the performance and viability of the mutual health organisations, as explained below.

9.2.4.1. Source of Income as a Percentage of Total Income of the MHOs: 2005–2006

The income patterns of the mutual health organisations are matched against the three sources. These are National Health Insurance Fund (NHIF); Paying Informal Sector (PIS); and Other Income (OI). The percentage of income source to total income

determines how much each source contributes to their overall financial resources. The breakdown is given in appendix I and discussed below.

Aduana MHO

In 2005, the Aduana MHO raised a total income of ₦1,873m. The National Health Insurance Fund (NHIF) component was ₦1,158m, representing 62 percent; Paying Informal Sector (PIS) component was ₦652m, representing 35 percent; and Other Income (OI) component was ₦62m, representing 3 percent. In 2006, the total income was ₦1,983m. From this, the NHIF contribution was ₦1,656m, representing 84 percent; the Paying Informal Sector (PIS) constituted ₦294m, representing 14 percent; and the Other Income (OI) component was ₦32m, representing 8 percent. It is evident that the NHIF contributes the highest income to the Aduana MHO's overall income. The management team must make extra efforts to increase its income from the Paying Informal Sector component. This will help them pay any claims to health care providers if the NHIF component is delayed (compare with 10.2).

Asakyiri MHO

In 2005, the Asakyiri MHO accrued a total income of ₦1,474m. The NHIF contribution to this was ₦875m, representing 59 percent; PIS component was ₦439m, representing 30 percent; and Other Income (OI) consisted of ₦158m, representing 11 percent. In 2006, it accumulated a total income of ₦1,588m. The NHIF's contribution was ₦1,245m, representing 78 percent; PIS's component was ₦274m, representing 17 percent; and the OI's component was ₦68m, representing 4 percent. Decisively, the Asakyiri MHO also depends heavily on the NHIF to increase its total income. The management team must undertake other activities to increase the revenue from both the PIS and OI sources. This will enable it pay claims to health care providers when the NHIF component is delayed (compare with 10.2).

Asona MHO

In 2005, the Asona MHO collected an amount of ₦2,758m as total income. The NHIF contributed ₦1,897m, representing 69 percent; PIS contributed ₦842m, representing

31 percent; and OI contributed ₪18m, representing 0.7 percent. In 2006, the annual income totalled ₪8,404m. The NHIF contributed an amount of ₪6,544m, representing 78 percent; PIS contributed an amount of ₪1,769m, representing 21 percent; and OI constituted ₪90m, representing 1 percent. The results show that the Asona MHO depends on the NHIF to raise much of its total income. The management team should develop strategies to increase the PIS membership so as to boost the revenue from this income source. They need to encourage philanthropists in the municipality to demonstrate altruism towards the financial viability of the scheme. This is how it will be able to pay claims to health care providers when the NHIF component is delayed (compare with 10.2).

Biretuo MHO

In 2005, the Biretuo MHO's total income was ₪4,876m. The NHIF component was ₪2,797m, representing 57 percent; PIS's contribution was ₪1,993m, representing 41 percent; OI's contribution was ₪85m, representing 2 percent. In 2006, its accrued annual income totalled ₪9,256m. The contribution from the NHIF was ₪5,768m, representing 62 percent; PIS's contribution was ₪3,472m, representing 38 percent; and OI's contribution was ₪15m, representing 0.2 percent. Although the Biretuo MHO is making strenuous efforts to encourage altruism and accruing sufficient income from both the PIS and OI sources, it still relies heavily on the NHIF. It is recommended that the management team should emphasise on the relevance of the community members' contributions to the financial viability of the scheme so as to entice them to register in large numbers. This will enhance its ability to pay claims to health care providers when the NHIF component is delayed (compare with 10.2).

9.2.4.2. Expenditure as a Percentage of Total Income of the MHOs: 2005-2006

The income and expenditure patterns of the mutual health organisations are assessed to see whether the management teams are making efforts to assure financial stability. The analysis shown in appendix J covered the 2005 and 2006 financial periods for the four mutual health organisations and explained below.

Aduana MHO

It can be seen that in 2005, when the Aduana MHO's income was ₵1,873m, its corresponding expenditure was ₵1,776m, representing 95 percent. In 2006, when the income was increased to ₵1,983m, its equivalent expenditure was ₵997m, representing 50 percent. The indication is that in as much as the Aduana MHO is increasing its income, there is also corresponding expenditure resulting from payment of huge claims to health care providers. As indicated earlier, the Aduana MHO is located in a district where there are only health centres. Therefore, members either report directly to nearby hospitals or specialist health institutions for secondary and tertiary care instead of following the gate keeping system. Nonetheless, the management team must institute measures to prevent the occurrence of health insurance risk factors such as moral hazards, adverse selection and abuse of health care services by its members (refer to 3.3 and compare with 10.2).

Asakyiri MHO

It would be seen that when the Asakyiri MHO in 2005 accrued annual income of ₵1,474m, its concurrent expenditure was ₵864m, representing 59 percent. In 2006, when its income increased to ₵1,588m, its matching expenditure was ₵1,327m, representing 84 percent. The Asakyiri MHO is located in a district which is closer to the Komfo Anokye Teaching Hospital in the Ashanti region. As a result, members utilise the services of this tertiary health facility without recourse to laid-down gate keeping procedures. Although it has introduced quota on members' access to health facilities by giving them three (3) health facility attendance cards per year, it would be seen in chapter 10 that this procedure is usually not followed or over-used. Thus, the Asakyiri MHO is facing serious issues with regards to risk management techniques to deal with members' over-utilisation of health care service and further training to strengthen the skills of the management team members is required (compare with 10.2).

Asona MHO

The Asona MHO in 2005, accrued an income of ₵2,758m and its comparable expenditure was also ₵2,340m, representing 85 percent. In 2006, when its income

increased to ₺8,404m, its related expenditure also increased to ₺7,874m, representing 94 percent. This pattern shows the lack of management's ability to deal with risk management issues of the scheme as its members are over-utilising health care services. Although a quota on the number of times members can access health care services may be difficult to implement due to the regulatory provisions under NHI Act 650 (MOH, 2003d, 2004b), this must be considered by the management team on a pilot basis (compare with 10.2).

Biretuo MHO

The Biretuo MHO's accumulated income in 2005 was ₺4,876m and its parallel expenditure was ₺2,656m, representing 54 percent. In 2006, the income increased to ₺9,256m, and its corresponding expenditure also increased to ₺7,972m, representing 86 percent. The management team is unable to control over-utilisation of health care services by its members. Considering the socio-economic composition and geographical location of the Biretuo MHO, it is recommended that the management team liaises with the health institutions to intensify public health education, which will help bring this trend down (compare with 10.2).

9.2.4.3. NHIF Claims as a Percentage of Total Health Care Claims of the MHOs: 2005-2006

Analyses of the rate of government subsidy (NHIF) component released to the mutual health organisations against reimbursement of total claims made by the healthcare institutions for fiscal years 2005 and 2006 respectively are shown in appendix K. Claims are made towards the costs of healthcare services utilised by members. The National Health Insurance Act 650 provides under section 33 (2) that:

A District Mutual Health Insurance Scheme shall be provided with subsidy from the National Health Insurance Fund (MOH, 2003d:15)

This is supposed to serve as reinsurance. A cheque is issued to the mutual health organisations by the National Health Insurance Council and Authority (NHIC and NHIA) under two expenditure items: 'Claims' and 'Administrative Costs'. For the

mutual health organisations, the difference between the amount released under 'NHIF Claims' and the 'Total Health Care Claims' is the amount accessed from the two other income sources: 'paying informal sector' (PIS) and 'other income' (OI) to pay the overall health care claims. This is the case where the NHIF Claims is less than 100 percent. The 'NHIF Claims as a percentage of Total Health Care Claims' for the four mutual health organisations during 2005 and 2006 is discussed below.

Aduana MHO

It would be seen that in 2005, the Aduana MHO received claims from health care providers, which amounted to ₦592m. The NHIF released by the National Health Insurance Council and Authority (NHIC and NHIA) towards claims was ₦689m, representing 116 percent. The difference was a surplus of ₦97m. In 2006, the scheme received a total health care claims totalling ₦661m, from health care providers. The NHIF released towards claims amounted to ₦1,295m, representing 196 percent. After paying off the claims, it was able to accrue a surplus of ₦633m. It is clear that the Aduana MHO depends heavily on the NHIF to be able to pay off its health care claims to contracted health care providers. Although there were surpluses recorded after paying off these health care claims, the question arising is whether the Aduana MHO can meet its health care expenses to providers without relying on NHIF. This is not certain since members continue to utilise health care services frivolously (see tables 10.1 and 10.2).

Asakyiri MHO

In 2005, the Asakyiri MHO received claims from health care providers totalling ₦295m. The NHIF released towards defraying the costs of claims totalled an amount of ₦750m, representing 254 percent. The surplus accrued after paying off the claims was ₦454m. In 2006, the scheme received health care claims amounting to ₦722m from healthcare providers. The NHIF released towards claims amounted to ₦220m, which represents 30 percent. The shortfall of ₦502m was mobilised from PIS and OI sources. The analysis of the financial viability of the Asakyiri MHO on this basis is a mixed one. While the Asakyiri MHO cannot rely solely on the NHIF released towards claims to pay off its total health care claims to providers, it is important that

the management team should do much more to raise enough revenue from local sources to deal with any eventuality. It may wish to increase the registration fees to be able to do this. However, the implication of this for people with large family sizes must be considered (see tables 10.1 and 10.2).

Asona MHO

The total health care claims received by the Asona MHO in 2005 from health care providers was ₦1,620m. The NHIF component released towards claims was ₦1,483m, which represents 92 percent when the claims bill was paid off. The remaining amount, which was raised from PIS and OI to pay up the total claims was ₦137m. In 2006, the total health care claims received from healthcare providers amounted to ₦17,206m. The NHIF released towards claims totalled an amount of ₦13,200m, representing 77 percent. The shortfall was an amount of ₦4,006m, which was raised from the PIS and OI, to complete the payment. Obviously, the financial viability of the Asona MHO on this level of spending raises concerns. The Asona MHO relies heavily on the NHIF claims to pay off its indebtedness to health care providers even though it has to supplement this with its internally generated funds. The management team should institute strategies to deal with the moral hazards, adverse selection and abuse of services by its members (see tables 10.1 and 10.2).

Biretuo MHO

In 2005, the Biretuo MHO received total health care claims from healthcare providers, which was ₦1,736m. The NHIF released to set this off amounted to ₦1,947m, representing 112 percent. The surplus realised after paying the claims off was ₦211m. In 2006, the scheme received health care claims totalling ₦5,869m, from healthcare providers. The NHIF released towards claims was ₦5,455m, representing 93 percent. The difference, which was an amount of ₦414m was raised from PIS and OI, to complete the payment. The analysis is indicative that the financial viability of the Biretuo MHO on this basis is mixed. Although it supplements the NHIF released towards claims with its own funds to settle its unabated debt to health care providers, the evidence shows that it depends heavily on the NHIF. The management team of

the Biretuo MHO should undertake extra-income activities to meet any contingency (see tables 10.1 and 10.2).

9.2.4.4. Paying Informal Sector (PIS) Income as a Percentage of Total Income of the MHO: 2005–2006

The initial strategy of policy makers in the health sector was to wean the district and municipal mutual health insurance schemes (MHOs) off 'Government subsidy' within two years of implementing the National Health Insurance Scheme (NHIS). For this to happen, contribution of the informal sector is imperative so this is also explored. The analysis made covered 2005 and 2006 financial years respectively and are shown in appendix L. The contribution of PIS to total income is given in percentages.

Aduana MHO

In 2005, the Aduana MHO had 5,000 PIS members who contributed ₵652m, representing 35 percent. In 2006, it registered 9,000 PIS members who contributed ₵294m, representing 4 percent to its income. The financial viability on the basis of the contribution of PIS is not convincing since it could not reach 50 percent in each period. Even though the Aduana MHO is classified as a deprived district in the Greater Accra region (GSS, 2005), accounting for this trend, the management team should encourage prospective members in the informal sector to register to boost this source of income. The administration fees should be set within the financial abilities of the people in the district. This will persuade prospective members with large family sizes to enrol. Otherwise, it will not be able to pay off claims to health care providers without supplementing it with NHIF component of the health care claims (refer to 9.2.4.3).

Asakyiri MHO

In 2005, The Asakyiri MHO had 3,000 PIS members who contributed ₵439m, representing 30 percent. In 2006, it registered 6,000 PIS members who contributed ₵274m, representing 17 percent to its income. The Asakyiri MHO could not accrue up to 50 percent of its income from the PIS in both 2005 and 2006. Many of the

people in the informal sector are private traders and few farmers (GSS, 2005). Therefore, the management team should intensify its education on the concept of health insurance amongst the informal sector members to be able to increase its income base from this source. Without this, it will find it difficult to pay off claims to health care providers without supplementing it with NHIF component of the health care claims (refer to 9.2.4.3).

Asona MHO

In 2005, the Asona MHO had 22,000 PIS members who contributed ₦842m, representing 31 percent. In 2006, it registered 25,000 PIS members who contributed ₦1,769m, representing 21 percent to its income. Although the Asona MHO was able to raise some income from its PIS source, this could not reach 50 percent in 2005 and 2006 fiscal periods. Although the Asona MHO is located in an urban township, it still has quite a number of people in the paying informal sector group who the management team should do well to attract to register by adopting personal advertising strategy instead of its over-reliance on radio and television advertisements. Unless this is done, it will be difficult for the management team to pay off claims to health care providers without supplementing it with NHIF component of the health care claims (refer to 9.2.4.3).

Biretuo MHO

In 2005, the PIS members of the Biretuo MHO were 26,000 who contributed ₦1,993m, representing 41 percent. In 2006, it registered 27,000 PIS members who contributed ₦3,472m, representing 38 percent to its income. Even though the Biretuo MHO was able to accrue enough revenue from its PIS, this still fell short of 50 percent in 2005 and 2006 respectively. It is clear that the changes in the premiums are discouraging a lot of people with large family sizes to enrol or re-enrol: most of them are peasant farmers. The management team should revive its traditional method of education and mobilisation to attract these people. Anything short of this will mean that the management team will not be able to pay off claims to health care providers without supplementing it with NHIF component of the health care claims (refer to 9.2.4.3).

9.2.4.5. Reserve Funds of the MHOs: 2005-2006

In financial terms, if an organisation is able to post reserves in its balance sheet, it means that its performance is good and it might have a bright future (see Cripps *et al.*, 2003). As explained in chapter 8, there were no balance sheets in the financial statements provided by the four mutual health organisations. This made it difficult to assess the financial viability of the mutual health organisations on the basis of their actual reserves (see ILO, 2005). Therefore, reserve fund is defined as total income minus total expenditure. Thus, 'surplus' is used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150). This approach is used to measure their performance and possible financial viability in this study similar to what was applied in other studies (see Atim, 1998, 2001; Atim *et al.*, 1998). Therefore, the status of the reserve funds for the four mutual health organisations for financial years 2005 and 2006 are given in appendix M.

Aduana MHO

While it could be argued that the Aduana MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to justify this assumption. Hence, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Aduana MHO at the end of the financial year (refer to p.150). In 2005, when the Aduana MHO paid its expenditure of ¢1,776m from its income of ¢1,873m, the accrued reserve fund showed a surplus of ¢97m. In 2006, when it paid its expenditure of ¢997m from its income of ¢1,983m, the accumulated reserve fund figure was a surplus of ¢985m. The analysis shows that the Aduana MHO has no liquidity problems (refer to p.150; 9.2.1, 9.2.4.1; and see appendices I and M). However, the question remains as to whether these reserves (refer to p.150) will be able to help it pay off its debts as and when they arise within a period of six months. The certainty in this can only be adduced when considered against the utilisation rate of health services by its members, among other factors (compare with chapter 10).

Asakyiri MHO

Although it could be argued that the Asakyiri MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to justify this assumption. Hence, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Asakyiri MHO at the end of the financial year (refer to p.150). In 2005, when the Asakyiri MHO paid its expenditure of ¢864m from its income of ¢1,474m, the reserve fund figure was a surplus of ¢609m. In 2006, when its expenditure of ¢1,327m was paid from its income of ¢1,588m, it gave accumulated reserve fund figure, which was a surplus of ¢261m. Based on this analysis, it is glaring that the Asakyiri MHO has no liquidity problems (refer to p.150; 9.2.1, 9.2.4.1; and see appendices I and M). Nevertheless, the question to be asked is in relation to whether these reserves will be enough to settle its future health care claims and other expenses within a period of six months without recourse to borrowing. This must be viewed concurrently with the utilisation rate of health services by its members, among other factors (compare with chapter 10).

Asona MHO

Even though it could be argued that the Asona MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to justify this assumption. Hence, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Asona MHO at the end of the financial year (refer to p.150). In 2005, when the Asona MHO paid its expenditure of ¢2,340m from its income of ¢2,758m, the accrued reserve fund showed a surplus of ¢418m. In 2006, its expenditure of ¢7,874m was paid from its income of ¢8,404m and the reserve fund accrued was a surplus of ¢530m. From hindsight, it is conspicuous that the Asona MHO is not facing any problems with liquidity (refer to p.150; 9.2.1, 9.2.4.1; and see appendices I and M). All the same, the issue arising is whether the Asona MHO can depend on these reserves (refer to

p.150) to pay off recurring debts up to a period of six months without difficulties. It is important to consider this issue against the utilisation rate of health services by its members, among other factors (compare with chapter 10).

Biretuo MHO

While it could be argued that the Biretuo MHO might have some reserves because its third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1; and see 9.2.4.1 and appendix I), there were no balance sheets available to justify this assumption. Hence, as explained in chapter 8, 'surplus' is used as a proxy for 'reserves' to indicate the surplus (es) accrued by the Biretuo MHO at the end of the financial year (refer to p.150). In 2005, the Biretuo MHO incurred expenditure of $\text{¢}2,656\text{m}$, which was paid from its income of $\text{¢}4,876\text{m}$, leaving reserve fund figure, which was a surplus of $\text{¢}2,220\text{m}$. In 2006, it incurred an expenditure of $\text{¢}7,972\text{m}$, which was also paid from its income of $\text{¢}9,256\text{m}$. The reserve fund figure was a surplus of $\text{¢}1,284\text{m}$. The indications are that the Biretuo MHO is not having problems with liquidity (refer to p.150; 9.2.1, 9.2.4.1; and see appendices I and M). On the other hand, the concern arising here is whether it would be able to pay its health care claims and other expenditures beyond at least a period of six (6) months if it did not receive external support in cash or in kind. This should be seen in the light of utilisation rate of health services by its members, among other factors (compare with chapter 10).

It would be concluded from the above analyses that the financial viability of the mutual health organisations based on their current financial analysis is also influenced greatly by health insurance risk factors (refer to 3.3). Hence, the financial arguments reflect the nature of actuarial or statistical problems facing the mutual health organisations in this study. While the management teams lack the technical capability to deal with the health insurance risk factors orchestrated by the uncontrollable utilisation of health services by their members, they are also constrained by the rigidity in the National Health Insurance Act 650 to effect any context-specific changes (see MOH, 2003d, 2004b). The inapplicability of some of the indicators in

the financial viability model in this study shows that there is the need to analyse other non-financial factors to help make a cogent conclusion about the financial and overall sustainability of the mutual health organisations in this study. These will also help explain why the four mutual health organisations are spending so much on health care claims. It will also reveal why their expenditures increase with increment in their incomes (see 9.3, 9.4; chapters 10, 11 and 12).

9.3. Perceived Benefits of the Mutual Health Organisations

This sub-theme examines the perceived benefits of the mutual health organisations. This measures how the mutual health organisations are beneficial to their members through increasing financial access to health care to greater members of the population. Whenever people lack access to orthodox medicine, they tend to find solace in traditional medicine, which is sometimes described by the medical professionals, particularly in Ghana as 'below standards' ('GNA', Friday October 3, 2008b). The benefits of the mutual health organisations are presented below in the context of their beneficial impact on the population. Institutional viability indicators have been analysed to support the benefits that emerged from the interview data.

9.3.1. Understanding and Reasons for Joining the MHOs

The mutual health organisations have broadened the understanding of the community members, regarding what the concept of health insurance was in a country where this was not in the lexicon of public health financing and delivery. In communities where people do not have enough financial deposits in the banks, the desire to join a mutual health organisation is based on the need to plan ahead to avoid exorbitant health care costs and facilitate easy access to a health facility. A member gives a vivid definition as:

...a health insurance is the easiest way to the hospital...(BRMHO-M-2)

The concept of health as defined in the Ghanaian traditional context can be summed up as: *Yadee Ye Ya*, translated to mean, ill health is debilitating. Therefore, any benefit derived from the operations of the mutual health organisations involved how they are helping people to find preventive health measures. People's perception of illness and poverty is that these are unpredictable events. As soon as sickness strikes, it deprives the individual of the ability to independently do a lot of essential things:

...one thing is that if I am sick and bedridden, it is someone who would have to support me, but now that I am not sick, I have to help myself... So by contributing to the health insurance ahead of sickness, it provides me with the security I need when incapacitated...I think that the health insurance can help me at that time...(BRMHO-M-1)

Thus, people in the communities believe that there is a relationship between ill-health and poverty:

...sedee mpaninfoo ka no, se eka wo nanti a, na aka woto. Yades woho yi, enker aansa na aba, translated to mean, I think that the elderly would say that when one is injured at the heels, it affects the buttocks, leading to immobility: sickness could strike suddenly...(ASNMH0-M-3)

The mutual health organisations are operating in such a way that people, especially, those in the informal sector have to enrol voluntarily. This is why one major benefit of the mutual health organisations was measured on how members understood the concept of health insurance. The idea is that the mutual health organisations would benefit if members had a clear understanding of what they were getting involved in, this encouraged sustained membership. The benefits of members' understanding of the concept of mutual health organisations is to some extent also manifesting in how they are helping to mobilise others in the communities to join:

...the various groups and the Churches are organising themselves and undertaking additional income generating activities like 'aburo-hwane' (contract for peeling of maize); to get money to pay for members who cannot pay. The pastors and the leaders of the groups understand our financial abilities so they give us information during announcement time at Church service for us to start preparing towards it...(ASKMH0-M-1)

Even though these are among the core aims of members in the communities, they have formed different understandings, opinions and reasons regarding why they have joined the mutual health organisations. Respondents' understanding sometimes depends on whether or not they had experienced pre-NHI 2003 MHOs (refer to chapter 7). Members in both Aduana MHO and Biretuo MHO have better understanding of the concepts of health insurance and mutual health organisations than their counterparts in the Asakyiri MHO and Asona MHO. This is because the Aduana MHO and Biretuo MHO had transformed as pre-NHI 2003 MHOs to post-NHI 2003 MHOs (refer to 9.1). Therefore, respondents could recall memories of the health care benefits they had enjoyed under the two regimes. This had also enhanced their sense of appreciation of the risk sharing concept and had reinforced their commitment:

...when the insurance scheme started in the community (pre-NHI 2003 MHO), I did it. Now that it is the government's scheme (post-NHI 2003 MHO), I have done it. I had my membership card for the old scheme and I now have my membership card for the present one... (BRMHO-M-8)

The perception of respondents who had experienced the pre-NHI 2003 MHOs is that the community initiated the mutual health organisations, which were subsequently taken up by the government to encourage members to continue their membership. They have realised that their efforts had been recognised by the government:

...since we did it well, the government also realised the usefulness of it and has now taken over the ownership... (BRMHO-M-10)

This has resulted in a healthy competition because people do not want community projects they undertake to fail. This has also given them the incentive to plan ahead while there is good health and financial resources. A sense of prepayment is evident by the young men who have started raising their families. They have understood that as they have been able to enrol with the mutual health organisations their wives could take their children to the hospital for necessary health care in their absence:

...I have registered with the health insurance scheme as it can happen that I may not be available: I do travel frequently...when any of my children falls sick and there is no money home, my wife can send them to the hospital so that they could access health care... (ASNMHO-M-4)

Although, there were few pre-NHI 2003 MHOs in the regions where the Asakyiri MHO and Asona MHO are located, respondents who had not had any prior interaction with these mutual health organisations show understanding and reason for joining based on the government's introduction of the National Health Insurance Scheme (NHIS) in 2004. Respondents perceive that the mutual health organisations are a good package from the government as it was fulfilling its electioneering campaign promise (compare this with 11.3.1):

...during the electioneering campaign of the current government [New Patriotic Party] in power, they proposed that when they come into power, they would establish the health insurance programme so that the people would enjoy good health. So

immediately they came into office in 2001, they selected few districts to run the health insurance scheme on pilot basis to see if it would be feasible...(SMMHO-4)

Under such circumstances, members try to identify the benefits they are expected to have rather than their contribution to risk sharing and risk pooling. The idea of free health care benefit is what has informed their decisions:

...we made the people aware that at first it was for the community, but now it is a government run scheme. The interesting thing is that the people's awareness and related benefits of the scheme has improved tremendously...(SMMHO-3)

It is perceived that the message they took from the initial education they received was that membership of the mutual health organisation would give them the opportunity to be treated free of charge, given free drugs (medication) on prescription so that they would just walk in and out of the health facilities without much financial burden (compare this with 9.4.2.5):

...they told us that if we paid the money, we could go to the hospital free of charge. That is what they taught us...(ASNMHO-NM-1)

Consequently, some aged (70 years and over) members in the communities who are accessing free health care under the exemptions, after experiencing the ordeals of the cost recovery (Cash and Carry) for a long while, are quick to show their appreciation to the government:

...I will say that President Kufour and his Government have done very well by giving us free health care... (ASKMHO-M-2)

There are other respondents in the communities who also believe that joining the mutual health organisations is a call to national duty and demonstration of their sense of patriotism:

...now that it is a national health insurance scheme, there must be uniformity...(ASNMHO-M-6)

Thus, this view is mostly held by respondents who had heard about the pre-NHI 2003 MHOs but did not have the opportunity to belong to one.

9.3.2. Institutional Viability Indicators

The few people who have shown understanding have registered and are reaping the benefits of their membership. Thus, the performances of the four mutual health organisations in respect of how they are increasing membership coverage were examined for 2005 and 2006. The indicators used for measuring the mutual health organisations' bid to increase membership are the rate of membership coverage of the catchment population; and the rate of penetration or new registration (refer to table 8.8). Thus, the applicable intermediate indicators are analysed below.

9.3.2.1. Rate of Membership Coverage of the Catchment Population of the MHOs: 2005-2006

This shows the relationship between the registered members and the total number of people in the catchment population. This helps the management to know how effective it is in reaching people in the population. The analysis is over the course of two years: 2005 to 2006 for the four mutual health organisations and shown in appendix D1 to D4.

As can be seen in appendix D1, in 2005, the Aduana MHO registered 14,000 members in its catchment population of 98,000, representing a rate of membership coverage of the catchment population of 14.2 percent. In 2006, it registered 21,000 members in its catchment population of 121,000, representing 17.3 percent. In 2005, the Asakyiri MHO registered 18,000 members in its catchment population of 126,000, representing 14.2 percent. In 2006, this increased to 42,000 in its catchment population of 146,000, representing 28.7 percent (see appendix D2). On its part, the Asona MHO in 2005 registered 87,000 members in its catchment population of 138,000, representing 63 percent. In 2006, this number increased to 88,000 in its catchment population of 147,000, representing 59.8 percent (see appendix D3). As shown on appendix D4, the Biretuo MHO in 2005 registered 69,000 members in its catchment population of 139,000, representing 49.6 percent. However, in 2006, this

rather reduced to 65,000 members in its catchment population of 150,000, representing 43.3 percent.

The conclusion is that almost all (apart from the Biretuo MHO) the four mutual health organisations were able to increase their coverage of their respective catchment population between 2005 and 2006. This explains why the rate of drop-out of membership was not analysed. Again, it can be observed that in 2005, the four mutual health organisations achieved between them rate of coverage of the catchment population of 14.2 percent and 63 percent. In 2006, the rate of coverage of the catchment population achieved between them ranged from 17.3 percent to 59.8 percent. From hindsight, these rates were not significant.

However, considering the difference in population increase between 2005 and 2006, the rates could be considered as significant. It is only the Biretuo MHO which could not increase its enrolment in the second year: 2006. The factor which might have caused this trend was that the Biretuo MHO, like the Aduana MHO was a pre-NHI 2003 MHO, and changed to post-NHI 2003 MHO. When the people in the communities heard of the government's take over, they were quick to join in the first year because of the enhanced health care benefits package:

...It will surprise you to go to the hospital as early as 7:00am and find the number of people who are at the OPD to see a doctor...The new concept is that the people feel they have contributed to the scheme by paying their premiums so they must enjoy their benefits accordingly... (SMMHO-3)

However, this level of enthusiasm died out in the subsequent year due to varied reasons (see sub-theme 9.4 for some of the reasons which account for the differences).

9.3.2.2. Rate of New Adherents or Penetration into the Target (Formal and Informal Sectors) Population of the MHOs: 2005-2006

This shows the relationship between the number of new members and the total number of old members, enabling an assessment of the relative growth in membership. The results of the analysis of the rate of penetration into the respective

target district population of the mutual health organisations are shown in table 9.1. Between the periods 2005 and 2006, the number of new members registered by the Aduana MHO was 7,000. This shows the difference between the 14,000 members registered in 2005 and 21,000 members registered in 2006. As a result, the rate of penetration into the target population or the membership was 50 percent. The Asakyiri MHO registered 24,000 new members in 2006. This shows the difference between the 18,000 members registered in 2005 and 21,000 members registered in 2006. Hence, the rate of penetration into the target population or membership was 133 percent.

Between 2005 and 2006, the Asona MHO was able to register 1,000 new members. This illustrates the difference between the 87,000 members registered in 2005 and 88,000 members registered in 2006. Therefore, the rate of penetration into the target population or membership was 1.1 percent. However, the Biretuo MHO could not increase its membership for the same period as it was rather reduced by 4,000 (-4,000). This indicates the difference between the 69,000 members registered in 2005 and 65,000 members registered in 2006. Consequently, the rate of penetration into the target population or membership was negative (-6) percent.

Table 9.1: Rate of New Adherents or Penetration into the Target (Formal and Informal Sectors) Population of the MHOs: 2005-2006

Scheme	2005 Membership	2006 membership	New Entrants Difference (2005- 2006)	Rate of Enrolment (%)
Aduana MHO	14,000	21,000	7,000	50
Asakyiri MHO	18,000	42,000	24,000	133
Asona MHO	87,000	88,000	1,000	1.1
Biretuo MHO	69,000	65,000	(4,000)	(6)

The conclusion is that apart from the Biretuo MHO which could not increase its membership, Aduana MHO, Asakyiri MHO and Asona MHO were able to increase their membership in their respective target population (see 9.4.2.1 for reasons which account for the differences).

9.3.2.3. Rate of New Adherents or Penetration into the Formal Sector (SSNIT Contributors) Population of the MHOs: 2005-2006

The results of the analysis of the number of registered formal sector members in the target population of the mutual health organisations are shown in table 9.2. The table shows that in 2005, the Aduana MHO registered 816 formal sector members. This increased to 1,710 in 2006 and the difference was 894. The rate of penetration into the formal sector membership was 109 percent. The Asakyiri MHO registered 3,315 formal sector members in 2005. However, this was reduced to 2,562 in 2006, showing a difference of negative (-753), representing negative (-22.7) percent. Whereas the Asona MHO was able to register 15,145 formal sector members in 2005, this was reduced to 12,203 in 2006, showing a difference of negative (-2,942), representing negative (-19.4) percent. In the case of Biretuo MHO, it was able to increase its formal sector membership from 1,986 in 2005 to 2,426 in 2006, showing a difference of 440, representing 22.1 percent.

Table 9.2: Rate of New Adherents or Penetration into the Formal Sector (SSNIT Contributors) Population of the MHOs: 2005-2006

Scheme	2005 Membership	2006 Membership	New Entrants Difference (2005-2006)	Rate of Enrolment (%)
Aduana MHO	816	1,710	894	109
Asakyiri MHO	3,315	2,562	(753)	(22.7)
Asona MHO	15,145	12,203	(2,942)	(19.4)
Biretuo MHO	1,986	2,426	440	22.1

The observation is that whilst the Aduana MHO and Biretuo MHO were able to increase their economically active membership, the Asakyiri MHO and Asona MHO recorded decreases. Therefore, the mutual health organisations which are able to count on the large numbers of these economically active people (refer to chapter 5), would be able to boost their revenue base from the administration fees component of their income.

9.3.2.4. Rate of New Adherents or Penetration into the Paying Informal Sector Population of the MHOs: 2005-2006

As there could be transfers out of the population and the fact that some of the economically active members might not be indigenous people who could decide to spend their retirement in their hometowns, villages, regional or the national capital towns, it was considered appropriate to verify how the mutual health organisations are managing to penetrate into their informal sector population who should be their bedrock of sustainability. The results are shown in table 9.3. The results show that the Aduana MHO registered 5,000 paying informal sector members in 2005. This increased to 9,000 in 2006, showing a difference of 4,000. In view of this, the rate of penetration into the paying informal sector membership was 80 percent. The Asakyiri MHO registered 3,000 members in 2005 which increased to 6,000 in 2006. The difference was 3,000, representing 100 percent. The Asona MHO registered 22,000 members in its paying informal sector in 2005. This increased to 25,000 in 2006, showing a difference of 3,000, representing 13.6 percent. On its part, the Biretuo MHO registered 26,000 members in 2005, which increased to 27,000 in 2006. The difference was 1,000, which represents 3.8 percent.

Table 9.3: Rate of New Adherents or Penetration into the Paying Informal Sector Population of the MHOs: 2005-2006

Scheme	2005 Informal Members	2006 Informal Members	New Entrant Difference (2005-2006)	Rate of Enrolment (%)
Aduana MHO	5,000	9,000	4,000	80
Asakyiri MHO	3,000	6,000	3,000	100
Asona MHO	22,000	25,000	3,000	13.6
Biretuo MHO	26,000	27,000	1,000	3.8

The observation is that in terms of paying informal sector income, some of the mutual health organisations are more viable than others (compare this with 9.2.7).

9.3.2.5. Rate of New Adherents or Penetration into the Social Group Membership of the MHOs: 2005-2006

Another landslide benefit of the operations of the mutual health organisations is their ability to have improved the coverage of people considered as the social elements: indigents, the aged (over 70 years) and children (under 18 years) in their respective populations. The results of this analysis are shown in table 9.4. From the table, the Aduana MHO registered 8,152 members in the social group in 2005. This increased to 10,209 in 2006, showing a difference of 2,057 and the rate of penetration into the social group membership was 25 percent. The Asakyiri MHO registered 11,646 members in 2005, which increased to 33,358 in 2006. The difference was 21,712, representing 186 percent. The Asona MHO registered 34,633 members in 2005. This increased to 49,192 in 2006 and the difference was 14,559, representing 42 percent. The Biretuo MHO registered 40,907 members in 2005, which was reduced to 36,398 in 2006. The difference was negative (-4,509), representing a negative (-11 percent).

Table 9.4: Rate of New Adherents or Penetration into the Social Group Membership of the MHOs: 2005-2006

Scheme	2005 members	2006 members	New Entrants – Difference (2005-2006)	Rate of Enrolment (%)
Aduana MHO	8,152	10,209	2,057	25
Asakyiri MHO	11,646	33,358	21,712	186
Asona MHO	34,633	49,192	14,559	42
Biretuo MHO	40,907	36,398	(4509)	(11)

The observation is that apart from the Biretuo MHO which reduced its membership coverage between 2005 and 2006 registration periods, the sheer numbers show the magnitude of the problem of poverty in the communities. This is why the provision of subsidy by the government through the mutual health organisations is seen as a benefit. For this to have happened to many people under the current market-oriented economic policy reforms propelled by the World Bank and the International Monetary Fund (refer to 5.3.2), especially, as Ghana is a non-welfare state or economy, is highly commendable. This perception is supported by an editorial of a newspaper:

...the new bid to provide care for even the poor and the vulnerable among Ghana's 19 million people was described just this week by one editorialist as: perhaps the biggest social development project undertaken by any Government since Kwame Nkrumah after Ghana's independence...(Lewis, 2008)

Thus, since the social group members are not paying the premiums, this has remarkably reduced their financial burden (refer to 9.2.2). However, the management teams are finding it difficult to deal with the issue of indigents:

...I think that now the major issue to address is how to assess indigents: who qualifies to be an indigent? We are saying that about 5 percent of the population is described as indigent(s)... We need to be able to identify such people to forestall abuse of the facility... (SMMHO-4)

There is limited public administration system and technological capacity to identify these people in the population:

...we have a problem with the identification of indigents because there is no accurate database; it is not the priority of the District Assembly...(HMP-6)

The observation is that the number of informal sector members of the mutual health organisations might not have appeared to be significant when compared with their population figures and the number of formal sector employees (SSNIT contributors). However, all of them were able to enrol new members from the informal sector particularly, in the social group. This conforms to the main belief of the mutual health organisations under the National Health Insurance Act 650 (refer to 6.5.4.3). On the basis of penetration into the catchment population and therefore improving health care financial access for members, it is concluded that all the mutual health organisations (MHOs) saw gradual increases in their second year of operation. A Ministry of Health policy document observes that:

Government has introduced the National Health Insurance Scheme (NHIS) as a social protection policy with the objective of improving financial access to quality health services. The coverage of NHIS has been increasing steadily. All districts have functional District Mutual Health Insurance Scheme (DMHIS) with over 17 percent of the population registered and eligible to

receive covered services with little or no payment at the point of service. This level of coverage is nevertheless too low to remove the financial barriers to services experienced under the Cash and Carry system (MOH, 2007e:26).

9.3.3. Enhanced Universality in Health Financial Protection

Another major benefit of the mutual health organisations is their ability to extend universal financial access to health care for the population. There is a difference between coverage and universality. The main tenet of health financing is that governments all over the world seek to attain universal health care financial protection (refer to chapter 2). There is the potential for attaining universality to health financial protection because of the wide spread of the mutual health organisations on district and regional levels. The measurement of universality is not based on the number of people who have the opportunity to register. Universality involves two main areas: affordable health care and affordable premiums. The universality objective of the mutual health organisations is being enhanced by the health service benefits package, which is 100 percent for both outpatient (OPD) and inpatient (Admissions) care at the health facilities:

...the interesting thing is that the benefits package is now more enhanced...When it was under the management of the community [pre-NHI 2003 MHO era] the benefits package covered only in-patients (admissions) care. During such a period, if a member had not spent 24 hours at the hospital or even at the casualty ward, they would not be entitled to the benefits. However, all these restrictions are no longer there under the current scheme [post-NHI 2003 MHO era]... (SMMHO-3)

This is encouraging people in the informal sector of the economy to enrol so they might access health care when they need it most. The inability of many people to receive basic drugs (medicines) after being given a prescription was the main reason why the cost recovery (Cash and Carry) policy was introduced in public health facilities in the 1980s and early 1990s:

...drugs were to be fully paid for by the patient and then there were various fees graduated... (PMS-8)

The government of Ghana is keen to reverse this situation by making the cost of health care affordable within the financial reach of the large number of people. Hence, the introduction of the health insurance policy under the National Health Insurance Act 650 in 2004 (MOH, 2003d), was to allow the people to make good use of the near free health care.

The uniformed premium being charged by the mutual health organisations is encouraging curiosity and enthusiasm in the benefits of membership. Since all the mutual health organisations are charging the minimum premium (refer to 9.2.2), it is easing the health care financial pain of the poor people in the communities. The rationale behind the introduction of the National Health Insurance Scheme and graduated premiums is:

...our system is aimed at addressing issues of equity...we have the poor as the core of our insurance scheme, of course without disregarding the rich...it covers a broad range of diseases, broad range of groups in terms of the benefits package. In terms of even the financing, there is a combination of tax, social insurance and premiums... (PMS-2)

The setting of uniformed premium is advantageous to members as the total cost of their insurance policy is relatively low. This is helping a lot of people who could find the money to pay for subscriptions for the mutual health organisations based on affordable premiums. The downside is that when people felt unfairly treated by this system, their levels of fervour could equally diminish. Thus, whenever people in different communities became aware of differential premium rates, it could serve as a source of discouragement to enrolment.

9.3.4. Advertising the Benefits of Membership

The mutual health organisations have to undertake a sustained marketing campaign to encourage more people to enrol. The management teams have introduced their own strategies to teach the benefits of health insurance to the community residents. The insured members themselves are also doing their best to encourage their friends and relatives to embrace the ideals of membership. Advertisement of the perceived advantages of health insurance by existing insured members is serving as a motivating

factor for prospective members to join, especially, in communities where fee for service had been the norm at the available health care facilities:

...in fact, it was initially difficult, but as time went on and understanding of the people improved, they accepted it and the membership began to increase...Currently, the membership is increasing rapidly, because those who have registered and have enjoyed the benefits have testified to others and that has encouraged many people to become members...(SMMHO-4)

The traditional marketing strategy: 'word of mouth' is an effective mode of communication in most communities. This has the ability to impact on people's sense of conviction. Members are using their own experiences as examples for others who have yet to register. Members' access to the photo identification (ID) cards is considered to be a guarantee to improve their financial access to orthodox health care services:

...If I am now ill, I will only pick up my membership card...even if I do not have a hospital card, they will know I am a member of the scheme so they would attend to me without hesitation and give me medicines prescribed...(BRMHO-M-2)

In most cases, insured members have realised some marked benefits in that their membership and attendant health care benefits are better than uninsured clients who would have had to pay for the costs of health care services from their own pockets at the point of service use. The different themes under which members are demonstrating their perceived benefits are discussed below.

9.3.4.1. Financial Peace of Mind and Renewed Confidence

Peace of mind is an essential element for a healthy living: one's financial ability to meet the costs of health care enhances this peace of mind. Lack of funds during times of illness can put an entire family in an awkward situation:

...the reason why I joined was that I needed to have a peace of mind when I am sick and come to the hospital. With the health insurance, I will not need to think about how to pay. I really feel

free to attend hospital without a thought of having to go and pay directly after receiving services... (BRMHO-M-3)

There are some people who could not attend hospital because they would have to make direct payment for the costs of health care. The treatment of a chronic illness of a family member could lead to huge financial demands from both traditional medicine and orthodox medical care. The economic implications in terms of loss of man hours that the patient's relatives would have to manage to support them are enormous. It sometimes required them to leave their own hometowns to live in another township for purposes of health care:

...we realised that people refused to report to the health facility when sick and would do so only when the condition became a bit critical to manage...We advised them that their health status could improve through health insurance as one would not have to wait until a condition became critical... (SMMHO-3)

However, insured members do not have to face such problems since the health facilities in their communities are contracted by their mutual health organisations to provide health care. Members of the mutual health organisations are relieved by the current arrangements:

...my mother suffers from high blood pressure (BP): hypertensive. She reports to the hospital every month for check up...she used to go to the next town as the medical officer was not stationed here...she could pay five hundred thousand old cedis (¢500,000.00) per visit. Since the start of the insurance and when the government took over, she has been coming here and gets all her prescribed medication without paying a pesewa... (BRMHO-M-1)

The mutual health organisations are providing means to enable both the relatively rich and the relatively poor people to be part of a pre-payment scheme. While ambulatory patients could be treated the same day, those whose conditions required hospitalisation could be admitted accordingly. This peace of mind is convincing members that they could go to the health institutions anytime they fell sick. Insured members in the communities do not need to think about going for a loan to go to the

hospital as: '*...registered members are free to come to the hospital anytime...*' (BRMHO-M-3). Even though, lack of money had reduced the confidence levels of some people in their search for modern health care, the reassurance of prepaid health care bills was helping to restore this confidence. The belief is that membership and pledged payment by the mutual health organisations is also giving health personnel an extra incentive to double their efforts in providing treatment.

9.3.4.2. Collective Bargain of Health Care Costs

Insured members expressed satisfaction with the cost of health care since their mutual health organisations are assumed to have negotiated on their behalf. Even as they are contributing to their own premiums, they are aware that greater part of the costs is borne on their behalf through the collective funding stream (refer to 9.2.1). They would have had to pay heavier bills if they had acted individually. This has cost-benefit implications for the members:

...the simple analysis is that by paying a total premium of about one hundred thousand old cedis (¢100,000.00), you could enjoy the benefit of the difference in cost, which is very good... (ASNMHO-M-5)

Insured members explained that before they joined the mutual health organisations, they could incur costs in respect of the various services provided at the health care facilities: consultation fees, laboratory investigations and drugs (medicines). All these could culminate in huge amounts of money to be paid by an individual at a single visit. This was under a circumstance where they were lucky to have been attended to by a medical officer, who would make the diagnosis and prescribe the needed drugs (medicines) since some of the health facilities lacked qualified health personnel. Insured members are satisfied with improved financial access to modern health care as they can: '*...now bring home whatever money is left...*' (ASNMHO-M-6).

9.3.4.3. Reduced Costs of Transportation to the Health Care Facilities

The cost of transportation to and from health care facilities located away from the communities has been one of the reasons why most people resort to unorthodox health

care practices and only report for modern health care as a last resort. However, some members of the mutual health organisations are taking advantage of their proximity to health facilities to access orthodox health care:

...In terms of access, if the district hospital is 20kms away but the regional hospital is only 5kms away, the person will prefer to go to the regional hospital because it is cheaper in terms of transportation...of course, when it comes to quality of care or tertiary care, they get it here...because of that some of the mutual health organisations have been forced to sign agreement with these facilities because they are nearer... (HMP-1)

Due to the sparse nature of the population in most communities, the cost of people travelling to and from rural areas to the urban towns for health care is factored into their decision making process about whether to access or not to access orthodox health care. There are occasions when people could mobilise the funds to meet the costs of the health care services but would be short of funds for transportation and incidental expenses. This could be discouraging, especially if they do not have any relations in the town or city where the health facility is situated.

As the costs associated with the health care services are being subsidised by the mutual health organisations, members are encouraged to seek orthodox health care during the initial stages of their illness instead of waiting for it to degenerate to a critical stage: '*...the only thing is to get money for transport(ation)...* (BRMHO-M-1). Thus, even if they did not have money when they became sick, they could solicit for money for transportation to the health facility, which they have to pay themselves:

...before the health insurance was introduced, we could stay home for a while without coming to the health facility because of lack of funds and fear of the cost of health care...(ASKMHO-M-3)

In most of the communities, there are some individuals who would only be satisfied with the services provided at an orthodox health facility when they could obtain an injection in addition to the drugs (medicines) prescribed for malaria. The cost of chloroquine injection could increase the total costs of health services. However, their

membership with the mutual health organisations is more useful when they are able to access all the available treatment at the health facilities:

...immediately, I come here, they hurry to attend to me and give me injection and medicines for my sickness before I go back home. They really look after me well, that is appreciated... (BRMHO-M-8)

The conclusion is that the mutual health organisations are showing potential to increase their membership: *'...of course, under this regime there is a better potential... (PMS-17)*. This would be realised when they had achieved autonomy after policy makers have pursued their corporate finance objectives and made them (MHOs) answerable to their communities. The above discussions show a positive impact on the financial viability and overall sustainability of the mutual health organisations.

9.4. Perceived Problems of the Mutual Health Organisations

This sub-theme examines the perceived problems facing the mutual health organisations. The mutual health organisations need to be able to prevent problems. However, there are some problems, which are indicators of inevitable insolvency and collapse. These could be grouped under educational, economic, socio-political-cultural, behavioural, health as well as administrative sub-themes. The analysis of these would help draw inferences and references to show how such perceived problems, if not guarded against, could undermine financial viability as well as overall sustainability (compare this with 10.2).

9.4.1. Insufficient Education on the Concept of Health Insurance

Education is a continuous process in any health insurance programme, and anything less could lead those already registered astray. If this element is missing, then the sustenance of the mutual health organisations as well as the National Health Insurance Scheme (NHIS), as a whole, would be in doubt. The introduction of the National Health Insurance policy on a large scale for the first time in the country in 2004 was not preceded by extensive public education and sensitisation. This should have been done since a society like Ghana was used to free health care services:

...but before Ghana (Gold Coast), there was no payment for health care...(ASNMHO-M-2)

Respondents emphasise the need for extensive education:

...there should be mass education of the population to address the issue of misconceptions people have about the schemes...(PMS-12).

The channels of communication being used are not comprehensive. At national and regional levels, the communication channels being used for disseminating information about the National Health Insurance Scheme (NHIS) are in most cases billboards, radio, and television advertisements:

...you see things on television, you hear things on radio, we are going to be doing more of those types of education, we are even considering using mobile cinema vans to go to the rural areas...(PMS-13)

However, these are failing to meet the needs of the target population because some of the villages are still not hooked into the national electricity grid and could not be reached by television network. At district and community levels, the mutual health organisations are giving announcements and doing public education using public address systems (PAS) or information vans and local frequency modulation (FM) stations. Therefore, the problem of insufficient education is contributing to low recruitment:

...they [MHOs] face logistics problems especially, transportation to reach the people in the remotest parts of the communities...They are facing problems with the registration of members...They lack the ability to build capacity and market the schemes...Even marketing at the national level is via radio and television to educate the population...(PMS-12)

The idea is that when people see an advertisement on television or hear jingles on the radio, they could go to the community health insurance committee (CHIC) representatives who would give the rest of the information. Some policy makers perceive that it is rather the people who are not responding to the call to enrol since they have other priorities:

...we are educating, but at the end of the day, remember how human beings behave, until they get sick, they don't think going to pay seventy two thousand old cedis (¢72,000.00) to get health insurance is all that necessary... (PMS-13)

However, what is not coming out clearly is what prospective members would have to do: payment of premiums, waiting periods, renewal of membership every year, rights and responsibilities, among others:

...the information given did not mention that the benefits package had limitations... (PMS-11)

This is what would encourage people in the first instance, to go to these representatives who themselves, have some health insurance knowledge gaps, anyway. However, this strategy has not been successful with the majority of people as they do not understand the message being given: '*...they say we should pay money for free health care...*' (ASNMHO-NM-1). Some respondents do not understand the English word: health insurance, being used in the advertisements:

...I did not know of any health insurance until President Kufuor's insurance [NHIS] was introduced... (ASKMHO-NM-2)

Some of the insured and non-insured members alike do not appear to exhibit in-depth knowledge of the continuity of membership needed to sustain an insurance venture. This could be attributed to the fact that the vigorous activities of the pre-NHI 2003 MHOs were confined to certain regions, while there were inactive trends in other regions (refer to chapter 7):

...you could have one region a lot of action taking place but another region, nothing taking place...We heard everything, but we heard very little effort in Volta Region, Upper East region, Upper West region, Central region...even in Ashanti region, it was much later that it was initiated...(PMS-17)

Respondents perceive that the national firebrand of the mutual health organisations phenomenon was at its highest flame when it was quenched by the introduction of the National Health Insurance Act 650 in 2004. Thus, in communities where there were no pre-NHI 2003 MHOs, people do not know much about how such schemes operated. Meanwhile the current schemes are using the name 'district or municipal mutual health insurance scheme'. The evidence shows that the post-NHI 2003 MHOs like the Asakyiri MHO and the Asona MHO did not start on a massive community mobilisation, education and sensitisation activities:

...personally, I don't think there was enough education on the health insurance scheme (NHIS)... (PMS-14)

This problem of insufficient education is reflecting in two main areas of the operations of the mutual health organisations. The first concerns the seeming absence of education on membership rights and responsibilities. The National Health

Insurance Council and Authority (NHIC and NHIA) had developed few posters on the National Health Insurance Scheme (NHIS) and displayed them at vantage points in health facilities. However, the mutual health organisations do not have leaflets and printouts of the rights and responsibilities of membership in the local dialects for their members in the communities. The reason given by some management teams is that members should read the National Health Insurance Act 650 (MOH, 2003d), which codifies the rights and responsibilities of membership of the health insurance schemes. However, other respondents perceive that they are failing to realise that there are many people in the population who lack 'formal' educational literacy (illiterates: cannot read or write in the English language) and as such they could not read and understand the contents of the NHI Act 650:

...the argument that everything is enshrined in the NHI Act 650 and as such members should read for themselves is a porous one as the question: how many legal experts may even be aware of the content of the Act 650?...is not answered... (SMMHO-4)

The second issue relates to insured members' apparent lack of knowledge about the waiting period. Since members are not being educated on the expected waiting periods, there are complaints about the length of waiting time before a member could be eligible for health care access (see 10.2.1.1). Members do not seem to have problems with their relationships with the management staff of the mutual health organisations *per se*:

...Oh as for relationship with the staff of the scheme, that is no problem because they know they are delaying you so they have to be nice to you... Over here, the staff are okay... (ASKMHO-M-8)

Respondents perceive the mutual health organisations to be a possible source of health care financing that could assist most poor people in the communities to access health care: this depends on demonstration of truth from the management teams:

...the service we will get through the health insurance scheme can be seen as a source of easy access to orthodox health care (costs) and there is the need for truth from the management... (BRMHO-M-2)

As indicated earlier, the process of registration in the communities involves community health insurance committee (CHIC) representatives registering people and forwarding the details with monies collected to the secretariat of the mutual health organisations situated in the district capital towns (refer to 9.1.2.3). Members are then required to wait for a period of three (3) or six (6) months, depending on a particular mutual health organisation, before they would be eligible to access health care which would occur upon the issuance of their membership photo identification cards (see 10.2.1.1). The waiting period is being applied for two main reasons. The first is that it is being used by the management teams as a gate-keeping technique to prevent adverse selection and moral hazards of registrants, for example people who would wait to feel sick before registering to receive health care benefits. The second is that it serves as a means to generate additional revenue through investment in treasury bills or bonds:

...I think that the mutuals are not well resourced... they have also devised a way of delaying the issuance of the cards so that the monies that they collect could be accumulated to be able to meet their obligations...when you buy treasury bills you cannot discount immediately, you will have to wait for about three months or whatever...It means you do not have money readily available to be able to meet your obligations and by so doing, you delay the payment of the bills that have been submitted to you by the hospitals...(PMS-6)

However, the members are only told that their membership photo identification (ID) cards are not ready. The management teams attribute the delay in the issuance of the photo identification cards to inadequate number of staff available to deal with the huge numbers. This is refuted by some members who perceive that it is also due to the lackadaisical attitude of the staff toward their work roles and responsibilities. They perceive that in the era of computerisation, procedures and processes should be speeded up. They also attribute the delay to the administrative loopholes or lack of decentralisation on the part of the management teams:

...why is it three months waiting time?...The issuing of the membership cards is not smooth as we expected it to be...They should give the cards to those community representatives to

distribute instead of members going to the scheme office... (ASNMHO-M-6)

The delay in issuing photo identity cards is causing difficulties for some of the registered members when they report at the health facilities even under emergency situations. While insured members thought they could access health care free of charge, the contrary was the case: they were not eligible members (see 10.2.1.1):

...I think that during the time Biretuoman (pre-NHI 2003 MHO era) was doing it, we did not suffer too much with the photo-taking exercise... Since the government took over, the photo-taking exercise has become a big problem. There are cases where some people could be admitted at the hospital and it is only when they are being discharged that they would take them the photo... (BRMHO-M-1)

They are being refused treatment for their failure to produce their membership photo identification (ID) cards. The alternative is to pay promptly for services at a time when they had not financially prepared. They could be turned away due to their inability to raise the money immediately. A practical scenario occurred in the presence of this researcher. A sick mother of a man who had both registered with one of the mutual health organisations was refused treatment. She had been referred to the district hospital from a health centre in a nearby community on Saturday. As the patient (sick mother) had not yet satisfied the waiting period of three or six months she had not been issued with the membership photo identification card. They were asked by the health personnel to either pay as 'non-insured' clients or return to the village and report again on the following Monday because the staff of the mutual health organisation did not work weekends:

...my mother and I have contributed to the scheme since its inception in this district but have never fallen sick or used the benefits before. I thought it was a very laudable idea until what happened today, which has caused me a lot of distrust and in-confidence. What would happen if I send her back to the village and she dies? ... (BRMHO-M-5)

In short, the *modus operandi* of any health insurance scheme is that registered members should be able to maintain their membership. This depends to a large extent on constant education.

9.4.2. Low Enrolment amongst the Paying Informal Sector Members

The percentage of informal sector members in the overall membership of the mutual health organisations for periods 2005 and 2006 was analysed as shown in table 9.5. It can be deduced from the table that in 2005, Aduana MHO registered a total membership of 14,000. Out of this, 5,000, representing 36 percent were paying informal sector members. In 2006, it registered 21,000 members out of which 9,000, representing 43 percent were paying informal sector members. The Asakyiri MHO registered 18,000 members in 2005. Out of this, 3,000, representing 17 percent were paying informal sector members. In 2006, a total of 42,000 members were registered out of which 6,000, representing 14 percent were paying informal sector members.

Asona MHO also registered a total of 87,000 members in 2005. Out of this number, 22,000, representing 25 percent were paying informal sector members. In 2006, it registered a total of 88,000 members and 25,000 of them representing 28 percent were paying informal sector members. On its part, the Biretuo MHO registered a total of 69,000 members in 2005. Out of this number, 26,000, representing 38 percent were paying informal sector members. In 2006, it registered a total of 65,000 members out of which 27,000, representing 42 percent were paying informal sector members.

Table 9.5: Rate of Coverage of Membership (Paying Informal Sector Members) of the MHOs: 2005 – 2006

Scheme	2005	informal	%	2006	informal	%
Aduana MHO	14,000	5,000	36	21,000	9,000	43
Asakyiri MHO	18,000	3,000	17	42,000	6,000	14
Asona MHO	87,000	22,000	25	88,000	25,000	28
Biretuo MHO	69,000	26,000	38	65,000	27,000	42

The overall observation is that in 2005, while the Aduana MHO and Biretuo MHO's paying informal sector members were between 30 and 40 percent of their entire membership, both the Asakyiri MHO and Asona MHO did not have even 30 percent paying informal sector members. In 2006, the Aduana MHO and Biretuo MHO had between 40 and 50 percent. At the same time, the Asakyiri MHO and Asona MHO's coverage was still less than 30 percent of the total paying informal sector members. This could be explained by the fact that both the Aduana MHO and Biretuo MHO are

located in rural areas with a large informal sector pool. There is a relationship between the informal sector population and their economic status:

...so if you look at our social status, there appears to be a big problem on our hands. We have a greater percentage of our people to be peasant farmers as there are few people in the formal sector, who form an insignificant fraction of the economic status and standing. I think that it is another reason why we are not progressing with the registration of new members... (BRMHO-M-10)

Paradoxically, the seeming lack of in-depth knowledge in health insurance is contributing to the low coverage of the people in the informal sector of the economy. As the National Health Insurance Act 650 encourages all residents of Ghana to belong to a health insurance scheme (MOH, 2003d), it was expected that almost all the relatively poor people register with the district-wide and municipal-wide mutual health insurance schemes in order to enjoy the comprehensive health care benefits. Despite this policy statement, there are still people in the communities who are yet to enrol with any health insurance scheme (compare this with 9.1.3.4). Therefore, the question: how inclusive is the mutual health organisations of the entire population? - had yet to be answered (refer to table 6.6).

The irony was that some of the non-insured members had either registered with the pre-NHI 2003 MHOs or had been members of the post-NHI 2003 MHOs in the previous year (2005) but could not renew their membership in the following year (2006). Discussions with management and members in the communities unearthed the underlying factors, which accounted and are still accounting for the low enrolment amongst the paying informal sector members as explained below.

9.4.2.1. The Effect of Premium on Membership Enrolment

The immediate reason for the low informal sector membership coverage is attributed to the high cost of premiums. When people complain about the premium rates, they mean the consequence of it on their incomes taking into account the number of people in their families or households. Emphasis is placed on how the increases in the

premium rates are impacting upon enrolment. The Ghanaian population is relatively a youthful one. While youth unemployment is becoming a problem there is no government provision in terms of social assistance (refer to chapter 5):

...the only problem might be the yearly increment. If that happens frequently, then some could not raise the money to pay...If we could have a stable premium that will help since most people do not have lucrative jobs or sources of income... (BRMHO-M-7)

Despite the fact that the government of Ghana reimburses the mutual health organisations on behalf of the exempt group members, they need to be able to pay the health facilities ahead of the release of this subsidy (refer to 9.2.1). The issue is how they could continue to provide free health care to the large number coming under the exempt categories by depending primarily, on the financial contributions of the few paying informal sector members. It is perceived that even employees of some private organisations who previously enjoyed free private health insurance cover are having difficulties coming to terms with the payment of their own premiums upon the withdrawal of such facilities:

...as a staff of the 'Adarkwa Medical Centre', we used to have free medical care facility. We are no longer going to access that facility: we have been advised to register with the district mutual health insurance scheme... (ASKMHO-NM-3)

In contrast people who had joined and paid premiums under the pre-NHI 2003 MHOs perceive that the total cost of the health insurance policy under the post-NHI 2003 MHOs is too high for them to meet:

...the premium [under pre-NHI 2003 MHO era] was as little as twenty thousand old cedis (¢20,000.00)...so I feel that if the government has taken over, then that [premium] should be lesser than what we used to pay...the government needs to do something about the dues [reduction in premium]... (ADMHO-M-3)

A comparison of the premiums charged by both the Aduana MHO and Biretuo MHO (both operated as pre-NHI 2003 MHOs) and had seven and fifteen years operational experiences was conducted. However, the Asakyiri MHO and Asona MHO were not compared because data was only available for 2005 and 2006 as they were post-NHI 2003 MHOs and had only operated for almost three years (see appendix G).

Aduana MHO

The registration fees were compared of Aduana MHO under its pre-NHI 2003 MHO operations in 2002 and 2003 with its post-NHI 2003 MHO operations in 2005 and 2006. The results are shown in table 9.6. As shown in the table, the difference in the 2003 and 2005 subscriptions represents an increase of 228 percent on the amount charged in 2003.

Table 9.6: Premium Rates of the Aduana MHO: 2002 to 2003; and 2005 to 2006 (old cedis, ¢)

Year	Membership	Premium (¢)	Admin. Fees (¢)	Total (¢)	Difference (¢)	Increment (%)
2002	8,200	15,000.00	-	15,000.00	-	-
2003	12,400	25,000.00	-	25,000.00	10,000.00	67
2005	14,000	72,000.00	10,000.00	82,000.00	57,000.00	228
2006	21,000	72,000.00	28,000.00	100,000.00	18,000.00	22

NB: £1 was an equivalent of ¢18,000.00 old cedis as at November 2006.

-Data not available.

The premiums of ¢15,000.00 and ¢25,000.00 charged in 2002 and 2003, included administration fees. These were separated during 2005 and 2006 registration periods. The exempted members paid only the administration fees of ¢10,000.00 in 2005 and ¢28,000.00 in 2006 respectively.

Biretuo MHO

The registration fees were compared of Biretuo MHO under its pre-NHI 2003 MHO operations in 2002 and 2003 with its post-NHI 2003 MHO operations in 2005 and 2006. The results are shown in table 9.7. The table shows that under its pre-NHI 2003 MHO operation in 2002, the subscription charged by the Biretuo MHO was ¢20,000.00. During the 2003 registration period, the subscription was ¢22,000.00,

increasing by only €2,000.00. However, the difference in the premiums charged by the Biretuo MHO under its pre-NHI 2003 MHO operations in 2003 and post-NHI 2003 MHO operations in 2005 represents 355 percent increase on the 2003 premiums.

Table 9.7: Premium Rates of the Biretuo MHO: 2002 to 2003 and 2005 to 2006 (old cedis, €)

Year	Membership	Premium (€)	Admin. Fees (€)	Total (€)	Difference (€)	Increment (%)
2002	40,000	20,000.00	-	20,000.00	-	-
2003	43,000	22,000.00	-	22,000.00	2,000.00	9
2005	69,000	72,000.00	28,000.00	100,000.00	78,000.00	355
2006	65,000	72,000.00	28,000.00	100,000.00	78,000.00	0

NB: £1 was an equivalent of €18,000.00 old cedis as at November 2006.

The unit of registration was the household between 2002 and 2003 registration periods. However, the unit of registration was based on the family between 2005 and 2006 registration periods. This seems to be creating problems for the management and large family sizes:

...there is a problem with operational definition of the unit of household or family; to use for the registration. There is a problem with the collection of premium as a result of using family and not household as unit of registration... (HMP-6)

Again, Biretuo MHO operated between 2002 and 2003 without any membership categorisation as: indigents, aged (over 70 years) and children under 18 years. However, this was applicable during 2005 and 2006 operational periods.

9.4.2.2. Seasonality of Income

Some of the non-insured members consider economic constraint to be the most important factor, which is discouraging them from participating in the activities of the mutual health organisations, although they are interested in enrolling. It is indicative that individuals' wealth and financial status are deciding factors for enrolment into the mutual health organisations:

...there are some people who wish to register but are prevented from doing so due to lack of funds for registration...(SMMHO-2)

While the decision to enrol into a health insurance scheme is boosted amongst the relatively rich members in the communities, it is not the same for poor individuals. Respondents perceive that many people are engaged in petty trading, small-scale artisanship, fishing or peasant farming. The problems for the unemployed do not need mentioning at all. The unfavourable outputs and the deteriorating economic conditions are making it impossible for those with low income to mobilise the needed funds to enrol. Meanwhile, as indicated in a newspaper report, the implementation of the Economic Recovery Programme (ERP) introduced in 1983 had caused the:

...government to withdraw subsidy to many sectors of the economy: the agricultural sector had been badly affected... ('The Statesman', August 1, 2008).

It was apparent that many people in the communities could not get access to credit facilities or loans from financial institutions such as the commercial banks to support the expansion of their businesses or the acreage of their farms. The few people who are fortunate to gain access to credit facilities do so from what could be described as 'loan sharks' who charge exorbitant interest rates. People in the communities are facing difficulties with repayment of such loans:

...what I am thinking about doing right now is how to offset my indebtedness to my creditor...There has been poor yield this season, the price of foodstuffs is low and it is making it difficult for me to raise even the capital...(BRMHO-NM-3)

Consequently, the re-payment of such loans is usually on top of their priority lists, rather than contribution to a health insurance scheme. In communities where subsistence farming is the major occupation of the people, it is having wider repercussions for their involvement in the mutual health organisations since the route of entry is financial. As these people do not have money, even the benefits packages are not attractive enough to entice them to register:

...unfortunately, for Biretuo MHO, there has been a negative change...our clientele base has reduced instead of increasing

...the scheme can now pay huge claims up to about ten million old cedis (¢10,000,000.00). So we expected that now the membership coverage would improve, but it appears that the people are shying away...It is a mystery... (BRMHO-M-10)

The availability of funds is seasonally directed: it depends on either a good or poor harvest of farm produce and bumper fish catch. Therefore, weather and crop failures coupled with price fluctuations for the sale of their farm produce are creating big financial problems for these families. Their immediate concerns are how to pay their children's school fees and meet day to day costs of living:

...unfortunately, most of the people are peasant farmers. With the current trends, there appears to be economic failure as the people's main source of income is from the sale of their farm produce... (SMMHO-3)

The uninsured members appear to have little motivation to even approach the management of the mutual health organisations to enquire about how to enrol:

...yes, we were told but because I could not raise the funds, I did not make it a priority to locate their offices... (ASNMHO-NM-1)

They know very well that they would not be able to meet the required registration fees.

9.4.2.3. Timing of Registration

The timing of the registration was another difficult issue particularly if there had been a lean farming season when farmers had cash-liquidity problems:

...any failure in the weather or price fluctuations could affect them negatively...When there is such a failure; it is a big case in the family... (SMMHO-3)

Most heads of family and households in the Ashanti, Eastern and Brong Ahafo regions, where the Asakyiri MHO, Asona MHO and Biretuo MHO are located respectively, have cocoa farms and coffee plantations in the Sefwi area of the Western region. They spend a considerable period of time during the year growing and

harvesting their cocoa and coffee beans and only return home after the harvest. Therefore, this presents another case scenario where the failure to enrol sometimes depends on the presence or absence of the head of the household or family:

...na mekunu atu kwan, gye se oba ansa na w'abeye ama yen nyinaa, meaning, my husband had travelled during the registration period, I have to wait until he returns to register all of us... (BRMHO-NM-1)

All the mutual health organisations generally allow a 3-month registration period in a calendar year within which old members had to renew their membership as well as prospective members registering. This usually takes place between either August and October or October and December, when it is the harmattan or dry season (summer). This period enable the staff to enter the remotest parts of the districts, which are impassable during rainy season; to carry out mobile van sensitisation. The inability of people to enrol within the registration period compelled some of the Board of Directors to carry out a mopping up exercise:

...the Board has Education Committee that is supposed to find this out. Recently when we finished with the first registration, we realised that we had to do a second one to get more people covered. What we did was that we travelled to the communities to discuss the issues with the people. Even after that, we are still not satisfied with the number we got, so we shall sit down to find out the root cause of the problem... (SMMHO-3)

There was the need to have registration periods throughout the year because:

...the Chiefs and opinion leaders have expressed concern about timing of the collection of premiums... (HMP-6)

This would assist those who could register but could not pay their premiums upfront to pay on an instalment basis. However, the NHI Act 650 appears as a limitation for the management teams:

...now we work within a framework, the legal framework in which we cannot say we are asking people to pay half of the premium but we can make this registration very flexible so that we can accept instalment payment such that everybody, whoever

wants to register can register and benefit after the person has made full payment...(SMMHO-1)

9.4.2.4. Prioritising Social Commitments over Health Care

Four areas of socio-cultural significance are identified, which explain why some people had yet to register with the mutual health organisations. The first is the traditional conviction of some people who although might have or might not have had the money, are reluctant to join due to their beliefs. Traditional believers who formed 8.5 percent of the country's population in 2000 rely on the prowess of the 'gods' as the mediums through which they can make supplications to the omnipresent God (refer to 5.1). This belief is expressed in the way they offer appellations when praying through the pouring of libation where they refer to God as *twieduampong*, translated as a solid tree upon which one could lean without falling (compare this with 10.1.4). This belief could motivate people to assume that sickness or any form of strange disease has spiritual undertones. This perception is confirmed by a newspaper report:

...Prof. Yankah recounted various cases in some parts of Ghana...where strange diseases, such as unusual enlargement of testicles or swelling of the foot in vicinities encircled by 'mountains of refuse dumps' were attributed to spiritual forces by the people... ('GNA', Wednesday, 9 September 2009d)

Based on their belief, adherents expect that such diseases must be treated with supernatural powers rather than reliance on orthodox medicine. This notion is explained by a renowned Ghanaian Clergy:

...in traditional Ghanaian thought, disease is almost never believed to be natural; it may be a form of curse, or punishment by God, or caused by divinities, ancestral spirits, evil sorcerers and witches, or through individual fate. Health is equated to being at peace with God. The remedy to any ailment depends upon what spiritual agent is thought to have caused that ailment...(Sarpong, 1985)

As a corollary, joining a health care pre-payment scheme to provide financial cover against future cost could be interpreted as joining a 'sick people's association'

because social organisations in the communities are formed and named on the basis of their objectives:

...when this mutual health organisation started, some people were thinking and asked: if I am joining, it means, I am joining a sick group and I don't want to fall sick...why do I have to join?... (SMMHO-1)

The second area of socio-cultural significance is how some people are observing traditional and cultural protocols in the communities. There are some uninsured people who believe in cultural niceties to the extent that using the information van and local frequency modulation (FM) stations (refer to 9.4.1); to announce to them about the need to join a mutual health insurance scheme do not appear respectful enough. To them, anything other than the observance of cultural protocols (for the elderly) or the use of culturally acceptable modes to market a product are highly regarded as disrespectful. For this reason, policy makers perceive that the issue is not inability to pay, but rather lack of education and lifestyle choices on the part of such people:

...it is not affordability, it is lifestyle choices. If you take the average informal sector woman who sits in / at the market, the profits that they generate in a day, some of them make more money than even people who are in the formal sector... So we don't think that the issue is affordability: the issue is lifestyle choice, yes, prioritisation...So for us the issue I will repeat is not affordability, not at all, the issue is one of education and prioritisation... (PMS-13)

The management of some of the mutual health organisations are failing to recognise and utilise the 'traditional' methods of approaching people on one-to-one basis. Therefore, they are making little impact upon those who might have the financial resources to enrol. This was observed in some of the communities where the idea of health insurance and mutual health organisations had never been propagated until the National Health Insurance Act 650 was implemented in 2004:

...I have not joined because of the way the staff of the scheme go about their education. They do not come to me to explain it into details. They only make public announcements and think that it is enough. Until I have been spoken to directly, to be convinced, I will not enrol...(ASKMHO-NM-1)

The ability of the management of the mutual health organisations to combine both modern and traditional channels of communication could enhance their chances of attracting these yet to be convinced individuals to become members.

The third factor is how some people in the communities prioritise other necessities of life over health insurance. They compare the expected benefits to be derived from joining a mutual health organisation with the expected benefit to be gained from using the money for meeting other needs. The opportunity cost of satisfying basic necessities of life such as food and clothing is the 'opportunity cost' in the health insurance membership 'forgone' (Palmer and Raftery, 1999). Financial difficulties had encouraged a lot of drastic decisions against health care choices:

...it is not like today they are thinking about health insurance, they want to think about what to eat...if they are thinking about what they will eat today, then it means money is a problem here...(SMMHO-1)

The final contributory factor is how some people prioritise other community commitments such as funeral celebrations over the need for health care insurance. The perception is that if a family is unable to organise a 'befitting' funeral celebration for a departed family member (deceased), it would be seen as a 'disgrace' in the wider societal context. This is extremely difficult when the prospective enrolees are not capable of meeting these demands, in the short to medium term. People who have 'sufficient' but not 'enough' financial resources are contemplating whether to set aside the money in anticipation of the death of a family member so as to organise the funeral celebration or enrol with the mutual health organisations or when these two events occur at the same time:

...people should be able to prioritise health insurance over funeral celebrations. I have taken a considerable amount of money transferred from abroad for a family, which is organising a funeral this week end... When we have good health, we may not die prematurely... (SMMHO-4)

In conclusion, economic difficulties being experienced by members coupled with the seeming lack of understanding of the way of life of the people in the communities by

some of the management teams of the mutual health organisations is contributing to low enrolment.

9.4.2.5. Unfulfilled Expectations and Reduced Levels of Motivation

A different identified factor was unfulfilled expectations, which had both political and social undertones. This was distinct within the mutual health organisations, which started as post-NHI 2003 MHOs. Necessary changes could lead to conflicting expectations. Three main reasons were identified. The first reason was unfulfilled political expectations. The government under the leadership of the New Patriotic Party (NPP), which had replaced the National Democratic Congress (NDC) in 2001 had made electioneering pledge: to replace the cost recovery (Cash and Carry) policy with health insurance. Therefore, introduction of the National Health Insurance Scheme was characterised by greater involvement of political activists:

...political activists initially discouraged some of the people whilst the government also makes noise about the scheme (NPP members teasing NDC members)... (HMP-6)

The assumption of the people was that 'health insurance' was a 'free' health care package different from the cost recovery (Cash and Carry) system (compare 9.3.1 with 9.4.1). The reality, unknown to them was that health insurance was introduced as an additional financial mechanism for increasing health sector resources:

...the health insurance is taking care of the dimension of service delivery but with an increasing allocation to cover the totality of what is required to provide clinical care; I mean that is what is happening...(PMS-2).

When the Asakyiri MHO started as a pilot district-wide mutual health insurance scheme (DMHIS) in 2001, the mode of reimbursing the costs of health care was direct payment to the members. Members had to pre-pay and produce a receipt from the health care providers to the interim management team. This was subject to health insurance fraud and abuse and was ceased forthwith, when detected. A new method was devised to reimburse health care providers directly. However, when the actual programme commenced between 2004 and 2005, people were still expecting to have

direct financial reimbursement. Since this expectation was not met, those who had registered previously were discouraged from re-enrolling in the subsequent registration periods. There was a sense of disappointment:

...so this particular one, members were thinking that once they have the card, they could go to the hospital and come back to the scheme office for reimbursement...this was dwindling the finances of the scheme...The whole of last year, we were able to register only approximately, 18,000 out of a population of 126,000...(SMMHO-4)

There are also difficulties posed by politicisation of the mutual health organisations in the districts:

...there was an issue where someone visited the hospital and when asked whether he/she had registered for the insurance, the answer was: I have not registered for the President Kufour's insurance scheme. We went to a village and realised that some opposing group had gone there to discourage them about the usefulness of the insurance scheme. When we explained the whole idea to them, it appeared relatively new to them... This means that there are people who are politicising the whole issue, which is rather unfortunate...(BRMHO-M-10)

Thus, as the mutual health organisations are being implemented under the supervision of the district and municipal Assemblies, there are political associations and suspicions (compare this with 11.3.1).

A second issue was how the establishment of the post-NHI 2003 MHOs were led by the government's appointed consultants. They seemed to have little or no knowledge about the local communities and how to develop a system out of community mobilisation and participation which also might incorporate social control measures to prevent the imminent occurrence of any untoward behaviour:

...the state provided start up funds and there was a consultant around... They tried to mobilise the community... (SMMHO-4)

These consultants were paid to carry out functions which could have been performed by local people or were hitherto, being performed by the community leadership in

areas where there were pre-NHI 2003 MHOs. Some community members were advocating that they should be financially, motivated or compensated, and given a share of the government funds to carry out community mobilisation. There was perceived sense of dissent between the consultants and community leadership in some locations:

...the PRU District in 2004...prevention of some communities to be educated or pay premiums; all led by one traditional ruler....
(GNEMHO, 2004:38)

The third identified reason was the uncomfortable past experiences described by some respondents with the operations of some 'Susu schemes' or 'credit unions'. The promoters of these financial contributory schemes, which had similar objectives to the mutual health organisations ended up duping their membership of huge sums of monies. They ceased operations abruptly without refunding monies to their clients. Accidentally, any scheme with a pre-payment mechanism was perceived to be the same and measured with 'halo effect' (Nisbett and Wilson, 1977). Therefore, there are doubts about the future sustainability of the mutual health organisations:

...the case is that the uninsured are many than the insured people in the district. We need to put in efforts to convince people as others are not really convinced about the prospects of the scheme... (ASKMHO-M-5)

These help to explain how some of the communities are suspicious of the underlying reasons of the health insurance scheme. The above discussions show a negative influence on the financial viability and overall sustainability of the mutual health organisations.

9.5. Summary of the Chapter

The entire chapter has analysed the performance of the mutual health organisations in the areas of management and administration; financial management; perceived benefits; and perceived problems. It is obvious that they are making efforts to

guarantee their financial viability and enhancing financial access to healthcare for their members in the communities. However, they are confronted with some problems as they are unable to increase their paying informal sector membership so as to raise enough premiums on their own. Several constraints have been identified and explained. It has also been established that there are some limitations when analysing financial viability using the ratios in the model designed by Cripps *et al.* (2003), in this study. Hence, other indicators especially, using the institutional viability model has been considered in this chapter while the social viability model has been considered in chapter 10, to support the financial analysis. The next chapter presents analyses of other external factors, which have influence on the performance of the mutual health organisations.

CHAPTER 10

CASE RESULTS: EXTERNAL INFLUENCES ON THE PERFORMANCE OF THE MUTUAL HEALTH ORGANISATIONS

10.0. Introduction

This chapter presents the second part of the case results of the empirical study of the mutual health organisations in Ghana. The main theme is external influences on the performance of the mutual health organisations. Both positive and negative affects were observed. There were three main sub-themes identified. The first sub-theme is the contribution of community leadership upon the performance of the mutual health organisations. The second sub-theme is the effect of health care services on the performance of the mutual health organisations (compare this with 9.4). The third sub-theme is the implications of regulatory changes on the mutual health organisations. The chapter ends with a summary.

10.1. Contribution of Community Leadership upon the Performance of the Mutual Health Organisations

This sub-theme identifies the contribution of community leadership upon the performance of the mutual health organisations. The community provides the conduit through which the government could translate its policies into action. Community leaders help to organise social and human capital to facilitate policy implementation. The leaders influence their members' decision-making processes and commitment. If the management of the mutual health organisations are able to tap into these social networks, they might greatly enhance their chances of increasing membership coverage, thereby influencing financial viability. Their success was measured against the interplay between them and these stakeholders within and outside the communities.

10.1.1. District and Municipal Chief Executives

The District and Municipal Chief Executives (DCEs and MCEs) are charged by the government under the NHI Act 650 to ensure the success of the National Health Insurance Scheme (NHIS) by sustaining their respective mutual health organisations (DMMHIS). As the representatives of the President of the nation at the district and municipal levels of governance (refer to 5.2.1), they are responsible for uniting the people to work towards achieving development goals while they dispense with Local Government resources impartially. Their involvement in the management of the mutual health organisations as members of the Board of Directors is to ensure unity amongst the people:

...initially, there were few problems as a result of politicisation and people's lack of understanding of the concept of health insurance, but now it is improving. The concept of health insurance is what we call 'nno boa' as singular and 'nno mmoa' as plural, which translates as, we assist each other to weed their farm...it is a support for each other as we are all in the same boat and can sink together...(PMS-20)

The District and Municipal Chief Executives (DCEs and MCEs) are to display dexterity because of the multiparty system of governance in the country. It is perceived that the district and municipal Assemblies are doing their best to help to sustain the schemes. Depending on the financial resources capacity of the district and

municipal Assemblies, they are providing logistics and other support including, office accommodation for their district-wide and municipal-wide mutual health organisations:

...look over there, we are constructing a separate office building to accommodate the scheme...it is at the lintel level... (PMS-11)

Other Assemblies are also providing means of transport (vehicles) to enable the mutual health organisations to carry out community mobilisation campaigns:

...the district Assembly used to assist us, we used to organise meetings at the Assembly Hall...The Assembly also repaired an abandoned vehicle which we are using currently for the activities of the scheme: going to the villages and communities, though we are expecting a better one from the government... Since the car is relatively old, this has increased the maintenance and running costs, but it is better than not having anything at all... (SMMHO-3)

They also assist with the recruitment of the management staff of the mutual health organisations (refer to 9.1.2.3):

...but the honest truth is that the schemes are now being seen as government departments...staff recruited by government...staff seem to be looking at the NHI Council as their employer and not their Board of Directors who on paper are their legitimate employers...(PMS-17)

The district and municipal Assemblies are responsible for paying salaries and other conditions of service for the management teams of the mutual health organisations.

10.1.2. The Role of Assemblymen and Assemblywomen

Under the Local Government decentralisation, Assemblymen and Assemblywomen serve as local Parliamentarians. They make bye-laws to raise revenue from local taxation. During the era of the pre-NHI 2003 MHOs, except in the few communities where the mutual health organisations were established, their involvement was not compulsory. However, it is incumbent upon them to support their respective post-NHI 2003 MHOs. Thus, the involvement of these local politicians in the activities of the mutual health organisations is crucial to the mobilisation of people to register. If

they had adequate understanding of the concepts of health insurance and mutual health organisations, they would be able to do a good job. Formal educational qualifications are not the yardsticks for their election:

...wonderful, I think, those days it wasn't all that...you would find an assemblyman talking about health insurance but he himself had not registered...I think now it is changing and I will not put it at their doorsteps. I will say we need to do more to make sure that we sell the idea to them, we need to go and introduce ourselves, we need to go and visit them...(SMMHO-1)

They are involved in the information dissemination and education of the people in their constituencies. As they were elected by their own people in the communities, their people listen to them when they canvass for support for the mutual health organisations. This position of trust in the community can also place additional financial responsibility on the leader, especially, if the community is economically less endowed. Formal employment opportunities are located mostly in the district, municipal and regional capital towns. In some of the districts, the only job avenues are the few decentralised departments, which cannot employ everyone, not even the youth. As people move beyond capital towns, they are likely to find that there are no formal job avenues, and engagement in peasant farming becomes a major pre-occupation as a form of 'boredom alleviation' rather than as a means to economic enrichment.

Under such circumstances, the few wealthy people in the communities are appointed to serve their people as Assemblymen and Assemblywomen. As some of the people are finding it difficult to mobilise their premiums, these opinion leaders are compelled to use their personal funds or their allocated Common Fund (if available), to enrol for the 'willing-but-needy' members in their communities:

...I closed from work and went home to hear the news about the recommendation from the assemblywoman...a lot of people who are here are not working. I heard that she even paid the premium for some of the people in the community to register...(ASKMHO-M-5)

Thus, these leaders are demonstrating traits of philanthropism.

10.1.3. The Role of District Directorate (Director) of Health Service

As part of health sector reforms (refer to chapter 6), the District and Municipal Health Directorates of the Ghana Health Service (GHS) are supposed to work hand in hand with the district and municipal Assemblies; to improve community development, health and the well-being of the people. The District or Municipal Directors of Health Services (DMDHS) supervise all the district hospitals, polyclinics and health centres. They serve on the Board of Directors of the mutual health organisations, and they have good working relationships with management. This made achievement of the sustainability objective more plausible. They are combining expertise and resources to identify problems and finding common solutions to them:

...what we have to deal with in the district is to answer a question like: where do the uninsured go for health care? There are people who do not want to register; with the reason that 'I do not fall sick'...At the sub-district levels, the standard treatment guidelines are not suitable for use due to non-availability of qualified medical officers... (HMP-6)

The working relationship between the public health sector institutions and the mutual health organisations helped to give the latter comparative advantage and economies of scale in terms of health care access for their members:

...all the 11 Health facilities are involved in the scheme because every district signs 'service agreement' with all the health facilities. There are also local arrangements... (HMP-6)

The Ministry of Health and the Ghana Health Service have almost 80 per cent of health facilities in the country (MOH, 2003e, 2005). The Ghana Health Service institutions charge lower user fees than their counterparts in the private 'for-profit' health sector: '*...the GHS charges lowest user fees...there is only a 10 per cent mark up on cost...*' (HMP-6) on the revolving drugs funds they are operating. There is a new paradigm shift where the community-based health planning and services (CHPS) are being established under the auspices of the Ministry of Health and Ghana Health Service (MOH, 2005; Sodzi-Tettey, 2008). This is based on a collaborative action between the health care providers and the communities they serve. This is in tune with the gate keeping principle underlying the operations of the mutual health organisations (see 10.2.1.5).

10.1.4. The Role of Religious or Faith Leadership

Ghana is a country where religion has an important part to play in the lives of the people. People are free to belong to any religious or faith-based group. This encourages a peaceful co-existence amongst the diverse socio-cultural groups in the country (refer to 5.1). The majority of the poor people in the Ghanaian population are members of the various religious groups. This is why some religious groups have taken it upon themselves the duty to address both the spiritual and social needs of their members:

...It was in 1999 when I was reflecting on what could be done to assist Church members in their social difficulties. The Church was catering for the needs of the Ministers and their families... There was the need to answer a question like what should happen to the members because it was realised that Church offertory was been used to offset medical bills of some members who were relatively poor... (PMS-10)

The role of the Church in health care delivery and the formation of mutual health organisations in the country cannot be overstated (refer to chapter 7). The Christian Health Association of Ghana (CHAG) institutions in the private 'not-for-profit' health sector have their own administrative structures, which put the Diocesan Health Committees, headed usually by the Bishops of the Dioceses, as Chairmen. In view of the spiritual position of the Clergy in the Christian community, their active involvement in the promotion of the mutual health organisations served as added incentive for the members:

...we have written to Churches and organisations to help with fundraising activities to support their needy members...(SMMHO-2)

Thus, the role of the religious establishments in encouraging their membership to accept health insurance as part of their 'Godly' duties saw the rapid development and increased membership of the mutual health organisations. Leading members had contributed in one way or another and are still contributing to the educational programmes. This effort is given further boost if the leaders involved belonged to the medical profession. Inspired by the goal of the spiritual growth of the individual members, they are also filled with the desire to see the members manage the vagaries

of economic difficulties and poverty. They have a good appreciation of the problems of financial access to health care in the communities:

...The Catholic Church took a pioneering and innovative lead in establishing the first community-based mutual health insurance scheme in Ghana at the St Theresa's Hospital, Nkoranza...health insurance has now been accepted as a viable option to make healthcare financially accessible to all Ghanaians, especially, the poor and marginalised...Dr Ineke Bossman...your personal involvement gave birth to the first ever community-based health insurance scheme in Ghana... (GNeMHO, 2003:40-42)

Richer members believe that it is an expression of religious solidarity when they are able to contribute towards mutual funds, which would assist the needy individuals in their midst (refer to chapter 7). They believe that this is a fulfilment of scriptures because the Bible encourages them to laugh with those who are laughing and mourn with those who are mourning. The Bible quotations which enhance religious or faith solidarity, are in the books of Hebrews 13:3 and Matthew 25:34-40. These encourage Christian believers to clothe those who are naked, feed those who are hungry and visit those who are sick or imprisoned (Kliner, 2008; Siloam Mission, 2008). The Churches are encouraging their members to support each other:

...I started with the Church-based scheme and have got my membership card with which I pay my dues every Sunday...Of course, I have never been sick since I joined it...We are told at Church that we have to help the needy in the society and so I think that it is one of my obligations as a Christian to assist the disadvantaged in our community... (ASNMHO-M-1)

The Ghana Muslim Council and their health institutions (MOH, 2003d, 2004b; GHS, 2004b), are also drafted into the management of the mutual health organisations as members of the Board of Directors:

...the Bishops, you know people in the church, a religious person... It is more like if you take the Local Council of Churches so they will have somebody and that person will represent all of them on the Board and then Muslims too will take somebody who will represent them, the Ahmadiyas and the rest, so you pick somebody who will represent all of you. So that is how it is now...(PMS-16)

They are also doing a great deal of work to encourage their members to join the mutual health organisations. The members are trying to practicalise their conviction to their faith. As solidarity and mutuality are part of the culture of Ghana, these beliefs are reinforced by faith (see 10.1.6.2).

10.1.5. The Role of Traditional Leadership

It is obvious that any change process is prone to some form of resistance. As some of the pre-NHI 2003 MHOs were established by the communities themselves, there was the anticipation that government's introduction of similar schemes could be met with some form of resistance due to fear of the unknown or uncertainty by the people (see MOH, 2003d, 2004b; GNeMHO, 2003, 2004). However, the involvement of traditional rulers in the process helped to neutralise any tensions that might have impeded the process. Traditional leaders like the Chiefs and the various traditional councils are also involved in the mutual health organisations. This was reassuring the people to embrace the concept and had confidence in the promoters (refer to 5.2.2). People are confident that should any dispute arise as a result of financial misunderstanding, the Chiefs would ensure a peaceful settlement:

...we met and still meet the people in the communities at all levels: village, community, opinion leaders to discuss the need to enrol as clients of the scheme so that we could help address the health needs of all the people... (SMMHO-1)

Chiefs command the respect and trust of the people more than the Judiciary in the remote villages (people lack access to judicial services in some communities). Much of the stability in the country is attributable to the ability of Chiefs to settle trivial squabbles within their communities before they escalate into national confusion. They uphold the virtues of integrity and dispense their duties dispassionately. In the remotest parts of the communities, these leaders are recognised as embodiment of wisdom and maturity. They have the moral obligation to ensure that members conform to acceptable behaviour whilst at the same time resolving internal family misunderstandings. These are necessary ingredients for the sustenance of the mutual health organisations as well as national cohesion. As community leaders, they receive

complaints which they have to help to resolve. The Chiefs ensure fairness during arbitration:

...Yenim se suban bone bi tese nsemkeka, nkontompo ne ntwatosoo bo kuro. Se obi tane obi mpo a, otumi keka nsemsem de gu onipa koro no ho fi. Eno nti, se yeredi asem a, na ese se yebue yen ani na yede yen aso to fam ansa na yeabu aten. Yema obiara akwannya ma no ka n'asem ansa. Translated as we know that certain devious behaviours are recipe for disunity. We try to resolve them amicably. For instance, when someone has a misunderstanding with or dislike for another person, they could slander them to win our sympathy. However, we need to be circumspect by allowing each party the opportunity to explain their side of the story; we do not jump into hasty conclusions in our arbitrations... (PMS-19)

The Chiefs have fair understanding of human behaviour in their community. They put this adage into perspective: *se wosene woyonko a, otane wo* interpreted as 'one's level of success could be a source of envy or enmity'. Therefore, they guard against unscrupulous behaviours where certain individual (s) might take undue advantage to tarnish the reputation of other innocent and hardworking individual (s). The leaders perceive that: '*...if pettiness was not checked, some people could give the dog a bad name just so they could hang it...*' (PMS-19). Therefore, they try to step in to allow sanity to prevail so that: '*...the innocent people could go about their activities in peace...do not turn them into community enemy / enemies...*' (PMS-19). Such behaviours do not encourage community unity.

Acquisition or ownership of land for farming and other personal purposes could be a major cause of community conflict. Resolving such a dispute requires tact and diplomacy from the leadership. The members in the communities studied showed much confidence in the Chiefs because they demonstrate adeptness in conflict resolution. This perception is justified by the following newspaper report:

The Nkoranza Omanhene [Paramount Chief], Okatakycie Agyemang Kodom IV and the elders of the Benkum [Left] Division of the traditional area have called for peaceful atmosphere in the area to consolidate stability and development (Lawson, 2009; 'Ghanaweb' Friday, 28 August 2009c)

The people perceive that conflict in the communities was reduced because the Chiefs tried to avoid a situation where issues brought before them were not thoroughly investigated. The leaders even perceive that such an approach could lead to bias judgment which could have consequences on their integrity, if followed. They contrast this position with what happens within the modern governance system or the public system. Some respondents perceive that because of the unfair manner in which sometimes officials put in positions of trust handle misunderstandings resulting from allocation and acquisition of land, there is diminished confidence in the modern governance or public system (refer to 2.3.4.3). People believe that some officials could use their positions of trust to marginalise individuals who do not have formal educational abilities (illiterates-cannot read or write in the English Language) in the communities if allowed to handle such issues. Some policy makers share this perspicacity and describe it as a possible cause of misunderstandings in some communities leading to community disunity. This view is aptly captured in the following statement:

...driven by our own perceptions, needs and prejudices...we're not always objective. We're blind to our blind spots and think we 'know', and the results can be disastrous for our relationships. I know what your real intentions are....I can tell by the look on your face exactly what you're thinking...such words indicate we've got the other person 'pegged', and feel no need to consider the situation further because we couldn't possibly be wrong...(UCB, 2009:51)

Respondents recognise the truth that in communities where disputes are rife, socio-economic development also lags behind in terms of national comparison. This could be attributed to the fact which was expressed in a newspaper article that:

...most of the time, quarrels and serious conflicts are fuelled by intended ignorance... (Dotse, 2009; 'Ghanaweb', Saturday, 29 August 2009d).

It was evident that the organisational expertise of the Chiefs as 'crowd-pullers' could not be underestimated in respect of the mutual health organisations:

...the Techiman District Scheme started about two years ago with the active support of the late Paramount Chief of Techiman

Traditional Area. Following the death of the Chief, activities slowed down... (GNEMHO, 2004:32)

Thus, one key fact that cannot be neglected in any community-based project in Ghana is the role these traditional rulers play. They serve as the pivot around which local communities revolve as they promote community cohesion: '*...I listen to the Chiefs because they are our fathers...*' (BRMHO-M-8). Their involvement and cooperation with the mutual health organisations, is helping to bring the people together as they are perceived to be voice of the people and seek to unite them rather than divide them.

10.1.6. The Role of Community Members

The mutual health organisations have a brighter future if they are able to marshal both the human and social capital resources available in the communities where they are located. They operate on social capital elements such as the sense of accountability, trust, mutuality, solidarity, autonomy, ownership and participation (refer to chapters 3 and 7). Although all these elements are present in this study, three main concepts which are used under this sub-theme, are mutuality, solidarity and ownership. It is sometimes difficult to separate trust, mutuality and solidarity because they complement each other. For instance, solidarity enhances mutual trust. However, an attempt has been made here to put these into perspective considering their advantages and disadvantages.

10.1.6.1. Sense of Mutuality

The mutual health organisations phenomenon operates on the basic doctrine of mutuality, hence, their name: mutual health organisation. The government of Ghana realised that the country's health financing strategy could be supported if it was able to build upon the mutuality instincts of the people by designing the National Health Insurance Act 650 (MOH, 2003d), as a fusion of social health insurance and community-based health insurance schemes. This is the reason why it is using two basic types of health insurance: commercial health insurance and mutual health insurance schemes as the model of the National Health Insurance Scheme (refer to 6.5.4.3):

...for instance, we could have gone for a national health insurance scheme that is centralised with branches throughout the country...we decided that it was better to have the schemes established on a district by district basis so that rather than a national health insurance scheme that is single with branches, we have instead district mutual health insurance schemes, supervised by a National Health Insurance Council (NHIC), which is central... (PMS-13)

The view of policy makers was that the mutuality component of the Ghanaian society had to be safeguarded. Policy makers envisage that the fundamental desire for people's enrolment in the mutual health organisations should be how best they could help extend the bond of mutuality towards each other, especially, those who lack the financial means to access orthodox healthcare:

...this year, I paid one million old cedis (¢1,000,000.00) for myself and paid four hundred and ninety thousand old cedis (¢490,000.00) for my Security Guard while another philanthropist also paid five hundred thousand old cedis (¢500,000.00) ... (HMP-4)

Thus, mutuality expects people within the communities to exhibit philanthropists' attitudes. There are few people who are demonstrating the sense of mutual benefits of their membership, despite their lack of financial power:

...If I contribute and do not benefit but other people benefit, it is like in the Bible where it is written that as you have done it for your little ones, you have done it for Christ...(ASNMHO-M-5)

However, there is a perceived sense of complacency among insured members of the mutual health organisations. This is manifesting to the extent where even those who could afford to pay more than the minimum premium are apparently overjoyed. They view the benefits as a huge advantage and yet fail to pay extra towards the funding of their respective mutual health organisations:

...you see hitherto when everything was free, I don't think we belong to that era again...I believe we need to find ways to encourage philanthropists to pay more or pay for others... (SMMHO-1)

Some respondents perceive that although, people are queuing to enrol, it appears in some cases that they are not doing it because they have been convinced to do so. They are judging whether the mutual health organisations are good or not on the basis of what profits could be accrued to them individually. Moreover, even the management teams are beginning to see their members as not part of their set up but were doing them some kind of:

...favour and that it is in their interest that they should join, you know... (PMS-17)

However, the mutuality phenomenon also fashions on the need for demonstration of a sense of belonging between the management teams of the mutual health organisations and the health care institutions. A Ministry of Health document emphasises this point:

It is compulsory for every person living in Ghana to belong to a health insurance scheme type. This is in the light of the spirit of solidarity, social responsibility, equity and a sense of belongingness in the building of a healthy and prosperous nation (MOH, 2004d: 2)

This needs to equally translate into the kind of mutuality needed by health personnel in providing health service to the members of the mutual health organisations. Even as the evidence points to the existence of the mutuality component, it has been reduced to a different stage because of the nature of the businesslike manner that both the mutual health organisations and the health institutions are run under a market-oriented economy (refer to 5.3.2).

10.1.6.2. Sense of Solidarity

Another major element of the mutual health organisations concept identified was the sense of solidarity, which was uplifting the members to see each other as one people with a common purpose. Solidarity is said to have been felt when community members know that by contributing to their mutual health organisations, they are helping to accumulate funds so that when a member fell sick, their financial contribution could be used to offer health care to them:

...yes, the brotherliness and unity amongst us is that maybe there is someone who is also a poor person as I am, who may have nobody to support them in times of sickness. I know that if I pay my premium into the pot of fund, they can use it to buy medicine to treat them so that they can have their life restored: saa nhyira no na ebia emmma me nso mennyare no, translated to mean it is the blessings thereof, which I am enjoying, which is the reason why I have never been sick since I joined the health insurance scheme...(BRMHO-M-1)

The bond of solidarity amongst community members could be grouped according to three different levels at which respondents thought they owed such allegiance: the national, urban and rural. At the first level, respondents relate their solidarity to each other because they want to contribute to national cohesion and unity. They see their membership with the mutual health organisations as an expression of this objective: bringing citizens together for a common goal. The second level on the solidarity trail relates to the district or municipal areas where by virtue of people being inhabitants of the same administrative districts or municipalities, they relate to each other as such. Here, community solidarity is not defined on tribal or ethnic lines, although, there are different tribes and cultures within all the districts and municipalities. This type of solidarity is almost the same as that of the national level solidarity:

...we are citizens of the country and as citizens; we owe it a duty to take part in anything that everyone is supposed to be part of so that if there is any help we could also benefit from it accordingly...(ASNMHO-M-5)

The third level is the rural sense of solidarity and it is very pronounced on tribal or ethnic lines. This level is the foundation stone of rural life and the people in the communities have this feeling of oneness based on which the spread of health insurance risk and pooling of financial resources inform their notion of membership of the mutual health organisations:

...I can see that we are united as a community to support the health insurance scheme. We are all one people, everyone pays the insurance and we do it with sense of commitment...people are always 'shaken' about issues of the health insurance scheme...Even those who do not have money go about borrowing to register ...(BRMHO-M-5)

This sense of solidarity is stronger in rural-based mutual health organisations such as the Aduana MHO, Asakyiri MHO and Biretuo than the urban-based mutual health organisations like the Asona MHO.

10.1.6.3. Sense of Ownership

The ability of the community members to identify with each other and think about the collective ownership was serving as motivation for their commitment towards mobilising financial resources to support those in need. The members of the mutual health organisations based in the rural communities: Aduana MHO, Asakyiri MHO and Biretuo MHO are demonstrating a stronger sense of community ownership, which surpassed any political sense of belonging than the members in the urban-based mutual health organisation: Asona MHO. Health care is not an issue they see to be a 'political' game:

...we have a lot of political parties in the country but when you are going to register, they do not ask whether you belong to 'Party A' or 'Party B'. Similarly, when you report sick at the hospital, they do not ask you the above questions. They will attend to you as they would for everyone. So it really brings about unity, it really helps the friendship amongst people in the community... (BRMHO-NM-1)

There are two different courts where the members in the communities place their sense of ownership of their mutual health organisations. Understandably, members of the Aduana MHO and Biretuo MHO who experienced the pre-NHI 2003 MHOs era could explain the shift in the sense of ownership from the community to the government. Respondents perceive that their contribution to the pre-NHI 2003 MHOs had culminated into the implementation of the National Health Insurance Scheme (NHIS). They were eager to congratulate themselves and their communities:

...the only difference I can see is that before the government's scheme was introduced, we had already taken the lead...the government commended the people....So the government's health insurance came to confirm ours... (BRMHO-M-4)

There were respondents who might have only got to know of the mutual health organisations upon the implementation of the National Health Insurance Act 650 (MOH, 2003d). They place their sense of ownership in the courts of the central government: '*...It is for the government...*' (ADMHO-M-3). The view that the government has ownership is having the effect of encouraging these people to exhibit nationalistic intuitions through their membership. In a sense, government's ownership of any project was considered as a national resource for which every citizen must have the right to participate in it. However, other respondents perceive that the sense of ownership is gradually changing:

...the sense of ownership should have been the same but political involvement is giving it a different meaning because the Ministers, DCEs and all government political functionaries are taking part in the schemes. In the formation of the NHIS bill, the opposition party members of Parliament did not take part in the debate... (PMS-12)

This is particularly pronounced in communities where there were pre-NHI 2003 MHOs. For instance, the Aduana MHO and Biretuo MHO:

...the answer is yes and no: let us take it that previously, it was Biretuoman (pre-NHI 2003 MHO era) as a whole that owned the scheme and felt as such. By now, the government has seen the benefits of the scheme and has taken over. As the government came in, what the people say is that it is for the government 'government's health insurance scheme'. So if we compare the two regimes: at first it was in the name of Biretuoman and the people felt that sense of ownership of the scheme. However, since the government took over, the ownership has been transferred to the central government: the sense of ownership has been shifted... (SMMHO-3)

Summing up on this sub-theme, it could be seen that all the major stakeholders in the districts and municipalities are somehow involved either directly or by representation in matters concerning the mutual health organisations. The sustenance of the mutual health organisations largely, depends on large membership. To attract the members also require the management to understand the issues around community politics and community mobilisation.

10.2. Efficiency and Effectiveness of Health Care Services on the Performance of the Mutual Health Organisations

This sub-theme examines the efficiency and effectiveness of health care service provision and consumption on the performance of the mutual health organisations. A popular Ghanaian proverb or folktale, which glamorises poverty, is: '*Ohia Ma Adwen*', translated as: 'poverty begets wisdom'. Thus, in the extreme end of poverty, people are able to devise strategies to circumvent their plight and make good use of limited resources. Although this is a humane attitude, its interpretation in the health economics parlance is what may be termed as health insurance risk factors: moral hazard, adverse selection, fraud, abuse and cost escalation (refer to 3.3). Some of the attitudes described here are rather seen as negative interpretations of this concept since they are compounding the problems of the mutual health organisations (compare this with 9.4). The discussions are also related to the social viability indicators (refer to 8.5.1.3 and table 8.9).

10.2.1. Social Viability Indicators

This part analyses how the four mutual health organisations increased healthcare financial access to their members through their contracted health institutions between 2005 and 2006.

10.2.1.1. Rate of Access to Medical Care (Eligible Members and Health Care Benefits of the MHOs): 2005-2006

This measures the performance of the four mutual health organisations on members' access to healthcare. This is considered as positive impact of the four mutual health organisations as they have been able to increase members' financial access to orthodox healthcare amongst their catchment population. In real health insurance access terms, it is only members who have satisfied the waiting period of between three (3) and six (6) months who are referred to as 'eligible members' or 'cardholders', who could access health care services at the point of service use without direct payment. They have been issued with membership photo identification (ID) cards, which granted them access to free healthcare services at the

point of service use. Health care benefits of insured members are outlined in appendix E.

Table 10.1 shows the results of how the eligible members accessed free health care for years 2005 and 2006.

In 2005, out of the 14,000 members registered by the Aduana MHO, 13,000 were eligible to receive health care, representing 93 per cent of the membership. Similarly, in 2006, out of the 21,000 members, 20,000 were eligible, representing 95 per cent.

The Asakyiri MHO registered 18,000 members in 2005 out of which 7,000 were eligible, representing 39 per cent. In 2006, it registered 42,000 members out of which 32,000 were eligible, representing 76 per cent.

The Asona MHO also registered 87,000 members in 2005 out of which 46,000 were eligible, representing 53 per cent. In 2006, it registered 88,000 members out of which 77,000 were eligible, representing 88 per cent.

The Biretuo MHO registered 69,000 members in 2005 out of which 68,000 were eligible, representing 99 per cent. In 2006, a total of 65,000 members were registered out of which 39,000 were eligible, representing 60 per cent.

Table 10.1: Rate of Access to Medical Care (Eligible Members and Health Care Benefits of the MHOs): 2005–2006

Scheme	2005 Members	Eligible Members	Rate of coverage (%)	2006 Members	Eligible Members	Rate of coverage (%)
Aduana MHO	14,000	13,000	93	21,000	20,000	95
Asakyiri MHO	18,000	7,000	39	42,000	32,000	76
Asona MHO	87,000	46,000	53	88,000	77,000	88
Biretuo MHO	69,000	68,000	99	65,000	39,000	60

It can be observed that whereas the Biretuo MHO provided the highest eligibility to its membership in 2005 than all the other three mutual health organisations, it provided the least eligibility in 2006. The conclusion is that all the four mutual health organisations performed creditably, between 2005 and 2006.

10.2.1.2. Rate of Access to Medical Care (OPD Attendance): 2005 -2006

As indicated earlier (refer to 10.2.1.1), this measures the performance of the four mutual health organisations on members' access to health care. This is considered as negative impact on the finance and financial viability of the four mutual health organisations because rising rate of attendance must be investigated. A picture of the out patient department (OPD) attendance of the insured members of the mutual health organisations for 2005 and 2006 respectively is depicted in table 10.2. Since in-patients are usually admitted through the out patient department (OPD), adding admissions figures could lead to double counting. Health care benefits of insured members are outlined in appendix E.

There is awareness among the insured population to report early for check up and treatment of common ailment:

...people report early for health care because they have now understood the scheme and health...(HMP-6)

Therefore, utilisation of health services had increased astronomically within the first two years of operations of the mutual health organisations. The positive side of this is that it is enhancing the health efficiency goals of the mutual health organisations in the entire country. A Ministry of Health document summarises this as:

...other issues the NHIS is addressing include attending increasing numbers of people visiting hospitals and clinics because of increased accessibility of health care under the NHIS...(MOH, 2006)

It can be seen from the table that whereas the Aduana MHO registered a total of 14,000 members in 2005, the number of OPD attendances recorded was 19,000, representing 136 per cent. In 2006, it registered 21,000 members and the number of OPD attendances recorded was 20,000, representing 95 per cent.

Whilst the Asakyiri MHO registered a total of 18,000 members in 2005, the number of OPD attendances recorded was 73,000, representing 406 per cent. In 2006, it

registered a total of 42,000 members and the number of OPD attendances recorded was also 77,000, representing 183 per cent.

As the Asona MHO registered 87,000 members in 2005, the number of OPD attendances recorded was 123,000, representing 141 per cent. In 2006, it registered a total of 88,000 members and the number of OPD attendances was 70,000, representing 80 per cent.

When the Biretuo MHO registered 69,000 members in 2005, the number of OPD attendances recorded was 39,000, representing 57 per cent. However, when it registered 65,000 members in 2006, the number of OPD attendances rose to 116,000, representing 178 per cent.

Table 10.2: Rate of Access to Medical Care (OPD Attendance of the MHOs): 2005 -2006

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Membership	14,000	18,000	87,000	69,000
OPD Attendance	19,000	73,000	123,000	39,000
Rate of OPD coverage (%)	136	406	141	57
2006				
Total Membership	21,000	42,000	88,000	65,000
OPD Attendance	20,000	77,000	70,000	116,000
Rate of OPD coverage (%)	95	183	80	178

The evidence shows that attendance at the out patient department (OPD) of the health facilities studied within the districts where the mutual health organisations are located was showing incremental numbers. For instance, health facilities, which hitherto used to attend to fifty (50) OPD patients per day, were treating between one hundred and fifty (150) and three hundred (300) OPD patients per day. The demand for orthodox health care is increasing as the cost is 'near zero' or 'zero'. However, this is creating difficulties for the management:

...some members could utilise all their three (3) allotted health facility attendance cards, within a month... (SMMHO-4)

From the point of view of the management teams, the difficulty arose because no one could determine the number of times they would fall sick and require health care at the facilities. The reasons which accounted and are still accounting for the over-utilisation of health care by the insured members from the perspectives of both the insured members and management of both mutual health organisations and health institutions are discussed under the subsequent sub-titles.

10.2.1.3. Health Risk Factors of Rural Dwellers

From the perspective of the management of the Aduana MHO and Biretuo MHO, members were judicious in their access of health care when they operated as pre-NHI 2003 MHOs. However, when they transformed into the post-NHI 2003 MHO, the utilisation to some extent had increased. The management perceive that the insured members want to test the National Health Insurance system to authenticate its effectiveness:

...others too say it is genuine health problem that they have presented but others after receiving their membership card they want to go because of what people say, they want to go to the providers and find out if it really works... (SMMHO-1)

There are cases where the medical personnel could advise the insured patients that their conditions are not critical enough. However, this might not be accepted and rather interpreted or misinterpreted as they are being denied health care because they possess the membership card:

...here we call it the 'P' card, they don't want to attend to you... (SMMHO-1)

From the perspective of the insured members, their utilisation of health care services is based on genuine health problems. There are rural-urban disparities in the health conditions and the rate of access of health care services had either positive or negative effect on the performance of the mutual health organisations. Rural poverty is

associated with poor health status. There are the aging population who are suffering from chronic health conditions like hypertension, diabetes and other farming related illnesses. The treatment of these had high cost implications and some individuals could not raise money to pay for treatment on their own due to poverty:

...in the community, I think that we should be one people despite our individual financial differences...That is the money we are finding it difficult to raise at the moment...I am sick, I have some lump in my breast, I need to see the doctor to be treated but I have not been able to receive the treatment I need...it is disturbing me...(ADMHO-NM-1)

At the same time as it is recognised that there is over utilisation of health care services by the insured members, there is also the recognition that this is due to genuine cause as poverty had prevented most people from having regular health check up.

10.2.1.4. Joining based on Selective Health Status

There is perceived adverse selection on the part of insured members because health insurance is the source of funding for health care services. The reality is that members who previously had certain health conditions (high risks) but could not seek health care due to associated costs under the system of pay at the point of service use, are taking advantage of the enhanced health care benefits packages to enrol with the mutual health organisations and are accessing treatment for such conditions. For men, the common condition, which is mostly reported is hernia (herniorrhaphy) the treatment of which requires minor surgical procedure. The common condition presented by women is fibroid (fibrosis), which requires major surgical procedure. These have financial implications for the mutual health organisations and health care utilisation:

...this has also led to perpetration of health insurance risks by members...there is an abuse of the service where people who had hernia for a long time are now taking advantage of the district mutual health insurance scheme to have it removed...There is also personal abuse by clients because services are almost free...there is influx of clients at the health facility... (HMP-4)

Respondents perceive that most ordinary people in the informal sector of the economy find it difficult to raise the funds to pay for these treatments under the cost recovery system. The inclusion of these treatment episodes in the membership health care benefits packages is encouraging those affected and offering them the opportunity to access treatment accordingly:

*...even the money to go to the referral centre is also a problem...
So these are mix of factors that have somehow directly or
indirectly affected our operations... (SMMHO-1)*

In as much as these are good because they show how such conditions could be funded through the mutual fund, the adverse selection occurred when prospective members used these as fundamental motives for joining the mutual health organisations. They had the tendency to withdraw immediately the conditions were treated. The associated costs are affecting the financial performance of the mutual health organisations:

*...now the capital outlay is so much high that the scheme could
collapse... (HMP-1).*

10.2.1.5. Non-Adherence to Gate Keeping System

The problem identified was that some of the mutual health organisations are located in administrative districts or municipalities where there are only one or two hospitals with no polyclinics or health centres:

*...hitherto people were registering as a district-wide scheme and
you could not go beyond it, where people were following the
referral rules strictly; you needed to go to the health centre or
facility before you are referred to a hospital. It was only in
emergency cases that you could find yourself anywhere else. So
it was such that we understood it... (SMMHO-1)*

For instance, the Asona MHO is situated in a town where there are only one private specialist hospital and a referral public hospital. On the other hand, some of the mutual health organisations are based in districts where there are no hospitals. For

instance, the Aduana MHO is based in a district where there is no hospital but health centres providing health care to the members:

...unfortunately, in our district we don't have a hospital. All our facilities are health centres, so somebody needs to go to the health centre before s/he is referred to a hospital... (SMMHO-1)

This is providing difficulties for the effective functioning of the gate-keeping system:

...we are supposed to be a referral hospital but it happens to be the only medical facility in the metropolis, the people come to the hospital straight away and the gatekeeper system doesn't work...we treat primary as well as tertiary cases... everybody comes to the facility...(HMP-1)

Another problem identified was the lack of up to date medical facilities, which the members in the communities had to contend with. Despite the fact that insured patients' numbers had increased due to perceived excessive utilisation of health care, health facilities remain virtually the same. They lack upgrading:

...the health facilities are expected to do certain things...we need to think about how to sustain input for high standards of care... we think that the tax and national health insurance levy could be used to upgrade the facilities...(PMS-7)

The perception is that members report directly to these hospitals as their first point of call, but the hospitals should rather serve as referral points. The cost of health care at a health centre is relatively cheaper than at a hospital due to different costing systems. Meanwhile, in some cases, there are only two medical officers at post at the district hospitals. This is compounding the problems caused by the shortage of key health personnel to deal with the high attendance:

...because of the numbers we had to rearrange the duty rota so that if a doctor is not doing ward rounds, he / she could start work early at the consulting room...unfortunately for us the problem we had was that about half of the medical officers are under training (house officers)...(HMP-1)

The medical assistants and senior nurse or midwives are managing the health centres.

There is really pressure on the few health personnel:

...we have to know that health insurance has come so pressure will come at every corner: at the end of the providers there will be more work...how do we in the event of all these pressures still work towards achieving customer satisfaction?...(SMMHO-1)

The management teams of both mutual health organisations and health providers are hopeful that control mechanisms including, gatekeeper system and hospital attendance cards could help to reduce the massive attendance and abuse.

10.2.1.6. Lack of Knowledge of the Costs of Health Care

The trend was also related to the fact that some of the insured members are enjoying a new breadth of life in their health insurance membership. When the Aduana MHO and Biretuo MHO operated as pre-NHI 2003 MHOs, their health care benefits packages for members were restricted to only in-patient (admissions) and few selected out patient department (OPD) care. However, under their post-NHI 2003 MHO operations, they are offering both OPD and inpatient (admissions) care at no direct cost to the members. The difference here was that during the pre-NHI 2003 MHO period, members were well educated on how their accumulated funds were being utilised. Members were issued with payment receipts to show the actual costs of drugs (medicines) and services dispensed with their prescriptions:

...we recorded short recovery rate of illness as a result of the implementation of the community health insurance scheme[pre-NHI 2003 MHO]...it covered only admissions at the time...The NHIS covers OPD and inpatient care...attendance has increased...there was average of 70 patients before NHI 2003, which currently, is between 250 and 260 per day...(HMP-2)

However, what is happening under their post-NHI 2003 MHO system is that the costs associated with insured members' access to health care are not made known to them.

Hence, they are unable to put a high premium on the rate at which their perceived 'frivolous' use is dissipating the funds of their mutual health organisations.

10.2.1.7. Abuse of Privileges by Insured Members

Negative interpretation of the proverbial 'Ohia Ma Adwen' concept comes to play when the problem of perceived clients' health insurance fraud and abuse was raised. It is perceived that individuals who had registered are able to devise strategies to assist their fellow poor members to access orthodox health care on their accounts: solidarity in poverty. Thus, insured members are adopting different strategies to obviate a situation where an uninsured member of a family who fell sick would not be denied health care:

...the problem we have all identified as a serious abuse is that the insured clients 'misrepresent' the medical conditions on behalf of their uninsured relatives just to be able to get drugs for them because the services are virtually free for the insured...(HMP-5)

Thus, the common perception of management of both mutual health organisations and health care institutions is that some insured members are misrepresenting the medical conditions on behalf of their uninsured relatives and friends just to be able to get prescription:

...as a scheme, we can tell a client if you go and pick somebody's card and you are caught, we can discontinue your membership and all those things...For instance, if somebody in the house says to you that: I'm suffering from my stomach and because you have the health insurance card you also pick it and go to the health facility and present those conditions, we know all those things...(SMMHO-1)

Thus, under such an arrangement, the medication prescribed would be sent to the 'uninsured sick relative'. The root cause was identified to be economic. The financial constraint in most families had created situations where all the family members are unable to enrol due to implications of the cost of the health insurance policy (refer to 9.1.3.4). Some policy makers perceive that while it was accepted that

the average Ghanaian was genuine in their dealings with issues related to health care services among other things, the problem was caused by:

...the current market-driven economic environment within which they survived had made some of them susceptible to all sorts of behaviours just so they could provide their health care needs...they could not wait to see a member of their family to die just because of inability to pay for health care at the point of service use... (PMS-12)

Other respondents perceive that even as health insurance seemed a laudable idea for many people and they would have wished to be part of it, the lack of financial resources to do so had pushed them to stay out. Management of the mutual health organisations assume that this could partly be curtailed if the health care prescribers could request for *insitu* laboratory investigations from any insured client they suspected of such an apparent misdemeanour:

...humorously, we can look forward to a day when laboratory investigations would find a man declared 'pregnant' ... (HMP-5)

Respondents perceive that the expectations of the people who had insured with the mutual health organisations are very high. These might have led to the high utilisation rate leading to the abuse of the services because some of them try to utilise their part of the premium before the year ends:

...what they do is that getting to the end of the year, when their expiry dates are near; they rush to the health facilities to access health care... (SMMHO-3)

That is, there are other insured members who also presume that once insured with a mutual health organisation, the entire family needed to go to the health service providers when a member fell sick, lest the condition escalated and affected others. This conforms to the concept of prevention is better than cure.

10.2.2. Provision of Orthodox Health Care by MHOs' Contracted Health Care Institutions

This part examines how the contracted health institutions within the proximity of the four mutual health organisations provided quality healthcare to the members of the four mutual health organisations between 2005 and 2006.

10.2.2.1. Dwindling Funding Inflows of the Health Care Institutions

There are few problems with the financial inflows into the health care institutions for their smooth operations. The budget allocation from the central government (GOG) funds is irregular (refer to 6.5.1). This is released through the financial encumbrance (FE), which is the financial authority given to the Treasury to disburse government funds to ministries, departments and agencies (MDAs). The Ministry of Finance and Economic Planning (MOFEP) releases the financial encumbrance on quarterly basis. Again, the contribution from the Donor Pool Fund (DPF) is dwindling due to changes in operational modalities by the Ministry of Finance and Economic Planning (refer to 6.5.2). Policy makers perceive that Donor Pool Fund (DPF) is dwindling for two reasons:

...one is that some of the donors are going into budget support, and therefore we are expected to be able to engage the Ministry of Finance to ensure that the health sector continues to be financed. The second reason for the dwindling of donor pool fund is basically because some of the donors are also going into projects... (PMS-2)

These developments mean that the health institutions need to rely heavily on their Internally Generated Fund (IGF), which they are amassing from the patients coming under the Cash and Carry system (refer to 6.5.3). The management of health care institutions are greatly affected by the sudden shift in funding streams:

...in the past whether they [patients] paid or not we all depended on government's subvention, but now gradually the government is pooling away...If we are doing the insurance and we are able to entice a lot of people we will be able to break even so that the pressure on the government will also come down...(HMP-1)

Currently, the health insurance fund is a major component of the Internally Generated Fund (IGF) of the health institutions. They are offering the mutual health

organisations credit facility when they treat their members. However, the evidence shows that the mutual health organisations are unable to reimburse claims on time or give front loading to the health care institutions. Front-loading is an amount of money which they could provide to their contracted health care institutions to meet their operational requirements. The National Health Insurance Regulation 2004 (L.I. 1809) specifies in section 38 (1) and (2) that:

1. A claim for payment of health care services rendered, which is submitted to a Scheme shall, unless there is any legal impediment, be paid by the Scheme within four weeks after the receipt of the claim from the health care facility.
2. All claims shall be paid directly to the health care facility and on no account shall direct payment be made to a patient (MOH, 2004b:10)

However, the situation with the mutual health organisations is that they are finding it difficult to honour their claims to the health institutions without the subsidy from the central government (NHIF). As soon as the bills are presented but payment delayed, the health institutions are then put under real pressure. They also had contracts with suppliers who provide them the required drugs and medical consumables on credit. They had to re-negotiate with the suppliers, to give them 90 days credit period instead of the initial 30 days; otherwise, they could not service their debts. This is creating some difficulties:

...now we are providing services on credit basis and it is like the government funding of services has stopped... We are indebted to our creditors and running of the health facilities has become very difficult... (HMP-5)

Table 10.3 shows how the funds of 'Biako Ye Hospital' had been locked up due to late payment by nine (9) mutual health organisations. The hospital had been contracted to provide health care to the members of these mutual health organisations (MHOs) in its catchment area. The held-up capital was based on a costing mechanism in the areas of services: consultation, administration, laboratory examinations; and drugs (medicines). The table shows that all the nine (9) mutual health organisations had not been able to reimburse health care claims to 'Biako Ye Hospital'. The amount owed in respect of services: totalled ø541m old cedis. The

amount owed in respect of drugs: totalled ø511m old cedis. The total outstanding health care claims totalled ø1,058m old cedis.

Without any iota of doubt, this trend would just halt the hospital's business; if continued. From the point of inaction of the mutual health organisations, the delay in reimbursing their health care providers is caused by several reasons, including problems with the compilation and vetting of the claims submitted by the health care institutions. However, the major cause is also down to the laid down procedures for disbursing government funds:

...delay is contingent on the vetting process, because they [MHOs] also depend on national subsidy which is also based on certain formula in terms of the number of registered under 18yrs or over 70yrs members... (HMP-1)

The National Health Insurance Council and Authority (NHIC and NHIA) have to follow through the approved financial procedures by the Ministry of Finance and Economic Planning (MOFEP) to be able to access funds from the National Health Insurance Fund (NHIF):

...it is more of the government's way of releasing money...the schemes are given quarterly allocation...but people get sick not on quarterly basis!...they get the bill and apply to the national level...but they will have to wait for the national level to send the money to them...that is the problem...I know some of them can come to the national secretariat before their funds are released to them... (PMS-16)

Table 10.3: Outstanding Health Care Claims owed 'Biako Ye Hospital' by MHOs: January to December 2006 (old cedis, ¢)

MHO	Service (¢)	Drugs (¢)	Balance (¢)
A	(352,714,722.00)	(382,874,443.00)	(741,599,165.00)
B	(65,002,600.00)	(41,491,438.00)	(106,494,038.00)
C	(48,653,678.00)	(44,226,964.00)	(92,880,742.00)
D	(41,489,700.00)	(20,916,862.00)	(62,406,562.00)
E	(18,115,300.00)	(15,533,794.00)	(33,649,094.00)
F	(4,971,500.00)	(2,935,945.00)	(7,907,445.00)
G	(3,822,600.00)	(824,381.00)	(4,646,981.00)
H	(2,939,922.00)	(2,318,276.00)	(5,252,198.00)
I	(3,592,211.00)	(65,355.00)	(3,657,566.00)
Total	(541,302,133.00)	(511,187,458.00)	(1,058,499,791.00)

NB: £1 was an equivalent of ¢18,000.00 old cedis as at November 2006.

Due to the prevailing funding constraint, the health care institutions are also playing it safe to maintain financial survival (see sub-titles below).

10.2.2.2. Health Treatment Protocols (Availability of Drugs)

It is expected that health providers demonstrate a professional attitude towards members of the mutual health organisations. It is also important that the management of the mutual health organisations measure how health institutions comply with treatment protocols (refer to table 8.9). Therefore, using the availability of drugs at the health care facilities to measure quality of care or efficiency of service delivery was paramount. Health care clients' perception with regards to their level of satisfaction or quality of care on the basis of this is a mixed one. It usually depends on the type or aetiology of the disease presented, the diagnosis and prognosis made and the cost of the prescription given to serve as prophylaxis. The problem arose where the health care providers are adopting some prescribing habits, which are seen as discriminatory against the members of the mutual health organisations:

...there are cases where members go to the health facilities and do not get the drugs...There is concern about the prescribing attitude of health personnel...We have reports that they

sometimes prescribe some drugs outside the NHI drugs list...(SMMHO-2)

The perception is that quite expensive drugs (medicines) are being prescribed as substitutes for the more generic ones:

...an expensive drug like artesunate tablet(s), which is an anti-malaria drug costing about thirty-five thousand old cedis (¢35,000.00) could be prescribed instead of chloroquine tablet(s) or injection(s), which cost about ten thousand old cedis (¢10,000.00)...The latter is relatively, cheaper in cost and good for the treatment of common malaria ailment... (HMP-7)

The bare truth is that the artesunate tablet is not on the National Health Insurance Drugs List (NHIDL). Therefore, when prescribed for members of the mutual health organisations, they would have had to buy it from outside the health facility at a cost to themselves:

...they have also complained about the prescribing attitude of the health personnel, but this is due to the fact that there is a treatment guideline which ensures that there is different prescription for different patients... (HMP-6)

Some of the mutual health organisations had not yet entered into contract with some of the private pharmacies; to enable their members to access medication free or get refund after buying them on credit basis. Health managers explain to the contrary that they need to ensure that quality health care was provided for their patients:

...I will give you a typical example where one of the drugs was in the NHIDL, but one of the alternatives is called amlodipine and they are in the same bracket in terms of efficacy, compliance may be better and it may even be cheaper, but because it is not stated in black and white...They should give us this freedom to operate, once we are not operating outside the law, we should be able to use alternatives... (HMP-1)

The economic and financial disagreements to the narratives are that the health care providers need to generate immediate revenue for their operations. This was one of the strategies adopted to save cost so as not to deplete their stock of drugs (medicines). They know that serving the insured clients, especially, the outpatients

could cause the hold up of their capital funds. Hence, they serve the available drugs (medicines) to the uninsured clients who are termed 'fee-paying clients'. By this, they would be able to recoup their monies invested so that they could also pay their suppliers; in accordance with their contractual obligations:

...It is a very big factor...it is common knowledge that when you submit your returns [claims] to the mutual health organisation, sometimes it will take you three months or even more before you are reimbursed...to solve this problem, what we in this region have done is to meet the scheme managers and ask them to provide at least 70 per cent of the cost of the claims submitted to the facilities...If they look through the entire bill and it's okay, then the 30 per cent will be sent to the facilities. I believe this is working out well...money to keep running... (PMS-6)

A different issue identified was recurring inflation in the economy. This means that the health institutions are losing heavily on their mark up of between 10 and 15 per cent on the drugs sold (refer to 6.5.3.1) if the limited medicines available were dispensed to the members of the mutual health organisations whose reimbursement is being delayed anyway. Their aim is to break-even in order to deal with the cost of inflation. The health institutions are unable to plan and implement their budgets according to available resources. To avert being cash trapped, a survival strategy put in place is to 'cash cow' the uninsured patients.

The health care providers were perceived to be taking undue advantage of the ignorance in medicine of the management of the mutual health organisations in the preparation and submission of their claims for reimbursement. The management of the mutual health organisations suspect the health care institutions of unfair documentation:

...we had two schemes delaying payment because we had to provide diagnosis to ensure that the patients were seen...about thirty-five million old cedis (¢35,000,000.00) owed where eleven million old cedis (¢11,000,000.00) was rejected instead of the whole thing being rejected because these things were not properly done... (HMP-1)

Most of the Claims Managers (CM) of the mutual health organisations struggle with how to vet the claims submitted. They lack the pharmacological know-how to interpret the terminologies used on the prescription forms. This partly, explains why the reimbursement to the health facilities was frequently delayed. This issue had brought up the question as to whether:

...it would have been appropriate to employ staff with expertise in medicine... (HMP-1)

However, some policy makers disagree to this suggestion:

...there is a mixture of high and low calibre of personnel but I believe that performance will not depend on who is highly qualified or not. At least, 1st degree is important, 2nd degree is an advantage and the basic level should be alright... (PMS-11)

Another dimension to the perceived health provider health insurance fraud was in relation to how the seeming ignorance of some insured members was being exploited. The premise is that an insured member who is well informed of the concept and operations of health insurance is equally, a confident patient when he or she reports ill at the health care facility. The opposite is that management teams:

...receive complaints of charging for drugs that are on the NHI drugs guidelines... (SMMHO-2)

The lack of dispositional knowledge in health insurance (refer to 9.3.1) is predisposing the insured clients as the endangered species to be preyed upon by the unprincipled health care personnel as reported in the Western region (see 'The Daily Graphic' Thursday, January 18, 2007, pp. 1 & 3). Even though, the health insurance clients are not required to pay for the costs of health care services upfront, in practice, it is perceived that some of them are being asked to pay prompt cash for some of the health care services, as though, they were 'fee paying' clients:

...obviously, things have not gone as smoothly as we would have hoped...part of that has to do with people running the cash and carry system for a while...ways of making money...all they hear

is health insurance is putting an end...there is a little bit of sabotage...that is happening...(PMS-13)

The cost did not appear to be high under the mainstream health facility user fees. Management of some health institutions have instituted mechanisms to check this problem:

...to stop the illegal charges, we have informed the clients at the OPD of the need not to pay any unauthorised monies –under the table fees collection is handled privately...arrange with the patient to carry out this operation privately and charge even though it's covered under the NHI guidelines for clients...(HMP-5)

The issue of some health personnel perceived to be extorting money from patients outside the institutionally approved user fees had been the trend under the user fees system (refer to chapters 2 and 6). Stamping this out would also require disciplinary actions as it happened in the Western region (see 'The Daily Graphic', Thursday, January 18, 2007, pp.1 and 3). However, some policy makers have a different view regarding how disciplinary issues were handled in the health facilities:

...some health managers allow professional interest to override administrative competence: meting out sanctions to a colleague would be construed as an affront to their profession...(PMS-6)

Thus, it appears that the management of the health institutions are somehow incapable of instituting appropriate sanctions against the staff who disregard the ethical rules of conduct:

...about 70 per cent of all doctors and nurses who work in this country work for government...we are implementing a government policy...that is why there is this regulatory authority...soon we are going to have an inspectorate unit that will be monitoring the provider side...we will take people on if they are deemed to be cheating or doing things that are inimical to the survival of the health insurance scheme... (PMS-13)

Respondents perceive that this could be controlled if there was a strong monitoring system.

10.2.2.3. Waiting Time

On the basis of patients' waiting time at the health facilities, it is perceived that patients are spending some considerable time at the out patient department (OPD). Health care clients perceive that they are unduly delayed by the health personnel when they report sick at the health facilities:

...they need to treat us of our sicknesses and diseases...my child got sick while in school and was brought home...I asked my sister to send her to the health facility. It was about 10:00am but when I got there at 1:00pm, they had not even issued a card to her. It was after 2hrs of my arrival that we were called...we went again the following day and the same attitude was repeated. I always go there and end up exchanging words with the staff...(ADMHO-M-3)

There was also an administrative dimension causing the delay in attending to the insured clients. As mentioned earlier, patients are classified as 'insured clients' and 'fee paying clients'. The administrative procedures set up by the health care institutions to attend to these two groups differ:

...the calibre of staff trained at the operational level was not adequate...the medical records staff for instance, find it difficult retrieving information from the computerised system... Therefore, card bearing patients (insured patients) wait for about an hour or two before they move from the OPD where we have the medical records department...(PMS-6)

Since the 'fee paying clients' pay their bills with cash upfront, their procedures appear to move a little faster than the 'insured clients' whose procedures involve computerised systems, where available. These procedures are unknown to all the clients and each perceive that the other is being given preferential treatment.

10.2.2.4. Relationship between Health Personnel and MHO Members

Excellent relationships marketing strategies adopted and used by the health care providers in their dealings with their clients was paramount to the assessment of the perceived quality of care. Apart from the symptomatic relief patients receive after administration of drugs, the other means of ensuring speedy recovery of some health

conditions is the use of psychotherapy. This can be imparted to patients through effective use of relationships marketing methods such as receptive welcome to the facility, ability to recognise clients by names and other culturally acceptable means of handling people by the health personnel:

...it is about perception, and sometimes treatment in quotes: what they say is that the user facilities do not give them the kind of attention that they deserve...Because of that they don't want to register...They complain about the quality of service, they say they are given substandard drugs, they say the nurses are not talking to them well, they are not getting the referral facilities... all those things... (SMMHO-1)

Mostly, the people in the informal sector who had insured with the mutual health organisations are the relatively poor individuals in the communities who might have been denied crucial health care services for quite some time. They needed to be treated with good care and attention so that their recuperation could be boosted. However, clients perceive the attitudes exhibited by some health personnel as unfriendly:

...wɔn nom nte wɔn animu mma wo, enno me kɔn mpo biem, me nnamfo mpo na wɔretu me fo se menyɛ ma mmofra no, meaning, they do not give you good reception or welcome you enthusiastically, it's no longer appealing to me...it is my friends who are even advising me that I should sustain my membership with the insurance scheme for the sake of the children, I would not have renewed it...this particular year, the attitude of the health personnel has been different... (ADMHO -M-3)

The perception of most of the patients with regards to how they valued their relationships with health care providers was two-fold. Whereas some insured clients express satisfaction based on good reception, others express dissatisfaction. For instance, the utterances of some health care personnel are considered as a source of discomfort for some insured clients:

There have been reported cases of NHIS card bearing patients having to spend several hours to trace their cards or folders at the OPD because they are not paying cash. There are problems of over-prescription of drugs for patients, derogatory remarks about

the scheme by some staff and fraudulent practices by some staff are some of the problems militating against the smooth implementation of the scheme (Boamah, 2006:1)

The people who had been able to register had the idea that they would not be confronted with the issues that characterised the adverse effect of the cost recovery policy:

...what we expected to happen is not what is happening...This means that the purpose of the insurance is rather defeated because we cannot get the needed help from contributing to the scheme... (ASNMHO-M-7)

The apparent unfriendly attitude of the health care personnel is partly attributed to lack of in-depth understanding of the concept of health insurance, which is also reflecting in their actions (refer to 9.3.1). As indicated earlier, the introduction of the National Health Insurance Scheme (NHIS) under the NHI Act 650 was the first of its kind in public health facilities. Some policy makers concede that this was not preceded by intensive education involving all health cadres:

...I must say that the GHS' role was not well defined during the initial stages of the formation of the NHIS and we had to get involved at a point...(PMS-7)

It was observed that 'training of trainers' workshops were organised for the in-service training co-ordinators of the health institutions: '*...we provided money for the training...*' (PMS-16). However, these personnel lacked the necessary logistics from their institutions; to organise similar institution-based dissemination workshops for other colleagues:

...we have educated staff on the concept of health insurance but I can assure you that it is not every member of staff who has benefited from the training as yet...(HMP-5)

Professional nurses, who are in the majority, were affected. Meanwhile, it is the nurses who in most cases explain health policies to the members of the communities.

There are problems caused by the seeming lack of understanding of the concept of health insurance amongst health personnel:

...I even met some of my colleague nurses at the hospital who had just started registering for the health insurance, so you see, even the so called literate retired nurses were not very much aware of the health insurance concept... (ASNMHO-M-6)

The inappropriate attitudes of the health care providers are equally affecting retention of old members and the attraction of new members to enrol with the mutual health organisations. With the high level of utilisation of health care services, against the dwindling number of health personnel sacrificing their comfort and lacking incentives (refer to 6.4.1), it is a cause for concern and a pointer to a possible rift between the three publics in the health insurance environment: the mutual health organisations plus the health care providers plus the insured clients (GHS, 2004b). These problems associated with quality health care delivery had consequences on the health status improvement, creating conditions where there was deterioration in people's health:

...on quality of health care, I would say that it has been compromised and I know that patients' perception of quality is negative: quality of care has gone down... (HMP-5)

The fact that the insured clients are visiting the health facilities might not correspond with improved health status (see 'GNA', Monday, 17 November, 2008d).

10.3. Implications of Regulatory Changes for the Mutual Health Organisations

This sub-theme explores the implications of regulatory changes for the mutual health organisations. The mutual health organisations are operating under the new arrangement orchestrated by the introduction of the National Health Insurance Act 650 (MOH, 2003d, 2004b), as formalised institutions opposed to when they operated without any legal framework, nationally. The government of Ghana was not formally involved in their operations either by way of regulation or funding (refer to chapter 7). However, since the NHI Act 650 was introduced in March 2004, the government has become a major stakeholder by using the mutual health organisations' strategy as an addition to the sources of revenue for financing the health sector.

10.3.1. Regularised Management System for the MHOs

As the communities were free to choose anyhow they wanted to operate their pre-NHI 2003 MHOs, the government felt it had to lead the process by setting some standards. The NHI Act 650 has provided a framework in Ghana, which is giving the management and members of the mutual health organisations the needed confidence that there is protection for their investments:

...but when the law came then you see that it is something which has been established because it is an Act of Parliament. As it is something the Legislature has passed, then it gives some of us the authority to sit here and do whatever we want to do. The law has really come to give us some sort of confidence, to support us and to direct us as to how we should go about our activities...(SMMHO-4)

There is a legal provision for redress in the event of financial malfeasance. The organisational and administrative structures of the mutual health organisations have been regularised under the companies' code. All the mutual health organisations in this study are registered with the Registrar General's Department as companies limited by guarantee so that they could sue and be sued:

...the law has come to regulate the MHOs and we also need to be under that kind of umbrella where we will be protected. For instance, when something happens like epidemic, the law will be there, NHIC will be there to come to your aid... (SMMHO-1)

Thus, they have been mandated to register with this regulatory body and also confirm the same with the National Health Insurance Council and Authority (NHIC and NHIA). They have the regulatory responsibility to pay income tax and social security contributions on behalf of their employees, which is providing the employees with some form of pension cover towards their retirement. This is giving the management staff a sense of job security. The mutual health organisations are operating with standards of formalised organisations: delegated duties, unity of command and span of control:

...now you see a whole organisation on its own: we are autonomous...you have your board, manager, and now the claims will go to a certain department...unlike those days we were doing everything from the health facility in a small room...(SMMHO-1)

It would be recalled that a lot of the pre-NHI 2003 MHOs were scattered across the length and breadth of the country (refer to chapter 7). They were independent of each other and did not necessarily come under any umbrella. A summary of the mutual health organisations' evolution in Ghana since their discovery in the early 1990s is shown in table 10.3. The table indicates that between 1992 and 2001, there were 47 mutual health organisations established in Ghana with membership of 90,000 in the informal sector. This had increased to 170 mutual health organisations between 2001 and 2003. The total membership was 500,000, representing 59 per cent of people in the informal sector. These periods: 1992 to 2003 preceded the introduction of the National Health Insurance Act 650 in 2004 (MOH, 2003d, 2004b), and is described as the pre-NHI 2003 MHOs era. However, since the National Health Insurance Act 650 became operational in 2004, most of these smaller and group-based schemes either changed into district-wide mutual health insurance schemes (MHOs) or ceased to operate (see 10.3.5 and 10.3.5.1 for reasons).

Thus, since the implementation of the National Health Insurance Act 650 in 2004 (MOH, 2003d, 2004b), a period termed post-NHI 2003 MHOs era; membership coverage and expansion of the mutual health organisations had increased considerably. Between 2005 and 2006, there were 134 district and municipal mutual health insurance schemes (DMMHIS) established. This was out of the 138 district

and municipal Local Government administrative territories. The membership was 8,000,000, representing 34 per cent of the national population (both formal and informal sectors). Between 2006 and 2007, there were 145 district and municipal mutual health insurance schemes (DMMHIS) established. This was out of the 170 district and municipal Local Government administrative territories (Ghana Districts, 2010). The membership was 11,279,678, representing 55 per cent of the national population (both formal and informal sectors).

Table 10.4: Evolution of MHOs in Ghana: 1990 - 2007

Period	Number of Schemes	Membership	Rate of coverage (%)
1992 - 2001	47	90,000	Not available
2001 - 2003	170	500,000	59 (informal)
2005 - 2006	134	8,000,000	34 (national)
2006 - 2007	145	11,279,678	55 (national)

Consequently, the government's intervention through the implementation of the National Health Insurance Act 650 (MOH, 2003d), has enabled the mutual health organisations in the country including the Aduana MHO and Biretuo MHO to re-organise into large groups with the expectation that they could enjoy some level of economies of scale. They have been transformed into district-wide and municipal-wide schemes.

10.3.2. Competition between the MHOs and the Private Commercial Health Insurance Schemes

Increasingly, the detachment of private commercial insurance companies from the mainstream health insurance provision had become more apparent. Most of them did not offer health insurance policy (benefits packages) to members of the general public especially, those in the informal sector. Companies in this sector who are regulated by the National Insurance Commission (NIC) restrict their operations to motor, property and life insurance policies. Their objective has always been to invest their monies in order to accrue huge returns from their clients by charging high premiums.

There is lack of growth in this sector of the economy because the experience of people regarding their operations has been one of distasteful venture. People have had raw deals when they invested their funds but their claims were not honoured when due or on rare occasions, it took considerable period of time. This has created an unpalatable and unenthusiastic image about anything related to private commercial insurance in the country:

...everybody is a stakeholder in this industry and very soon, we will create a database to check fraudulent act to ensure effective management of resources... (Baba, 2008; 'GNA', Tuesday, 23 September, 2008a)

In the light of some of these events, the National Health Insurance Act 650 specifies the establishment of private commercial health insurance schemes in the country (MOH, 2003d). The aim of policy makers is that it would facilitate the development of the sector by providing channels for legal redress, should there be the occurrence of any fraudulent act of commission or omission. They are expected to cover a certain proportion of the population who can afford their premiums:

...we believe that the private commercial health insurance schemes should express themselves by going for the markets that are not covered...one recognises that that is where private sector should invest its funds: in more catastrophic expenditures...(PMS-2)

Their involvement in the health insurance market against the operations of the mutual health organisations has also provided an avenue for sustained competition, which is enhancing professionalism. People with financial ability search the health insurance market thoroughly when seeking to buy health insurance policy.

10.3.3. Pluralistic Health Sector Approach through the MHOs

Another landmark effect of the implementation of the National Health Insurance Act 650 (MOH, 2003d), is the institution of a nationally recognised health facility accreditation for all health care providers and service performance contract between them and the mutual health organisations. This aims to enhance a pluralistic health system comprising the public sector, private sector and community sector

organisations (refer to chapter 6). The support of private health sector institutions, especially, the private 'not-for-profit' health institutions contributed to the achievement of efficiency and equity goals. A Ministry of Health policy document explicates the objective for private health sector involvement in health financing and delivery:

The policy thrust for 2007 is to drive the private health sector to be the significant contributor to the vision of the Ministry of Health of Creating Wealth through Health (MOH, 2007c)

This is further boosted because the legislative instrument L.I. 1809 (MOH, 2004b), has deepened the sense of financial security required by the private 'not-for-profit' health care providers in their dealings with the mutual health organisations. Many more private 'not-for-profit' health care providers have taken advantage of the enabling environment to provide health care to people in the rural communities, using the mutual health organisations as a means of reimbursement of their funds from the central government. Already, these institutions particularly members of the Christian Health Association of Ghana (CHAG) are subsidised as their staff salaries are being paid by the government.

The crucial issue with their involvement is that they are providing health cover in areas where there are no public health facilities. In some localities, the only health care providers available are the maternity homes and chemical shops, which provide basic drugs and primary care to patients who would have had to travel a very long distance to access health care (MOH, 2003c; CHAG, 2006):

...the CHAG institutions are also partnering with the MOH to deal with human resource shortage...Client satisfaction is important and we have instituted peer review to share experiences. We have contracted community members to assist with some of the issues that need identifying and quality is high. Many members [of CHAG] have reduced waiting time at the OPD of most facilities. We have identified that the 'unpleasant staff' are usually the non-qualified ones and we have offered to train them on issues of public relations...(PMS-12)

This is seen as a very useful progress as they are confident that their bills are acceptable by the mutual health organisations.

10.3.4. Private Health Sector Conundrum

Despite the above, there are few obstacles militating against the total involvement of private 'for-profit' health sector providers in the country. They do not appreciate certain modalities within which they are to operate with the mutual health organisations under the National Health Insurance Scheme (NHIS). The problems, which have yet to be resolved, are the benefits packages and premium setting. There appears to be no clear-cut procedure to make it possible for them to share their experiences relating to the levels of fee for service system they operate:

...It is the responsibility of the private providers to apply to get accredited. Not all the private providers today want to treat health insurance clients. Why, the very simple reason: they charge astronomical rates for the service they provide. Once you apply and you get accredited you must stick to the tariff structure established... (PMS-13)

The implication is that if they are to go by the National Health Insurance Drug List (NHIDL) and offer the comprehensive health benefits packages at the basic premium, they would find it difficult to break-even on their investments. Policy makers perceive that these difficulties are hindering universal health care delivery in the country:

...one other area is for the insurance scheme [NHIC] to work closely with the providers [private 'for-profit'] because in the beginning, it was like they were fighting over 'something' and not collaborating very well...Some of them don't know how they can be part of it and those who know it; it's not all of them that are comfortable with the rules of engagement... (PMS-3)

Respondents also perceive that some actions of policy makers are not encouraging the private 'for-profit' health providers to get involved. Drafters of the NHI Act 650 did not involve the practitioners or the Directorate of Traditional and Alternative Medicine in the process of policy development:

...but did not look at traditional medicine... (PMS-15)

Even though, the contribution of private 'for-profit' health providers to the health delivery of the country is somehow recognised by the Ministry of Health (MOH, 2003c, 2005), it is claimed that their methods especially, traditional and alternative medicine practitioners are below the international standards of health delivery set by the World Health Organisation. This perception was confirmed by a retired health practitioner:

...Dr Mensah,...[noted] there were no training schedules for the native practitioners...they often made unsubstantiated claims on the efficacy of their medicines, putting users of such medicines to high risks....('GNA', Friday, October 3, 2008b)

The private 'for-profit' health sector is usually self-financing and providers have to charge exorbitant prices for their services. As these entrepreneurs do not receive any financial support from the central government, they prefer to be independent of the mainstream health sector, showing *laisez-faire* attitude:

...integration of the private health sector into the mainstream Ministry of Health?- not much involved but they are doing their own things. The sector is lacking in policy making and decision...We have identified ways of remedying the situation, which include: training to involve them in the Coalition of NGOs in Health... (PMS-4)

Economically, the major problems in the development of the private health sector in general are many. The first is the absence of credit facility for people who want to enter into private investments. Credit facilities are provided by the central government through the commercial banks with few private financial institutions springing up in the securities markets. This situation is impeding the private providers in their desire to expand their businesses as expected. The lack of formal business knowledge is also making it impossible for them to develop a more solid and credible business base, which would see the sector mobilise available resources to help the government to achieve universal health financial protection.

Whilst these remain the core issues, policy makers perceive that the private health sector organisations, especially, 'for-profit' providers, do not understand the issues of business development. They expect them to invest their money to ensure a viable business sector because the current marketing strategy subsists on the perspective of segmentation. The government's position is to pursue its equity objective. This is being manifested through the provision of funding to the district-wide and municipal-wide mutual health insurance schemes (DMHIS) to ensure the provision of a certain package of primary services for the people. This leaves out another package of interventions that the private health sector is expected to cover so that they could compete at the point of equity:

...that is how we assure equity...I mean, certainly the private sector will want to compete at the point of equity but the evidence is that they have not been able to generate equity or help us achieve equity objectives... (PMS-2)

That is to say that this opportunity is rarely utilised by many private 'for-profit' health sector practitioners. Policy makers assume that their current contribution to health coverage of the population is not encouraging:

...as at 2003, they were covering about 35 per cent of the health sector over all... (PMS-4)

Despite the reason that the concept and model of the National Health Insurance Scheme (NHIS) is based on pro-poor or equity considerations, there is some trade-off between equity and efficiency (see Arrow, 1963; Broome, 1988; Olsen, 1997a; Carrin, 2002; Hauck *et al.*, 2004; James *et al.*, 2005). Some members are not satisfied with the kind of health care they are receiving and do not have alternative health care providers under the arrangements with the mutual health organisations. The inadequate staff numbers is affecting quality of care:

...we are poorly staffed to meet the increasing number of patients attending the facility...of the 23 nurses we have, 17 are qualified nurses managing a 93 bed capacity hospital...We sometimes create beds on the floor when the wards are full...For instance,

we can attend to 250 clients a day with 1 qualified nurse and 2 ward assistants...It is a problem but we are coping... (HMP-3)

The non-accreditation and non-involvement of some private 'for-profit' health care providers is causing the long waiting times at the few accredited health institutions. Even so, the difference is that whereas the object of the National Health Insurance Scheme (NHIS) is to help remove the financial barriers, it is believed that quality of care would only improve if this is harmonised with the provision of improved equipment, efficient transport system, quality training of health personnel, good management of health facilities as well as the reformation of the behaviour of health personnel in their relationship with patients (Issah, 2008).

This shows that what matters for health care quality is not correlated to the traditional health care facilities such as more hospital beds, intensive care unit (ICU) days or specialists for patients. Quality is rather more connected with social capital or social networks, which culminate in a well-functioning public and private organizations (Skinner *et al.*, 2008). It is needful to expect the private health sector to be more entrepreneurial and business-oriented, while the government should be urged to provide the enabling environment for them to operate and flourish.

10.3.5. Collapse of Pre-NHI MHOs and Non-Establishment of PMHIS

While the intent of the NHI Act 650 is to encourage and promote the establishment of private mutual health insurance schemes (PMHIS), which covers the pre-NHI 2003 MHOs, it has also put in place clauses that are rather frustrating these same groups. Even though the NHI Act 650 stipulates that the government wanted to increase coverage in the informal sector of the population by using two tiers of mutual health insurance: district and private schemes; it is at the same time crippling the private mutuals (refer to 6.5.4.3). The reality is manifesting in the perceived bias against the private mutual health insurance schemes or the pre-NHI 2003 MHOs.

Consequently, during the transitional period leading to the implementation of the National Health Insurance Act 650 in 2004, the management of some of the pre-NHI 2003 MHOs, who felt they could re-constitute their schemes as district-wide mutual

health insurance schemes (DMHIS) had discussions with their respective district and municipal Assemblies about the need to transform, which was mutually agreed:

... if you go to Jaman North and South; the private mutual was already in existence but then the district Assembly looking at the numbers thought it was already big, so why don't we just change the face and make it our district-wide mutual...that is what happened in some of the places but the very small ones had to collapse... (PMS-16)

Those that metamorphosed were already based in the district capital towns with large membership. For example, the Aduana MHO and Biretuo MHO were very active pre-NHI 2003 MHOs but had to transmute into their current status as district-wide mutual health insurance schemes in their respective districts for reasons beyond the control of the promoters. However, those that were located outside these localities or had smaller membership decided to close down completely. The reasons accounting for the collapse or metamorphosis of the pre-NHI 2003 MHOs are the same as those for the non-establishment of the private mutual health insurance schemes (PMHIS) as defined by the Act 650 (see sub-titles below).

10.3.5.1. Policy Minutiae and Funding Uncertainties of the PMHIS

While, it is difficult to justify the perception that a calculated attempt was made to frustrate the pre-NHI 2003 MHOs, it is not far from right to point out that the clause in the NHI Act 650 about the non-provision of subsidy for the private mutual health insurance schemes (PMHIS) was deliberate to some extent. The NHI Act 650 notes:

A private mutual health insurance scheme is not entitled to receive subsidy from the National Health Insurance Fund established under Part VI of this Act (MOH, 2003d:19)

This apparent unfairness is even evidenced in the stipulation of the huge health care benefits packages, for the citizenry who register with the district-wide and municipal-wide mutual health insurance schemes as explained in appendix E. This has greatly reduced the financial confidence levels of the promoters in the communities. They have therefore, relinquished their mutual health organisations to the government:

...the reasons why the defunct 'Adarkwa Medical Centre's Mutual Health Organisation' collapsed were that the management and members decided to join the district-wide scheme as they could not challenge the premium offered and pay for the same benefits package. They would need huge capital outlay to continue to operate, and could not operate in isolation in the district...(HMP-4)

That is, to forestall any financial clouts in their operations, the private mutual health insurance schemes (pre-NHI 2003 MHOs) decided to close down completely. This has also discouraged the promoters of the private mutual health insurance schemes (PMHIS) instead of encouraging them to establish and operate side by side with the district-wide and municipal-wide mutual health insurance schemes (DMMHIS). Some policy makers are pessimistic about the future of the private mutual health insurance schemes in the country:

...no, they cannot resurrect for the simple reason that government is exempting so many people from paying premium to the district and municipal mutual health insurance schemes...the private mutuals cannot operate without everybody paying...the government has insisted that they will not subsidise the private mutuals, so they cannot survive, so they are dead!...(PMS-16)

Logically, continuing their operations would mean that they would need to increase their subscriptions, to be able to provide the same or similar health care benefits that their members would have struggled to afford. The procedures and processes of registration are very cumbersome for any community group of an informal nature with limited manpower capacity. Most of the managers of the pre-NHI 2003 MHOs were working on voluntary basis and educational qualifications were not the criteria for their appointment by their members. The NHI Act 650 requires highest level of professionalism from the management of the health insurance schemes. Certain minimum qualifications have been spelt out (MOH, 2003d). However, these are almost absent in the remotest communities.

There are also the administrative bottlenecks, which the promoters considered as critical to their continuous operations. By the contents of the NHI Act 650, every individual(s) who wanted to establish and operate a health insurance scheme would

have to register officially, with the Registrar General's Department and the National Health Insurance Council (NHIC). This must be done before they could be issued with a certificate to enable them receive and manage funds on behalf of the people. The NHI Act 650 also sets out the minimum number of people a health insurance scheme must enrol before it could be described as acceptable entity (MOH, 2003d). These requirements are seen as limitations to the promoters:

...you see the essence of health insurance is not to spend the whole money on covering administrative expenses...We want to spend the money to provide health services to people...(PMS-13)

They also face a difficult task of raising the initial registration fees of ₦5m old cedis and the renewal fees of ₦2m old cedis after every two years (MOH, 2003d, 2004b). Their attempt to do this would rather deplete their financial base and would also have had consequence on how they could raise enough money to meet their health care claims and other expenditures given the economic status of their target groups. Policy makers are aware of the difficulties encountered by private health insurance investments in the country:

...the private mutual requires a lot of capital outlay to establish...If you remember, there was one that was established two years ago, it was called Metropolitan Health Insurance Scheme...It was not viable because they could not rope-in the number of premium holders that could enable them break-even, it was a problem...(PMS-14)

The mere fact that the government was involved in the district-wide and municipal-wide mutual health insurance schemes (DMMHIS) is rather creating a sense of inertia in the promoters in the communities. The anticipation is that no individual or group of individuals could compete in any programme that the government was directly involved in. This is why they are being risk averse instead of risk takers (Kraus, 2007). It is perceived that the promoters also argue that they and their members should be granted access to public funds. Their contributions form part of the 2.5 per cent National Health Insurance Levy from which the government is financing the

district and municipal mutual health insurance schemes through the National Health Insurance Fund (NHIF):

...I must also admit that a lot of these community based schemes [pre-NHI 2003 MHOs] transformed themselves into district mutual health insurance schemes [post-NHI 2003 MHOs] under the supervision of the district Assemblies and the transformation was clearly in the hope that they could access public funds. So the public funds may have created incentives for people to transform themselves...(PMS-2)

The best they thought they could do was either to re-strategise or cease to exist altogether; after all, they are also citizens of Ghana:

...they [PMHIS] may also have problems with the benefits packages to provide for their members...about 60 per cent of the population are covered, but who are the 40 per cent to pay for the rest?... the people said they were waiting for the government's scheme to come into effect... (PMS-12)

The promoters of the private mutual health insurance schemes (pre-NHI 2003 MHOs) realised that there were going to be challenges given that a lot more people want to register with the district-wide and municipal-wide mutual health insurance schemes (DMMHIS).

10.3.5.2. Non-State Actors

The influence of international donors and non-governmental organisations (NGOs) in reinforcing the belief that community mutual funds could provide the stepping stone to ushering in a national health financing strategy cannot be painted blurred. However, they do not appear to know how and where to formally get involved in the activities of the National Health Insurance Scheme and the district-wide and municipal-wide mutual health insurance schemes, as the government is seen as the main financier. One of their main objectives in the health sector is to help identify solutions to the problems of health financial access:

...if there is any need for research by the NHIS, how do you do it in such a way that it actually touches on the poor, improve

access or quality of service, those are the kind of things that the partners are interested in...(PMS-16)

Their areas of expertise also include supporting the organisational structure and functional areas of the mutual health organisations. Although they have the expertise and experiences with regards to the nitty-gritty of the operations of the mutual health organisations, the need for their support is perceived to be dependent on the National Health Insurance Council and Authority (NHIC) to decide as to how to involve them in the educational activities. From the perspective of the donor partners and non-governmental organisations, they are interested and wish to be involved in the implementation of the National Health Insurance Scheme:

...the donor partners are really interested. They have offered themselves, but the problem is that the NHIS did not have a strategic plan where partners can easily slot in. What most of them have been trying since 2003 to ask government is: give us some role to play, but we want the big picture so that we buy into the big picture... (PMS-16)

The rather difficult issue at the moment is the absence of a business plan which would enable these health sector partners to get involved in the process:

...there seems to be some misunderstanding between the NHIS and the Donor community over which channels to use to make their contributions... (PMS-11)

Some respondents are rather unenthusiastic about the possibility of their involvement:

...but if it is like with the knowledge that we have gained over the years from the community experiences; all that will go to rot because there is no formal mechanism for tapping into the current system...(PMS-17)

Although some of these health sector partners are going their own way to support some mutual health organisations, the seeming lack of interest from or integration by policy makers is making it difficult for some of the mutual health organisations to organise their own training programmes for their staff due to lack of financial and logistics support:

...what we assumed was that as central government took over, it was all for the better. However, we wished that their support could go side by side with contribution from central government. That will help improve the system tremendously...There are still some people who need financial assistance. There are some people who wish to register but are prevented from doing so due to lack of funds for registration. So we think that such a support can help such people to be part of the scheme... (SMMHO-3)

Generally, it can be concluded on this sub-theme that the implementation of the National Health Insurance Act 650 had impacted enormously, both on the positive and negative sides, with respect to the concept and operations of the mutual health organisations in Ghana.

10.4. Summary of the Chapter

This chapter has analysed the external influences on the performance of the mutual health organisations. It has revealed that policy makers, traditional leadership and other opinion leaders have the ability to encourage their members in the communities to embrace policies introduced by the government. In addition to their roles as motivators, educators and counsellors, these opinion leaders are also ensuring that unity amongst community members is enhanced so as to support the mutual health organisations. Again, the chapter has shown that the mutual health organisations are confronted with some problems beyond their control. These include the unsupportive attitudes of both members and health care providers. Moreover, it has been made known that the introduction of government regulation (NHI Act 650) has had both positive and negative effects in the mutual health organisations' environment in Ghana. The next chapter presents the analysis and discussion of the empirical findings.

CHAPTER 11

ANALYSIS AND DISCUSSION OF EMPIRICAL FINDINGS

11.0. Introduction

This chapter presents the analysis and discussion of the study based on the interpretation of the empirical findings using the social policy and community field theories. The elements identified in the empirical study are extended to help in the interpretation of these theories (refer to chapter 4: figures 4.1). The chapter is divided into four (4) sections. The first section discusses the social policy theory or government's intervention in the health sector reform and its effect on health financing and the mutual health organisations' environment in Ghana. The second section examines the community field theory or the community's involvement in the health sector reform and their acceptance of the mutual health organisations as newly emerging health financing strategy in Ghana. The third section discusses the effect of complementarity resulting from the use of the two theories: social policy and community field or the relationship between the government and the community. Section four is the summary of the chapter.

11.1. Social Policy Theory

As discussed in chapter four (4) the social policy theory explains the intervention of government in bringing about the necessary change in society. The various areas such as: financial, institutional and social, where the actions of the government of Ghana are being demonstrated in the operations of the mutual health organisations, including those in this study, have been discussed.

11.1.1. Financial Performance and Viability of the MHOs

Measuring the financial performance of the four mutual health organisations in this study on the basis of the financial viability model used (refer to chapters 8 and 9), the analyses show that the results are mixed depending on a particular mutual health organisation. However, these must also be considered in the light of certain limitations resulting from multifaceted risk management and/or statistical problems:

...what we found out was that the premium was fixed...there were no actuarial studies done to determine how much the potential contributors could pay...after determining the disease burden...because they did not do that, there have been problems...(HMP-1)

Some researchers explain that the financial perspective is meant to determine how far an organisation has accomplished its financial goals by identifying how the organisation wishes to be seen by its shareholders and other stakeholders: 'key measures of the financial perspective include operating income, return on capital employed, sales growth, return on assets, and asset turnover' (Tsamenyi *et al.*, 2008:4). However, for a non-profit making organisation like a mutual health organisation, the desire to achieve the financial objectives may not necessarily be to ensure profitability, return on capital employed and sales growth, among others. The aim is to break-even by ensuring that there are enough reserve funds (refer to p.150) to cover average expenses, control spiralling operating costs and be able to pay claims to healthcare providers (Cripps *et al.*, 2003; Wipf and Garand, 2008). As indicated in chapter 9, it is difficult to assess the financial viability of the four mutual health organisations on the basis of their long term liabilities due to limitations in the

financial statements provided for analyses. The discussions below help to amplify this point.

11.1.1.1. Liquidity Ratio

The analysis in chapter 9 showed that the liquidity ratio of all the four mutual health organisations could not be calculated due to lack of adequate data, as the accounts had not been audited (refer to chapter 8). However, since their reserve funds (refer to p.150) show surpluses instead of deficits, it could be concluded that they do not have liquidity problems (refer to 9.2.4.5; and see appendix M). Nonetheless, there is a delay in the release of the National Health Insurance Fund (NHIF) for disbursing with Claims to healthcare providers (compare with 10.2.2), which is affecting how frequently they could pay off their liabilities, if any. The issue relates to the applicability of the financial viability indicators used to assess the mutual health organisations in this study. The mutual health organisations need to ensure that their financial statements are audited annually (see MOH, 2003d, 2004b), to be able to measure their performance on the basis of liquidity ratio.

11.1.1.2. Solvability Ratio

Like the liquidity ratio, there was lack of adequate data to measure the solvability ratio of the four mutual health organisations since the accounts had not been audited (refer to chapter 8). However, since their reserve funds (refer to p.150) show surpluses instead of deficits (refer to 9.2.4.5; and see appendix M), it could be concluded that they are not at the brink of insolvency. This also brings to the fore the suitability of the financial viability indicators used to assess the sustainability of the four mutual health organisations in this study. Therefore, the management of these mutual health organisations will have to comply with the regular auditing of their financial statements as contained in the regulations underlying their operations (see MOH, 2003d, 2004b). They also need to open assets register to be able to monitor, evaluate and provide depreciation on them for future audit purposes. The Ghana Audit Service must be resourced in areas of technological innovation and administrative systems to be able to carry out their duties effectively and timely.

11.1.1.3. Ratio of Coverage of Expenses

As pointed out in chapter 9, although it could be argued that the MHOs might have reserves because their third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1, 9.2.4.1; and see appendix I), there were no balance sheets available to support this claim. As explained in chapter 8 'surplus' is used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150; 9.2.4.5; and see appendix M). This was used to measure their financial performance and viability on the basis of ratio of coverage of expenses. Hence, using the ratio of coverage of expenses to measure their financial performance, the study observes that there are inconsistencies in the way the mutual health organisations are performing: the results are mixed. Whereas the Aduana MHO achieved a ratio of 0.65 in 2005, which is not satisfactory, this increased to 11.85 in 2006, which is impressive. While the Asakyiri MHO attained a ratio of 8.45 in 2005, which is commendable, this was rather reduced to 2.36 in 2006, which is above average but not encouraging. In the case of the Asona MHO, whilst it was able to record a ratio of 2.14 in 2005, which fell below expectation, this decreased further to 0.80 in 2006. In its case, the Biretuo MHO achieved a ratio of 10.03 in 2005, which is impressive. However, this was reduced to 1.93 in 2006, which is not all that impressive.

In the light of the above, it is evident that none of the four mutual health organisations maintained any consistency and their overall financial performance could be seen as poor. The overall observation is that there are some variations in regards to how the four mutual health organisations are making expenses against their accumulated reserves. That is, with regard to ratio of coverage of expenses, it is uncertain whether these accrued reserve funds could correspond to the average expenses for at least a period of three or six months without recourse to borrowing (refer to p.150; 9.2.4.5; and see appendix M). However, this must be seen in the light of the approach used to analyse the reserve fund (see Atim, 1998, 2001, Atim *et al.*, 1998, 2001a; Cripps *et al.*, 2003). The management teams need to improve their financial and administrative capacity to be able to bring down incidental expenses to the barest minimum.

11.1.1.4. Ratio of Subscriptions to Expenditure

From the analyses in chapter 9, it is apparent that all the four mutual health organisations could not achieve a ratio of 1, in respect of their ratio of subscriptions to expenditure. All the four mutual health organisations are facing serious problems with regards to the determination of suitable premiums for their informal sector population groups. Moreover, there were some difficulties in determining this ratio as the subscriptions figures used are based mainly on premiums accrued from the paying informal sector (PIS) members. The formal sector members' premiums, which form 2.5 percent of their 17.5 percent contribution to Social Security, do not go directly to the mutual health organisations. These are paid directly into the National Health Insurance Fund (NHIF) by Social Security and National Insurance Trust (SSNIT). The social group members do not pay premiums at all. Therefore, these could not be accounted for by the four mutual health organisations as part of their subscriptions. Thus, the financial viability ratio could not be applied effectively in this study. The government, through the National Health Insurance Council and Authority (NHIC and NHIA) should be able to give the management teams some idea about the expected revenue from their formal sector membership, which will help them make projections about how much subscriptions they accrue from this source of income.

11.1.1.5. Ratio of Operating Costs to Income

The financial performance of the four mutual health organisations in relation to the ratio of operating costs to income is not very good. The study reveals that overall all the four mutual health organisations are not doing remarkably well in curtailing incidental costs to running the schemes. The Aduana MHO did not do well by controlling these costs as it recorded 18 percent in 2005 and 14 percent in 2006, which are more than the stipulated 5 percent (see Cripps *et al.*, 2003). Beyond this, its financial performance on the basis of ratio of operating costs to income would be described as poor or unacceptable. In its case, the Asakyiri MHO recorded a ratio of 16 percent in 2005 and 11 percent in 2006. These show a poor performance by the management of the scheme since the ratios are still more than the stipulated 5 percent. Whilst the Biretuo MHO was able to break-even by recording a ratio of 5 percent in 2005, it performed unsatisfactorily in 2006 as it achieved a ratio of operating costs to income of 23 percent. However, the Asona MHO's financial performance on the

basis of this ratio is motivating as it achieved a ratio of operating costs to income of only 3 percent and 1 percent in 2005 and 2006 respectively.

Generally, all the four mutual health organisations are performing differently with regards to how they are spending on administration and management. They are spending between them 1 percent and 23 percent of their incomes in meeting operating costs. It is only Asona MHO, which spent less than 5 percent in 2005 and 2006 consecutively. These costs could rise as time goes on depending on the intensity of their respective activities. The problems emanate from the fact that all the four mutual health organisations are located in district and urban areas where there are sparse population settlements (GSS, 2005). Most of the people cannot be reached easily by radio and television advertisements (refer to 9.4). The management teams have to travel to these communities to educate the people during registration periods. There is the need for the management teams to sensitise the community leadership with regards to the concept of health insurance and mutual health organisations. While this will enable them to educate and convince their own people, it will also help cut down on vehicle running costs and the costs of paying for radio and / or television advertisements, which will not reach all the people, anyway.

11.1.1.6. Ratio of Efficiency in Collecting Dues

Although the 2005 expected dues could not be estimated, all the four mutual health organisations obtained different results in respect of the rate of payment of dues or ratio of efficiency in collecting dues in their second year of operation in 2006 (refer to chapter 9). Even so, there are contributory factors, which go beyond their physical inability to collect dues or subscriptions. There were some difficulties in calculating this ratio. Only the paying informal sector (PIS) members' dues could be used as the amount of dues collected in 2005 and 2006. Making estimates in 2005 was problematic for the mutual health organisations as they did not have the information needed to estimate their premiums until members, especially, the paying informal sector (PIS) members had registered. Therefore, in calculating the ratio of efficiency in collecting dues for 2006, the 2005 subscriptions collected were used as the expected subscriptions since none of the four mutual health organisations had actually

made any projections. The issue relates to the applicability of the financial viability model applied in this study (refer to chapters 8 and 9).

As explained earlier, the mutual health organisations do not receive the 2.5 percent Social Security and National Insurance Trust (SSNIT) contributions from their formal sector members directly into their accounts. The MHOs prepare estimates for submission to the National Health Insurance Council and Authority (NHIC/NHIA) regarding the social group members (indigents, under 18 years and 70 years) they would provide services for, to enable the NHIC/NHIA pay claims on their behalf to health providers (compare with 9.1.3.3 and 9.2.1).

In addition, the tariff set under the NHI Act 650 (MOH, 2003d, 2004b), is creating problems for the mutual health organisations to set flexible premiums to meet the financial ability of the people who cannot mobilise the minimum ₦72,000.00 to enrol. Whilst the government should review the NHI Act 650 (MOH, 2003d, 2004b), to address the inequities caused by the tariff (in setting premiums), the management teams should also endeavour to intensify their educational activities. This will convince the people in the paying informal sector (PIS) to enrol and contribute to the financial viability of their respective mutual health organisations without over-reliance on the NHIF (compare this with 11.1.1.8).

Since the above financial viability indicators could not help to give a clearer picture of the financial performance and viability of the mutual health organisations, other financial indicators have been considered, as discussed below.

11.1.1.7. The Effect of Excessive Healthcare Utilisation Rate on the MHOs' Income and Expenditure

It must be emphasised that healthcare utilisation rate is a non-financial indicator or issue. It measures the performance of the mutual health organisation in respect of how members access health care (refer to tables 10.1 and 10.2 for detailed analyses). This in itself is not bad because the aim of the MHOs is to increase their members' financial access to health care (see chapters 3 and 7). A relationship has to be established between 'excessive utilisation' and MHOs' Income and expenditure,

which has a negative effect on their incomes and the management teams of the MHOs need to check it (see Cripps *et al.*, 2003).

It would be realised (refer to 10.2) that there are issues of health insurance risk factors: moral hazards, adverse selection, and abuse of services affecting the operations of the mutual health organisations in this study. These are being perpetrated by both insured members and contracted health care institutions (refer to 3.3 and 10.2). The financial implications of excessive healthcare utilisation rate and associated health insurance risk factors on the mutual health organisations in this study can be seen in how they are paying huge healthcare claims to their contracted healthcare providers (refer to 9.2.4.3 and see appendix K). These have tremendous effects on their incomes, expenditure patterns and reserve funds (financial viability) as explained below.

It is clear from chapter 9 that increases in the overall revenue of the four mutual health organisations are dependent upon 'National Health Insurance Fund' (NHIF) or government subsidy. It is evident (refer to 9.2.4.3) that all the mutual health organisations depend heavily on the 'Government subsidy' (NHIF) released towards 'Claims' to meet their total health care Claims. It would be recalled that in the 2005 accounting period, the 'NHIF Claims as a percentage of Total Health Care Claims' ranged from 92 percent to 254 percent between the four mutual health organisations. Subsequently, in the 2006 accounting year, the rate ranged between 30 percent and 196 percent. This is attributed to the fact that:

...now we have increased the package with more benefits ...If we are to allow the new system to continue without government's intervention, it will collapse the scheme within days... (SMMHO-3)

The analyses show that the 'National Health Insurance Fund' (NHIF) is their major source of funding. It contributed more than 50 percent to more than 70 percent to their incomes in the 2005 and 2006 fiscal periods respectively. Although, the mutual health organisations are making efforts to generate incomes from premiums or their 'Paying Informal Sector' (PIS), this constituted less than 50 percent in 2005 and less than 40 percent in 2006 financial periods respectively. Whereas some of the mutual

health organisations are receiving donations and or accruing interest on their fixed deposits under 'Other Income' (OI) source, others are not receiving much. This means that people who have the ability to pay more are not paying more than their stipulated premiums. This is defeating the intention of policy makers to encourage benevolence amongst the people in the communities:

...the law takes due cognizance of the fact that individual circumstances differ...There are those who can even afford to pay a million old cedis (¢1m) if we so ask them to, but for reasons best known to the lawmakers, they set the ceiling at four hundred and eighty thousand old cedis (¢480,000.00) and the floor is seventy two thousand old cedis (¢72, 000.00), which is a wide gap...(PMS-13)

This means that some of the mutual health organisations might have had financial problems:

...yes, some will not be able to reimburse their health providers, you see the way they are operating, it is not strange because you have a situation where there is a big number of people who don't pay premium(s) and it has to come from government...(PMS-16)

The intention of policy makers is that the NHIF is to serve as reinsurance for the district and municipal mutual health organisations (see MOH, 2003d, 2004b). However, it is obvious that attaining this goal in the short to medium term is becoming rather difficult:

...yes, I mean the fundamental design is that they will be autonomous institutions but the process that will lead to full autonomy is one that will take time. We wanted to wean ourselves from or wean them from complete public funds in a two-year period. We have learnt that is not feasible and that we needed to revise the timetable for achieving autonomy... (PMS-2)

Among other things, the rate at which the four mutual health organisations are utilising their incomes in meeting expenditures has been discussed to help draw some conclusions from their reserve funds (refer to p.150; see appendix M). These would help explain as well as give credibility to the argument as to whether the mutual health organisations are performing well financially or not. The financial

performance of the four mutual health organisations in relation to how they are utilising the accrued incomes to settling expenditures, the study argues that all the four mutual health organisations are not ensuring financial prudence. Obviously, all the mutual health organisations are generating high incomes, but with corresponding increases in their expenditure patterns. In the 2005 fiscal year, all the mutual health organisations spent between them 54 percent and 95 percent of their incomes meeting expenditures. Equally, in the 2006 fiscal year, they spent between them 50 percent and 94 percent of their incomes on expenditure. Therefore, future viability on the basis of this level of spending is questionable:

...brought a lot of pressure on the finances of the scheme. For instance, we sometimes pay as much as five million old cedis (¢5m) monthly as claims from the health facilities... (BRMHO-M-10)

Although the results indicate that the four mutual health organisations are doing well in meeting their expenditure, they are not able to meet their expenditure solely on the income from their 'paying informal sector' (PIS) source but the NHIF component. The results draw attention to the fact that whilst there is room for optimism on one hand, there is equally room for pessimism about future financial viability. This apparent lack of economic and financial management prudence on their part might speed up their early collapse. Efforts at achieving financial self-sufficiency would be hindered when the government withdraws its subsidy:

...they are in a very potentially dangerous situation as they continued to receive top up money from government. The value of the subsidy and corresponding expenditures had never been heard of before in the lifespan of the mutual health organisations in the country... (PMS-17)

Although the subsidy (NHIF) was required to assure their financial viability, this seeming sense of complacency is creating challenges for their financial viability:

...without government support...we are not sustainable if government doesn't come in. Government will not come in and it means they will allow the schemes to do their own things, that is why...for now we are not financially sustainable if government doesn't help... (SMMHO-1)

Crucially, these analyses were made against the background of certain limitations faced by these four mutual health organisations. The analyses show that the mutual health organisations are facing financial challenges posed by the provision of free health care to the social group members who are in the majority. They are operating within the parameters of uncontrollable utilisation of health services by their members. The management teams need to improve their technical capability to be able to deal with the health insurance risk factors: adverse selection, moral hazards and abuse of health services (refer to 3.3 and 10.2).

Thus, the observation is that their expenditure patterns are essentially influenced by excessive health care utilisation rate (refer to 10.2), as the four mutual health organisations are paying huge sums of monies against expenditures, especially on claims to their contracted health care providers. In 2005, the Aduana MHO paid claims to health care providers which amounted to ₺592m. This increased to ₺661m in 2006. The NHIF contribution used to pay these off constituted 116 percent and 196 percent in 2005 and 2006 respectively. The Asakyiri MHO also paid claims to health care providers to the tune of ₺295m in 2005 and ₺722m in 2006. The NHIF released towards health care claims represented 254 percent in 2005 and 30 percent in 2006. The Asona MHO received and paid health care claims of ₺1,620m in 2005, which increased to ₺17,206m in 2006. These were paid off with the NHIF released towards health care claims, which represented 92 percent in 2005 and 77 percent in 2006. The Biretuo MHO also received and paid its contracted health care providers claims, which totalled ₺1,736m in 2005 and ₺5,869m in 2006. It was able to offset these bills by using NHIF income towards health care claims, which represented 112 percent in 2005 and 93 percent in 2006. The mutual health organisations were able to pay off these claims using funds released under the NHIF, which constituted between them 30 percent and 254 percent (see appendix K).

Some policy makers perceive that the management teams seem to have been turned into: '*...cashiers and dispensers...*' (PMS-17) of funds from the mutual health organisations to the healthcare institutions:

...the current schemes are enjoying the release of funds by the government... (PMS-12)

The two actors (mutual health organisations and health care providers) are seen as government institutions dependent on central funding. Therefore, the mutual health organisations find it difficult to negotiate with the healthcare providers about quality of care issues (refer to chapter 3). The view is that although the amount of money paid in healthcare claims depends on the size or membership of the mutual health organisation, the payment of claims or expenditures increases with concomitant increases in income:

...we have about 10,000 average monthly health facility attendance and we pay close to about eight hundred million old cedis (¢800m), a month in claims... (SMMHO-2)

The perception of respondents is that the management teams of the mutual health organisations (DMMHIS) are complacent in the management of their funds since they could rely on huge subsidy inflows from the National Health Insurance Fund (NHIF). They appear to lack the ability to plan any meaningful budget based on the revenue from their paying informal sector (PIS) membership as well as deal with the health insurance risk factors mentioned. The increasing healthcare bills far outweigh the money generated and available from their own paying informal sector (PIS) domains. While it is difficult to determine and regulate the number of times members might fall sick and utilise health services, it is important for the Ghana health sector (MOH/GHS) to intensify its public health educational campaigns. This will reduce preventable diseases in the population. Some of the reasons why the mutual health organisations are not able to raise enough revenue from their paying informal sector memberships to meet increasing health care claims are discussed below.

11.1.1.8. The Effect of NHI Act 650 Tariff Structure on PIS Income

It must be noted that 'tariffs' cannot be discussed on its own unless its impact is measured against the Paying Informal Sector (PIS) Income of the MHOs. The tariff structure under the NHI Act 650 (MOH, 2003d, 2004b), as discussed in this study is just a price list ranging from ¢72,000.00 to ¢480,000.00 (refer to 9.2.2). Based on this list, the four MHOs decided to charge their PIS members the minimum premium of ¢72,000.00 per annum (dues, premiums and subscriptions or even the tariff can be used interchangeably). The tariff structure has both positive effects (in respect of how

PIS members' access to health care has been improved by enrolling) and negative effects (in respect of how other people in the paying informal sector cannot raise the minimum premium to enrol) on the operations of the MHOs. The discussions on the above sub-title in this study are focused on the negative effects of the tariff structure on the PIS Income (refer to chapters 9, 10 and see 12).

It was important to explore whether the four mutual health organisations could pay claims to their health care providers from their own internally generated funds. From the analyses in chapter 9, it is evident that some of the mutual health organisations are mobilising more revenue from their paying informal sector (premiums) than others. In 2005, the Aduana MHO's paying informal sector contribution to its total income was ₦652m (35 percent) and ₦294m (14 percent) in 2006. The Asakyiri MHO in 2005 accrued income of ₦439m (30 percent) from its paying informal sector and ₦274m (17 percent) in 2006. The Asona MHO received an amount of ₦842m (31 percent) in 2005 and ₦1,769m (21 percent) in 2006. The Biretuo MHO also accrued income from its paying informal sector which amounted to ₦1,993m (41 percent) in 2005 and ₦3,472m (38 percent) in 2006 (see appendix L).

In the second consecutive fiscal periods, the Asona MHO and Biretuo MHO were more active in mobilising substantial revenue from their paying informal sector than their counterparts - the Aduana MHO and Asakyiri MHO. The reason is that the Asona MHO and Biretuo MHO are located in regions richly endowed with natural resources, and where agricultural activities are booming. However, the Aduana MHO is located in a region where the major natural resources and activities are fishing and some fruit and vegetable farming. This region has a large formal sector employee pool because it is the headquarters of many central government departments and industries. The Asakyiri MHO is also located in a region where the majority of people are in the civil service, public sector, mining companies, and self-employed trading with few agricultural activities. As can be seen from appendices B and D1-D4, all the mutual health organisations in this study have different membership based on their respective regional, district and municipal populations (see GSS, 2005).

Significantly, in any particular year and for the two years (2005 and 2006) put together, contributions from informal sector members of all the mutual health organisations did not equal 50 percent of their entire revenues generated. When this was set against expenditure patterns, it emerged that they were finding it difficult to meet health care claims through the premiums from paying informal sector members. This could be attributed to the reason that there are few people in the population who are paying direct cash and form only about:

...20 percent of the population paying cash...what happens to the 80 percent not paying cash?...we should also look at the economic activities and wealth of the communities to target premiums...No society is static and we think production will improve which will lead to national economic growth...(PMS-12)

The Asona MHO and Biretuo MHO are able to raise substantial premiums from their paying informal sector (PIS) members in comparison with Aduana MHO and Asakyiri MHO. To sustain the schemes on the basis of their informal sector premiums, respondents suggest:

...the need for additional sources of revenue especially, by encouraging those who can pay more to pay more. We should also encourage the Churches and Mosques to be involved in the fund-raising activities... (HMP-4)

There is the need to raise additional funds through community fund-raising activities.

The above notwithstanding, it is evident that many people in the paying informal sector cannot raise the minimum premium of ₵72,000.00 set under the NHI Act 650 tariff structure (MOH, 2003d, 2004b), to be able to enrol together with their large family sizes (refer to 9.1.3.4 and 9.4). The NHI Act 650 tariff structure is set between ₵72,000.00 and ₵480,000.00 (refer to 9.2.2). At the same time, the mutual health organisations do not have the power and authority to set premiums below the minimum ₵72,000.00 to meet the financial capabilities of the poor people in their communities since the tariff structure was set by the Parliament of the Republic of Ghana. Any review of the tariff structure under the NHI Act 650, must have recourse to Parliament rather than to the Board of Directors or General Assemblies of the

respective mutual health organisations (see 11.3.3 and 11.3.4). A critical review of the NHI Act 650 to reflect the economic circumstances of the people in the informal sector of the economy will help address this imbalance (see MOH, 2003d, 2004b; GSS, 2005).

11.1.1.9. Reserve Funds of the MHOs

While it could be argued that the MHOs might have reserves because their third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1, 9.2.4.1; and see appendix I), there were no balance sheets available to firm up this assumption. In view of this, it would be recalled from chapter 8 that 'surplus' is used as a proxy for 'reserves' in this study to show the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150; 9.2.4.5; and see appendix M). This was the approach used to measure their financial performance and viability in chapter 9. Despite the fact that the mutual health organisations are paying huge sums of monies against expenditures, their reserve funds (refer to 9.2.4.5) show a contrasting picture indicating that they are in good financial position because they recorded surpluses: none of them posted deficits (see appendix M). Therefore, the analyses in chapter 9 show that the Aduana MHO's reserves were ₦97m in 2005 and ₦985m in 2006. The Asakyiri MHO recorded reserves of ₦609m and ₦261m in 2005 and 2006 respectively. On its part, the Asona MHO's reserve fund figures were ₦418m in 2005 and ₦530m in 2006. Equally, the Biretuo MHO posted reserves of ₦2,220m in 2005 and ₦1,284m in 2006 financial periods.

In the light of the above, the question is whether these reserve funds could help them survive and operate up to at least three or six (6) months without recourse to borrowing, despite using the approach where the surplus at the end of the financial year is used as a proxy for reserves (refer to p.150; 9.2.4.5; and see appendix M). The point of view is that it is difficult to establish the financial viability of the mutual health organisations in this study on the basis of their actual reserves (see ILO, 2005), due to limitations in the financial data provided (refer to chapter 8). This must also be seen in respect of statistical difficulties with regards to determination of prospective

members and suitable premiums as well as risk management inadequacies on the part of management. These are affecting the financial issues in this study.

Generally, the main limitation in the analysis of the income and expenditure patterns of the four mutual health organisations is that their incomes are 'undervalued' since they could only account for what was accrued from the 'PIS' and 'OI' sources (see appendix I). Obviously, the formal sector members' contributions do not go directly into the schemes' coffers but into a government chest-NHIF. Additionally, the social group members do not pay for their premiums since they are exempted under the NHI Act 650 (see MOH, 2003d, 2004b). This greatly affected the application of the financial viability model used in this study (refer to chapters 8 and 9). Invariably, the apparent lack of data or inadequate financial information seems to be a recurring feature in the study of mutual health organisations, a point hinted by earlier researchers (see Atim, 1998, 1999, 2001; Atim *et al.*, 1998, 2001a; Musau, 1999).

11.1.1.10. Uses of the Financial Information by the MHOs

The discrepancies in the financial performance of the four mutual health organisations could be explained by the accounting system in place and how the management teams understand and use the financial information generated. The income and expenditure information generated are used as a means of financial reporting to their respective Board of Directors and the General Assemblies during Annual General Meetings (AGMs) rather than using the financial ratios to give a vivid picture of the growth or decline in the accumulated funds like any other profit making organisation (see Tsamenyi *et al.*, 2008).

Since they have been incorporated into the Ghana Civil Service as civil service institutions, the mutual health organisations have to comply with the public sector accounting principles (see Rahaman and Lawrence, 2002; Mensah *et al.*, 2003; ECA, 2004; ICAGH, 2010). Even as the management of the four mutual health organisations are able to use their accounting systems as a form of internal control measures, their efforts are also thwarted by inadequate staff with requisite accounting skills. It must be emphasised that most of the current staff of the four mutual health

organisations who have professional qualifications than their predecessors who operated during the pre-NHI 2003 MHO era, were appointed in 2005 (see appendix F). Each of the four mutual health organisations has only one accountant, who is supported by the claims manager (CM). The overwhelming nature of the tasks to be performed by these personnel coupled with other factors, which are external to their environment, are making the realisation of effective internal control objectives rather difficult:

...with the accounting system, the provider provides the service and the bill is submitted...we go there to check the background and we pay...it is possible certain documents will slip through but...if you work in league, sometimes some of these things are possible, they go to minimum level and that will not go to affect the source of the business...you need to have the expertise to do all these things... (SMMHO-1)

Moreover, the financial information generated is not used for planning purposes or in-depth budgeting of their operations. As they are operating as civil service organisations under the supervision of their respective district and municipal Assemblies, the four mutual health organisations are required to prepare budget estimates for submission to the National Health Insurance Council and Authority (NHIC and NHIA) on the basis of the number of social group members they would provide healthcare to within any given period:

...we depend on national subsidy, which is also based on certain formula in terms of the number of registered indigents, under 18 years and 70 years and over members...if at the beginning of the year we give the impression that we have about only 30 percent of the people but in course of the year we register about 60 percent...whatever problem we have... we have to wait... (SMMHO-4)

This is done on quarterly basis according to the public sector financial regulations and the procedures set for the release of the financial encumbrance (FE) by the Ministry of Finance and Economic Planning (MFEP) through the Controller and Accountant General's Department (CAGD) [(see Mensah *et al.*, 2003)]. The aim of the budget

estimates is to ensure that the social responsibility of the government is fulfilled. Furthermore, this accounting practice is characteristic of public sector organisations in sub-Saharan Africa in general and in Ghana in particular (see ECA, 2004). This bureaucratic protocol together with other factors results in inefficient performance in most public sector organisations in these countries. There is the need to review this system to enhance performance. Some researchers have made a similar observation that when organisations in less-developed countries like Ghana are under the administrative control of central government, they tend to perform poorly in financial terms (see Tsamenyi *et al.*, 2008). Therefore, this finding is consistent with the positions of other researchers who argue for a balance of economic and social measures of performance since the financial indicators may not reflect all facets of performance of an organisation (see Prizzia, 2001; Tsamenyi *et al.*, 2008).

Despite this, the study argues that the intervention of the government of Ghana through the introduction of NHI Act 650 has contributed to streamlining the financial management system of the mutual health organisations as they can now access external funding in addition to the premiums they accrue from their paying informal sector (PIS) memberships (refer to chapters 7 and 9). They also have the regulatory responsibility to audit their accounts, despite the delay (MOH, 2003d, 2004b). This has enhanced their financial viability objectives (see Tsamenyi *et al.*, 2008). This perspective is consistent with the observation made by other researchers that when regulations are introduced into the operations of 'not-for-profit' organisations like charities or the mutual health organisations, they tend to have enormous influence on their accounting practices and standards of financial management (see Palmer *et al.*, 2001; Palmer and Randall, 2002; Morgan, 2009). Further, this supports Morgan's observation that changes introduced under the Charities Act, 1993 and Statement of Recommended Practice on Accounting and Reporting by the Charity Commission in the United Kingdom had led to an improved professionalism in the finance and financial management of such organisations since the treasurers or accountants endeavour to make substantial efforts to meet the new rules (see Central Board of Finance, 1997; Charity Commission, 2005; Morgan, 1999, 2003, 2009).

Due to the paucity in the financial data coupled with the need to consider other non-financial factors to determine the viability of mutual health organisations, the study

argues that there is the need to examine the performance of the mutual health organisations on the basis of their contribution to social, economic and political dimensions of the economy. This somehow supports the observation by Wipf and Garand (2008), that although most micro-insurers do not collect sufficient or the right kind of data, there are some that collect too much data. For that reason, there is a trade-off between the cost of collecting additional data and the incremental gains from the added information. These analysts observe that whereas too much data collection can be costly, it is also true that inadequate information will impair management capability and the development of the business, in this case, the mutual health organisations (see Wipf and Garand, 2008).

However, this study argues that the management of the mutual health organisations do not measure their performance and financial viability solely on financial performance (financial viability indicators). Respondents including the scheme managers have different perspectives on the issue of financial viability and the overall sustainability of the mutual health organisations:

...sustainability depends on education and then numbers...I will not go for the highest level of the premium...I believe that with the numbers, if we have more people on board, the sustainability will be assured...(SMMHO-1)

Other respondents also perceive financial viability as well as overall sustainability of the mutual health organisations to be dependent upon:

...financial viability depends on a number of factors, important among which is that they [MHOs] will need to have more members because few people will lead to less viability. We need to also intensify education...at the moment we have not even managed to cover 50 percent of the population. We need to do the following: cover 95 percent of all health conditions, 5 percent of HIV/AIDS, cancer, increase revenue mobilisation, the Act 650 should be amended to close the gap in age...the current law implies that people between the ages of 18 and 69 years are paying the premiums...however, those between 1 and 17 years; and 70 years and over are not paying premiums...meanwhile, they are the majority in the population...we might require government subsidy for sometime...all schemes will not be sustainable if the government does not subsidise or give subvention...(SMMHO-3)

It is against the background of this finding that the study recommends the need to extend financial performance measures of the mutual health organisations beyond the traditional financial indicators, which is similar to what has been suggested (see Brignall, 1993; Brignall and Ballantine, 1996; Cochrane, 1993; Johnson and Kaplan, 1987; Johnson, 2001; Tsamenyi *et al.*, 2008). This finding further confirms similar recommendations that there is the need to identify and re-focus performance measures from the extant short-term financial orientation to that of a long-term qualitative analysis, highlighting the human, social and environmentally sustainable development aspects (see World Bank, 2000; Tsamenyi *et al.*, 2008).

The finding is similar to and has a relationship with the approach adopted by some researchers who evaluated the performance of some organisations in Ghana using a range of financial and non-financial measures (see Tsamenyi *et al.*, 2008). Tsamenyi *et al.* (2008), argue that the community perspective is an additional dimension, which is crucial for measuring the outcome of organisations. Thus, there is the urgent need to examine the success or failure of mutual health organisations in terms of services provided to the community. They suggest that the main measures of the community dimension of the performance of organisations encompass employment creation, contribution to government revenue, public image and contribution to community or society projects. This perspective is principally important because state-owned organisations such as the district and municipal mutual health organisations were established with the sole aim to serve the interest of the community or society in which they are located (see Leith and Soderling, 2000; Tsamenyi *et al.*, 2008).

A Ministry of Health document confirms this and notes that the design of the National Health Insurance Scheme (NHIS) takes cognisance of the fact that about 70 percent of Ghanaians are in the non-formal sector of the economy (MOH, 2004d):

The health insurance scheme has been designed with the aim to offer healthcare access to the poor and vulnerable in society taking into consideration principles [such as]: equity, risk equalisation, cross-subsidisation, solidarity, quality care, efficiency in premium collection and claims administration, community or subscriber ownership, partnership, reinsurance and sustainability (MOH, 2004d: 7-8)

Some of the areas where government's intervention is demonstrated in meeting the interests and expectations of the community or society through the mutual health organisations have been discussed below.

11.1.2. Financing and Improved Financial Access

The government of Ghana has the poor at the heart of decision-making process because majority of the people are economically disadvantaged and are in the informal sector (refer to chapter 5 and table 6.6). The pre-NHI 2003 MHOs were providing health care financial access to their members as evidenced in earlier studies (see Atim, 1999; Dablu, 2001; Aikins, 2003; Arhinful, 2000, 2005). The study reveals that since the government has intervened and is providing subsidy through the NHIF to the post-NHI 2003 MHOs, it is serving as a strong incentive for people to join them (Marcadent, 1999; Ron, 1999; Desmet *et al.*, 1999; Eisenblaetter *et al.*, 2001).

The evidence further shows that without the involvement of the government of Ghana in the identification and institution of a viable health financing mechanism, through the implementation of the National Health Insurance Act 650, there might not have been the institution of an additional health financing strategy to meet the costs of clinical care. The members of the mutual health organisations are not paying for public health services: immunisation, health education, and family planning. All these remain free services and paid for by the central government because they are essential components of the health of the population. The government anticipates that improvement in public health services could also ensure the sustainability of the National Health Insurance Scheme itself:

...the health insurance is the dedicated source for funding clinical care...it refinances the recurrent cost component of clinical care...to provide the subsidy to the health insurance schemes to ensure that they are sustainable...there are so many fixed costs that are provided for through the budget...what is emerging under the financing reform is for us to look closely at the few public health services... (PMS-2)

The strategic decision adopted by the government to ensure sustainable funding of the mutual health organisations in Ghana through the National Health Insurance Fund (NHIF) is two-fold. The first is the deduction of the 2.5 per cent of the 17.5 per cent of formal workers' contribution to the social security pension fund (MOH, 2003d, 2004b; Osei, 2003, 2006). The evidence of this study shows that until the government became involved in the mutual health organisations through the NHI Act 650, not many people in the formal sector employment were participating in the activities of the pre-NHI 2003 MHOs (Apoya, 2003).

It would be recalled from table 9.2 that the number of formal sector employees registered by the Aduana MHO represented 5.8 per cent of total membership in 2005; and 8.1 per cent of total membership in 2006. The number of formal sector employees registered by the Asakyiri MHO represented 18.4 per cent of total membership in 2005; and 6.1 per cent of total membership in 2006. The number of formal sector employees registered by the Asona MHO represented 17.4 per cent of total membership in 2005; and 13.8 per cent of total membership in 2006. The number of formal sector employees registered by the Biretuo MHO represented 2.8 per cent of total membership in 2005; and 3.7 per cent of total membership in 2006 (refer to 9.3.2.3).

Thus, the universal role of government has been demonstrated by coaxing formal sector employees into joining and also making it possible for the district-wide and municipal-wide mutual health insurance schemes, including those in this study to access the 2.5 per cent from each SSNIT contributor in the country. Without such an intervention, it would have been difficult for some of the mutual health organisations to be sustained financially, by depending solely, on the contributions from the few formal sector employees in their respective districts and municipalities; if they were to register them separately. Meanwhile, there are few decentralised departments in some of the districts and they are understaffed.

The second strategy is the institution of the National Health Insurance levy of 2.5 per cent on selected goods and services (MOH, 2003d, 2004b). This has made it possible for the National Health Insurance Council and Authority (NHIC and NHIA) to

disburse the funds to all the district-wide and municipal-wide mutual health insurance schemes, including those in this study for the common good of all the people. It is evident from appendix I, that government subsidy released under the National Health Insurance Fund (NHIF) component of the total income of the mutual health organisations was substantial. Thus, the NHIF as a percentage of total income constituted 62 per cent of the income generated by the Aduana MHO in 2005; and 84 per cent in 2006. This constituted 59 per cent of total income generated by the Asakyiri MHO in 2005; and 78 per cent in 2006. The Asona MHO's share constituted 69 per cent of total income in 2005; and 78 per cent in 2006. This formed 57 per cent of the total income generated by the Biretuo MHO in 2005; and 62 per cent in 2006 (refer to 9.2.4.4).

It was only the government that could marshal the needed courage against the protest from workers groups in the country to have deducted the 2.5 per cent of the 17.5 per cent of the formal sector employees' salaries and impose a 2.5 per cent National Health Insurance Levy on selected goods and services (Abbey, 2003; PANA, 2003). This is the best objective thing for all African countries to emulate. The contribution of mutual health organisations to raising additional revenue for the health sector is encouraging:

...I believe it is growing...like the previous year 2005, we raised about ₵1 trillion old cedis, the second year 2006, it came to about ₵1.1 trillion old cedis...For next year, 2007, we are expecting around ₵1.7 trillion old cedis, so I think it is mounting...(PMS-8)

Recent evidence shows that the total per capita health expenditure grew in 2005 and 2006 by 40 per cent in nominal and 26 per cent in real terms. The annual per capita expenditure was over \$25, using existing accounts which reflects some of the National Health Insurance Scheme (NHIS) expenditure. This includes revenues from public and donor sources as well as user fees paid through public facilities. The proportion of total government expenditure on health increased from 12 per cent in 2002 to 14 per cent in 2005 and 2006. The biggest growth came from the government of Ghana (GoG) funding. Government's share increased by 10 per cent compared with 2005: it grew by 54 per cent in real terms (MOH, 2007a, 2007d). Even though,

the government of Ghana (GoG) funding for health as a proportion of overall government of Ghana expenditure was predicted to diminish from 13 per cent of the budget for 2006 to 12 per cent in 2007, the medium term expenditure framework (MTEF) was projected to be around 10 per cent for 2008 and 2009 (MOH, 2007a, 2007d).

11.1.3. Social Health Insurance

The bold steps taken by the government of Ghana has helped to provide the springboard for the formation of contemporary social health insurance scheme as additional method for mobilising financial resource for the health sector in the country. Theoretically, the above strategies justify the definition of a social health insurance in our study. For instance, the deduction of the 2.5 per cent of workers' social security contributions relates to Zschock's (1982), conventional definition of a social health insurance as a system of financing health care and invalidity and old age support for employed workers by imposing mandatory insurance payments as a percentage of their wages and imposing on their employers a similar or somewhat higher payroll tax (Zschock, 1982; Hoare, 1987). The imposition of the 2.5 per cent National Health Insurance Levy also agrees with Carrin and James' (2005), definition of a social health insurance as a mechanism which helps to pool health risks of members on the one hand and the financial contributions of enterprises, households and the government on the other (Carrin and James, 2005).

This has partially fulfilled the avowed aim of the government of Ghana towards finding a health financing strategy that would assure universal health financial protection for the population. This is being achieved by the arrangement where the informal sector members' premiums collected by the mutual health organisations (DMMHIS) are to be supplemented with funds from the National Health Insurance Fund (NHIF) as reinsurance; to enable them to reimburse healthcare providers. This has been enshrined under section 33 (2) of the NHI Act 650, which is crucial for financial viability (MOH, 2003d, 2004b).

The evidence in this study confirms the earlier proposition that the mutual health organisations are emerging private sector initiatives that aim to make health care

accessible to wider sections of the population by contributing to resource mobilisation (Musau, 1999; Atim, 2000; Jakab and Krishnan, 2001; WHO, 2001; GHS, 2004b; World Bank, 2004a, 2004b, 2008; Preker, 2004b; Poletti *et al.*, 2007). A Ministry of Health document confirms that the contribution of mutual health organisations to resource mobilisation has been positive:

The NHIS is contributing 5 per cent of total sectoral resources, according to the MOH financial statement, but in real terms this figure is higher, as the financial statement only covers IGF payments and national level transfers at present. The NHIF income and expenditure figures reveal that its main income source is the VAT-levy [National Health Insurance Levy] (MOH, 2007d)

This approach has been described as extremely innovative in the African context and has many similarities to the insurance reforms introduced in Thailand. It has also highlighted the magnitude of learning from experience in low-income and middle-income countries and across continents (McIntyre and Gilson, 2005).

11.1.4. Regulation of Mutual Health Organisations

Divergent views have been expressed about the kind of regulatory framework to be provided by the state in the operations of mutual health organisations (see Liu *et al.*, 1995; Desmet *et al.*, 1999; Huber *et al.*, 2002; Atim, 2003; Carrin and James, 2004). The government of Ghana became involved in regulating the mutual health organisations for several reasons. It is the duty of the government of Ghana through the Ministry of Health (MOH) to set its public health objectives and to decide what kind of organisation would be able to drive people towards achieving them (see MOH, 2005, 2009). As the mutual health organisations were providing health service benefits packages for some Ghanaians, the government felt it was necessary that a minimum level of organisation was also designed to ensure that there was some minimum level of protection provided for the people to make their contributions. This would make them sustainable, importantly as the model suits the socio-economic milieu of Ghana:

...prominently, it suited the socio-economic composition of the Ghanaian society; there is low functional literacy rate in the country; the administrative infrastructure development is not the best in the world; and the income levels of people are pretty low. In the light of all these the government was the only entity that could play a central role in bringing all the proposed objectives for introducing the health insurance into fruition...(PMS-13)

The government's involvement in the mutual health organisations using the National Health Insurance Act 650 (MOH, 2003d, 2004b), has ensured the institution of regulatory bodies: National Health Insurance Council and Authority to oversee the operations of the mutual health organisations from the national through regional to district levels (refer to 6.5.4.4). This confirms the findings of other researchers that governments' involvement would encourage people to join these risk pooling schemes as well as protect the poor people against impoverishing effects of unpredicted health care expenditures (Ranson, 2002; Poletti *et al.*, 2007).

Thus, the study identifies that the NHI Act 650 has provided a legal framework through which the mutual health organisations in Ghana are being considered as legitimate organisations with the mandate from the government to operate. This has given them a new sense of dimension (compare this with 7.2 and 10.3). This has also encouraged the government to do more than just being initiator and enabler as suggested by Carrin and James (2004). Policy pronouncements are being made to the effect that the government is managing the district-wide and municipal-wide mutual health insurance schemes on behalf of the people. A Ministry of Health document reiterates this point:

...the National Health Insurance Scheme (NHIS), which is established [is] to provide access to health services for all citizens, especially, the poor and vulnerable... (MOH, 2006)

The government of Ghana anticipated that without setting the required institutional and administrative mechanisms, the change process under this phase of the health sector reform could never have been initiated and implemented (MOH, 2003d, 2004b). This attests to the suggestion that the government could set up a national agency with the responsibility of providing assistance in the design, leadership and co-ordination for mutual health organisations (Ron, 1999; Preker *et al.*, 2002).

Specifically, it confirms Atim's suggestion that there was the need for government legislation in Ghana to enable the mutual health organisations to acquire legal and corporate status through registration (Atim, 1998; Atim *et al.*, 2001a, 2001b).

11.1.5. Setting up and Subsidy for Mutual Health Organisations

The study reveals that the government's intervention in the initial stages of the development of the mutual health organisations on a larger scale in Ghana could not be overlooked. A political will has been shown in how the government is providing initial start-up capital fund of ₵150m to the respective district and municipal Assemblies for the establishment of the district-wide and municipal-wide mutual health insurance schemes (DMMHIS) throughout the country including the four in this study; to enable them operate as business entities. Furthermore, at the district and municipal levels of administration, the district and municipal Assemblies are also directed to supervise their respective district-wide and municipal-wide mutual health organisations (MOH, 2003d). The mutual health organisations are being used as a criterion for boosting and measuring the performances of the District and Municipal Chief Executives:

...the District Chief Executive is actively involved because his performance will be measured on the success or otherwise of the mutual health organisation in the district... (PMS-21)

Although, it is recognised that the actual incentive to establishing the NHI Act 650 is the need for the political will and not much about the development component of the mutual health organisations phenomenon in the country, the study shows that there are equally resource limitations in some parts of the country:

...yes, the government came in because of the initial operational difficulties...Some of the schemes did not have adequate or requisite resources to establish the structures, the government started it... it is envisaged that when they are able to get enough premium holders and they have been able to increase their seed capital, government will relinquish its grip over the scheme and just play its monitoring role... (PMS-14)

Whilst it is the aspiration of the government of Ghana to ensure that the communities take total control over their own health financing and related affairs in the long run, it also recognises that it has to play the umpire by encouraging a sense of responsible behaviour, which would also empower the people. The thrust of government's action is that when the communities are confident in undertaking and managing local projects, it could also enable it to transfer national resources equitably to the people. Looking at the logistics requirements that they need to operate with, there is no argument to the contrary that it was the government alone, which could support them financially:

...if they rely on the district Assemblies to come and give them the money, or the materials to produce the ID cards, for ever and ever, you will not be able to do it...(PMS-16)

Evidently, it would be unwise to leave all the operational expenditures to the management and Board of Directors of the mutual health organisations in the country. There are few district and municipal Assemblies, especially those that are economically deprived, which but for the intervention of the government, could not have provided the needed funding to establish their district-wide mutual health insurance schemes. It would be recalled from chapter 7 that the number of pre-NHI 2003 MHOs in Ghana had increased from 47 in 2001 to between 160 and 170 in 2003 (Atim *et al.*, 2001a, 2001b; Kankye *et al.*, 2001; Apoya, 2003; Bennett, 2004). The intervention of government of Ghana through the implementation of NHI Act 650 had enabled the mutual health organisations to operate as 'District-wide' or 'Municipal-wide' institutions in the country. The post-NHI 2003 MHOs are enrolling more people than their counterparts who operated under the pre-NHI 2003 MHOs.

Statistically, there were one hundred and thirty-four (134) district-wide and municipal-wide mutual health insurance schemes established in 2006, two years since the Act 650 was implemented in Ghana. This was out of the one hundred and thirty-eight (138) district and municipal Assemblies in the entire country. The expanded coverage was more than eight million (8m) people in the estimated population of twenty-two million (22m). This represented 34 per cent coverage as at September, 2006 (MOH, 2006, 2007a, 2007d). Between 2006 and 2007, this had increased to 145 district-wide and municipal-wide mutual health insurance schemes out of the

estimated 165 district and municipal Assemblies. The membership was 11,279,678, which represented 55 per cent of the population (MOH, 2007a, 2007d, 2008; Joint DP Mission, 2007). The number of district and municipal Assemblies had increased to 170 in 2010 (Ghana Districts, 2010).

11.1.6. Social Group Members

It would be recalled from chapters 2 and 6 that some researchers argue that the implementation of the cost recovery or 'Cash and Carry' system in public health facilities has deprived many people in the informal sector of the economy access to basic health services due to their inability to pay (Waddington & Enyimayew, 1989, 1990; Asenso-Okyere, 1995; Asenso-Okyere *et al.*, 1998; Van den Boom *et al.*, 2004). The effect of this policy on utilisation rate at public health care facilities in Ghana has equally been negative:

...utilisation rate had reduced to less than 50 per cent and has yet to pick up even after the introduction of the National Health Insurance Scheme... (PMS-8)

Aryeetey and Goldstein (1999), argue that due to lack of social policy and welfare framework in Ghana, programmes are geared towards alleviating poverty. This is why the government of Ghana is involved in the financing of the mutual health organisations. The Ghana Poverty Reduction Strategy I (Fayemi *et al.*, 2004), was incorporated into the National Health Insurance Scheme (NHIS) to facilitate this objective:

...there was this poverty alleviation programme: if you wanted to go for a loan, it was hooked to the health insurance so that you pay your premium as a qualification to securing the loan facility...It compelled people to also pay, ahaa!...(SMMHO-4)

Exempting vulnerable citizens from paying the premiums is enabling those who could raise the administration fees required; to register with the mutual health organisations (refer to 9.2.2). As the evidence in table 9.4 shows, the number of social group members registered by the Aduana MHO represented 58.2 per cent of total membership in 2005; and 48.6 per cent in 2006. The Asakyiri MHO's social group

membership represented 64.7 per cent in 2005; and 79.4 per cent in 2006. The number of social group members registered by the Asona MHO represented 39.8 per cent in 2005; and 55.9 per cent in 2006. The number of social group members registered by the Biretuo MHO also represented 59.2 per cent in 2005 and 55.9 per cent in 2006 (refer to 9.3.2.5). This is helping to improve financial access for majority of the deprived citizens, who otherwise would have been denied access to orthodox health care at the point of service use as discussed by some researchers (Criel, 2001; Medici Con-L'Africa, 2001; MOH, 2004d, 2008).

By this exemption by the government, the mutual health organisations are helping to accommodate more members for the various Local Government administrative boundaries in Ghana. Already the National Health Insurance (NHIS) programme has been described as the single most important poverty alleviation strategy ever introduced (Botwe, 2008; 'The Ghanaian Chronicle', 17 November, 2008). This agrees with Besley's (1989), argument that when insurance is paid as task of health expenditures it ties together the demand for health insurance and health care (Besley, 1989).

The study observes that the government could be seen as having a framework to implement some of its policies in other sectors of the economy as it is using the mutual health organisations as preparatory grounds to develop its social services framework and a welfare-state-oriented health care (see Esping-Anderson, 1990; Giaimo and Manow, 1999), which are lacking. The mutual health organisations in Ghana are seen as effective social organisations which are contributing to saving people's lives, and offering comparative monetary value. Hence, the ability of the mutual health organisations (MHOs) to be sustained after all the high costs of investment would help provide a procedure by which the government could provide exemptions for any group of people in the country. They could effectively target those with social needs: all these are adding up to the cost effectiveness equation.

Culyer (1989a), argues that if marginal social costs are incurred in administering insurance, a price for insurance which ignored such costs would imply a state in which social welfare could be increased, assuming that there was a negative sloped demand curve for risk avoidance. That would mean that too many people would be

insured (see Culyer, 1989a, 1989b). Moreover, as argued by Hauck and other researchers, the extra-welfarists' position, which uses the priority-setting criterion to maximise health such that health care resources need to be directed toward the programmes and individuals for which health gains are highest has been satisfied (Hauck *et al.*, 2004).

The current health care delivery with pro-poor focus is indicative of the health financing mechanism, which existed under the first Republican President of Ghana, Dr Kwame Nkrumah and his Convention People's Party (CPP). This was based on 'Afro-socialism': the Africanised version of socialism due to the prevailing political ideology at the time (FCO, 2004). The finding confirms the argument that governments' involvement in health financing and delivery is one aspect of enhancing equity and eradicating inequities from the society (Arrow, 1963, Pauly, 1986, Culyer, 1989a, 1989b, McGuire *et al.*, 1989).

11.1.6.1. Inadequate Public Administration System and Oversight

However, Preker (2004a), expresses the opinion that many people in developing countries, including Ghana, are being excluded from accessing even the under-funded public health care. The study reveals that some of the people who are enjoying the exemption could have paid the premium and administration fees themselves or by other means. The result is that there are some people in the informal sector of the economy who could neither be considered as they are outside the eligibility criteria nor having the financial resources to pay the administration fees. There are issues with the identification of the very poor: indigents in the population. The National Health Insurance Act 650 and the Legislative Instrument L.I. 1809 (MOH, 2003d, 2004b; GHS, 2004b), do suggest two main criteria to be used in identifying the indigents. These are: assessment by a social welfare official and the community's own assessment of who is an indigent in their midst. The difficulties for the management of the mutual health organisations in this respect are many:

...the management of the schemes lack the instrument to determine who the indigents are... (PMS-12)

A policy maker confirmed the difficulties in identifying the long standing poor population in Ghana:

...there are people who cannot contribute, it is just the size and the efforts to try and target them that still remain a challenge...The net for health insurance is so broad and the pause to allow people to fall through the cracks is in my opinion, quite small...we need a bit more evidence to understand who is being missed and that is where we are investing our efforts at the moment...(PMS-2)

Due to lack of national database on the vast majority of the Ghanaian population, identifying and targeting this group of people has become a difficult task for the management of the mutual health organisations in their dealings with people who are unable to register. Apart from few organisations such as the Civil Service (CS), Controller and Accountant General's Department (CAGD), Electoral Commission (EC) and Social Security and National Insurance Trust (SSNIT), which have data on a cross section of the population, there is no other way to gain access to a national database covering all the population. Even the birth and death registry could not provide up-to-date information on the national population due to lack of information and technological difficulties. This shows that the public administration system is underdeveloped. This explains why many sub-Saharan Africa countries had yet to implement comprehensive social health insurance (Carrin, 1986, 2003; Arhinful, 2000; Carrin *et al.*, 2005; GSS, 2005; NDPC, 2005a, 2005b).

In some districts and communities, there are no social welfare officials posted to assess the situation. Moreover, the community's own assessment of who is an indigent is difficult to implement. Thus, unless there are committees constituted which could nominate these people for consideration, the task is left to be performed by the management or Board of Directors of the mutual health organisations. They are already overstretched by administrative functions and other commitments:

...no, we have not been able to achieve set targets just because sometimes we have difficulties in trying to sustain the programme itself...We have the programme all year round going to the communities talking to the people to change their mindset...(SMMHO-1)

There is also a problem with respect to cultural perspectives of indigents: '*...no one voluntarily wants to show their status as such...*' (PMS-11). On the negative side, this criterion is open to favouritism, which could be described as a health insurance moral hazards as genuine indigents are deprived of the opportunity to access health care:

...you know we register people as indigents, so if they are classified as indigents it means the person is going to be under the NHIS free of charge...what is happening in this district is; it is a rural area, ok, if you are not careful, you are going to register almost a quarter of the population as indigents...So we need to really go down and find out who is an indigent...(SMMHO-1)

This finding contravenes the argument by some researchers that the availability of subsidy would encourage self-righteousness in the beneficiaries (Ron, 1999).

Additionally, the 'aged' population (over 70 years) is entitled to automatic enrolment with the mutual health organisations (MOH, 2003d). However, the study shows that they are required to pay the administration fees to their respective mutual health organisations. The population has been grouped under rich members, relatively rich, relatively poor and the core poor (GHS, 2004b, MOH, 2004d). The 'rich and aged' people are able to afford the administration fees:

...my mother is over 70 years but she is very rich and can pay the premium... (PMS-16)

However, those who are 'poor and aged' find it extremely difficult to mobilise the administration fees to be able to join the mutual health organisations. Although the aged population is covered, it could still be challenged that this has not been totally extended to the 'poor and aged' in the communities. At their age, they could not engage in any active farming or trading to raise money to pay for the administration fees. When people are very poor, even free commodities become essential and inaccessible. It is for such people that the intervention of the government of Ghana in providing subsidy would have had the most expected impact:

...the government has done very well...the only thing I want is that he [government] should also see how he can help us pay the

fees (administration fees) because as I am not working, it is difficult for me to mobilise it... (ASKMHO-M-2)

The NHI Act 650 (MOH, 2003d, 2004b, 2004d), has also failed to make any provision for the 'silent minority': people with disability, especially those who have no means of livelihood: the blind, deaf, lame and cripple in the Ghanaian population. They are supposed to register and pay the premiums and the administration fees just as their 'able-bodied' counterparts. They do not in most cases enjoy any exemptions in their use of public resources. This evidence has direct and indirect relationship with the observation by Sulzbach and other researchers that older adults (50 years and over) are significantly more likely to enrol whilst adults between the ages of 25 and 40 are significantly less likely to enrol, especially, if they are relatively young, between the ages of 20 and 25 years (Sulzbach *et al.*, 2005). However, in this study, it is obvious that all the age groups are eager to enrol, but are only constrained economically. The evidence also provides for the need to look at the suggestion that the design of mutual health insurance schemes have had to take into account the issue of affordability of the premium (Lund and Bygbjerg, 2003; Arhinful, 2005).

11.1.7. Health Benefits and Utilisation

As the evidences in chapters 2 and 4 show, the failures of the market economy in the health sector are many. This is the reason why the health system in Ghana operates with the government providing financing and regulation to ensure efficiency (Olsen *et al.*, 1999; Carrin and James, 2005). Comparatively, if the mutual health organisations were to provide benefits packages with high costs, it would increase their premiums. This would have had repercussions on enrolment and re-enrolment of the people in the community, particularly those in the informal sector as the evidence in this study shows. Whilst only a few people who could afford the premiums would be able to participate in them, there would be others who might lack the financial enablement to enrol. The enthusiasm of the people in joining such financing schemes with high premium rates could be killed by the economic deprivation and the irregular incomes from their occupations (refer to chapter 9).

The health care providers contracted with the mutual health organisations are somehow motivated to deliver services to the insured members since the mutual health organisations are able to reimburse them, albeit with delay. This is gradually improving members' satisfaction of health care services as discussed by other researchers (Ensor, 1995; Leighton, 1995; Offei *et al.*, 1995; Atim, 2000; Atim and Sock, 2000; Akua-Agyepong *et al.*, 2001; Carrin *et al.*, 2005; Ndiaye *et al.*, 2007). That is, even as they are understaffed, health care providers are giving their utmost best. The sacrifices of the few health personnel delivering health care to the poor populations in Africa is recognised by President Barrack Obama of the United States of America thus:

Yet because of incentives - often provided by donor nations - many African doctors and nurses understandably go overseas, or work for programmes that focus on a single disease. This creates gaps in primary care and basic prevention (Obama, 2009a; 'GNA', Saturday, 11 July 2009a)

The study shows that as the government of Ghana is providing comprehensive health benefits packages for members of the mutual health organisations including those in this study, it is helping to absolve them from the imminent catastrophic health care expenditures they might have faced. The aims of the minimum healthcare benefits are *inter alia*: 'to ensure that every citizen has access to a level of healthcare that provides adequate security against disease and injury, and promotes and maintains good health; and to secure the financial sustainability of the schemes through protection from excess cost burden' (MOH, 2004d: 15). It is evident that insured members could access out patient (OPD) care without paying consultation fees and could also receive free medicines at the pharmacy or dispensary of the health institutions, if available (refer to table 10.2). Members who go on admission (in-patient care) do not have to pay any deposit before or pay for any costs on their discharge.

The evidence in table 10.1 shows that through government's intervention, the mutual health organisations are improving financial access to healthcare for members in the communities studied (compare this with 11.1.1.7 for its financial implications). That is, out of the total membership of the Aduana MHO, 93 per cent were eligible to

receive healthcare in 2005; and 95 per cent were eligible to receive health care in 2006. Similarly, in the case of the Asakyiri MHO, 39 per cent were eligible to receive free healthcare at the point of service use in 2005; and 76 per cent had improved financial access to healthcare in 2006. On its part, 53 per cent of the Asona MHO's registered members were eligible in 2005; and 88 per cent had improved access to healthcare in 2006. Of the total members registered by the Biretuo MHO, 99 per cent were eligible to access healthcare in 2005; and 60 per cent were eligible to access healthcare free of charge at the point of service use in 2006. Thus, the members could report to the health facilities without contemplating how to pay for the costs of health care. There is some kind of financial relief for the people in the informal sector population:

...I am not really rich but have managed to join the health insurance scheme. There are people who could not come to the hospital because of direct payment of hospital costs. By the grace of God, the insured do not have to pay upfront...you come today and you are treated the same day, so you can return... (BRMHO-M-1)

This is encouraging people to report early for diagnosis and treatment of their sickness, instead of waiting for it to degenerate into a critical stage, which used to happen a lot under the cost recovery policy (Tsey, 1997). This evidence grants validity to the claim that the role of government in providing the enabling environment and stewardship for mutual health organisations has the predisposition to encouraging orthodox health care access, particularly, where taxes could be raised to support them (see Musgrove, 1996; Huber *et al.*, 2002; Skinner and Staiger, 2007; Skinner *et al.*, 2008).

11.1.8. Developing Local Initiatives

As discussed in chapter 7, some international financial institutions helped in highlighting the potentials embedded in the mutual health organisations phenomenon in Ghana. However, it would be recalled from chapter 3 that some researchers are pessimistic that health system and health financing reforms in sub-Saharan Africa promoted by international donors since the 1970s had not resolved the problem of reduced access to care (Huber *et al.*, 2002). Perhaps, this is the reason why the

intention of the government of Ghana was not to rely on these donor and non-governmental organisations to provide funding and direction for the mutual health organisations during the current phase of the health sector reform, which is risk sharing. This qualifies as the 'big R' reform. The experiences of the cost recovery policy, which is the 'little R' reform are still fresh in the minds of the policy makers, especially, the politicians (Hsiao, 2000; Berman and Bossert, 2000).

The intervention of the government of Ghana in health sector reform and the mutual health organisations has offered a better example for other sectors of the economy to emulate. For instance, most sectors of the Ghanaian economy have relied and are still relying heavily on external donor assistance in carrying out basic development activities:

...for instance, if you take the water sector, nearly every single borehole you see is provided by outsiders-international aid organisations...95 per cent of all support that goes into the water sector is provided by outsiders to the communities...it is the same for the agricultural sector...but for the health insurance scheme, one positive thing...was the fact that government did say that no, this is not something that I can depend on donors to do... (PMS-17)

This is why Ghana has been described as aid-dependent by other researchers (Whitfield, 2005; Chisala, 2006; Whitfield and Jones, 2007; Gutman, 2009; Sundewall *et al.*, 2009). Of course, the government of Ghana is aware of the glaring experience that being dependent on donor funding tips the balance of power in favour of donors and the institution of their policies (Okorafor, 2008). The evidence is that the health sector demonstrates that there was the need for a sharp focus on how the country could generate its own resources through viable local initiatives, with strong government intervention. This line of argument is supported by President Barack Obama of the United States of America thus:

Here in Ghana, you show us a face of Africa that is too often overlooked by a world that sees only tragedy or the need for charity (see Obama, 2009b; 'Ghanaweb', Saturday, 11 July, 2009a)

This sets an example of how the government of Ghana could begin to look internally, to mobilise its own resources to solve developmental problems. This has demonstrated how the intervention of governments in the health sector reform could revolve to evolve.

However, some policy and economic analysts like Abbey (2009), anticipates that there would be 'sharp increase in donor-dependence and the dominance of donor preferences in public capital expenditure in 2009 and beyond'. This is due to the 'stubbornly high and widening fiscal deficits'. The concern is whether the accompanying conditionalities would allow the government of Ghana to use these borrowed resources according to its 'own priorities as envisaged by the International Monetary Fund' (Abbey, 2009; 'GNA', Thursday, 3 September, 2009c; 'Ghanaweb', Thursday, 3 September, 2009e). It is against this background that Mills (2009), urges the International Monetary Fund (IMF) to put in place a new facility with relaxed conditions to support African economies during the current economic crisis period.

These notwithstanding, the evidence supports the argument in chapters 4, 5 and 6 that the government of Ghana did not have to relinquish its responsibility in regulating the health insurance schemes as a new health financing mechanism. The bold assertion that could be made based on pragmatic evidence from this study is that Ghana would one day meet the demands of universal health financial protection and coverage as discussed by other researchers (Bärnighausen and Sauerborn, 2002; Carrin and James, 2005; Jacobs *et al.*, 2008).

11.2. Community Field Theory

This section explains the findings of the study with the conceptual framework of the community field theory. The community field theory explains how the community is involved in the health sector reforms. The community members are utilising available social and human capital as well as material resources to shape their own destiny. The community members are setting up their own social organisations and establishing linkages within the communities with identifiable groups and outside the communities with external stakeholders in Ghana. They are playing vital roles in supporting each other. This is helping to enhance the policies designed by the

government (Wilkinson, 1972, 1991). The role of the community and its members in the health sector reform has been touted by many researchers and even the framers of the reform as very crucial to the sustainability of health financing schemes like mutual health organisations in particular, and the health sector in general (Frenk, 1994; Berman, 1995; Collins *et al.*, 1999; Bennet *et al.*, 2004). This confirms the view often expressed by the promoters of health sector reforms that it (HSR) will benefit the society. As explained by other researchers, the community perspective is considered essential to analyse how the services of the mutual health organisations to the community have helped to advance health sector reforms. This viewpoint seeks to assess how the mutual health organisations have performed in respect of the community or society, which is often ignored as a performance indicator in health sector reforms (see Prizzia, 2001; Shaoul, 1997; Tsamenyi *et al.*, 2008).

11.2.1. Community Wealth

The usefulness of social and human capital is enhancing the understanding of how the communities are mobilised. There are invaluable human and material wealth within the communities, which the community members have been able to mobilise to turn them into cash or otherwise. This is assisting them to maintain the momentum needed for the running of their respective mutual health organisations. This confirms the argument that mutual health organisations help their communities to plan, finance, organise and operate their health care services and financing schemes (WHO, 1978; Coleman, 1990; McPake *et al.*, 1992; Fukuyama, 1995; Garson, 2006).

The empirical evidence from the Aduana MHO, the Asakyiri MHO and the Biretuo MHO shows that among some Ghanaians, especially, in the rural areas, the idea of community ownership motivate them to see certain resources as belonging to the entire community members for their common use (refer to 10.1.6.3). Organisations in the community are creating the shared demand for utilising existing community resources like health care through the mutual health organisations (Wilkinson, 1991; Martin, 2003). This is why the mutual health organisations in Ghana are being developed as viable social institutions. This confirms Develtere's, explanation that social movements or organisations are spontaneous collective attempts to further common interests or to secure common goals through specific organisations and

collective practices, which are used as vehicles for the realisation of a more or less articulate vision (Develtere, 1993; Atim, 1999).

The common economic argument is that the mutual health organisations in the well-endowed communities have chances to operate and are operating effectively. While some districts are endowed with rich natural resources like gold, diamond, bauxite, manganese and other agricultural-led income generating ventures, others are faced with abject poverty. The economic environments in the Eastern and Brong Ahafo regions are relatively better. The evidence shows that the paying informal sector members of the Asona MHO and Biretuo MHO are able to generate enough funds to pay their subscriptions because of their ecological constituents. As shown on appendix L, the percentage contribution of the paying informal sector members of the Asona MHO constituted 31 per cent of total income in 2005; and 21 per cent in 2006. Similarly, the paying informal sector members of the Biretuo MHO contributed 41 per cent to the total income generated in 2005 and 38 per cent in 2006 (refer to 9.2.4.4). These are incomes generated beside the government subsidy:

...Brong Ahafo had the largest number, and if you look at the statistic, Brong Ahafo is far ahead of any of the regions. Eastern region also had a few examples like Kwahu and the rest, so they too had actually taken off faster. So these two regions are the best regions in terms of membership and performance...(PMS-16)

The evidence also shows that in Ghana some districts in some regions are disadvantaged when it comes to using wealth creation to support their mutual health organisations. The informal sector members of the Aduana MHO are relatively less able than the members of the Asakyiri MHO. From appendix L, it is obvious that the percentage contribution of the paying informal sector members of the Aduana MHO consisted of 35 per cent of total income in 2005, and 14 per cent in 2006. In the same way, the paying informal sector members of the Asakyiri MHO contributed 30 per cent to the total income generated in 2005, and 17 per cent in 2006 (refer to 9.2.4.4). These people would need assistance from other members of the community. Thus, in the country as a whole, the situation in the Northern, Upper East and Upper West regions, does not favour people in their informal sector population to generate enough funds to support their mutual health organisations:

...wealth is an index of well being...There is a clear divide between the north and south of the country. In the north, it is estimated that about 80 per cent of the people cannot pay whereas in the south, it is only 20 per cent who cannot pay... (PMS-12)

Their wealth is embedded in the few farm produce and animal husbandry they possess. The mutual health organisations in these regions might have the need to decide whether to accept the farm produce and products 'in kind' as method of payment for their health insurance policy, instead of direct cash. Accepting these products would also bring additional burden on the management of the mutual health organisations as they would encounter problems with storage and marketing. In fairness, the mutual health organisations in these areas might not be able to support themselves in the near future because of the nature of their agricultural sector and the natural resource deposits. The evidence indicates that the sustainability of the mutual health organisations in Ghana depends upon the socio-economic configuration of the communities involved. Similar observations have been documented in the literature (Musau, 1999; Schneider *et al.*, 2001a, 2001b; Ranson, 2002; Mariam, 2003).

11.2.2. Members and Non-Members of the MHOs

The sense of social and human capital elements, which are used to develop community cohesion, could be seen in many acts performed by the members in the communities. As discussed in chapters 3 and 4, the community cannot exist in isolation of the people who occupy its frontiers. Hence, the critical group is the members of the community, who are commencing the formation of the mutual health organisations. Both members and non-members are translating their desire to see their community programmes succeed by making attempts to mobilise funds to pay their premiums and /or administration fees to the mutual health organisations.

The study postulates that it is the socio-economic indicators, health status and people's desire for an efficient and effective health system, which are the propellers of a workable health reform policy. The people in the communities have health risk factors and old age associated conditions (refer to 10.2). The evidence is shown in the

way members are utilising health care services (refer to table 10.2). It would be recalled that the OPD attendances recorded by the Aduana MHO represented 136 per cent in 2005; and 95 per cent in 2006. The Asakyiri MHO recorded 406 per cent OPD attendance in 2005; and 183 per cent in 2006. The Asona MHO recorded 141 per cent OPD attendance in 2005; and 80 per cent in 2006. The Biretuo MHO also tabulated 57 per cent OPD attendance in 2005; and 178 per cent in 2006 (compare this with 11.1.1.7 for its financial implications). The common adage used by many people in Ghana when discussing community development issues is: 'a healthy people make a wealthy nation'. Some analysts and researchers argue that health has correlation with the poor and poverty (Wagstaff, 2002), and the link between health and income also seems uncontroversial; after all, healthy people can work longer and harder than sick people ('The Economist', November 22, 2008).

The study reveals that the people are showing commitment against the backdrop that in Ghana, the growth of the community sector is not evenly distributed. Most of the people in the communities are peasant farmers, artisans or fishermen, whose financial availability is seasonally directed. Despite their poor socio-economic circumstances, the evidence in table 9.5 indicates that the Aduana MHO increased its paying informal sector membership between 2005 and 2006, showing a rate of penetration of 80 per cent. The Asakyiri MHO also increased its paying informal sector membership between 2005 and 2006, showing a rate of penetration of 100 per cent. The Asona MHO added to its paying informal sector membership between 2005 and 2006, indicating a rate of penetration of 13.6 per cent. The Biretuo MHO increased its paying informal sector membership between 2005 and 2006, showing a rate of penetration of 3.8 per cent. This shows that the people are aware that health has a relationship with how wealth is generated. Therefore, if they are healthy, they would equally be wealthy. When people are wealthy, it is expected that they would follow healthy eating regimes and do the right things to keep the right healthy standards and promote public health. This study confirms the truth in the policy of the Ministry of Health: creating wealth through health- a new paradigm for Ghana's development (MOH, 2005).

As discussed in chapters 2, 5 and 6, Ghana's economy is impacted by both internal and external influences. The International Monetary Fund (IMF) and World Bank

(WB) coaxed the government to introduce economic reforms in the 1980s. The Structural Adjustment Programmes (SAPS) which were implemented led to as high as 90,000 redundancies in the labour markets between 1985 and 1990 (Jonah, 1989; Asante *et al.* 1993; Boafo-Arthur, 1999; Musa, 2001). The health sector was also affected (Dovlo, 1998). However, the private sector was not well developed to absorb this human capital component of the economy. This explains why poverty, which may be defined as the deprivation as regards a long, healthy life, knowledge, an appropriate standard of living and participation is prevalent in most of the communities (Palma-Solis *et al.*, 2008). Poverty is widespread in the district where the Aduana MHO is located (Agyepong, 1999). There is a strong relationship between poverty and health (UNDP, 2000; Wagstaff, 2002; Palma-Solis *et al.*, 2008).

As the above factors are affecting the people in the communities, it is helping to enlighten community members on how their involvement in health sector reform could not be ignored as they seek practical solutions to their economic predicaments. Thus, they have recognised the imbalances in these conditions and are craving for the necessary changes to occur in their environs. In finding antidote to their health problems, they are therefore encouraged to join the mutual health organisations. This justifies why the mutual health organisations are making in-roads with regards to enrolment in their catchment population.

The evidence in appendix D1 to D4 illustrates this optimism. The Aduana MHO registered 14.2 per cent of people (members) in its catchment population in 2005; and 17.3 per cent of people (members) in its catchment population in 2006. The Asakyiri MHO registered 14.2 per cent of people (members) in its catchment population in 2005; and 28.7 per cent of people (members) in its catchment population in 2006. Equally, the Asona MHO registered 63 per cent of people (members) in its catchment population in 2005; and 59.8 per cent of people (members) in its catchment population in 2006. The Biretuo MHO registered 49.6 per cent of people (members) in its catchment population in 2005; and 43.3 per cent of people (members) in its catchment population in 2006. Nonetheless, the overall performance of the people in supporting their mutual health organisations is incredible. They believe that by joining the mutual health organisations, they would be able to solve the common ailments that afflict them so that they could work to earn

a living or better their lives in an environment full of economic uncertainties (Acquah, 2008).

In Ghana, the sense of community feeling is motivating people to contribute to the development programmes such as health financing in their neighbourhoods. This is also encouraging them to participate in communal activities. Family heads are mobilising funds from their members and paying the same to the 'Community Development Fund' and the mutual health organisations. Wealthy parents pay on behalf of their children who could not mobilise the funds or children who are abroad. Community members who are abroad are also remitting funds to their families and relatives for such purposes. This shows that the extended family system provides the route for people to interact with immediate siblings within the nucleus of their families as well as in the larger community:

...one of my children lives and works at 'Jeyi town', which cost more than fifty thousand old cedis (¢50,000.00) but I register for him in this district instead of there... (BRMHO-M-1)

In spite of this commitment, MacLean (2004), argues that the 'divergent local experiences of agrarian capitalism in Ghana and Cote d'Ivoire' has altered the ways in which the 'boundaries of family and community are imagined in the two countries', noting that 'solidarity between the young and old has been weakened in Ghana, but reinforced in Côte d'Ivoire' (p.470). As discussed in chapter 7, the stimulus for the introduction of the mutual health organisations in Ghana is firmly rooted on inter-family and inter-tribal relationships (Arhinful, 2000). Even Wilkinson (1991), contends that the contact that people have with the society transpires first in the family and then, more meticulously, in the community. As argued by the African Union (AU), despite the presence of ignorance, poverty and disease (AU,2005b), one thing that cannot be taken away from the people of Ghana in particular and sub-Saharan Africa in general is the presence of traditional values of solidarity (see Miller, 1987; Titmuss, 1987:7).

The mutual health organisations in Ghana are successful because of the enthusiasm of the members and their appreciation of their health care needs. This confirms the assertion by some researchers that when the willingness of the people is high their support for the sustenance of a national policy will be high (Liu *et al.*, 1995, 1996; Carrin *et al.*, 1999). Furthermore, this attests to the argument by some economists that an important feature of any modern macroeconomic theory is an explicit aggregation of the microeconomic behaviour of all agents in the economy (Rossi-Hansberg, 2009). Therefore, the micro-level interest is aggregating to form the macro-level interest in the search for equitable health financing mechanism in Ghana:

...in addressing the issue of equity in health; we have the poor forming the basis of what we are doing in the health sector...The institutional arrangement is to mobilise the community to ensure community ownership. We have to express our interest through the financing and care by providing the poor people with access against catastrophic health cost and therefore make it cheap for them to afford...(PMS-2)

People are contributing to the success of their mutual health organisations by encouraging others to be part of it. They are doing this by undertaking personal promotional campaigns within the communities (refer to 9.3.4). A simple point of reasoning is that even at the current premium level, if all the number of people in the informal sector in the respective districts and municipalities were to register and pay their premiums, then the chances of the mutual health organisations' sustainability would improve beyond comprehension (Boateng, 2008; Essel, 2008). This confirms the suggestion that the mutual health organisations need to develop some workable strategy to ensure the promotion of these non-financial elements, which are equally, invaluable wealth located within the communities (Atim, 1999; Musau, 1999; Schneider *et al.*, 2001a, 2001b; Cripps *et al.*, 2003).

11.2.3. Traditional Leadership

The evidence of the study shows that in Ghana, the active involvement of all the stakeholders in the communities in the activities of the mutual health organisations could not be overlooked. Traditional and other opinion leaders are very important

actors as they command considerable influence over the behaviour of their members (refer to 10.1.5). This is why the management of the mutual health organisations have found it necessary to establish closer relationship with all the traditional social institutions, which represent the voices of their communities. Since the opinion leaders had been given due recognition in the framework of the operations of their respective mutual health organisations, especially, at the rural level, they are reciprocating this gesture by showing their philanthropic instincts by registering other willing but needy members of the communities:

...I could tell you for a fact that there was one Chief who paid about one million old cedis (¢1m) for himself alone and also paid for other poor members...(SMMHO-4)

Traditional leaders like the Chiefs are also demonstrating that they have air of importance, influence and wield enormous power over the modern government system in their respective domains. They serve as the pivot around which social and human capital of the communities revolve in the developmental process of the country. Their acceptance or rejection of central government policy could have negative consequences. There is the acute need to involve them in the formulation and implementation of national policies (Boafo-Arthur, 2001). There is an adage that: 'if a Chief fails to lead his army to war, his subjects do not go either'. This means that exemplary traditional leadership serves as motivation for the people to follow a particular line of action and direction.

As the evidence of this study shows, the unique traditional ecology of the Ghanaian society is that most of the communities are set up and administered under traditional administrative systems, where every local area is headed by a sub-chief of the Traditional Council (refer to 10.1.5). Their roles on the Council are significant in the administration of the entire Chiefdom in view of their respective abilities to mobilise their people for development, peace, stability, law and order. From a historical perspective, the traditional role of the sub-chiefs during wartime was that they had to pitch their positions side by side with the Omanhene (Paramount Chief) in his fight for conquest and territorial supremacy over the land.

The sub-chiefs owe allegiance to the Paramountcy and they sit in state with the Paramount Chief anytime there was a grand durbar. They also assist to organise their people for community development projects. This signifies the bond of unity existing amongst the people coming under the Paramountcy, which is being translated into their support for the respective mutual health organisations. This arrangement negates Ubink's (2007), argument that:

...customary land management in peri-urban Ghana poses some serious questions regarding the merits of customary systems and the presumption that customary law offers security to members of a customary community and that Chiefs represent developmental, sustainable and somewhat equitable and inclusive governance... (Ubink, 2007:3)

Ubink (2007), failed to understand the dynamism of the traditional system because talking to any aggrieved person over land issue was likely to result in a negative concordance. Even under modern democracy and in the developed economies, governments' decision and attempt to take over people's land for development purposes have been met with some form of resistance (see 'Free Metro', Friday, January 16, 2009:5). Under Ghana's land title administration, certain lands are demarcated as Stool lands and the Chiefs have jurisdiction regarding allocation. As tradition and custom demand, visitors to any town or village are required to report and make their missions known to the Chiefs who are custodians of the land. The violation of this customary norm could lead to a team being denied the permission to speak to the people concerned. This could be a recipe for likely conflict with the traditional authority if acts of gross disrespect were deemed to have occurred (Boafo-Arthur, 2001). This is confirmed in a newspaper report:

...Nana Kwadwo Fordjour, head of the Peteli Royal family told newsmen in Kumasi, yesterday, that the fact that there is a protracted chieftaincy dispute in the area over the last 30 years, does not allow government to invite, deal or enter into any negotiations over payment of compensation without referring to the original owners of the land... (Freiku, 2009; 'Ghanaweb', Thursday, July 30, 2009b)

For example, Ashanti region has a great tradition, which suggests that all lands in the Kingdom belong to the Asantehene (King) as the head of the Asante Confederacy, while the various Paramount Chiefs act as caretakers on his behalf (Brempong, 2001; Larbi *et al.*, 1998; Ubink, 2007). This position accords the Asantehene (King) the authority under customary law to demand performance from all Chiefs in all areas of development including embracing policies such as the National Health Insurance Scheme (NHIS). This confirms the reason why at the regional level, a call was made by the Asante King, Otumfour Opoku Ware II, to all the Paramount Chiefs in the Ashanti region, during the formative stages of the mutual health organisations in the country (Apoya, 2002). The study observes that the people have confidence in the authenticity of any project which is led by the community leaders. This is why the National Health Insurance Act 650 has included representatives of the traditional council and district and municipal Assemblies on the Board of Directors of the district and municipal mutual health insurance schemes (refer to 9.1.2.2).

The mutual health organisations in this study are located within distinct socio-cultural milieu where the customs and traditions of each particular community have effect on the vigour of their membership. These also have effect on how members understood their community leadership in helping them accept government policies. It is observed that people's access to information from the traditional leadership depend on which lineage they belonged. The management of the mutual health organisations need to understand the different cultural traditions of these Chiefs and their people to be able to interact with them. This awareness ensures that they do not hurt the feelings of any particular group or be seen as taking sides when there was a traditional misunderstanding between different Chiefs and lineages. Their people have reposed their trust in them and expect them to be involved in the mobilisation programmes:

...we need direction from the leaders because if there is no direction, there is no future...I have had discussions with a lot of people who had not yet registered and they have listened to my advice and have joined accordingly, because it can help us to realise many important things as a community...(ADMHO-M-9)

In the remotest localities, they have always been the instrument for disseminating information on official policies. In the district where the Aduana MHO is located, there are inadequate formalised administrative structures with few decentralised personnel. This glaring fact encourages the management of the mutual health organisations to liaise with traditional leaders in their activities:

...we need to sensitise them and bring our programmes to the Chiefs; that this is it, Nene (King), we need you...we need to do much to bring them in... (SMMHO-1)

The involvement of community leadership in the initial set up of the Asakyiri MHO motivated as well as compelled the people to enrol. This enhanced the change process that was needed to take place. They persuaded their people to clasp this laudable health insurance initiative as they understood it as a kind of cross subsidisation (MOH, 2004d). Members of the various groups and associations have admiration for their leadership and they understand them better because they speak a common language and have a special way of eliciting their support. Through the use of local means of communication, messages on community and national development issues are transmitted from the Chiefs and opinion leaders to their people:

...se nananom ka a, na asi pi, emaa me hunuu se insurance yi ye adee bi a eho hia oman yi, translated as messages are validated when the Chiefs speak about it...their involvement convinced me that the health insurance scheme was not a joke but a serious issue of national importance... (ASKMHO-M-1)

There are other Paramount Chiefs in the region where the Asona MHO is located who are demonstrating their enthusiasm in the activities of the mutual health organisation by physically being present at functions and delivering speeches. This is encouraging management and the people to continue the good work of attempting a solution to the health financing problem in the communities. This had contributed to a rejuvenated trust, which is for the betterment of the people and the mutual health organisation's sustainability. Likewise, the inter-agency and stakeholders' role in the promotion of the Asona MHO is helping to whip up enthusiasm as well as encourage participation from all members of the communities. Durbars are occasionally jointly organised where all the leaders educate their people:

...there was solidarity for the pre-NHI 2003 MHOs (PMHIS) than the post-NHI 2003 MHOs (DMHIS)...there were no government subsidy and they were able to sustain themselves for 5 years...Currently, there is dis-equilibrium in the social dynamics...(PMS-9)

The traditional leadership had accepted the challenge to lead their people for accelerated development. The adage: *obi nnom aduro mma oyarefoo* translated as 'no one can take medication on behalf of the sick person' is put into good use as the communities through their leadership are always attempting to identify their own problems and suggesting permanent solutions to them. The people in the communities where the Biretuo MHO is located try to bestow their support for uplifting the virtues of their leadership when undertaking projects. Their conviction is deep-rooted in the hope that while there was strength, they had to accumulate wealth as well as provide for health care cover ahead of old age and in times of chronic illness. The reason why this strategy was working perfectly was that people understood a message better depending on who was giving it, the type of language used and the respect they accord the messenger.

A policy may be said to be viable when the appropriate mode of communication had been used to achieve the expected impact. It is observed that in some remotest communities where traditional literacy (one's ability to communicate effectively in the local dialect) superimposes itself on formal literacy (one's ability to communicate in exotic dialect), it would be appropriate to adopt the traditional communication channel to deliver the message to the audience. Modern education and the study of different languages, for example, English language by the youth of Ghana today, had affected their ability to communicate effectively in the local dialects (see Kuyini, 2010; Khalid, 2010; 'GNA', Monday, 5 April, 2010). Even as the management teams of the mutual health organisations are doing their best to explain the concept of health insurance to their community members, their lack of appropriate choice of the local vernacular is somehow betraying them. In the process, the substance of the messages is being lost:

...they [post-NHI 2003 MHOs] lack the ability to build capacity and market the schemes...The previous schemes [pre-NHI 2003 MHOs] adopted the traditional educational methods...(PMS-11)

However, the impact was far greater when a traditional leader conversant and fluent in the local dialect delivered it. When the Chiefs and opinion leaders want to transmit a message, they could use the 'town-criers' who beat the 'gong-gong' (metallic instrument) to arrange a meeting or summon the people where they encourage them to support community development projects. When people accept 'truth' from a traditional leader, no amount of words could convince them to renege on a pledge of support they had made:

...Nananom and other opinion leaders want the scheme to progress. They know that if you are an Omanhene (Paramount Chief) and your people are always sick, that would not augur well for the success and development of their community and kingship. It is also their desire that their people would show humility and work hard to make the scheme very successful. This can help the whole community and the entire nation...(BRMHO-M4)

Again, the Chiefs in general have the power to initiate a move for the transfer of decentralised workers or impeachment of District or Municipal Chief Executives appointed by the government if there are justifiable grounds for any action resulting from misunderstanding (Boafo-Arthur, 2001; Adjei-Darko, 2007; Baffour Awuah, 2007). They would not allow any action from any individual or group of individuals that had the potential to thwart their efforts at unifying their people. This presumption is what is encouraging the management of the mutual health organisations to harmonise relations with the traditional leadership:

...we have a very good relationship with the Traditional Council. The Omanhene himself places high premium on the health insurance scheme...We cannot do anything without their consent and involvement. We need to give them their due respect...(SMMHO-3)

Thus, the Chiefs and opinion leaders are strengthening the bond of national unity against the background of a country that has diverse tribal and linguistic groups. They are encouraging their people to tolerate and co-exist peacefully with one another. They encourage their people to understand that among the fundamental components of any peaceful country are unity and trust:

...praye woho yi, woyi baako a na ebu, se woka bo mu a emmu, se etua wo yonko a, na wose etua dua, meaning, It is easy to break a stick of broom but it is difficult to break a bunch, nobody should be complacent when their neighbour was suffering... (BRMHO-M-4)

The perception of the Chiefs and opinion leaders is that it was only a peaceful country that could attract foreign investments. They also believe that through the mutual health organisations, health care could be extended to all residents in the country, including foreigners:

...If we look around us, we can find that there are a lot of foreigners in the country. If the nation was full of only sick people, I do not think that it could attract a lot of foreigners to come and live or do their respective businesses. In that case, they would have come only as medical volunteers to offer their support. We all know that it is good and it is for us, but it is the unemployment which is making it difficult for people to demonstrate their passion and commitment towards the stability of the scheme (PMS-19)

The performance of the Chiefs and opinion leaders in Ghana is very effective and efficient. They know very well that often times, the promises of the modern government machinery had never been fulfilled (Boafo-Arthur, 2001). This confirms the findings that for many people in developing countries, not excluding Ghana, customary norms form the reality, whereas state law and state courts are seen as remote, strange, expensive and difficult to access. Therefore, it is recommended that policy and law should start from existing realities and systems because the modern government's top-down imposition rather marginalises the people and exacerbates poverty (DFID, 1999; Platteau, 2000; Toulmin and Quan 2000; Ubink, 2007). This is also the reason why the Chieftaincy institution is being strengthened. A framework was being developed where customary law was being accepted and put forward as a solution to the limited reach of government in the localities (van Rouveroy van Nieuwaal, 1995; Palmer, 2000; Brempong, 2001; World Bank, 2003a; Lutz and Linder, 2004; Ubink, 2007). In the absence of modern government resources and provisions reaching them, rural folks rely and rally behind the traditional leadership to provide basic development projects.

11.3. Complementarity between Social Policy and Community Field Theories

As discussed in chapter 4, social policy and community field theories are used to interpret the findings of this study for several reasons, particularly, complementarity: each theory cannot do without the other. Whilst social policy theory on its own could explain the findings relating to the intervention of government in health sector reform, it could not deal with all the issues which relate to the communities' perspective as far as the analysis of the community involvement in health sector reform was concerned. There are handicaps for using community field theory unilaterally, which had to be rectified by using social policy theory. In order to create the necessary sense of balance, there is the urgent need to triangulate the social policy theory with the community field theory. In the nutshell, the evidence of this study shows that a combination of the social policy and community field theories is appropriate for the interpretation of the findings of this research. Thence, harmonisation is the common thread needed to tone down the uncertainties created from either side of the theoretical divide (refer to 4.4).

The lack of complementarity could lead to possible conflict in the use of the two theories to explain the findings of this study or between the actions of government and the community due to the socio-cultural composition of Ghana. Despite the interaction between the government and community actors in the management of the mutual health organisations, it must be observed that some respondents perceive that there is less complementarity between the government and the community. This is affecting the role that the actors had to perform in order to enhance the harmonisation needed. Whereas there is active community involvement in the activities of the mutual health organisations at the rural and district levels, this tends to be passive at the regional and national levels.

Social policy theory explains how the government organise and encourage social movements and mutual fund schemes in the country to form the basis of a social security or social health insurance by providing the enabling environment (Titmuss, 1974, 1987; Develtere, 1993; Atim, 1999). The evolutionary process could take a considerable period of time as evidenced by countries like Belgium and Italy, among others (Carrin and James, 2005). Germany spent about 100 years to finally institute its social health insurance or attain universal health financial protection. The

Bismarck health reform policy of 1880s built on the mutual funds in the country rather than collapsing them (Barnighausen and Sauerborn, 2002; Jacobs *et al.*, 2008). Carrin *et al.* (2008), emphasise that developing prepayment mechanisms may take time, depending on countries' economic, social and political contexts. Importantly, they argue that specific rules for health financing policy will need to be developed and implementing organisations will need to be tailored to the level that countries can support and sustain (Carrin *et al.*, 2008).

There are various areas where the perceived less-complementarity between the government and the community actors are being manifested in the operations of the mutual health organisations in Ghana, which must be resolved in order to enhance the complementarity required. The discussions below explain the complementarity between the government and the community as well as emphasise on the perceived less complementarity, concurrently.

11.3.1. Inter-Organisational Consensus

The study observes that there are some inter-organisational relationships between all the stakeholder organisations in the environment of the mutual health organisations particularly, at the rural and district levels in the country. However, some respondents perceive that there was apparent lack of inter-organisational consensus at the national level during the development of the National Health Insurance policy (Act 650). The process was politicised, as it was characterised by political euphoria, instead of building a national consensus. Key policy makers were discriminated against as the then opposition Parliamentarians led by the National Democratic Congress (NDC) refused to endorse the National Health Insurance Bill. They argued that there should have been prior extensive consultation, education and debate (Abbey, 2003). These were ignored by the then ruling New Patriotic Party (NPP) members of Parliament, who were in the majority:

...because of the political upheaval that came up with the set up processes, they felt the administration of the NHI Council had to be replaced with entirely a new compliment of staff...who are very clueless about the working of the concept of community

insurance, that bit of it, will make it difficult for them to imagine other's roles... (PMS-17)

The initial acceptance of the concept of health insurance was rather slow as people were reluctant to demonstrate their passion for the mutual health organisations and the National Health Insurance Scheme as a whole:

...the people have taken a lukewarm attitude: wait and see... The transition was slow and difficult and people thought it was going to be free...Initially, some people didn't want to participate in the scheme...Churches were a bit quiet and they transferred their schemes to the government agencies...(PMS-10)

Additionally, the major flaw caused by the National Health Insurance Task Force, which constituted mostly, Ministry of Health staff, was that they failed to consult widely with the promoters, institutions and stakeholders who were providing technical and other support for the pre-NHI 2003 MHOs (refer to chapter 7 and 10.3). The top hierarchy of the Ghana Health Service (GHS) was somehow ignored in the process. Initially, this created a problem for the health sector itself as a community of people with diverse health professional expertise:

...I don't know who you have spoken to...let's say when the previous Minister of Health came in, he indicated that he had a mandate (from the President) to set up the National Health Insurance Scheme...His strategy was not a very popular one, some of us did openly comment to him but it didn't change. His view was that the Ghana Health Service [should] act as a provider and not a purchaser so we shouldn't be interested in the processes, when it is getting started, we should wait till, yes, then we would provide for them (Ministry of Health) as a payer...(PMS-3)

As discussed in chapter 6, the implementation of the Ghana Health Service and Teaching Hospitals Act 525 (Republic of Ghana, 1996; MOH, 1996a), as part of the institutional reform, has created a sharp division in power and role confluence at the headquarters of the health sector (refer to 6.3.2). This had also created problems of role sharing even in the area of the National Health Insurance Scheme (NHIS). The difficulties in the implementation of the Ghana Health Service and Teaching

Hospitals Act 525 are also creating problems when dealing with exigencies in the health sector. This perception is confirmed in a newspaper report:

...Dr Elias Sory, Director-General of the Ghana Health Service (GHS)...called for an amendment of the legislative instrument [L.I] that established the Ministry of Health [MOH] and the Ghana Health Service to facilitate swift response to contemporary issues... ('GNA', Thursday, July 23, 2009b)

As a result, it is pertinent to understand the concept of participatory approach as suggested by Musau (1999). This will ensure that this new health financing mechanism in the country achieved its expected sustainability goals.

11.3.2. Traditional and Modern Management Systems

The study argues that there is interaction between the two main governance systems in the country as these are mixed together in the running of the mutual health organisations (refer to chapters 5 and 10). However, other respondents also perceive that there is less harmonisation between the traditional and modern management systems, which is caused by the complex governance environment within which organisations operate in Ghana. The line between the modern state (Government) and the traditional state (Chieftaincy) institutions has always been blurred (refer to 5.2.1 and 5.2.2). Although people may see themselves as one people belonging to a country, they sometimes feel aligned to their local communities and feel rather 'unconnected' to the communities in which they reside as a result of peculiar linguistic and cultural differences (Freudenburg, 1986; Krannich *et al.*, 1989; Allen, 1998). The study observes that most of the communities have identified leaders of the various tribes and cultures. These leaders are recognised in the administration of the local affairs just so cohesion may be enhanced. The only way to bring about national cohesion is how the community and group leaders could mobilise people to see themselves as one, projecting a common front.

Although the National Health Insurance Act 650 (MOH, 2003d), empowers the communities to establish and implement their own mutual health organisations, the active participation of the government through the district and municipal Assemblies

has caused uncertainties in the management of some of the mutual health organisations in this study. While the traditional leadership could identify themselves with the traditional management style of the Aduana MHO and Biretuo MHO, which were pre-NHI 2003 MHOs, the traditional leadership in Asakyiri MHO and Asona MHO, which are post-NHI 2003 MHOs are feeling somehow 'unconnected'. The modern style of management seems complex to some of the representatives of the traditional council and identifiable organisations serving on the Boards of Directors who are not formally educated (illiterates) due to the technical language associated with health insurance usually applied by the decentralised staff and local elites at the Board meetings:

...se yen hyia mu a, akrakyefoo no kasa no bi nti, emmma me nte nsem no bebre ase yie, translated to mean, I don't usually understand most of the issues discussed at the board meeting due to the language used by the educated people... (BRMHO-M-4)

This is the result of the fusion of the social health insurance and the community health insurance schemes into the National Health Insurance Scheme (NHIS). The mutual health organisations are currently operating like the Social Security and National Insurance Trust (SSNIT) or a state enterprise (MOH, 2003d). The management teams have also assumed the civil service style of management. They have been engulfed by the existing civil service bureaucratic system, which has been described as red-tapism (Bozeman, 2000). In theory, they could be classified as social health insurance schemes (refer to chapters 2, 3 and 7). Additionally, this is more evident since the mutual health organisations are operating under the title: 'District or Municipal Mutual Health Insurance Schemes' (DMMHIS).

Although there is interaction between the management of the mutual health organisations and the district and municipal Assemblies, some respondents raised some questions about the full autonomy of the management staff of the mutual health organisations (DMMHIS) because they do not appear to be free from the claws of the political machinery in order to operate effectively (refer to chapters 7 and 10). Moreover, since the District and Municipal Chief Executives are given charge by the government to ensure the survival of their respective district and municipal mutual health insurance schemes, it has created a perceived tension between the key actors in

some of the communities: district and municipal Assemblies; traditional leadership; and the management of the mutual health organisations where the actors differ on political lines (see GNeMHO, 2004):

...there is issue with the schemes operating as economic entities and as autonomous companies without undue influence from the government. There is the need for proper collaboration between the providers, schemes and all stakeholders...It appears they are on competitive sides – blaming each other for the poor performance, they need to agree mutually on how to do business...(PMS-11)

A similar interference and associated disagreement was reported in Guatemala by Ron (1999). There is a school of thought that if the mutual health organisations are seen as community-based and community-owned, they should be accountable to the members in the communities without undue interference from the political administrative set up. This perception is accentuated thus:

...the DCE should allow us to operate freely... (SMMHO-4)

This will encourage massive community involvement as suggested by Musau (1999).

In addition, some respondents see the NHI Act 650 as an impediment to the zing required for operating the mutual health organisations:

...the government is supposed to enable the schemes think about being self-financing... (HMP-5)

It is to prevent the occurrence of such 'unconnectedness' that the study recommends that attention would have to be paid so that the rural elite do not undermine the participative approach to community-based health care management (Desmet *et al.*, 1999; Atim, 2000, 2001; Huber *et al.*, 2002; Franco *et al.*, 2004, 2006).

11.3.3. Community Sense of Initiative in Health Financing Schemes

While chapter 3 has evaluated the pros and cons of the provision of subsidy for mutual health organisations, chapter 10 has also appraised the effect of the regulatory changes in the environment of the mutual health organisations in Ghana. These have shown that the intervention of government had helped a lot in changing the direction of mutual health organisations by enabling the district and municipal Assemblies to take the lead in the formation of mutual health organisations in Ghana. However, the study observes again that the lack of subsidy for the private mutual health insurance schemes (PMHIS) or the pre-NHI 2003 MHOs is seen as the major cause of the reduction in enrolment of the informal sector membership:

...I think that the other argument has been: why don't you provide subsidy to private health insurance schemes; the private mutuals for them to be able to insure the poor people as well? ... So far, they have not been able to develop business principles that should allow that to happen. I mean, indeed for us to even change the law to respond to that...(PMS-2)

This has led to perceived less complementarity, which is also manifesting itself in the diminished sense of community initiative in the area of health financing strategies (refer to 10.3.5). The study reveals that until the government initiated the move, no mutual health organisation could be established in any community with the type of zeal which saw their spread in the 1990s as discussed by Apoya (2002, 2003).

Some respondents perceive that in the wider community, while the current approach is seen as an effective means of demonstrating the government's commitment to realising that the mutual health organisations are established, there has been excessive government interference in their activities and people have a different perception of the mutual health organisations' phenomenon. They tend to relate the district and municipal mutual health insurance schemes (post-NHI 2003 MHOs) to the political orientation of the government rather than seeing them as initiatives to be undertaken by the communities. The current vision of the communities is rather encapsulated in the belief that it was the central government that had the responsibility to establish the mutual health organisations as the performance of its civic responsibility in the area of health care provision to the citizenry; free of charge. A similar observation has been made by other researchers (Baku *et al.*, 2006).

There is the issue of how to draw the line between the actual role and involvement of the state on one hand and the role of the community in establishing the mutual health organisations, especially, the private mutual health insurance schemes (PMHIS):

...you know, some of us thought in the beginning that the existing mutuals (community-based, Youth Association based) should be allowed to go ahead...people who have meagre funds could join them... but they were discouraged, now some of the people who do other things and cannot raise the premium cannot join, so there are some difficulties... (PMS-3)

As discussed in chapter 3, some researchers show pessimism that excessive government involvement could cripple the initiative of mutual health organisations (Ron, 1999; Huber *et al.*, 2002; Atim, 2003; Derriennic *et al.*, 2005). By government's intervention in Ghana, the approach has ignored the earlier suggestion that governments should not create and manage mutuals. Of particular relevance is the advice by Huber *et al.* (2002), that it would be unwise to subsidise the premium level because mutual health organisations could not count on significant budgetary support by governments of the Africa sub-region.

Economist Musgrove, observes that the appropriate role of the state in health is complex both in economic theory and in practice. He contends that in the event where there was a rise in income, it would be relevant for governments to finance an increasing share of health care, which could lead to the displacement of out-of-pocket expenditure by using tax-financed care or social security contributions (Musgrove, 1996). Increasingly, the role of the government of Ghana has become more complex because of lack of economic growth. It is becoming impossible for the government of Ghana to provide enough budgets for the health sector to be able to displace out-of-pocket expenditure for the citizenry. The study observes that the cost recovery (Cash and Carry) is still operating side by side with the risk sharing scheme (health insurance).

Respondents perceive that continuous provision of subsidy to the mutual health organisations by the government is relatively uncertain since the country's economic growth rate stood at 6.3 per cent in 2007. Inflation ended at 18.1 per cent with an overall budget deficit to GDP standing at 13.42 per cent by the end of December 2008

(see Acquah, 2009; 'GNA', 23 September, 2009e). Despite recent increase in resources, the health sector ran a small: 0.2 per cent of overall revenue deficit in 2006 for the first time in the 5 year programme of work (5YPOW) [(MOH, 2007a)]. The question relates to whether the government of Ghana would be able to generate enough revenue from taxation to be able to continue with its subsidy for the mutual health organisations. This point is argued by some researchers (Liu *et al.*, 1995; Ron, 1999; Huber *et al.*, 2002).

11.3.4. Membership Involvement in the Management of MHOs

The study found that the system of appointing community members to serve on their respective Board of Directors has been streamlined where some identifiable organisations and civil society groups are represented. However, the perception of some respondents is that there are still problems with how people sometimes understand and identify who is an indigenous member of a particular community in a heterogeneous country like Ghana (compare this with 11.3.2). The study observes that there is the perceived less complementarity or reduced sense of community representation related to the appointment of the Board of Directors and management staff of the mutual health organisations (refer to 9.1.2.2). The question arising from the process is that it is not perceived to be granting indigenous community members enough opportunity to elect their own people:

...The key success factors [in the case of pre-NHI 2003 MHOs] included high sense of ownership, great community involvement: interest in the survival of the schemes was high. Currently, the government's involvement is seen in the appointment of staff of the schemes [post-NHI 2003 MHOs] and they are not under the MHOs ... (PMS-11)

The perception is that apart from the traditional councils' representatives who are seen as representing the indigenous people, the rest are appointed by virtue of their positions as employees of the decentralised departments in the districts and municipalities. The representatives of the district and municipal Assemblies and the district and municipal Directorate of Health Services, are the people who have made an impact on their communities. Their level of understanding and commitment to

local issues are not sufficient to fully appreciate the needs of the people, especially, the relatively poor people:

...let us say you have the District Co-ordinating Director as part of the Board. The Co-ordinating Director may not come from the District. So he or she is not somebody they actually picked like a native, that person's commitment... (PMS-16)

This is contrasted with the pre-NHI 2003 MHOs period, where the entire members in the communities used to meet during their General Assembly Meetings (AGMs) to democratically choose who they wanted to serve on their Board or the management that should be in charge of the day-to-day running of their mutual health organisations. The appointees were said to have possessed commitment and were dedicated to the cause of their mutual health organisations (refer to chapters 3 and 7).

Another area of concern is the perceived reduced communities' sense of voluntarism. Due to lack of adequate number of personnel working with some of the mutual health organisations in this study, they have to request for the services of National Service Personnel, who offer one year allowance-based service to the nation upon the completion of their tertiary education. They are paid by the National Service Scheme (NSS). These personnel assist the insured members to go through the administrative procedures by cross-checking with the list of registered members and certify them to enable the health facilities to provide health services. A Ministry of Health policy document notes:

...district mutual health insurance schemes are being resourced to enable them keep pace with registration and ID card issuance...300 National Service Personnel have been engaged to help process identification cards (ID) for insured members... (MOH, 2006)

These National Service Personnel do not work during the weekends and the core management teams do not work on the weekends either when the shortage is much felt (refer to 9.4.1). This is also contrasted with the management staff of the pre-NHI

2003 MHOs who made a calculated attempt to ensure that members had access to health care irrespective of the time of visit. Whenever the health institutions were unsure about the veracity of a member's claim, they could provide the health care services and later seek verification. Members in the communities could volunteer to serve as verification personnel during the weekends. Community voluntarism was at its apex as observed in other studies (Musau, 1999; Atim, 2001; Ndiaye *et al.*, 2007). However, this is gradually diminishing in the current dispensation:

...the concept was that the providers realised that the communities could not afford the costs of inpatient care due to poverty and resource constraints...It was part of the providers' responsibility to come together to contribute resources...The community also provided support for their members. This is why the Mutual Health Organisations [pre-NHI 2003 MHOs] received tremendous support... (PMS-12)

Some respondents perceive the challenge to be that the current operational procedures under the post-NHI 2003 MHOs era had encouraged an attitude where people are no longer willing to work for the mutual health organisations on voluntary basis. The community members have different department towards programmes that are government-led. The widely held notion is that any project funded by the central government must have financial provision for hiring its human resources component.

Additionally, the perception is that the implementation of the National Health Insurance Act 650 (MOH, 2003d, 2004b), has changed the scope within, which community participation is interpreted. Members' participation in the running of the mutual health organisations is somewhat limited leading to low participation. This is the cause of problems such as the health insurance moral hazards, adverse selection, fraud and abuse of rights that are being perpetrated (refer to 10.2). However, other researchers argue that if members' participation was high, it would encourage the exercise of social controls as well as ensure responsible behaviour (Griffin, 1989; Upton, 1991; Atim, 1998, 1999; Musau, 1999; Ranson, 2002; Eyre & Gauld, 2003).

As the National Health Insurance Act 650 was passed by the Legislature of the Republic of Ghana which is the people's representative Assembly, it is difficult for the ordinary members to call for amendments if they are not happy with any aspects

of the provisions (MOH, 2003d, 2004b). Even when people are finding it difficult to pay their part of the bargain or literally crying that they are finding it difficult to mobilise funds to pay for the costs of their health insurance policies, they could not take any action to review the NHI Act 650:

...I have been following the performance of the schemes very closely and there is no basis for overall simple judgment of better or worse. But if you want to take them issue by issue, then you can say, it was better here, it was better there. For instance, the first issue we talked about is in terms of the community involvement in the management; that one, definitely, it is worse off now than before... (PMS-17)

Another point of view is that the members' sense of ownership has greatly reduced to the level where they do not owe much allegiance. Once a member is able to pay up the premium to register, it is assumed to be enough. Anything that happened from there should be the responsibility of the management of the mutual health organisations. Thus, some respondents perceive that despite the regulatory demonstration of the people's participation, getting members actively involved in their running is doubtful, even though some of the mutual health organisations are making the effort to get some few people on board:

...communities had a wide spectrum of choices to model their schemes [pre-NHI 2003 MHOs]. So they led, they made key decisions, they managed their funds and they led the process of recruitment of members and where they encountered difficulties in terms of resources to bring people together for meetings during the initial stages, the donors and the development partners supported...(PMS-11)

It is further perceived that even though the NHI Act 650 (MOH, 2003d), requires the management teams with the support of their Board of Directors to revise the premiums, in practice, any revision of the administration fees is done without the full involvement of the entire members. It was not demonstrable as yet to see any Annual General Meeting (AGM) decision, which had resulted in the modification of how they are run or packaged:

...the Annual General Meetings (AGMs) were being organised and held to fulfil a requirement and governance of the mutual health organisations as codified under the Act 650...People's involvement had been reduced and oversimplified to the Board of Directors and once the Boards were involved, the people were involved...(PMS-17)

The evidences confirm the observation that in most developing countries, the role of the state in the health sector has normally sought to weaken civil society and subdue private and community initiatives (Mills *et al.*, 2001). However, it could also be argued that while the community's role has been re-organised on the basis of modern governance model, this appears unsuitable to the remotest communities in Ghana (refer to 5.2.1). Given that the above issues are resolved, then the need for triangulating the social policy theory with community field theory can be enhanced. Similarly, the actions of the government on one hand and the community actors can also be enhanced (see sub-title below).

11.3.5. Enhancing Complementarity between Social Policy and Community Field Theories

It would be recalled from chapters 3 and 4 that whilst it is viewed that governments' role in providing tax funded health system as well as regulatory mechanism is not commensurate with efficiency, reviews of rural risk-sharing schemes try to project the idea that governments and other social actors would have to play a major role if mutual health organisations are to be scaled up as part of a national strategy (Vogel, 1990b; Creese and Bennett, 1997; Atim, 1998, 2001; Tabor, 2005; Poletti *et al.*, 2007). This is true in the case of the mutual health organisations in Ghana. Again, as the role of government in sustaining the mutual health organisations cannot be overemphasised, the challenge remains as to how to balance the need for government support with how to guarantee the freedom of the mutual health organisations from excessive government control (Huber *et al.*, 2002). There is the need to balance political interest with the spirit of the operations of the mutual health organisations such that they might not be placed in any awkward situation.

Hence, to interpret the findings of this study, it is imperative to resolve the issue of perceived less complementarity arising from the roles supposed to be performed by the government and community. This is aided by a combination of the social policy and community field theories. It is important to ask whether the community can co-exist with the government. The social policy and community field theories need to be propelled to achieve maximum effect in the mutual health organisations environment. This would harmonise the activities of government and the community so that they could achieve uniform objectives rather than working in parallel to each other. The government and the community have to work in unison. Anything to the contrary would spell the collapse of the mutual health organisations. This is because of the delicate governance system operating in Ghana, where people owe allegiance to their Chiefs first and foremost before anything else (Baffour-Arthur, 2001). Geelhoed (2003), observes that the specific context of living of the Akan people in Ghana implicated the existence of alternative understandings of disease aetiology and its influence on health care seeking behaviour. There are socio-cultural circumstances, which must be recognised (Geelhoed, 2003; Stekelenburg *et al.*, 2005).

11.4. Summary of the Chapter

This chapter has explained the findings of the empirical study from the public sector's perspective using the social policy theory. Additionally, it has explained the findings from the point of view of community sector using the community field theory. Thus, these two theories have been triangulated due to the empirical findings. This is the result of the interaction between the government and the community. However, the findings indicate that in the context of Ghana, there could be perceived less complementarity when using two theories to explain health sector reforms from both the public and community perspectives. This must be resolved before the necessary complementarity can be enhanced. The next chapter presents the conclusion of the study.

CHAPTER 12

CONCLUSION OF THE STUDY

12.0. Introduction

This chapter presents the conclusions from the entire study. It is divided into five (5) sections. Section one (1) is the summary of the study, which takes cognisance of all the findings of the empirical study and their relationship to the key research objectives and questions. Section two (2) postulates the contributions that this study makes to knowledge. Section three (3) presents a brief limitation to the study. Section four (4) presents possible areas for future research. Section five (5) is the concluding statement where the major ideas are summed up.

12.1. Summary of the Study

The study aimed to investigate the health sector reform in the context of developing countries. To meet this aim, it has analysed the problems of financial access to health and evaluated the financial, institutional and social dynamics of mutual health organisations as innovative and newly emerging mechanisms seeking to help resolve these problems in Ghana. This was also realised by relying on empirical study conducted in Ghana which assessed the current financial viability of the four mutual health organisations in this study. Additionally, other external agencies whose activities have influence on the performance of the mutual health organisations have been examined. Thus, apart from using the financial performance indicators to establish the current status of the organisations as well as project into their future financial viability, other equally important non-financial indicators were also used to determine sustainability. Social policy and community field theories were combined to explain the empirical findings.

12.1.1. Financial Viability of the Mutual Health Organisations

The government of Ghana was expected to step in to ensure that the mutual health organisations operate effectively and remain financially viable. The study concludes that the mutual health organisations in this study are financially viable as long as there will be government subsidy through the National Health Insurance Fund (NHIF). However, they would not be financially viable without subsidy-funding due to the

perceived uncontrollable high utilisation rate, occurrence of health insurance fraud, moral hazard and associated exorbitant claims made on them by their contracted health care providers. That is, even though their reserve funds (refer to p.150; 9.2.4.5; and see appendix M) show that they are able to generate revenue, their expenditures and other overheads indicate that in the foreseeable future they would require regular government subsidy through the National Health Insurance Fund (NHIF), which is serving as reinsurance (Dror and Preker, 2002; MOH, 2003d). Otherwise, they would encounter financial difficulties in meeting unabated debts to health care providers (Osei *et al.*, 2007).

The study argues that the financial viability of the mutual health organisations is not dependent only on informal sector premiums, as they could not pay off their claims to health care institutions without supplementing it with the government subsidy (NHIF). Therefore, if they do not make any conscious attempt to recruit more people from the informal sector, they would be unable to pay necessary bills when they achieve autonomy in the long run (MOH, 2003d). This confirms the findings of Fairbank and Diop (2003), among other researchers, in that while community-based health insurance schemes (CBHI) may offer the benefits of risk-spreading (health-risk) they themselves may be at risk of insolvency (Fairbank and Diop, 2003; Derriennic *et al.*, 2005). Prudent financial measures are also needed to ensure that the subsidy from the government is judiciously utilised.

The reasons for the above conclusions have been expatiated. That is, applicable indicators have been examined to put the above conclusions in a certain perspective, as explained below.

12.1.1.1. Reserve Funds of the MHOs

The study argues that whilst the MHOs might have reserves because their third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1, 9.2.4.1; and see appendix I), there were no balance sheets to strengthen this point. Thus, it is essential to recall from chapter 8 that 'surplus' is used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150; 9.2.4.5; and see appendix M). This was the

basis upon which their financial performance and viability was measured in this study. Even though their reserve funds (refer to p.150; and see appendix M) show that they are performing well, their expenditures and other overheads (operating costs) indicate that in the foreseeable future they would require regular government subsidy through the National Health Insurance Fund (NHIF), which is serving as reinsurance (Dror and Preker, 2002). The reserve funds (refer to p.150; and see appendix M) will not be able to help them meet increasing expenditures caused by excessive utilisation of health care by their members within a period of at least three or six months (refer to chapters 9 and 11). This must also be viewed in relation to the approach adopted to define 'reserve fund' in this study, which is appropriate under the circumstance since other researchers have applied it in their studies. Therefore, there are limitations in using the actual reserves (see ILO, 2005), to establish the financial viability of the mutual health organisations in this study, which is similar to earlier findings (see Atim, 1998, 2001; Atim *et al.*, 1998, 2001a; Musau, 1999).

12.1.1.2. Ratio of Coverage of Expenses of the MHOs

In as much as the study argues that the MHOs might have reserves because their third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits (refer to 9.2.1, 9.2.4.1; and see appendix I), there were no balance sheets available to establish this fact. Therefore, it is imperative to recall from chapter 8 that 'surplus' is used as a proxy for 'reserves' in this study to signify the surplus (es) accrued by the four MHOs at the end of the financial year (refer to p.150; 9.2.4.5; and see appendix M). This was the approach used to measure their financial performance and viability (refer to chapters 9 and 11). In view of this, on the basis of the ratio of coverage of expenses, the study observes that there are variations with regards to how the mutual health organisations are performing to ensure their own financial viability. The overall conclusion is that it is not certain whether their accumulated reserve funds (refer to p.150) could help them pay average expenses for at least a period of three or six months without resorting to borrowing (refer to chapters 9 and 11). A similar observation has been documented by other researchers (see Atim, 1998, 2001; Atim *et al.*, 1998, 2001a; Musau, 1999).

12.1.1.3. Ratio of Operating Costs to Income of the MHOs

Using the ratio of operating costs to income to measure the financial performance and viability of the mutual health organisations, the study concludes that their performance is not very good because the management teams are not doing very well in restraining subsidiary costs to running their schemes. All the mutual health organisations are performing differently in respect of how they are spending on administration and management-related costs. Almost all the mutual health organisations recorded ratio of operating costs to income of more than the stipulated 5 percent (refer to chapters 9 and 11). The mutual health organisations depend heavily on FM radio stations and mobile van to educate and sensitise the people in their respective communities during registration periods. Meanwhile using these channels of communication have high cost implications. These costs have the propensity to rise as time goes on since the mutual health organisations are located in district and urban areas where there are sparse population settlements (see GSS, 2005). As management teams have to travel to these communities, they will continue to incur huge vehicle running costs. Hence, traditional modes of communication have to be integrated into their social marketing strategies to bring these costs under control. This observation is common with studies conducted on similar schemes in Ghana and other parts of Western and Central Africa region (see Atim, 1998; Atim *et al.*, 1998, 2001a; Musau, 1999).

12.1.1.4. The Effect of Excessive Healthcare Utilisation Rate on the MHOs' Finances

The study concludes that the mutual health organisations would not be financially viable without subsidy-funding due to the perceived uncontrollable high utilisation rate. Importantly, the increase in the expenditure of the mutual health organisations is orchestrated by certain factors which are beyond their control as their members are utilising high rates of health services. The intensity of this problem can be understood when measured in financial terms with respect to how much they are paying for health care claims from their contracted health care providers (refer to chapters 9, 10 and 11). The study concludes that the management teams seem to lack the capacity in risk management techniques to deal with these health insurance risk factors: adverse selection, moral hazards and abuse of health services (refer to 3.3, 10.2 and chapter

11). This is the root cause of the doubt usually expressed about the financial sustainability of such schemes (see Musau, 1999).

12.1.1.5. The Effect of NHI Act 650 Tariff Structure on PIS Income of the MHOs

The study argues that the financial viability of the mutual health organisations is not dependent only on informal sector premiums as they could not pay off their claims to health care institutions without supplementing it with the government subsidy (NHIF). The study concludes that the inability of the mutual health organisations to raise enough revenue from their paying informal sector members is caused by the rigidity in the tariff structure set under the NHI Act 650 (see MOH, 2003d, 2004b). While there is the urgent need for government to review the tariffs under the NHI Act 650 (MOH, 2003d, 2004b), the management teams also need to make conscious attempt to recruit more people from the informal sector. Otherwise, they would be unable to pay necessary bills when they achieve autonomy in the long run (see MOH, 2003d; Fairbank and Diop, 2003; Derriennic *et al.*, 2005). However, prudent financial measures are also needed to ensure that the subsidy from the government is astutely utilised.

Due to lack of, or inadequate financial data obtained from the mutual health organisations, some of the ratios in the financial viability model (refer to table 8.3) were analysed but found to be insignificant in drawing conclusions about their financial performance and viability in this study. These are: ratio of subscriptions to expenditure and ratio of efficiency in collecting dues. However, liquidity ratio and solvability ratio could not be computed due to lack of financial data like balance sheets (refer to chapters 8, 9 and 11). As a result, 'surplus' was used as a proxy for 'reserves' in this study to indicate the surplus (es) accrued by the four MHOs at the end of the financial year. Nonetheless, when the financial performance on the basis of the ratio of coverage of expenses of the MHOs; and ratio of operating costs to income of the MHOs were evaluated, these were found to be less encouraging. The results were constrained by both internal and external influences. Therefore, the study concludes that the financial issues in this study are influenced by complicated statistical or health insurance risk management problems in the operations of the mutual health organisations (refer to chapters 2, 3, 8, 9 and 11).

12.1.2. Influence of Government Regulation on the MHOs

The study also concludes that the intervention of the government of Ghana in the operations of the mutual health organisations through the implementation of the National Health Insurance Act 650 (MOH, 2003d), increased and expanded the number of mutual health organisations in Ghana: from small group-based schemes to district-wide schemes (refer to 10.3 and chapter 11). The recruitment of the people in the country has been encouraging, which is in common with the findings of Apoya (2003), and other researchers (see Atim *et al.*, 2001a, 2001b; Kankye *et al.*, 2001; Apoya, 2003; Bennett, 2004; MOH, 2006, 2007a, 2007b, 2007d, 2007e, 2008; Boateng, 2008).

The study findings demonstrate that the implementation of the National Health Insurance Act 650 and the Legislative Instrument L.I. 1809 had institutionalised the mutual health organisations as a health financing mechanism in Ghana (MOH, 2003d, 2004b). This has provided a well defined management structure and regularised staff within the civil service human resources codifications. Hence, the focus of the mutual health organisations in Ghana has changed due to the strong political will and commitment being demonstrated by the government. There is a gradual acceptance of the concept of mutual health organisations as defined by the government of Ghana. The conclusion is similar to other studies which argue that the intervention of government in the mutual health organisations environment has the propensity to increase their membership as well as ensure fair financing in a country (Atim, 1998, 2001; Carrin *et al.*, 2003; Devadasan *et al.*, 2004; Poletti *et al.*, 2007).

The study also argues that the effect of government's regulation of the mutual health organisations in Ghana has been a difficult process. Despite observed positive effects, the implementation of National Health Insurance Act 650 (MOH, 2003d), has equally led to diminished community initiatives in the area of health financing strategies and has contributed to the complete collapse of the original small group-based schemes. This conclusion confirms similar observations that excessive government involvement could lead to interference and collapse of mutual health organisations (Ron, 1999; Atim, 2003).

12.1.3. Influence of Government Participation on Health Financing

The International Monetary Fund (IMF) and World Bank (WB) economic development agenda within which Ghana is operating supports the neo-classical economic theorists' position that economic development is closely linked to the private sector. Hence, the thrust for operating this health financing strategy is that health insurance will grow if the economy grows but if the economy does not grow, health insurance may collapse (Arrow, 1963; Lees, 1963; Henry, 1990; Berman, 1995; Culyer, 1989a, 1989b; McGuire *et al.*, 1989; Preker and Harding, 2000; WB, 2008). The study argues that government's participation has influenced health financing by instituting a social health insurance scheme in Ghana. This is why the mutual health organisations strategy was fused with the social health insurance under the National Health Insurance Scheme (NHIS).

Ultimately, the expectation of government of Ghana is that as the National Health Insurance Scheme (NHIS) is linked to access through the National Health Insurance Levy, therefore the assumption is that if the economy grows and consumption improves, more money would be pumped into the National Health Insurance Fund (NHIF) [(MOH, 2003d, 2004b)]. This would enable the government to contain any social costs of adjustments. Thus, this would encourage more people, especially, the poor to enrol and utilise health care through the mutual health organisations (MOH, 2003d). On the other hand, the government realised that since the informal economy is not growing rapidly, more people could not manage to enrol into the social health insurance scheme because they could not afford the premiums or are not SSNIT contributors.

The study reveals that in communities where infrastructure and resources are available, the number of economically active members of the population had increased, and with such increases people had become financially more self-sufficient. Therefore, the numbers with social health insurance (refer to 9.3.2.3) show that the mutual health organisations are more successful in the urban areas than rural areas, which could be attributed to disparity in economic resources. However, in terms of their community health insurance (refer to 9.3.2.4) approach the mutual health organisations are more successful in rural areas than in urban areas. This confirms the findings of other researchers that mutual health organisations have the potential to

attract more people in the informal sector economy (Atim, 1998, 2001; Carrin *et al.*, 2003; Devadasan *et al.*, 2004; Poletti *et al.*, 2007; Jacobs *et al.*, 2008).

12.1.4. Influence of Community Wealth (Social and Human Capital) on the MHOs

The study concludes that the sustainability of the mutual health organisation strategy based on the community 'self-health-financing' initiative depends upon the active involvement of traditional leadership, socio-cultural dynamics and a vibrant informal sector of Ghanaian economy. The findings demonstrate that the cost required by a viable mutual health organisation is dependent upon the vibrant informal sector of the community, district and region in which it is situated. The informal sector depends on community resources: both human and social capital to generate income (refer to chapter 4). Thus, the wealth of the community is one of the yardsticks for measuring the sustainability of mutual health organisations. This is similar to the findings of researchers like Schneider *et al.* (2001a, 2001b). However, there is the need to resolve the problems of transport and communication between the urban and rural health facilities, which is having a negative impact upon members' finances and health care access. This agrees with findings of Stekelenburg and other researchers (Tsey, 1997; Stekelenburg *et al.*, 2005).

12.1.5. Problems facing the Mutual Health Organisations

An irregular flow of funding has been the main reason why health financing strategies had failed to achieve universal financial protection for Ghana (Mwabu, 1990, Hoare, 1987). The mutual health organisations are facing some critical problems, which are likely to affect their financial and sustainability overtime. There are observed problems with late release of reimbursement funds from central government for discharging claims to contracted health care providers (MOH, 2003d, 2004b). Thus, despite the institution of management structures to streamline their operations, the mutual health organisations are experiencing problems due to government bureaucracy (refer to 10.2).

This is impacting heavily on the financial and strategic management and decision making processes of the health institutions located in the operating districts of the mutual health organisations in this study. Health managers are unable to fulfil their contractual obligations to suppliers as their capital funds are locked up with the mutual health organisations. Thus, the study argues that the delay in the release of government subsidy is a critical factor leading to delay of insured clients to health care institutions. The health institutions therefore, prefer to treat patients who come under the 'Cash and Carry' group since they provide prompt payment; to the detriment of insured clients whose reimbursement is delayed with the overall effect of causing the institutions to be cash-trapped. This is affecting members' perception of quality of care (refer to 10.2). This is similar to the findings of Anie and other researchers (Anie *et al.*, 2001; De Allegri *et al.*, 2006). Therefore, there is a perceived tension between the mutual health organisations and health care institutions, which it is recommended requires urgent attention.

12.1.6. Improving Financial Viability of the Mutual Health Organisations

This part presents a number of recommendations for policy makers and mutual health organisations regarding how to improve financial viability and overall sustainability in the long term. In sub-Saharan Africa, mutual health organisations have contributed immensely to the general goals of the health sector. With respect to national health financing policy reforms, they are contributing to Primary Health Care goals (WHO, 1978). This study argues that the mutual health organisations might be used as test beds for embarking on nationwide social health insurance schemes. This confirms the findings of researchers such as Atim (1998, 1999, 2000, 2001, 2003).

Specifically, in Ghana, from 2004, the mutual health organisations had been able to assist the government in identifying the main areas of health financial risks they could share. They had provided the grounds for the next phase of the health sector reform, which saw the introduction of the National Health Insurance Scheme (MOH, 2003d, 2004b). This confirms the recommendations of Carrin and other researchers (2001), that there is the need for a certain degree of government regulation if mutual health organisations are to be scaled up and considered as intermediate stage towards

universal risk protection (Xu *et al.*, 2003; Carrin *et al.*, 2001; Poletti *et al.*, 2007; Chankova *et al.*, 2008).

To assuage the few problems, there is the need for a mechanism that would ensure that the system becomes efficient. In the light of this, the following recommendations are made for policy consideration as discussed below.

12.1.6.1. Prudent Financial Management System for MHOs

This part suggests the need for prudent financial management and monitoring systems to ensure the viability of the mutual health organisations. Although, the evidence from this study suggests that the overhead cost (operating cost) of running the mutual health organisations is an insignificant fraction of their expenditures, individual mutual health organisation analysis shows that this component is rising (refer to chapters 9 and 11). Unquestionably, the community approach to health insurance has a certain cost dimension and if the overhead cost is high, it will provide a source of concern. One important dimension of financial viability is the urgent need to examine the overhead costs (operating costs). This also depends on other indicators involved but not restricted to managerial competencies in managing limited financial and material resources. A more robust financial disbursement system should be fashioned out of the Ministry of Finance and Economic Planning (MOFEP) funding regime for the National Health Insurance Council and Authority (NHIC and NHIA). This will facilitate early release of NHIF to enable the mutual health organisations to reimburse health care claims to their contracted health care providers, promptly. The Monitoring and Evaluation units of both the National Health Insurance Council and Authority (NHIC and NHIA); the Ghana Health Service/Ministry of Health (GHS/MOH) and the Ghana Audit Service should be resourced to be able to carry out their expected functions.

12.1.6.2. Flexible Tariff Structure for MHOs

This part presents a recommendation on the need for flexible tariffs for all mutual health organisations in the country. There is the need for policy makers to look at the whole tariff structure. The tariff under the NHI Act 650 (MOH, 2003d, 2004b), is designed in such a way that it covers very little of the total cost of providing health services, and that is problematic. There had been recent review of some aspects of the

National Health Insurance Drugs List under the NHI Act 650 (see Akanzinge, 2007, 2008). However, the tariff structure remains problematic for many people in the rural communities whose sources of income depend on agriculture. This confirms the argument by Wagstaff and other researchers (2001), that poverty is widespread in most developing economies (Wagstaff *et al.*, 2001; Carrin, 2003; Carrin and James, 2005). A review of the tariffs under the NHI Act 650 (MOH, 2003d, 2004b), would encourage the people in the communities to enrol and maintain long term membership. That is, flexible and graduated premiums should be set. This should start from below the minimum ₵72,000.00 to meet the financial capacity of the people in the informal sector of the economy. At the same time, government must institute some mechanisms for co-payment for people who can afford the premiums.

12.1.6.3. Government Subsidy to Enhance Financial Viability of MHOs

This part also indicates the need for government subsidy to ensure financial viability of mutual health organisations, especially, in Ghana. The intention of the government of Ghana was to put measures in place to ensure that the poor people had access to health care (MOH, 2003d, 2004b). This might mean that the mutual health organisations might not be financially viable if they continue to register only people in poverty with acute social needs. The concern is that there might be less incentive to register poor people because it costs more money to register them. Therefore, in the short to medium term, the government would have to support the mutual health organisations with a subsidy to enable them to cover people living in poverty in the population (see GSS, 2005). This also means that there is still the need for the full integration of the private mutual health insurance schemes (PMHIS) which might be facilitated by providing them with some sort of government subsidy (refer to 10.3). This will ensure that they contribute to the attainment of the universal health care financing coverage by enrolling people in the informal sector who are not able to raise the minimum premium of ₵72,000.00 set under the NHI Act 650 tariffs structure (MOH, 2003d, 2004b). Hence, there is the need to create incentives for more people to enrol with the mutual health organisations. The absence of these would make the mutual health organisations less sustainable. A similar recommendation has been documented by some researchers (see Devadasan *et al.*, 2004).

12.1.6.4. Portability of MHOs' Services

This part recommends the need for portability of mutual health organisations' services in the country. The lack of portability where insured members are unable to move from one mutual health organisation to another to access health care services that are of the expected quality outside their localities means that the mutual health organisations are operating independently of each other. This is affecting membership enrolment because people see the mutual health organisations as national institutions which should therefore, have national standards (refer to chapters 9, 10 and 11). The accepted understanding is that their success or failure is largely dependent on how they could link up with the agencies and groups that operate within and outside the communities. The mutual health organisations need to realise that the activities of external agencies and stakeholders, including, health care institutions would impact either positively or negatively on their performance as they strive for financial and overall sustainability. This agrees with the recommendations by previous researchers (Scott, 1981; Forsyth, 1990; Atim, 1998; Carrin, 2003; Sonnemans *et al.*, 2006).

12.1.6.5. Non-Politicisation of MHOs

This part makes a recommendation regarding the need for non-politicisation of the mutual health organisations in Ghana, in particular and sub-Saharan Africa, in general. In a country where matters of national interest are sometimes politicised it is important for the management of the mutual health organisations to be cautious of their association with any one particular political group. A clear message is needed to the effect that the National Health Insurance Scheme (NHIS) is for the whole nation and not for any one particular group of political adherents (refer to chapters 9, 10 and 11). If this is achieved it would increase enrolment because the Chiefs and the Churches would encourage their constituents; health providers would give the necessary health education to their clients; and the politicians would add their voices. Failure to do this would encourage members who do not share similar political ideals to stand up against the programme by dissuading other people. This is similar to the recommendations made by Ron (1999) and other researchers, that there should be less government interference in the management of mutual health organisations (Ron, 1999; Atim, 2003; GNeMHO, 2003, 2004).

12.1.6.6. Replication of MHOs' Model of Health Financing

Here, the need to identify a suitable development model for Ghana in particular and sub-Saharan Africa in general is recommended. There is the need to find common grounds to enhance development by reconciling the difficulties encountered in adopting reform models which do not appear suitable to the Ghanaian context. The study concludes that development models need not be imposed on the community due to the nature of Ghanaian socio-cultural environment (refer to chapters 4, 5, 6 and 11). The study argues that a purely community led programmes may not be financially viable as this could lead to implementation difficulties. Therefore, for developing countries including, Ghana, there is the need to bring together all development paradigms to ensure effective centralised initiatives and activities. However, this must not neglect the community's involvement (refer to chapters 9, 10 and 11). Analysis of this area may help to develop suitable models needed for effective public health financing and administrative practices.

As a result, there is the need to replicate mutual health organisations' experience in sub-Saharan Africa. The study identified some important outcomes or influences. It contributes towards emerging health financing policy. The study is relevant at a time that most developing countries are struggling to find suitable and lasting solutions to their health financing problems. There are suggestions in this study for policy considerations concerning the way forward, using Ghana as a benchmark (refer to chapter 11). There are practical outcomes for government policy-making with implications for the people of Ghana and the health care delivery efforts. The study highlights the implications of the involvement of Chiefs as well as the Clergy in supporting the mutual health organisations. The influence of customs and community leadership and how such factors influence policy implementation has been revealed (refer to chapters 7,9,10 and 11).

Even though the location and focus of the research is on Ghana, policy makers from other developing countries could draw implications from it to their countries. The study concludes that there is the need for governments and their communities to work hand in hand in managing the mutual health organisations. Excessive interference from the government can kill the community's sense of initiative in the area of health financing strategies. There is a clear need to enhance complementarity in the

operations of the mutual health organisations based on harmonisation of the actions of government and the activities of the community (refer to chapter 11). This complements the suggestions of researchers and analysts including Titmuss (1974, 1987) and Wilkinson (1970, 1991).

12.2. Potential Contributions to Knowledge

The study makes some significant contribution to knowledge. This has been examined in three perspectives, as explained below.

12.2.1. Contribution to Theory

It is important to note that both social policy and community field theories have been applied separately with success in studies conducted in the western world due to the ideological undertones (refer to chapter 4). However, this study has established that in the developing economies like Ghana, it is not possible to apply these theories independent of each other due to the complex social, economic and political contexts (refer to chapters 5, 9, 10 and 11). It shows some elements of perceived less complementarity in the application of social policy and community field theories in the Ghanaian context if used independent of each other. This was only resolved through amicable interplay between both social policy and community field theories (refer to chapters 4 and 11).

Therefore, to be able to apply these theories to explain the findings of this study, there was the need for theory triangulation (see Denzin, 1970, 1978). Hence, the study contributes to knowledge in the sense that it has shown the need for complementarity between social policy and community field theories to explain the findings of this study since one theory may not be sufficient. It also shows that even though health sector reform is explained from public, private and community perspectives (refer to chapter 4), the researcher uses more than one theoretical approach to analyse the findings of the empirical study (see Titmuss, 1974, 1987; Wilkinson, 1970, 1991; Denzin, 1970, 1978; Bowling, 2000). Therefore, health sector reforms in the context of sub-Saharan Africa, especially, Ghana, will have to be interpreted with two theories since one theory may not be sufficient (refer to chapters 4 and 11).

12.2.2. Contribution to Policy

The study contributes to policy by showing the contributions that the emerging mutual health organisations are making towards health financing in developing countries particularly, Ghana under health sector reforms (refer to chapters 2,3,6,7,9, 10 and 11). Under the World Bank and International Monetary Fund economic reform policy which Ghana has been implementing since 1980s, health sector reforms were recommended (MOH, 1996a). This led to the implementation of cost recovery or cash and carry policy as a major source of raising revenue to finance the health sector (MOH, 1985). However, this has proved unsuccessful in Ghana's case because of how its economic environment is constituted. Majority of the people in Ghana are in the informal sector of the economy while the private sector is simply underdeveloped. This has contributed to reduced access to orthodox health care by the people, especially those in the informal sector (refer to chapters 5 and 6).

The government realises this fact that: 'the implementation of the 'Cash and Carry' compounded the utilisation problem by creating a financial barrier to health care access, especially for the poor' (MOH, 2004d: 5). Majority of the people prefer to either stay at home until their health conditions become very critical or patronise the activities of herbalists and other unorthodox health care practitioners, whose methods of health care provision and delivery have been described by the medical professionals as unhygienic and unprofessional (refer to chapters 6, 9 and 10). Moreover, cost recovery or cash and carry's contribution to health sector funding is negligible (see Asenso-Okyere, 1995; Nyonator and Kutzin, 1999; Atim *et al.*, 2001a, 2001b).

This is the reason why the government of Ghana considered another health financing policy option in 2004 (Abbey, 2003; MOH, 2003d). Thus, '...health insurance is to replace the 'Cash and Carry' system of payment of health services consumed...' (MOH, 2004d: 5). Undoubtedly, the implementation of the National Health Insurance Scheme (NHIS) as a source of raising additional revenue for the health sector would have faced serious problems if it had not been modelled on the basis of combined social health insurance and community-based health insurance schemes (see MOH, 2003d, 2004b).

Without a doubt, the social health insurance model alone would have been unsuitable to the socio-economic composition of Ghana (refer to chapter 5). While formal sector employees might have been covered under social health insurance (refer to chapter 2), it is evident that majority of the people who are in the informal sector of the economy would have struggled to be part of it (refer to chapters 3, 6, 7, 9 and 10). In essence, the poor people in the informal sector of the economy might not have seen much difference between the user fees policy and the health insurance policy because the reality is subsumed in the fact that: ‘...it is note worthy that health insurance does not abolish cost recovery but it does replace direct out-of-pocket payment at the point of service use...’ (MOH, 2004d: 5).

The study argues that even with the implementation of the current health financing model under the National Health Insurance Scheme (NHIS) the evidence is still clear that whilst poor people want to contribute their quota in the provision of funding for the health sector through their own subscriptions (refer to chapter 9), they are restricted by the provisions of the National Health Insurance Act 650 (MHO, 2003d, 2004b). Despite the provision of free subsidy or subscription by the government of Ghana for people in the social group: indigents, children under 18 years and the aged (people over 70 years old), most of these beneficiaries are unable to raise the administration fees being charged by the district and municipal mutual health organisations to take full advantage of this facility (refer to 9.1 and 9.4). The study shows the viewpoint that while the government cannot universally provide health care for everyone in the country, it is also clear that the community may feel reluctant to initiate and support their own schemes when there is government intervention (refer to 10.3).

However, the study argues that the implementation of the NHIS as a combination of social health insurance and community-based health insurance schemes by the government of Ghana has shown tremendous benefits for majority of the people in the informal sector of the economy (refer to chapters 9, 10 and 11). The mutual health organisations gave the government of Ghana a strong basis for achieving its policies with regards to the implementation of the risk sharing (health insurance) policy in the year 2004 (see Abbey, 2003; MOH, 2003d, 2004d) under the health financing reforms (refer to chapter 2). Since mutual health organisations are widely available in the

country, it is pertinent to observe that funding health in Ghana can be developed from mutualisation.

The study argues that there is some level of interaction between public sector funding and community sector revenue mobilisation under health sector reforms in Ghana. Consequently, the study contributes to policy by showing that there can be a successful interplay between public sector funding and community sector revenue mobilisation for financing the health sector in Ghana. This justifies the complementarity between the government funding and the community's resource mobilisation efforts in the health sector. This has proved very successful through social movements such as mutual health organisations in Ghana (see Develtere, 1993; Atim, 1999). There is therefore, the need for the government to work with the community to get support for its level of intervention in health sector reforms (refer to chapters 2, 3, 7, 9, 10 and 11).

12.2.3. Interplay between Financial, Institutional and Social Viability Models

The study raises methodological issues about the right model to use to measure financial performance and viability of mutual health organisations in Ghana (refer to chapters 3, 8, 9, 10 and 11). Although the financial viability model is adapted for use by mutual health insurance schemes in western, central, eastern and southern Africa (Atim, 1999; Cripps *et al.*, 2003), some of the indicators are not applicable in the current study. It is therefore, important to harmonise the financial viability with institutional and social viability models (refer to tables 8.3, 8.8 and 8.9). The reasons have been explained below.

From the financial viability perspective, the study argues that while liquidity ratio and solvability ratio were difficult to apply in the current study, due to lack of data, some other ratios were calculated but found to be insignificant in the interpretation of financial performance and viability of mutual health organisations in Ghana. This also shows the intricate statistical issues embedded in the financial analyses in this study (refer to chapters 9 and 11). Arguably, the measurement of the performance of the mutual health organisations on the basis of ratio of coverage of expenses showed some inconsistencies. Their overall performance on this is seen as poor. Again, measuring their performance on the basis of ratio of subscriptions to expenditure was

difficult to measure since they could not raise enough dues from their informal sector membership to meet their recurring expenditures. Moreover, it was difficult to calculate this ratio as the subscriptions from all the members of the mutual health organisations could not be accounted for apart from the paying informal sector memberships.

Using the ratio of operating costs to income to measure financial performance and viability of the mutual health organisations also indicate that they are not performing creditably. It was only Asona MHO which managed to control its operating costs within the 5 per cent limit. The Aduana MHO, Asakyiri MHO and Biretuo MHO exceeded the 5 per cent limit within the two financial periods of 2005 and 2006. This is due to the vastness and sparse nature of their population settlements and the kind of mobilisation efforts they have to put in to encourage paying informal sector members to enrol (refer to chapters 9, 10 and 11).

Similarly, measuring their performance on the ratio of efficiency in collecting dues or rate of payment of dues was characterised by some difficulties as well. While the four mutual health organisations did not make any projections for the 2005 and 2006 financial periods, the researcher had to use the 2005 accrued premiums from the paying informal sector memberships to project for the 2006 financial year. Even here, the performance of the four mutual health organisations was adjudged to be poor. Apart from the Asona MHO which was able to raise substantial revenue from its paying informal sector members because it is located in an urban town, the Aduana MHO, Asakyiri MHO and Biretuo MHO could not mobilise enough revenue from this category of membership during the 2006 fiscal period due to rigidity in the implementation of the NHI Act 650 tariff structure (see MOH, 2003d, 2004b). The general conclusion is that these ratios were found to show little impact on the assessment of financial performance and viability of the mutual health organisations in this study (refer to chapters 9, 10 and 11).

Therefore, the study argues that it is important to look beyond financial ratios as basis for measuring financial viability of mutual health organisations in developing countries especially, Ghana (see Brignall, 1993; Brignall and Ballantine, 1996; Cochrane, 1993; Johnson and Kaplan, 1987; Johnson, 2001; Tsamenyi *et al.*, 2008).

Consequently, other performance indicators which are suitable to the socio-economic circumstances of Ghana must be used in concert with the financial indicators to explicate the financial as well as overall sustainability of mutual health organisations. This explains the need to use institutional and social viability as other models to examine the viability of mutual health organisations, as evidenced in this study (refer to chapters 3, 9, 10 and 11).

From the perspective of institutional viability, the study argues that the implementation of National Health Insurance Act 650 (MOH, 2003d, 2004b), since 2004 had enabled mutual health organisations to be recognised as viable institutions in Ghana (refer to 9.1 and 10.3). Mutual health organisations are able to enrol more members in the population since they are operating on district-wide and municipal-wide levels, according to the policy of decentralisation (refer to 9.3). The provision of subsidy to serve as reinsurance is making the viability objective of mutual health organisations very encouraging. This has also enabled mutual health organisations to address the problem of access to health financing confronting people classified as social group members in the population (refer to chapters 9, 10 and 11).

From the perspective of social viability, the study argues that Ghana is a dynamic country and there is the need to utilise existing social networks to ensure the viability of mutual health organisations. Through inter-family and inter-tribal relationships, people are able to support one another in times of economic and financial difficulties in accessing health care (refer to chapter 5). They are demonstrating the sense of mutuality, solidarity and community ownership to embrace and support the ideals of their respective mutual health organisations. Members of the communities are using the invaluable social and human capital instincts, enhanced by their respective community resources and wealth to sustain the various district and municipal mutual health organisations. These are invaluable instincts or ingredients needed to enhance government policies. As a consequence, the study contributes to knowledge by arguing for interplay between financial, institutional and social viability models when measuring the financial and overall sustainability of mutual health organisations, at least in Ghana (refer to chapters 3, 7, 9, 10 and 11).

12.3. Limitations of the Study

There are some limitations to this study, which future researchers should note and seek to address. Use of qualitative research methodology means that it can be difficult to generalise from individual experiences in the case studies since they are not population based (Gummesson, 1991). Thus, out of the total 134 district-wide and municipal-wide mutual health organisations established at the time of the study in 2006 (MOH, 2006), only four (4) operating mutual health organisations were selected for this study. However, the criteria used assisted with the fair selection of these mutual health organisations based on regional and geographic levels (refer to chapter 8).

The financial viability model adopted could not be applied effectively in this study to establish the financial performance of the mutual health organisations due to limitations in the financial statements provided (refer to chapters 8, 9 and 11). The study shows that the model is difficult to apply in Ghana's case since the mutual health organisations in this study are modelled as a fused social health insurance and community-based health insurance schemes under the supervision of their respective district and municipal Assemblies. They are not operating as smaller and group-based schemes (compare with chapters 3 and 7). However, this problem was rectified by successful interplay between financial, institutional and social viability models to explain the financial and overall sustainability of the mutual health organisations in this study (refer to chapters 3, 9, 10 and 11).

There are arguments regarding validity and reliability of qualitative research when case studies and interviews have been used. Hence, the researcher was cautious in drawing general conclusions from the study. Criticising case studies, Gummesson (1991), surmises they lack statistical validity and can be used to generate hypothesis but not to test them. Due to this, generalisations cannot be made on the basis of case studies. However, the findings of this study are justified since all the district-wide and municipal-wide mutual health organisations in Ghana are confronted with the same problems, which they share at their peer review meetings under the auspices of the Network of Mutual Health Organisations-Ghana (see GNeMHO, 2003, 2004).

Moreover, the process of triangulation was applied to validate what appeared to be valuable explanation (see Denzin, 1970; Silverman, 2006). That is, data were collected at different times and places and from different people or tribes. Multiple methods were used to collect the data and multiple measurements were also applied within the same method. This agrees with methodological triangulation and is further augmented by the application of two theories: social policy and community field. There was the use of more than one theoretical approach to the analysis which satisfied theory triangulation. This way, the validity and reliability of the data are enhanced (Denzin, 1970, 1978; Bowling, 2000).

12.4. Directions for Future Research

The findings of the study highlight the problem of health financing facing the government of Ghana in particular and in sub-Saharan Africa countries in general. Certain areas are suggested for consideration for future research.

1. Although the study brings to light the fact that the health care institutions are using client and price discrimination strategies to ensure their own financial sustenance, there is still the need to evaluate the effect this has on health efficiency goals. There is the need to investigate the implications of the complaints that health insurance card bearers are being discriminated against.
2. Even though the study identifies that the mutual health organisations are charging the minimum premium set under the National Health Insurance Act 650 (MOH, 2003d, 2004b), there are still immeasurable number of people in the informal sector who could not raise the premiums due to rigidity in the application of the NHI Act 650. There are problems with statistical determination of suitable premiums for people in the informal sector coupled with the management teams' inability to manage health insurance risks. Whilst means testing might not be the most suitable option, there must be real actuarial studies of the costing of health care services; to explore a system for equity of payment in the informal sector of the economy.

3. Improved access to orthodox health care through the mutual health organisations is likely to prolong the life expectancy of the population. However, in Ghana at the moment, there is no scientific study to show whether the increased life span equates to health status. This must be investigated in future research endeavours.

12.5. Concluding Statement

The evidences through this study respond to the generally held view in the literature that while employers seek to contain their health care costs and politicians create coverage mechanisms to promote individual empowerment, there are still people with health problems forced to bear the brunt of their own medical costs (Crossley, 2005). The seeming presence of inequity amongst the very poor people in the population also agrees with similar studies, which conclude that although the mutual health organisations have the potential to extend coverage of health care to the informal sector population, they are not able to achieve comprehensive coverage of the poorest of the poor in all cases (see Ron, 1999; Atim, 1998, 2000; Carrin *et al.*, 2001; Huber *et al.*, 2002; Xu *et al.*, 2003; Devadasan *et al.*, 2004; Poletti *et al.*, 2007; Franco *et al.*, 2008). In order to ensure their effective scaling up and maintain financial viability the study concludes that there is the need for some form of government regulation and subsidy. However, since government regulation cannot work without the acceptance of the community, there is the need to integrate these actors in policy formulation.

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Appendices

Appendix A: Administrative Structure of Pre-NHI 2003 MHOs

Design Features

The tools developed by these international donors and non-governmental organisations (NGOs) provided a form of organised structure with the community context in mind. The main features have been explained by Kankye (2001) as below.

Constitution

The Mutual Health Organisations have their own constitutions, which spell out the legal provisions that define and regulate their business operations. The rights and obligations of officers and members, benefits package and established procedures and processes are coded in the constitution. It also establishes the kind of relationship that exists between the Mutual Health Organisations and their members and the health providers.

Membership and Responsibilities

Membership is via one or all of the following criteria: anyone who lives in a particular area or community and is able to pay their premium regularly; anyone who comes from the area or community but lives outside the community and is able to pay their premium regularly; and people may also join through groups and other associations extant in the locality. Duties of members may include: paying up contributions on regular basis and promptly; the need to attend meetings on regular basis; no attempt to cheat on the scheme because punishment is outright dismissal from the group; the need to observe agreed rules and regulations; and the right to have a say in the management of the scheme.

Ownership

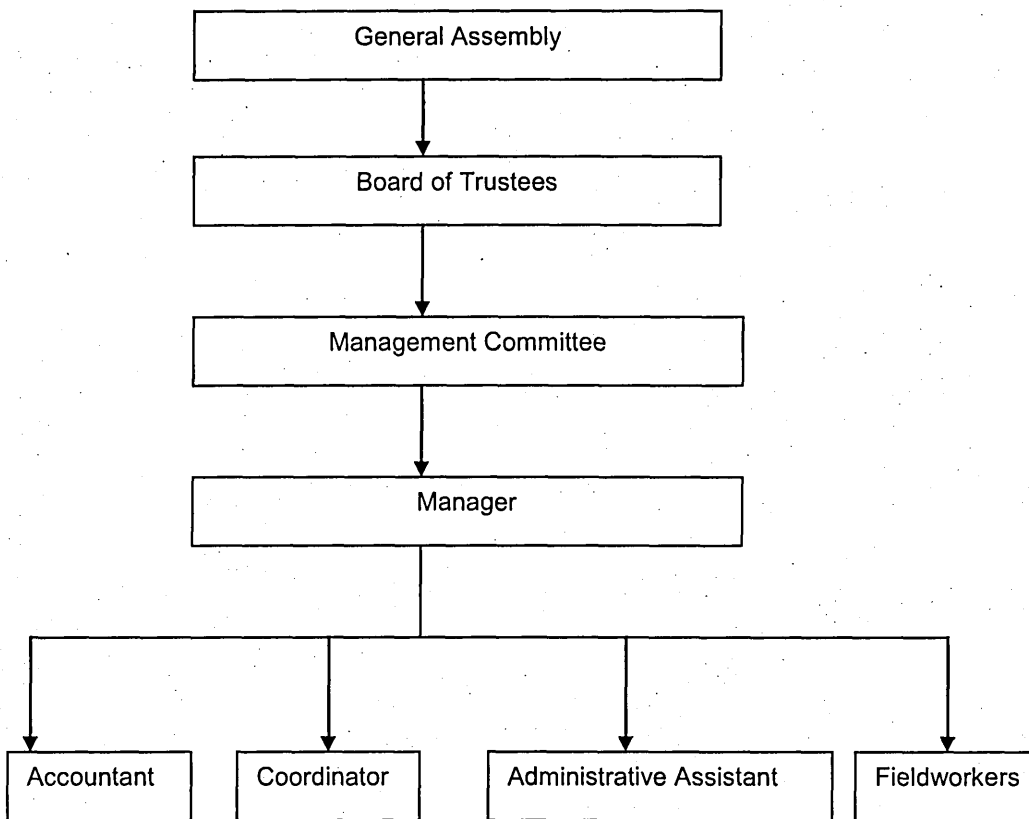
The ownership is unique in the sense that all members who have paid up fully their premiums have ownership rights and they meet to elect those who will manage the scheme. They exercise their right of ownership at the Annual General Assembly meetings as enshrined in their constitutions. The amount and level of premium to be paid is decided amongst the members who have to agree to it. This subsists on the type and cost of health services members decide to provide for themselves. Large

membership is the aspiration of Mutual Health Organisations so they try to keep the premium low by going for inexpensive services so that the members can afford.

Organisational Structure

A Mutual Health Organisation may be designed to suit the local human resource capacity of the community in which it is located. Typically, the organisational structure may be as shown in the figure below. The main arms of the organisation are as discussed here (Kankye, 2001).

Organisational Structure of an MHO



Source: Kankye, 2001

General Assembly

This is the supreme body of the Mutual Health Organisation and comprises all members who have paid up their dues up to date. This body ensures that duties are delegated to all the other sub-arms of the scheme and meets once a year but may also

meet under ordinary and extra-ordinary sessions. In large communities, there could be 'nominated delegates' who attend the Annual General Assembly and may be democratically, nominated on a quota or proportionate basis. For instance, one delegate nominated for every hundred members by the respective communities. The delegates may usually include members of the insurance sub-committees, who are selected on such qualities as: probity, competence and availability. Their duty may be to ensure that the information and decisions taken are communicated to the members and members' wishes also communicated to the General Assembly (Kankye, 2001).

Board of Trustees

The Board of Trustees may consist of the Chairman, the Vice-Chairman, the Secretary General and six (6) other members appointed by the members.

Management Team and Management Committee

The Mutual Health Organisations have their own management teams who administer the day-to-day efficient and effective operations. The management team may usually compose of people like the vice-chairman of the Board, Secretary General, the Insurance Manager and two (2) Co-ordinators. The specific task of the management team consists of putting into action risk management measures, data management systems for monitoring costs, and internal control measures to prevent health insurance fraud. They also liaise with the community members, service providers and administrative staff. The management team members are supposed to be translucent and make sure that they give regular detailed reports to their members.

Internal Audit Committee (IAC)

For effective monitoring and supervision, an Internal Audit Committee (IAC) with three or more members is nominated by the General Assembly. The committee has the responsibility to supervise, monitor and control the activities of the management of the scheme so as to ensure its survival as well as protecting the interest of the members. This committee is empowered to call extra-ordinary General Assembly meetings if they discover any anomalies caused by management. It is also expected to redress grievances brought before it by members (Kankye, 2001).

Appendix B: Characteristics of Case Study Mutual Health Organisations

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
Region	Greater Accra	Ashanti	Eastern	Brong Ahafo
Status	Ordinary District	Ordinary District	Municipal District	Ordinary District
District Population 2006	121,000	146,000	147,000	150,000
Regional Population Labour Force-2000	Male: 15.3 Female: 15.4	Male: 19.4 Female: 18.8	Male: 11.1 Female: 11.2	Male:9.7 Female: 9.5
Regional Economically Active Population-2000	Urban:88.3 Rural:11.7	Urban:50.7 Rural:49.3	Urban:33.4 Rural:66.6	Urban:36.3 Rural:63.7
Duration	7years	2years	2 years	15 years
Membership 2006	21,000	42,000	88,000	65,000
Health Facilities	Health Centres (No Hospital)	District Hospital, Private Hospital, CHAG Hospital	Regional Hospital and Private Hospital	District Hospital and Health Centres

Population figures were estimates as at 2006

Appendix C: Research Participant's Consent Form
Sheffield Hallam University – United Kingdom
Research Participant Information Sheet

Project Title: Health Sector Reforms – A Study of Mutual Health Organisations in Ghana

This Participant Information Sheet explains the nature and purpose of the research. It is important that you read and understand before you agree to take part. You are invited to participate in the study voluntarily.

The purpose of the research is to assess (find your views about) the Mutual Health Organisations as new health care financing mechanism(s) helping to resolve the problems of health care financing facing developing countries with reference to Ghana. It is a study which is in partial fulfilment of the award of Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University in the United Kingdom.

You have to understand that you may withdraw from the research at any stage and that this will not affect your status now or in the future. You need to understand that while information gained during the study may be published, you will not be identified and your personal results will remain confidential. However, where there would be the need to quote you, this will be mutually agreed upon with the researcher.

Please understand that you will be digitally recorded during the interview. However, if you do not want to be digitally recorded, make this known to the researcher.

Please understand that data will be saved on the laptop when it is downloaded from the digital recorder pen. The hard and electronic copies of the transcript will also be stored for a maximum period of 5 years after the completion of the thesis by the researcher. Also understand that access to this data will be granted to only people who will use it for academic purpose(s).

There will not be any material benefits to you for taking part in this research. However, the expected benefits will be derived when the outcome of the study has made useful contribution to knowledge now or in the future.

It is also useful for you to understand that you may contact the researcher or supervisors if you require further information about the research. You may also contact the Research Ethical Review Committees of both Sheffield Hallam University, United Kingdom and the Ghana Health Service, if you wish to make a complaint relating to your involvement in the research.

Contact details:

Researcher: Mr Augustine Afari-Adomah,
Sheffield Business School
Sheffield Hallam University, City Campus, Howard Street,
Sheffield, S1 1WB, South Yorkshire, United Kingdom
Supervisors: Prof. J.A. Chandler & Prof. G.A. Mountain (address as above).

Appendix D1: Rate of Membership Coverage of the Catchment Population of the Aduana MHO: 2005-2006

2005				2006	
Group	Category	Number	Total	Number	Total
Subsidised Members	Indigent	2,319	9,000	1215	12,000
	SSNIT Pensioners	32		81	
	SSNIT Contributors	816		1710	
	Aged (70+)	525		1045	
	Children (under 18 years)	<u>5,308</u>		<u>7,949</u>	
	Paying Informal Members	18-69 years		5,000	
Grand Total		14,000		21,000	
Population		98,000		121,000	
% coverage of population		14.2		17.3	

Appendix D2: Rate of Membership Coverage of the Catchment Population of the Asakyiri MHO: 2005 - 2006

2005				2006	
Group	Category	Number	Total	Number	Total
Subsidised Members	Indigent	326	15,000	1,038	36,000
	SSNIT Pensioners	39		80	
	SSNIT Contributors	3,315		2,562	
	Aged (70+)	2,190		1,741	
	Children (under 18 years)	<u>9,130</u>		<u>30,579</u>	
	Paying Informal Members	18-69 years		3,000	
Grand Total		18,000		42,000	
Population		126,000		146,000	
% coverage of population		14.2		28.7	

Appendix D3: Rate of Membership Coverage of the Catchment Population of the Asona MHO: 2005 - 2006

2005				2006	
Group	Category	Number	Total	Number	Total
Subsidised Members	Indigent	4,140		1,315	
	SSNIT Pensioners	5,222		1,605	
	SSNIT Contributors	15,145		12,203	
	Aged (70+)	7,756		8,938	
	Children (under 18 years)	22,737		55,000	
	Paying Informal Members	18-69 years	22,000		25,000
Grand Total		87,000		88,000	
Population		138,000		147,000	
% coverage of population		63.0		59.8	

Appendix D4: Rate of Membership Coverage of the Catchment Population of the Biretuo MHO: 2005 - 2006

2005				2006	
Group	Category	Number	Total	Number	Total
Subsidised Members	Indigent	444		4,521	
	SSNIT Pensioners	107		176	
	SSNIT Contributors	1,986		2,426	
	Aged (70+)	4,109		4,052	
	Below 18 years	36,354		43,000	
	Paying Informal Members	Informal (18-69 years)	26,000		27,000
Grand Total		69,000		65,000	
Population		139,000		150,000	
% coverage of population		49.6		43.3	

Appendix E: Health Care Benefits of Members – Post-NHI 2003 MHOs

The benefits discussed under the Act 650 apply to both the District Mutual Health Insurance Schemes and the Private Mutual Health Insurance Schemes. However, the Private Commercial Health Insurance Schemes are also been required to provide acceptable level of health care benefits to their members. Members of the Mutual Health Insurance Schemes are to enjoy benefits spelt out under section 33 subsections 1 and 2 of the Act 650 as:

1. A District Mutual Health Insurance Scheme is to be operated exclusively for the benefit of the members.
2. A District Mutual Health Insurance Scheme shall be provided with subsidy from the National Health Insurance Fund (MOH, 2003d:19).

The health care benefits prescribed by the Act 650 are summed up in section 19 subsections 1 to 4 of the Legislative Instrument LI 1809, which include:

1. For the purposes of section 64 of the Act, the minimum health benefits set out in Part 1 of Schedule II to these Regulations shall be available to members registered with a scheme licensed under the Act,
2. A Scheme may despite sub regulation (1) provide for its members health care services over and above the minimum benefits specified in Part 1 of Schedule II subject to the payment of such additional premium as is agreed upon by the Scheme and the members; and for this purpose the scheme is not required to adhere to the National Insurance Drug List.
3. A District Mutual Health Insurance Scheme shall not provide the healthcare services over and above the minimum specified in Part I of Schedule II unless it has the prior approval of the Council.
4. The public health care services specified in Part 3 of Schedule II shall be paid for by Government and shall be free (MOH, 2004b).

Specifically, outpatient (OPD) and In-patient (Admissions) services have been summarised under the Legislative Instrument (LI 1809), which the District Mutual Health Insurance Schemes are to provide for their members. The Ghana Health Service (GHS) has also summarised these services for health care institutions as presented below (see GHS, 2004).

Outpatient Services

The following out-patient services shall be provided for members by the Schemes: consultations, including, reviews by both general and specialist; requested investigations for general and specialist outpatient services such as laboratory, x-ray, ultrasound scanning among others; medication, including prescription drugs on the National Insurance Scheme Drug List (NISDL), traditional medicines approved by the Food and Drugs Board (FDB) and prescribed by accredited practitioners; out-patient or day surgical operations such as hernia repair, incision and drainage, haemorrhoidectomy and outpatient physiotherapy (see MOH, 2004b; GHS, 2004b).

In-patient Services

Included in the in-patient services for members and exempted members of the schemes are: general and specialist inpatient care; requested investigations for in-patient care in the areas of laboratory, x-ray, ultra sound; medication covering prescription drugs on the NHI drug list, blood and blood products; surgical operations; in-patient physiotherapy; accommodation on the general ward and feeding, where available (MOH, 2004b, 2004d; GHS, 2004b).

Specific Services

Among the specific services to be provided by the schemes include oral health:

1. Pain relief for tooth extraction, temporary relief, incision and drainage;
2. Eye care services: refraction, visual fields, a-scan, keratometry, cataract removal and eye-lid surgery;
3. Maternity care: antenatal care, deliveries both normal and assisted, caesarean section and postnatal care; and
4. Emergencies: medical emergencies, surgical emergencies, paediatric emergencies, obstetric and gynaecological emergencies and road traffic accidents (MOH, 2004b, 2004d; GHS, 2004b).

The NHI 2003, Act 650, also spells out the type of health service providers to deal with the health insurance schemes for purposes of accreditation as indicated below.

Categories of Health Service Providers

The following health service providers may be accredited by the National Health Insurance Council (NHIC) to provide health care to the members of the Mutual Health Insurance Schemes:

1. Teaching, Regional and District Hospitals.
2. Quasi public hospitals, including, the Police and Military.
3. Public Health care centres.
4. Private hospitals and clinics.
5. Mission hospitals.
6. Pharmacy and chemical shops.
7. Accredited traditional health practitioners.
8. Other health care facilities as determined by the National Health Insurance Council (MOH, 2004b, 2004d; GHS, 2004b).

The health care providers are required to apply to the National Health Insurance Council for accreditation before they can enter into contractual agreement with the Mutual Health Insurance Schemes.

Appendix F: Professional Background of Staff of the four MHOs

Position /Qualification	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
Manager	1 st Degree	1 st Degree/Diploma Ed, LLB	Tertiary	Bachelor of Arts
Accountant	HND	HND (A/c), BSc. (Finance)	Tertiary	HND
Public Relations Officer	1 st Degree	HND (Marketing)	Tertiary	GCE O'Level
Claims Manager	HND	HND, BSc. (HR)	Tertiary	GCE O'Level
Management Information Systems Manager	1 st Degree	HND, Diploma in Computer Science	Tertiary	Vacant at the time of study
Date Entry Clerk	SSS Graduates	Diploma in Computer Science	Secretarial (NVQ)	Secretarial (NVQ)

Appendix G: Cost of Health Insurance Policy of the MHOs: 2005-2006 (old cedis, €)

Scheme	Premium 2005	Admin Fees	Total	Premium 2006	Admin Fees	Total
Aduana MHO	72,000.00	10,000.00	82,000.00	72,000.00	28,000.00	100,000.00
Asakyiri MHO	72,000.00	28,000.00	100,000.00	72,000.00	28,000.00	100,000.00
Asona MHO	72,000.00	28,000.00	100,000.00	72,000.00	48,000.00	120,000.00
Biretuo MHO	72,000.00	28,000.00	100,000.00	72,000.00	28,000.00	100,000.00

NB: Exchange rate: £1 = €18,000.00 old cedis in November, 2006.

**Appendix H: Summary of Financial Performance & Viability Ratios of the MHOs: 2005 – 2006
(old cedis, ₵)**

Scheme	Indicator	Year: 2005	Year: 2006
Aduana MHO	Total Income	1,873,000,000.00	1,983,000,000.00
	Total Expenditure	1,776,000,000.00	997,746,000.00
	Reserve Funds*	97,000,000.00	985,254,000.00
	LR	-	-
	SR	-	-
	RCE	0.65	11.85
	RSE	0.36	0.29
	ROCI	0.18	0.14
	RECD	-	0.45
Asakyiri MHO	Total Income	1,474,000,000.00	1,588,000,000.00
	Total Expenditure	864,742,000.00	1,327,000,000.00
	Reserve Funds*	609,258,000.00	261,000,000.00
	LR	-	-
	SR	-	-
	RCE	8.45	2.36
	RSE	0.50	0.20
	ROCI	0.16	0.11
	RECD	-	0.62
Asona MHO	Total Income	2,758,000,000.00	8,404,000,000.00
	Total Expenditure	2,340,000,000.00	7,874,000,000.00
	Reserve Funds*	418,000,000.00	530,000,000.00
	LR	-	-
	SR	-	-
	RCE	2.14	0.80
	RSE	0.35	0.22
	ROCI	0.03	0.01
	RECD	-	2.1
Biretuo MHO	Total Income	4,876,000,000.00	9,256,000,000.00
	Total Expenditure	2,656,000,000.00	7,972,000,000.00
	Reserve Funds*	2,220,000,000.00	1,284,000,000.00
	LR	-	-
	SR	-	-
	RCE	10.03	1.93
	RSE	0.75	0.43
	ROCI	0.05	0.23
	RECD	-	1.74

NB: Exchange rate: £1 = ₵18,000.00 old cedis in November, 2006.

* The surplus at the end of the financial year (see appendix M).

- Data not available.

**Appendix I: Source of Income as a Percentage of Total Income of the MHOs:
2005 – 2006 (old cedis, ¢)**

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Income	1,873,000,000.00	1,474,000,000.00	2,758,000,000.00	4,876,000,000.00
NHIF Income	1,158,000,000.00	875,635,000.00	1,897,000,000.00	2,797,000,000.00
NHIF as %	62	59	69	57
PIS Income	652,773,000.00	439,595,000.00	842,289,000.00	1,993,000,000.00
PIS as %	35	30	31	41
Other Income*	62,950,000.00	158,898,000.00	18,743,000.00	85,689,000.00
Other Income as %	3	11	0.7	2
2006				
Total Income	1,983,000,000.00	1,588,000,000.00	8,404,000,000.00	9,256,000,000.00
NHIF Income	1,656,000,000.00	1,245,000,000.00	6,544,000,000.00	5,768,000,000.00
NHIF as %	84	78	78	62
PIS Income	294,430,000.00	274,352,000.00	1,769,000,000.00	3,472,000,000.00
PIS as %	14	17	21	38
Other Income*	32,758,000.00	68,645,000.00	90,765,000.00	15,496,000.00
Other Income as %	8	4	1	0.2

NB: Exchange rate: £1 = ¢18,000.00 old cedis in November, 2006.

* This might be part of the MHOs' reserves since it constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits. However, there were no balance sheets to prove it.

**Appendix J: Expenditure as a Percentage of Total Income of the MHOs: 2005 – 2006
(old cedis, ¢)**

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Income	1,873,000,000.00	1,474,000,000.00	2,758,000,000.00	4,876,000,000.00
Total Expenditure	1,776,000,000.00	864,742,000.00	2,340,000,000.00	2,656,000,000.00
Exp. as %	95	59	85	54
2006				
Total Income	1,983,000,000.00	1,588,000,000.00	8,404,000,000.00	9,256,000,000.00
Total Expenditure	997,746,000.00	1,327,000,000.00	7,874,000,000.00	7,972,000,000.00
Exp. as %	50	84	94	86

NB: Exchange rate: £1 = ¢18,000.00 old cedis in November, 2006.

**Appendix K: NHIF Claims as a Percentage of Total Health Care Claims of the MHOs:
2005 – 2006 (old cedis, ¢)**

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Claims	592,594,000.00	295,586,000.00	1,620,000,000.00	1,736,000,000.00
NHIF Claims	689,865,000.00	750,435,000.00	1,483,000,000.00	1,947,000,000.00
Difference*	97,271,000.00	454,849,000.00	137,000,000.00	211,000,000.00
NHIF Claims as %	116	254	92	112
2006				
Total Claims	661,647,000.00	722,205,000.00	17,206,000,000.00	5,869,000,000.00
NHIF Claims	1,295,000,000.00	220,120,000.00	13,200,000,000.00	5,455,000,000.00
Difference*	633,353,000.00	502,085,000.00	4,006,000,000.00	414,000,000.00
NHIF Claims as %	196	30	77	93

NB: Exchange rate: £1 = ¢18,000.00 old Ghana cedis in November, 2006.

* Shows only: 1) the amount of money accrued to the MHOs as a surplus when the NHIF released towards Claims only, is in excess after paying off the Total Health Care Claims to their contracted health care providers (when the NHIF Claims is above 100%); and 2) the amount of money the MHOs had to supplement with the NHIF released towards Claims only, to pay off the Total Health Care Claims submitted by their contracted health care providers (when the NHIF Claims is less than 100%).

**Appendix L: Paying Informal Sector (PIS) Income as a Percentage of Total Income of
the MHO: 2005–2006 (old cedis, ¢)**

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Income	1,873,000,000.00	1,474,000,000.00	2,758,000,000.00	4,876,000,000.00
PIS Income	652,773,000.00	439,595,000.00	842,289,000.00	1,993,000,000.00
PIS as %	35	30	31	41
Members	5,000	3,000	22,000	26,000
2006				
Total Income	1,983,000,000.00	1,588,000,000.00	8,404,000,000.00	9,256,000,000.00
PIS Income	294,430,000.00	274,352,000.00	1,769,000,000.00	3,472,000,000.00
PIS as %	14	17	21	38
Members	9,000	6,000	25,000	27,000

NB: Exchange rate: £1 = ¢18,000.00 old cedis in November, 2006.

Appendix M: Reserve Funds of the MHOs: 2005–2006 (old cedis, ¢)

Description	Aduana MHO	Asakyiri MHO	Asona MHO	Biretuo MHO
2005				
Total Income	1,873,000,000.00	1,474,000,000.00	2,758,000,000.00	4,876,000,000.00
Total Expenditure	1,776,000,000.00	864,742,000.00	2,340,000,000.00	2,656,000,000.00
Surplus* (+) or Deficit (-)	97,000,000.00	609,258,000.00	418,000,000.00	2,220,000,000.00
2006				
Total Income	1,983,000,000.00	1,588,000,000.00	8,404,000,000.00	9,256,000,000.00
Total Expenditure	997,746,000.00	1,327,000,000.00	7,874,000,000.00	7,972,000,000.00
Surplus* (+) or Deficit (-)	985,254,000.00	261,000,000.00	530,000,000.00	1,284,000,000.00

NB: Exchange rate: £1 = ¢18,000.00 old cedis in November, 2006.

NB: Reserve Fund is defined as total income minus total expenditure (refer to p.150).

* Surplus at the end of the financial year is used as a proxy for reserves/reserve funds due to unavailability of balance sheets. However, it could be argued that the MHOs might have reserves because their third source of income: the 'Other Income' (OI) constitutes financial contributions from donor organisations and philanthropists or accrued interests on fixed deposits.

Appendix N: List of Research Participants

Participant's Institution	Acronym of Participant	Date of Interview
Policy Makers, Stakeholders etc	PMS-1	15.12.2006
	PMS-2	04.01.2007
	PMS-3	19.12.2006
	PMS-4	20.12.2006
	PMS-5	20.12.2006
	PMS-6	19.12.2006
	PMS-7	04.12.2007
	PMS-8	12.12.2006
	PMS-9	27.11.2006
	PMS-10	28.11.2006
	PMS-11	18.12.2006
	PMS-12	14.12.2006
	PMS-13	03.01.2007
	PMS-14	13.12.2006
	PMS-15	20.12.2006
	PMS-16	12.12.2006
	PMS-17	12.12.2006
	PMS-18	07.12.2006
	PMS-19	20.11.2006
	PMS-20	28.11.2006
	PMS-21	24.11.2006
	PMS-22	21.11.2006
Health Managers and Personnel	HMP-1	30.11.2006
	HMP-2	16.11.2006
	HMP-3	16.11.2006
	HMP-4	23.11.2006
	HMP-5	04.12.2006
	HMP-6	21.11.2006
	HMP-7	17.11.2006
	HMP-8	24.11.2006
	HMP-9	16.11.2006
	HMP-10	20.11.2006
	HMP-11	30.11.2006
	HMP-12	07.12.2006
Scheme Managers of the Mutual Health Organisations	SMMHO-1	08.12.2006
	SMMHO-2	28.11.2006
	SMMHO-3	18.11.2006
	SMMHO-4	23.11.2006

Appendix N: List of Research Participants

Participant's Institution	Acronym of Participant	Date of Interview
Aduana Mutual Health Organisation -Members	ADMHO-M-1	08.12.2006
	ADMHO-M-2	07.12. 2006
	ADMHO-M-3	08.12. 2006
	ADMHO-M-4	08 .12.2006
	ADMHO-M-5	07.12. 2006
	ADMHO-M-6	08.12. 2006
	ADMHO-M-7	08.12. 2006
	ADMHO-M-8	08.12. 2006
	ADMHO-M-9	08.12. 2006
	ADMHO-M-10	07.12. 2006
-Non-Members	ADMHO-NM-1	07.12.2006
	ADMHO-NM-2	08.12.2006
	ADMHO-NM-3	08.12.2006
	ADMHO-NM-4	07.12.2006
	ADMHO-NM-5	07.12.2006
Asakyiri Mutual Health Organisation -Members	ASKMHO-M-1	23.11.2006
	ASKMHO-M-2	24.11.2006
	ASKMHO-M-3	24.11.2006
	ASKMHO-M-4	23.11.2006
	ASKMHO-M-5	23.11.2006
	ASKMHO-M-6	23.11.2006
	ASKMHO-M-7	23.11.2006
	ASKMHO-M-8	23.11.2006
	ASKMHO-M-9	23.11.2006
	ASKMHO-M-10	23.11.2006
-Non-Members	ASKMHO-NM-1	23.11.2006
	ASKMHO-NM-2	24.11.2006
	ASKMHO-NM-3	23.11.2006
	ASKMHO-NM-4	24.11.2006
	ASKMHO-NM-5	24.11.2006

Appendix N: List of Research Participants

Participant's Institution	Acronym of Participant	Date of Interview
Asona Mutual Health Organisation -Members	ASNMHO-M-1	03.12.2006
	ASNMHO-M-2	01.12.2006
	ASNMHO-M-3	05.12.2006
	ASNMHO-M-4	30.11.2006
	ASNMHO-M-5	01.12.2006
	ASNMHO-M-6	01.12.2006
	ASNMHO-M-7	03.12.2006
	ASNMHO-M-8	27.11.2006
	ASNMHO-M-9	28.11.2006
	ASNMHO-M-10	28.11.2006
-Non-Members	ASNMHO-NM-1	01.12.2006
	ASNMHO-NM-2	29.11.2006
	ASNMHO-NM-3	01.12.2006
	ASNMHO-NM-4	01.12.2006
	ASNMHO-NM-5	04.12.2006
Biretuo Mutual Health Organisation -Members	BRMHO-M-1	18.11.2006
	BRMHO-M-2	17.11.2006
	BRMHO-M-3	17.11.2006
	BRMHO-M-4	18.11.2006
	BRMHO-M-5	18.11.2006
	BRMHO-M-6	20.11.2006
	BRMHO-M-7	18.11.2006
	BRMHO-M-8	17.11.2006
	BRMHO-M-9	18.11.2006
	BRMHO-M-10	21.11.2006
-Non-Members	BRMHO-NM-1	18.11.2006
	BRMHO-NM-2	17.11.2006
	BRMHO-NM-3	20.11.2006
	BRMHO-NM-4	21.11.2006
	BRMHO-NM-5	17.11.2006

Appendix O: Interview Schedule for Policy Makers and Stakeholders

Questions for Empirical Study: November, 2006-January, 2007

SHEFFIELD HALLAM UNIVERSITY – UNITED KINGDOM

Interview Questions

The aim of this interview is to assess your views about the Mutual Health Organisations, as a new health care financing mechanism in Ghana. It is part of a study which is in partial fulfilment of the award of a Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University, United Kingdom. Please be assured that whatever discussed here will be taken in strict confidence. Where there will be the need to quote you, this will be mutually agreed upon.

Question: Are the Mutual Health Organisations (MHOs) financially viable?

1. How did the idea of Mutual Health Organisations come about / what is the main phenomenon (underlying the formation) of Mutual Health Organisations?
2. What accounting systems do you have in place for MHOs' reimbursements in the country?
3. What accounting control mechanisms do you have in place to curtail health insurance risks?
4. Would you say that the MHOs are financially viable to ensure their members' access to health care in the country?
5. Would you say that the schemes are financially viable beyond donor funding or support?
6. Would you describe the MHOs as cost effective enough to assure financial access to health care in the country?

Question: How does the institutional framework influence the financial viability and performance of the mutual health organisations (MHOs)?

1. Which framework did the MHOs operate with before the introduction of the new law (NHI 2003)?
2. Could you explain the reasons for the introduction of the NHI 2003 and inclusion of MHOs? Thus, what do you see as the role of MHOs under the NHI 2003?
3. Have the MHOs satisfied the NHI 2003, NHIR LI1809 staffing requirements?
4. What is the expected effect of the NHI 2003 on MHOs which were not operating under government regulation? Thus, have there been any changes in the operations of MHOs since the introduction of NHI 2003?

5. Are there any strategies in place to expand membership /coverage of the scheme(s) in the country?
6. How would you assess the performance of the scheme in terms of membership coverage, before and after the introduction of the new law (NHI 2003)? Thus, what is the impact of new policies /legislation on the financial viability of MHOs in the country?
7. What are the benefit packages for members of the MHOs in the country?
8. What is the framework for international donors and NGOs under the NHI 2003 in their dealings with the MHOs?
9. Would you say that the current membership of the scheme(s) is a true reflection of what they can achieve in meeting the targets of their catchment population(s)?
10. What is the framework for other supporting institutions (e.g. district institutions, social traditions, etc) in the national health care financing drive?
11. What is the relationship between National Health Insurance Secretariat (NHIS) and other institutions in the health insurance domain (e.g. MHO self developed institutions and others nationwide)?
12. What is the National Health Insurance Secretariat (NHIS) doing to assist MHOs scale up?

Question: To what extent is the participation of government affecting health financing?

1. Could you give an idea about the government's current funding of health care services in the country?
2. What is the proportion of private health care financing in the country?
3. Could you give an idea about the impact of user fees on health service delivery in the country?
4. Could you explain the expected contribution of health insurance to universal health access and coverage?
5. Could you describe the extent to which community financing schemes (MHOs) can help alleviate the problem of health care financing and access in the country?
6. What do you see as the effect of government subsidy or the absence of it on the financial viability of the scheme(s)?
7. Could you explain the reasons why some of the MHOs are not getting any subsidy from the government?

8. Do the health institutions operate any essential drugs policy in their dealings with the health insurance schemes / MHOs?
9. Would you say that the new law (NHI 2003) provides the enabling environment for the scheme(s) to increase membership coverage?

Question: How do the role of community leadership and social dynamics improve the performance of the mutual health organisations as well as enhance the acceptance of government policy?

1. What was, and is, the level of the community's involvement in the establishment and management of the schemes in the country?
2. How would you assess the community's sense of ownership of the schemes?
3. Could you describe the role played and being played by the opinion leaders (Chiefs, Bishops, MPs, Assemblymen & Assemblywomen) in sustaining the schemes?
4. How would you assess the influence of opinion leaders on the implementation of the new law (NHI 2003)?
5. Would you say that the wealth of the community gives credence to the viability of the schemes in the country?
6. What would you describe as the solidarity elements of the schemes and how members feel socially accepted?
7. Could you describe how people's knowledge of health insurance /education, promotion and prevention has/have improved since the introduction of NHI 2003 in the country?
8. Could you describe how you are involved in the decision-making processes of the scheme?
9. Did you offer staff of the MOH/GHS any training in the principles of health insurance to enable them deal with clients of MHOs/Insurance Schemes?
10. Could you explain how you influence the local community to embrace the ideals of health insurance?
11. Could you describe the framework / networks for bringing all stakeholders in the insurance domain together?
12. What basically is your organisation's role in the field of health insurance? Thus, how did you / your organisation get involved with MHOs in Ghana?
13. How would you describe the level of the community's participation in the sustainability of the schemes in the country?

14. What are the steps taken to manage conflict likely to arise from the implementation of the new regulation, and the MHOs self-developed institutional structures?

Question: What are the problems faced by the mutual health organisations?

1. Would you say that the schemes have achieved membership targets?
2. How long do you envisage continuing with your assistance to the MHOs?
3. How do (es) the operation(s) of health insurance affect cost recovery policy in the health sector?
4. Have there been any changes in attendance rate at the health facilities since the implementation of NHI 2003 in the country?
5. Could you describe the kind of support and assistance the health sector receives from international donors or NGOs and the effect of such support on health sector funding?
6. Could the health sector have done, or can do, without support and assistance from International donors and NGOs?

Question: How can the financial viability of the mutual health organisations be improved?

1. What do you think is the costs required by viable MHOs against the background that the new law (NHI 2003; NHIR 2004, LI1809) requires schemes to pay fees for their licenses every two years?
2. What do you think can be done to ensure financial viability of the MHOs?
3. Would you say that citizen's financial access to orthodox health care has improved since the introduction of NHI 2003?
4. Do you believe that the economic status of the members in the communities can ensure financial viability of the schemes?

Appendix P: Interview Schedule for Health Managers and Personnel

Questions for Empirical Study: November, 2006-January, 2007

SHEFFIELD HALLAM UNIVERSITY – UNITED KINGDOM

Interview Questions

The aim of this interview is to assess your views about the Mutual Health Organisations, as a new health care financing mechanism in Ghana. It is part of a study which is in partial fulfilment of the award of a Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University, United Kingdom. Please be assured that whatever discussed here will be taken in strict confidence. Where there will be the need to quote you, this will be mutually agreed upon.

Question: How can Mutual Health Organisations (MHOs) improve health care financial access in the population?

1. Are you an accredited health institution to deal with health insurance schemes (MHOs)?
2. Do you operate any essential drugs policy in your dealings with the Health Insurance Schemes / MHOs?
3. What are the current sources of revenue / income into your health facility (GOG, DPF, IGF)?
4. Could you give an idea about the impact of user fees on your service delivery at the facility?
5. How would you describe the effect of health insurance schemes (MHOs) on financial access to health care? Thus, could you explain the expected contribution of health insurance (MHOs) to universal health access / coverage?
6. How would you assess the performance of the health facility / hospital in terms of utilisation / attendance before and after the introduction of the NHI 2003? – documents
7. Could you describe the extent to which the MHOs can help alleviate the problem of health care financing and access in the country?
8. What procedures and processes do you have in place to attend to members and non members of the MHOs in the health facility?
9. What accounting mechanism / systems do you have in place for your reimbursements (claims) from the MHOs?
10. How do you resolve any financial disagreements with your contracted MHOs?

11. Would you say that the new law (NHI 2003) provides the enabling environment for the schemes to increase membership coverage which will have effect on the performance of the health institutions?
12. Would you say that the MHOs are financially viable to ensure access to health care in the country against the background of the utilisation of health care by their members?
13. How would you assess the influence of opinion leaders on the implementation of the NHI 2003 with consequential effect on health care access?
14. Would you say that the availability and proximity of health care facilities to the MHOs is encouraging their operations?
15. What are the provider-client relationship mechanisms in place to ensure satisfactory service provision to your clients?
16. What is the quality of care systems in place towards improving patients' waiting time?
17. Do you offer your staff any training in the principles of health insurance to enable them deal with clients of MHOs/Insurance Schemes?
18. How do (es) the operation(s) of health insurance affect your cost recovery / abscondence problems?
19. Could you explain how you influence the local community/clients to embrace the ideals of health insurance?
20. How do members of health insurance schemes (MHOs) assess their satisfaction with services received at the health facility?

Appendix Q: Interview Schedule for Scheme Managers-MHOs

Questions for Empirical Study: November, 2006-January, 2007

SHEFFIELD HALLAM UNIVERSITY – UNITED KINGDOM

Interview Questions

The aim of this interview is to assess your views about the Mutual Health Organisations, as a new health care financing mechanism in Ghana. It is part of a study which is in partial fulfilment of the award of a Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University, United Kingdom. Please be assured that whatever discussed here will be taken in strict confidence. Where there will be the need to quote you, this will be mutually agreed upon.

Question: Are the Mutual Health Organisations (MHOs) financially viable?

1. What is / are your source (s) of income?
2. How much is the due(s) / premium (s) for the members?
3. How do you determine the premiums in relation to the benefits packages for members?
4. What accounting system(s) do you have in place for your operations? Thus, how do you reimburse your contracted health care providers?
5. What internal control mechanisms do you have in place to curtail health insurance risks?
6. Would you describe your MHOs as cost effective enough to assure financial access to health care for members in the community?
7. Do you believe that the economic status of the members will help ensure financial viability of the scheme?
8. Would you say that your MHO is financially viable?
9. What do you think can be done to ensure financial viability of the scheme?
10. Could you describe the extent to which your MHO is helping to alleviate the problem of health care financial access for members?
11. How do you assess your financial performance? Thus, how often do you audit your accounts or who are your auditors?
12. Have you measured the scheme's annual income and expenditure over the last 1yr, 2yrs or 3yrs (depending on years in existence)? –documents

Question: What is the impact of government policy or regulation on financial viability of Mutual Health Organisations (MHOs)?

1. What is the current membership of your MHO (compare since introduction of NHI 2003, Act 650)? –before and after NHI- documents
5. Are there any strategies in place to expand membership /coverage of the scheme?
6. How would you assess the performance of the scheme in terms of membership coverage, before and after the introduction of the new law (NHI 2003)?
7. Would you say that the current membership of the scheme is a true reflection of what you can achieve in meeting the targets of the catchment population(s)?
8. What is the impact of new policies /legislation on the financial viability of your scheme?
9. Would you say that the scheme is financially viable beyond donor funding or support?
10. What do you see as the effect of government subsidy or the absence of it on the financial viability of your scheme?
11. Have you satisfied the NHI 2003, NHIR LI1809 staffing requirements?
12. What is the professional background of your staff? –Documents?
13. How do you remunerate / motivate the staff of the scheme?
14. Do you engage in any extra income activities to support the finances of the scheme?
15. What is the effect of the registration fees under NHI Act 650 on the finances of the scheme?

Question: What is the influence of institutional framework on the operations of Mutual Health Organisations?

1. Have you been accredited by NHIC to operate health insurance scheme?
2. How was your Mutual Health Organisation formed / what is the main objective or phenomenon underlying its formation?
3. Which framework (Pre or Post NHI 2003 MHO) did you operate with before the introduction of the NHI 2003?
4. What is the effect of the NHI 2003 on your operations? Thus, how do you foresee your viability under government regulation?

5. How did you / have you managed the change process (if Pre-NHI 2003 MHO) since the introduction of NHI 2003?
6. Would you say that the NHI 2003 provides the enabling environment for your scheme to increase membership coverage?
7. How would you assess your relationship with other supporting institutions (e.g. district institutions, social traditions, etc) in the running of the scheme?
8. What do you think is the costs required to make your MHO viable against the background that the new law NHI 2003 and NHIR 2004, LI1809 require MHOs to pay fees for licenses every two years? Thus, what do you see as the effect of the registration and renewal of license fees (every 2yrs) on the operations (sustainability) of your scheme?

Question: How do (es) the role of the community affect(s) the performance and viability of the Mutual Health Organisations?

1. How do you mobilize/educate the community members on the concepts of health insurance and MHOs in order to encourage them to register with the scheme?
2. Could you describe the role played and being played by the opinion leaders (Chiefs, Bishops, MPs, Assemblymen & Women) in sustaining the scheme?
3. How would you assess the member's sense of ownership of the scheme?
4. How would you describe the level of member's participation in the sustainability of the scheme(s)
5. Would you say that the wealth of the community gives credence to the viability of the scheme?
6. What would you describe as the solidarity elements of the scheme and how members feel socially accepted?
7. How do members assess their satisfaction with services received at the health facility through the scheme?
8. Could you describe the kind of support and assistance you receive from international donors or NGOs and the effect of such support on your operations?
9. Could you have done, or can do, without such support and assistance from International donors and NGOs?
10. What do you see as the major problem(s) impeding the smooth operation of the scheme?

Appendix R: Interview Schedule for Contributors of the MHOs

Questions for Empirical Study: November, 2006-January, 2007

SHEFFIELD HALLAM UNIVERSITY – UNITED KINGDOM

Interview Questions

The aim of this interview is to assess your views about the Mutual Health Organisations, as a new health care financing mechanism in Ghana. It is part of a study which is in partial fulfilment of the award of a Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University, United Kingdom. Please be assured that whatever discussed here will be taken in strict confidence. Where there will be the need to quote you, this will be mutually agreed upon.

Question: How can Mutual Health Organisations (MHOs) improve your financial access to healthcare?

1. How were you motivated to enrol with the MHO? (if insured). Thus, could you describe how you were motivated to join the scheme?
2. Do you have an idea about what health insurance is?
3. How much do you pay as premium for your membership?
4. Could you describe how you manage to pay your premiums looking at your sources of income? Thus, what is the effect of the subscription fee(s) on your finances?
5. Do you know the benefits of your membership?
6. What is the impact of new policies /legislation on your financial ability to pay your dues to the scheme?
7. Could you describe how your knowledge of health education, promotion and prevention has/have improved since joining the MHO?
8. What do you see as benefits of joining a scheme where resources are pooled together to offset costs of health care at the time of need?
9. Could you describe how the scheme worked for you the last time you needed health care?
10. Would you say that the current membership of the scheme is a true reflection of those who can join in the catchment population(s)?
11. How would you assess the performance of the scheme before and after the introduction of new law (NHI 2003)? (if Pre 2003 MHO member)

12. How would you assess the performance of the scheme since joining after the introduction of the NHI 2003? (if Post 2003 MHO member)
13. Could you explain how the scheme can contribute to universal health access?
14. Could you describe how you think the scheme can help alleviate the problem of health care financing in the country?
15. Would you say that the scheme is financially viable to ensure your access to health care in the country?
16. What do you think can be done to ensure financial viability of the MHO/scheme? Thus, can your economic status ensure financial viability of the scheme?
17. Has your financial access to health care improved since joining the scheme?
18. Do you see the scheme as a viable mechanism for your financial access to quality health care in the future?
19. Have you experienced any changes in your dealings with the scheme since the introduction of NHI 2003?
20. What is the framework for other supporting institutions (e.g. district institutions, social traditions, etc) in the national health care financing drive?

Question: How do (es) the role of the community affect(s) the performance and your decision to remain with the Mutual Health Organisation?

1. What was, and is, the level of your involvement in the establishment and management of the scheme?
2. How would you assess the community's (your) sense of ownership of the scheme?
3. How would you assess the influence of opinion leaders on the functioning of the scheme?
4. Would you say that other members of the scheme are willing to sustain the scheme?
5. What would you describe as the solidarity you enjoy as a member of the scheme and how you feel socially accepted?
6. What do you see as the social bonds of belonging to the MHOs?
7. Could you describe what may discourage you from participating in the scheme?

8. Could you describe how the proximity to health care facility encouraged your membership?
9. Could you describe how you are involved in the decision-making processes of the scheme?
10. What are the provider-client relationship mechanisms in place to ensure satisfactory service provision?
11. How do you assess your satisfaction with services received at the health facility / scheme?
12. Could you describe the role played and being played by the opinion leaders (Chiefs, Bishops, MPs, Assemblymen & Women) in sustaining the scheme?

Appendix S: Interview Schedule for Non-Contributors of the MHOs

Questions for Empirical Study: November, 2006-January, 2007

SHEFFIELD HALLAM UNIVERSITY – UNITED KINGDOM

Interview Questions

The aim of this interview is to assess your views about the Mutual Health Organisations, as a new health care financing mechanism in Ghana. It is part of a study which is in partial fulfilment of the award of a Doctor of Philosophy (PhD) degree by the Sheffield Business School, Sheffield Hallam University, United Kingdom. Please be assured that whatever discussed here will be taken in strict confidence. Where there will be the need to quote you, this will be mutually agreed upon.

Question: How can Mutual Health Organisations (MHOs) improve your financial access to healthcare?

1. Have you heard about the Mutual Health Organisation?. Thus, could you describe why you have yet to join the scheme?
2. Do you have an idea about what health insurance is?
3. What do you think will be some of the benefits if we all contribute money into a common fund so that we could access it when sick?
4. As you have not registered, how do you manage your health care costs when sick or go to the health facility?
5. How will it affect your finances if you were able to pay up the premium?
6. What is the impact of new policies /legislation on your financial ability to pay your dues to the scheme if you did register?
7. Could you give an idea about the impact of user fees on your health care access?
8. Could you describe how your knowledge of health education, promotion and prevention can improve if you join the MHO?
9. How would you assess the performance of the scheme before and after the introduction of new law (NHI 2003)? (if Pre 2003 non-MHO member)
10. Could you explain how the scheme can contribute to universal health access?
11. Could you describe how you think the scheme can help alleviate the problem of health care financing in the country?

12. What do you think can be done to ensure financial viability of the MHO/scheme? Thus, can the economic status of the people in the community ensure financial viability of the scheme?
13. Have you experienced any interaction with the management of the MHO since the introduction of NHI 2003?

Question: How do (es) the role of the community leadership affect (s) your decision to embrace government policy?

1. How would you assess the community's (your) sense of ownership of the scheme?
2. How would you assess the influence of opinion leaders on the functioning of the scheme?
3. Would you say that members of the community are willing to sustain the scheme?
4. What would you describe as the solidarity to be enjoyed if you register with the MHO and how you will feel socially accepted?
5. What do you see as the social bonds of belonging to the MHOs?
6. Could you describe what may discourage you from participating in the scheme in the future?
7. Could you describe how the proximity to health care facility can encourage you to join the MHO?
8. Have you experienced any provider-client relationship that can ensure satisfactory service provision by the health care facilities and the MHOs?
9. How do you assess your satisfaction with services received at the health facility as a non-member of MHO?
10. Could you describe the role played and being played by the opinion leaders (Chiefs, Bishops, MPs, Assemblymen & Women) in influencing your decision to join a MHO?
11. What role does your social institution (e.g. district institutions, social traditions, churches etc) support you in accessing health care?

Appendix T: Research Framework: Health Sector Reforms: A Study Of Mutual Health Organisations in Ghana
Analytical and Data Collection Plan- November, 2006-January, 2007
Sheffield Hallam University – United Kingdom

Objective	Research Question	Key research issue	Source of Data	Method /Instrument
1. Describe and analyse problems of financial access to health in developing countries, especially, sub-Saharan Africa	What are the main sources of health financing and delivery?	Current policies and regulations on health financing	Literature Review	-Documentary Analysis
2. Evaluate the reforms in the health sector and the emergence of health financing schemes, especially, mutual health organisations, as innovative mechanisms seeking to help solve the above problems	What is the justification for the health sector reforms in sub-Saharan Africa and Ghana?	-Emergence of mutual health organisations in sub-Saharan African; and -Ghana	-Literature Review -Policy makers and stakeholders -Initiators/Promoters -Donors/NGOs -Staff of MHOs	-Documentary Analysis -Interviews -Audio recording

**Appendix T: Research Framework: Health Sector Reforms: A Study Of Mutual Health Organisations in Ghana
Analytical and Data Collection Plan- November, 2006-January, 2007
Sheffield Hallam University – United Kingdom**

Objective	Research Question	Key research issue	Source of Data	Method /Instrument
<p>3. Evaluate the financial and performance of mutual health organisations as mechanisms to enhance access to quality health care</p>	<p>-Are the mutual health organisations financially viable? -What are the problems faced by the mutual health organisations or health financing? -How can the financial viability of the mutual health organisations be improved?</p>	<p>-Current financial performance and viability of MHOs -Income and expenditure patterns of MHOs -Proactive plans to ensure viability of MHOs</p>	<p>-Case Study -MHOs' financial statements /reports etc -Staff of MHOs -Policy makers and Stakeholders -MHO Members -Non-members of MHOs</p>	<p>-Documentary Analysis -Interviews -Audio recording</p>
<p>4. Investigate the impact of institutional framework such as the National Health Insurance Act 650 (MOH, 2003d) on the operations of mutual health organisations to assess the evolution of the system within an institutionalised context</p>	<p>-How does the institutional framework influence the financial viability and performance of the mutual health organisations? -To what extent is the participation of government affecting health financing?</p>	<p>-The level of understanding of policy makers and stakeholders regarding health insurance in general and mutual health organisations -Implications of government regulation for health financing and access -Membership coverage of MHOs</p>	<p>-Policy makers and stakeholders -Health managers and personnel -Health care utilisation etc -Staff of MHOs, -MHO self-developed support institutions</p>	<p>-Documentary Analysis -Interviews -Audio recording</p>

Appendix T: Research Framework: Health Sector Reforms: A Study Of Mutual Health Organisations in Ghana
Analytical and Data Collection Plan- November, 2006-January, 2007
Sheffield Hallam University – United Kingdom

Objective	Research Question	Key research issue	Source of Data	Method /Instrument
5. Investigate the effect of social dynamics on the performance of mutual health organisations to show the influence of community wealth (social and human capital) and community leadership on policy implementation	How do the role of community leadership and social dynamics improve the performance of the mutual health organisations as well as enhance the acceptance of government policy?	<p>-Perception of the potential contribution of mutual health organisations to enhancing efficiency, utilisation, quality health care delivery and related matters</p> <p>-The influence of the National Health Insurance Act 650 (MOH, 2003d), on the operations of MHOs</p>	<p>-Health managers and personnel</p> <p>-Health utilisation statistics etc</p> <p>-Staff of MHOs</p> <p>-Policy makers and stakeholders</p> <p>-MHO self-developed support institutions</p> <p>-Contributors of the MHOs</p>	<p>-Documentary Analysis</p> <p>-Interviews</p> <p>-Participant observation</p> <p>-Audio recording</p>
		<p>-Perception of the performance and the effectiveness of the mutual health organisations to meeting health care financing needs</p> <p>-Perception of the viability of mutual health organisations as a mechanism to increasing their financial access to health care</p>	<p>-Non-contributors of the MHOs</p>	