

Improving health insurance coverage in Ghana

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Improving health insurance coverage in Ghana: A case study

Agnes M. Kotoh

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This book is dedicated to:

My family and friends who provided my past
and inspired me to realise my academic goals.

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Preface

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Agnes M. Kotoh
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Introduction

Since Ghana gained independence in 1957, the government has searched for health financing arrangements that would ensure equity in access to healthcare. The country is a constitutional democracy with an executive president. Ghana in West Africa is bordered by the Gulf of Guinea to the south, Ivory Coast to the west, Burkina Faso to the north and Togo to the east. The country is divided into 10 regions: Ashanti Region, Brong-Ahafo Region, Central Region, Eastern Region, Greater Accra Region, Northern Region, Upper East Region, Upper West Region, Volta Region, and Western Region. The regions are then divided into second-level administrative districts, and currently there are 170 districts. In line with the country's decentralisation policy, the districts are the basic unit of planning and political administration. The districts implement government policies and their input influences administrative and developmental decision-making. District assemblies provide input that informs Government decisions and policies. The population is 25 million people living in a country that is approximately the size of the United Kingdom and occupies a total land area of 238,539 square kilometres.

In the mid-1980s, a dream of a national health insurance began, but this did not materialise until the National Health Insurance Act (Act 650) was passed in August 2003. The Act enjoined all districts to establish mutual health insurance schemes (Government of Ghana 2003). The National Health Insurance Schemes (NHIS) became operational in March 2004 with the projection that within five years, every resident of Ghana should belong to a health insurance scheme that adequately provided access to quality healthcare. The objective of the NHIS is stated in the National Health Insurance Policy Framework as follows:

Ultimately, the vision of government in instituting a health insurance scheme ... is to assure equitable and universal access for all residents of Ghana to an acceptable quality package of

essential healthcare... Within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out of pocket at the point of service use to obtain access to a defined package of acceptable quality of health service (Ministry of Health 2002 and 2004).

Figure 1.1 Map of Ghana



Source: Google maps

Policy-makers based their decision to introduce the NHIS on the risk-sharing elements that were similar to the traditional solidarity networks that many Ghanaians already participated in. Traditional solidarity networks are based on a relationship of mutual trust and reciprocity for mutual benefit. Therefore, the government presented the NHIS as an opportunity for Ghanaians to protect themselves against ill health, which is not the focus of most informal mutual support groups. Despite the high aspirations and ambitious target, five years later the majority of Ghanaians are still without health insurance. At the beginning of my fieldwork, when I asked a community leader why people were not enrolling, he gave me a sermon. Below is a summary of his words that gives a clear picture of the complex reasons why NHIS coverage is low:

Health insurance is good in the sense that it provides the insured quick access to healthcare. Some of us have not renewed our card because our expectations have not been met. The problem is not so much about the cost of premium, but we want to get drugs at the hospital and not to go about roaming looking for drugs that sometimes you have to pay for even though you are insured. We also want to be treated with respect. There are people who register and wait for so long before getting their card. Others just don't understand why they should pay if they are not going to fall sick.

This study is the anthropological component of a larger research project: 'Reaching the poor in Ghana's NHIS' that explores barriers to enrolment and retention of members and the effect of a multi-stakeholder problem-solving programme (MSPSP) for improving NHIS' enrolment and membership retention rates and

identification of indigents for premium exemption. The project set out to investigate how to improve NHIS coverage using multi-stakeholder groups. The research team for the project included two health economists (Jehu-Appiah and Aryeetey) and one medical anthropologist, the author of this book. Specifically, the research team investigated the low rates of enrolment and retention in the NHIS in Ghana. For the anthropological component of the study, I used an ethnographic approach to hear from stakeholders at all levels of the Ghanaian healthcare system including the patients. Local-level stakeholders of the NHIS (community members, health providers and DHIS staff) gave suggestions for interventions to improve enrolment and retention. The suggested interventions were implemented and their effectiveness evaluated. The findings that are presented in this book include work I performed as a member of the research team, as well as work I conducted alone.

The study used a multi-level approach to determine the feasibility of using multi-stakeholder collaborative groups – problem-solving groups¹ (PSGs) – to stimulate NHIS enrolment and retain members. This approach encourages the engagement of public policy stakeholders to address public policy implementation challenges. The rationale for the PSG concept is encompassed in an Akan² proverb: “*Tikorɔ nkɔ agyina*” (One head does not go into consultation). This implies that problems are better solved when two or more people engage in consultation and share ideas. Thus, PSGs comprised of key NHIS stakeholders were set up in fifteen intervention communities in the Central Region (seven communities) and Eastern Region (eight communities) of Ghana to identify barriers to enrolment as well as to develop and implement interventions to increase enrolment and retain members. The study makes significant contributions to public policy consideration of the use of stakeholder collaborations to address implementation challenges.

Health insurance in Ghana: A brief overview

It is necessary to provide a brief overview of the National Health Insurance Scheme (NHIS) as a relatively new health financing policy in Ghana to contextualise this study.

¹ PSG is a concept used in this study to describe a multi-stakeholder problem-solving group made up of representatives of the three key local stakeholders of the NHIS. The rationale underlying the PSG is that many issues that affect implementation of the NHIS are multi-dimensional such that interventions designed by a single stakeholder working alone might not address problems in the communities; health facilities or DHISs (see further Chapters 4 and 5).

² Akan is the dominant Ghanaian language and spoken by the majority of Ghanaians.

Evolution of national health insurance in Ghana

The genesis of modern healthcare in Ghana dates back to the mid 1800s when the first hospital was built in 1868, which was a British colony at the time (see Senah 1997, Arhinful 2003). Initially, the British wanted to provide affordable healthcare for Europeans, so public health facilities were established in the southern part of the country. Civil and public servants enjoyed free healthcare while the rest of the population paid minimal fees. Interestingly, despite the limited facilities, equity was assured by a payment structure that required higher income earners to pay more when their utilisation exceeded a certain limit (see Arhinful 2003). However, this situation changed in 1930-31 as a result of the Great Depression when the Gold Coast Medical Department increased the fees for private patients. With the passage of the first Hospital and Dispensary Fee Ordinance in 1898, government officials and their dependants were charged small admission fees, while non-official Africans and Europeans paid according to their occupation and status (Arhinful 2003).

In 1952, Ghana was given self-rule, and the Maude Commission's report recommended free healthcare service in public facilities for all Gold Coasters. Since then, attempts to ensure equity in access to quality healthcare resulted in the introduction of various health-financing policies including fee-free³, user-fees⁴, cash and carry⁵, and health insurance.

When Ghana achieved independence in 1957, fee-free healthcare was introduced in all public facilities and at all levels as part of President Nkrumah's socialist development agenda to ensure equity in access to quality healthcare for all Ghanaians. However, during the economic decline in the 1960s, sustaining the free healthcare regime became a challenge. As a result, the government introduced the Hospital Fees Regulation in 1963 (Legislative Instrument (LI) 1277) leading to the implementation of what was termed 'insignificant fees'. After the overthrow of Nkrumah in 1966, the National Liberation Council (NLC) set up the Easmon Committee to revise a range of social and economic policies. The committee recommended that hospital fees be raised. This led to the enactment of the Hospital Fee Decree 360 in 1969, which was followed by the Hospital Fee Amendment Act 325 in 1970 and the Hospital Fee Act 387 in 1971 by the Progress Party under Prime Minister Busia, who took over power from the National Liberation Council (NLC). Under these regimes, user-fees were charged in all public health facilities in the country. The fees were heavily subsidised and negligible, and therefore, healthcare was often described as virtually free. Unsurprisingly, the fees did not solve the

³ Fee-free refers to free access to healthcare for all residents in Ghana at public facilities.

⁴ User-fees refer to out-of-pocket payments for some healthcare services at the point of utilisation.

⁵ Cash and carry led to out-of-pocket payment for full cost of drugs in public health facilities. It was a WHO and UNICEF initiative adopted by African Health Ministers in Bamako, Mali, in 1987, that was expected to improve drug supplies in public health facilities.

problems of shortages of essential drugs, deteriorating buildings or the quality of services (Goodman & Waddington 1993). Nonetheless, further decline in the economy in the late 1970s and 1980s resulted in heavy cuts in budgetary allocations to the health sector and made the system unsustainable. This resulted in consistent shortfalls in drugs, unavailability of equipment and other consumables in public health institutions (Ministry of Health 2002, 2004).

In 1981, the Provisional National Defence Council (PNDC) raised fees for hospital services since the government could no longer bear the full cost of healthcare for all Ghanaians. Notwithstanding the adverse findings that user-fees denied many Ghanaians access to healthcare, the LI 1277 was replaced with LI 1313 in 1985. The LI 1313 was a comprehensive cost-sharing and fee-for-service system except for specified conditions and communicable diseases. The Act aimed to improve the quality of healthcare service, and create a 15 per cent recovery of recurrent expenditure as well as the full-cost recovery of drugs. Although the policy improved the quality of care, shortages of drugs and poor staff motivation negatively impacted the accessibility of vulnerable groups and this was publically criticised. The availability of medicines in health facilities improved, but not all patients were able to pay for their drugs (Asensu-Okyere et al. 1998, Nyongator & Kutzin 1999, Waddington & Enyimayew 1989, 1990, Garshong et al. 2001).

The projection of the negative impact of user-fees on the utilisation and affordability of drugs by vulnerable groups made an alternative healthcare financing policy imperative. As expected, the reaction to the inequity in access to healthcare in a low-income country like Ghana was strong; so the PNDC responded to these criticisms by contracting local and international experts in the early 1990s to make recommendations for creating a national health insurance organisation. At this time, the first Health Sector Five Year Programme of Work project analysed the nation's health. Several challenges including geographical and financial access to basic services, inadequate funding of health services, poor quality of care and poor inter-sectoral linkages were identified as constraints to improving the health of Ghanaians (Aikins 2003). Consequently, many organisations including the International Labour Organisation (ILO), World Health Organisation (WHO) and the European Union proposed establishing national health insurance to improve healthcare delivery in the country.

As a result, in August 1995, the Ministry of Health (MoH) received proposals from a private consultancy group on the feasibility of establishing a centralised company to provide a compulsory social health insurance for all Social Security and National Insurance Trust (SSNIT)⁶ contributors and registered cocoa farmers. The

⁶ SSNIT is a government pension scheme in Ghana that most formal sector workers and their employers contribute to.

report also recommended setting up pilot rural-based community-finance schemes for non-formal sector workers. These events finally led to the launch of a pilot national health insurance scheme by the National Democratic Congress (NDC) government in four districts (New Juabeng, Birim South, Kwawu South and the Suhum Kraboah Coaltar) in the Eastern Region in 1997. This pilot stalled and was never realised (see Arhinful 2003). Though the pilot could not provide practical lessons about the feasibility of a national health insurance in the country, it increased awareness about alternative healthcare financing mechanisms and served to stimulate further debate to find a sustainable healthcare financing system that reflected the needs and aspirations of Ghanaians.

These events culminated in the creation of community-based health insurance schemes (CBHISs) run by religious and community groups and local government administration in the early 1990s. The MoH encouraged the creation of CBHISs with support from international donors. Many CBHISs received logistic, cash and technical support at various times from the MoH, religious organisations and development partners such as The World Bank, Danish International Development Agency (DANIDA) and Partnership for Health Reformplus (PHRplus)⁷. Following the establishment of CBHISs, district-based voluntary mutual health insurance schemes proliferated between 2001 and 2003. The numbers increased from 47 in 2001 to 168 in 2003. Although some of the initial schemes collapsed, many of them endured until the NHIS was introduced. The Nkoranza scheme, which was judged as the best performing scheme, covered 30 per cent of their target population. However, it must be noted that this scheme was supported by DANIDA and other NGOs (Arhin Tenkorang 2001), which might have accounted for their relative success.

Despite the fact that the pilot NHIS stalled in 1999, the MoH maintained that they should remain the promoter and facilitator and not an implementer of the NHIS after re-examining the scheme. The government was inspired by the modest success of some CBHISs and continued the initiative of establishing a viable NHIS. The SSNIT also began planning another centralised health insurance scheme to be run by a company, the Ghana Health Care Company (Agyepong & Adjei 2008), but this did not materialise before the change in government on 7 January 2001.

In January 2001, upon resuming office and having committed to implement a national health insurance, the New Patriotic Party (NPP) created a seven member Ministerial Health Financing Task Force under the chairmanship of the Director for Policy, Planning, Monitoring and Evaluation of the MoH. The Task Force was to

⁷ PHRplus is an organisation funded by the United States Agency for International Development (USAID) as an attempt to address the growing inequality in healthcare access.

advise the government on how to develop appropriate health insurance legislation and finance it.

The NHIS was a major policy shift in health financing therefore, experts in the field, service providers and all Ghanaians keenly followed the development of the programme. This explains why the NPP (the main opposition party) capitalised on the NDC's inability to institute a national health insurance and included the NHIS in their manifesto for the 2000 general election. Many social commentators described the policy-making process as full of wrangling and political rhetoric (Rajkotia 2007, Agyepong & Adjei 2008) and being dominated by "trusted and close political associates" of the government (Agyepong & Adjei 2008: 55). This led to the resignation of several members of the Task Force so that by the end of 2002 only one original member remained. Nevertheless, the NPP government was determined to implement the NHIS before the general elections in December 2004, so they put the bill before Parliament one week prior to their recess in July 2003 (see Agyepong & Adjei 2008). This drew various reactions from individuals depending on which political side they belonged to. Notwithstanding the bickering in and outside Parliament in protest, the bill was passed as a new National Health Insurance Law (Act 650)⁸ under a certificate of urgency in 2003 (Government of Ghana 2003). The NHIS became operational in March 2004, and District Health Insurance Schemes (DHISs) were established in all districts in the country by the end of 2005. The goal was to replace cash-and-carry systems, correct the inequity in access to healthcare, and protect people (especially the poor) from the high costs of healthcare services. Though the Act enjoins every Ghanaian to belong to an insurance scheme, the individual does not suffer a penalty for not enrolling.

The NHI Act established three main health insurance schemes:

- District Mutual Health Insurance Schemes
- Private Mutual Health Insurance Schemes
- Private Commercial Health Insurance Schemes

Structure of the National Health Insurance Authority

The Act established the National Health Insurance Council, now Authority (NHIA), as a governing body that is headed by a Chief Executive Officer (CEO). The Act gives the President of Ghana the sole power to appoint the chairperson and members of the Council (Government of Ghana 2003). As an implementing agency of the NHIS, the NHIA is responsible for policy planning, monitoring and evaluation of DHISs. It has the following structure:

- The National Health Insurance Authority (NHIA)

⁸ The NDC walked out of Parliament in protest against the passage of National Health Insurance Bill.

- The National Health Insurance Secretariat
- Regional Offices
- District Health Insurance Schemes

Since the healthcare system's preparedness for the smooth beginning of the NHIS was critical, the criteria for healthcare facilities for accreditation⁹ to operate under the NHIS were specified in the National Health Insurance Regulations (NHIRs) 2004 (LI 1809). The NHIA grants accreditation to both public and private healthcare providers and monitors their performance. It also administers the National Health Insurance Fund (NHIF), which includes:

- 2.5 per cent Value Added Tax (VAT)
- 2.5 per cent SSNIT contribution of formal sector workers as their premium
- Premiums from non-SSNIT contributors in the formal sector and informal sector
- Money allocated to the NHIF fund by Parliament
- Income from investments by NHIA, donations and gifts.

The NHIA pays service providers from the fund. It also makes proposals to the MoH for policy formulation (such as reviews of the NHIS drug list) and sets tariffs and benefits for subscribers in consultation with stakeholders.

Regional managers, who serve as links between the NHIA, DHISs and healthcare providers, run NHIA regional offices. They monitor and supervise DHISs' operations and provide technical support for capacity development and claims management. The District Health Insurance Assembly supports the Board of Trustees to appoint the management team to handle the day-to-day administration of DHISs. The functions of the Board are enforcement of the constitution and budget approval. The Board also checks the DHISs' operations and the financial accounts. The Board was dissolved in January 2009 and its functions were taken over by a Caretaker Committees.¹⁰ The management team consists of the scheme manager, accountant, management information system manager, claims manager, publicity and marketing manager (popularly called public relations officer, PRO) and the data entry operator.

⁹ To qualify for accreditation, a healthcare facility must have: operated for at least six months, a good record in healthcare services delivery and the required human resources, equipment, physical structures and other requirements set by the NHIA. There must be acceptance of quality assurance standards and payment mechanism and adoption of the referral protocols, practice guidelines and health resource-sharing arrangements of the schemes as approved by the NHIA. Also, health facilities seeking accreditation must have their own formal quality assurance programme, respect the rights of patients, adhere to information system requirements, have a reporting mechanism and maintain accurate client records, results and cost of services rendered. The healthcare facility must comply with all corrective actions to ensure quality of service and agree to allow inspection of facilities and financial and other records relevant to health insurance (National Health Insurance Regulations 2004).

¹⁰ The Caretaker Committee consists of the District Coordinating Director, the District Finance Officer, a representative of the NHIA from the regional office and the DHIS manager.

The DHISs mobilise revenue from informal sector workers, and recruit and train collectors who collect premiums from informal sector workers and undertake education about health insurance in the district. For efficient operations, each DHIS was expected to be divided into Health Insurance Communities and a Community Health Insurance Committee (CHIC) formed to oversee the collection of premiums and registration fees and to ensure that monies collected are deposited in the District Health Insurance Fund. The CHIC members are meant to be selected from the community and include a chairman, secretary, collectors, PRO and a member. However, the few CHICs that were set up collapsed soon after formation due to lack of financial support. Other DHISs never set up these communities and committees. Only the collectors were active in the communities at the time of data collection.

Features of Ghana's National Health insurance Scheme (NHIS)

The NHIS is unique in the sense that unlike other schemes in African countries, such as Benin, Rwanda, Senegal and Tanzania (Chankova et al. 2008), it is a fusion of elements of both the social health insurance scheme (SHIS)¹¹ and community-based health insurance scheme (CBHIS)¹² models to ensure nation-wide coverage of formal and informal sector workers. Thus, the NHIS is the first scheme in Africa initiated by a government with a centralised authority and national coverage. With the NHIS, residents in a district (local government administration area) prepay for healthcare services under a united nationalised system of service provision and financing determined by the NHIA. The DHISs operate under a decentralised administration with some level of operational autonomy.

Though enrolment in the NHIS is meant to be compulsory, in essence, it is voluntary and based on a mutual or participatory model in which the NHIA functions as the insurer. In this model, an insurer collects contributions from members or households and pays service providers. As a third party, it protects the contributors' interest by ensuring good quality of care and negotiates both benefit packages and the cost of care (Criel 2000, Ekman 2004). The NHIS is run on the basis of the household as the unit of registration; children are registered under at least one parent

¹¹ SHISs take many forms. They are usually set up with government funds as part of social security systems and are compulsory. Premiums are generally subsidised by the government and applied to formal sector workers with pre-defined payments (related to their income) by employer and employee rather than risks with specified benefits. The advantages include: coverage for more people, regular flow of funds into the scheme and protection of patients' rights. The greatest disadvantage is the exclusion of the poor since the insurance is usually biased towards urban areas and government employees while neglecting the rural and informal sector workers (Con & Walford 1998, Atim 1998).

¹² CBHISs are normally locally based and often found in rural areas. They cover both rich and poor informal sector workers and have a very strong social solidarity function (Atim 1998). Though CBHISs have failed to meet their intended objectives due to poor design and implementation, they stand a better chance of improving healthcare access for the poor than user-fees (see Bennet & Gilson 2001) and of reducing the gap between the poor and the less poor (De Allegri & Sauerborn 2007).

or guardian. Furthermore, unlike many other schemes that depend mainly on cross-subsidisation of contributions from formal and relatively “better off” informal sector workers to subsidise the contribution from the poor, the NHIS is also dependent on 2.5 per cent value-added tax specifically introduced to support it. The NHIA also sets a minimum premium level¹³ for non-SSNIT formal and non-formal sector workers determined by economic groups. It provides an exemption for vulnerable groups. The rationale is to ensure that NHIS does not become an unequally distributed national resource and to minimise the exclusion of vulnerable people while helping the government fulfil the vision of providing equitable and sustainable quality healthcare as a model for poverty reduction (National Health Insurance Authority 2008). Vulnerable groups include: the aged (70 years and above and SSNIT pensioners), indigents, and children below 18 years (if at least one of the parents is registered) (National Health Insurance Regulations 2004). Pregnant women were subsequently added to the exempt group under a special safe-motherhood initiative. Everyone, except pregnant women, pays a registration fee and wait for a three-month mandatory period before accessing services. Memberships are renewed annually. However, it must be noted that since 2010, children below five years of age do not have to be registered in concert with their parents or guardians and their waiting period has also been waived.

The Act specifies a minimum package that covers 95 per cent of diseases reported in health facilities in Ghana and requires no co-payment. The insurance covers healthcare services at all levels except the following:

- Rehabilitation other than physiotherapy; appliances and prostheses; cosmetic surgery; HIV retroviral drugs; assisted reproduction; echocardiography; photography; angiography; orthoptics; kidney dialysis; heart and brain surgery other than those resulting from accidents; cancer treatment other than cervical and breast cancer and organ transplant, VIP wards and treatment abroad
- Non-listed drugs
- Medical examinations for visas, employment and admission to academic institutions etc.
- Mortuary service (National Health Insurance Authority 2008).

It is worth mentioning that among the three schemes established by the NHI Act, only the NHIS has been embraced by most Ghanaians. This could be because of the low premium levels due to the significant governmental financial support and subsidy for enrolling vulnerable groups. These are features that were not applicable

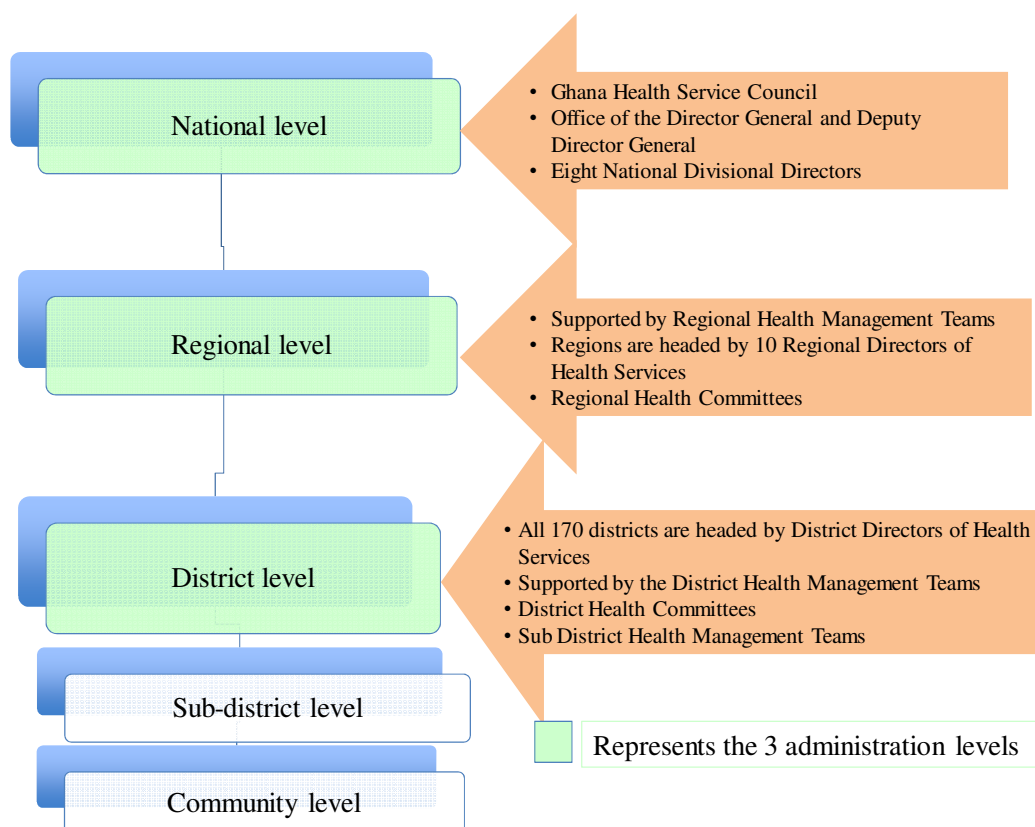
¹³ A minimum premium paid by the poor is about GH¢ 14 [about US\$10], middle income earners pays GH¢ 22 [about US\$15] and maximum of GH¢ 48 [about US\$30] is paid by the very rich per adult household member per annum in addition to GH¢ 4.00 [US\$2.5] as a registration fee.

in the other two schemes. As a result, the private mutual health insurance schemes died a natural death since they could not mobilise adequate resources from the private sector to sustain their operations. The private commercial schemes on the other hand, continue to exist, but cover less than one per cent of the population (Ghana Statistical Service et al. 2009).

Healthcare delivery and seeking care under the NHIS

The health sector in Ghana functions on an agency model. The MoH is responsible for policy making, sector oversight and coordination and is headed by the Minister of Health. The Ghana Health Service (GHS) is the implementing and regulatory agency responsible for public sector service delivery and controls all healthcare professionals. The GHS is headed by a Director General of Health with autonomous power to administer health services.

Figure 1.2 The structure of the Ghana Health Service



Source: Ghana Health Service, <http://www.ghanahealthservice.org>

Functionally, GHS is organised at five levels: national, regional, district, sub-district and community. The structure is vertical with a centralised administrative system. However, as a result of the decentralisation of the government and health sector reform with an emphasis on primary healthcare and participation of the lowest level, services are now integrated from the national level to regions, districts, sub-districts and communities.

The GHS is governed by the Ghana Health Service Council, which recommends healthcare delivery policies and programmes to the Minister of Health and advises him or her on posts in the service. In addition, the Ghana Service Council promotes collaboration between the MoH, teaching hospitals and the GHS. The three teaching hospitals located regionally (in Accra, the capital city located in the Greater Accra Region; in Kumasi, the capital of the Ashanti Region; and in Tamale, the capital of the Northern Region) are autonomous and used as referral facilities.

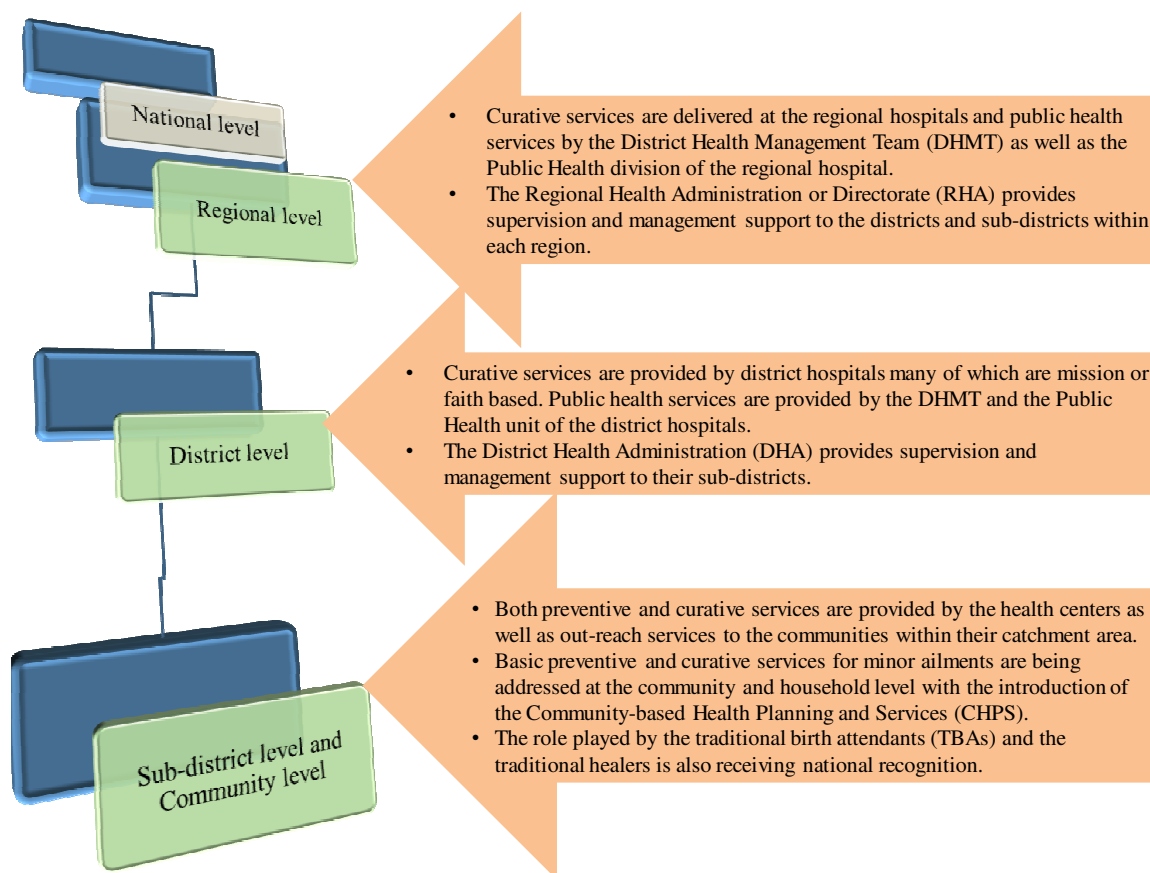
At the regional level, there are Regional Health Directorates managed by Regional Directors of Health Services and services are delivered at the regional hospitals, which are the final referral point within the regions. At the district level, the District Director of Health Services (DDHSs) heads the District Health Directorate (DHD) that supervises all health facilities in the district and provides support to the sub-districts. All but the newly created districts have a district hospital that serves as referral point in the district. The sub-district also provides preventive and curative services and supervises health centres, health posts, community-based health planning and services (CHPS)¹⁴ under their area of control. At the community level, basic preventive and curative services for minor illnesses are addressed at health post and CHPS compounds. Although the majority of health facilities in Ghana are public, there are a significant number of faith-based (mainly Christian Health Association of Ghana¹⁵) and private facilities owned by institutions and individuals throughout the country.

Under the NHIS, healthcare is obtained within an approved network of providers: all public health, faith-based, quasi-government and some private facilities. In addition, some private pharmacies and chemist shops are also approved. The

¹⁴ CHPS is a national programme of community-based care provided by resident nurses who are referred to as community health officers. CHPS, introduced in 1999, reduces barriers to geographical access to healthcare and provides basic level preventive and curative services for minor ailments at the community and household levels (Nyonator et al. 2005).

¹⁵ The Christian Health Association of Ghana (CHAG) is a non-governmental organisation that brings together churches that provide health services. CHAG is the second largest provider of health services in the country (about 42% of care in Ghana is delivered by the 183 member institutions, including district hospitals), and is predominantly located in rural and underserved communities throughout the country. CHAG's ultimate goal is to improve people's health status, especially the marginalised and the poor in fulfilment of Christ's healing ministry and to help translate the government's policy of ensuring equity in access to healthcare through the NHIS (see also <http://www.chagghana.org>).

Figure 1.3 Ghana Health Service healthcare services by level



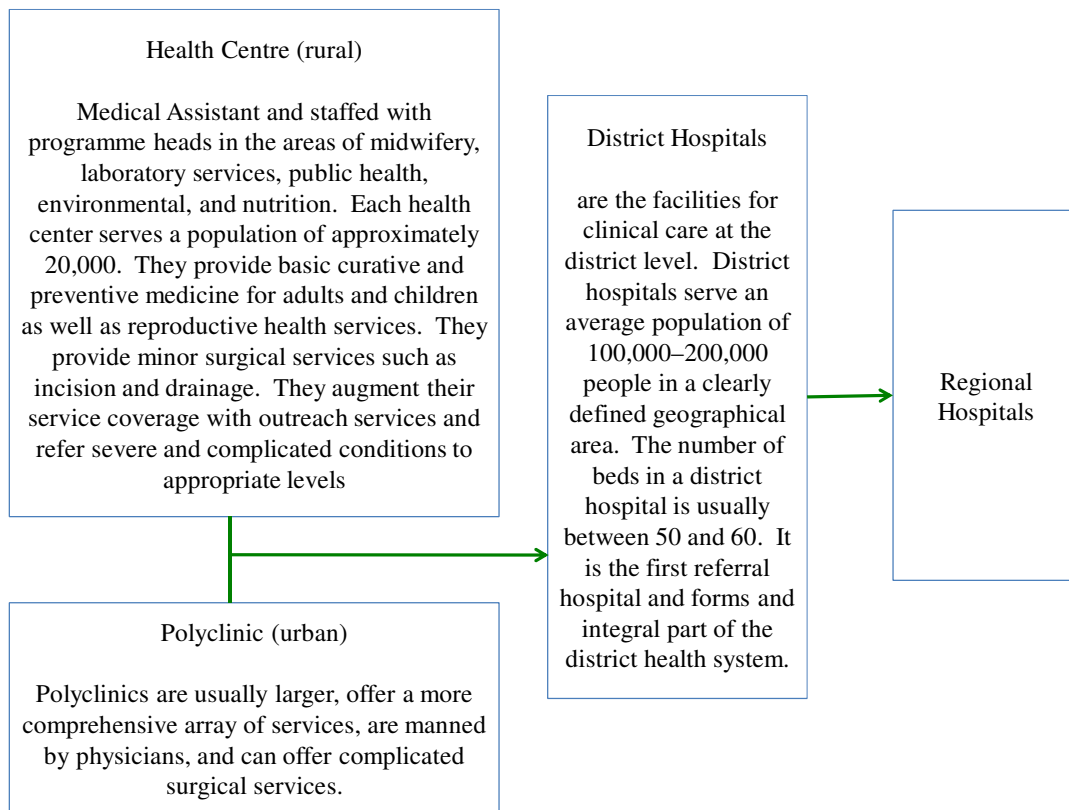
Source: Ghana Health Service, <http://www.ghanahealthservice.org>

LI 1809 mandates that the first point of access to healthcare under the NHIS should be a primary healthcare facility that includes community-based health planning and services (CHPS), health centres, district hospitals, polyclinics¹⁶, quasi-public hospitals, private hospitals, clinics and maternity homes. However, where the only facility in the community is a regional hospital, it is also considered a primary healthcare facility.

Health providers operate under contract with the NHIS and are paid a predetermined tariff based on a diagnostics-related structure for all service providers. Claims are made within specific guidelines for reimbursement. The National Health Insurance Regulations (NHIRs) oblige health providers to apply and pass renewable accreditation appraisal to qualify for service provision. This requires that healthcare

¹⁶ A polyclinic is the urban version of a health centre and usually larger, Polyclinics are found mainly in metropolitan areas, manned by physicians and offer more comprehensive healthcare services.

Figure 1.4 Ghana Health Service facilities



providers are professionally qualified and have adhered to the quality assurance programme set by the GHS. The NHIA also applies a performance-monitoring system that involves periodic inspection of health facilities, data collection for service rendered to determine the cost and effectiveness of service, and adherence to accepted and known standards of healthcare practice (National Health Insurance Regulations 2004).

Research objective and questions

Research objective

The main objective of this study (as the anthropological component of the larger project, ‘Reaching the poor in Ghana’s NHIS’) is to explore if and how problem-solving groups (PSGs) can increase enrolment in the NHIS and help retain members. The use of PSGs to identify barriers to enrolment and design and implement interventions aims to encourage stakeholders to adopt an open and critical posture needed to address NHIS implementation challenges at the level of the community, health facility and DHIS as well as improve NHIS coverage.

This study provides information on how the multi-stakeholder problem-solving programme (MSPSP), a bottom-up participatory intervention approach can be used to influence people to enrol and stay in the NHIS. It seeks to add to the knowledge base of how to effectively engage key stakeholders to address the challenges of public policies. This study also provides information that can guide other developing countries struggling to expand SHISs and CBHISs coverage. Conclusions drawn from this pilot study might make the MSPSP attractive to policy makers in Ghana and allow for nationwide scale-up. This work is also expected to prompt further research in the field.

Research questions

The central question this study addresses is: How effective are PSGs in increasing NHIS enrolment and retention of members? To answer this question, this study focused on both the process and outcome of the MSPSP and posed the following questions:

- What factors influence enrolment in the NHIS and non-renewal of membership?
- What are the processes involved in setting up PSGs?
- How do PSGs identify barriers, and develop and implement intervention activities?
- What factors enhanced problems-solving groups' achievements?
- What are the outcomes of PSG intervention activities?

Each empirical chapter in this study focuses on one of the above questions. The study presents the process and attendant activities of creating PSGs as well as the intervention implementation process and outcomes. The work is based on the assumption that many stakeholder collaborations are not successful because they do not follow a rigorous process of recruiting members and effectively engaging them to identify and implement locally tailored solutions to achieve a maximum impact.

Significance of the study

We have done everything possible since the introduction of the scheme to get people insured. But the people are difficult and will not register. Some will register and will not renew their card until they are sick, then they come to worry us. We always educate them on the benefits of health insurance and the need to regularly renew their card. But they think if they don't fall sick, then they have been cheated (Henry, a DHIS manager).

The comment above is the summary of a chat I had with Henry, a District Health Insurance Scheme's (DHIS) public relations officer (PRO), when I went to register my mother in the NHIS, a year before the start of this study. His lamentation about the limited progress in expanding NHIS coverage can be summarised with an expression in Akan as follows: “*Se wotwe ahoma na se emma a, na biribi kura mu*”

(If you are pulling a rope and it does not come, there is something holding it back). In the context of this study, the expression highlights the need to explore what is holding back the DHISs' ability to improve NHIS coverage to appreciable levels and retain members.

Since health is a merit good, the government introduced the NHIS to ensure that all Ghanaians had optimal healthcare. Despite the significantly subsidised premiums, evidence shows that NHIS enrolment is low. In 2008, the Ghana Demographic and Health Survey found that a high proportion of men (70%) and women (60%), aged 15-49 and 15-59 respectively, were not covered by health insurance (Ghana Statistical Service et al. 2009). Although health insurance premium exemptions in general were shifted from a health facility-based system plagued with implementation problems (see Nyongator & Kutzin 1999, Garshong et al. 2001, Badasu 2004) to a national health insurance-based exemption, the latter also appears to exclude the core poor population (Aikins & Arhinful 2006, Witter & Garshong 2009, MoH 2008). Unfortunately, it appears that very few people benefit from the NHIS premium exemption.

Bitran & Giedlon (2003) reviewed health insurance exemptions in low-income countries (Kenya, Ghana, Zimbabwe, Indonesia, Thailand, and Chile) and concluded that they all have problems with eligibility criteria. Thus, the DHISs' failure to reach the majority of Ghanaians, especially the core poor, despite granting them premium exemptions, undermines the objective of the NHIS policy. This is a critical issue that needs to be explored in a period when the government of Ghana is making frantic efforts to reach the health-related Millennium Development Goals (MGDs) using the NHIS.

This study goes beyond the scope of most studies that focus on one stakeholder and often use only quantitative methods (Asante & Aikins 2008, Basaza et al. 2008). This research used ethnographic methods to engage local NHIS stakeholders to explore and address barriers to enrolment and retain members. An effective investigation that included all stakeholders was required. Thus the multi-level approach made it possible to assemble the findings into categories and provided evidence that captured the 'whole story' of low NHIS enrolment and retention rates. The findings also provided in-depth information about the interplay of barriers at the community, health provider and DHIS levels; therefore, we now have a better understanding of how each stakeholder's actions affect the people's health insurance decision-making.

The NHIS is a new payment mechanism for healthcare services and this creates a new relationship between insured patients and health providers with attendant challenges. This study explores this new relationship and provides an ethnographic account of the patients, and providers' experiences. The NHIS was introduced within a historical context that made it an inherently political intervention. This

study also explored how the politics surrounding the introduction of the NHIS affected people's decision to enrol or not and the work of DHISs.

In the social sciences, approaches that engage stakeholders to share ideas and carry out intervention activities have been found to be helpful in solving social problems (Van der Geest 1990, Tones & Green 2004). Unfortunately, the use of stakeholder input at the local level to explore the challenges of public policy implementation has not been explored much in Ghana. As rightly pointed out by Lasker & Weiss (2003), collaborations where community stakeholders and members are only asked to provide feedback and input about their plans do not produce the best result for solving community problems. Thus, the effective engagement of stakeholders from the onset of a programme like the NHIS is more likely to address the challenges, since the local stakeholders have a better understanding of the local context and what works best for them. Also, using the MSPSP's approach and examining the views of participants involved in the intervention while exploring contextual factors provides a rigorous interpretation of the situation.

Finally, stakeholders' intervention studies in health financing, especially to improve enrolment in SHISs, are scarce. This study generated evidence to show that it is feasible to engage stakeholders of the NHIS to improve coverage and make a valuable contribution regarding how to stimulate enrolment and retain members. Also, analysing PSG members' and stakeholders' participation in an intervention provides information about factors that might elicit cooperation and sustain commitment as well as identifying who should lead such efforts. The MSPSP, therefore, provides an evidence-based intervention and shows how stakeholders at the local level can be mobilised to develop and carry out interventions that address public policy implementation challenges. This approach contributes to the theory and practice of a stakeholder-collaborative intervention and provides a useful framework to guide the NHIA, DHISs and other institutions managing similar schemes in low-income countries for addressing the difficult task of expanding and retaining members to translate the goal of ensuring equity in access to healthcare into reality.

Theoretical framework and concepts

The theoretical orientation of this study is situated within critical medical anthropology, which advocates for stakeholder engagement to respond to problems with interventions (Singer 1989, Scheper-Hughes 1990). In response to criticism that medical anthropologists have failed to contribute to solving mankind's problems (Kiefer 1971) and lacked accountability to the researched (Glasser 1988), medical anthropologists began to consider that the discipline has both a professional and moral obligation to reveal, discuss and address broad socio-economic, cultural and political contexts in which health inequities are manifested (Farmer 2005, Scheper-Hughes 1992). This also addressed the concern that medical anthropology had too

restrictive a focus on the micro-level (Singer 1989). Others added that decision-making without considering what happens at local levels effectively misses a majority of people whose lives are affected by those policies (Van der Geest et al. 1990, Press 1990). These authors argued that traditional anthropologists who confine themselves to one level when studying a phenomenon gain limited information, since important factors at other levels may be overlooked.

In this study, the theoretical concepts of a multi-level perspective as well as resilience and trust were chosen based on the principles that the NHIS was introduced as a social development agenda that required the effective engagement of implementers and targets of the policy to identify and address implementation challenges. The collaboration must be based on trust to enable the group to work effectively to improve confidence in the NHIS and ensure the goal of strengthening patients to manage the adversities of ill health is attained. These concepts are intertwined and provide an in-depth understanding of NHIS coverage and the outcome of a multi-stakeholder problem-solving programme. The concepts are explained and the background of each is discussed to provide a theoretical introduction to the empirical chapters.

Multi-level perspective

The multi-level perspective (MLP) departs from the early medical anthropology perspective, which often excluded a wider context of stakeholders' experiences in analysing healthcare issues (Baer et al 1986). The MLP approach emphasises that to understand a phenomenon, information should be gathered from actors and events at various levels of a social organisation. This will enable the researcher to provide a comprehensive description of the phenomenon, give a more credible explanation and draw more convincing conclusions. Proponents of the MLP argue that macro- and micro-level processes and structures as well as actors' varied interest interact to affect a phenomenon (Van der Geest et al. 1990, Press 1990). The MLP is thus based on the assumption that:

Developments at the various levels are linked to one another and that the nature of these linkages has to be studied in order to understand properly what takes place at a specific level. The word 'level', a metaphor, refers in particular to the international, national, regional and local tiers of social organisation (Van der Geest et al. 1990: 1026).

Regarding healthcare issues, the MLP is used as a tool to explore and explain actors' interest, behaviour and power relations and how these affect the outcome of policies and programmes. Press (1990) was concerned about the inequality of medical resources and the control of Western biomedicine over local medical systems, especially in countries with limited resources. He asserted that both patients and clinicians tend to have disparate values and behavioural characteristics that may not be fully understood or explained through a model that gives excessive weight to a 'single element' of a 'single actor' compared to one that uses a 'multi-

level', 'multi-element' approach (Press 1990: 1001-1002). Press put nationalism, Islam and Christianity at the top of the social organisational ladder. Communities and sub-systems were next. Finally, at the individual level were the worldviews of participants in a clinical interaction. In general, Press proposes a multi-level approach to counter a 'mono-focal' approach to provide a causal explanation of a phenomenon (1990: 1002). For the MLP, the theoretical assumption is that various actors on multiple levels are involved in a policy or programme and have their own interests that determine how they react. The MLP thus highlights how these interests guide the actors' beliefs and actions and why they may clash with those who have other interests.

The MLP also considers that ideas and events that affect a phenomenon are not uni-directional. The influence of these ideas and events can be from higher to lower levels and vice versa or even be circular (Van der Geest et al. 1990: 1026). As will be seen later in this book, actors' dissenting views during the implementation of the NHIS policy-making process transcended from the MoH to the remotest community in Ghana and drew distinct reactions from various people depending on their political affiliation. Those who saw the NHIS as a governmental political tool to retain power prevented DHISs' staff from promoting the scheme and discouraged people from enrolling. This means that actors at the lowest level can also influence reactions to a policy and undermine implementers' efforts.

Van der Geest et al. (1990: 1025) argued that with growing state intervention in rural societies and the increase of global economic interdependence, researchers who confine their work to one level gain only a one-sided perspective on a phenomenon. They emphasised social phenomenon studies should be linked to all levels of social organisations and called it 'linkages perspective' (1990: 1026). The authors referred to the 'linkages' as: "Some form of communication transmitted by man or by material means and moving from one level to another" (Van der Geest et al. 1990: 1026).

The MLP also considers that linkages take place across time. Thus considering the historical development of a phenomenon ensures a deeper understanding and helps to provide a better explanation than focusing only on the present. As shown in the empirical chapters, events leading to the introduction of the NHIS and the policy-making process affected how stakeholders reacted to it and had consequences for acceptance.

These points indicate the potential benefits of the multi-level perspective (MLP) for anthropological work. I used the MLP as a conceptual and methodological tool to guide this study. The MLP provides an appropriate framework to help conceptualise the NHIS as a health financing policy that involves various actors at multiple levels of the health system. As will become apparent in the empirical chapters, policy makers, implementers and community members have varied interests in the

NHIS that determine their behaviour and practices, which often conflict with policy goals and make it difficult to achieve the goal of universal coverage and ensure equity in access to healthcare. The nature of these interactions and subsequent effects are complex and can only be fully understood by exploring what happens at all the levels. I will thus use the MLP to unearth various types of linkages to capture the varied interests, beliefs and practices as well as contextual factors that affect enrolment in the NHIS and retention of members. This will help provide in-depth information that reflects stakeholders' worldviews about the NHIS and give credible explanations to the persistent low enrolment and retention rates.

Methodologically, the MLP provides a useful tool that will help achieve the goals of the multi-stakeholder problem-solving programme (MSPSP) to be instituted by this study. I thus posit that engaging local stakeholders at multiple levels in the MSPSP (rather than focusing on a single level or stakeholder) has the potential of producing the synergy needed to get to the root causes of barriers and develop appropriate intervention activities that can address their varied concerns. It will also help develop implementation strategies to reach all targets and improve enrolment and retention of members in the NHIS.

Literature supporting the use of MLP

Van der Geest et al. (1990) applied the MLP to examine why Primary Healthcare (PHC) did not work in many countries as intended though it was unanimously approved at a WHO meeting in Alma Ata, Kazakhstan, in 1978. They show how national governments, health professionals and community members had conflicting interests in the PHC. Governments were interested in the PHC because it could provide cheap healthcare services and advance their political interest. Health professionals disliked PHC because of a lack of financial opportunities and local communities often saw it as inferior healthcare. The authors' study thus provided a comprehensive explanation why PHC's goal of providing health for all by the year 2000 was not achieved. Twelve years after the PHC deadline of providing health for all by the 2000, many countries still have poor health indicators.

Kinsman (2008) employed the multi-level approach to evaluate HIV/AIDS intervention programmes in Uganda and showed that policy change can come from both higher and lower levels and vice versa. His study showed how national- and local-level actors involved in the provision of anti-retro virus (ARV) medications resisted scale-up because it was not in their interest. At the national level, some actors feared a loss of authority and financing in other areas of AIDS control in which they were important players. At the local level, there was discomfort when some of the best doctors moved into ARV provision and about the negative effects this had on other aspects of the health system. The doctors' interests were prioritised above saving dying patients. Kinsman shows that the doctors' interests were eventually given up,

though reluctantly, and the government was forced to change their policy when cheap generic drugs were imported into the country by a private organisation. This indicates how a major policy change can emanate from lower to higher levels.

Although Agyepong & Adjei (2008) did not explicitly mention the MLP, they demonstrate that interests of actors involved in the NHIS policy making process weakened the checks and balances needed to protect the reform processes. They illustrate how the government's interest in the need to prove the regime's legitimacy along with the technocrats' and bureaucrats' desire to maintain scientific integrity and political neutrality did not result in the best policy choices. Their paper revealed the need to effectively engage key stakeholders in defining and addressing the challenges of a new policy to ensure attaining the goals. With the concept of conflicting interest in mind, one can see how actors' interests often undermine the policy making process so explanations of low enrolment must not only be sought at the community level, but also at the national level. In addition, events during the policy making process must also be considered.

Regarding the planning and implementation of intervention programmes, studies have illustrated the value of employing a multi-level approach in promoting and addressing challenges of health policies. They show that engaging key stakeholders in intervention programmes has the potential of success. Nastasi & Hitchcock (2009) in their study of a community-based multi-level sexual risk-prevention programme in the United States found that involving stakeholders from various levels built ownership and commitment to the intervention. Their study showed that adopting a multi-level approach and engaging key stakeholders in an intervention programme translated into adequate support and created the necessary conditions for achieving positive outcomes.

Challenges when using the MLP

The concept of the MLP and results from studies that used it as presented above, indicate its value for anthropological research and intervention studies. But the approach has challenges. The most difficult is the methodological requirement of research being performed at multiple sites using several data sources. This usually involves significant travel, making the research expensive, time-consuming, and complex compared to studies that focus on a single level or one stakeholder.

Another challenge is that although intervention programmes can be well designed and theoretically grounded, the natural settings of the social context, implementers and targets can be more varied than initially expected. This increases the linkages to be explored and may lead to an expansion of the research focus to cover a wider context than initially planned further compounding logistical problems. However, the advantage to this approach is a more comprehensive explanation of the phenomenon, since significantly more interacting factors are captured.

The MLP, like many other anthropological perspectives, has been criticised for its complexity in data interpretation. The more data sources, the more difficult it is to determine relationships and draw conclusions. Duncan et al. (1998: 114) point out that the multi-level approach has great potential, but needs to be used cautiously. They argued that the model: “Opens up the possibility of interpretive confusion and overstatement of conclusions.” As seen later in this book, the difficulty in this study was the complexity of determining the most important factor or factors at each level or levels that had the greatest effect on NHIS enrolment and membership non-renewal rate. This problem may be seen as a threat to the validity and generalisability of the results, especially in the context of the effectiveness of randomised control trials. But, this is actually the reality of the NHIS intervention that involves a social phenomenon. When many factors interact, they become an asset instead of a threat to validity. The multiple factors help explain variations in the intervention’s outcome.

In summary, regardless of these difficulties, the MLP has the advantage of helping reveal more hidden layers of information and produce results that more accurately reflect the reality than a focus on a single level or one stakeholder would have done.

Resilience

Resilience, as a concept, has been used for investigations in a number of disciplines such as ecology, climate, psychology and healthcare. For example, ecologists apply the concept to ecological systems to explain environmental sustainability despite exposure to adverse conditions. Violanti et al. (2000) define resilience in the field of trauma as a function of personal characteristics and the existence of community practices that help mitigate the consequences of adversity and maximise the potential for recovery and growth. In clinical terms, resilience is used to account for successful adaptations to ill health (Brown & Mueller 1970). According to Niehof (2008: 217) the concept of resilience overlaps with vulnerability and is socially and culturally embedded and shaped by emotions and personality characteristics. Niehof suggests that the ‘sources’ of resilience can be external (e.g. social support or financial help) as well as internal (e.g. psychic strength).

In this study, I define resilience as the capacity to access resources that strengthen a person’s ability to regain health or adapt to a disease. Thus resilience does not mean ignoring feelings of stress nor does it necessarily remove stress, but rather resilience strengthens the patient to adapt positively to the condition and overcome the worst impact of disease. Despite the variation in the definition and use of resilience as a concept, it is generally defined across all disciplines as coping with adversity and the ability to ‘bounce-back’ (see Davis 1993, Niehof 2008, Van der Geest 2008).

Two main tenets of resilience are as follows: (1) an individual must first experience adversity that encompasses negative life circumstances, which makes him or her vulnerable, then resilience is developed to manage the stress and resume previous levels of functioning and (2) resilience is a function of internal strength that enables an individual to take action to utilise external support to produce sustained strength to recover from or adapt positively to an adverse condition. This conceptualisation of resilience applies to my study because sickness is a stressful condition that needs both inner power and external support. People must make a choice to enrol in the NHIS to harness financial protection against expensive healthcare costs and in doing so, they are strengthened to prevail over the hardship and recover from the suffering that accompanies sickness and bounce back to normalcy or adapt to it and live positively with their condition.

Studies have shown the relevance of both internal and external factors in the development of resilience. Van der Geest (2008) explored the experience of old people in Ghana who were confronted with declines in health and precarious economic conditions. He reports that although these conditions usually cause misery, his respondents accepted their adverse conditions, without giving in to bitterness, and adapted positively. One woman's adaptive behaviour was attributed to her personal strength and family support. In a study of HIV/AIDS patients in northern Zambia, Wieggers (2008) observes that differences in responses to AIDS-related adversity largely depend on resilience that is a result of social protection, economic support and access to ARV treatment. She contends that the individual's ability to mobilise resources plays a role in determining whether resilience is developed or not.

While I agree with the abovementioned authors that various external factors aid the development of resilience during ill health, I emphasise the economic factor because sickness diverts productive work and seriously impairs livelihoods, thereby increasing patients' vulnerability. With the monetisation of healthcare, patients face a heavy financial burden (especially those suffering from chronic diseases); hence there is a need for economic support to recover from or cope with their condition. As Kitano & Lewis (2005) point out, poverty plays a key role in the lack of resilience during ill health. In Ghana, support from extended family members who provide material and social support to sick people has dwindled or is no more (Kumado & Gockel 2003, Arhinful 2003). The nuclear family's support is also lost due to the high cost of treatment. Poor patients are more vulnerable to the adversities of sickness due to a lack of access to healthcare or expensive healthcare payments. In Ghana, protracted sickness is usually interpreted as a curse resulting from wrong doing on the part of the patient (cf. Dapaah 2012). This often leads to the withdrawal of social and financial support even by nuclear family members, which causes considerable stress and weakens the patient's resilience to manage the devastating

effect of the disease. From these perspectives, the NHIS as a support that is outside the family has become a critical factor in the development of resilience when sick.

Considering one important focus of this study – reaching the poor in the NHIS – I use resilience to explain why people enrol and renew their membership in the NHIS, or do not. I use resilience to examine three main issues: (1) whether the NHIS strengthens patients not to succumb to adversities of sickness, but rather strive to regain their health or adapt to chronic diseases, (2) explain what happens to uninsured patients, especially the poor, (3) to identify factors that prevent people, especially the poor who need health insurance most, to manage the adversities of ill-health by enrolling in the NHIS. I conceive the NHIS to be an external support that enhances people's resilience and people must act and use their internal power to harness its potential benefits to manage ill health.

The studies presented above, show the value of resilience in healthcare and health insurance research, but also present methodological challenges. As mentioned earlier, resilience is a function of inner strength and external support. The difficulty is that one has to also rely on the patient's report to estimate their inner strength while developing resilience. This often depends on a person's emotional state, which can fluctuate. As Van der Geest (2008) observes in his study, one respondent gave contradictory responses regarding her feelings about her adverse condition. Moreover, there are many external factors that can prevent people from developing resilience, so the difficulty is how to determine their resilience or lack of it. For example, how can the researcher estimate whether not enrolling in the NHIS is due to lack of inner strength or structural factors that prevented people from enrolling or remaining in an insurance scheme?

I suggest that resilience in healthcare and health insurance is best measured through combining qualitative information with quantitative data. This gives better insight into whether health insurance is a resilience-enhancing factor or not and what factors account for the non-enrolment of people who need it most. Spending a significant amount of time interacting with key informants on several occasions makes it possible to reconcile the ambiguities in their narratives. Otherwise, the results could be understated or overestimated. This means that resilience cannot be accurately measured using only quantitative methods or even one-time interviews, since these techniques are often snapshots of before and after and likely to miss relevant information to give a credible account. These difficulties highlight the need to use resilience with caution in healthcare and insurance research and conclusions should be drawn with restraint.

Trust

In this study, trust will be used to: (1) explore the reasons for enrolling, not enrolling and remaining in the NHIS, (2) explore the basis for PSG members' and stakehold-

ers' participation in the MSPSP. Trust is described as an optimistic expectation of honest behaviour by agents involved in a transaction based on the belief that the outcome will be beneficial to them. By and large, trust is used to explain the reasons behind actors' behaviour towards one other and or institutions involved in a transaction. Gambetta (2000) contends that trust in human relations is based on the expectation that they are likely to behave in ways that are beneficial or at least not harmful to them.

In the social sciences, trust is classified in two ways: personalised trust and generalised trust (see Simmel 1990, Kääriäinen 2007, Gilson 2006). Personalised trust develops on the basis of experience and interaction with the other person who has proven worthy of trust. Generalised trust refers to trust in people and institutions whether we know them or have interacted with them or not. The main principle is that we expect others and/or the institutions to act in our interest. For example, institutions such as the church, police, health system and their employees are expected to protect our interest. Trust serves as a lubricant of social relations at various levels that ensures that society functions smoothly (Simmel 1990, Kääriäinen 2007). Simmel (1990) makes the strongest point about the value of trust contending that without general trust, society will disintegrate.

In Ghana, people trust traditional leaders and the chieftaincy institution because they are considered to be the repository of traditional norms and values and are expected to act in ways that protect the community members' interests. Community members see their chiefs and elders as trustworthy and rely on them to settle civil and some criminal cases such as land disputes, marriage problems and theft because they believe they will receive fair judgement. Trust also serves as the basis of support systems and networks such as *pataase*¹⁷ and *nnoboa*¹⁸. Trust thus ensures the survival of individuals and communities as a whole. However, there is also general distrust in some formal institutions because of past experiences with local mutual support schemes and inefficient enforcement of regulatory mechanisms to address corruption and ensure accountability among state officials (cf. Arhinful 2003).

Trust in health insurance is generally defined as health providers' competence and quality of service (Gilson 2003, Mechanic 1998, Schneider 2005). These are considered important in building trust in health insurance schemes because health providers have been contracted to provide healthcare and make vital decisions

¹⁷ *Pataase* is an association of mostly fishermen who come together to support each other in times of economic stress. They provide financial assistance to members. Their main focus is funeral costs of members or their close relatives.

¹⁸ *Nnoboa* (support weeding) is a mutual help group. The name refers to local support networks formed by farmers to support each other on their farms. In these groups, trust and commitment to achieve individual and group objectives is the key principle.

concerning the patient. How they provide the services and interact with insured patients affects enrolment in the scheme. In the context of healthcare, Gilson (2003: 1456) describes trust as “A strategic behaviour rooted in risk and expectations about how another person will behave.” She explains that trust ranges between complete trust and complete distrust and contends that effective healthcare requires not only care, but also a trusting relationship between providers and patients. Hall et al. (2001) also defines trust as an optimistic acceptance of a vulnerable situation in which a person believes that their interest will be considered by another person. They argue that illness makes patients vulnerable and so they need to trust a physician whose duty is to promote their interest by providing appropriate treatment. For health insurance, trust gives the insured assurance that he or she will be treated well when sick and influences him or her to enrol. Studies have revealed that trust and mistrust are based on multiple factors. Mechanic (1998) describes trust in health insurance in three dimensions:

1. Patients’ trust in health providers, which is based on their previous experience with providers’ technical and interpersonal competence, that is, their ability to diagnose and treat illness and act in patient’s interest.
2. Patients’ trust in insurers is based on their reputation of providing consistent and improved access to healthcare.
3. Trust is generated by the control mechanism for legal enforcement of commitment like contracts.

Mechanic concludes that insurers can build a reputation of trustworthiness by demonstrating control over the healthcare process and their responsiveness to consumers needs, and ensuring quality healthcare. Schneider (2005), in his study of health insurance schemes in Rwanda, confirms Mechanic’s observation and adds that state authorities who join the same scheme and campaign for membership as well as supervise providers’ performances create trust-building structures. Thus health providers and insurers are expected to create a trustworthy relationship with the clients to stimulate enrolment; making trust an important element in health insurance decision-making.

The above-mentioned conceptualisations and pre-conditions of trust are relevant for this study because individuals are potentially vulnerable to sickness, so they make a strategic decision to enrol in health insurance with the belief that the insurer will contract a physician to provide good quality healthcare services. In addition, the NHIS benefits stated in the policy are to regulate the behaviour of the insured, health providers and insurers. However, the NHIS’ inability to pay health providers promptly and provide insured patients with what is promised often creates distrust and discourages people from enrolling. I present a few examples of health insurance

studies that show the relevance of trust and mistrust in health insurance decision-making.

Arhinful (2003) reports that enrolment in insurance schemes in Ghana is based on trust and mistrust leads to non-enrolment. Some of his respondents indicated that they would not join a health insurance scheme because they had no trust in the scheme. He showed that the health facilities' inability to meet insured patients' expectations of good quality healthcare services discouraged other people from enrolling. Basaza et al. (2007) in their evaluation of two health insurance schemes in Uganda identified a lack of information, limited community involvement, and lack of trust in the management of the schemes as contributing to their underachievement. In a study of health insurance schemes in Rwanda, Schneider (2005) reveals that the companies often lack the capacity to bring about better quality of care and this negatively affects enrolment. He observes that providers' interpersonal skills are one of the key factors in building trust in service providers.

Given the objective of this study – to explore if and how problem-solving groups (PSGs) can improve NHIS enrolment and retention rates – my interest was to understand the pre-conditions of trust and distrust and their effect on enrolment. Therefore, I use trust and mistrust to assess two main issues: (1) to examine the reasons for low enrolment in the NHIS and retention rate, (2) to determine the approaches PSGs could adopt to improve trust and stimulate NHIS enrolment and retention of members. I used trust to analyse how people strategically take the risk of purchasing health insurance premiums based on the expectation that DHISs would issue NHIS cards promptly and health facilities would provide access to quality healthcare services. When the patient's expectations are not met, there can be complete distrust and they do not renew their membership. Alternatively, the patient's level of trust declines, but they still remain in the insurance scheme because it is better than accessing healthcare as an uninsured patient.

Regarding the MSPSP, I assume that trust elicits cooperative behaviour and ensures the effective participation by members and stakeholders in the intervention. From this perspective, I use trust to examine factors that elicit cooperation among PSG members and stakeholders and sustain their commitment to the intervention while working together to achieve positive outcomes.

Studies have shown that trust elicits cooperation among group members and leads to a commitment to achieve common goals (D'Amour et al. 2005, Henneman et al. 1995, Gambetta 2000, Currall & Inkpen 2006). Gambetta (2000), in his analysis of the basis of cooperative behaviour, contends that trust facilitates collective action, and elicits cooperation. He suggests that trust is built through individual and group member's attitudes (that contain information about their trustworthiness or mistrust) towards each other. Currall & Inkpen (2006), in their study about how trust evolves, reported that building trust follows an incremental pattern. According to the authors,

trust originates from one-on-one relationships among individuals, groups and organisations and evolves over time. During the development phase, one may first trust in small ways, observe whether the trust is upheld or violated, and then proceed with caution to develop trust in the group. This signifies that trust is built through constant interaction among those involved and maintained through conscious activities, such as effective communication and respect for each other's views. Thus, although groups are formed by mutual consent, trust-based relationships need to be created and sustained to encourage individual members to remain committed to the group to ensure their effective participation in activities. Since my study involves engaging representatives from communities, health facilities and DHISs to form problem-solving groups (PSGs), I will examine how PSG facilitators build trust among group members and stakeholders to elicit and sustain their cooperation and commitment to the intervention. In this respect, I discuss trust as a factor that creates the synergy needed to enhance PSG activities and achievement of intervention goals. I argue that with trust, PSG members talk openly about their challenges and expectations without fear of intimidation. This reveals conditions that usually affect participation in group activities and intervention outcome and provides guidelines for developing effective intervention programmes to promote public policy.

Despite the relevance of trust in helping understand enrolment in health insurance schemes and retention of members, assessing trust conditions might be difficult because other factors influence health insurance decision-making. For example, accepting the need to invest in health insurance influence enrolment and does not depend on trust or mistrust. However, respondents might not disclose other reasons for not enrolling or renewing their membership if they feel it might be embarrassing. As made apparent in the empirical chapters, respondents can give socially desirable responses that contradict their real motives for not enrolling and renewing their membership in the NHIS. Their real motives only emerged after further discussions. This means a methodological approach that provides the researcher the opportunity to delve into the key informants' real motives and capture the non-verbal cues that add meaning to their expressions is required. This helps isolate trust-building factors and other factors that create mistrust and provide a more credible explanation for low NHIS coverage.

Regarding participation in PSG activities, group members could have other interests apart from trust as the basis for their participation in collaborative groups and not necessarily the commitment to the programme objectives. This can only be revealed using ethnographic methods that create the opportunity to probe further why people participate or do not participate in group activities other than only relying on their expressions. This helps the researcher to carefully examine the participant's narratives about the basis and conditions of trust before drawing

conclusions. Again, the participants' level of trust cannot be measured through surveys or one-time interviews that risk capturing only socially desirable answers.

Outline of the study

The study is organised in nine chapters. Chapter one introduces the study and provides an overview of health insurance in Ghana and health service delivery under the NHIS. I state the study objective, research questions, and significance of the study. I also discuss the theoretical orientation of the study and explain the concepts that will appear in the book. The chapter ends with an outline of the book. The study design, relevant information about the study sites, data collection tools and analytical techniques are presented in chapter two. I conclude the chapter with a reflection on the researcher's role as participant observer in the intervention group.

Chapter three discusses barriers and enablers to enrolment in the NHIS and retention of members. It presents NHIS implementation challenges experienced by community members, health workers and DHIS staff and how they affect enrolment and retention rates. Attention is also given to the politics surrounding the introduction of the NHIS and the effect on enrolment.

Chapters four, five and six focus on the MSPSP and the outcomes. Chapter four describes procedures followed in setting up the intervention group, PSGs and processes used to select members and facilitators. Chapter five discusses the tools and approaches that the PSGs developed to identify barriers to enrolment in the NHIS and retention of members, and the implementation of intervention activities. Chapter six presents and explains the outcome of the intervention.

Chapter seven discusses factors that enhanced PSGs' functioning while chapter eight examines factors that limited their efforts at improving enrolment and retention rates.

Chapter nine concludes the book with a brief overview of the MSPSP and the theoretical reflection on the findings taking up the concepts of MLP, resilience and trust. I end the chapter with conclusions and recommendations regarding what could be done to improve NHIS coverage and retention of members and implications for further research.

Study design, fieldwork and methodological issues

Introduction

In recent years, multi-level stakeholder interventions have become common in the social sciences using various study designs depending on the level at which change is measured. The aim of this study – to explore if and how problem-solving groups (PSGs) can stimulate enrolment and retention of members in Ghana's National Health Insurance Scheme (NHIS) – requires a methodological approach that can capture the perspectives of all stakeholders involved and the factors that influence peoples' decisions to enrol (or not to enrol) and remain in the scheme. In this chapter, I discuss the research design, study sites and methodological issues. I start with a description of the design and study sites, the data sources and techniques. Next, through reflection, I discuss methodological issues encountered in the field. I end with presentation of the ethical issues related to the conduct of health-related research in Ghana.

Study design

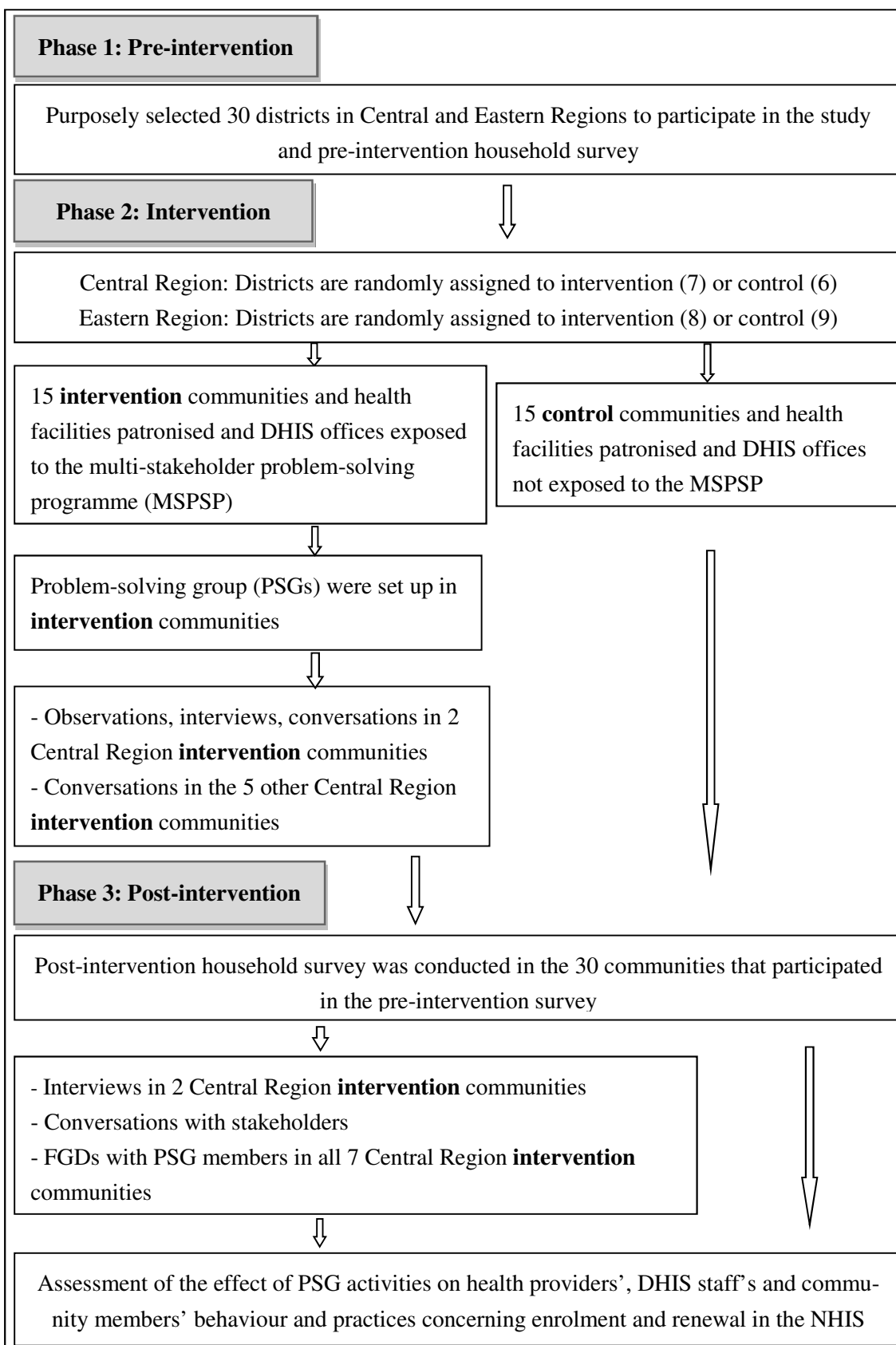
This study is the anthropological component of a multidisciplinary cluster-randomised trial (CRT) to explore problems of low enrolment in the NHIS and the high rates of membership non-renewal. The research project, 'Reaching the poor in Ghana's National Health Insurance Scheme' includes 30 districts in the Central and Eastern Region of Ghana. The research team included two health economists whose main focus was on barriers to enrolment in the NHIS, utilisation of healthcare services and identification of the poor for premium exemption. Although this

ethnographic study was carried out in two intervention communities in the Central Region (Assin Achiano and Anomabo), it also draws on data from five other intervention communities in the Central Region and pre- and post-intervention household surveys conducted in 30 communities in the Central and Eastern Region.

A cluster-randomised trial (CRT) design is a form of randomised controlled trial in which communities rather than individuals or households are randomised into either intervention or control groups. The CRT generally stands out as an approach to gather evidence and provide the clearest possible results on the effectiveness of interventions (see Donner & Klar 2000). Randomisation ensures that there will be an even distribution of the demographic, economic, behavioural and other characteristics of study participants for all interventions and control groups; hence, this approach permits comparability of results across communities (Hennerkens & Buring 1987). However, a major challenge for intervention programmes carried out across multiple sites is the potential for variation in the context, participants and implementers. Questions of causality are usually best addressed via randomised controlled trial (RCT) designs (Shadish et al. 2002); however, nuances that are missed in RCT may be examined through qualitative approaches (Brantlinger et al. 2005). The combination of quantitative and qualitative methods accounts for process and context factors as noted by Tones & Green (2004). Traditional notions of experimental designs for implementing and evaluating intervention using only quantitative methods do not consider contextual variations within natural settings that may be more varied than initially expected; hence they miss the possible interaction of process and context factors that determine outcome. To account for these factors, I used both qualitative and quantitative data to assess the intervention outcomes to make the generalisability of results under specific conditions acceptable (see Roland & Torgensen 1998). Mixed methods provide comprehensive explanations and bring out critical elements such as the interest, behaviours and practices of stakeholders that interact to influence outcome. In this respect, Nutbeam (1999:100) suggests: “The most compelling evidence of effectiveness comes from studies that combine different research methods – quantitative with qualitative.” Hence my combined methodologies permitted me to triangulate process and context information about the intervention with survey data to evaluate the effectiveness of the PSGs’ intervention activities across communities. Using the best of ‘both worlds’, I am able to provide a holistic picture of the intervention and better explanation of the outcomes.

The study was divided into three phases. Figure 2.1 shows the three phases of the study: pre-intervention, intervention and post-intervention. Phase one was the pre-intervention household survey conducted in 30 communities in the Central and Eastern Region of Ghana. The purpose of the pre-intervention survey was to provide

Figure 2.1 Study framework



information about the NHIS status of households and individuals in all communities¹ against which the effect of the intervention could be measured.

The second phase involved creating problem-solving groups (PSGs) consisting of representatives of communities, health providers and DHISs staff in seven of the 13 randomly selected communities in the Central Region and in eight of the 17 randomly selected communities from the Eastern Region that were designated as intervention communities. The intervention communities were matched with non-intervention communities with similar characteristics (seven non-intervention communities in the Central Region and eight in the Eastern Region). The intervention was launched in June 2009. During the intervention I was a participant observer in two PSGs in the Central Region (Assin Achiano in the Assin North District and Anomabo in the Mfantiman East District). I focused on PSG meetings and intervention activities designed to improve NHIS enrolment and retention. I also conducted key informant interviews and had conversations with stakeholders in both communities. However, I also had conversations with PSG members in the other five intervention communities in the Central Region, while visiting them during the course of the intervention.

In the third phase, the post-intervention, the post-intervention household survey data was collected once again in all 30 communities that had participated in the pre-intervention household survey. I held focused group discussions (FGDs) with all PSG members in the Central Region. The results of the pre- and post-intervention household surveys were used to assess the effect of PSG activities on enrolment with the NHIS and retention of members, while the qualitative information was used to explain the outcome of the intervention.

Study setting

Figure 2.2 shows the two regions – Central and Eastern – where the study was conducted. Ghana is divided into 10 administrative regions, which are further divided into 170 districts with well-defined geographical boundaries. The two regions were purposely selected because it was essential to have similar regions with comparable demographic, socio-economic and cultural characteristics to include 30 districts with DHISs offices in the CRT. Both regions are comparable in terms of rural/urban composition, poverty incidence, major socio-economic activities, social organisation (in terms of living arrangements), informal support network and access to healthcare. These characteristics were considered to be possible influences on a person's decision to enrol in the NHIS and renew their membership. The dominant

¹ A community is defined as a unit of social network within a geographical area. In this study it is defined as an enumeration area (EA) demarcated by Ghana Statistical Service (GSS). An EA covers a whole community, part of a community or a number of small settlements.

ethnic group in both regions is Akan and minority groups are the Krobo in the Eastern Region and the Effutu in the Central Region. Access to healthcare services is 60.1 per cent and 67.2 per cent in Eastern and Central Region respectively, compared to the national average of 57.8 per cent (Ghana Statistical Service et al. 2004).

Figure 2.2 Map of Ghana showing the two study regions with the number of districts with DHIS offices



The Central Region is situated in coastal and forest zones in Southern Ghana with 17 administrative districts and a population of 1,843,403. At the time of the pre-intervention household survey, the Eastern Region had an estimated population of 2,322,030 and 21 administrative districts and was a forest area. The majority of the work force in both regions is engaged in the agricultural sector – mainly farming and fishing. The sector employs 33.1 per cent of women and 35.7 per cent of men

aged 15-49 years in the Central Region and 22.5 per cent of women and 45 per cent of men in the Eastern Region (Ghana Statistical Service et al. 2009). Fishing is the predominant occupation along the coast in the Central Region, but less so in the Eastern Region (only persons living in communities along the Volta Lake are engaged in fishing). The two regions have similar poverty incidence of 45 per cent and 40 per cent respectively (Ghana Statistical Service 2007), but the Central Region has a lower (23.2%) currently insured population aged 15-49 years than the Eastern Region (49.6%) (Ghana Statistical Service et al. 2009).

Selection of study sites for intervention activities

The district assembly concept and the on-going decentralisation process make the districts the focus of government policies. The district officials are thus responsible for implementing public policies with the regions having a supervisory role. Hence, the district level was the focus of the study intervention. Each district has a health directorate that coordinates and supervises all activities of both public and private health facilities that provide basic and referral services. Many, but not all, districts have at least one hospital. Similarly, the DIHSs offices are located in each district capital with NHIS collectors based throughout the communities.

All 30 districts with DHIS offices in the two regions – 13 in the Central Region and 17 in the Eastern Region – were included in the study. Newly created districts without DHIS offices were excluded from the study.² One census enumeration area (EA) was randomly selected from a district using computer-generated numbers in Excel and a lottery approach. For the purpose of this study, EAs are referred to as communities. Of the 30 communities, 39.5 per cent were urban, 38.8 per cent semi-urban and 21.8 rural.

Since it was not possible to blind control communities located within the same district to intervention activities, the district was the unit of randomisation to prevent experimental contamination. Therefore, one community was randomly selected from each of the 30 districts to ensure that control communities were blinded to intervention activities and the risk of a spill-over effect was eliminated. Following the pre-intervention household survey, we stratified the 30 communities in the two regions into rural, semi-urban and urban and randomly selected 15 communities in each region for the intervention. We took into consideration the current enrolment levels and poverty incidence as captured by our baseline household survey to minimise an imbalance of socio-economic and demographic characteristics in the two groups.

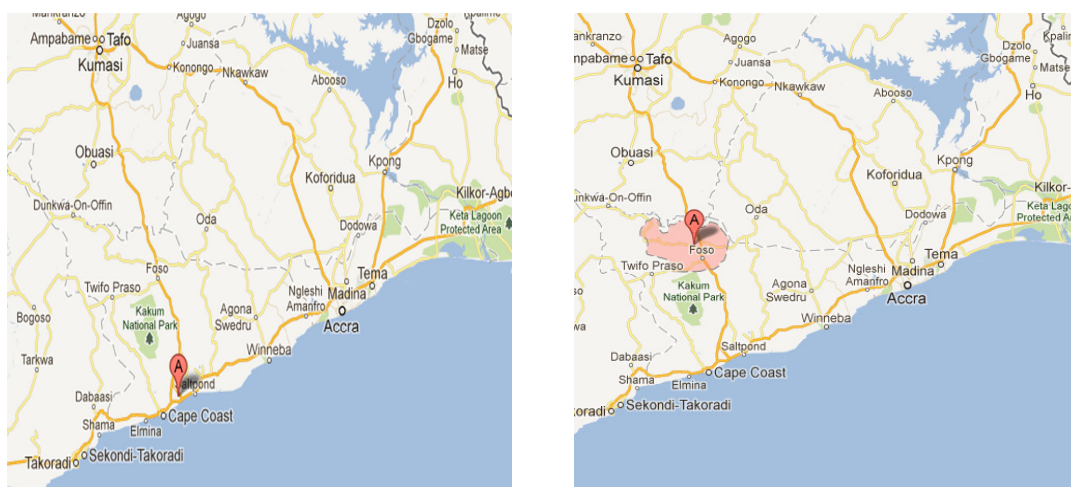
Intervention activities were carried out in 15 intervention communities, the health facilities they patronised and DHIS offices (eight in the East Region and seven in

² There were newly created districts in both regions that did not have DHIS offices, hence were ineligible for the study.

the Central Region). No activity was carried out in control communities. These measures made it possible for drawing causal inferences between intervention and control communities about the effect of PSG intervention activities on the dependent variable (enrolment and non-renewal rate).

In the Central Region, two intervention communities – Anomabo and Assin Achiano – were selected for the anthropological component of the study that is reported here (Figure 2.3/4).

Figure 2.3/4 Map of Anomabo (A on left) and Assin Achiano (A on right)



Source: Google maps

Selection of Anomabo and Assin Achiano as case study communities

Both Anomabo and Assin Achiano are in the Central Region. They were used as case study communities for the anthropological component of the study because they represent the ecology and the main economic activities of the region – coastal and forest as well as fishing and farming. Anomabo is a fishing community while farming is the main economic activity in Assin Achiano. They also have similar socio-cultural practices and proximity to health facilities. Indicators in the two communities that affect enrolment and retention in the NHIS include the seasonality of income and proximity to health facilities.

Anomabo, an urban fishing community in the Mfantseman East District of the Central Region, is located along the Atlantic Ocean on the Accra-Cape Coast Highway. It is approximately 10 kilometres from Cape Coast, the regional capital. The main source of income for the men is fishing, while the women engage in trading, which is normally selling fish. Assin Achiano on the other hand, is a rural farming community located in the forest zone in the Assin North district of the

Central Region. It is off the Cape Coast-Nyamoransa-Kumasi Highway. Both men and women are engaged in farming. They grow cocoa and oil palm as commercial crops and food (cassava, plantain and cocoyam) mainly for their own consumption.

Though income is seasonal in both communities, the situation is worse in Anomabo where the majority of the population are unemployed half of the year. Fishing is done mainly from June to November after which only few fishermen engage in deep-sea fishing and earn income. The situation is slightly better in Assin Achiano, where, after the cocoa season (September to December), people still receive some minimal income from palmtree, cassava and plantain.

Our pre-intervention household survey result showed that only 4.8 per cent of the population were currently insured³ in Anomabo, 11.3 per cent had been previously insured⁴ and 83.8 per cent had never insured⁵. In Assin Achiano 20.5 per cent were currently insured, 12.7 per cent previously insured and 66.9 per cent had never insured.

The educational level of the population is relatively low in both communities but worse in Anomabo where almost half the population (46.2%) have had no formal education and 44.2 per cent completed primary school. Only nine per cent have completed secondary school and less than one per cent (0.6%) tertiary education. In Assin Achiano, 18.5 per cent had no formal education, 64.5 per cent completed primary education, 42.3 per cent completed secondary education and 3.7 per cent completed tertiary education (Table A.1, Appendix 2).

In terms of access to health facilities, both districts have a district hospital with numerous lower levels of health facilities (health centres, clinics, private health facilities and CHPS compound (see figure 1.4 in chapter one). Access to healthcare is 74.3 per cent and 67.0 per cent in the Mfantseman and Assin North districts respectively (Ghana Statistical Service 2004). However, with the expansion of the community-based health planning and services (CHPS) in recent times, the situation has improved with many more communities having access to a health facility within five kilometres. Regarding proximity, there is a health centre in Anomabo and a district hospital at Saltpond, the district capital, about eight kilometres away. Achiano on the other hand, is located between two health centres – Kushea about five kilometres away and Praso seven kilometres away. However, Praso Presbyterian Health Centre is patronised by the majority of the people in Achiano because of its strategic location close to the district hospital.

³ People who are currently insured with a valid NHIS cards are eligible to access healthcare services without paying.

⁴ People who were previously insured but did not renew their membership, could not access healthcare with their NHIS cards.

⁵ People who were never insured are those who had never registered with the NHIS.

Social organisation and social security in Anomabo and Assin Achiano

Anomabo and Assin Achiano are closely knit communities with extended families living close to each other as is usual in Ghanaian rural and traditional urban settlements. The typical living arrangement is extended families living in one structure referred to as a compound house⁶. Compound houses usually consist of various households⁷ and/or nuclear families as sub-units. The people live in the compound house and interact with each other, but function separately. Although this kind of communal living is expected to translate into offering support in times of adversity such as ill-health, these traditions have diminished with modernity making extended-family support a secondary responsibility. The majority of respondents in this study live in compound houses with other extended family members, but do not necessarily receive support from them.

Quantitative data collection

Quantitative data was obtained from two rounds of household surveys (pre-intervention and post-intervention), conducted in the Eastern and Central Regions of Ghana between 8 March and 6 April 2009 and 7 March 2011 to 4 April 2011 respectively.

Selection of respondents for the household surveys and data collection

The sample was drawn using a three-stage procedure. First, the research team purposely selected all the 30 districts with District Health Insurance Scheme (DHIS) offices from the two regions (17 from the Eastern Region and 13 from the Central Region). Second, we randomly selected one enumeration area⁸ (community) from each district. Third, the research team mapped and numbered all residential structures within the selected communities out of which 110 households were randomly selected. The pre-intervention survey involved 3,301 households, which covered 13,857 individuals. This total consisted of 1,646 households (7,234 individuals) in the intervention communities and 1,635 households (6,623 individuals) in the control communities in the two regions. In 2011, all 3,301 household heads who participated in the pre-intervention household survey were followed-up to assess the effect of the MSPSP on enrolment and retention rates. In the post-intervention household survey, 149 households were lost reducing our post-intervention sample to 3,152 households with 12,810 individuals. This included 1,562 households (6,790

⁶ A compound house is a structure made up of one or more households who see themselves as separate units with distinct living arrangements.

⁷ A household consist of a person or persons who live together in the same house or room in a compound and share the same housekeeping arrangements and see themselves as one unit.

⁸ EAs are clusters of residential structures classified by the Ghana Statistical Services (Ghana Statistical Services 2002).

individuals) from intervention communities and 1,590 (6,020 individuals) from control communities in the two regions. The changes in the number of households and individuals were mainly due to household relocations to other communities or the death of individual household members.

The data collected in the pre-intervention survey included socio-demographic information about the respondents' age, sex, occupation, education, religion and marital status, income and expenditure, NHIS status, reasons for enrolling or not enrolling with the NHIS or not renewing membership and the effect of NHIS on utilisation of healthcare services. There were also questions on opinions related to health providers' attitudes and behaviour, DHIS services, quality of healthcare services and community beliefs and practices.

To address the issue of validity, households were randomly selected to participate in the pre-intervention survey and data sources were effectively triangulated. The pre-intervention household survey questionnaire was translated using a back translation method. Experienced research assistants were trained in techniques of questionnaire administration to reduce interviewer bias. The questionnaires were pretested and challenges identified and addressed. Pre- and post-intervention household surveys were identical. Finally, research assistants worked independently from the PSG members who implemented the intervention to also reduce bias.

Quantitative data analysis

Quantitative data from the pre- and post-intervention household surveys was used to measure the effect of the intervention on enrolment in the NHIS and retention of members. The analysis included descriptive statistics including: frequencies, crosstabs and chi-square to show relationship among variables. NHIS status was placed into three categories: currently insured, previously insured and never insured.

Probit logistic regression was used to analyse the effect of PSG intervention activities on the two outcomes measures: enrolment in the NHIS and membership non-renewal rate. The model is often used to predict treatment effects in case control and intervention studies to determine the success or failure of the programme. The category coded 1 is the 'response' category, exposed to experimental condition and the referent group, not exposed to the experiment is 0 (Field 2009). The model predicts changes in the dependent variable, that is, enrolment in the NHIS and membership non-renewal rate in intervention communities as a result of their exposure to PSG activities compared to the control group. It shows how likely or unlikely residents in intervention communities are to enrol or not renew their membership compared to those in the control group. For example, if the estimated

(β) (the treatment effect for enrolment),⁹ is 0.5 then respondents in intervention communities are 50 per cent more likely to be enrolled compared to those in the control group (see Hosmer & Lemeshow 2000: 47-50). The associated confidence interval (CI) standard errors are used to assess the suitability of the model and p-values, the strength of the association. To assess if the change in enrolment is explained by exposure to PSG activities, key socio-demographic variables including: place of residence, wealth, sex, age and education, marital status, religion, household size and chronic disease known to affect enrolment in SHISs and the NHIS (see Asante & Aikins 2008, Adusei-Asante 2009, Sarpong et al. 2010, Jehu-Appiah et al. 2011) were used as covariates in the model.

To assess whether the intervention improved enrolment and membership non-renewal rate among the poor, cross tabulation was used to examine changes in enrolment among wealth quintiles between baseline and intervention period (2009 and 2011). Finally, the impact of the intervention on the enrolment and retention rates in specific communities was assessed using Pearson's chi-square test conducted as two-sided and declared significant for p-values <0.05. All analyses were done in STATA 10 and SPSS version 16.

Qualitative data collection

Qualitative information to assess the effect of PSG activities on community members, health providers and DHIS staff was gathered throughout the three phases of the study. Key informants were selected from community members, health providers and DHIS staff. My data collection focused on PSG activities, the behaviours and opinions of community members, health providers and DHIS staff. Techniques used to gather information included participant observation, informal conversation, key informant interviews and focus group discussions (FGDs). I triangulated these methods and data sources by asking various participants the same questions in disparate contexts. These data sources and varying techniques helped generate in-depth information about the issues being explored. For example, barriers identified at PSG meetings were discussed with key informants in individual conversations with community members, health providers and DHIS staff. I also presented information gathered from key informants and individual conversations, community leaders and stakeholders' meetings for discussion at PSG meetings. This approach of triangulation described by Jenkins (1992: 55) as a 'promiscuity of methods'

⁹ β is the coefficient of the independent variable (dummy for intervention) on the dependent variable. It shows the amount of change on the dependent variable and is used to predict the effect of the intervention on enrolment and non-renewal rates. Positive values show positive relationship and negative indicates inverse relationship.

provided multiple perspectives about the issues explored and in-depth information while creating a means of verifying the authenticity of the data.

Selection of key informants

Twenty key informants were purposely selected from each of the two study sites for a total of 40. The key informants were as follows: 11 from the community, 5 from local health facilities, 2 from the District Health Directorate and 2 from the DHISs. Additional key informants were selected from the national level of healthcare: two from the NHIA and one from the MoH and one from GHS headquarters.

Key informants were not selected before going to the field. They were chosen after a few weeks of fieldwork. I began identifying key informants after I had met PSG members or was approached by people who wanted to share their experiences with either DHIS staff or health providers when it became known that I was investigating insurance. Some key informants were selected by serendipity since they happened to be in the same location where I was doing my research. The selection of community key informants was based on two issues: their potential to provide meaningful information and their representativeness of one of the three categories of the population of interest (currently insured, previously insured and never insured). Gender, education and health status were also considered.

Key informants who were health providers or worked in the DHIS offices, on the other hand, were purposely selected at the onset of the fieldwork. The main criterion used to select them was their work schedule and their contact with community members or insight into NHIS operations in their institutions.

Key informant interviews

In intervention studies, changes in individual behaviours and institutional practices can be measured using surveys, but they do not really go beyond the observed change to provide reasons for the outcomes. Critical information about participants' perspectives, processes and contexts that explain the cause-and-effect relationship characteristic of intervention studies is often missed. As Lapan (2004) observes, face-to-face interviews provide perspectives and insights into special knowledge that only participants possess. I heard the participants' perspectives and opinions and observe what they often expressed through their gestures. As a result, I was able to capture their perspectives, experiences and how the social environment affected their decisions about health insurance. Nonetheless, interviews were time consuming since discordant views often led to long arguments. Another difficulty was that the interviews attracted on-lookers who express opinions that had to be discussed.

I conducted 44 key-informant interviews with community members and health providers in Anomabo and Assin Achiano and staff of DHISs, the NHIA, MoH and GHS headquarters (see Table A.2, Appendix 2, for their profiles). The interviews lasted between 20 and 30 minutes. They were either audio recorded or hand written

depending on the interviewee's preference or the circumstances¹⁰. I engaged all informants (except the four from the NHIA, MoH and GHS) in conversation during the intervention. In addition, I had informal conversations and discussions with community members, DHIS officials and health providers who I did not consider to be key informants. Information gathered from community members included reasons why they did not enrol or renew their memberships, the benefits they derived from the NHIS, insured patients' experiences accessing healthcare, and quality of service delivery among others. I solicited information on the challenges experienced in implementing the NHIS policy from DHISs' staff and health providers.

When the intervention was complete, I engaged all key informants in follow-up interviews to explore the results. Discussions usually started with a presentation of the pre- and post-intervention household survey results from the entire study (30 districts) and specific community survey results. The survey results were used to explore factors that may have accounted for the observed outcome. The key informants who were interviewed before the intervention were also engaged in regular informal conversations during the course of the intervention and had follow-up interviews after the intervention (except for two, a community leader who died and a District Director of Health Services (DHSSs) who was transferred during the intervention). I did however interview the two key informants who replaced the missing two mentioned above, because they were well aware of the intervention and had participated in some PSG activities. The topics explored in these key informant interviews included knowledge of intervention activities and the effects on community members, health providers and DHIS staff.

Participant observation

Participant observation was a main technique for data collection. This trademark distinguishes anthropologists' work from other social scientists. As Spradley (1980) argues participant observation creates a social situation that makes it possible for the researcher to engage in activities appropriate to the situation by observing the subject of study and their activities. He points out the approach allows pertinent features of the daily life of the study setting to be recorded even if they are not discussed by interviewees. Thus, my participation in the intervention PSGs allowed me to observe aspects of the participants' activities and gather relevant information that might not have been revealed through interviews.

¹⁰ For example, when the interview was conducted at a noisy place, audio recording was not feasible. This normally occurred at the beach where fishermen were busy mending their nets or in compound houses where others played loud music.

During the intervention, I was a participant observer in the PSGs in Anomabo and Assin Achiano. My daily research tasks were observation and participation in PSG meetings and intervention activities. I also had informal conversations with members of the two intervention communities, health providers in the local health facilities and district health directorates they patronised and staff from their respective DHISs. Since the majority of my fieldwork was in Anomabo and Assin Achiano, I divided my time between the two communities and planned my schedule around those PSG activities and frequently went to health facilities that the people patronised and the respective DHIS offices for observation. I also chatted with staff and the clients. In addition, I visited the other five PSGs in Central Region at least three times and took part in their meetings and intervention activities. During my stay in each community, I had informal interactions with community members, health providers and DHIS staff.

I also visited key informants at home and shared meals with them in Anomabo and Assin Achiano. I adopted this strategy because it was not possible to observe sensitive issues such as corruption or get information from people directly involved. These strategies gave me the opportunity to eavesdrop on conversations about the research issues. This approach also ensured that individual perspectives were not missed which was particularly helpful because participants talked more in informal individual conversation than in group discussions, interviews or in answers on questionnaires. Sometimes, I heard rumours that helped me re-direct my line of enquiry. I also observed how problem-solving tools and participatory approaches were used to identify barriers to enrolment, develop and implement intervention activities to improve enrolment and retain members.

Focus group discussions

Focus group discussions (FGDs) are used to gain in-depth information (see Senah 1997). FGDs generally provide information that is not captured by other data collection methods. In my case, FGDs were particularly useful for obtaining relevant feedback on collected data and to enrich my understanding of various key-informant perspectives.

At the end of the intervention, I held FGDs with PSG members in all seven intervention-communities in the Central Region to assess the effect of the intervention on all stakeholders. The main issues discussed were views on the intervention and outcome. The information gathered included: (1) PSG members' views about the intervention, (2) how stakeholders were involved in PSG activities, (3) the effect of the intervention on community members, health providers and DHIS staff, and (4) the processes and intervention activities and factors that contributed to the outcome. This provided evidence to construct a holistic picture of what had happened, how it occurred and why a particular outcome was achieved. The interactions provided

deeper insight into the data as participants' information was probed and sometimes challenged and credibility established.

To address the issue of validity, four steps were taken to ensure that the information gathered reflected the studied phenomena. Regarding the implementation of the MSPSP and the conduct of PSG activities, PSG members and facilitators were selected using the same method. All facilitators were trained in leadership and facilitation skills. The application of problem-solving tools was given in one workshop to ensure uniformity in the execution of the MSPSP. I also explored and verified issues that emerged across communities and groups to explore contradictory data. Above all, I used the FGDs as a final check on data gathered from interviews, observations and survey results. The reaction and feedback that I received from PSG members provided deeper insight into the data, which helped me ensure that it reflected the views of participants and minimised subtle biases in my interpretation of the data. I believe that I present a fair reflection of participants' views and represent the target population.

Qualitative data analysis

The information gathered was manually analysed. Qualitative information processing started with regular organisation of my observations, discussions and conversation notes while in the field to address my research questions and identify initial patterns in the data. As fieldwork progressed, I manually transcribed my interviews and grouped them according to themes. At the end of my fieldwork, the data set was then analysed in its entirety and responses from various participants grouped under each theme according to the three stakeholder groups: community members, health providers and DHIS officials.

As Oakley et al. (2006) observed using process and outcome data to measure the effectiveness of intervention activities enriches the interpretation of results. I arranged typical narratives by key informants and PSG members that described barriers to enrolment in the NHIS and retention of members, the intervention process (including activities), and events that occurred during the intervention period and finally, my respondents' observed changes among community members, health providers and DHIS staff. I also categorised what my respondents thought had caused the changes. The information from my respondents (key informants and PSG members) was grouped according to what was observed at each level that they linked to the changes in enrolment and retention rates. I used the typical expressions that my respondents used to create summary statements. Next I created a list of comments related to each theme and systematically checked them for information that supported the summary statements and explained the quantitative results of the outcome of the intervention. When respondents' comments suggested dissimilar points of view, the contradiction was described and observations in the field were

used to explain what I believed guided people's reasoning. Summary statements that described each stakeholder's points of view were verified by discussing my summary statements with key informants and PSG members to determine whether I had summarised their comments accurately.

Finally, the information was subjected to thematic and content analysis to examine factors that had direct effect on PSG activities and thus on enrolment in the NHIS and non-renewal of membership from the stakeholders' perspectives. This helped me to explore the respondents' narratives that depicted antecedents that governed participants' behaviour and practices as well as the intervention outcome (increase in enrolment and no improvement in retention rates). Thus interrogation of the data highlighted the core issues that the stakeholders were most concerned about. These analytical approaches, careful selection of key informants and effective triangulation of data sources minimised bias in the data presented in this book.

Double role of the researcher: An asset or hindrance?

The ensuing discussion explores whether the researchers' dual role as a member of an intervention group was an asset or an obstacle in the research process. The issues raised in this discussion are situated within the entire research process and focus on methodological issues. I start with the peculiar advantages that I gained as a result of my dual role. I then address the dilemmas and challenges I faced and how I managed them to optimise playing both roles.

Benefits of dual roles in a research process

In this study, my combining observation of and participation in PSG intervention activities was a complex enterprise with opportunities and challenges. I used reflective skills and an empathic understanding of the social context to effectively manage the challenges and benefit from the opportunities.

A number of social scientists have discussed the benefits of dual roles in ethnographic studies (Harrington 2002, Kinsman 2008, Kyakuwa 2011, Dapaah 2012), while others have given account of challenges they faced (Oosterhoff 2008, Mulemi 2010). According to Van der Geest & Finkler (2004), the tenets of anthropological study pose peculiar challenges for carrying out fieldwork especially in a health facility. For example, it is not uncommon for research projects to be delayed because gatekeepers, such as health providers, are apprehensive about allowing an outsider into their work space. As a result, some researchers have hidden their identity or gone completely undercover to gain access. For instance, Dapaah (2012) reports on healthcare providers' reservation about his presence in a Ghanaian hospital. However, a double role in this case can help a researcher to bypass powerful gatekeepers. Since I was a participant in the intervention group, access to the

healthcare facilities was not a problem. Eventually, I derived three benefits from my dual role.

First, my membership in the PSG gave me the advantage of gaining access to the 'field' and I had a smooth entry to my study sites: communities, health facilities and DHISs' offices. At health facilities, I was introduced to colleagues of the PSG members as a group member, and thus I was allowed into their midst and the staff willingly accepted my interview appointments. Moreover, because I was often seen in the company of health providers and DHIS staff on the premises, after a few weeks my presence became less noticeable and invasive.

Second, it could have been very difficult for me to explore my research topic with healthcare personnel and community members as a complete outsider only playing the role of a researcher. I resolved the problem of obtrusiveness that could have led to pretence and holding back information by hanging out with individual PSG members and engaging them in informal conversations. It also helped that I am a Ghanaian and speak the local language. This made me less of a stranger, not only to PSG members, but also their colleagues. So I easily went to the beach, church services and visited PSG members and key informants at home. The frequent informal interactions minimised pretence and the PSG members and key informants allowed me to have conversations about the study even when I did not initiate the subject. Thus, I was able to observe the backstage behaviour of some community members, health providers and DHIS staff. I had the opportunity to ask follow-up questions within and outside group meetings on sensitive issues such as malpractice and confirmed that it does occur. For example, the collection of unauthorised fees was denied at PSG meetings and could not be observed, but was revealed during these more 'casual' times with PSG members as I probed what had transpired during intervention activities and listening to spontaneous remarks at PSG meetings.

Third, my deep involvement in PSG activities helped me experience the reality of the intervention process and gain deeper insight into contextual factors and structural challenges that affected the PSGs' work and by consequence the outcome of the intervention. My role as a PSG member made stakeholders see me as someone who appreciated their challenges and could help improve their situation, so they had forthright conversations with me. Community members in particular saw my presence as an opportunity for expressing their dissatisfaction about the quality of healthcare services. Thus my dual role facilitated data collection and provided reliable information that helped me construct a more accurate picture of the intervention programme as it unfolded. This role also established the credibility of my reports, since I heard stories with deeper nuances than an outsider just observing the intervention process would have done.

Despite the advantages, I also point out that playing a dual role creates the problem of the researcher's persona hindering some people from participating in inter-

vention activities. Based on the behaviour of a few PSG members, heads of health facilities and DHIS managers towards my presence, I sometimes believed that they thought I was evaluating their work to write a performance report. Some PSG members defended negative things said about them during discussions and I noticed from their gestures that their defence was just an attempt to present a good image of their institution. Their gestures sometimes showed that they were not sure whether or not my observations would be shared with the authorities. I believe these key informants held back information that they thought was embarrassing. In the case of heads of institutions, I observed what I refer to as ‘a gentleman’s behaviour’. Some of them did not honour invitations to stakeholders’ meetings and intervention activities. The impression I got was that they were reluctant to have an open and frank discussion because they feared it might reveal negative things about them or their institution. Perhaps due to their apprehension, they sent subordinates when invited. This did not create the same impression as their presence would have done. For example, the presence of heads of health facilities and DHIS managers in stakeholders’ meetings and community durbars¹¹ created a better impression of the intervention since community representatives perceived it as a show of support for the NHIS and the intervention thereby increasing their commitment to PSG activities. Health providers and DHIS staff also attached more seriousness to the intervention when the head of their institution attended PSG activities. The head’s presence thus assured health providers and DHIS staff (within and outside PSGs) that the challenges they faced implementing the NHIS would be addressed. Unfortunately, not many heads of institutions attended stakeholders meetings and community durbars.

Methodological dilemmas

I faced three main challenges during this research. First, whether or not to contribute to discussions during PSG meetings and thus not disrupt the group environment, or how and to what extent I should participate in intervention activities; second, how I should manage participants’ expectations; and third, how I could ensure that the intervention process and events were recorded objectively and the outcome results interpreted dispassionately.

I decided to only prompt PSG facilitators when I believed that the theoretical basis of the intervention was not being followed. If I had not done so, then the purpose of the intervention would have been defeated. In this action, I drew their attention to critical issues that the group sometimes overlooked. This occurred early

¹¹ Community durbars are usually public gatherings held to celebrate festivals or used as a platform to sensitise community members and other stakeholders about public issues that affect them. Durbars are usually attended by chiefs and their elders and community members and officials who interact and communicate their views on the issues discussed.

in the PSG activities, especially during problem identification. At this time, I observed that depending on who facilitated a meeting, the PSG member consciously or unconsciously tried to focus on negative behaviours and practices attributed to others and paid less attention to barriers at their level. For example, when health providers or DHIS staffs were leading discussions, they focused on barriers at the community level as the main cause of low enrolment in the NHIS and high membership non-renewal rate and gave less attention to issues related to their negative behaviours and practices. In such situations, I drew their attention to the need to be open-minded and look at barriers from all levels and not draw hasty conclusions. After a few such contributions to discussions that provoked debates in critical areas of the intervention, I noticed PSG members were better at conceptualising the intervention and rationale. Addressing a similar methodological concern Harrington (2002: 50) points out: “Making ethnography credible depends on walking a fine line between participation and observation: being immersed enough to know what you are talking about while being separate enough to offer a critical analysis.”

In this study, I can say that my double role helped me to give a critical and in-depth account of the intervention process and events. What is important is to develop strategies to be a successful participant observer. Self-management and critical reflection abilities are essential to set limits and maintain a good balance between observation and participation during data collection.

Further, though every researcher encounters problems in the field, playing double roles especially in an intervention programme that involved multiple stakeholders in the researcher’s home country presents challenges that may affect data collection. First, since enrolment in a health insurance scheme is based on values and behaviour, I anticipated that my background as a Ghanaian studying in my home country and my personal views on the subject might bias discussions at meetings. My familiarity with the subject might make me take many things for granted and not pay attention to details, thereby biasing my interpretation of participants’ views. I managed these issues by not being on the frontline of PSG activities, limiting my talking, and increasing my listening during discussions; I only asked questions to clarify observations I had made. By not making my views known on pertinent issues, the discussions remained open for participants to express their views. My questions helped me to understand the participants’ perspectives and realities and decreased biased interpretation.

The second dilemma was how to manage the expectations of key informants especially so I could continue to enjoy their cooperation. The problem of participants requesting financial assistance from social researchers has been widely discussed in the literature. Scott et al. (2006: 34) speak of a ‘project syndrome’ when researchers are treated as sources of financial support for study participants. I had to manage the key informants who asked me for financial support. PSG mem-

bers asked me to help the elderly pay their registration fees for the NHIS and help the core poor receive an exemption. Although I was introduced as a researcher and reminded PSG and community members several times about my role and that the project did not provide financial support, their expectations of financial support and demands did not stop. Some PSG and community members considered me as a programme manager working in a non-governmental organisation (NGO); hence they expected me to provide financial support for their participation in intervention activities and the study. I must state that some demands were made because of a lack of experience with intervention studies. In my conversations with some PSG members and key informants, they indicated that they only knew of NGOs that implement interventions, which are accompanied by some financial assistance or hand-outs. So I occasionally gave gifts to ensure their continuous cooperation. However, I did take the opportunity to clearly explain my role as a researcher and not a programme manager, so they should not expect any financial assistance.

PSG and community members also expected me to confront the DHIS staff and collectors who did not want to register people they considered as qualified for exemption. Similar to Evans-Pritchard (1976) and Scheper-Hughes (1992), who both intervened during their research to help their study participants, I found myself initiating procedures to help people by recommending to collectors and DHIS staff that the core poor must be exempted. In a few cases, I was successful; however, I was cautious and tried not to show signs of aligning with a particular stakeholder. Some community representatives in the PSGs expected me to confront health providers and DHISs staff who they accused of corruption. But considering the implications of this action for my study, I turned down the requests. However, I did raise these incidents during key informant interviews, PSGs and stakeholders' meetings for the group to decide on what action to take.

The third issue was how to ensure that my participation did not bias my interpretation of the intervention process, events and outcomes. There is a general perception that when doing fieldwork in one's home country, a researcher runs the risk of developing 'over rapport' with research subjects, which might impede receiving objective information (Zaman 2005 : 31). In my case, it was not just that I was doing research at home, but I was also working with an insider's perspective on the NHIS, which I term as both 'positive' and 'negative' information. The mutual trust that I developed with PSG members led to empathy and sometimes sympathy. For example, my familiar relationship with DHIS staff and community members sometimes led me to sympathise with some of their corrupt practices that they termed 'giving favours', e.g., not sanctioning defaulters and collecting more than the premium and registration fees. This created a problem on how to distance myself from the 'negative' information that was important to the subject of study but may have been embarrassing to individual group members when published. As Okely

(1984) observes, the research report bears the mark of future scrutiny and I call this image management. Is it more important to maintain a researcher's position when the findings are made public, or to be concerned about upholding the trust of key informants? In this respect, my dilemma was whether to publish the 'negative' without looking over my shoulder for PSG members' reaction when they read about what they had told me in confidence. In this regard, Van Ginkel (1994: 15) notes: "Many ethnographers refrain from writing things that are potentially harmful to their key informants' interest." This demands a negotiated approach to maintain objectivity while keeping the participants' trust. I used an interpretive perspective in my analysis (O'Brien 2001). I did this through self-reflection and employed emic¹² perspectives and etic¹³ accounts of the various issues. I maintained my position as a researcher and brought out both the positive and negative information while keeping stakeholders' identities confidential.

I was also cautious of Davidson & Layder's (1994) observation that reflexivity could lead to researchers' hypersensitivity to their role in constructing the data and lack of confidence in the findings. I was personally disappointed that the intervention did not achieve all objectives. In the end, the intervention only increased enrolment overall, but failed to improve retention rate and enrolment among the core poor. As an initiator of the intervention and with my interest in the PSGs' performance, I had to make a conscious effort to stand back while writing and interpreting the processes dispassionately. I was assisted by the survey results, which determined the final outcome of the intervention. The post-intervention household survey provided the final quantitative answers about the success and failure of the project. Triangulating qualitative and quantitative data helped me to interpret the results. I also organised a focus group with all PSG members in the Central Region after the intervention was complete to examine the outcome. These discussions provided additional explanations for the intervention outcome, which I added to my final data making me confident that I captured the participants' reality and point of view in my interpretation and conclusions. Although the information presented in the following chapters may be complex and sometimes conflicting, it is my interpretation of events based on data that I believe to be reliable, and no more. My participant role might have prevented me from being an independent interest-free researcher and thus, I make no universal claims that what I present is bias free.

To conclude, the debate regarding the advantages and disadvantages of a researcher playing dual role is not an either/or affair. I am convinced my participation in PSG intervention activities was necessary. It helped me capture more dimensions

¹² An 'emic' perspective describes behaviours and understandings in terms of meaningful experiences to the actor.

¹³ By contrast, an 'etic' account is a description of a phenomenon in terms of its meaning to the observing outsider.

of the phenomenon and process factors that enabled me provide in-depth causal explanations to the outcomes of the intervention. As Oosterhoff (2009: 257-258) argues: “In public health action research, the goal is not just to learn but also to change and improve the status quo.” Similarly, my involvement in PSG activities made it possible for me to offer suggestions in critical areas of the intervention that helped the PSGs to better conceptualise the intervention and enhanced their work. In addition, my insider’s knowledge of what PSGs’ experienced implementing the problem-solving intervention programme helped me give an in-depth account of the intervention process, factors and challenges that influenced PSGs’ work and by consequence the outcome of the intervention. My dual role thus helped me not to be disconnected from reality, so I could offer insightful suggestions to improve intervention practice.

Ethical issues

For health-related research to be conducted in Ghana, it is obligatory to obtain ethical approval from a recognised board to protect the interests of participants. The Ghana Health Service (GHS) vets research proposals to ensure that proposed studies use appropriate designs especially for data collection, storage and publication to ensure researchers do not cause harm to participants. The proposal for this study was vetted and approved by the ethics committee of the GHS.

Before I had access to health facilities and DHISs, we [the project team] had to seek approval from the National Health Insurance Authority (NHIA) and GHS, the two institutions directly involved in the implementation of the NHIS policy. Before the study commenced, we held discussions with the top officials at the headquarters of both institutions to inform them about the project. Then we went to the regional and district levels before going to individual health facilities that provide healthcare to the communities and which were selected for the study to discuss the project. We also sought the officials’ permission to use their staff as PSG members. These visits were preceded by official letters to NHIA and GHS headquarters and the two Regional Directors of Health Services (DDHSs) and NHIA regional managers who in turn wrote to the District Directors of Health Services in their respective regions, heads of health facilities and District Health Insurance Scheme (DHIS) managers. Many of these officials were gatekeepers who provided protection against undesirable interference in the study and intervention.

Following these protocols was quite easy because of the principal investigator’s (one of my local supervisors in Ghana and a regional director of GHS) connection with regional directors of GHS and DDHSs. Equally important was seeking permission from traditional leaders to carry out the study in their communities. The staff of the various District Health Directorates facilitated our approval from the traditional

leaders as they had good relationships with them. They introduced us to the chiefs and opinion leaders who readily granted us permission to go forward.

Anonymity of respondents

Although there was no potential risk in participating in this study, utmost care was taken to protect the confidentiality and identity of participants. The political perception of the NHIS makes the issue of protecting respondents' anonymity rather complex in the writing of this book. Similar to Van der Geest's (2003) observation that all key informants in his study of old age in Ghana were disappointed when their names did not appear in his book, here the desire for anonymity was mixed and I had various reactions from key informants. At the community level, the need for anonymity was less relevant as they did not care about revealing their identities. They wanted their names and pictures to be attached to their views in my study. However, health providers and DHIS staff did not want to be associated with views on topics they perceived as critical of their organisations. Some were reluctant to have their interviews recorded, so I had to write their responses.

As Green & Thorogood (2005: 60) note: "Case studies present particular challenges in terms of anonymity." The following comment was typical of some DHIS staff's reaction when I presented the summary of the preliminary findings for their feedback: "Though the results reflect what was discussed, I am not comfortable with the political issues in your report because of the politics surrounding the NHIS and our work" (a DHIS manager). Fortunately, because I used two study sites and also visited other five intervention communities in Central Region, I was able to use pseudonyms when discussing the results to hide the identity of the communities and protect their confidentiality so that sensitive information could not be linked to a specific person. The individual identities of informants were also protected by using pseudonyms.

To prevent others from having access to the database, after data entry, the questionnaires were stored in a safe room and only the research team had access. Recorded conversations were destroyed while soft copy transcripts were protected by a password. I did this to ensure that information provided could not be easily associated with particular individuals, communities, or health facilities and DHISs.

Informed consent

The consent form stated the aim of the study and the expected contribution to increasing access to healthcare in Ghana. Participants were told about the option to participate or decline and the right to opt out at any time. I had consent forms that I gave to those participants who could read and verbally explained the study to those who could not before seeking their permission to conduct interviews. Although the consent form had a column for participants who agreed to take part in the study to sign, nobody signed; they told me it was not necessary. I also asked permission to

take photographs, record interviews and include informants' pictures in presentations and publications if necessary to which nobody objected. However, a few people told me not to associate them with some information they had given me. In such cases, I did not record those portions of the interviews.

In conclusion, I have provided detailed information about the study design and context, and various approaches used to carry out this study. Also, I have presented methodological reflections regarding the double role I played as a researcher and a member of an intervention group. This information provides context to the empirical chapters and yields a better understanding of the findings and conclusions I present next.

Barriers and enablers to enrolment and retention in the National Health Insurance Scheme in Ghana

Introduction

The focus of this chapter is to explore barriers and enablers to enrolment in the National Health Insurance Scheme (NHIS) and member retention. The operation of NHIS, has earned Ghana the reputation of having a relatively reliable nation-wide health insurance. Despite this achievement, there are barriers that have resulted in low enrolment and high membership non-renewal rates. The pre-intervention household survey carried out in March 2009 in Eastern and Central Regions showed that only a third (30.1%) of the 3,301 households were currently insured, 14.3 per cent had been previously insured and 55.6 per cent had never been insured. Current enrolment of households varied considerably among communities ranging from 9.2 to 56.9 per cent and non-renewal rates from 2.7 to 27.5 per cent. Of the 13,857 individuals covered in the survey, only a third (30%) was currently insured, 15.6 per cent had been previously insured and 54.4 per cent had never enrolled. Individual enrolment also varied among communities ranging from 4.8 to 66.2 per cent (Table A.3, Appendix 2). The reasons why enrolment is low and non-renewal rate high are discussed in this chapter.

A multi-level perspective (MLP) was used to analyse stakeholders' (community members, health providers and DHIS staff) behaviours and practices and the challenges of implementing the NHIS that influence enrolment and retention rates. The MLP emphasises that stakeholders and events at all levels of social organisation

must be considered when studying a phenomenon (instead of focusing on one level (see chapter 1).

This chapter presents the problems of the NHIS that are the focus of this study – to identify barriers to enrolment and establish interventions to expand coverage and retain members. It should be noted that despite the barriers presented here, health providers¹ and district health insurance scheme (DHIS) staff are acknowledged for their contribution to promoting the scheme despite the challenging circumstances under which they work.

For my analysis, I draw on qualitative information from seven intervention communities in the Central Region and data from the baseline household survey we conducted in 30 communities in the Central and Eastern Regions of Ghana. Both techniques were used in an effort to present holistic information on barriers and enablers to enrolment with the NHIS and retention of members (see chapter 2).

In health economic literature, low coverage of health insurance schemes is generally linked to economic determinants that give excessive weight to the ability to pay and the cost of premiums (Asante & Aikins 2008, Basaza et al. 2008, Jutting 2004). This chapter looks beyond economic determinants by engaging the three key NHIS stakeholders (community members, health providers and DHIS staff) to explore factors that influence people's decision not to enrol or renew their membership. Attention is also paid to the historical antecedents to the introduction of the NHIS and their effect on enrolment.

Barriers experienced by community members

In everyday conversation in the community, people described the NHIS as an advance payment towards healthcare and asserted that it was a good arrangement to ensure that everybody had access to healthcare. Views gathered from key informants and discussions in problem-solving group (PSG) meetings indicated that almost everyone has heard about NHIS and believes that it has improved access to healthcare. A community member described the NHIS as: “Advance payment that gives access to healthcare. When you have the hospital card [NHIS card] you do not have much problem when sick. It is helping many people go to the hospital nowadays.”

However, the overwhelming endorsement of the scheme does not translate into high enrolment and regular renewal of memberships. The actual decision to enrol and stay with the scheme is influenced by a number of factors categorised as poverty, “not often sick” and traditional concepts of risk-sharing, poor quality of

¹ Health providers referred to in this study include medical doctors, medical assistants, nurses, disease control officers, dispensary assistants, health assistants and laboratory technicians among others who are in contact with insured patients and work on NHIS forms in public health facilities.

service delivery, payment of unauthorised fees and political overtones in the perception of the NHIS.

“No money to pay premium”

When I engaged community members in conversations on why they were not enrolling or renewing their membership in the NHIS, poverty was often mentioned. “No money to pay” was normally the first response given by previously or never-insured informants. This trend was reflected in pre-intervention household survey (N=3301) results in which an overwhelming majority said they did not enrol (72.5%) or renew their membership (61.4%) in the NHIS because they could not afford the cost of premium (Table A.4, Appendix 2).

Serwa, a disease surveillance volunteer and community-based growth promoter used by Ghana Health Service for field activities, told me some people could not pay the premium and needed help. For example, she wanted me to help Ama to get exemption from paying NHIS premium. Ama was known by almost everyone in the community as being extremely poor. Serwa summarised the situation of the core poor as follows:

They are very poor individuals who have no stable source of income. They live on the benevolence of family members, friends and neighbours. They struggle to survive. Even to get one meal a day is a problem and they cannot afford the cost of premium.

I discussed Ama’s situation with the NHIS collector and requested she submits her name for exemption. But when I asked the collector what had happened after two months, she had not submitted her name for an exemption. I decided to speak to Ama to ascertain if what Serwa had told me was true and to ‘push’ for Ama’s exemption. What I saw actually confirmed that Ama could not enrol in the NHIS because of poverty. She was living with a woman, an acquaintance, who decided to house her when she first came from a nearby village to the town looking for a job. Ama described her situation as follows:

I have five children, including twins. I want to enrol because if I compare the cost of premium to the cost of healthcare it is cheap, but I have no regular source of income and even what to eat is a problem. I do menial jobs and live with this woman. Though she is not a relative, she was kind enough to host me. People in this house support me, but they are not ready to give me money to enrol. As you know, one of my twin daughters died because I had no money to take her to the hospital when she was sick. It was so painful that I lost my daughter because of poverty.

The death of Ama’s daughter and her inability to obtain an exemption illustrates that poverty accounted for some people’s failure to enrol, even if they wanted to. Ama’s complaint also indicates that she knew the NHIS would give her access to healthcare and could have prevented her child’s death.

That said, I talked to a number of people who were not poor by local standards to explore further the “no money to pay” response and found that the issue goes beyond the premium. For example, although the premium and registration fees are

relatively low, enrolling all members of large households in the Ghanaian social context is problematic since it may not be affordable despite families owning cocoa and food crop farms and engaging in fishing (both of which create substantial incomes). Therefore, some households did selective enrolment of specific household members – often those who needed healthcare. Kwame, a cocoa farmer and a father of six children (one above 18 years) and two adult dependents (his mother and a nephew) said he could only enrol his wife and four children because he did not have money to pay for everybody. Paying GH¢ 4.00 (about US\$2.5) for each child and his mother to cover the registration fee and premium for an adult dependant was a problem. When I asked him why he made this choice, he replied:

Though premium and registration fees are low, enrolling the whole household is expensive so I enrolled my wife and four children and left the others because there was no money to pay for everybody. I enrolled those who go to the hospital and are likely to use the NHIS card.

Nonetheless, other respondents gave additional reasons for not paying: “not getting sick often”, poor quality healthcare service delivery, negative behaviour of health providers and health insurance is not a priority. Discussions in PSG, stakeholders’ and community leaders’ meetings indicated that the core reasons for not enrolling or renewing NHIS cards was neither poverty nor the high cost of premiums. There was a consensus that the premium cost was reasonable: GH¢ 4.00 (US\$2.5) initial registration fee and GH¢ 14.00 (US\$10) per year premium (if applicable – GH¢ 1.00 annual administrative renewal fee). Although income is seasonal, the respondents stated that anyone really committed to enrolling could do so during harvest time when most healthy people could afford to pay.

This assertion by most key informants caused me to question the “no money to pay” response. So, I analysed the poverty situation in both the farming (Assin Achiano) and fishing (Anomabo) communities to explain the difference between the pre-intervention household survey and qualitative results from my conversations. The pre-intervention household survey was conducted at the peak of the dry season when poverty was at its worst. Qualitative data on the other hand was gathered throughout the year and the inhabitants’ poverty was observed and discussed. Views from key informants, community leaders and PSG members indicate that poverty is seasonal. People experience less poverty during a bumper harvest when almost everyone has income. In the fishing communities, men work for boat owners or do canoe fishing while women sell fish and other goods. Similarly, in farming communities, people have income either from their own cocoa or food crop farms or work for commercial farmers. After the harvest time, income levels fall drastically for the majority of fishermen and farmers (except those who own boats and do deep-sea fishing or large food crop farmers who still earn substantial income). The respondents’ financial status on the pre-intervention survey was not recorded during harvest time; therefore, their reported income did not reflect their average financial situation

throughout the year. This explains why the majority of respondents said they could not afford the cost of premium. An uninsured fisherman summarised the situation as follows:

It is a pity that most of us have not enrolled when in fact we can afford to pay GH¢ 18.00 [for premium and registration fee] to enrol and GH¢ 15.00 [~ US\$10] to renew our card every year at least during harvest time. The low level of enrolment in our community shows how insuring against ill-health is not our priority. Ghanaians in general don't prepare for sickness until it happens.

The “no money to pay premium” response can be questioned when the pre-intervention household survey results are compared across communities. With the exception of Koforidua and Akosombo (in the Eastern Region), where the majority of the respondents are Social Security and National Insurance Trust (SSNIT) contributors², a low poverty incidence does not necessarily lead to high enrolment in the NHIS. The poverty incidence was calculated using data from detailed consumption expenditure on food and non-food items and the dwelling characteristics (e.g. water supply and availability of electricity among others) that are used in the Ghana Living Standard Survey (GLSS V) (Ghana Statistical Service 2007). Durable goods were not limited to the month preceding the survey since their prices are more stable and less amenable to seasonal fluctuations (Deaton 1997, Deaton & Zaidi 1999). The GLSS V (chosen to have uniformity with existing data) set the lower poverty line at GH¢ 288/year (US\$ 206) and the upper poverty line at GH¢ 370/year (US\$ 264). We also estimated *monthly household per capita expenditures* as the monthly consumption expenditure divided by household size. This represented the total amount of money needed to meet food and non-food consumption requirements of household members (for more details see Aryeetey et al. 2010). Thus, all households whose *monthly per capita expenditure* fell below the *upper poverty line* (GH¢ 370/year) were considered poor. Households whose *monthly per capita expenditure* fell below the lower poverty line (GH¢ 288/year) were considered to be extremely poor. For this study, poverty incidence (PI) is defined as the number of households identified as poor divided by the total number of households in the community (see Ghana Statistical Survey 2007, Aryeetey et al. 2010). We considered this as proxies for household wealth and used principal components analysis to estimate a household socio-economic status (SES) score. Finally, households were ranked into wealth quintiles based on their SES (core poor, poor, average, rich and very rich) quintiles (see Jehu-Appiah et al. 2011 and, Aryeetey et al. 2010 for details).

² The Census enumeration areas in Koforidua and Akosombo are communities where the majority of residents contribute to SSNIT and NHIS registration is compulsory for them. Their premium is directly deducted from their salary. They only pay registration fee of GH¢ 4.00 [about US\$2.5] and GH¢ 1.00 [about US\$0.75]. In Koforidua for example, where I was part of the household survey team, the community is popularly called SSNIT Flats, an estate built for government workers. Almost all household heads, who were interviewed, were SSNIT contributors.

Table 3.1 is an extract from the analysis of our pre-intervention household survey data showing the PI and the individual insurance status in 30 communities. It shows that Winneba (Central Region) with 11.8 per cent PI had only 8.7 per cent current enrolment and 12.4 per cent previously insured compared to Burukum Maumi (Eastern Region) with the highest (56.4%) PI had higher current enrolment (31%) and lower previous enrolment (11.5%). Also, Oframase (Eastern Region) with a PI of 29.4 per cent had the highest current enrolment (66.2%) and one of the lowest non-renewal rates (5.2%). This was in contrast to Koforidua (Eastern Region) where no one is below the poverty line and NHIS premiums for the majority of respondents are directly deducted from their salaries here, only 56.1 per cent of the population were currently insured and 22.7 per cent were previously insured (Table 3.1). These examples indicate that enrolment does not neatly correlate with economic status; there is more to the “no money to pay premium” response.

Table 3.1 Poverty incidence in selected communities and NHIS status of individuals

Community	Poverty incidence(%)	Current enrolment (%)	Previous enrolment (%)
Winneba (Central Region)	11.8	8.7	12.4
Anomabo (Central Region)	32.1	4.8	11.3
Burukum Maumi (Eastern Region)	56.4	31.0	11.5
Akosombo (Eastern Region)	11.9	35.7	33.6
Oframase (Eastern Region)	29.4	66.2	5.2
Koforidua (Eastern Region)	0	56.1	22.7

See the complete Table A.3 in Appendix 2 for further details

Multinomial logistic regression shows that current enrolment is significantly ($p=0.000$) higher among the richest quintile (41%) than the poorest quintile (27%). The non-renewal rate is significantly ($p<0.000$) lower among the core poor (13%) than the richest (17%) (for details see Jehu-Appiah et al. 2011). This indicates that although poverty contributes to low enrolment, it is less significant for renewing membership. This findings supports the large number of informants who state that poverty is the main reason why they do not enrol, but does not explain why affluent communities, like Koforidua (SSNIT Flats) where residents’ premiums are deducted from their salaries and they pay only registration fees, had lower enrolment and higher non-renewal rates than Oframase, for example, which is a relatively poor farming community.

The NHIS was introduced as a poverty reduction strategy to provide accessible, affordable and good quality healthcare to all Ghanaians. Therefore, the minimum premium for informal-sector workers was fixed taking into consideration the prevailing economic conditions of the majority of Ghanaians. Premiums are therefore heavily subsidised with a value-added tax (VAT) and SNNIT contributions (Government of Ghana 2004, Witter & Garshong 2009) to minimise the exclusion of poor people. Also, participants' comments and my observations indicate that for most people the "no money to pay" response was a convenient excuse to rationalise non-enrolment and non-renewal of their membership in the NHIS. "No money" served as a socially accepted idiom to hide negligence and lack of responsible parenthood. Key informants suggested that most uninsured people have the ability to pay, but are just apathetic towards the NHIS. Yet, the key informants did accept that the NHIS was a better alternative to 'cash and carry'. The conclusion at all PSG and stakeholders' meetings and interviews was that apart from the core poor and poor people with large households, household heads willing to enrol and renew NHIS cards for their members can do so during harvest time. This suggests that the significant factor that influences the average Ghanaian and rich Ghanaian's decision to enrol and remain in the NHIS is neither the high cost of premium nor the affordability of the premium. This view differs from previous studies in which poverty was found to be largely responsible for low enrolment with SHISs (De Allegri & Sauerborn 2007, Asante & Aikins 2008). Poverty as an excuse for most respondents who did not enrol or renew their membership in the NHIS is ingrained in other factors, which will be discussed below.

"I'm not often sick" and traditional concepts of risk sharing

Another typical response from the previously insured or never insured respondents was: "*Mentaa nyare*" (I am not often sick). They saw themselves at very low or no risk for illness, so there was no need to enrol or renew their NHIS membership. A community key informant asked me in an interview: "Why should I pay for or continue to pay toward something I'm not likely to benefit from?" Others said they only registered their wives and children because they were most in need of healthcare. During a PSG meeting, one member explained his non-enrolment as follows:

You know health insurance is new and means little to most of us. We, Ghanaians don't think about securing ourselves against ill health until we are seriously ill. Health insurance is not our priority. I registered my children and wife because they have the greatest need for healthcare. I did not enrol because I hardly get sick.

The perceived health status of each household member influenced the decision by the head of the household to enrol in NHIS and who to enrol. Healthy individuals were less likely to enrol, while those who thought they would need healthcare were more likely to enrol and regularly renew their membership. Criel (1998) also found

this phenomenon in his work on Masisi hospital insurance in Eastern Congo where women of child-bearing age enrol because of the prediction of need for healthcare.

Further discussions at PSG meetings revealed that community risk-sharing arrangements also influenced their enrolment decisions. Two prominent informal mutual support groups similar to the NHIS were identified: *pataase* in fishing communities and *nnoboa* in farming communities. The two groups are somewhat similar to the NHIS; the difference lies in the reasons for joining the groups and the benefits. *Pataase* members see death as a greater concern than ill health. One *pataase* member argued: “Death is a certain event, so one must prepare for it but sickness may or may not befall you.” In the case of *nnoboa*, people join when they need support on their farms and withdraw afterward. Benefits for both support groups are commensurate to one’s contribution and not need. These operational principles contrast with the NHIS’ risk- and cost-sharing based on need. In many of my conversations, I noticed that those who see health insurance as a kind of large *pataase* or *nnoboa* often gave the “I’m not often sick” response. They compared the two programs and did not understand why people who have expensive operations, such as for a hernia, and those who continuously access healthcare pay the same amount as those who have not gone to the hospital in the past year. They felt cheated and argued that their premium for subsequent years should be reduced if they had not accessed the healthcare system. This argument conflicts with the fundamental principles of health insurance where premiums are based on income irrespective of a members’ risk level. The respondents’ behaviour and argument suggest that they have not fully understood the redistribution principles of health insurance and have confused it with their mutual support groups. As Vander Geest et al. (1990: 1026-1030) wrote: “differences in stakeholders’ interpretations affect policy outcomes.” Thus, although the aggregate meanings of risk-sharing of traditional mutual arrangements and health insurance could be the same, the differences make it wishful thinking that people will easily appreciate the need to enrol in the NHS and consistently renew their membership because of the policy makers’ assumed benefits.

Those who did not enrol in the NHIS because they did not have a need for healthcare pursue their short-term self-interest with little consideration for what may happen to them in the long term or in the event of rare adversity. This phenomenon could be the influence of traditional risk-sharing groups where every member is certain to benefit according to his or her contribution, while an insured person has largely unlimited access to healthcare when sick but receives nothing if they are well. As Van der Geest (1992) posits, a cultural perspective limits the possibilities for thinking and acting in new situations. Though solidarity and reciprocity are predominant features of both traditional mutual risk-sharing arrangements and health insurance, the respondents’ reaction to the latter is influenced by the principles of the former. Thus, people’s existing knowledge largely determines their

reaction to new policies and not simply the benefits; traditional ideas undermine enrolment in health insurance schemes. Therefore, more education is needed to improve Ghanaians' understanding and appreciation of the cost- and risk-sharing embedded in the NHIS so they do not consider the operational principles of the NHIS as the same as traditional mutual support groups.

Quality of service

Medical practice in many countries including Ghana has come under scrutiny in recent years since clients are demanding better care. A study by Ballard et al. (2004) observes that quality healthcare should aim at providing care that is timely, efficient, equitable and patient-centred. Literature on the quality of care is generally categorised as the quality of technical care and service delivery. Technical care includes doctors' diagnoses, the effectiveness of treatment and the quality of drugs. In this study, the technical quality of care did not seem to influence the participants' NHIS enrolment or renewal decisions; the respondents were, however, concerned with healthcare service delivery.

In developed countries, healthcare services have become market goods supplied by healthcare providers to satisfy patients' needs. Insured patients are guaranteed quality services, while uninsured patients have difficulty navigating the health system (Ferlie & Shortell 2001) and in some cases face delays in obtaining care. This study found the opposite – NHIS insured patients in Ghana experience delays at health facilities while uninsured patients are served earlier and better. Respondents who were insured complained of health providers' negative behaviour, long waiting times and the lack of drugs at health facilities.

Complaints about healthcare providers' negative behaviour

This section describes the behaviours of health providers during their clinical encounters with insured patients and the influence of this on enrolment and retention in the NHIS. I used behaviour as a term to describe how health providers interact with clients and not as a theoretical concept. The behaviours that discourage people from enrolling and remaining in the NHIS are referred to as negative and those that encourage people to enrol and renew their membership are labelled as positive. I dwell more on the negative behaviours in this section because that is the focus of the study; positive behaviours that encourage people to enrol are acknowledged later in the chapter.

The issue of health providers' negative behaviour towards insured clients (as opposed to uninsured) arose at all the PSG, stakeholders' and community leaders' meetings and community durbars I attended. Forms of negative behaviour mentioned by respondents were not showing respect to insured patients and using derogatory language. The phrases the insured used to describe their treatment was: "*Wommu yen*" (They don't respect us). In Ghana, showing respect is crucial in

social life and is the basis for judging the quality of interaction between people. This compels people to initially respect those they come into contact with. Good communication between health providers and patients leads to patient satisfaction while poor communication results in frustration. In Ghana, it is common that health providers do not show respect to patients. As Senah (2002) observed, practicing and assessing biomedicine is embedded in and influenced by master-servant relationship where patients must submit to the authority of health providers.

To explore the veracity of these reports in my two study locations, I spent time at health facilities and observed that some health providers capitalise on the difference in their power and the patients' power and show disrespect. Further discussions with participants show that after the introduction of the NHIS, new patient categories have emerged – the insured and the uninsured – with implications for health provider-patient encounters. While it is acknowledged in Ghana that health providers do not respect patients, the categories of insured and uninsured patients have introduced a new dimension to this phenomenon. Andersen (2004) discussed the various ways that patients were treated in a regional hospital in Northern Ghana depending on their social status such as education, wealth and relationship with staff members. This study found that being insured exposes a patient to worse treatment by the health providers resulting in a greater dissatisfaction among insured patients. The informants believed that these experiences contributed to the high membership non-renewal rate. The level of disrespect shown by healthcare staff differed across Ghana. In one research site, people spoke unfavourably about their experience at the health centre. However, participants in a second research site said that they occasionally experienced such behaviour at the district hospital, but rarely at the health centre. In the second site, a medical assistant asked me in a conversation: “Who should I give preference to; is it someone whose bill will be paid even if there are delays or one who I’m not sure can pay since the uninsured sometimes abscond after treatment?”

Health providers' negative behaviour is a sensitive issue. Since they knew that I was a researcher, the providers did not openly show negative behaviours in my presence. Nonetheless, what they told me suggests that it does happen. For example, I overheard nurses making derogatory remarks about insured patients several times. At PSG meetings, nurses also described insured patients as ‘difficult’. A typical phrase when discussing issues related to insured patients was: “*Wɔn a wɔkuta apomuden nsiakyibaa krataa no ha yen adwene*” (NHIS card holders disturb us). One respondent narrated his experience when he accompanied a relative to the hospital during a PSG meeting.

When you go to the hospital they talk to you anyhow. They make you wait for several hours. In fact, I nearly quarrelled with a nurse when we took a family member with insurance card to the hospital. But for the sick person, I would have insulted her and left the hospital. They don't respect us.

During PSG meetings, healthcare providers' reactions to complaints about the disrespect of insured patients were divided. There were those who argued that ideally health providers should strive to provide quality service to their patients irrespective of their NHIS status. Others acknowledged accusations of disrespectful behaviour, but argued that not all health providers show negative behaviour towards insured patients.

I verified these accusations by exploring the views of other healthcare providers who were not PSG members. One reacted.

These are genuine complaints; health workers' behaviour is not predictable. I've spoken to some of my colleagues several times on this. Some of us don't respect patients and see the insured in particular as giving us extra work.

Nurse Julia responding to allegations that she described as 'false rumours' ended by saying:

They [insured patients] think because they have insurance they can come here [health facility] anytime. They wait and come to disturb us after working hours with all sorts of complaints that are not emergencies [meaning conditions they can manage at home or report the next day].

This implies that some health providers, and certainly those at that facility, are not happy when the insured report for treatment when the outpatient department (OPD) has closed. Their concern was that they were already overburdened during the day, so when the insured come to the facility to complain about an illness that started three days or a week ago, this was irritating. They consider these patients as: "Disturbing them after a hectic day's work."

DHIS staff also confirmed the insured patients' claims and emphasised that it was hindering their effort to promote the NHIS. James lamented: "Some health workers are not helping us. Their attitude and behaviour undermine our effort. We work hard to get people enrolled, they [healthcare workers] do not treat them [patients] well and we lose them." Although experiences of disrespect could arise from the nurses being overburdened with a heavy workload in busy health facilities, they are exacerbated by the insured patients' increased use of services. The healthcare workers' disrespect discourages people from enrolling and or remaining in the NHIS.

Long waiting time

It is a common sight of patients waiting for hours in a busy health facility in Ghana. The insured's concern was that they wait longer than those who are uninsured. From my observations, what makes the situation worse is that health providers do not follow a 'first come, first serve' principle. Although both insured and uninsured patients indicated their dissatisfaction with this approach, insured patients seemed to be most affected. Evidence shows that long waiting times at health facilities are partly due to an unorganised flow of patients and this undermine patients' satisfac-

tion with their care (see Rondeau 1998). But the situation is more complex in Ghana. Abena's description of her experience illustrates that delays for insured patients go beyond the lack of an organised patient flow. She showed me both her expired NHIS card and her six year old son's and said:

I didn't renew my card because health providers here do not treat us nicely. The only time I sent my son to the hospital, the nurse kept us waiting for a long time well over an hour without telling me anything. Others come, pay and go and nobody told me why I had to wait. I was fed up and asked her why she was not attending to us. She retorted, "You wait". From that day I decided I was not going to renew my card. This actually discourages many of us from enrolling or renewing our card. If you have your money, why should you go and waste time at the hospital? They should be told to change their behaviour.

When I asked a health provider about insured patients' complaints about delays at health facilities, he acknowledged their concerns and said:

Health providers are suffering from 'patient fatigue'. The NHIS has come to expose the weakness of our health system; delay in service delivery and negative attitudes. If we improve our attitudes and everything remains the same, we will get better results. ...When people go to an overcrowded facility they don't mind waiting patiently, provided you explain to them why they have to wait. If you tell them politely that you are alone so they should have patience and you will attend to all of them, it will be fine with them. But when you shout at them, why are you now coming, and tell them because of health insurance you are coming to worry me, how would they understand the situation?

Even though this assertion is true in some cases, I also observed many instances where health providers were chatting with each other and showed no sense of urgency while patients were waiting. As one PSG member indicated: "They [health providers] think it is normal for patients to wait for hours, so they don't care if they see many people waiting."

Though insured patients attribute their long waiting times to the fact that they are not paying cash, this might not always be the case. The long waiting times may be legitimate and related to the providers' heavy workload. However, the health providers lack good communication skills to explain the situation in the facility and tell insured patients why they have to wait. Most insured patients I spoke with were not even aware of the extra time needed to fill their NHIS forms – something that is not required for the uninsured. Unfortunately, due to poor communication, some health providers are not able to explain the staffing situation and administrative procedures that accompany the NHIS coverage and instead make comments that the insured attribute to their NHIS status. This echoes Criel's (1998) observation that the low enrolment in health insurance schemes and the populations' perceived quality care is influenced by the health workers' lack of consultation skills.

Lack of drugs in health facilities

Being given drugs at health facilities was generally regarded as an essential aspect of quality service delivery. Access to drugs motivates people to seek healthcare and also to enrol and remain in the NHIS; a lack of drugs makes health insurance less

attractive. John told me he feels disappointed when he is not given medicine, but instead is given a prescription to go and look for drugs in accredited pharmacy shops that he sometimes must pay for. These assertions are supported by the pre-intervention household survey, where an overwhelming majority (87%) of currently insured respondents, previously insured (90.2%) and never insured (84.7%) indicated that drug availability at health facilities needs to be improved (Table A.6, Appendix 2). Kumah's description shows insured patients' dissatisfaction:

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

These incidents make insured patients feel disappointed about the quality of service at health facilities. Insured patients think that because they have prepaid for healthcare, they have a strong entitlement and anticipate quality service including drugs. A boat owner I conversed with told me:

I did not enrol or renew my membership because some health providers do not respect us. Moreover, you waste a lot of time when you go to the hospital so why do I bother myself if I can just go and buy drugs at the store when sick.

My findings are similar to Kroeger (1983) who noted that health system factors influence health-seeking behaviour and lead to the decision not to seek care at a health facility. The author mentioned health professionals' attitudes, satisfaction with treatment and the shortage of drugs as factors that determine health-seeking behaviour in developing countries. Both findings show that there are similarities between the factors that determine health-seeking behaviour and insurance decision-making. Thus, there is a need to address factors that undermine patients seeking formal care when promoting health insurance since these factors have implications for enrolment.

The shortage of drugs on the Health Insurance Drug List in health facilities in Ghana highlights the practice of Ghanaians depending on pharmacy and chemist shops for treatment when they cannot afford the cost of treatment under user-fees. This has been documented in earlier studies (Senah 1997, Asenso-Okyere et al. 1998), but has now taken a new direction. I found that under the NHIS, pharmacy and chemical shops are being used as suitable options to health facilities not because of financial barriers, but rather due to the lack of drugs at health facilities. This situation should be of interest to Ghanaian health policy makers for two reasons. First, an overreliance on pharmacy and chemist shop-keepers, who act like doctors, discourages people from enrolling and remaining in the NHIS scheme. Asenso-Okyere et al. (1998) observed that treatment from unqualified people at chemist and pharmacy shops to health facilities has a negative effect on people's health. Second, this practice undermines the policy makers' ambition of using the NHIS as a social

security to provide quality healthcare to all Ghanaians and might lead to the collapse of the NHIS in the long run.

The findings of this study also echo earlier findings that show a growing dissatisfaction with perceived quality of healthcare among insured clients in the Dangme West Health Insurance Scheme in Ghana (Bruce et al. 2008). Thus, participation in the NHIS does not necessarily lead to better healthcare services. It must also be noted that health facilities can hardly be blamed for not having essential drugs. The problem is partly due to delays in claim reimbursement by the NHIA and also the DHISs inability to taking steps to ensure that there are accredited pharmacy shops in every town where there is a hospital or health centre. In conclusion, the burden of having to travel outside healthcare facilities for prescribed drugs undermines health providers' efforts to deliver quality service and has serious consequences for health insurance enrolment.

Accusation of corruption among health providers

Community members cited cases of corruption among healthcare providers associated with healthcare service delivery. Several instances of nurses, pharmacists and other health providers exploiting insured patients for private gains were reported. Information gathered from my interviews and informal conversations suggest that some health providers collect unauthorised fees from insured patients. They asked them to pay for drugs covered by the NHIS and hospital cards and also undersupply prescribed drugs.

A major complaint was that health providers demand cash payments before treating insured patients after normal working hours and on weekends. The phrase normally used to describe their behaviour was: *Wɔsisi yen*" (They cheat us). At a community durbar combined with a mass NHIS registration campaign, Adjoa narrated her experience at the health facility the previous evening just after we had ended our monthly PSG meeting Adjoa went to the facility at about 5 pm because of a sudden stomach pain. The nurse on duty told her she would not accept her NHIS card because she came late and demanded that she pay cash. She said the nurse did not listen to her explanation for arriving late, so she left without treatment and bought drugs from the chemist shop. Reflexively, I asked her whether she was telling me the truth. She quickly responded: "If you don't believe me I can go and show you the nurse who demanded that I pay before receiving treatment even though I showed her my NHIS card."

As a researcher, I asked myself if I should take such an allegation seriously and follow it up. I decided not to, since it was just about three months into my fieldwork and I was worried it might jeopardise my data collection. Moreover, the health centre where Adjoa had this encounter was where we usually held PSG meetings and had educational activities. However, to ascertain the authenticity of Adjoa's

accusation, I spoke to Anas, a nurse, while walking home after the durbar. I asked her to comment on what Adjoa had said about the nurse's behaviour. She replied:

It is true, I wish the people involved and my bosses were here. I won't deny it because I'm a nurse. It is true that after normal working hours some of my colleagues don't want to treat insured patients. The reason is that filling forms for insured patients is tedious, so they don't see why they should wait till after OPD had closed before coming. They see it as giving them extra work especially when the condition is not an emergency.

I also asked her about those who pay cash. She replied: "Well with them you don't have to fill any form for any claims. You treat them, they pay cash and that is all."

In regard to the issue of paying for drugs and syringes covered by the NHIS, informants told me that sometimes they have no choice but to pay even though they know they are being cheated. An assemblyman³, told me he paid for drugs when he took his insured child to the hospital after working hours. He said: "They told me to pay because the person to fill the claim form was not at work. I paid, though I knew I shouldn't."

In another incident, a volunteer, a PSG member and I intervened to collect money that an insured patient at a health facility had paid for a hospital card. The patient, unhappy about the demanded payment, reported the incident to the volunteer who happened to be at the facility and wanted to be reimbursed. The volunteer called me immediately and this time I decided to follow-up. I felt it was an opportunity for me to have concrete evidence to support the earlier reports that I had received. It is interesting that the provider refunded the money after a short argument. Though she tried to justify her action and said she thought the patient had misplaced her card, I observed that this was just 'a facing saving excuse'. The patient insisted that she had told the healthcare worker that this was not the first time she had come to the facility. The volunteer told me after the incident: "When we talk, people think we are exaggerating. I often receive similar complaints almost every day in the community."

Health providers respond about corruption

To check the authenticity of these allegations, I asked DHIS officials for their comments. They confirmed the community members' complaints. One of them lamented: "Collection of unauthorised fees by health providers is undermining our effort. When we struggle to get people enrolled, they lose confidence and do not renew their membership because of the payment of unauthorised fees." This comment and others that were similar suggest that building trust in the NHIS is heavily

³ Assemblymen are part of the political structure in Ghana; they are non-partisan local representatives in the District Assemblies. They work with the district chief executive who is the representative of government at the district level.

dependent on health providers' commitment to the scheme and the acceptance of NHIS as a viable health financing policy.

Health providers also confirmed the activities of some of their colleagues that undermined the credibility of the NHIS card. One health provider told me that his colleagues sell drugs that are covered by the NHIS to insured patients and 'pocket the money' and charge the DHISs; some do not supply drugs to insured patients, yet bill the scheme. They also told me about a recent case of health providers being investigated for charging insured patients a 'lateness fee' for coming to the facility late.

At a stakeholders' meeting organised by a PSG, Dr Atte, who is a medical superintendent of a district hospital, confirmed the allegations of health providers' negative practices and narrated the experience of two of his patients. One was supposed to come for a review after finishing his drugs, but came earlier and insisted he had taken all his drugs. When Dr. Atte followed up with the pharmacy, he discovered that the patient had not been given all his drugs. The second incident was when a patient suspected that she was not given all her drugs, so she reported this to the nurse. When the nurse and Dr. Atte followed up, they found that the patient had not been given one of her drugs. In both cases, the DHIS was billed for all the drugs. Kwesi, who is a DHIS staff and a PSG member, narrated his experience of receiving a prescription for his child to buy a drug. He followed up and found that the DHIS was billed for the drug even though the drug was not supplied.

These negative practices by health providers resulted in a lack of trust from community members, and the insured questioned their commitment to the NHIS. Thus, people who do not have regular need for healthcare prefer the user-fees or receiving treatment at a pharmacy or chemical shop, even though it is more expensive.

Basaza et al. (2007: 10) mentioned the "poor interest of health professionals" in community health insurance as a barrier to enrolment in Uganda. In Ghana, the health providers' lack of interest in the NHIS must be added to their malfeasance as in the cases of the assemblyman, Adjoa, and Kwesi. A community leader describes the extent of distrust and scepticism about health providers' commitment to the NHIS: "In fact, I don't trust them [health providers]. I don't think they like health insurance. I wonder if they genuinely support it." The healthcare providers' behaviour can be explained as an excessive pursuit of their parochial interests, which is to gain from the policy and not contribute to the goal of ensuring equity in access to quality healthcare by removing financial barriers.

Accusation of inefficiency and corruption among DHIS staff

Community members complained about delays in receiving their NHIS cards after registration and also waiting for hours in DHIS offices to obtain their cards. The

most common complaint was waiting for more than three months after registration before they had their ID cards to access healthcare. They complained that the mandatory waiting period of three months is too long and that some registrants even wait for as long as five to six months, while others never receive their cards. A typical response I got when I asked people about waiting was:

If you are lucky you get your card after waiting for three months. Otherwise you have to come here several times before you get it. Others never find theirs. This is not fair because while waiting for so long you may fall sick and have to pay, then when you receive the card you might not fall sick before it expires.

The other common complaint was that people have to spend about two hours waiting before they get their NHIS cards and in some cases the DHIS office could not find the card at all. Many DHIS offices I visited were crowded with people waiting to collect their ID cards. Several community members I spoke with told me that this is the normal situation. One of them expressed her frustration as follows: “I’ve been here for about two hours and have not yet got my card. I don’t understand why it is taking them so long to get me my card.”

I decided to inquire about the status of this woman’s card from the public relations officer (PRO) in whose office the cards were kept. I spent just ten minutes in his office, but even in this short time I had insight into the problem. The office had piles of cards in small boxes on the floor and a single staff member had to look for the cards for about thirty people waiting that morning. Obviously, this was an operational problem. The situation could be described as inefficiency regarding storage of documents and retrieval or insufficient funding for DHISs. Inadequate space, lack of cabinets and proper filing systems made card retrieval difficult and this resulted in clients waiting for hours.

The common complaint of malfeasance by some DHIS staff and collectors was unauthorised fee collection from their clients. Several reports of ‘fast track’ registration came up in the interviews, conversations, and discussions at PSG meetings. Fast track registration is when DHIS staff connive with collectors and register and issue NHIS cards to people through the ‘back door’ without their having to wait for the three months window. Some collectors also charge above the approved premium and registration fee, while others take money for transport before giving out the NHIS cards. Participants told me they were aware of such behaviours and described them as undercover activities that damage the credibility of DHISs and erode confidence in the NHIS.

Although most DHIS staff denied this behaviour, others confirmed the practice. For example, when I asked a collector why people were still not enrolling after a PSG community durbar:

My people are difficult. Some of them wait until they are in trouble then they run to me for help. Sometimes you have no choice but to try and help them. In such cases, I had to take them to the office and see somebody [DHIS staff] with some money to prepare the card for them instantly.

I observed another negative practice when I went to a DHIS office for a usual visit. While I was conversing with two DHIS officials, two men walked in and wanted to renew the NHIS card of a relative who had been involved in an accident and admitted to the hospital for three days. After complaining that people do not renew their card until they are sick, the DHIS staff told the two men to go and come back and see the manager. From their conversation, I understood that they were aware of their negative behaviour. When the two men left one of the DHIS staff turned to me and said: "This is how they worry us." I went back to the DHIS office the following day to find out if the two men had renewed the card for their relative in the hospital. They had indeed renewed his card without having to wait for three months before accessing healthcare since his card had expired more than three months ago (see National Health Insurance Regulations 2004). These favours are not done for free; they are usually rewarded. Unfortunately, these rewards are difficult to verify since I could not observe what transpired between the DHIS staff and the two men when I left. Malfeasance by DHISs' staff can be explained as an excessive pursuit of self-interest instead of supporting the sustainability of the NHIS. The staff seemed to have little concern about sanctioning defaulters to deter others and influencing people to develop a habit of voluntary enrolment and membership renewal.

Health providers' and DHIS staff's dishonesty are not uncommon in Ghana (Gyimah-Boadi 2004, Kpundeh 2004). Armstrong (2006) discusses cheating as a moral term and notes that although it is unacceptable, it is adopted because of the financial gains. In the same vein, the malfeasance reported in this study, which is against the ethics of public office holders in Ghana, occurs daily in public institutions. In Ghana, where salary levels are low and inadequate to meet expenditures, the problem of supplementing incomes by collecting unauthorised fees from clients in public offices is not peculiar to health providers and DHIS staff. This situation has bedevilled the health sector where payment of unauthorised fees has been a long-standing tradition (Agyepong 1999, Asenso-Okyere, 1998, Blas & Linbambala 2001, Aikins & Okang 2006). Thus, some public servants pursue extra income to have a comfortable life. This is often termed 'the survival strategy' of public servants and in certain circles it is not even perceived as a crime. Aryee (2005: 33), in his assessment of anti-corruption and public accountability, described official attitudes towards corruption as ranging from lukewarm to open hostility and calls it the 'AIDS of democracy in Africa'. I found that corruption undermined the confidence and the trust people had in the NHIS and this threatened its long-term survival. Obviously, corruption does not lead to the development of moral responsibility that would make Ghanaians voluntarily enrol in the NHIS and religiously renew their membership to achieve NHIS' goal of universal coverage.

Barriers experienced by healthcare providers

In this section, I focus on what health providers perceived as barriers to NHIS enrolment and retention. According to the health providers, both their heavy workload and delays in claiming disbursement undermine their quest to provide the quality healthcare service needed to build trust in the NHIS and make it a better alternative to cash payment.

Heavy workload

The introduction of the NHIS has increased both the clinical and administrative burden of health providers. Administratively, a significant amount of documentation is required to give service to insured patients. According to health providers, the NHIS has increased the utilisation of healthcare services and consequently, their workload. Filling NHIS forms prolongs the time spent attending to insured patients and this results in long working hours. Dr. Kasa's, a District Director of Health Services, assertion typifies the health providers' description of the situation:

Insurance has increased utilisation services. On some busy days the OPD closes at 4 pm and sometimes I leave here after 5 pm. In fact, the time spent treating one insured patient amount to two uninsured. You spend about five minutes filling forms for one patient. This is what insured patients don't realise and make too much demand on us. They think because they are insured, when they come, you should leave everything and attend to them.

The NHIS form (see Appendix 3) requires information on patient's personal data and all services provided at a facility. Providers complete the information about the diagnosis, drugs, and claim summary. The time spent to fill out the NHIS form carefully prolongs the insured patient's consultation as described by Dr Kasa above. This NHIS procedure accounts for the long waiting that insured patients complained about. There were cases of NHIS forms having been rejected due to mistakes, which cause delays in claims reimbursement. So in facilities where patient attendance is high, filling NHIS forms is an arduous task for already overburdened health providers. According to the health providers, they fill endless forms every day, week and month. Thus the complexity of NHIS forms could explain why some health providers ask insured patients who seek healthcare after working hours to pay cash.

Moreover, although NHIS has increased the utilisation of healthcare, there has been no corresponding expansion in the capacity of health facilities to cater for the increasing number of patients. Health facilities still operate with virtually the same infrastructure, limited equipment and staff. This results in overcrowding, particularly in district hospitals and busy health centres. Thus the burden of the few health providers who attend to so many patients under difficult working conditions frustrates some providers. This may explain their negative reaction towards insured patients who appear to be making unnecessary demands on them. In the providers' view, the insured patients' conditions could be managed at home till the following

morning. They collect fees from insured patients, not only to make extra income, but also to scare them from using the service after closing times and to avoid filling out the NHIS forms.

Delay in reimbursing NHIS claims

Although NHIS helps improve health providers' revenue, the health providers complained that delays in claim reimbursement negatively affect their cash flow and supplies. This leads to low stock levels of drugs in health facilities. As discussed earlier in this chapter, drug shortages in health facilities contribute to patients' dissatisfaction about the quality of service and health providers see this as undermining their work.

The frequent shortages of drugs in health facilities were of great concern to health providers especially those working in facilities in communities where there were no NHIS-accredited pharmacies to augment the drug supply. A medical assistant lamented:

Having drugs in health facilities increases the attendance of patients and a lack of drugs makes a facility less attractive to them. Insured patients in particular often show dissatisfaction about the outcome of their consultation when they are not provided drugs at facilities, especially when there are no accredited pharmacy shops and insured patients have to travel to other towns to get drugs or buy from anywhere and pay. Due to this, people prefer going to pharmacies and chemist shops to buy drugs directly or seek healthcare instead of coming here.

The medical assistant's assertion confirmed the health providers and insured patients' concerns that drug supplies in health facilities need to be improved as stated earlier.

The NHIS has increased healthcare utilisation as Dr Kasa indicated. However, the inclusion of a large exemption group that accounts for about 50 per cent of the general population (Table A.1, Appendix 2) does not make the NHIS cost-effective. Therefore, the NHIS must rely on the value-added tax from which the DHISs receive about 80-90 per cent of the revenue from the NHIA (Witter & Garshong 2009: 7). This reimbursement policy could be responsible for delays in claim payments. The authorities are not always able to provide funds promptly for the implementing institutions (including social intervention programmes), to perform their task efficiently. Although some improvements have been made recently in claims reimbursement decreasing the waiting time from five to six months (see Witter & Garshong 2009) to about three months, it is still far from the stipulated four-week period after submission. The delay in reimbursement makes it very difficult for health providers to meet all the drugs requirements of their clients. It also contributes to some health providers giving preference to uninsured patients or demanding cash payments from insured patients to ensure that the facility has enough money to meet their drug needs while they wait for their DHIS claims to be paid.

Patrick, a health provider expressed his frustration regarding drug shortages in health facilities as follows:

That is why I'm against the idea that facilities should generate income and spend. The business of health providers should be to provide quality healthcare and not to be concerned about income generation to manage their facilities. Due to this, health providers do anything to get money. There is a general overuse of drugs. Some providers are prescribing drugs they are not qualified to administer, while others are charging insured people in order to get money to meet some of their basic needs and maintain their stock levels, especially when the NHIA owes them huge sums of money. Things should be streamlined. The provision of equipment and drugs needed by facilities should be managed by a different body at the district level and controlled by a centralised body with very efficient monitoring systems. It should not be the business of facilities to generate income for internal use.

Patrick's argument could also be considered as 'generate and spend'. Facilities with low patronage are adversely affected in their internally generated fund (IGF), which in turn leads to low stock levels and low utilisation, thus perpetuating the problem of drug shortages. Therefore, to fulfil the objective of increasing access and providing quality service to all Ghanaians the government should make drugs available to all health facilities irrespective of their IGF, especially in communities with low enrolment. After all, health facilities can only encourage people to enrol and remain in the NHIS by providing quality service and that depends on drug availability to a large extent.

To learn about others' perspectives on claim disbursement delays, I approached the staff that processes claim forms at the District Health Directorate and DHIS offices. A staff member explained that some clinicians are part of the problem. He said:

I think some of my colleagues, especially those at the facilities, have not yet come to terms with filling the NHIS forms as part of their job and carefully fill them according to the instructions. They see it as a burden and make too many avoidable mistakes. This makes the vetting difficult and slow, hence the delay.

He showed me some of the forms that were rejected because the basic instructions were ignored. This indicates that following the bureaucratic procedures in delivering healthcare to insured patients is yet to be fully accepted by service providers, which makes the vetting laborious and delays claim reimbursement.

Barriers experienced by staff of District Health Insurance Schemes

This section examines the challenges experienced by the DHIS officials when implementing the NHIS. These challenges undermine their efficient functioning and quality service, and consequently discourage people from enrolling and remaining in the scheme. The barriers include inadequate staff, office space and equipment, and problems processing NHIS registration forms and granting exemption to indigents.

Inadequate staff, office space and equipment

A major DHIS staff complaint is that inadequate staff undermines their desire to provide quality service. They asserted that although the volume of work has increased since the NHIS was introduced; the number of permanent staff remains the same, which puts pressure on them. However, a DHIS manager explained that although they have the option to hire extra hands, they have to pay them from their IGF which he claimed was not adequate to even meet their basic needs. Thus they are not able to hire enough temporary staff, and the heavy workload falls on the few permanent staff members.

Office accommodation for many DHISs was not adequate. Many of the offices I visited were congested. The office space used by two or three officers crowded in a small room made moving and serving clients difficult. During my visits, I observed that DHIS staff, especially those at the front desk attend to many clients every day. It was common to see many clients waiting for hours at the DHIS offices, which frustrated not only them but also the staff.

Another DHIS staff concern was the inadequate number of cameras to take people photographs for their insurance cards especially in communities outside DHIS office locations. As a result, the registration process takes much longer time. A PRO explained the situation as follows: “Collectors register people and arrange for their pictures to be taken later. It makes processing NHIS registration forms difficult and slow.” This complicates the registration process, since the two events take place at separate times and are performed by two separate persons.

The DHIS staff complained about the inadequate number of computers to process registration forms; the computers they have are often not functional. The staff told me their data entry clerks often work on a rotational basis because they do not all have access to computers. I saw non-functioning computers in many offices that the staff explained were as a result of a lack of funds to repair them immediately.

A lack of cabinets to properly file registration forms and other documents for easy retrieval hampered the DHISs’ effort to ensure that clients did not wait too long before receiving their ID cards. As mentioned earlier, when I visited DHIS offices, I saw piles of ID cards in small cartons on the floor and staff spending a great deal of time going through the piles before retrieving cards for their clients. Thus inadequate equipment and supplies made it difficult for DHIS staff to achieve efficiency in their work.

Problems regarding processing NHIS registration forms

Delays in issuing NHIS ID cards are also attributed to people providing more than one name when registering and having their photo taken. For example, when the person has three names ‘Benedict Kwesi Mensah’, he might use Benedict Mensah to register and Kwesi Mensah for his photo. Matching the two sets of names is prob-

lematic when processing the registration form. Data entry clerks told me they spend a great deal of time matching registration forms with photos. I was told about an incident when a man came to the office several times and could not find his ID card until they asked him for all his names. Next, they asked which name he had used for registration before they could retrieve his card.

I observed the same situation at a PSG mass NHIS registration exercise. Although the registration and photo taking occurred at the same time, each was performed by a specific person, so there were incidents of registrants using one set of names for registration and another for their photo. Although I drew the officials' attention to the situation, they still had a difficult time matching photos with registration forms due to the differences in given names.

Problems of granting exemption to the core poor

The primary goal of social health insurance schemes (SHISs) is to ensure that everybody, including the poor, has access to healthcare. It is generally asserted that since wealth is unfairly distributed, some people cannot make wise insurance decisions because they simply cannot afford to do so (Clackson 2008). This implies that SHISs, and in this case the NHIS, need to have exemptions to ensure that those who cannot pay premiums are covered. Ensuring equity in access to healthcare and reducing the exclusion of the poor has always been part of all health financing regimes in Ghana. Unfortunately, attempts to provide exemptions have historically been challenging, dating back to the regime of insignificant fees in the 1960s and the hospital fee regulations policies of 1972 and 1985.

Ghana, as a low-income country, has decided to help the poor gain access to healthcare under the NHIS. Policy makers having recognised that no matter how small premiums are some people cannot pay and therefore, they have provided exemptions for them. But previous studies show that earlier Ghanaian exemption policies were not successful (Badasu 2004, Aikins & Arhinful 2006, Ministry of Health 2008). The Ministry of Health (2008) notes that the NHIS risk excluding the poor due to identification difficulties.

A key finding of this study is that exemptions under the NHIS have only been applied to a few indigents since the beginning. Witter & Garshong (2009: 5) found that exemptions for indigents were one per cent in 2008. There are many reasons for the implementation gap.

First, the DHIS staff claims the criteria set for identifying the core poor for premium exemption makes implementation difficult. However, after chatting with them, I realised that the problem is not so much the difficulty of identification, but rather the commitment to grant the poor an exemption due to bureaucratic procedures. So DHISs use the strictest criterion for an exemption that in fact eliminates almost everyone. The staff put homelessness at the heart of the conditions for a

person to qualify as an indigent, even if homelessness does not exist in their districts. They often ignore the other indications of indigent status that consider local descriptions of indigents as persons afflicted by severe poverty (see National Health Insurance Regulations 2004, LI 1809, 58: 1-3). Indicators that the local population and PSGs used to describe the poor are: individuals with no stable source of income who live on the benevolence of friends and neighbours with no or inadequate support from family members and struggle to survive while living in dilapidated houses. For this group of people, having a meal a day is problematic. Other conditions stated in the NHIS policy, such as unemployment, are often ignored. This makes the application of the policy quite restrictive since in Ghana, apart from the cities, only 'mad' people live in the street. Everybody has a home no matter how poor. Indigents normally live in family houses, with friends or acquaintances as Serwa and Ama mentioned when describing the core poor earlier in this chapter. So using homelessness as the core criteria for exemption means almost all potential beneficiaries are disqualified.

Second, in my interactions with DHIS managers and staff, it became clear that they rarely grant an exemption to people who are not sick. They wait until people are sick and cannot pay their hospital bill. Responding to my question about why they do not grant exemption to the core poor, a DHIS manager argued: "The criteria disqualify almost everybody but we occasionally give exemptions when health providers refer patients who cannot pay their hospital bill to us. In such cases, we go to their aide and register them."

I describe this as 'amnesty' and not exemption since the person is rescued when in crisis, which is not the objective of the NHIS policy. DHISs are supposed to ensure that the core poor can access healthcare when ill. In other words, being insured will encourage them to seek treatment in spite of their inability to pay. The DHIS officials agreed that it is their moral obligation to ensure that the core poor have access to healthcare. However, my conversations with them revealed underlying issues that do not motivate them to grant exemptions to the poor. Their concern was that since the DHISs are expected to build up their IGF to meet some of their operational costs, giving exemptions to the poor means they lose money that they need. Therefore, considering their weak revenue base, it was not in their best interest to vigorously look for indigents to exempt from premium payment. So they were not keen to let people know about the exemption policy. One DHIS official said: "We have the problem of low enrolment and we need money so if we go to communities and continue telling them we want to exempt some people, the others won't pay. So how do we get revenue?"

Collectors who are supposed to be on the frontline identifying the poor (NHIS 2004, LI 1809, 58: 3) were found to rarely send people to be considered for exemption. When I asked Emma, a collector, why she has not registered a single indigent,

she told me that she had not found a core-poor person. At this point, I told her about Ama, the 'core-poor' woman mentioned earlier in this chapter and suggested she goes and verify Ama's situation. A month later, I enquired whether she has gone to see Ama. She answered in the negative, so I presented the case at PSG meeting and all those present including the DHISs staff agreed that Ama should be exempted. After two months, when a mass registration was organised by the PSG in the community, Ama was still not registered. At this moment, Serwa, the volunteer who had introduced Ama to me, told me that one of Ama's twin daughters had died. She had died at home since Ama did not have money to take her to the hospital. Even after discussing Ama's misfortune with Emma, she still did not register her until the next mass registration campaign two months later. This time the volunteer brought Ama to Emma and so she had no choice but to register her. Emma's attitude showed that she was not willing to register Ama, but could not refuse because PSG members were present watching her. This shows the collectors' reluctance to register indigents for an exemption, even when they are easily identified and their impoverish situation is established.

I later learnt that collectors are paid a commission only on collected premiums and not for registration and administrative fees. So Emma's behaviour and other collector's behaviour show that processing exemptions for core poor is not in their interest, hence they lack motivation to do so. However, I observed that the collectors were registering children and the elderly. When I discussed the issue with DHIS managers and other officials, they admitted that they had not granted an exemption to any core poor person in those communities. Also, in my conversations with Ama and many community members, they revealed that they were even not aware of the exemption policy.

It is obvious that the exemption policy under the NHIS is far from achieving its objective, since the homelessness criterion does not reflect local conditions and excludes potential beneficiaries. I acknowledge that even if the criteria for identifying indigents is complex, my observation and discussions with DHIS staff, PSG members, community members and leaders show that at least in closely knit rural and urban communities (like Achiano and Anomabo), indigents are not difficult to find. People who are eligible for an exemption are known by almost everyone in the community as living in abject poverty, as the case of Ama shows (see also Aryeetey 2012). However, DHISs' staff were not keen to identify indigents because it was not in their interest and did not help them increase their IGF.

Further discussions and observations suggest that the pressure put on DHISs to improve their IGF could explain the DHISs' lack of commitment to grant exemptions to the core poor. A DHIS manager told me that their current premium revenue is only 5 per cent of their claims. He also said that all the DHISs' revenue accounts for about 10 per cent of their total expenditures. The ratio of revenue to expenditures

is used to measure the DHISs' performance. Thus, low revenues put the DHISs in a dilemma about granting exemptions. Should they grant exemptions to indigents and improve enrolment? Or is it better to apply the most restrictive exemption criteria thus eliminating potential beneficiaries and rely on people who can pay cash, which increases their IGF.

The findings above highlight three important issues for policy makers. First, the homelessness criterion for granting exemption to indigents disqualifies potential beneficiaries. Second, the lack of a commission to collectors for registering the core poor does not motivate them to recommend indigents to be considered for exemption. Third, the inadequate funds provided to DHISs forces them to focus on revenue generation rather than recruiting the poor for exemption. The three issues suggest a need to rethink the exemption policy, particularly the homelessness criterion and payment of registration fees by the core poor.

In conclusion, the decision of the average Ghanaian to enrol and remain in the scheme is not necessarily influenced by poverty, but rather by factors such as a lack of interest in health insurance, poor quality healthcare services delivery, delay in receiving NHIS cards and the possibility of enrolling through the back door when healthcare is needed. This calls for intensive education directed to healthcare providers on the principles of the NHIS and effective mechanisms to stop corrupt practices. In addition, the quality of the DHISs' service needs to be improved to attract and retain people, especially those in the NHIS rich category, by providing adequate drugs at DHISs facilities and improving health providers' behaviour towards insured patients to assure better treatment. Also, the DHISs should give equal attention to identifying the core poor for exemption to prevent their exclusion to achieve the equity goal of the NHIS.

Effects of politics on enrolment

The politics surrounding the introduction of NHIS and the effect of politics on enrolment are discussed in this section because politics as a barrier to implementation was mentioned by respondents in all three stakeholder categories and others involved in NHIS implementation. Community members, DHIS staff and health providers spoke about how the NHIS policy-making process and the timing of its introduction had adverse effects on enrolment. The political undertones of the concerns of the Ministry of Health (MoH), Ghana Health Service (GHS) and the National Health Insurance Authority (NHIA) regarding the NHIS are also addressed.

The issue of politics and the NHIS arose when I asked community members, DHIS staff and health providers why people were not enrolling in the scheme. Their responses indicated that politics negatively affected NHIS uptake irrespective of knowledge about the potential benefits. I was amazed at how the politics within the Ministerial Health Financing Task Force set up at the Ministry of Health to draft the

NHIS bill had reached households in the remote communities I visited. The media had widely published the acrimony of debates in the Task Force (see Agyepong & Adjei 2008) and Parliament and this was keenly followed by community members and influenced some not to enrol.

Discussions with both uninsured and insured participants reflected their political sentiments about the NHIS. The respondents expressed their sympathy for either the New Patriotic Party (NPP) or the National Democratic Congress (NDC). NPP sympathisers described the NHIS as the best healthcare policy ever introduced in the country. Their typical response was: “You don’t mind them. It’s unto them [NDC supporters]. They are saying because they are NDC they won’t enrol. For me, I think NPP did well by providing such a good policy.” The NDC sympathisers, however, saw the policy-making process as acrimonious and felt that the only way they could show their disapproval was by refusing to enrol. They also said they were not happy about the process and the way NPP discredited the NDC government. John, a petty trader and NDC sympathiser did not hesitate to mention politics as a factor that influenced his decision not to enrol. He said:

I didn’t register because of politics I don’t belong to NPP who introduced health insurance. I hate what they did and said about my party who first conceived the idea even long before they won the elections. They should have acknowledged NDC as being the first to introduce the idea of health insurance even if it did not materialise before they left power. That was why I waited till now before registering.

Kwesi, a community member, also told me: “I thought the NHIS cannot survive any change in government and that it was going to be a ‘nine days wonder’ and will die when a new government comes to power.” I also had reports about how NPP politicians wrote people’s names and promised to register them in the wake of the 2008 general elections, however, they never returned after the elections to do so. This issue arose at the beginning of my fieldwork when people asked me whether I was part of the group that had come to write their names and promised to register them. Collectors at the PSG meetings confirmed the NPP politicians’ action and claimed that the politicians had contacted them during the campaign to compile lists of widows and the poor, but they never heard from them after the election.

Health providers also confirmed the situation described by community members and spoke about the effect of politics on enrolment. Dr. Gyena told me:

Politics influenced people not to enrol when health insurance was introduced. This still lingers on even after the change of government. I noticed in my consulting room that most patients from particular communities, which are strongholds of the then opposition party, are not insured.

DHIS staff believed that the politicisation of the NHIS, especially during its introduction, contributed to their operational difficulties. They said that the NHIS was used as a tool by both the ruling and the main opposition parties to canvass votes during their campaigns. As a result, political opponents who felt the NHIS was used by the government to secure electoral victory refused to enrol. DHIS staff believed

they were often perceived as political activists pursuing the interests of a single political party and not as public servants who were implementing public policy. This perception undermined the DHISs efforts to promote the NHIS. A DHIS manager described the situation in his district as follows:

The timing of the introduction of NHIS made it political and contributed to people's reluctance to register. They thought because it was government 'A' who introduced it they should not join. In some communities we were treated as belonging to a political party and chased out when we went there to educate them. They hooted at us and said we had come to take their money for the electioneering campaign. Communities that were NPP strongholds were more receptive and attended our promotional activities. You can see it in our enrolment figures. Generally, communities that were NPP strongholds registered more than those that were NDC supporters.

A DHIS staff also told me they were chased out of a village because it was predominantly an NDC stronghold. He said:

Due to the timing of the introduction of the NHIS and the political climate at that time, just before national elections in 2004, politicians took advantage of the situation and played politics with it. The main opposition party criticised the policy, while the ruling party painted a vivid picture promising that the NHIS gives free treatment as if everything was covered. So people expect to get everything at the facility. When this doesn't happen they feel disappointed and say all sorts of things against us.

Furthermore, MoH and the GHS staff expressed concerns about the lack of collaboration with the NHIA since the three institutions expected to ensure effective implementation of the NHIS. The staff told me that the politics were responsible for the lack of collaboration and this undermined efficient service delivery and ultimately enrolment. The main concern of the MoH and GHS staff was the lack of openness on the part of the NHIA. A GHS staff said that the lack of consultations and regular discussions were the main challenges they faced in service delivery. He asserted attempts to institute regular meetings of the MoH, GHS, NHIA and DHISs to discuss their activities and problems to make and implement decisions together failed after the first meeting. The NHIA stopped honouring their invitation and gave excuses including stating that the MoH could not summon them to meetings. He said:

Delay in claim reimbursement, which is at an average rate of five months, is because we [GHS] have no way of finding out what the real problems are in claim processing. We [GHS and NHIA] have not sat down at the national level to agree on exactly what to do. Facilities send both soft and the hard copies of NHIS claims. The question is why should we continue to make claim processing so difficult for health facilities? Also, when it comes to monitoring, they [NHIA] don't involve us. They write to the facilities without due regard to us. They only come to us when there is a problem.

Moreover, NHIA piloted new software and set up their ICT system to authenticate NHIS membership without talking to us. They dealt with health facilities directly. We told them to involve us so we could send our staff with them to study the system. They refused and have gone ahead to do their own thing. Now that they are about to set up the second phase which requires all facilities to be computerised, have internal network and be connected to their system, they are now compelled to involve us so our facilities could prepare bills to fit the new system. As you

know some facilities don't have electricity. It means we have to provide generators and train our staff to know how to use the new system; I don't know at whose expense. We have not discussed these issues. These situations undermine operational efficiency and do not make NHIS attractive for people to enrol.

The MoH staff also told me that the major problem they faced as a policy-making body was the lack of collaboration. According to the official, NHIA claims they are under the Office of the President, so the MoH cannot call them to a meeting. The official said:

The biggest challenge facing us is not only lack of collaboration, but that the NHIA doesn't share information. Their reports on NHIS are classified. This doesn't help build systems that improve quality of service, hence the numerous complaints.

An official of the NHIA spoke about the MoH and GHS officials' allegations of a lack of collaboration and transparency when discussing the NHIS issues:

NHIS is a pro-poor policy with premiums based on the poverty level in the country. Premium levels are low enough to make it possible for the majority of Ghanaians to enrol and exemptions are also in place for vulnerable groups. But, the problem is those implementing the policy. Some of DHISs and health facilities have not performed creditably while others engage in all sorts of corrupt practices. This has resulted in delays in claims reimbursement and other issues they are complaining about. They have not yet absorbed themselves into the NHIS. They read politics into whatever we do. The issues they are complaining about are measures aimed at improving and reducing corruption in the system. I'm sure we will get there soon.

When I asked why they did not want to give out information, another official quickly responded: "It depends on what you are going to do with the information." This statement confirms the concerns expressed by MoH and GHS officials about lack of collaboration. This situation suggests that systems that could make NHIA more responsive to implementation challenges and the emerging needs of stakeholders to improve service delivery are not really being developed in a participatory manner. Thus, effective collaboration to ensure efficient implementation of the NHIS policy seems to be lacking at the highest level.

John's and Kwesi's decision not to enrol, the MoH and GHS staff's concerns about the lack of collaboration and the NHIA not sharing information are underlying issues that are worth discussing. The situation shows that governments act in ways that elicit negative reactions towards the very policy they are trying to promote in pursuit of their political ambition. Community members who politicise the NHIS undermined the credibility of the scheme as a social security provision aimed at ensuring equity in access to healthcare. Concerns expressed by MoH and GHS staff suggest that the lack of collaboration does not build systems that will help improve service delivery, since initiatives by NHIA alone could miss important challenges confronting implementers and service providers. By politicising social policies such as the NHIS, politicians are stabbing themselves in the back. The more they try to ensure equity in healthcare access without effectively engaging key stakeholders, the

more they seem to miss the real challenges that need to be addressed, hence increasing the likelihood of failure.

International politics and healthcare policy-making

Events at the international level indicate that healthcare reforms, especially health insurance, generally generate fierce political debates. For example, the US 2008 elections were also characterised by intense debates when President Obama campaigned heavily on restructuring health insurance. This led to enactment of the Patient Protection and Affordable Care Act (PPACA) in March 2010, informally referred to as Obamacare. The main observation relevant in this discussion was the US approach to the policy-making process that included lobbying within the legislature and civil society groups as well. Powerful lobbyists were used to manoeuvre the legislation process to get the bill passed and safeguard transparency. This is not to say that the process was a perfect one, but as political scientists have argued, the formulation of successful public policy fundamentally depends on the political environment and the checks and balances that guide the process. Brinkerhoff (2004) observes that stakeholder engagement ensures accountability and compliance with procedures and improves performance in his study of health systems in the US. He argues that this engagement helps generate a system-wide perspective and reveals gaps that require attention and interventions to improve service delivery.

Another example is Mexico's Ministry of Health that led the process of developing stakeholder support for a healthcare reform, which expanded social insurance coverage to the poor. They used strong persuasive arguments and an evidence-based approach to win the support of competing political and special interest groups. In Mexico, dissenting views did not lead to resentment. This effort has been acknowledged as one of the most successful policy reforms of President Fox's government (see Frenk 2006). It demonstrates that the effective engagement of stakeholders ensures that public policy-making does not degenerate into bitter wrangling among key actors.

The Mexican and the USA approaches both provide relevant information and lessons for politicians and policy makers in Ghana. Their experiences show that lobbying and engaging political opponents in the policy-making process is essential. De Swaan (1988: 156), writing about state intervention to promote social security in nineteenth century Western Europe, provides insight into the role of politics in social policy making: "Creating social security was hard political work. It demanded strategic coalition building and tactical parliamentary and bureaucratic manoeuvring". His observation shows that politicians should endeavour not to politicise health insurance to advance their careers, but rather use diplomacy and negotiation to allow for experts' input to guide the policy-making process. This would build

trust in the NHIS and encourage people to enrol, while ultimately ensuring the equity that the politicians very much desire to achieve. Thus, when all stakeholder voices are heard, the possibility of failure is reduced.

Factors that encouraged enrolment in the NHIS and renewal of membership

During my fieldwork, I found issues that promoted the NHIS that deserve attention as well. These are discussed under two themes: (1) positive attitudes of health providers and (2) benefits derived from membership in the NHIS. These factors encouraged people to enrol and remain in the scheme. The NHIS provided financial relief for insured patients and reduced their vulnerability to ill health. For healthcare providers, the NHIS was perceived as reducing delays at home since insured patients presented with less complicated cases. They appreciated that the NHIS enhanced their work and encouraged their patients to enrol.

Positive behaviours of health providers

As stated earlier in this chapter, health provider-patient interaction affects NHIS enrolment and membership renewal. This study found that community members did not perceive all health providers as hostile and disrespectful towards insured patients. This observation is contrary to the popular perception that health providers do not support the NHIS. Some health providers were also seen as kind and helpful towards insured patients. They discussed the benefits of the NHIS with their uninsured patients and encouraged them to enrol. During my fieldwork, I heard some health providers advising their patients to enrol, especially those who had difficulty paying for their treatment. A key informant told me that he had registered because he was persuaded to do so by a medical assistant. He said:

The Medical Assistant always convinces patients to register. The last time I was at the hospital, she advised me to register so that I can get some relief from paying my son's hospital bill. It was because of her persuasion that I went to register. In that facility, the first thing they ask a patient is whether he or she has an insurance card.

Therefore, some health provider-patient interactions created the impression that the NHIS would benefit patients and encouraged people to enrol. This supports Arhinful's (2003) observation that perceptions ultimately play a role in people's decision to join SHISs and indicates that conscious efforts by health providers to behave favourably towards insured patients created confidence in the NHIS and encouraged people to enrol.

Benefits of the NHIS

Previous studies in Ghana show that health insurance has a positive impact on healthcare utilisation (Sulzbach et al. 2005, Ansah et al. 2009). Sulzbach (2008)

compared baseline data in selected districts before and after the NHIS, and found that it increased access to formal care and significantly decreased out-of-pocket expenditures. This study also found that the NHIS reduces healthcare delays at home and in facilities, thus resulting in fewer complications among insured patients. It also helps the management of vulnerabilities and adversity presented by ill health, specifically for people suffering from chronic diseases such as diabetics and hypertension. This confirms previous findings that the household cost of ill health contributes to impoverishment since poorer households that are affected by chronic disease that uses up resources which leads to the loss of livelihoods (Russel 2004, Save the Children UK 2005, Mulemi 2010).

Conversations with both insured and uninsured people suggest that NHIS benefits (for themselves or relatives) encouraged them to remain in the scheme. The insured, especially those who seek healthcare regularly, were happy about the benefit package and the economic and social relief of the NHIS. This is reflected in the survey results in which the majority (76.2%) of all respondents, in Anomabo (100%) and Achiano (75%) said they enrolled because NHIS gave them financial protection against illness, helped them save money when paying hospital bills and made them independent since they did not need to ask for money from elsewhere (Table A.4, Appendix 2). A typical statement made by the insured was: “Even if there are problems such as negative behaviour of healthcare providers, the benefits outweigh such inconveniences.” Akosua narrated how her persistent ill health and high cost of treatment caused her to spend her capital and her husband nearly divorced her, but she did enrol in the NHIS a year ago. She said:

I used to worry about my condition when I was paying for treatment every month. I think this even worsened my condition at a point because in addition to the disease I was also worried about how to pay for treatment and the threat of divorce. Now NHIS helps me get my drugs regularly. I don't have crises anymore. Thank God I've regained my strength and able to go about my daily activities without feeling any shame⁴. I was able to accumulate some capital and resumed my trading. I don't spend all my money on healthcare anymore.

Furthermore, insured patients said that all that they think about is their transport to the healthcare facility and not how to get money to pay a deposit before treatment. This is what Anoma said when I asked him why he continues to be a member of the NHIS:

The premium compared to the cost of healthcare is reasonable. I was lucky to have insurance when I had to remove my hernia. I didn't think of money to pay a deposit. Things would have been very difficult for me since it was during the dry season and I didn't have money, it means I had to wait for the fishing season or borrow money. At the hospital too they just asked me of my NHIS card and immediately admitted me because I was in great pain. Otherwise they would

⁴ She explained shame as her inability to get close to people because she was always sick and not contributing anything to the family or community's activities. People sometimes were also unwilling to get close to her and her husband wanted to divorce her.

have asked me to pay deposit before treatment. All these delays would have ended in something else; maybe death.

Akua, a diabetic patient also narrated how the NHIS enables her go to the hospital regularly and have all her drugs. She said:

This hospital card [NHIS card] has reduced my burden and worries. I don't have to spend the little money for my trading activities to pay hospital bills. Though the sickness is still there, because I know I can get healthcare anytime, I am relaxed. Insurance has given me peace and relieved me from thinking about ill health. So for me, I regularly renew my card even though I am not satisfied with the quality of service in this hospital. Sometimes you have to spend so much time there.

The above reports suggest that when the NHIS covers healthcare expenditures and insured patients are assured of receiving care, they are more likely to live positively with their disease. Thus, the NHIS reduces a person's vulnerability to the adverse effects of ill health. Since this reduction in vulnerability occurs in a community, some people who are initially reluctant to enrol are ultimately encouraged to do so. Although people may be dissatisfied with health providers' negative behaviour, this might be overlooked if drugs are available at the local healthcare facility.

Healthcare providers told me that the NHIS reduces delays at home and health facilities and solves the problem of deposits for healthcare as indicated by Anoma. Dr. Gyena described the benefits as follows:

The good thing about NHIS is that it has improved utilisation and reduced delays; many more people are coming to the hospital now. At least the insured are reporting early with less complicated cases. They also have fewer problems getting their drugs. This makes treatment more effective as people come for reviews regularly.

According to hospital administrators, the NHIS has improved their revenue despite the delay in the payments for claims. The NHIS has helped them recover funds from people who access healthcare and cannot pay. He said: "Comparing NHIS to the past when we lost so much money to people who cannot pay their cost of treatment to now when we contact the DHIS, they help such people with exemption and pay us."

Dr Gyena's account and the medical assistant's persuading her patients to enrol show that some health providers see the NHIS as enhancing their effort of providing quality healthcare and advise their patients to enrol to ensure they have access to treatment when they need it.

Anoma, who faced the risk of death but for the NHIS, shows the linkages between SHISs and protection against health risk. Her example supports Criel's (1999) assertion that SHISs avert risk. Akua, Akosua and Anoma also show that the NHIS helped them regain their livelihood in addition to providing economic relief from paying catastrophic healthcare costs. The NHIS helped to enhance their ability to cope with and adapt to their chronic condition and resume their economic activity. This underscores the importance of the exemption policy as a safety net for the core

poor in the midst of inadequate support from family and friends. The NHIS was therefore found to facilitate prompt access to healthcare and adequate treatment. Lack of membership in the NHIS can result in fatalities as in the case of Ama's daughter who died due to lack of access to healthcare. This suggests that exemptions for the poorest households are critical.

Conclusion

This chapter has shown the multidimensional factors that affect enrolment and retention in the NHIS. Reasons given for not enrolling and renewing memberships seemed to be simple: "No money to pay premium and registration fees." There are, however, more complex factors at all levels: community, health facility, DHISs and politics converge to influence member enrolment and retention.

Most of the participants indicated that neither poverty nor premium costs were a significant reason for not enrolling. Thus, in addition to the "no money to pay" response, people mentioned that they were "not often sick." Since people could obtain 'cheaper' healthcare at chemical and pharmacy shops when they were sick, this encouraged them not to enrol in the NHIS or renew their membership. They did not see health insurance as a pressing need. Further, dissatisfaction about the lack of drugs at health facilities and health providers' (including DHIS staff) negative behaviour and malfeasance all make people question their commitment to the NHIS. In addition to the community members' low interest in health insurance, the outcome of insured patients' encounters with health providers discourages people from enrolling and remaining in the NHIS. At the same time, health providers' persuasion makes some uninsured patients appreciate the NHIS, as in the case of the medical assistant who showed her NHIS card to patients to increase confidence in the scheme and thereby encourage them to enrol and renew their membership.

For health providers, the increased utilisation of healthcare services and completion of the complex NHIS form both exacerbated their heavy workload and caused them stress, which resulted in some being hostile and showing disrespect to insured patients by asking them to pay cash or giving preference to uninsured patients. These issues, coupled with delays in claim payments, adversely affected the quality of service delivery health providers' desire to provide quality service.

DHISs' staff shortages, inadequate funding and lack of equipment adversely affected their work output and resulted in delays in issuing NHIS cards. To manage their distressed financial situation, DHISs are in a dilemma as to whether or not to focus more on revenue generation to increase their internally generated fund or to grant exemptions to the poor to improve enrolment.

Given the significance of trust in SHIS, this study shows that the lack of trust erodes public confidence in the NHIS and undermines its potential as a viable alternative to 'cash and carry' and to ensure access to quality healthcare for all

residents in Ghana. This was demonstrated by the alleged involvement of health providers, DHIS officials' and NHIS collectors in malfeasance, which led to distrust among stakeholders and negatively affected the credibility of the NHIS.

Finally, situating barriers and enablers at the level of local stakeholders and highlighting their concerns, makes revealing the reality involved in implementing the NHIS policy to policy makers critical. This study provides a guide for developing interventions that can create confidence in the NHIS and encourage people to enrol and regularly renew their membership. How local level multi-stakeholders collaborative groups were set up and were able to develop and implement interventions activities to reduce these barriers, increase enrolment and retain members in the NHIS is the focus of the next three chapters.

Creating problem-solving groups

Introduction

In Tiase (not real name), the selection process changed three times before the community could select problem-solving group (PSG) members. After a hectic durbar in Tiase, George, a health provider, walked straight to me. He wanted to know the necessity of the elaborate participatory process (described later in this chapter) we used to select PSG members with a string of questions as follows:

Why do you have to go through all these? Why didn't you just let the chief give you people to join us [health providers and DHIS staffs]? That's what we have been doing. Who has time to do all these? We don't follow any laborious process like what you have done. We normally discuss what we want to do with the chief or people we know in the community and request for people to work with. If necessary then we organise a community durbar to inform them about the intervention.

George's statements represent his experience (and perhaps that of many others) of how community representatives are selected to form stakeholder collaborative groups. His expression of surprise about the elaborate process used in forming PSGs and why we¹ committed ourselves to it suggests that in spite of all the rhetoric about community involvement and participation, a few people probably decide on what to do and who to engage in the process. It also suggests that even those who claim to engage stakeholders in their intervention programmes often do not involve them from the onset.

¹ Since my study was part of a multidisciplinary research project, some, but not all activities were carried out by the research team (two health economists and me, the medical anthropologist). Research assistants were hired to lead the PSG creation process.

A literature search on partnerships and participation shows that despite the long history of collaborative groups globally, the process of creating them is given less attention. Many studies argue in favour of and give positive accounts of partnership outcomes (Hawkes et al. 2004, Hawkins et al. 2002, Schensul et al. 2004). However, processes involved in reaching that goal are not well documented. The UK Department of Health (2004) notes that despite the desire to include patients and the public in the planning and development issues, it is less clear how their involvement should be undertaken. This implies that even though partnership formation is not new, there are no blue prints to follow for creating partnerships, so most programme officers do their ‘own thing’.

This chapter provides a systematic description of the selection processes and specific activities carried out to create and initiate PSGs. It seeks to answer three main questions: What processes are followed when creating PSGs? Who are involved? How are PSG members and facilitators selected? I provide insight into the complexity of the process. I also describe the challenges we encountered and how they were addressed. Lastly, I give suggestions to improve the PSG creation processes.

Steps and activities in problem-solving group formation

Figure 4.1 shows the four major processes and activities followed in the creation and initiation of PSGs. The PSG formation process started with a stakeholders’ orientation and ended with the PSG facilitators training. Although I was active in contacting stakeholders and arranging the logistics to ensure that PSGs’ were formed, I did not play a lead role during the sensitisation durbar or in the selection of PSG members and facilitators. However, I did observe events, listen to discussions and contribute ideas when necessary. I also engaged community members, DHIS staff and health providers in conversations during the process.

Figure 4.1 Steps followed in setting up problem-solving groups



Stakeholders' orientation

The PSG formation began with a stakeholders' orientation. During this phase we interacted with key stakeholders (community members, health providers and DHIS staff) and created awareness about the problem of low enrolment and membership retention rates. After opinion leaders, health providers, DHIS staff and the research assistant presented the purpose of the intervention (see chapter five for details) in open forum, those present asked questions for clarification and also added their observation. The research team believed that sensitising the stakeholders about the purpose of the intervention (increasing enrolment and retention in the NHIS) would make them interested and willing to work together for change. I will describe how the community members, health providers and DHIS staff were mobilised, oriented and motivated to address the problems of low enrolment in the NHIS and high membership non-renewal rates. Before this could happen, the stakeholders had to recognise the problem and be concerned about coming together to address them.

Guided by the multi-level perspective (MLP) that emphasises studying a phenomenon by engaging actors at all levels (Press 1990, Green et al. 2001, Van der Geest et al. 1990), key stakeholders of the NHIS were engaged in the mobilisation effort to set up PSGs from the onset. The process started with visits by the research team to the District Director of Health Services (DDHSs), District Health Insurance Scheme (DHIS) managers, heads of local health facilities and community leaders. After our meetings with the DDHSs, we were introduced to disease control officers² (DCO) who had in-depth knowledge about all the communities in their districts. The DCOs led us to the community-based disease surveillance volunteers³, popularly called 'volunteers', who they engage in outreach programmes. The volunteers led us to the chiefs, elders and opinion leaders of the intervention communities. Discussions with the volunteers focused on the intervention and its purpose. We solicited their support for the intervention and asked permission to engage their staff and community members in the programme. We also sought the volunteers' views on the selection of PSG members. These visits gave us the opportunity to learn about the community dynamics and to utilise community structures and leaders to lead the PSG creation process. The orientation phase lasted three weeks during which an average of two visits was paid to each community, health facility and DHIS office.

As researchers in the communities and among health providers and DHIS staff, we (the research team) were not sure what process would be acceptable and how to

² Disease control officers are staff of GHS stationed in the district health directorates. Their job is surveillance and reporting on disease outbreaks.

³ Community-based disease surveillance volunteers are community members who work with DCOs. They are key persons in health-related community educational and intervention programmes. Their main task is to report the presence of any communicable or infectious disease in the community to the DCOs. They also give advice to community members to seek appropriate medical care promptly when sick.

motivate interest in the intervention. We decided to start our discussions by presenting the pre-intervention household survey results that generally showed low NHIS enrolment and high membership non-renewal rates. We arranged a meeting to introduce the project to opinion and community leaders, the DDHSs and DHIS managers and their staff. We discussed the problems captured by our survey. After presenting the results, the discussions generally became brainstorming sessions. All stakeholders spoke about their concerns regarding the NHIS and focused on challenges at their level: the community, health facility and the DHIS. Our meetings usually ended with discussions on how to address the raised concerns and the best strategy for selecting PSG members. Next, we introduced the purpose of the intervention and rationale for the multi-stakeholder problem-solving programme (MSPSP).

At the health provider level, discussions were held with DDHSs, doctors, medical assistants, disease control officers, nurses, and those who work on NHIS forms among others. In most of the discussions, these stakeholders voiced concerns over the lack of consultation by the DHIS and NHIS operational difficulties. Dr Gyena, a DDHS staff member made remarks about the NHIS and support for the intervention and typified the health providers' concerns. He said:

The National Health Insurance Authority (NHIA) is not listening to those of us on the ground providing service. They could have improved their operations if they had a 'listening ear'. Now we have all sorts of problems; even they can't pay us. By bringing all of us together half the problem is solved. Many people come here and talk of collaboration but they tell us what to do. They think we don't know anything. Our 'voices' don't go anywhere. They forget that we also know what is 'workable' at the local level. Sometimes what is lacking is that the right people are not selected into such groups. We will support the intervention and make sure we get the right people in the group.

The DHIS staff included DHIS managers, public relations officers (PROs), management information system (MIS) officers and other staff who took part in the discussions. They were all excited about the intervention and indicated that enrolling people in the NHIS was their core business, so they would support any programme aimed at helping them achieve their goal. However, they lamented the lukewarm attitudes of people towards the NHIS and the challenges of implementation. They indicated they had been conducting many educational activities, but people were just not responding. However, some DHIS staff were utterly surprised at the low enrolment and high non-renewal figures we had obtained from our pre-intervention household survey; nevertheless they did not dispute our data. One of them said: "Though I know that many people are not enrolling, I didn't know the situation was all that bad. In fact, we really have to act."

In the community, chiefs and their elders, volunteers, NHIS collectors and opinion leaders (such as assemblymen and Unit Committee chairmen) were those involved in discussions. Our meetings with them focused on why some people were

not enrolling and others were not renewing their memberships. Similar to other stakeholders, these respondents expressed worry about the low enrolment situation and some admitted that they had not registered themselves. Others recounted their own experiences with the NHIS. Below is an excerpt from one meeting with community leaders:

Agnes (member of research team and medical anthropologist): We are here this morning as a follow-up to the baseline [pre-intervention] survey we carried out in March this year [2009]. Our purpose is to share our survey results with you. The results generally showed low enrolment in the NHIS and high non-renewal rates⁴. Out of the 13 communities surveyed in this region [Central Region], only four had 33 per cent of households enrolled. Individual enrolment was less than 10 per cent in three communities. In this community, when you count 10 households only one (9.2%) had at least one member with valid NHIS card. The situation is even worse when you consider everybody.

Community elder: Thank you for your information. I didn't know so many people have not enrolled. I'm happy you are here to let us know how serious the situation is. I'll say that the problem with health insurance is not just that we are not enrolling, but also the problems people encounter when they enrol or go to the health facility after enrolling.

Agnes: So, we are here to discuss what could be done to improve the situation. Specifically, what action we can take to encourage people to enrol and remain with the scheme.

Assemblyman: Definitely something must be done to get more people enrolled. Though we all agree that health insurance is good and that everybody should register, there are problems that discourage many of us from enrolling. We were told when you have the hospital [NHIS] card and you go to the hospital you do not have to pay, but that is not what is happening. Insured patients are still paying at health facilities. In this town there is no accredited drug store so you have to travel to other places to get your drugs. Moreover the cards are delayed after registration. All these discourage people from joining and the insured renewing their cards.

Agnes: We are here to discuss how we can best deal with the problems you have mentioned. When we met healthcare providers and DHIS staff, they also mentioned a number of challenges that undermine their work. The SHINE Ghana project team thinks that factors that discourage people from enrolling or renewing their NHIS card could be better dealt with if community members, health providers and DHIS staff work together to identify and address them. We are proposing an intervention called a multi-stakeholder problem-solving programme to help address these barriers that undermine enrolment and retention of members. So we are here to seek your views and support for the project. The first step is how to set up what we called problem-solving groups consisting of representatives of the community members, health providers and DHIS staff. As the name implies this group is expected to meet regularly to identify barriers to enrolment and retention of members at each level, share ideas and develop their own solutions and implement them.

Chief: I'm happy you are here to discuss your ideas with us, and how we can work together. I'm also happy about the fact that you are involving health providers and the DHIS staffs. I think if we work together we can achieve better results.

Agnes: Thank you for accepting to be part of the process. The first step now is the method to use to get your representatives to join the PSG.

⁴ Of the 13 communities surveyed in this region (Central Region), four had enrolment levels between 31.8% and 39.1%, and the other nine had enrolment levels between 9.2 % and 29.6%. Individual enrolment was less than 10% in three communities and the lowest was 4.8% (see Table A.3, Appendix 2).

At the end of the visits, all professional stakeholders indicated that access to healthcare is an endemic problem that the NHIS is expected to solve. Therefore, since very low enrolment and high drop-out rates have been recorded in most communities, pragmatic interventions are needed to create and sustain community members' interest in health insurance while all stakeholders re-orient their world-views about the NHIS. For example, health providers and the DHIS staff lauded the MSPSP as an intervention that would help them address the demands of community members while giving them the opportunity to talk about the NHIS implementation challenges they were facing. They also promised to have their staff join the PSGs. Community leaders were happy about their involvement in the mobilisation process. The typical response after being briefed was: “*Yebehwe ayi won a wobetumi aye edwuma no*” (We will select people who can do the work). All key stakeholders provided very useful information about their communities.

Hawkes et al. (2004) analysed potential barriers to the implementation of a syphilis control programme. The authors observed that engaging key players is crucial to ensure that an intervention programme receives adequate support and health policies become effective in practice. In this study, we observed that the key stakeholders' involvement raised interest in the intervention. The question of the appropriate method for selecting community representatives to form PSGs was settled in our follow-up visits. After a number of techniques were suggested by community members, health providers and DHIS staff, a final decision was made. Some community leaders, who were in favour of handpicking members of PSGs, argued that an open selection method would be an arduous process and might not be successful. Others who supported the open selection process argued that the process would identify more credible individuals to represent the community since many people would be critical of the selected PSG members. In one community, an assemblyman who argued in support of the open selection at a community durbar described the advantage as follows:

It is better if everybody participate in selecting representatives to the group than the few of us gathered here decide to pick people to represent the community. More importantly, taking those who will finally be selected through a vigorous selection process will let them be more serious with the intervention. They will feel they are accountable to the whole community not the few of us and be serious with their work.

Kekeli, an assemblyman in another community explained why an open selection process in a community durbar was preferred:

Instead of a few people deciding on who should be PSG members, it is better we involve the whole community even if it is strenuous and time consuming. With the durbar, the right message will spread faster since many people will attend and start talking to their family members and friends. So awareness is created among the majority within a short time. It would actually influence the majority of them to take the intervention seriously and hopefully will motivate them to respond positively to whatever the group decides to do.

After extensive discussions, opinion and community leaders in the first two communities unanimously agreed upon an open selection process at a durbar to select PSG community representatives. The consensus was that the durbar would create awareness among community members and lay the foundation for the intervention even before it started. The meetings usually ended with opinion leaders taking the responsibility to mobilise people to attend the durbar.

The community orientation visits to the seven intervention communities went well except for the last one in Jakakrom (not real name), an urban community. As usual a volunteer arranged the pre-durbar meeting. Here the chief, Nana Ansah's⁵ first reaction was negative. After a briefing, he indicated that he was not going to tolerate such things (intervention programmes anymore), so he was not going to give me permission to enter the community. He told me he was not happy with the activities of NGOs who came to the community without properly consulting him. He indicated that the NGOs want to use communities to make money, so he would not allow me to do so. In fact, he nearly walked me out of the room. I asked politely if I could review what I had said and he agreed. So I repeated what I initially said and emphasised that I was just a researcher from the university and not from an NGO. Then he changed his mind and told me that he had also retired from the university two years ago. He explained his initial negative stand.

I agree that any intervention that will make my people have access to healthcare must be supported because development can only occur in a community if everybody is healthy and can work. But people come here without proper consultation. The 'so-called' experts think they know everything and don't involve us. The other day, I just heard a group was doing something down there [pointing his finger to a school]. They came without seeking our views [pointing to a number of elders he had summoned to come and listen to me] about what they want to do. They just waste money sometimes doing things that do not benefit us or solve the problem. It is good you want us to be part of the intervention. I'm happy you are also involving health providers and DHIS staff. I hope whatever comes out of your research will be used to improve the situation.

At this point, the meeting turned into a conversation and Nana Ansah recounted his experience with programmes that performed poorly because the people were not given the opportunity to add their input about how things should be done. He told me that he personally had gotten the women in his community to use treated mosquito nets.

Chambers (1983), a key proponent of participation, has noted the concerns like those of Nana Ansah and Dr Gyena. The author remarked that even when development workers talk about community participation, at the end of the day it is still an

⁵ Chiefs in Ghana have jurisdiction over a particular geographical area. So outsiders entering the community must seek his permission. This is sometimes violated especially in urban communities where the local government agencies, such as the district assemblies, have political power and oversee civic activities. As a result, a chief's authority is not felt as much and is sometimes taken for granted as the case of Nana Ansah shows. Nana Ansah lives in an urban community and is a retired public servant

outsider seeking to change things for local people. This was what the MSPSP sought not to do; it did not intend to treat key stakeholders of the NHIS as only consumers of the intervention to expand coverage, but rather to engage them from the onset.

Furthermore, casual remarks made during conversations with community members gave me insight into the local situation and appropriate measures needed for support of the intervention. For example, a conversation with Agya Mensah, a Unit Committee⁶ chairman, during one of our familiarisation visits in the Kaja community, alerted us to a chieftaincy dispute that required slightly changing the protocols we were following. This hint was dropped when the volunteer introduced us to Agya Mensah as someone we could talk to about the project. After telling Agya Mensah about the intervention and creation of the PSGs, I asked him which persons were likely to be nominated as PSG members. He told me there were many people, but the volunteer I was walking with had problems with a section of the community, so I should be careful how I involve him. I was curious and asked what kind of problem. He said the family of the volunteer was involved in a chieftaincy dispute so including him might not be helpful. To be sure about what Agya Mensah had told me, I verified the situation with the NHIS collector (the next person the volunteer took me to). He confirmed the story and said that the volunteer's family had refused to take part in community activities, so if he played a front role in organising the durbar, people might not attend." I came back to ask Agya Mensah about when we could visit the chief. He said: "Due to the chieftaincy dispute, if some people see you going to any of the contesting chiefs, they might boycott the durbar. They might associate what you are doing with him. So I think we don't have to visit any of them."

I must say that this advice yielded rich information. We gained significant insight into community dynamics that helped address stakeholders' concerns. Stakeholders' observations and advice informed us about the local conditions and procedures we could utilise to guide the selection of community PSG representatives. For example, due to the existing chieftaincy dispute in Kaja (not real name), Agya Mensah became the rallying point for mobilisation activities. He was perceived as neutral and acceptable to the whole community, so he took it upon himself to invite the feuding factions to the community-sensitisation durbar. He informed the community about the intervention and the need to attend the durbar. I did not visit any of the contesting chiefs. A public announcement was made by the village announcer inviting everybody, including the contesting chiefs, to the sensitisation meeting. Agya Mensah also advised that we use an open selection process to minimise the

⁶ A Unit Committee is the lowest level in Ghana's decentralisation structure of governance. It is at the community level. Elections are non-partisan, so members are supposed to be politically neutral and not to show open support for any party.

effect of local politics on the selection process. In fact, the durbar was well attended and true to Agya Mensah's word (and contrary to what happened in other communities where nominees were unanimously accepted), the nomination of one person was contested. The details of what happened will be discussed later in this chapter. It was also remarkable that no one nominated the volunteer to be a member of the PSG, which was not the case in other communities. My observation during the durbar and the selection process confirmed that the volunteer was not popular with the people because of his involvement in traditional politics.

Another important issue worth mentioning is that getting people to attend durbars in fishing communities was very difficult compared to farming communities. Though they could not give me a reason, I was happy to have been cautioned by DHIS staff and health providers of the low attendance they normally record when durbars are organised in fishing communities. Armed with this information, I made an extra effort to interest fishermen in particular to attend the durbar so they could also be selected. In fact, in my conversations with them during my community orientation visits, they were not enthusiastic about participating in the PSGs. Therefore, I took pains to talk to them while they were busy mending their nets. Even when I explained to them that the PSG meetings and other activities would not take much of their time nor disrupt their work since they would be scheduled at their convenience, they were still adamant about not participating. I later asked the volunteer who normally accompanied me about the fishermen's lukewarm attitude. He told me that the reason for their general lackadaisical attitudes towards such programmes could be because of their inability to converse in English. This was confirmed when I engaged one of them in a conversation. Below is an excerpt.

Agnes: Why are you not interested in being a member of the group?

Ebo: We don't understand English. When people come here, they will be speaking English and we will not understand. But also let me ask you what do you want from the group?

Agnes: The group is expected to meet at least once every month to discuss the reasons why many people are not enrolling in the NHIS and why the few who enrol some do not renew their membership. The group will plan activities that they think will improve enrolment and influence people to remain in the scheme. All communication will be done in Fanti (the local language), so you will have no problem communicating your views. Are there any other challenges?

Ebo: If the language problem is solved, then we will come. We don't have any problem with the group.

Despite Ebo's assurance, not many fishermen attended the durbars. As it was, fishing communities generally recorded the lowest attendance confirming what I had been told. The situation in fishing communities therefore demands a rethinking of how to get them into PSGs since they appear not to be interested in community durbars. This challenge is addressed in the next chapter that describes how PSGs devised other strategies in addition to community durbars that made it possible to reach fishermen with intervention activities.

Criteria for selecting PSG members

Having settled on a durbar as the best forum to select PSG members we (health providers, DHIS staffs, community leaders, my research assistant and I) discussed the best selection procedure. Ideas gathered from these discussions were used to develop detailed guidelines for the selection process. These ideas also helped me to develop the framework for the PSG creation process. The following criteria were determined after discussions with the DHIS staff, health providers and community members involved in organising the durbar. We agreed that any adult resident in the community was eligible to nominate someone and be nominated and that at least two women should be in the group. Another condition was that all speakers including the DHIS staff and health providers should communicate in the local language. The decision to include at least two women in each PSG was reached after the first community durbar when only one woman had been selected after the initial selection round. This attracted our (the research assistant and I) attention. We immediately alerted the assemblyman who was helping to facilitate the selection process. After a short discussion, he drew the community's attention to the sole woman participant. The situation was discussed and everyone agreed on the need to have at least two women in the group. The research assistant and all those involved in organising the durbar agreed that since women are caregivers, they should be part of groups that discusses healthcare issues. So a second woman was nominated to join the PSG and having at least two women became a condition for all other PSGs. This was to ensure that women were given the opportunity to participate effectively in the intervention. The argument was that if we left women's nominations open, they might not have been selected at all in some communities.

I must admit that the initial selection of only one woman was actually not a surprise to me since Ghana is a male-dominated society and women's leadership capacities are generally undervalued. There is the belief about the superiority of men and specific roles are assigned to men and women. In this regard, Cusack (1999: 25) observed that in Ghana, role expectations generally "confine women to specific spaces." Leadership positions for example, are seen as the preserve of men, and women are generally associated with reproductive functions. Farmer (2005) also contends that throughout the world, women are confronted with an ideology that situates them as inferior to men.

Lessons learned from community orientation

Key stakeholder engagement in setting the path for the formation of PSGs during the orientation phase of the process brings to the fore a number of key lessons that are relevant to intervention practices in Ghana. Not nominating women in the first group illustrates how women are relegated to the background when it comes to leadership

in many community gatherings and explains their under representation in leadership positions at the national level.

First, discussions with health providers, DHIS staffs and community members indicated they were interested in the intervention because of the opportunity for open dialogue. Health providers felt that by working together with DHIS staff, their situation could improve because these discussions provided them the opportunity to speak about how the NHIS affected their work.

With DHIS staff, their motivation to participate in the intervention was the opportunity to discuss the challenges they were confronted with when implementing the NHIS. They also said they were happy that the intervention was likely to enhance their work. Moreover, since they would be working with community members who were the targets of their membership drive activities and health providers who were expected to help them achieve their goal, the collaboration would help them expand NHIS coverage.

Community leaders and members I spoke with asserted that in the midst of low enrolment, the intervention was an opportunity for them to work with DHIS staff and health providers to address the issues that discourage people from enrolling and renewing their membership. They contended that this would help solve the problem of lack of access to healthcare in their communities, so it must be supported. Building collaborative groups around perceived problems and creating an environment of mutual dependency are strategies that are more likely to arouse stakeholders' interest and encourage them to participate. As Nana Ansah pointed out, consulting targets of an intervention made them commit to the intervention's success, since it reduced resentment towards such programmes by the people who are supposed to help mobilise support. This perspective echoes Hawkins et al.'s (2002) observation that it is imperative to use methods that effectively mobilise various sectors of a community to support the implementation of interventions. Similarly, this study found that stakeholder involvement from the beginning helped create a platform to discuss pertinent issues related to the intervention and its relevance.

Second, the massive attendance at the seven durbars shows that once stakeholders were adequately sensitised to the scope of the problem, they would mobilise their members to patronise the selection of PSG members and take the intervention seriously. Events at the durbar showed that people who were committed to work in a group to achieve the desired change attended the durbar and were consequently selected. They created the support base for the intervention from the outset. This echoes the observation of Van der Geest et al. (1990) that involving all actors when studying a phenomenon is important, so the various meanings of the same phenomenon can be revealed. The authors argued that what may appear as self-evident at one level may be totally irrelevant at another. Similarly, the pre-durbar consultations

led to a common understanding of the intensity of the problem of low enrolment in the NHIS, which was not perceived by community members. This resulted in stakeholders' commitment to help achieve the intervention goals.

Third, by involving stakeholders and incorporating their ideas, such as Nana Ansah's suggestion to thoroughly discuss objections raised against nominees during the PSG creation process, helped reduce conflict. Even when conflicts occurred, as in the Kaja and Tiase communities, they were resolved without confrontation. This shows that challenges may arise during the process, but when handled properly, positive results can be achieved.

Understanding community dynamics is of interest to many researchers. As Higgins & Metzler (2001: 490) have pointed out, "Insights and perspectives of community participants enhance the knowledge and understanding of researchers about community dynamics and conditions." This study in Ghana found that understanding community dynamics is not only useful to researchers, but also even more useful to those engaged in carrying out intervention activities. This is because the intervention groups' ability to tap information about local conflicts and dynamics helps them to address issues and ensure the successful formation of the PSGs.

Finally, presenting the intervention as three-pronged targeting the three key stakeholders of the NHIS (community members, health providers and DHIS staff) with 'no blame attached' was helpful. The stakeholders appreciated the low enrolment and the difficulty of retaining members as a mutual challenge requiring a collaborative effort. This finding was similar to the observation of Porter et al. (2007) in their study of a medicine and public health partnership that the reason(s) for group formation (though not very strong) contributes to their success. This study found that forming partnerships on the basis of mutual problems requires the contribution of all to improve the situation and results in the stakeholders' commitment to work together to solve the problem. Health providers', DHIS staff's and community members' recognition of their capacity to contribute to improve enrolment and that they were not expected to function only as recipients of intervention activities made them view the intervention in a positive way. They became more receptive to the idea of collaboration and their interest in participating increased. Thus, the participatory approach we adopted in setting up PSGs indicates that seeking local stakeholder support for intervention programmes from the onset provides a fertile ground for success.

Community durbars and selection of PSG members

Community durbars were held to sensitise stakeholders about the intervention and select PSG community representatives. The durbars were attended by chiefs and their elders, community members, health providers and DHIS staff who were targets of the intervention. Being quite conscious of my position as a researcher, I did not

take a leading role at the durbars. Research assistants⁷ facilitated the proceedings at the durbars assisted by opinion leaders and community leaders (Assembly and Unit Committee members).

On durbar days, we (the research assistant and I) always arrived early. From my observation, there was usually an air of anticipation before the durbar began. People who came early gathered in small groups and discussed the NHIS. Eavesdropping on their conversations, I heard community members generally talking about their experiences with NHIS, such as delays in receiving NHIS ID cards. Health providers were discussing the community's lack of interest in health insurance. DHIS staff discussed the lukewarm attitude of community members towards the NHIS. These discussions boosted my morale since it was obvious that barriers to enrolment and retention in the NHIS were real and cut across communities, health facilities and DHISs. These conversations also indicated that each stakeholder's perspective influenced how they define the barriers. Therefore, to understand and address the barriers adequately, each stakeholder's perspective needed to be explored.

Welcome and introduction: Typical of durbars in Ghana, proceedings started with the observation of the protocol⁸ related to traditional procedures at official functions, especially when chiefs are involved. We, the researchers and research assistants, were regarded as visitors to the community, so we were welcomed and introduced to the community by the *Okyeame* (the chief's spokesman). He asked about the purpose of our visit and the objective of the durbar. My research assistant briefly talked about the reasons for the durbar and the goal of the intervention emphasising the role of PSG members and facilitators. Next, a DHIS staff and health provider gave brief speeches emphasising the benefits of the NHIS. They indicated they were happy about their involvement in the intervention and were confident that the expected objectives of bringing about significant increases in NHIS enrolment and ultimately ensuring equity in access to healthcare would be achieved.

The durbar thus created a common platform for stakeholders to interact and communicate their views about the NHIS. It also created support for the intervention and highlighted the need to work together to reduce barriers to enrolment. This is in line with the issue of "cultural brokerage," which implies bringing about communication, interaction and mutual dependency as expressed by Bailey & Van der Geest (2009: 217). The absence of which, Kinsman (2008) observed, had accounted for the failure of HIV/AIDS interventions in Tanzania and Uganda. This study also showed

⁷ Research assistants were hired to facilitate the durbar and the selection of PSG members and train PSG facilitators. They were experts in community mobilisation and development.

⁸ Before the start of any gathering involving chiefs, especially among the Akans in Ghana, traditional protocol demands that visitors in a single file go to shake hands with the chief and his elders and vice versa as a form of greeting.

that it is essential to create a forum that encourages broader networking and integration of stakeholders' ideas into processes that reflect their reality from the onset. A NHIS collector's remark after one of the durbars typifies comments made by community members to show appreciation for their involvement in the intervention.

This is one of the best things that have happened in this community. Everybody must support it, since access to healthcare is an important issue. In fact, I have been trying to convince people to register, but they will not listen. I see this programme as something that will enhance my work. Bringing health providers, DHIS staff and community members together will send positive signal to all those sitting on the fence. They will see that the NHIS is good and change their mind and register.

Selection of problem-solving group members: The effectiveness of any intervention depends to a large extent on choosing the right people to form the group. Selection of the community representatives required special focus because the calibre of the people selected to form PSGs was likely to have impact on the intervention programme. Therefore, to ensure the acceptance of the selected community members, extensive consultation and locally designed procedures were used. This approach was guided by Butt et al.'s (2008) assertion that the success of interventions is related to who is involved and how they are involved. Since the intervention was guided by a multi-level perspective, each community was given the opportunity to decide on how to proceed. As mentioned earlier, the idea of an open selection procedure was raised by community members, such as Agya Mensah (a Unit Committee chairman) and Kekeli (an assembly member) in the first two communities we went to. Open selection then became the popular option when suggested by the research team to other communities, even when it was mentioned first. Open selection was therefore discussed and adopted as the procedure in all 15 intervention communities based on the assertion that if targets of the intervention selected their representatives and gave them the mandate to plan and execute their own activities, the likelihood of success appeared to be high.

With regard to the selection of DHIS staff and health providers for the PSGs, heads of their institutions using their wisdom determined the process. This was because of the study's emphasis on the effective participation of stakeholders in the selection of PSG members as an alternative to a predetermined top-down process. We requested a minimum of two representatives from DHIS staff and health providers to ensure that one would be available at all times. Therefore, the heads of the institutions selected PSG members who had insight into the NHIS in the District Health Directorate (DHD) and health facilities. All DHIS staff qualified for inclusion in the PSGs, so the selection was based on the manager's discretion with the PROs as the first choice since their main work is promoting NHIS.

A typical process of selecting PSG community representatives: The climax of the durbar was the selection of PSG members. Before the selection, my research assistant spelt out the criteria for membership and guidelines to be followed, emphasising the selection of women. Below is a summary of what took place:

Research assistant: “Who do you nominate to represent you in the PSG?”

A community member [Raised his or her hand and mentioned an individual’s name]: “Kwesi Mensah.”

Another community member [at least two other people needed to second the nomination] said: “I agree to Kwesi Mensah’s nomination”

The nominee was asked to stand in front of the crowd for everybody to see him or her and then return to his or her seat. Next, community members were asked whether anybody had anything to say against the selection of the nominee. This question was repeated three times. For each round, about a minute was given to allow people to think through the issue and raise objections if necessary. If nobody raised an objection, then the nominee was accepted. Every nomination was taken through the same process till the required number⁹ was obtained. When objections were raised, the person was asked to give reasons why the nominee did not qualify to be a PSG member. The research assistant led the community to discuss the issues thoroughly till an agreement was reached, either to accept or reject the nominee. If no consensus was reached, a vote (by show of hands) was conducted to arrive at a decision.

When all nominations had been accepted, all persons selected were shown to the gathering as representatives of the community. The research assistant then finally asked if someone had anything to say about a nominee. If no objection was raised, the nominated representatives of health providers and DHIS staff joined the selected community members for the inauguration. All participants in the durbar faced the crowd while the chief and his elders congratulated the selected nominees and declared them officially as PSG members. Next, a PSG member pledged the group’s commitment to the task ahead and asked the community to support them to achieve the goals of the intervention.

The chief or his representative normally gives the final word. This person advises the selected PSG members to work in harmony and uphold their virtues. He also asks the community members to support them in their work. A typical statement by the chief or the elder was:

You have been selected today to serve in this important group, make sure your conduct does not bring any disgrace to us. Don’t betray the confidence and trust the community has in you. Eschew any negative tendencies and work diligently to help achieve the objectives of the group.

⁹ The required number was determined by the number of health providers and DHIS staff already nominated.

The chiefs also pledge the community elders' support to ensure that the objectives of the intervention are achieved. When a chief agrees to witness the formation of PSGs, this means that the intervention is an important programme for the community and should be taken seriously.

Generally, the selection processes were smooth without incidents except in two communities when objections were raised against a nominee's selection and the selection process. However, these objections were discussed and an agreement was reached by a vote and the selection processes continued. The two cases with objections are presented below to show the importance that community members attached to the community participatory process, the important issues that informed people's decisions to nominate an individual to represent them, and how conflicts were addressed.

Rejection of nominees: In the few cases when a nominee was rejected, the participants at the gathering discussed the issues to ensure that the process was transparent and no one would be blamed for favouring a particular person. In the Kaja community (not real name), for example, the first three nominations were accepted without objection. When the name of a fourth nominee, Kwaku Manu was mentioned, the facilitator asked as usual whether all agreed to his nomination. A man got up and raised an objection saying that Manu was working and staying in the next town, so he did not qualify. However, another person supported the nomination and insisted that Kwaku Manu was almost always in town and his contribution to development activities was enormous. When given the opportunity, the nominator explained his position as follows:

You all know Kwaku Manu's contribution to the development and welfare of this town. Though he does not currently live in town, he is almost always here and his contribution to the development of this town cannot be compared to anyone of us here. Moreover, he is coming down to settle here soon. I think this qualifies him to be part of the group.

These arguments held up proceedings for about five minutes. A man then suggested that they vote to settle the issue by show of hands, his suggestion was accepted, and a vote was cast. An overwhelming majority supported his nomination. The selection continued without any incident and everything went well. From my observation, the majority of the people were happy with the process.

Rejection of selection process: In the Tiase community, the customary procedure used for selecting PSG community members was rejected three times. The first process, an open nomination of potential PSG members described above, was rejected when the selection process was almost complete. All seven candidates were lined up and shown to the community for the final approval. When the research assistant asked the final question of whether everybody agreed to the selection of the

nominees, a community member named Kisi protested against the selection process. He said:

Nominating only seven people and accepting them by clapping hands is not good enough. People were not given enough opportunity to reject nominees they do not want. More people should be added to the seven already selected so we could vote to determine who should be part of the group.

Kisi's comment brought arguments. Some people raised objections to his suggestion arguing that the process was not feasible given their situation. Others said that this was not a political event and there were no ballot papers to organise the election that Kisi wanted. This resulted in counter arguments holding up proceedings for about ten minutes. When the assemblyman helping to facilitate the selection managed to restore order, the group agreed to vote by a show of hands. Two more people were nominated, bringing the total to nine. The nine nominees were kept inside a room where they could not see what was going on in the hall. People were asked to vote for their favourite nominee when his/her name was mentioned. As people voted, they were moved to one side of the hall to prevent double voting. However, after the first two nominees were selected, another man also objected to this process. He said:

This cannot be a better selection process. How sure are we that people are not voting or counted more than once? This is not acceptable. It must be replaced by a better way of voting and counting votes if we still want to maintain an election process.

This resulted in another hold up with many arguments for a few minutes. Now people were not happy about what was happening and started leaving the hall. The assemblyman, and the research assistant had difficulty maintaining order and bringing those who were leaving back to the hall. Order was restored when Nana Ameyaw, one of the elders, intervened and asked everybody to remain calm. He appealed to those who were leaving to come back. He said:

These people [pointing to us] are here to involve us because they trust us. They trust that we can help solve the problem with insurance so we have to make sure the objective of this meeting is achieved. Let's co-operate and decide on a feasible selection process. It is an opportunity we have to handle well. We have to support the facilitators and make sure we form this group.

When the situation returned to normal, the on-going voting process was also abandoned. After a short discussion about what procedure to use, everybody in the hall realised it was not possible to hold a 'proper' election where everyone could vote in a secret ballot given the large number of people present (about 300). At this stage, Kisi, who had raised the first objection, looked confused and was worried that it might not be possible to form the PSG. Arguing about the community's inability to agree on a process to allow everyone to vote, he appealed to all those present to cooperate in setting up the group. Consequently, a community member suggested a third process and this was accepted after many arguments. In the new process, instead of the community members voting for the nominees, the nominees would be

in a lottery (explained below). Appealing to the people, the assemblyman, who was moderating the nominations said: “This is the only realistic process, you must all cooperate. There is no other way we can get these people elected since we can’t get ballot papers and boxes to make the process efficient.”

Before the selection resumed, the assemblyman raised the issue of a minimum of two women being selected to join the group. The conclusion was that if they did not select two women, the community would then decide what to do. To move the process forward, the assemblyman wrote the word ‘Yes’ on seven pieces of paper and ‘No’ on two pieces of paper and put them in a bowl for the nominees to pick in the full view of everybody. Those who picked ‘Yes’ formed the group and those who picked ‘No’ were left out. Interestingly, all the previous nominees picked ‘Yes’ and three women picked ‘Yes’. A young man, sitting beside me, dissatisfied about the earlier confusion, but happy with the results, commented: “Do you think we are children. After all what was earlier rejected is what we still had.” The rest of the PSG formation activities went smoothly. The durbar ended with the following remarks from Nana Ameyaw:

What happened today should be taken as something that should strengthen you [pointing to PSG members]. It means people are really interested in what you are going to do and want to see you perform. It also shows the dynamism of people in Tiase community and not division among them. I urge all of you to support the group to achieve the objective of the intervention.

After the durbar in Tiase, I asked a community member how she felt about what happened. She said:

I’m just happy that we were able to get the right people selected despite the confusion. I’m even surprised about how they had time to get all those problems solved [hold ups during the selection of PSG members]. It shows that they are serious and trust that if the right people are selected the problems will be solved. We have to support the group.

Drawing on the above comment and the peaceful atmosphere I observed after the durbar, most people were happy about their involvement in the selection of PSG members. Disagreements were discussed freely. Comments by Nana Ameyaw, the Unit Committee chairman and others showed that community orientation and extensive pre-durbar consultations made the community leaders and members recognise their involvement in the selection process and intervention as laudable. They saw participating in the selection process as an opportunity that should be utilised well. Interest in the intervention was generated. Tiase is a vibrant community where the people ensure issues are discussed objectively and the right thing is done to maintain unity and achieve positive results. As Nana Ameyaw observed, the ‘hectic’ selection process shows the dynamism of people and not division.

Profile of PSGs' members

At the end of the process in all seven communities, I found that the selected PSG members cut across all sections of the community. Neither age, religion, level of education nor disability influenced a person's selection. For example, a disabled man was selected as a PSG member and even as a facilitator, but unfortunately had to turn the position down because of the problem of how to attend the facilitators' training workshop. The man needed an aide to accompany him to the meeting, but the project could not provide funding for that. Intrigued by the disabled man's selection, I asked community members what informed their nomination. Yaw, like many people I spoke with, told me that the critical attribute he considered for selection was the individual's conduct, especially his or her commitment towards the welfare of the community. I asked a similar question after the incidents in Kaja when a nomination was contested and Tiase when the selection process was modified. Janet, who I saw arguing among the crowd in Tiase, told me that the person she nominated was "hard working, well-behaved and would bring development to the community. Not those who are only interested in their own welfare."

Others told me they did not want people who would bring confusion to the community because of their involvement in local politics. The two selection processes thus created space for everybody to participate and gave voice to those who rarely have the opportunity to select their representatives in forming such groups. The people appreciated the process since their involvement in the planning broadened the base of potential members. This was in contrast to the usual practice in Ghana of handpicking people to form intervention groups. The selection processes gave people like Ebo (fisherman), who were committed to the welfare of their communities but worried about alienation and their effective involvement, the opportunity to participate. As indicated earlier, in my conversations with community members after the durbar, the extent of the community members' involvement and the elaborate procedures followed in the selection processes were seen as a welcome development in intervention practice. This approach created room for the majority of the targets of the intervention to participate from the onset; this is rarely the practice in Ghana and that is a source of worry for most community leaders and experts in community development. For example, Chambers (1983) criticises the behaviour of development workers who claim to have used participatory approaches, but often end up deciding what to do for the community.

PSG members range from 11-15. The variation was due to the differences in the number of health providers and DHIS staff who were nominated to join each group. There were seven community members in all the groups. PSG members included:

- Fishermen, farmers, GPRTU¹⁰ chairman, self-employed
- Teachers and other formal sector workers
- Cocoa purchasing clerks
- Assembly/Unit Committee members¹¹
- Religious leaders

(See Table A.7, Appendix 2)

Figure 4.2 Map of Central Region showing all seven intervention communities where PSGs were established



Figure 4.2 shows the seven communities in Central Region where durbars were held to sensitise stakeholders about the intervention and select PSG community representatives.

Lessons learned from the PSG selection process

Lessons drawn from the participatory process used to form PSGs provide a framework to address concerns about stakeholders' involvement to attain positive results.

¹⁰ GPRTU – Ghana Private Road Transport Union is the largest association of private commercial drivers in Ghana.

¹¹ Assemblymen and Unit Committee members are part of the political structure in Ghana. They are local representatives in the District Assemblies and non-partisan. They work with the district chief executive who is the government representative at the district level.

For example, the UNICEF's Accelerated Child Survival and Development Programme to reduce death among children less than five years in Ghana did not achieve the expected targets because there was lack of engagement of the implementers and the target population of the intervention from the onset (Bryce n.d.). This suggests that excluding stakeholders from programmes and treating them only as consumers, increases the risk of failure.

Stakeholders exchanging ideas, participating in decision-making and planning the durbar all worked to establish linkages and build trust. Open selection of PSG members laid the foundation for the intervention. For example, Nana Ameyaw, an elder of Tiase who saw the process as based on trust, gave his support and this helped to convince the people to participate so the selection of the PSG members could succeed. This echoes Gilson's (2003) claim that trust facilitates collective action and elicits co-operation among people to achieve common goals. Similarly, Mantoura et al. (2007) and Bailey (1992) suggest that for networks to succeed a team should be well integrated in the community and be motivated to risk working together to prevent narrowly focused self-interest activities. Comments made after the durbar show that extensive consultation resulted in deeper community penetration since the message about the intervention was spread even before PSGs began their work. Thus, the stakeholders' motivation to work together could be enhanced if they are given the chance to take charge of events and decide on the process of selecting members of an intervention group.

The incidents of disagreement in Tiase and Kaja show that to have a positive outcome in setting up collaborative groups, the process should be painstakingly followed without rushing through the steps. Attention should be paid to issues that come up during the process and these should be addressed in an open manner. Since it is not likely that the provided guidelines can capture every possible scenario, provision should be made for adjustments (as was done in Tiase), so controversies can be properly handled and PSG members who are selected are acceptable to community members. The selection of appropriate community-supported people to form the PSGs laid the foundation for success in this phase of the project.

Finally, this study shows that extensive consultation with stakeholders and non-interference by outsiders in the selection of representatives to form collaborative groups created interest in the intervention and increased the probability of selecting committed PSG members. The incidents at Kaja and Tiase indicate that when community members assume the responsibility of forming PSGs, they will do everything possible to resolve the challenges that arise. Compromises are easily reached if outsiders do not impose their ideas on community members. Although local politics may mar community programmes, if properly handled, a positive outcome is possible. In the end, for successful PSG member selection and commitment to a community-based intervention, adequate space should be created for

community members to decide what to do and who to select since they know who can best represent their interests.

Selection of facilitators

Two facilitators were selected among the selected PSG members for each PSG in all seven sites. The facilitators were expected to act as the leaders of PSGs, stimulate change and work for the sustainability and effectiveness of the groups. Facilitators were selected immediately after each durbar. Their task was to lead the group through the intervention phase; they were responsible for organising meetings and carrying out intervention activities.

Guidelines for selecting PSG facilitators

The decision to have two facilitators for each PSG was because the project only had funding to support two. However, guidelines for selecting the facilitators were discussed by all stakeholders and finalised by the PSGs. The facilitator criteria included:

- One facilitator must be a community member and the second must be a health provider or DHIS staff
- Both facilitators must be literate
- Both facilitators must be relatively neutral and not actively engaged in local or national politics.

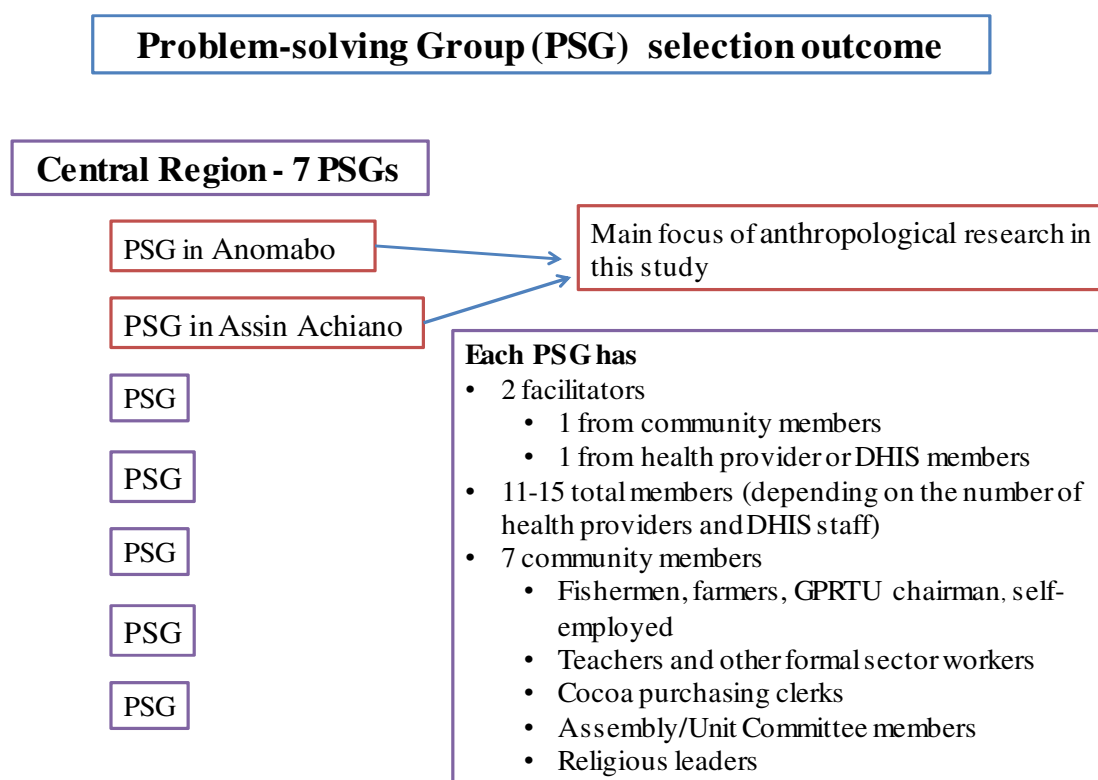
The rationale for using local facilitators for PSGs was that as part of the community they could best address practices within the group that might undermine the intervention. Thorp et al. (2003) in their work on the relevance of groups in economic development and poverty reduction in developing countries reported that the role of external leaders can be useful, but does not help in the long-term sustainability of groups. In this study, lessons learnt during formation of PSGs clearly indicated that internal leadership would help mobilise support for the intervention programme and resolve problems that might arise. Also, the non-engagement in politics criteria was informed by the rejection of potential candidates because of their relationships with local traditional leaders. This indicated that politics have the potential of undermining the collaborative process.

The brief meeting to select two facilitators and a secretary for each PSG was chaired by the research assistant. One facilitator was chosen from the community members and the other from either the health providers or DHIS staff. The facilitators were selected after the group members conferred among themselves. Community members met separately to select their facilitator, while the health providers and DHIS staffs also had a joint meeting to select one facilitator and a secretary. When a

facilitator was selected from the DHIS, a health provider became the secretary and vice versa.

It is interesting that at the end of the selection only two facilitators were health providers out of the fifteen facilitators selected from health providers and DHIS staff, (Table A.8, Appendix 2). This indicates that while all stakeholders showed interest in the intervention, the DHIS was seen as having the responsibility of leading the programme. Some health providers cited a lack of time when I asked why they were not keen to be facilitators. Others said they saw the NHIS as the core business of DHIS staff, so they should play the lead role. But, what became clear during the course of the intervention was that the health providers saw the leadership position as adding to their workload. Even when the field of play was level for participation, occupational interest and perceived gains determined the level of involvement.

Figure 4.3 Outcome of PSG selection process



Training the PSG facilitators

Facilitators were PSG members selected by their colleagues to lead the group through the intervention period. Evidence shows that management of intervention groups closely correlates with their ability to achieve positive outcomes. As Keltner (1989) posits, the role of a facilitator is complex because human beings are complex, suggesting the need to equip them with special skills to lead the PSG groups. In this study, a three-day training workshop equipped facilitators with skills that would help them perform their role effectively. Skills included leadership, facilitation of PSG meetings, and mobilisation of stakeholders to effectively participate in intervention activities to achieve positive outcomes. The trainers were consultants with expertise in community mobilisation and participatory approaches.

The training workshop was interactive and characterised by an exchange of ideas and experiences among the trainers and the facilitators. The facilitators were introduced to the problem-solving cycle and techniques. Three main techniques were addressed: 1) brainstorming, 2) 'but why' and 3) using a flow chart. Also, the various stages of the problem-solving cycle (problem identification and prioritisation, development of solutions and implementation strategies, drawing and implementation of action plans) using mock problem-solving sessions and several exercises were discussed and practised. After the practice sessions, the facilitators received personal feedback on their competency. This provided them with the 'hands on' experience needed to manage group members and stakeholders' participation for the task ahead.

Trainers engaged facilitators in exercises that helped them recognise that they occupied a position of relative equality; communication should be horizontal to dissolve any power differential with group members. They were asked to facilitate mock PSG meetings and they asserted that this was beneficial. The facilitators told me during and after the training that it had exposed them to skills they believed would help them perform their new role effectively. One said: "This training benefited me. I learnt skills that have improved my communication. This will help me be a good facilitator and build relationships among group members." Also, the course prefect, a DHIS facilitator made the following remarks at the end of the training session:

Initially most of us didn't know exactly what we were going to do. This training has motivated us. Now we have the zeal to do the work. The exercises and assignments gave us the opportunity to practice what we learnt. We now feel competent and prepared to take up the task ahead of us, and the challenge of mobilising stakeholders and commitment to participate in the intervention. I think we will have no problems applying the skills acquired to achieve positive results in our respective communities.

These comments show that the training created confidence in the facilitators to face their tasks. It also suggested a relationship between the training and the motiva-

tion to assume leadership positions. Lasker & Weiss (2003: 15), in their work in the US on how to make collaborations more effective, point out that collaborative groups need a special kind of leadership to turn the “rhetoric of abstract principles into practice” and maximise the benefits of collaboration. They argued that leadership influences how participants are involved in collaboration groups and determines outcome. In the current study, it appeared that the training was a critical component of the intervention programme, especially if it was to fulfil the purpose of increasing the facilitators’ commitment to the intervention. The training also helped to create a shared vision among stakeholders to develop the various intervention activities and strategies to reach all targets. In the subsequent chapters, I present how these skills (learned in the training workshop) were utilised to elicit the stakeholders’ cooperation and commitment to the intervention and outcome.

Reflection on the selection of PSG members and facilitators

The primary goal of choosing an open and participatory process was to provide community members the opportunity to nominate and be nominated for PSGs. The concerns of a community member, George, about the complexity and time-consuming process stated in the introduction may have been due to challenges to the status quo that come with an apprehension of the unknown and questions being raised about benefits. While I agree with George, that the process might not have been a perfect alternative to the ‘handpicking’ approach commonly used to select representatives, his remarks and my observations indicate that although the involvement of targets of intervention programmes has become popular, translating it into practice remains a challenge. Critical anthropologists and development experts have been advocating for multi-level and participatory approaches in planning and executing intervention projects to ensure that marginalised groups are included (cf. Farmer 2005, Chambers 1994). From this perspective, rather than demanding a choice between the two approaches, the analytical question should be whether or not the two main objectives were achieved. One, did ordinary people participate in the selection process and did dedicated people form the PSGs? Two, were targets of the intervention fairly represented in PSGs?

First, the reasons that the community members gave for their choice of candidates and their satisfaction with the outcome indicate that the open process of nominating, accepting and rejecting nominees (not necessarily democratic) with the objective of penetrating community structures and getting many people to participate in the process was achieved. Power brokers were the research assistants and opinion leaders who took charge of events and moderated the process. Nominations were keenly contested and the majority of people present took the final decision. The community appreciated that this innovation set aside the authority of the chiefs in deciding who should represent them. As revealed in the subsequent chapters,

although the process was tedious in terms of travelling to meet opinion and community leaders¹², the level of commitment of community representatives (compared with DHIS staff whose core duty it is to promote the NHIS) showed that it was worth the cost. The outcome suggests that the more critical people are about who represents them the more likely it is that committed people will be selected. However, since involvement of the targets of the intervention (the community) was an important factor for choosing the multi-level approach, the question is whether or not the elected PSG members fairly represented all sub-groups in the community.

As described earlier, the background of PSG members spanned various occupational and social groups so one may have been tempted to consider the group as representative of the community. However, the following observations question the effectiveness of the method: no woman selected in the first community, an average of two women out of thirteen PSG members in each group, only three women facilitators out of thirty (total) and no poor person in any PSG. These outcomes clearly indicate that the PSGs are not necessarily as representative of the targets of the intervention as expected. This revelation underscores the fact that participation in community groups is gendered and also not for the poor. Full participation in selecting group members is an admirable goal, yet it is quite challenging to make the final group fully representational. One could argue that women and the poor risk exclusion even from the groups that seek to promote their interests. I observed that while the poor were excluded because of poverty, women's exclusion was due to their position in society regarding leadership roles.

For women, the explanation for their exclusion is largely embedded in the culture and historical system in Ghana where women seem to be confined to their reproductive role. A woman's position is reflected in proverbs that reinforce traditional values. One popular Akan proverb is: "Even if a woman possesses a talking drum she keeps it in a room belonging to a man" (see Van der Geest 1975). Only chiefs in Ghana own talking drums. This means that no matter how great a woman is, she has to depend on a man. The proverb is emblematic of Ghanaian women's experiences and illustrates their subordinate position regarding public leadership. Therefore, despite women's inclusion in community and national activities being on the national agenda for decades, women continue to be less represented in heterogeneous groups – even if the project is in their domain.

Women's disadvantages in health and wellbeing have been documented. Buor (2004) observed in his study of utilisation of healthcare in Ashanti Region that women have greater need for services than men, yet they have less access to quality care. He reported that there is a male dominance of decision-making, including causing women to have poor access to healthcare. Ironically, this study was carried

¹² An average of three visits was paid to each intervention community during the PSG selection process.

out in communities with matrilineal dynastic descent and inheritance; yet, the women were not perceived to be capable leaders. This shows the contradictions that exist between women's social power and leadership roles in Ghana. Women's non-selection in the first community illustrates that despite all the rhetoric about gender equality and mainstreaming, women are still relegated to the background regarding leadership positions. One point that emerged during the community conversations was that most people find it difficult to accept a woman as a leader. Some authors have shown contradictions in women's positions. Van der Geest (1975), in his study in Kwahu, Ghana, observed that women's subordination does not reflect reality. He showed that women have considerable power in traditional and modern politics. Bartle (n.d.) speaks of a covert gynaecocracy. Both authors argue that women's power is hidden under a barrage of ideology expressing male dominance (Van der Geest 1975, Bartle n.d.) and illustrate this by pointing to women's position in traditional governance in Ghana. A queen mother is a member of the chief's counsel and influential in selecting a chief. On the lineage level, the male head is assisted by a female. In these positions, women take part in all discussions and their opinions are much respected, but remain in subordinate positions. At the national level, access to formal education and income generation activities have empowered and enhanced the image of women. They are seen as vessels of development just like men, yet their representation in leadership positions is still low. It is intriguing that women's leadership capabilities are underestimated and they are the last to be thought of as leaders.

Therefore, it is no surprise that in local and national gatherings women are not considered first as potential leaders. In Parliament, women generally occupy about 10 per cent of the seats in Ghana. In the current Parliament, they form only 8.3 per cent though they constitute the majority (52.1%) of the population (Ghana Statistical Service 2012). Women are perceived as trespassers or supporters who are often brought out to campaign and win votes for men. I observed during the PSG formation that even the women did not nominate fellow women for consideration. This suggests that their leadership capabilities hardly intrude into the consciousness of men and women. I argue that women do not see themselves as capable of occupying leadership positions and therefore do not elect each other. Otherwise, they would have nominated other women and voted for them, since they usually form the majority in such gatherings to enhance their image.

Critical feminist theorists emphasise women's social exclusion and the need for their emancipation. In the view of Lauer (2006: 622-623) for women to be able to take up leadership roles requires "Profound qualitative change in the nature of social transformation for the country overall, both in its crucial domestic development policies and in its profile as a nation participating in the broader geo-political environment." She showed that the causal effects of women's secondary leadership

roles go beyond correcting gender-specific injustices, because circumstantial conditions responsible for such a change have very little, if anything, to do with gender differences. I add that to achieve such a qualitative change, efforts should be directed at both men and women and the focus should be more on the later to encourage them to assume authoritative and self-efficacious positions. It is only when women recognise their capabilities and have confidence in themselves and their peers that they can nominate, be nominated and voted for as leaders. Taking such a stance could help break the antecedents of women's exclusion from leadership to make meaningful change.

With regard to the exclusion of the poor – the main targets of the NHIS policy and also the intervention – their exclusion from the PSGs indicates that the selection method did not achieve the objective that all actors must be engaged when addressing a phenomenon that affects them. The reason for their exclusion is pithily expressed in another Akan proverb: “*Ohiani ano nnuru badwam*” (A poor man's voice is not heard on the floor of meetings). When put in the context of this study, it means no one takes what the poor say seriously during community gatherings. Other researchers have made similar observations. In his study of respect among the elderly in Kwahu, Van der Geest (1997) observes that having money measures one's prestige and level of respect in the community. Similarly, Mercier (2002) found in her study of women's groups in Tanzania that groups consisted mainly of the middle class. She reported that the poorest women were excluded on social grounds. These observations demonstrate that poverty is not only associated with economic status, but also a lack of recognition and access to social networks and groups (even those groups that seek to promote their interest). As revealed later in this book, the core poor, who need health insurance most, are denied access to it as they are almost entirely overlooked.

Thus focusing exclusively on an open election process as the basis of involvement has the tendency to reinforce rather than challenge the status quo. Without devising strategies alongside an open election to ensure that all sub-groups are represented means that only lip-service is paid to participation. The implication of this finding is that this approach leaves the poor trapped at the bottom of a socially stratified class system with no possibility of challenging their condition. Lasker & Weiss' (2003: 39-40) also observe that to solve complex community problems, a collaborative process needs to “... involve diverse groups of people from different backgrounds to regularly listen to each other, talk with each other, and influence each other ... Without it, a collaborative process cannot achieve individual empowerment.” Concluding, I argue that when poor people are treated as objects of concern and not directly involved in intervention groups, they remain powerless, dependent and unable to harness external support to gain access to decent healthcare.

Conclusion

This chapter has shown that much is gained from involving stakeholders in an intervention programme from the onset. It indicates that if all stakeholders assume the responsibility of creating PSGs, they are capable of developing effective methods of selecting who can best represent their interest. Being in charge of events creates trust among participants and the commitment to achieve the set objectives is developed. Challenges might come up, but compromises are easily reached to ensure the task is completed. This approach also provided information on the important criteria people considered when selecting their representatives: the person's commitment to promoting the welfare of others and development of the community, good conduct and non-engagement in local politics. However, the low representation of women and exclusion of the poor indicate that unless strategies are developed to include these two groups, the open election processes reduce participation to abstract theory. The key challenge for critical medical anthropologists, then, is how to increase the participation of women and the poor within the context of multi-level perspective to ensure that no category of actors involved in a phenomenon is marginalised.

In the case of health providers and DHIS staff, with the benefit of hindsight, their selection based on their work schedule meant that some people who were not willing to devote their time and effort to PSG activities got into the group. As revealed in subsequent chapters, it was naïve for heads of institutions to base their selection solely on a DHIS staff work schedule and assume that they would perform. Their effective participation requires personal commitment and an inclination to pursue social interest rather than personal gains in the form of salaries and promotions that generally motivate them to excel. Therefore, there is a need to go beyond an employee's work schedule and use more rigorous procedures to select those who are truly interested in the intervention.

In the case of facilitators, selecting them on the durbar day meant that some unreliable persons were chosen to lead PSGs. Later events showed that those who nominated themselves were not honest enough to be given that responsibility as they misappropriated funds provided for PSG activities. This suggests that self-selection could be a sign of self-seeking individuals whose intention is to hijack leadership positions to pursue their selfish ends. This is a revelation that programme managers should watch out for and they should be sceptical about anyone who nominates himself or herself to be a facilitator. It is therefore important that facilitators are taken through a rigorous screening process to allow dubious characters to be rejected by their colleagues at the start. This would minimise the incidence of those who are not trustworthy becoming leaders. This is particularly important, since the facilitators were expected to be the catalysts around whom sustainability and effectiveness of the group rested. Further, training for facilitators was found to be an

important motivating factor that helped them develop the zeal to lead the group through the intervention period. The training equipped the facilitators with skills that increased their confidence and commitment to the intervention.

Finally, although the scope of this study is limited (covers only seven communities in one region), it provides systematic documentation of the steps that were followed, activities performed and the roles that the stakeholders' played at each stage. This contributes knowledge to the literature on the formation of stakeholder groups and could be a useful framework that can be adapted in other contexts. How PSGs function to identify, develop and implement interventions to improve enrolment in the NHIS and retain members is discussed in the next chapter.

How did problem-solving groups work?

Introduction

The National Health Insurance Scheme (NHIS) was introduced to address inequity in financial access to healthcare, one of the most enduring problems in Ghana since independence. Although the NHIS has made gains in improving access to healthcare, it has been beset with low enrolment and the inability to retain members. Concerns have also been raised at various forums about community and institutional barriers that undermine the achievement of the NHIS policy goals. Thomas, a District Health Insurance Scheme (DHIS) manager expressed his frustration about the limited progress despite efforts to expand NHIS coverage:

It is so disappointing that after all the education we have been carrying out doing everything possible to get people insured, many people have refused to register. We go to schools, hospitals, churches and communities, yet people are not registering. Some register but do not renew their membership. It's really difficult for us. For example, Ofram (not real name), the community you are conducting your study in is a difficult one. I don't know how you are going to help improve enrolment there.

Thomas' concerns were typical of responses given when low enrolment was discussed with DHIS officials. Efforts being made to expand the NHIS coverage and retain members were not yielding the desired results. His comment also indicates how the DHISs were tackling the problems of low enrolment and high non-renewal rates without sufficiently engaging other stakeholders – community members and health providers. In many cases, the NHIS target populations were not consulted to voice what prevents them from responding positively to the policy. Health providers were also left out and had not been consulted to speak about the NHIS implementation challenges that confront them. Decisions about how to manage problems of low

enrolment and retention rates are made by those who may not be in tune with the enormity of NHIS implementation challenges. Many studies have shown the value of engaging stakeholders in intervention programmes (Green et al. 2001, Hawkes et al. 2004), but how such collaborative groups operate has not been well discussed in the literature. This study fills this gap by closely monitoring the multi-stakeholder problem-solving programme (MSPSP)

The MSPSP was based on a multi-level perspective (MLP) that encourages stakeholder engagement for addressing a social phenomenon (see chapter one). As Farmer (2005) and Scheper-Hughes (1992) argue, without considering what happens at local levels, decision makers miss the majority of people whose lives are affected by their decisions. The rationale of the PSG concept was the assumption that engaging actors involved in public policy to address the challenges is more likely to achieve an impact than a single-level approach. This chapter describes the pathways of this study's intervention and examines the activities and strategies the PSGs used to identify and address barriers to enrolment in the NHIS and retention of members.

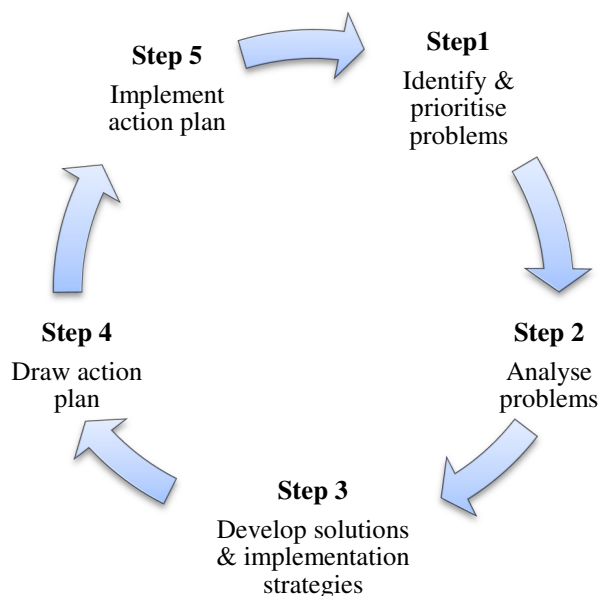
Problem-solving process

PSGs are normally formed around defined problems and in this study that was the low enrolment and retention of members in the NHIS. The pre-intervention household survey established the size of the problem that needed to be solved. The survey showed that of the 13,857 individuals covered, only a third (30%) were currently insured, 15.7 per cent had been previously insured and 54.3 per cent had never enrolled (Table A.3, Appendix 2). To carry out their task, the PSGs adapted problem-solving tools from the literature and used approaches that were tailored to the local context. Though PSG facilitators were introduced to three problem-solving tools (brainstorming, 'but why' and flow charts) during their training, they found two were the most beneficial for their task – brainstorming and 'but why'. According to facilitators, these tools were easy to explain and use. The PSGs were given a 'free hand' to operate and not restricted to any tool or approach. Facilitators were only required to follow the principles of the MLP and effective facilitation outlined in the 'SHINE Ghana training manual for facilitators developed by us (the research team) to guide the PSG facilitators when performing their task (see Kotoh et al. 2009).

Figure 5.1 shows the cyclical route that the PSGs went through to identify barriers to enrolment and develop and implement interventions. It started with problem identification and prioritisation and ended with the implementation of action plans. Some steps were repeated within the cycle, depending on the feedback, after an intervention activity was carried out. Throughout the process, facilitators engaged members in interactive activities to critically analyse their experiences, interests,

behaviours and all issues raised to help understand the identified problems, and develop and implement solutions.

Figure 5.1 Steps followed in the problem-solving process



Step 1: Problem identification and prioritisation

The venue where the PSGs met was typically a health centre, community centre or classroom, depending on the availability of a convenient place for such an exercise. The meetings were usually held on ‘taboo days’¹ (no work days). Generally, the first session started with facilitators briefing members about what brainstorming and ‘but why’ entail. The facilitator then would lead the group in a discussion to develop rules to guide the process by typically making them aware that: “Though the session involves ‘free talk’ it must be structured with rules to guide the process and encourage everyone to talk in a systematic way.”

After a lengthy discussion about the techniques, the rules that were agreed upon included: nobody should interrupt when someone was talking without the facilitator’s permission and every member had to make at least one contribution during the session. I must say that these rules motivated even members who appear to be shy to

¹ ‘Taboo days’ are days set aside by communities and people are not expected to work on their farms or go fishing. In farming communities, one can carry farm produce, but not engage in clearing the land or sowing crops. These days vary from community to community. In fishing communities, fishermen use the day to mend their nets. Generally, communities hold most of their social events such as naming ceremonies, meetings or community development activities on taboo days.

talk. The first activity of the problem-solving process was the identification and prioritisation of problems. Facilitators led the group in brainstorming using questions and answers. The main questions were: “Why are some people not registering with the NHIS?” “Why do some people not renew their registration?” and “What experiences do people have with the NHIS?” Health providers and DHIS staffs were asked specific questions about challenges in implementing the NHIS. All identified problems were listed on a flip chart in no particular order and without censoring. The duration of a typical brainstorming session was about two hours.

An extract of the first brainstorming session is presented below.

Facilitator [DHIS representative]: Today, we begin identifying barriers to enrolment. As we have already discussed, reasons why people do not enrol or renew their NHIS card can be found in the community, health facility and my outfit [DHIS]. We will start with community members, then health providers and DHIS staff. We will mention barriers we know while the secretary writes them down and later select those to be addressed. Everybody should endeavour to talk. We must be honest with what we say. If you are not sure of anything, don't say it. Now, can anybody tell us about problems he or she, family members or friends experienced or witnessed others go through?

Community representative: I have personally gone through a lot. I'll start with registration. I registered six of us and had five cards after four months. That of my last child came after six months. Meanwhile, I was paying his hospital bill. Just last week I had to pay for a drug covered by the NHIS when I sent a prescription the doctor gave me to an accredited pharmacy.

DHIS staff: My problem is the behaviour of nurses. Some of them don't respect insured patients and collect unauthorised fees especially in the evenings and weekends. Our concern in this town is not getting all drugs from the health centre. We have to travel to other towns to get most of our drugs.

Community representative: I'll also add poverty. There are people who have no income and cannot pay. Though I appreciate all these problems, the underlying factor for the majority of us not enrolling is lack of commitment to health insurance. The reality is that we have not yet accepted health insurance and made it part of our budget. It is not part of our culture to insure ourselves against ill health. We wait till we are sick before we think of insurance.

Health providers and DHIS staff also spoke about the NHIS implementation challenges that undermine their work. When ideas had been exhausted, similar problems were put together and arranged according to the level at which they were experienced or occurred and prioritised based on consensus. From my observation, this was an efficient way of eliciting problems from PSG members.

The first problem identification and prioritisation sessions were usually characterised by heated arguments when health providers and DHIS staff defended and rejected negative behaviours and practices attributed to them by others. For example, allegations of malfeasance against DHIS staff and health providers resulted in many arguments. However, the situation changed when facilitators reminded group members about the goal of the intervention and re-echoed the need for objective discussions. In subsequent meetings, I realised that the members were more relaxed and discussions were characterised with occasional jokes and laughter. The lesson

was that in such groups, time should be allowed for members to adjust to the group and grasp the task at hand and the essence of the exercise.

After problem identification and prioritisation sessions, PSGs held meetings with community leaders to solicit their reaction to the identified problems. These meetings were used to discuss challenges rather than apportion blame to any group. Generally, the community leaders' reactions provided new insights into identified problems while new ones emerged. For example, the use of chemist and pharmacy shops as alternatives to seeking healthcare at health facilities usually came up at community leaders' meetings. A community leader in one of such meetings explained the situation as follows:

I did not renew my card because I find the pharmacies [also referring to chemist shops] a better option than the hospital. It is faster and you do not experience any negative behaviour of nurses as is often the case when you go to the hospital. At the hospital you could spend several hours waiting and you are not treated with respect. *Wommu yen* (They [health providers] don't respect us).

In addition, PSGs also held discussions with individuals in the communities by performing house-to-house visits to further explore problems not identified at their meetings. For instance, the issue of 'not often sick' and politics as reasons for not enrolling in the NHIS were mentioned only in individual conversations.

Since the PSGs could not solve all identified problems, they selected those they could address and usually sought the support of the District Directors of Health Services (DDHSs) and DHIS managers at stakeholders meetings in dealing with others. This was because solving some of the problems required changing structures and operational systems at the national level, which was beyond the capacity of the PSGs. For example, the problem of heavy workloads and the complex nature of NHIS forms could not be solved by PSGs since they required policy action. However, PSG activities and recommendations raised awareness and highlighted the need for change and could put pressure on policy makers to act.

Step 2: Problem analysis

Another important component of carrying out an intervention programme is to understand the problem to be addressed. Before PSGs started looking for solutions, they analysed the problems to make sure every member understood the issues they were trying to address. For every problem, the group looked for a root cause(s). PSGs generally used the 'But why' technique (see Serrat 2009) to get to the root cause(s). During this process community members, health providers and DHIS staff brought up experiences regarding the NHIS at their respective levels. Details of problem analysis sessions are presented below.

'But why?' Asking 'but why?' is a technique used to explore the root causes of a problem to ensure that all issues that contribute to the problem are well understood.

Here, facilitators usually stated the problem and asked about why it occurred. He or she continued to ask follow-up questions using ‘But why?’ after every answer till the group could offer no further explanations. The last response was then taken as the root cause. However, there could be more than one root cause to a problem or one root cause could result in more than one problem. Below are examples of how the ‘But why’ technique was used to find the root cause(s) of problems and discussion that ensued between facilitators and PSG members (see Boxes 5.1-5.3). It must be noted that the process is not as straightforward as presented here. This is a complex activity that has been simplified for easy comprehension by readers. In practice, each ‘But why’ question elicited many answers which were discussed and agreement reached on which was the most feasible cause(s) of the problem.

Box 5.1 Analysis of “no money to pay reason for low enrolment”

Question (Q): Why are people not enrolling?

Answer (A): Because they don't have money to pay for everybody in the household.

Q: But why don't they have money to pay?

A: Because premium and registration fees for all household members are too much for the head of household to pay.

Q: But why is premium for the household too much when it covers the whole year?

A: Because they have competing needs, yet they have to pay registration fee for children and premium for other dependents above 18 years.

Q: But why do you have to pay for adult dependents?

A: Because they are not working.

In the above case, other root causes identified were the lack of a health-related risk, aversive culture among community members, lack of confidence in the NHIS, poverty and dissatisfaction with quality of healthcare services.

Box 5.2 Analysis of the delay in issuing NHIS ID cards

Question (Q): Why is there delay in issuing NHIS ID cards?

Answer (A): Because it takes so much time to process registration forms.

Q: But why is so much time needed to process the forms?

A: Because of the difficulty of matching names with pictures.

Q: But why is it difficult to match names with pictures?

A: Because people use different sets of names to register and take pictures since they were not done at the same time.

Q: But why do people use different names?

A: Because people have several names and they tend to use different ones at different places depending on the situation.

Other root causes of delay in issuing NHIS ID cards included: people did not know the implications of being inconsistent with the names they used for official documents and inadequate and non-functional computers and cameras. In some cases, collectors spent monies collected from registrants and delayed the submission of their forms. There were other problems peculiar to communities outside DHISs' office locations. These included DHISs staff's delay in taking photographs after people had been registered as a result of frequent break down of their motor bikes or inadequate cameras to go round the numerous communities in the district.

Box 5.3 Analysis of shortage of drugs at health facilities

Question (Q): Why do you experience shortage of drugs in your facility?

Answer (A): Because we don't always have money to buy drugs.

Q: But why don't you have money to buy drugs?

A: Because of delays in claims payment.

Q: But why does claim payment delay?

A: Because there are problems with claim processing.

Q: But why are there delays in claim processing?

A: Because the NHIS claim forms are complex and the bureaucracy involved in vetting them.

An additional root cause of drug shortages at health facilities was the low patronage of health facilities resulting in a low level of internally generated funds (IGF) to help maintain drug stock levels when the National Health Insurance Authority (NHIA) delayed paying health facilities. Normally, the DHISs vet bills prepared by accredited health facilities and submit them to the NHIA who pays the health facilities directly.

The 'But why' technique illustrated above shows the complex linkages that exist between problems and their root causes at various levels. It indicates how community, health provider, DHIS and national level factors converge to adversely affect enrolment in the NHIS and retaining members.

PSG problem analysis sessions were supported with a variety of activities. One activity was meeting with opinion and community leaders, health providers and DHIS staff. In coastal towns, PSGs met the chief fisherman, boat owners, *pataase* leaders and members with health providers and DHIS staff in attendance. The meetings were chaired by community PSG facilitators. Similar meetings were held with chief farmers, and cocoa purchasing clerks in farming communities. These meetings usually discussed the root causes of low interest in health insurance identified by the PSGs among others. In the case of health facility level barriers, meetings were held with the entire staff to discuss their concerns about increased

workloads and the cumbersome bureaucratic processes that NHIS brought into the healthcare delivery system. On the part of DHISs, the issue of people using multiple names only came up during meetings with the entire staff. As usual, these meetings were interactive and gave everybody the opportunity to express his or her concerns. Reactions from this group thus gave PSGs more insight into the problems.

Another popular activity that the PSGs used in problem analysis was house-to-house visits by members that were generally conducted by community representatives. The approach allowed for one-to-one interactions between community members and PSG representatives and provided an opportunity for individuals who were not confident talking in public to voice their concerns.

The main concerns usually expressed were: long waiting times at health facilities and DHIS offices, delays in issuing NHIS cards, health providers not respecting insured patients, shortages of drugs at health facilities, the difficulty of getting prescribed drugs in accredited pharmacy and chemist shops and having to pay for drugs covered by the NHIS. These activities provided in-depth information and better insight into the barriers the PSGs had identified, since they had the opportunity to probe further for the root causes. After a problem analysis session, a PSG representative told me: "Now I appreciate problems faced by health providers in providing better healthcare to insured patients. This has changed some of the negative perceptions I had about them."

This highlights the importance of the PSG problem-analysis sessions that brought out issues, which had not been captured at PSG sessions. For example, the issues of registration fee payments and premiums for many children and dependents that made the total amount of money to be paid by poor heads of households unaffordable were observed at first hand.

Lessons learnt: The broad-based involvement of the community through house-to-house visits and meetings with opinion leaders brought up many experiences related to key problems that had not been captured at PSG problem-analysis sessions. This showed the complexity of barriers to enrolment with the NHIS and retention of members and suggested that all the stakeholders did not know all the problems in the community. Therefore, depending on one category of stakeholders alone for information can lead to what Chambers (1983) described as 'people bias.' Chambers criticised the behaviour of development professionals who spoke of participation by targets of their development projects, but who had only spoken to rural leaders and people who represented the elite, dominant and wealthy groups. People bias can occur if stakeholder collaborations formed to address barriers to achieving a public policy promotion limit their problem identification and analysis activities to their own group members. To diminish this bias, it is necessary to step out and listen to

ordinary people in the community and workers in the institutions involved in an intervention's implementation.

In this study, people who were directly affected by the intervention and those purported to be the causes of the problem were jointly engaged to analyse the problem. This reduced aggressive reactions and created conducive atmosphere during the PSG problem-analysis sessions. Thus, the consideration given to all stakeholders' perspectives during the problem analysis reduced the initial aggression exhibited by some and led to an appreciation of others' complaints about them. The result was an agreement on the root cause(s) of the problems and made the issues less sensitive in the end. This suggests that there is great benefit in bringing stakeholders together to discuss even the most controversial issues. It is important to handle the sensitivities of all stakeholders tactically during the discussions to ensure that tempers are controlled (especially at the beginning), since they begin to appreciate each other's perspectives as the meeting progresses.

The problem-analysis sessions also highlighted the following conflicting interests of actors involved in the NHIS implementation:

- Some health providers sell drugs to insured patients and collect unauthorised fees.
- DHIS staff collects money and issue NHIS cards to patients without waiting for the mandatory three-month waiting period.
- NHIS collectors charge more than the approved premium and registration fees.
- The DHISs are reluctant to grant exemptions, especially to the core poor.

These revelations show that the behaviour of individuals at the frontline of the NHIS implementation is not homogenous and often conflicts with the policy goals. While policy makers' may be enthused with equity issues, those at the frontline of NHIS implementation may be more concerned with economic gains.

Step 3: Finding solutions to problems and implementation strategies

After the probable root cause(s) of problems were identified, measures to address them were developed. To ensure that the interventions had maximum impact, the questions of when, where and how to carry out solutions were found to be critical and explored. At this stage, facilitators explained the objective of the session to members and engaged them in finding appropriate solutions and implementation strategies. Brainstorming was usually used to critically reflect on the NHIS policy and the implementation challenges to generate possible solutions. To encourage members to talk, the PSGs adopted the slogan 'no idea is bad' used during facilitators' training workshop, which I observed encouraged everyone to contribute to discussions. All ideas were listed because some sounded ridiculous at the beginning, but turned out to be good after analysis.

Tailoring the interventions: The PSGs also developed strategies for implementing solutions to the identified barriers. This involved selecting specific targets, implementation sites, persons to implement solutions, and where and how to reach all target groups. Thus, the PSGs tailored their solutions to particular target group(s) and identified the venue and who should be involved considering local conditions and available resources. Although the PSGs utilised well-known DHISs approaches, such as education at community durbars and health facilities, new implementation strategies were developed to ensure all target populations were reached. These included education at churches, mosques, markets, the beach, basic schools and households. The PSGs also held joint meetings with community leaders, health providers and DHIS staff to solicit their support in carrying out intervention activities.

PSG members were divided into small groups of about four. Each group was assigned one or two problems to consider and report on. Next, a member of each group presented their work and explained their proposed solution(s) and implementation strategy(s) during the following meeting. PSGs then agreed on the presented alternatives (if any) and which one to implement. For example, when the solution was to provide education to fishermen on the need to insure oneself against ill health, the site was the beach and the team was made up of health providers and DHIS staff with community members in charge.

From my observation, the most significant impact of these interactions was establishing and/or strengthening the relationship between community members, health providers and DHIS staff. A PSG member after one of such sessions expressed his joy as follows:

We are motivated to contribute to discussions because facilitators appreciate the role everybody is playing in solving the problems identified. They encouraged us to talk about our experiences and reservations about the NHIS freely and suggest solutions to address the challenges. This made us appreciate others experiences and why they do certain things.

This comment shows that by involving others in finding solutions to problems, everyone developed the commitment to help solve them. The body language of PSG members suggested this was a major first step in reducing identified barriers. For example, the facial expressions of community members during problem-analysis sessions suggested that they appreciated the challenges confronting health providers and DHIS staff in implementing the NHIS policy. Similarly, health providers and DHIS staff acknowledged the community members' concerns. They normally nodded their heads when community members were talking about experiences indicating some level of appreciation of their concerns.

PSGs, community leaders, health providers, and DHIS staff work together: At this stage, the PSGs again strategically used stakeholders' and community leaders'

meetings to solicit support in carrying out intervention activities. As usual, they gave an overview of the groups' activities and the need to develop appropriate solutions and ensure that the intervention reached all their members so that enrolment and retention rates could be improved and ultimately, more people would have access to healthcare. My observations and comments by community members during these meetings indicated that they appreciated the health providers' presence at these meetings. A *pataase* leader's comment at one such meeting suggested that for the community members, the health providers and DHIS staff's presence conveyed a stronger message of their commitment to the NHIS than hearing it from only DHIS staff and the collector. He said:

It is good health providers and DHIS staffs are also here to talk to us. Some of them make us feel they don't like insurance. Nurses' attitudes don't show they support it. If you go to the hospital, they make you wait for too long. I hope when you go back you will tell the rest what we are saying.

This kind of reaction gave the PSGs more insight into how to involve community leaders, health providers and DHIS staff in implementing intervention activities in the communities. It helped them to change their strategies. For example, in coastal communities, the PSGs changed their implementation strategies when they realised that community durbars were not an effective means to reach the majority of the population, particularly the men. Men, mostly fishermen, spend all day at the beach either mending their nets or engaged in playing games. With this insight, the PSGs in coastal communities focused more on small group activities such as *pataase* meetings and house-to-house visits instead of community-wide activities to ensure everybody was reached. However, documentary films shown in the evenings in the community were also well patronised by community members including men.

Peer-to-peer conversations: One approach the PSGs used was to engage insured community members to educate their peers about the benefits of health insurance using their experience. During one of such meeting, a boat owner shared the NHIS' benefits to his household with his colleagues. His colleagues asked the boat owner about the details of the benefits and quality of healthcare services. Others, who were complaining about the viability of the NHIS at the beginning of the discussion, appeared to be convinced that insurance was better than cash and carry in the end. These peer interactions and the information shared about NHIS' benefits and experiences at health facilities reduced the negative perception about health providers' attitudes towards insured patients.

The benefit of the stakeholders' involvement in the development of solutions to barriers was that speaking about the NHIS' financial protection against ill health had a greater effect on people. It appeared that what PSG community representatives, community leaders and health providers say at such meetings had more weight than

what DHIS staff and collectors had been telling the community. For example, the NHIS's protection against catastrophic healthcare payments that was addressed by community members sharing their own experiences and citing cases of people they knew made their peers appreciate the NHIS better. This proved to motivate more people to enrol in the NHIS than the DHIS staff and collectors telling them what to do.

Step 4: Drawing an action plan

To facilitate the implementation of intervention activities, the PSGs drew action plans to guide the process. Table 5.1 presents an example of an action plan drawn and implemented by a PSG. Action plans served as road maps for the implementation of intervention activities. For the purpose of this intervention, PSGs adopted the following guidelines to help develop the outline of their action plans at our PSG facilitators training workshop:

- State the problem being addressed
- Set targets to be achieved at the end of each activity
- State the specific activity to be carried out
- Decide on the most appropriate person(s) to be responsible for each activity
- Do not assign all the tasks to one person
- Have a time frame within which each activity should be carried out
- Provide feedback at the end of every activity
- Provide evidence to show that the event has taken place for the purposes of monitoring

Table 5.1 Action plan for August-October, 2009

Activity	Community durbar	Stakeholders' meeting	NHIS mass registration
Target(s)	Community leaders & members	Community leaders, health providers & DHIS staff	Community members
Persons responsible	Kofi, Jacob, Lucy & Mercy	Philip & Judith	Eugene, Kofi & Adjoa
Time frame	August	September	October
Resources needed	Canopy, P.A system, chairs, refreshment	Pastries and drinks	Chairs, tables, lunch for participants
Budget	GH¢ 99	GH¢ 95	GH¢ 50
Feedback	Not well patronised	Most people invited attended	Patronage was good. Needs to be repeated
Evidence for monitoring	Pictures & report of events on file	Minutes of meeting & pictures on file	Pictures & Number of people registered

The PSGs agreed that intervention activities with the potential of reaching most community members would be given priority in their action plan. Brainstorming was generally used to break down solutions into specific activities to develop an action plan for every quarter of the year. Items in the action plans included specific activities, targets for intervention activities, time lines set for each activity and a budget. For example, the third intervention activity in Table 5.1 above was mass registration. For this activity, the entire community was targeted. Four members of each PSG were appointed to be directly responsible for organising the event and time frame. Items needed for the occasion were stated and a budget provided. Impressions about the event were written as feedback and photographs were taken as evidence that the activities had taken place for the purpose of monitoring the intervention. Feedback also provided information that served as a guide for the next line of action or for modifications of an intervention activity, if necessary. Evidence for monitoring helped ensure that the PSGs adhered to what they stated in their action plans and the guidelines of the intervention programme.

Step 5: Implementing intervention activities

The consensus at the PSG meetings was that since barriers to enrolment were multi-dimensional they would be better addressed when all stakeholders worked together to implement the activities outlined in their action plans. Thus, the PSGs provided structures for community members, while the DHIS staff and health providers met regularly to exchange ideas on how to reach all target groups. The PSGs' involvement in the delivery of intervention activities ensured smooth implementation and made it possible for all target populations to be reached. Since barriers to enrolment and member retention were multifaceted and linked to the culture of the communities and the context within which health providers and DHIS staff operated, intervention activities were delivered at the three levels of NHIS implementation – communities, health facilities and DHIS offices – to ensure maximum impact.

Intervention activities at the community level

At the community level, intervention activities projected the NHIS' benefits and tried to persuade communities to embrace the NHIS as a better alternative to paying cash at health facilities. The NHIS's operational challenges confronting health providers and DHISs staff were also explained. The main barriers were:

1. Low community member interest in health insurance
2. Misapplication of the operational principles of informal mutual support groups such as *nnoboa* and *pataase* to the NHIS. In the case of *nnoboa*, people join the groups when they need support and withdraw thereafter
3. Delays at health facilities experienced by insured patients when accessing healthcare with their NHIS card

4. Delays at DHIS offices when collecting NHIS cards
5. Payments for unauthorised fees and for drugs covered by the NHIS
6. Undersupply of prescribed drugs at health facilities
7. Community members' over-reliance on chemist and pharmacy shops for treatment
8. Political perception of the NHIS

Implementation strategies employed were meetings in community durbars, homes, beaches, markets, lorry stations, churches, mosques, schools, PTA² meetings and health facilities. These forums were used to educate community members on the need to be insured against ill health and about the NHIS' protection against catastrophic healthcare costs. The meetings also created platforms where detailed information was provided on NHIS' operational guidelines and challenges that the health providers and DHIS staff faced in implementing the NHIS. The intention was to enable community members to appreciate the reality of the challenges in delivering healthcare under the NHIS regime. As enhanced knowledge does not necessarily translate into action, promotional activities were also carried out to whip up interest in the NHIS, build trust and confidence in the NHIS and improve the credibility of health providers and DHIS staff in communities.

Community durbars: Community durbars in Ghana are held at designated places for large gatherings such as community centres and village squares. They are convened either by traditional leaders, opinion leaders, or community groups. Outsiders are invited or an institution may be invited to discuss important issues of public concern. The durbars are usually characterised by drumming, dancing, speech making and question and answer sessions.

The first intervention activity the PSGs organised was a community durbar. Many PSGs organised durbars every three months. The usual format was the observation of traditional protocol such as exchange of greetings between community leaders and invited guests. Next, PSG community facilitators provided information on the rationale for the intervention and outlined various activities to be carried out. Drumming and dancing followed, after which the PSG representatives from the community, health providers and DHISs' staff and other invited guests took turns addressing the gathering. The question and answer sessions fostered open discussion of the identified barriers and community members' concerns about the NHIS. Chiefs and elders, assemblymen and Unit Committee members, heads of health facilities, the District Director of Health Services (DDHSs) and DHIS managers or their representatives addressed most of the durbars I attended.

² Parent Teacher Association is an association of parents of children of a particular school. They meet to discuss issues that concern the welfare of their children.

All speakers at these durbars typically delivered explicit messages to sensitise the gathering about health insurance. They projected the NHIS as a resilience-building factor that provides financial protection and has the potential of helping achieve the ultimate goal of equity in access to healthcare. This was intended to create a commitment from the people to insure themselves against illness and consistently renew their membership. The speakers often used the experiences of people in the community to illustrate how health insurance had helped them avoid catastrophic healthcare payments and enabled them to manage the adversities of ill health. For example, a diabetic patient explained how her health became better after enrolling with the NHIS.

This hospital card [NHIS card] is good. It has really given me relief from thinking about my sickness. I no more have complications. I'm able to go for reviews and get my medicines every month so my worries about the disease have gone. You have seen how diabetics nearly destroyed my life. So for me, I always renew my card.

Health providers re-echoed the NHIS' benefits. They informed community members about how the insurance reduces patients' complications and vulnerability to ill health. They narrated specific instances where lives were saved due to health insurance and deaths occurred because patients did not have money to seek early healthcare. While acknowledging the barriers that community members had mentioned, health provider PSG representatives, heads of health facilities and officials from the District Health Directorate explained the cumbersome bureaucratic processes that the NHIS brought to the healthcare delivery system. They informed the public about the increase in their administrative and clinical workload due to the time spent filling out the NHIS forms. They explained that this prolonged the insured patients' consultations and the time they spent at health facilities. They also told them why health facilities were unable to provide patients with essential drugs at all times. This reduced the insured patients' complaints about spending more time at health faculties than the uninsured and the shortage of drugs at health facilities. Health providers used the durbars to assure community members of their intention to improve the services, but explained that they were constrained by NHIS implementation challenges.

DHIS representatives and DHIS managers in the PSGs also told community members about the NHIS benefit package. They acknowledged the community members' concerns about the delays in issuing NHIS cards and described the bureaucracy involved in processing NHIS claim forms. They also explained the implications of using multiple names and emphasised the need for patients to be consistent with the names they use in official documents such as the NHIS, hospital and voter ID cards, school and church records. One of them explained: "The use of different names to register and take pictures makes us spend so much time in processing the forms. This contributes to the delay in issuing the cards."

My observation and conversation with community PSG representatives during these durbars indicated that community members were encouraged by the health providers' and DHIS staff's acknowledgement that their colleagues' bad behaviour towards insured patients. They were also happy about the attempts being made to remedy the situation and improve quality of service. The DHIS staff's efforts influenced community members to respond positively and play an active part in the intervention. Also, using examples of beneficiaries to demonstrate the benefits of the NHIS had a positive effect. Several people usually enrolled after the durbars. Further, the explanation that patients needed to be consistent with the names they used in official documents reduced the complaints against DHIS staff.

Film shows and drama: Documentary films and drama are known to capture the attention of viewers and make a story more real and vivid. This technique was used by some PSGs to follow-up the community durbars and other intervention activities to make the NHIS implementation challenges real to the communities. The films documented actual NHIS registration and users accessing healthcare. The film shows were interjected with discussions to reinforce very important messages. The films and drama demonstrated the reality of barriers and illustrated the challenges health providers and DHIS staff faced. The intention was to attract community members' sympathies with the aim of changing their attitudes towards health insurance. For example, some PSGs showed documentary films to expatiate problems created when various names were used for photographs and registration and how this delayed the processing of registration forms. The films were shown in the evenings on 'taboo days' when everybody was at home, so they were generally well patronised.

The power of films in creating vivid and more lasting impression on the minds of people was apparent. I observed that the films were more appealing to those community members who were reluctant to attend community durbars. I often heard people discuss the films and debate issues that were raised long after they had been viewed. Community members often referred to the films in conversations and discussions during PSG meetings. As the community members saw people they knew in the films giving testimonies about the NHIS' benefits and using their card to access healthcare, the advantages of being insured was made real. Also, questions asked and comments made after the films indicated that the more people were exposed to the NHIS' benefits, the greater the likelihood that they would appreciate it as better than 'cash and carry'.

Some PSGs also used community groups, such as mother-to-mother support groups,³ to stage short dramas to demonstrate the difficulties the DHISs face when processing NHIS registration forms. They used the drama to portray how cumbersome it is for a mother to go to the DHIS office several times before she can get her NHIS card just because she used one name to register and another name for her photograph. In one community, in a drama, children showed how mothers wrote the names of all members of the household before registering them and then showed the names to the registrar and the photographer. School children were also used by some PSGs to stage a short play emphasising how non-enrolment can lead to delays in healthcare by staying at home and the death of children, especially those under five years.

Opinion and community leaders' engagement to promote NHIS: As Viswanathan et al. (2004: 28) observe: "Integration of residents' knowledge of what will work in their community makes it more likely that findings will address the problems." This study also found that it is not enough to integrate stakeholders' knowledge into intervention activities, but it is also necessary to engage them in knowledge dissemination. PSGs worked together with opinion and community leaders to implement intervention activities. Short meetings, not more than two hours, were regularly held with traditional, religious and opinion leaders to solicit their support in implementing intervention activities in communities. PSG community facilitators led discussions at these meetings. The leaders were informed about the dangers of over-reliance on pharmacy and chemist shops as alternatives to seeking healthcare at facilities. They were also encouraged to talk about the benefits of health insurance with community members to help improve NHIS coverage. Next, religious leaders included health insurance-related themes in their sermons and initiated discussions with their congregations.

In fishing communities, PSG members engaged chief fishermen, boat owners and *pataase* leaders to educate fishermen and mobilise them to enrol in the NHIS. PSGs in farming communities also met chief farmers and cocoa purchasing clerks and solicited their support to educate community members. From my observations and discussions with community members, the meetings helped clarify misconceptions about health insurance and raised their interest in the NHIS. For example, cocoa farmers who lived on their farms during the cocoa season and came to the communi-

³ Mother-to-mother support groups (MtMSGs) are groups of lactating mothers who organise themselves into clubs and engage in various activities. They share the common purpose of providing a safe environment where women can learn from one another, exchange experiences and concerns, and support one another in a variety of ways. MtMSGs affiliated with the GHS' Baby-Friendly Hospital Initiative are committed to improving infant and young child feeding practices and maintaining formal links between health institutions and communities (Linkages and Partners 2003).

ty only occasionally and others who spent the greater part of the day on their farms and were difficult to capture during durbars, house-to-house visits or film shows were reached through their leaders. Though the leaders continued to complain about payment for drugs and services covered by the NHIS, the meetings usually ended with some of their community members actually registering. After one such meeting during the bumper harvest, a boat owner pre-financed the registration of twenty of his employees. When I asked him why he did that, he explained his action as follows:

Irrespective of the problems associated with health insurance, it is still better than cash payment. My workers usually borrow money from me to pay their hospital bill during the dry season. So convincing them to register will take that burden off me.

Thus, by engaging chief farmers, cocoa purchasing clerks, chief fishermen, boat owners and *pataase* leaders in the intervention process, 'the difficult to reach' target populations were captured. One NHIS collector told me after our meeting with the cocoa farmers that some farmers came to register afterwards. I followed up to find out how the purchasing clerks had managed to convince the farmers to enrol. The purchasing clerks who were insured said they had shown the farmers their NHIS cards and told them about the benefits they had been enjoying. They explained how being insured reduced their vulnerability since they would not have to borrow money, give out their farms for a number of years or sell their farms or land to pay hospital bills during the dry season as was usually the case. The uninsured purchasing clerks also encouraged their peers to enrol. A *pataase* member told me after one of their meetings that "[k]nowing that our leaders are insured influenced those of us who are still apprehensive about the viability of the NHIS to change our mind."

These comments suggest that engaging opinion and community leaders, purchasing clerks, informal sector employers and business owners could help promote the NHIS. They could be consulted at harvest time to encourage their members, employees and people who do business with them to enrol. This is an important factor that needs to be considered when developing implementation strategies and the timing of intervention activities to ensure all sub-groups are reached at the appropriate time.

Schools: Basic [elementary] schools were another site for PSG intervention activities because that is where the children and teachers could be reached. As a PSG facilitator explained: "Basic schools provide good settings for reaching children, their families and teachers. Children need healthcare most, yet they do not have adequate knowledge of health insurance."

PSGs discovered that even though children are exempted from paying premiums and are only required to pay registration fees, most of them and their parents were not aware of this status. So, PSGs carried out educational activities at basic schools

to explain the NHIS operational guidelines to them. They reasoned that sensitising children about the need to be insured against ill health before they become adults would help reduce apathy towards health insurance, one of the enduring problems confronting the NHIS. Teachers could also educate their pupils and parents on the benefits of health insurance and help promote the NHIS. Teachers thus engaged parents in discussions during PTA meetings and other school activities and encouraged them to enrol every member of the household especially children. PSG community representatives explained that many older children earn some income during harvest season and could pay their registration fees if their parents could not pay for them. A PSG community representative stressed the importance of this as follows:

When children and teachers value health insurance, they will in turn influence parents to enrol. Children will engage their parents in discussions about the need to enrol all household members and maintain their membership. This will gradually improve their attitudes towards health insurance.

In summary, sensitising children about the need to insure against ill health had a positive impact not only on them but their parents as well. It improved knowledge about the NHIS and resulted in many households enrolling all members.

Health facility-based education: PSG community representatives, health providers and DHIS staff carried out both educational and advocacy activities in health facilities to reach patients. Nurses, volunteers, collectors and DHIS staff were specifically tasked to perform this role. They usually mounted platforms in the outpatient department (OPD) and pre- and post-natal clinics to educate patients on health insurance and encourage them to enrol and remain in the scheme. Pregnant women and mothers were told about the need to renew their card and register their babies before they were three months old, since free care under a mothers' card expires after this period. They explained the processes that insured patients have to go through in accessing healthcare and why they sometimes have to give prescriptions to patients to look for drugs elsewhere. The discussions were normally interactive and people asked questions and expressed their concerns about the NHIS.

It is worth mentioning the illustration by a medical assistant who showed her NHIS ID card to uninsured patients as a way of building their confidence as mentioned in chapter three. When I asked her why she did that, she told me: "Some patients need to be convinced by us [health providers] that health insurance is good for them. I believe if they know that we are also insured, they will be motivated to enrol."

Other PSG intervention activities in the community: Other intervention activities at the community level were visits to households, beaches, markets and lorry stations

on ‘taboo days’ when most people stayed at home. In fishing communities, for example, visits to households and markets were targeted mostly at women. Men were met at their places of work, such as the beaches and lorry stations. Both men and women were reached at home on ‘taboo days’ in farming communities.

Also, through the initiative of PSG community representatives, registration points were mounted in communities every ‘taboo day’ during the harvest period to encourage people to enrol. For example, a PSG set up a SHINE office in a community, which served as a registration point. The SHINE offices were used for meetings, registration and delivery of NHIS cards. A collector, assisted by other PSG community representatives, ran the office. This created interest in the NHIS as it brought the service to the doorstep of the community.

Regarding the difficulty of obtaining prescribed drugs in communities where there were health facilities, but no accredited pharmacy or chemist shops, PSG community representatives argued that although they knew that it was not the DHISs’ responsibility to convince pharmacy and chemist shop owners to apply for accreditation, they had the moral responsibility to intervene. Therefore, the PSGs persuaded pharmacy and chemist shop owners inside and outside the district to apply for NHIA accreditation and open branches where hospitals and health centres are located.

In the case of payment for drugs covered by the NHIS inside and outside health facilities and paying unauthorised fees to health providers and DHIS staff, PSG members encouraged insured patients to report such cases. I must mention that some reports were made, but only in a few cases were these followed up because insured patients were not bold enough to lead PSG members to confront the staff involved. I did witness two cases when insured patients paid for hospital ID cards and drugs covered by the NHIS and PSG members confronted the officials involved. The officials were made to refund the money to their patients.

I must also mention that in all the intervention activities, time was set aside to engage individuals who could not raise their concerns during group discussions and activities in one-to-one conversations. I observed that these strategies made it possible for PSGs to reach almost every community member. They improved the level of understanding of health insurance and appreciation for some NHIS operational challenges.

Intervention activities at the health provider level

PSG intervention activities were used to address challenges that the NHIS brought to the healthcare delivery system and the effect on health providers and ultimately on clients. The three main NHIS implementation challenges faced by health providers and addressed by PSGs were:

- Time spent filling out what they described as “the complex NHIS forms.”
- Heavy workloads as a result of increased utilisation of healthcare services by insured patients
- Irregular payment schedule of NHIS claims, which contributed to the health facilities’ inability to provide essential drugs to insured patients at all times.

Two main strategies, stakeholders meetings and documentary films, were used to tackle the problems.

Stakeholders’ meetings

PSG members made a decision that the NHIS implementation challenges would be better addressed if all stakeholders worked together to implement intervention activities. Rather than apportioning blame to specific stakeholders, intervention activities were intended to be a negotiation on how to improve enrolment and retention of members in the NHIS. As a result, regular meetings were held where PSG facilitators emphasised that although some NHIS operational problems were systemic, their negative impact on enrolment could be minimised. These meetings were usually attended by community leaders, heads of health facilities and their staff, DDHSs and DHIS managers or their representatives. Discussions focused mainly on health facility-level barriers, their relative contribution to low enrolment and high dropout rates, and how to improve the situation.

In a typical meeting, officials from the District Health Directorate working on NHIS claim forms explained the need to carefully complete the forms and avoid making mistakes to prevent rejection. DHIS managers took turns to inform health providers on the operational guidelines of the NHIS. They acknowledged that the NHIS has increased the managers’ workload and persuaded them not to vent their frustration on insured patients by being rude, but rather to communicate the challenges they face in a friendly manner to the patients.

Regarding delays at health facilities, the position of facilitators on how to address the problem was mentioned as follows:

Since filling the NHIS forms is part of healthcare delivery procedure and can only be changed at the national level, we could only educate people about what to expect when they seek healthcare with the NHIS card. This will show that the problem is real and not perceived as inefficiency on the part of health providers. Hopefully, this will help change the negative perception they have about us.

In the case of heavy workloads, the discussions focused on how to improve the quality of services in the midst of the increasing number of patients at health facilities and manage the stress. Health providers were urged to exercise patience with insured patients since this was an issue that PSGs could not solve. The PSGs suggested that the negative impact could be reduced through regular interaction with stakeholders to explain the health providers’ difficult working conditions. Citing cases of few staff attending to many patients at busy facilities, District Health

Directorate staff were invited to advise health providers on how to effectively combine their administrative and clinical workload to reduce the time insured patients spent at health facilities. These activities usually ended with a call to health providers by community leaders and DHIS staff to use open communication to make their clients understand the enormity of the challenges they faced.

In addition, PSGs held separate meetings with health providers and DHIS staff to discuss measures that they could take to minimise the negative effect of delays in claim payments on facilities. After lengthy discussions on how delays in claim payments contribute to the shortage of drugs and undermine the quality of healthcare services, DHIS managers and staff expressed their sympathy and described the situation as unfortunate. They explained that the problem was largely due to delays in claim submission, mistakes in the forms and the bureaucratic procedures. They assured the PSGs that the DHIS staff who vet the NHIS claim forms would contact health staff immediately to resolve problems to speed up the process. A medical assistant told me that these meetings established linkages that improved the relationships between health providers and DHIS staff working on the NHIS forms. She asserted: “DHIS staff now call me to discuss problems with NHIS claim forms and we are able to thrash out issues concerning the forms faster than was the case previously.”

For accusations of disrespect, collection of unauthorised fees and priority being given to cash-paying patients levelled against health providers, PSG facilitators and health providers’ representatives made a special appeal to their colleagues to convince community members that health providers support the scheme, but are constrained by operational problems when interacting with insured patients during consultations. In one such meeting, a facilitator who is also a health provider emphasised the need to change health providers’ behaviour and respect insured patients:

We need to convince people that we support health insurance and explain to them the difficulties we have in the facility in a friendly way. Much as we want them to appreciate our problems, we need to respect them. We can only show that we are committed to ensuring the policy succeeds, but our desire to provide quality service is undermined by inadequate staff and delay in claim payment, if we stop collecting unauthorised fees from insured patients and giving preference to patients who pay cash. These negate efforts at improving enrolment with the NHIS and retaining members.

This statement resulted in arguments in the meeting, but many health providers accepted that the issues raised were significant factors that they ought to address to help PSGs improve the enrolment and retention of NHIS members, while others thought it was an exaggeration of the situation. At one meeting, a District Director of Health Services (DDHSs) who was the chair, intervened and re-echoed his colleagues’ concerns, but reminded them that they needed to adhere to their motto

for service delivery – the interest of the client comes first and every patient requires respect. He emphasised:

As to whether these allegations are true or not, we cannot just dismiss them. Even though it might not be widespread, it is our responsibility to weed out the ‘bad nuts’ among us. If we are able to do this, our commitment to the scheme will not be in doubt. We should realise that under the NHIS we are dealing with a new type of customer who is empowered to demand quality service because he has paid before coming to us. If we charge them any unauthorised fees or make them pay for drugs covered by the NHIS then they are paying double. This undermines the credibility of the NHIS and they have the right to complain. We therefore need to develop new work habits and uphold our professional ethics. Insured patients must not be made to bear the consequences of problems we have with the NHIS. Otherwise how can we convince them to understand our problems?

DHIS managers spoke about the need for health providers to see their work as a business enterprise and handle their clients with decorum. They emphasised the critical role of health providers in promoting the NHIS and pointed out that its success or failure depended very much on them. He said:

How health providers present the NHIS to patients influences how people perceive it. Discussions so far show that almost everybody is not happy about the quality of service at your facility. I’ve also had numerous complaints about the practices that go on in your facility which discourage people from enrolling or renewing their membership with the scheme. I appreciate your problems especially the delay in reimbursing claims but it is no reason to make patients pay the price. If you do that, your problems will not be appreciated. So if you improve your services many people will enrol.

The frank discussions among key stakeholders at these meetings, contributed immensely to bridging the knowledge gap between what the policy states and the reality on the ground. The PSGs had better insight into the NHIS operational challenges confronting health providers. A PSG health provider representative asserted:

Such meetings would have saved us from many of the accusations community members levelled against us and the high hopes they have about the NHIS. DHIS projected the NHIS as covering everything, so insured patients believe they do not have to pay anything and should be given all drugs at the facility.

In addition, speakers at all intervention activities called on health providers to improve their relationship with insured patients, respect them and embrace the non-cash transactions under the NHIS to show that they support the scheme, since this would help build confidence in the NHIS. The PSGs seriously suggested that all health workers should show a personal commitment to promote health insurance and desist from collecting unauthorised fees from insured patients and making them pay for drugs covered by the NHIS. This was a call to health workers to demonstrate a true commitment to the implementation of the NHIS and improvement of their public image. In this regard, health providers in particular advised their colleagues to give up the practices and behaviours of the user-fees regime (health providers sometimes selling their own drugs to patients and collecting unauthorised fees) and

commit to the NHIS. I observed that despite all the nice things that DDHSs and DHIS managers said, these were tough issues in the health system and not easy to address. Community members' facial expressions during these discussions suggested that they felt helpless. A PSG community facilitator lamented after one of these meetings as follows:

Stopping corruption among health providers is a difficult task. None of the 'bosses' [DDHSs and DHIS managers] seem to have the zeal needed to fight these negative behaviours and corrupt practices head on. They seem not to be ready to punish severely those involved in cheating to deter others from doing the same things. So we [PSG members] can only appeal to the conscience of the perpetrators.

These comments show how handicapped the PSGs were in addressing some of the challenges. Despite the PSG members' scepticism about the health providers' willingness to change their negative behaviour, the intervention activities sensitised them about the contribution they could make to expand NHIS coverage.

Films

Some PSGs used documentary films of scenes of overcrowded health facilities with the few health providers having difficulty attending to so many patients. After acknowledging the negative behaviour of some of his colleagues, a health provider pointed out the issues that account for some of those problems. He explained:

Our heavy workload and long working hours make some of us resort to collection of unauthorised fees to compensate for their long working hours. Also, the frequent shortage of drugs and other supplies to take care of ever-increasing numbers of patients undermines our desire to provide quality healthcare.

The situation was made real in the films. Strategies they could adopt to manage the situation to reduce delays were discussed thereafter. The discussions also highlighted how some health providers maintain quality of service delivery even in the midst of the challenges to encourage others to do the same, since this is one of the core complaints that discourage people from enrolling.

I noticed that by the end of the intervention, health providers talked to patients about health insurance and the need to enrol and regularly renew their memberships and discussed the challenges of providing good healthcare with the patients more than they had done at the beginning of the programme. This suggests that some improvement in the situation could happen even if it was slow.

Intervention activities at the district health insurance scheme level

The main NHIS implementation challenges that were found to undermine DHISs' work and by consequence discourage people from enrolling or renewing their memberships were:

- Delays in processing NHIS registration forms attributed to the use of multiple names when registering and having photographs taken
- Delay in issuing NHIS cards due to inadequate staff, office space and computers to process NHIS registration forms
- Difficulties of granting exemption to indigents

Specific intervention activities PSGs used to address these challenges were meetings, set community registration points and provide collectors with cameras.

Stakeholders' meetings

Stakeholders' meetings that were organised by the PSGs created a platform and opportunity to reduce the negative effect of the NHIS implementation challenges confronting DHISs. At these meetings, DHIS staff were advised to be quite meticulous when registering people, so that they could detect the use of two sets of names – one to register and one for the photograph. They were urged to develop effective strategies to instruct people who register with one name and have their photograph taken with another to prevent mismatch of names and photographs on their NHIS cards. For example, interrogating people to be sure they used the same names to register and have their photograph taken and correct the inconsistency immediately.

Regarding delays in issuing NHIS cards, DHIS staff cited inadequate computers and cameras as making the registration procedure very complicated and prolonging the waiting period beyond the three-month period. They attributed this situation to insufficient funds from the government to meet their immediate needs such as repairing computers and providing adequate cabinets to properly file their documents including registration forms and NHIS cards. The issue of insufficient funds was linked to low enrolment and high non-renewal rates. The following summary was a typical advice given to the DHISs' staff at stakeholders' meetings:

Since much cannot be done about the government funding, we can only appeal to the NHIA through DHIS managers to increase the number of permanent staff, provide more computers and cameras. While we wait for more computers, which might not be provided now, we have to strategise to increase our revenue so we can repair our equipment promptly and ultimately reduce the delay in issuing ID cards. Fortunately, the PSG will help us improve coverage and increase revenue so we can repair our computers immediately when they break down and buy more cameras to reduce delays in issuing NHIS cards and improve service.

To counter corrupt practices, PSG community representatives, DHIS staff and managers explained how these undermine attempts to improve enrolment from their perspective. They explained how charging more than the approved premium and registration fees, prevents poor parents from registering all their household members. They emphasised that this menace should be addressed in a holistic manner. First, DHIS managers appealed to DHIS staff to desist from the shameful act and devise ways of providing efficient service to their clients. Collectors were asked to stop collecting more than the approved fees and pay the money collected to DHISs

promptly to overcome the temptation of spending it on their personal needs. Second, PSG community representatives were told to tell people to report any DHIS staff or collector who demanded money from them to avoid waiting for the three-month mandatory period. Third, community representatives suggested that DHIS managers monitor their own staff and collectors by occasionally visiting communities to check on the premium and registration fees being collected. A community facilitator argued:

The practice of collecting more than the approved fees and registering people through ‘the back door,’ will not help build confidence in the NHIS. It will rather encourage people not to enrol and renew their membership regularly. They will think they can be issued NHIS card instantly when they pay money to DHIS staff.

At the end of the discussions, the health providers and DHIS staff agreed that barriers to enrolment and renewals of membership exist and need to be resolved. Evans & Davies (1999: 379) describe what occurs in a policy transfer when those implementing a programme are not likely to do: “Exactly what was intended or specified by those who formulated it.” In this respect, the PSGs adopted a ‘no blame’ stance and advised DHIS staff to give up all negative practices and show true commitment to expanding NHIS coverage through a gradual process of desisting from current practices and adopting practices that build confidence in the scheme. A PSG facilitator re-echoed this concern and described the situation as: “Difficult issues for the group to solve since they are endemic, but we will keep on talking.”

These comments show how handicapped PSGs were in addressing the corruption that adversely affected enrolment in the NHIS and retention of members. However, concerns by PSG members sparked debates and made service providers more conscious of their behaviours that were undermining attempts to expand NHIS coverage than they had been at the beginning of the intervention.

The difficulty of identifying the core poor for exemption was also addressed by PSGs during stakeholders’ meetings. After extensive debate, PSG community representatives and facilitators asked DHIS PROs and collectors to play lead roles in the implementation of the exemption policy. They urged them to educate community members on the exemption policy and collaborate with community members to identify and recommend the core poor for exemption. During one of such meetings, a facilitator cited the case of a volunteer who persuaded the collector and DHIS staff to grant exemption to a woman described as core poor. He discussed how community members, DHIS staffs and collectors could help address the difficult issue of granting exemption to the core poor. He argued:

Though it took a lot of effort to grant her exemption, it indicates the core poor can be easily identified. If DHIS staff and collectors work with opinion and community leaders they can make the process less controversial. PSGs can come up with names and justify their nominations since their status is not questionable rather than sticking to the homelessness condition, which does not reflect the situation.

In this regard, DHISs were asked to liaise with community leaders and PSG representatives especially collectors and volunteers to identify and recommend the core poor for exemption.

Other PSG activities to address NHIS implementation challenges at DHISs

PSGs urged DHISs to appoint collectors in communities where there were none and set up registration centres to aid the registration campaign and help explain new policy directives to community members. Some PSGs purchased cameras for collectors to enable them to register people after their promotional activities, since more people registered when their photographs were taken at the same time. This helped speed up the registration process because when both activities took place simultaneously, difficulties associated with people using multiple names to register and having their photograph taken were reduced. Certainly, the cameras and the presence of collectors in the communities improved the registration process and subsequently reduced the delay in issuing NHIS ID cards, which increased confidence in the scheme. This underscores the need to provide every collector with a camera.

In conclusion, all intervention activities provided structures for community members, DHIS staff and health providers to exchange ideas about pertinent issues that negatively impact on NHIS coverage. Sociologists refer to this as creating opportunity structure – a form of enablement for collective action (see Boudreau 1996). In this case, the MSPSP created linkages and provided opportunities for community members, health providers and DHIS staff to be part of the process of improving enrolment and retention in the NHIS. Moreover, though the systemic challenges were beyond the scope of PSGs, their intervention activities created awareness about the depth of the problem and generated discussions among stakeholders. The intervention activities set the tone for more critical reflection by community members about insuring themselves against ill health. It also caused DHIS staff and health providers to reflect on their work and how their behaviours and practices impact NHIS coverage.

Reflections on problem-solving sessions

This discussion examines two main issues: (1) how PSGs were able to reach most of their targets and (2) the behaviour of some PSG members during the problem-solving sessions.

As a whole, PSG members felt the multi-level and participatory approaches helped create synergy⁴ that enabled them to reach their target populations. But, it is

⁴ Synergy refers to cooperative interaction among group members. It successfully combines effort, skills and resources of group members to achieve objectives (Lasker & Weiss 2003, Pathman 2008).

important to mention that enthusiasm for participation was not given and synergy did not just happen; facilitators played a key role. As Pathman et al. (2008: 10) note, synergy develops because “[l]eaders spotted opportunities and resources to support synergy, brokered relationships ... value and learnt how to create synergy.” In this study, bringing stakeholders together to participate in the intervention was not as simple as presented above; it was a daunting task. However, the facilitators training provided specific strategies that helped them create synergy, which elicited their commitment to participate in the intervention. Strategies that worked well were: (1) presenting the intervention as something that would reduce the NHIS’ implementation challenges at three levels (communities, health facilities and DHISs), (2) the recognition that PSG members’ and stakeholders’ were capable of contributing towards the success of the NHIS and (3) allowing PSG members’ and stakeholders’ to lead intervention activities. The three strategies created trust and a sense of responsibility among the PSG members. The history of participation has shown that plurality of methods and adjusting to local conditions yields better results. As Chambers (1994: 1449) notes: “Scientific method is not competent to predict or prescribe for the complex open systems which matter most.” This implies that what happens in the field depends on the decisions and actions of individuals and these are relevant for success of interventions. In this study, the facilitators’ openness and sharing of ideas during the intervention brought out a range of locally tailored techniques that helped reach all target populations.

The question of whether my presence in the PSGs limited discussions at meetings and problem-solving sessions was discussed in chapter two. Here, I wish to emphasise that with the exception of a few cases where participants denied accusations of negative behaviours and practices, the PSG members quite willingly shared their experiences and opinions. However, social desirability made some of them withheld information about their own negative behaviours. As discourse analysts point out, speakers construct alternative and sometimes contradictory versions of reality to achieve a goal (Potter & Wetherell 1987, 1994, 1995). In this study, my observation confirms earlier studies that individuals blame others and the social structure for their own failures (cf. Turner & Stets 2006). They portrayed an overly positive picture of themselves and attributed negative behaviours to others. Despite this shortcoming, my dual role helped maintain the group’s focus on providing the information needed to get to the root causes of barriers and helped develop locally tailored solutions and implementation strategies.

Conclusion

This chapter shows the potential of problem-solving tools and participatory approaches in opening spaces for community members, health providers and DHIS staff to work together to increase confidence in the NHIS. Interestingly, stakehold-

ers' meetings were accepted as safe places that provided a collegial setting not only for providing information for addressing problems, but also for establishing and strengthening relationships among them.

Furthermore, the chapter showed that the effective engagement of community leaders, informal sector employers such as boat owners and cocoa-purchasing clerks created a synergy that made it possible for the intervention to reach all target populations, particularly community members who were difficult to reach. Community members and leaders' testimonies about the NHIS' benefits and health providers' explicit support for the insurance scheme helped create the impression that the NHIS could ensure that everyone has access to healthcare and this increased the community members' interest in the scheme.

The findings thus contribute to the literature on the benefits of engaging stakeholders from the onset of interventions and using them to mobilise support for uptake of public policies. The results show that adopting multi-level and participatory approaches helped overcome the central issue of a lack of collaboration among community members, health providers and DHIS staff in promoting the NHIS. The approaches gave 'voices' to those at the front-line of NHIS implementation and those affected by the policy; these views are rarely heard. Therefore, the DHISs could consider the multi-level perspective as a useful framework to guide them in planning and implementing interventions to address barriers at various levels to achieve maximum impact. It was assumed that these effects would multiply and be continued in a network of stakeholders. Whether PSG activities yielded positive outcomes is the focus of the next chapter.

The next chapter assesses the outcome of the intervention in terms of the increment in enrolment in the NHIS and retention of members by comparing pre- and post-intervention survey results. It also presents qualitative information from community members, health providers and DHIS staffs within and outside PSGs to explain the outcome of the PSG intervention activities.

The effect of the multi-stakeholder problem-solving programme on enrolment

Introduction

In the previous chapters, the multi-stakeholder problem-solving programme (MSPSP), aimed at improving enrolment and retention in Ghana's National Health Insurance Scheme (NHIS) was described. In the next three chapters (six, seven, and eight), I address the main question of the study: how effective were problem-solving groups (PSGs) for improving enrolment and retention rates in the NHIS?

This chapter opens with a brief overview of the phases of the study and the MSPSP and addresses the question what effect PSG activities had on health providers, DHISs' staff and community members in the context of health insurance enrolment. It concludes with a brief overview of the survey results concerning the effect of the intervention on enrolment. Chapter seven will present and discuss the factors that enhanced the PSGs' functioning and led to increased enrolment, and chapter eight reflects on the factors that limited the PSGs' effort at improving NHIS enrolment and retention rates.

Phases of the study and overview of the MSPSP

The study was divided into three phases – pre-intervention, intervention and post-intervention. Phase one (pre-intervention) was the conduct of a pre-intervention household survey in 30 communities in Central and Eastern regions of Ghana (13 and 17 respectively). The results were used (in addition to rural, semi-urban and urban characteristics) to assign the communities to intervention and control groups

to ensure a fair representation of communities with similar characteristics in both groups. In phase two (intervention), the research team organised sensitisation durbars in the intervention communities to inform stakeholders about the MSPSP and select PSG community representatives. The community-elected PSG representatives met with health providers and DHIS representatives (already selected by their heads of institutions) immediately after the durbars to select two facilitators and a secretary to lead the group through the twenty-month intervention period. Next, a three-day facilitators' workshop was organised by the research team during which the MSPSP's rationale and implementation guidelines were discussed. Facilitators were also exposed to facilitation approaches and problem-solving tools and techniques to equip them perform their task competently. An important element of the workshop was the adoption of general guidelines for facilitating PSG meetings and intervention activities. Intervention activities were carried out in the selected communities and their respective health facilities and DHIS offices. No activity took place in control communities. The third phase was the repetition of the pre-intervention household survey in March 2011 to assess the effect of the MSPSP on NHIS enrolment and retention rates. In addition, I conducted follow-up key informant interviews, conversations and focus group discussions (FGDs). The survey results were used to measure the impact of the intervention on enrolment and retention in the NHIS. Participant observation, conversation, key informant interviews and FGDs were used to provide an in-depth understanding of 'how' and 'why' the observed impact occurred.

Assessment of the effect of PSG activities on stakeholders started before the end of the intervention and concluded with key informant interviews and FGDs after the post-intervention survey. The interviews and FGDs focused on observed changes in health providers', DHIS staff's and community members' behaviour and practices that directly or indirectly resulted in increased enrolment. The survey results showed that the intervention had a positive effect on all stakeholders and led to increase in enrolment; but renewal rates did not improve. Details of the quantitative results are presented later in a section that examines the effect of the intervention on community members. Due to the limited observations at the end of the intervention and to avoid an overreliance on self-reports by community members, health providers and DHIS staff; I also relied on changes they observed at different levels. For example, I used community members' observations at health facilities to verify what the health providers had told me.

Effect of the MSPSP on health providers

At the start of the intervention, health providers often complained that the NHIS led to increased utilisation of healthcare services and thereby resulted in an increased workload. Of particular concern, was the time spent filling out NHIS forms, which

prolonged the insured patients' consultations and staff's working hours. Health providers also indicated that delays in claim payments led to drug shortages and undermined their attempts to improve the quality of services. These challenges influenced some health providers' to be unfriendly towards insured patients and give preference to cash-paying patients. It also led to staff collecting unauthorised fees. The effect of the intervention (MSPSP) was assessed in terms of how PSGs were able to encourage health providers to manage their workload and improve their behaviour towards insured patients. In this regard, all three categories of stakeholders (community members, DHIS staff and health providers) observed three changes that can be linked to the intervention – improved attitude towards patients, a decline in delays in treatment and a reduction in requests for unauthorised fees.

Improved health provider attitudes towards patients

The consensus among health providers at all FGDs was that although the intervention did not reduce their workload, it helped change their attitudes towards insured patients. The main explanation was that the discussions at the community durbars, stakeholders meetings and other activities influenced them to accept their workload since insured patients could not be blamed. Others attributed the change in staff attitudes to meetings with officials from the District Health Directorate who sensitised them to understand that the NHIS enabled patients to report early to health facilities and with fewer complications. As a result, the staff adopted more friendly ways of communicating the challenges they faced when providing healthcare to insured patients. A nurse explained why she changed her behaviour towards insured patients as follows:

Though our workload has not reduced and treating insured patients involved a lot of writing, the benefit of fewer complications presented by them discussed at our meetings influenced many of us to stop blaming them for our heavy workload. We realised that it is better to encourage them to report early than come here in critical conditions, which make us spend more time on them. However, shortage of drugs still persists and undermines the quality service insured patients are asking for.

I also observed during my routine observational visits to health facilities that those who had used derogatory language when interacting with insured patients had now stopped. I engaged these staff in conversations to explore reasons for the change. I walked home with Nurse Julia who had been accused of being disrespectful and hostile to insured patients most often and had demanded that they pay cash for accessing healthcare in the evenings and weekends. She told me this:

After the many complaints about us during meetings, we accepted that we have to improve our behaviour despite the problems we face providing healthcare to insured patients. Also, since we are involved in the intervention, we explain to insured patients the difficulties we face providing them healthcare and educated them about the need to come to the facility during normal working hours rather than in the evenings and weekends if it is not an emergency to reduce the suspicion that it is because they are insured.

Reduction in requests for unauthorised payments

PSG activities led to improvements in provider practices and the quality of service. For example, incidences of payment for drugs and other supplies at health facilities were curtailed. To confirm what Nurse Julia said, I asked Nurse Anas (a PSG member) who had told me at the beginning of the intervention that she was not happy about the behaviour of some of her colleagues' towards insured patients, whether she had observed any changes in that respect. She stated:

Our involvement in the intervention created the awareness that whatever we do will be exposed. So we are careful about what we do. Nurse Julia for example, has stopped collecting money from insured patients who access healthcare in the evenings and weekends and talk to patients to enrol.

A medical doctor narrated how the PSGs' exposure of a staff member made him institute measures that helped stop illegal payment for medicines and other supplies in the facility. He stated:

As I told you at the beginning of the intervention, we are pleased to be involved from the onset, so I told my staff that despite the workload and other challenges we face, we need to work like professionals. So we instituted measures that ensured both insured and uninsured patients are served as they come and stopped those who sell drugs covered by the NHIS to insured patients. We also talk to patients to enrol and encourage them to report difficulties they face here. My staff are now careful about what they do since they know their bad behaviour will be exposed. I believe this encouraged people to enrol.

Since it was not possible to use observation to validate all the reports such as collecting unauthorised fees, I engaged community members and DHIS staff in conversations and FGDs to verify what I was told. For example, I asked insured patients whether there had been any improvement in the way health providers treated them at the facility. One of them, who criticised the behaviour of nurses with passion at the beginning of the intervention, told me another story. She said:

The group has made them change their bad behaviour when people complained about them. The nurses who were disrespectful and collected money in the evenings and weekends changed after the durbar. I think they were afraid. What is left is to provide drugs in the hospital as drug shortages discourage people from enrolling and renewing their insurance cards regularly.

Decline in delays in treatment

DHIS staff also confirmed an improvement in health providers' behaviour during a FGD and added this:

After discussions at stakeholders' meetings the clear change in the hospital is a reduction in waiting time and improvement in the way the nurses talk to insured patients. The excuse that time needed to fill NHIS forms was the reason for giving uninsured patients preference has been resolved and the situation is better now. Many of them no more separated insured patients' cards from the uninsured.

The observed effects of PSG activities on health providers' behaviour and practices revealed that though their workload did not decrease, the facilities instituted measures that influenced the staff to adopt more positive attitude towards insured

patients. These measures helped improve the staff's behaviour and service delivery and encouraged many people to enrol even in the midst of unresolved challenges. Both Nurse Julia and Nurse Anas' statements indicate that awareness and frequent discussions about insured patients' complaints at stakeholders meetings influenced them to adopt a positive attitude. I observed that the nurses stopped giving preference to uninsured patients in queues that were usually formed at the OPD and served everyone according to the order in which they presented their cards. Also, disrespect and use of derogatory language to describe insured patients as 'difficult' and 'disturbing them' gradually disappeared as the intervention progressed and by the end of the intervention period I rarely heard such language. Reports about payments for drugs and other supplies in health facilities and the demand for cash when assessing healthcare in the evenings diminished. As D'Ambruso et al. (2008) observes, client-provider interaction and patients' satisfaction about the care provided are particularly important in health insurance with the degree of participation determined by perceived quality of care. From this point of view, these positive health provider-patient relationships influenced many people to enrol and remain in the NHIS.

Various reasons may account for the positive changes in health providers' behaviour. It was conscious effort to behave favourably towards insured patients during the intervention even in the midst of the difficulties they face. As Turner & Stets (2006: 29) have noted, social actors' behaviour are often 'self-directed' to conform to what others expect from them. This implies that people sometimes alter their behaviour in particular situations to achieve an objective. Similarly, the positive change in health providers' behaviour and practices was a result of self-initiated measures either to create good impression about themselves to show the researcher and/or District Directors of Health Services and District Health Insurance Scheme (DHIS) managers that the negative perceptions about them were not true and to redeem their image. To a certain extent, these views could be true, but there are good reasons to believe that the observed changes were real and not acted. My assertion is based on the fact that the multi-level approach used in gathering information made it possible for me to verify what I was told and observed. For example, I observed health providers increasingly show respect and not using derogatory language when interacting with insured patients; insured patients and DHIS staff confirmed this change during spontaneous conversations.

Another possible underlying reason for the positive change in providers' behaviour was the feeling of being change agents in the intervention and a genuine commitment to help the intervention succeed. As pointed out, providers were previously not usually involved in intervention programmes from the onset and treated as objects. Now they were pleased to be part of the planning and execution, which motivated them to ensure that the objectives of the intervention were

achieved. Obviously, involving stakeholders in interventions from the onset to address barriers to public policy uptake, leads to a better appreciation of the challenges that accompany such policies and influence them to be committed to success.

Effect of the MSPSP on District Health Insurance Schemes' staff

Barriers identified and addressed at the level of DHISs included: (1) inadequate equipment, (2) difficulties in processing NHIS registration forms, (3) lack of filing systems and (4) overcharging for fees and back door registrations. By the end of the intervention almost all DHIS staff mentioned the main effects that the MSPSP had on them that helped improve their performance and by consequence enrolment in the NHIS. They indicated that the PSGs' sensitisation activities and stakeholders meetings had led to the adoption of strategies to manage the challenges they faced: providing cameras for collectors to take photographs immediately they registered people and being meticulous about people not using multiple names, improving their filing system (which made retrieval of information and NHIS cards easier), and exposing back door registrations and collectors and DHIS staff who overcharged for fees. These measures improved the registration process and made it possible for DHISs to issue NHIS cards by the end of the three-month mandatory waiting period.

Cameras, matching names, and improved filing systems

A DHIS representative during a FGD outlined measures that helped increase enrolment as follows:

The challenge the PSGs threw to us during our meetings made us introduce measures that helped improve the registration process. Our staffs now match names on registration forms with pictures and correct mistakes in the field. The collector was provided camera to help him do that. We also educated people about the problems created when they are not consistent with the names they use for registration and when taking pictures. These reduced delays in issuing NHIS cards, built confidence in the NHIS and encouraged people to enrol.

A DHIS manager, who had doubted that the PSGs could improve enrolment at the beginning of the intervention, gladly expressed his positive opinion about the group this time. He said:

Debates during stakeholders' meetings and other activities made us seriously reflect on our work and devise ways of improving our work. We repaired our computers promptly, gave camera to collectors and made shelves for filing documents. These improved the registration process and makes retrieval of documents faster. Though I cannot give you exact figures, because our data is not organised by communities, I can say for sure that since the intervention started, revenue from the community increased significantly compared to others.

Changes at the DHISs mentioned by health providers' during and at the end of the intervention were fairly similar to what others said. The following statement by a medical assistant captured their observation:

Before you [PSG] started work, we used to have problems with patients for having NHIS cards with their pictures but different names. We don't have such problems anymore. This shows the DHIS has improved its work.

Such assertions from DHIS staff were corroborated by community members who noted that the NHIS cards were delivered by the end of the three-month waiting period. Two views were expressed. A PSG community representative in a FGD stated:

This is the second time I registered. The first time they could not find my card so I decided not to register until the intervention. You can ask the collector [pointing to her]. Some people also had their names mismatched with other people's pictures. When I registered now, we all had our cards on time. No more missing cards.

Overcharging for fees and back door registrations

In addition, the PSGs' exposure of some collectors' and DHIS staff who charged more than the approved premium and registration fees for NHIS cards for people who were sick through the 'back door' led to reduction in this practice. For example, a DHIS manager applauded the PSG community representatives for their vigilance in helping to check their staff and collectors' corrupt practices in the following statement:

The group's exposure of the collector and DHIS staff who charged more than the approved fees and issue NHIS cards to people without waiting for three months led to the termination of the collector's contract and the staff was seriously reprimanded. Regular discussion of such issues minimise back door registrations and the cheating that was going on. My staff are afraid of being exposed and punished.

I overheard a community member telling the facilitator about the improvement in issuing ID cards:

You [PSG members] have come to put things right at the DHIS office. I remember before you people came, things were not working well. When you register, you wait for some time before your picture is taken; you wait again for four months before you get your card. It happened to me and before I had my card, I had waited for six months. These things are not happening any more. Now it is left with the DHIS manager to identify and punish the few staff that still cheat to deter others and grant exemptions to poor people as we have discussed at our meetings with them.

Summary

These key stakeholder views and observations about the positive effects the intervention had on DHIS staff indicate that service delivery improves if resources are provided and a group is monitoring the activities of public sector workers. For example, PSGs reported that 'undercover practices' such as collecting more than the premium and registration fees and back door registrations that were hidden from DHISs' managers diminished as a result of PSGs' exposure of those involved. My analysis revealed that the negative behaviours and practices persisted because of two mutually inclusive factors: First, lack of commitment by authorities' to sanction

those involved. Second, lack of courage on the part of victims to report those involved to the authorities. Together, these factors perpetuated malpractices among DHIS staff. Contrarily to Aryee's (2005) observation, official responses to corruption in Africa range from lukewarm to hostility; this study found that the DHIS managers willingly sanctioned staff found to be cheating. This posture shown by the managers at the beginning of the intervention encouraged residents to report (and some even demanded) that the offenders were sanctioned as it happened to the collector whose contract was abrogated because of malpractice. So the fact that PSGs were ready to report DHIS staff and collectors to the authorities prompted many of them to change their behaviour, which reduced malpractices.

The positive changes in DHIS staff's behaviour appeared to be a conscious effort to fulfil their promise at the beginning of the intervention that they would ensure that the intervention succeeded since expanding NHIS coverage was their core business. As Turner & Stets (2006) observe, social actors sometimes modify their behaviour to achieve an objective. It can be concluded that the changes in behaviour and practices was a self-directed action that improved the DHISs' operations and increased confidence in the NHIS ability to fulfil their promise of supporting PSGs to achieve their goal. This indicates that involving implementers of a policy from the onset of an intervention and providing the required resources motivates them to improve their performance. These findings reinforce the previous observation that engaging stakeholders to address public policy challenges yields better results since it captures all perspectives and provides better insight of the real situation instead of a single-level approach, which misses out majority of people whose lives are affected by the policy (Van der Geest et al. 1990, Press 1990).

Effect of the MSPSP on community members

The NHIS policy requires registration and annual renewal of all household members (Government of Ghana 2003). However, community members' poverty, low interest in protecting themselves against ill health, and political perception of the NHIS contributed to low enrolment and high membership non-renewal rates. The effect of the MSPSP was therefore expected to change community members' attitudes towards the NHIS, reduce the political perception of the NHIS and influence them to enrol and renew their membership annually. Conversations about whether the PSG activities influenced people to enrol in the NHIS and renew their membership started before the end of intervention and ended with discussion of the survey results.

Three major changes

Information consistently mentioned in my conversations during the course of the intervention and FGDs at the end demonstrated three main effects of PSG activities

on community members that led to increase enrolment. First, many community members indicated that the PSGs' educational activities helped them to understand the risk-sharing principles of health insurance and influenced many people to enrol all household members instead of the selective registration they had been doing. They also stated that the PSGs' promotional activities created interest in the NHIS and made them appreciate the need for protection against ill health to avoid paying expensive direct out-of-pocket charges. Second, the PSG activities made them change their negative perception about health providers and improved their relationships with them. Last, involvement of their peers as PSG members and leaders in identifying and addressing NHIS challenges as well as implementing intervention activities removed the community members' political perception of the NHIS.

Understanding risk-sharing and changing negative perceptions

The following comment by a boat owner captures the effect that the PSG activities had on community members.

The intervention improved our understanding of health insurance and changed our attitude towards health insurance. You know health insurance is not part of our culture, so many of us did not see why we should pay for health insurance. Now almost everybody including children knows that insurance is better than paying cash at the hospital. By discussing the problems at the hospital with us, we appreciate why insured patients have to wait longer than the uninsured and why they don't always give us drugs at the hospital. Also, the testimonies given at durbars created confidence in insurance and influenced some of us to register everybody in our house instead of only those who needed healthcare. However, many people are still reluctant to register. But I think if the group continues their education with time they will change.

To verify what community members told me, I talked to DHIS staff and health providers to find out their opinion about the statements from community members about the effect of the MSPSP. A DHIS manager, who at the beginning of the intervention held the notion that community members were difficult and was worried about how the PSG could improve enrolment, spoke highly of the MSPSP in the following remarks at the end of the intervention.

I think the education at durbars, house-to-house visits, the film shows and other activities made them [community members] think seriously about health insurance. Before the group started work, people were not serious about health insurance. I think the group has been able to improve their attitude towards health insurance. The more than double increase in enrolment achieved is very good. We were unable to achieve this all these years. But the high membership non-renewal rate is because some people still wait until they are ready to go to hospital before they rush to renew their card. This attitude tells you how difficult it is to keep people in the scheme. I don't know what can change that.

The above view was also shared by several health providers I engaged in conversations at the end of the intervention. The following example summarises their observation.

Before your programme started, not many people came here with insurance. I think your education has encouraged them to enrol. But there are still those who, though know insurance is good

for them, will wait till they have some serious sickness before rushing to register. They come here and cannot pay their bill and give the excuse that they registered about a month ago and their card is not ready.

Knowing how easy it is for people to tell a researcher what he or she wants to hear, I sometimes eavesdropped on conversations to obtain information healthcare providers would ordinarily not tell me. On one such occasion, I heard two nurses at the OPD, talking about how the PSG helped improve the enrolment of pregnant women and mothers. One of them said:

Have you noticed that since the group started work many pregnant women and mothers come here with insurance cards? They now understand the free enrolment for themselves and register their babies two weeks after delivery. You remember we used to have a lot of argument with them especially those who register late and their cards were still valid long after delivery and think their babies should also be given free treatment after six weeks without registering them. Now they register their babies early.

Political perceptions

A nursing mother also told me that though some problems still persist, the intervention increased her confidence in the scheme and influenced her to enrol. She said:

When health insurance started, we saw it as politics and many people were not interested, but your education at community durbars and the hospital and house-to-house visits helped us understand the benefits of the scheme and changed our perception. However, the problem of shortage of and paying for drugs at the hospital and going round looking for drugs is still there. But as I always say being insured is better than going to hospital without insurance.

Health providers' disappointment with outcome

Despite the positive remarks some health providers who were involved in promoting the NHIS were not too impressed about the outcome of the intervention. A medical assistant (a PSG member), who showed her NHIS card to uninsured patients and encouraged them to enrol, expressed her disappointment about the results as follows:

As I've always been complaining, people still come here without health insurance. Despite our efforts at encouraging them to enrol not even half of the people are registered. Many have seen the need to protect themselves against sickness, but still wait until they are sick before they think of health insurance. The men especially say they hardly fall sick. I don't know what can change them.

In summary, I observed that the regular interactions among community members and leaders, health providers and DHIS staff, testimonies given at community durbars and the documentary films had positive impression on the community members. These activities influenced many people to appreciate the need for protection against sickness. The community members also appreciated the challenges health providers face when providing healthcare under the NHIS and talked about them in a more positive way. This helped increase confidence in the NHIS and

influenced people to enrol. My findings were verified through spontaneous conversations with several stakeholders throughout the intervention period, at PSG meetings and during key informant interviews and FGDs. Stakeholders could not have continuously made up their observations just to please me. Thus the reported observed changes were a fair reflection of the effect the intervention had on each stakeholder.

Post-intervention survey results

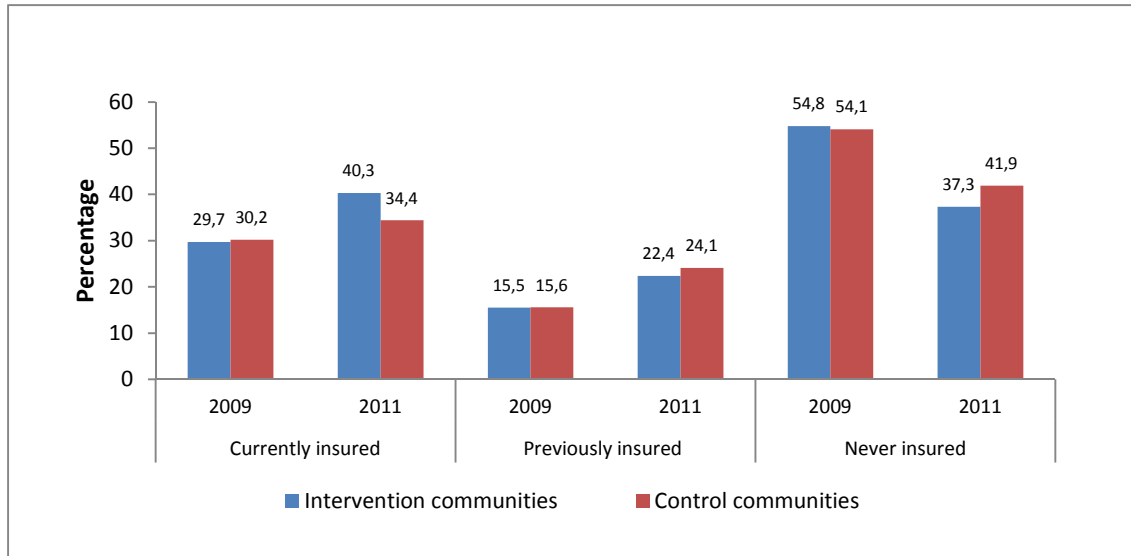
The positive effect of the intervention on community members comes out clearly in our post-intervention survey results on enrolment (currently insured) in the NHIS presented in Figure 6.1. The data covered 13,857 individuals at pre-intervention: 7,234 and 6,623 in intervention and control communities respectively. For the post-intervention survey, the data covered 12,810 individuals: 6,790 in intervention communities and 6,020 in the control group. Household heads were the respondents who gave information on the individuals (members of their households).

The results affirmed that PSG activities influenced people to enrol, but not to consistently renew their membership. Figure 6.1 shows the intervention significantly increased enrolment by 10.6 per cent ($p=0.000$) (from 29.7 to 40.3 per cent) and membership non-renewal rate by 6.9 per cent (i.e. from 15.5 per cent to 22.4). Further, we used a probit regression model to analyse the effect of the intervention on current and previous enrolment. The results showed that, holding all other factors constant, residents within the intervention communities were 17 per cent more likely to enrol and 5 per cent less likely to drop out of the NHIS compared to those in the control group following the intervention.

To find out whether the NHIS had reached the poor, the primary target of the policy and the intervention, the population was categorised into wealth quintiles using household consumption expenditure (see chapter three, Aryeetey et al. 2010). The health insurance status of all individuals covered in the survey was assessed and is presented in Figure 6.2.

Figure 6.2 shows the enrolment rate across the five wealth quintiles at baseline and post intervention. Enrolment in the poorest quintile declined from 23.6 per cent to 17.6 per cent. There was a slight improvement in enrolment for the poor quintile (28.6% to 31.3%). However, there were increases in enrolment for the third to the fifth quintile. A striking finding was that membership non-renewal rate was higher among the richest (23.7%) and rich (23.8%) than among the poorest (15.4%) and the poor (18.4%). This point will be discussed in the next chapter. The statistics indicate that although the intervention increased overall enrolment, it failed to achieve its main objective: to draw more poor people into the scheme.

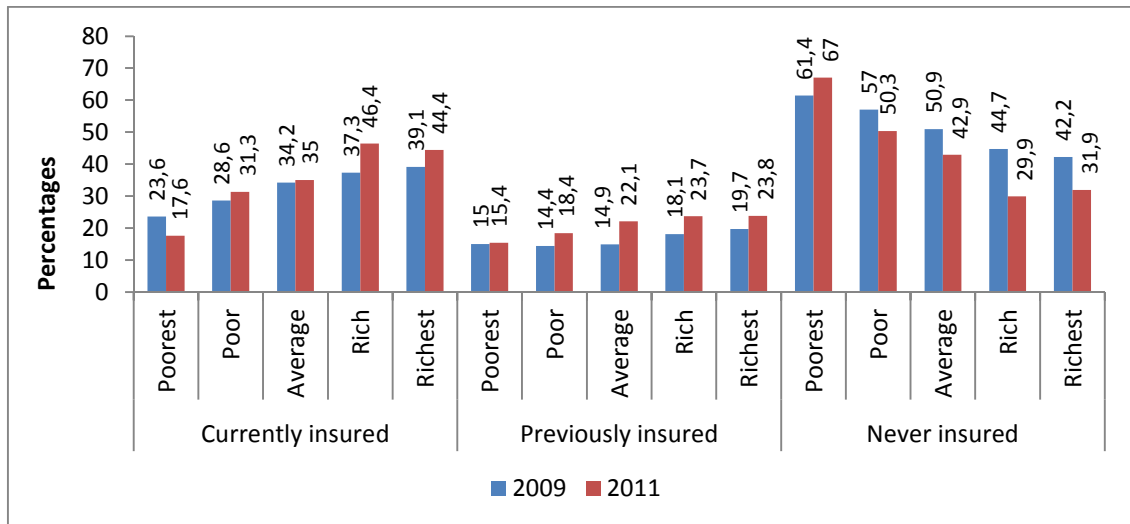
Figure 6.1 Changes in NHIS status in intervention and control communities



Estimated effect of PSG activities on enrolment and membership non-renewal rates			
<i>N</i> =13066	β^1 (95% CI)	Std. error	<i>P</i> -value ²
Currently insured	0.17 (0.12-0.21)	0.024	0.000
Previously insured	-0.05 (-0.01-0.00)	0.023	0.047

Source: Fieldwork, March 2009 and 2011.

Figure 6.2 Changes in NHIS status by wealth quintiles in intervention communities



Source: Fieldwork, March 2009 and 2011.

¹ β is the coefficient of the independent variable (dummy for intervention) on the dependent variable and used to predict the effect of the intervention on enrolment and non-renewal rates. Positive values show positive relationship and negative indicates inverse relationship.

² Statistical convention holds that a significant difference exist between two variables only if the 'p-value is less than 0.05 at 95% confidence interval. A p-value close to 1 indicates no difference between the two variables.

The lower enrolment observed among the poor supports previous studies that enrolment in the NHIS increases with income (Asante & Aikins 2008, Sarpong et al. 2010). In their study in a rural district of Ghana, Sarpong et al. (2010) found that 38 per cent of the population was enrolled in the NHIS. In this group, 21 per cent belonged to low, 43 per cent middle and 60 per cent to high socio-economic status households. The poor respondents cited the cost of transport to health facilities as the cause of their low enrolment. However, the higher non-renewal rate among the average and rich categories contrasts with the health economic literature in Sub-Saharan Africa, which gives excessive weight to the cost of premiums as responsible for low coverage in health insurance schemes (Jutting 2004, Asante & Aikins 2008, Basaza et al. 2008, Sarpong et al. 2010). The findings in this study indicate that although poverty contributes to low enrolment, it does not determine renewal rates. Low enrolment among the poorest quintile was attributed to the failure of DHISs to exempt them from paying premiums as the policy stipulates.

With regard to the enrolment within intervention communities, 10 communities showed significant increases in enrolment ($p=0.000$), two had no change ($p>0.05$) and three recorded significant decreases ($p<0.05$). Of the fifteen communities, only two had approximately two-thirds of the population enrolled (68%, 63%), two about half (53%), six between 30 and 50 per cent and five less than a third (15% to 25%). The non-renewal rates were generally high – between 13 to 41 per cent (see Table A.9, Appendix 2). The reasons and explanations behind these figures are examined in the next two chapters.

Conclusion: Dialogue among stakeholders and trust

In the current study, the positive effects of the MSPSP on enrolment clearly indicate that creating space for regular dialogue among stakeholders made it possible to capture barriers at all levels and helped to develop activities that led to the reduction in NHIS implementation challenges compared to the DHISs working alone. Community leaders' involvement encouraged members to develop interest in the NHIS and accept the need for protection against ill health. Moreover, since enrolment in an insurance scheme is partly about trust, health providers' involvement in the intervention and the observed changes removed doubts that they (community members) might not be treated well. As Schneider (2005) points out, trust-building practices reassure the insured that they will receive care when sick and motivate them to enrol. Similarly, the increase in enrolment can be explained by health providers directly promoting the NHIS and the adoption of practices that improved trust between them and community members. This reassured the community members in their support of the NHIS and increased their confidence in the scheme. However, the PSGs' inability to improve enrolment among the poorest quintile brings to the fore the reasons why the exemption is not reaching them, which will be discussed

elaborately in chapter eight. But, first in chapter seven we will examine the factors that enhanced the PSGs' functioning more closely.

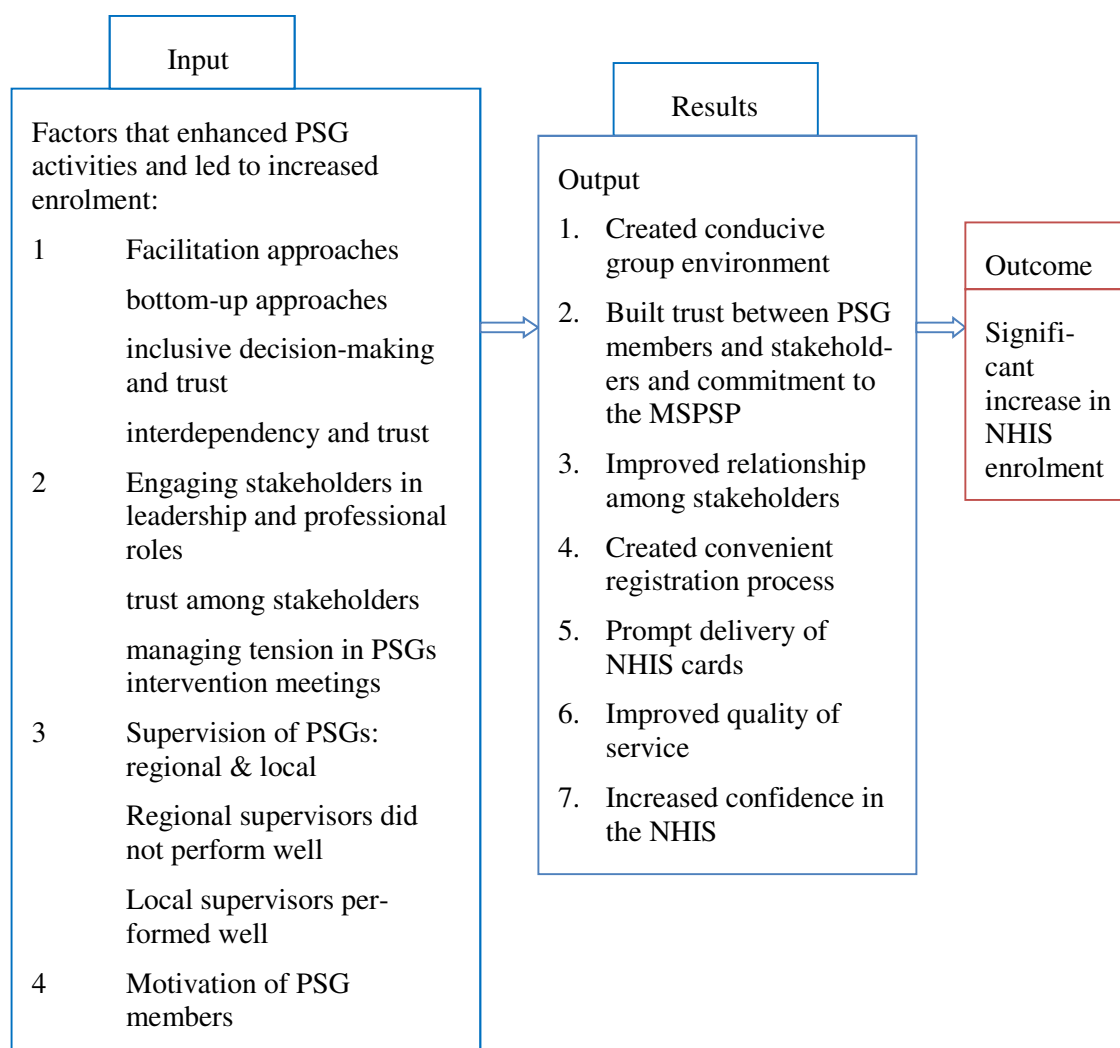
Factors that enhanced problem-solving groups' achievements

Introduction

This chapter provides insight into how the PSGs were able to improve enrolment in the NHIS and explains the results using both positive and negative cases to examine factors that influenced the outcome of the intervention. Five main factors were identified to enhance PSGs' work and led to positive outcome of the multi-stakeholder problem-solving programme (MSPSP) are presented in Figure 7.1 These factors were mentioned and discussed at the facilitators' training workshop, key informant interviews and FGDs and observed at PSG meetings and intervention activities.

A recent study suggests that emphasis on how multi-site intervention programmes are implemented is necessary for evaluating their impact (Oakley et al. 2006). In this study, the examination of the MSPSP implementation process revealed that facilitation approaches, stakeholders' engagement, supervision of PSGs and motivation for members led to positive results. These factors created conducive group environment, built trust among PSG members and stakeholders, sustained their commitment to the intervention and led to an increase in enrolment. A synopsis of how these factors enhanced the PSGs' work, ensured smooth implementation of the MSPSP and resulted in increased enrolment is provided in this chapter. Why some PSGs (those who did not employ these approaches) failed to increase enrolment is also examined and reference is made to particular cases to explain these outcomes.

Figure 7.1 Factors that enhanced PSGs' functioning and achievements



Facilitation approaches

Quality of facilitation describes how facilitators conducted PSG activities in a manner that promoted group cohesiveness, cordial relationships among members and a sustained commitment to the MSPSP. Since the MSPSP's objectives may not have been shared by every member to the same degree, facilitators needed to use approaches that would make them effective leaders and inspire the group to achieve positive results. Pillsbury (2008: 131) underscores the importance of facilitative skills as follows. "To be an effective leader, one must be driven by an impulse that solidifies a commitment to a vision...and connecting that vision and values to a position of responsibility for executing a programme." With PSGs, it was not only the facilitators' commitment to the vision of the intervention that was important, but also how to turn the intervention into a collective idea worthy of being followed by

members. Before they started work, facilitators were trained to adopt three main facilitation approaches: bottom-up, inclusive decision-making and interdependency.

Bottom-up approach

The bottom-up approach that the facilitators used was informed by Chambers' (1992) description of what effective participation should be in his work on community development. Chambers' proposition emphasised that community members should define their realities and mobilise resources to address their needs. This was discussed and adopted at the facilitators' workshop as a key guiding principle in implementing the intervention to ensure the effective participation of PSG members.

Facilitators employed non-dominating processes in the conduct of PSG activities. PSG members designed the intervention, controlled the resources provided, and drew and implemented their own action plans. A typical strategy that the facilitators employed to achieve this was that they did not always lead PSG meetings and problem-solving sessions, but instead they often took a 'back-seat' after introducing the activities. This posture encouraged PSG members to come out with ideas that formed the basis of their discussion. For example, during the problem identification and prioritisation sessions, facilitators opened the meeting by briefing PSG members about the agenda and asked a community representative, health provider or DHIS representative to lead the activities. Members primarily controlled the discussion. Facilitators contributed ideas when necessary and ensured that the discussions remained focused on the agenda. In essence, the members identified the barriers, developed solutions and implementation strategies and drew their action plans. A PSG DHIS representative described how the bottom-up approach helped sustain members' commitment in the intervention in the following statement.

We remained committed to the intervention because facilitators depended on our experiences and ideas to plan activities. This helped us identify the 'real' problems that discouraged people from enrolling in the NHIS and renewing their membership. Everybody's contribution led to the development of intervention activities and strategies that made it possible for us to reach everybody.

Inclusive decision-making and trust

The inclusive decision-making adopted as a benchmark for PSGs' effective functioning is in line with Lasker & Weiss' (2003) observation that collaboration must allow for inclusion and the equal participation of members in the process. In this study, facilitators addressed this issue in the PSGs' activities by ensuring that every member played a leading role in the identification of barriers, development and implementation of activities at one time or another, depending on their capabilities. The facilitators did not behave as if they knew all the problems and solutions. This approach created trust and allayed the fear of isolation while preventing self-alienation by members who were apprehensive about their effective participation from the beginning of the intervention. As Huckman (1987: 323) observed, "[g]roup

experience should satisfy rather than frustrate the personal needs of members.” This study also found that the facilitators’ encouragement of members to lead group activities and make decisions based on consensus satisfied the members’ sense of belonging. For example, Ebo who did not want to be part of the PSG because he could not speak English and feared alienation, became confident and contributed to discussions during PSG meetings and problem-solving sessions.

A brief background to Ebo’s case is useful to illustrate my observation. I noticed Ebo when he rejected his nomination during the PSG creation meeting. All attempts by his peers to convince him to accept his nomination failed. Realising that they saw him as somebody who could be an effective member, I persuaded him to agree to be elected. He accepted my plea and was elected. Later, I observed him closely. I noticed that Ebo did not talk during the first two meetings. The facilitator had to persuade him to contribute to discussions during the third meeting and later made him responsible for arranging PSG meetings and intervention activities at the community. Six months into the intervention, I had a conversation with him about how he felt as a group member. Ebo described his feeling as follows:

I’m happy in the group. At the beginning I didn’t want to be a member because I could not speak English so I felt I’ll be ignored, but when I became a member, the facilitator encouraged me to talk during meetings. We all decided how to do the work. I then realised I can do the work. Also, facilitators informed us about money received and we all decide how to spend it. There is no suspicion but trust among us. We are all working to achieve good results.

On the basis of Ebo’s comment and my observation as a participant in the PSGs, I can say that the inclusive decision-making and the active role everybody played in the conduct of PSG activities created trust and commitment to achieve the group’s objectives. Ebo’s statement indicates that the facilitators’ encouragement of less confident members and recognition of members’ contributions as important in the decision-making process led to their active participation. Also, since no PSG member dominated the problem-solving sessions, trust developed among them and sustained their commitment to the group and the intervention. According to Currall and Inkpen (2006) trust develops over time among groups and individuals. They observed that building trust is an incremental process; one may trust in small ways first, see whether it is upheld or violated, and then proceed with caution in trusting one step at a time. In the current study, I observed that trust developed slowly among PSG members as the intervention progressed as a result of respect for each other’s views. However, its sustenance depended on the leaders’ ability to engage all members in deciding the best way to get things done and distributing key roles across the group.

I must state however that this strategy was not applied in all PSGs. Some facilitators dominated the PSG activities. This created distrust and stifled the group’s work and so the groups did not achieve positive results. The details of what happened will be discussed in the next chapter.

Interdependency and trust

Interdependency means that the group members depended on each other to carry out a task instead of acting individually. In the context of the MSPSP, interdependency involved the facilitators' dependence on PSG members to plan and implement intervention activities and seeing each other as equals. This required that PSG members learned from each other and contributed towards the achievement of their objectives. The approach was used to create a conducive group environment similar to what Schwarz (2006: 300) described as a culture of collaboration: "All parties involved jointly design ways to work together to meet their related interests and learn with and from each other, sharing responsibility, authority, and accountability for achieving results."

In the case of the MSPSP, the PSG facilitators' created a collaborative environment that made it possible to harness the members' skills as the basis of their success. They achieved this by creating interdependent relationships so that the group could only function when everybody played his or her role. In applying this approach, the facilitators shared the roles for pre-intervention activities among members and ensured that each person played his or her role as expected. This led to smooth implementation of the group's activities. A facilitator explained during a FGD how his reliance on the PSG members fostered synergy and ensured smooth implementation of their activities, which ultimately resulted in increased enrolment.

I make sure every member felt as part of the group and we saw each other as equals. Everybody contributed to our activities. This inspired everybody to actively participate in the development and implementation of intervention activities and remained committed to the group.

Interdependence among PSG members created a relationship based on mutual respect so that members saw themselves as equals and prevented dominance by a few members. For example, some members led group meetings and problem-solving sessions, while others wrote letters to invite guests, called members to remind them about meeting dates and time and arranged venue for intervention activities. These assignments made members accountable to the group and contributed to achieving positive results. Consistent with this finding is the observation by Williams (2001) that the presence of trust facilitates cooperative behaviour. In his study on ways of developing trust among dissimilar groups, he suggests that managers may structure tasks to ensure inclusiveness and cooperation among members.

In summary, the bottom-up approach, inclusive decision-making and interdependency approaches created a favourable group environment and made it possible for PSG members to talk about issues that bothered them. The PSG facilitators' non-dominance and reliance on members encouraged the members to share their experiences and ideas as well as critically analyse stakeholders' behaviours and practices that negatively affected enrolment. This led to the appreciation of each other's

challenges and influenced the PSG members to see their contribution as valuable in the intervention process and put their shoulders to the wheel while contributing ideas to achieve set objectives. This discussion illustrates how the facilitation approaches influenced PSG members to attend meetings regularly and participate effectively in the intervention to ensure they achieved positive results.

Engaging stakeholders in leadership and professional roles

The key advantage of engaging all stakeholders, including leaders and professionals, in the MSPSP is that it helped reveal multiple perspectives of barriers to enrolment and retention in the NHIS and led to the development of appropriate solutions and implementation strategies. Instead of serving as targets of the intervention, the stakeholders in leadership and professional roles were engaged from the onset and participated in all phases of the MSPSP. The five PSGs (seven PSGs in total) that engaged with the community and opinion leaders, heads and staff of health facilities, DHIS managers and their staff were able to achieve a significant increase in enrolment. For example, in fishing communities engaging community and opinion leaders, chief fishermen, boat owners and *pataase* leaders in implementing intervention activities made it possible to access the difficult-to-reach community members. Similarly, chief farmers' and cocoa purchasing clerks' involvement in the intervention made it possible to reach all farmers. Difficult-to-reach community members included fishermen (who were mostly at sea) and farmers (who spent most of their time in their farms), who could not be reached with community-wide activities such as durbars and house-to-house visits. The support from key specific stakeholders contributed to an increased enrolment in those communities. The two other PSGs that did not engage specific key stakeholders (as mentioned above) failed to increase enrolment.

Health providers and DHIS staff's involvement in the MSPSP helped reduce negative practices such as a preference for cash-paying patients and the sale of drugs covered by the NHIS to insured patients in health facilities. Their contribution as advocates of the NHIS in health facilities convinced people who were sceptical about their commitment to the scheme to change their attitudes. A PSG community facilitator explained in a FGD how they were able to increase enrolment as follows:

We were able to increase enrolment because of the support of boat owners, community leaders, health providers and DHIS staff. All of them took part in executing intervention activities. This made things easy for us to be able to reach everybody. For us [as] community facilitators, our leaders' involvement in the intervention put pressure on us to work hard to sustain members' commitment to ensure success. For example, the nurse who showed her NHIS card to patients actually helped convince many people to enrol.

A community member who enrolled during a mass registration exercise in a conversation explained why she enrolled:

I enrolled because of how our leaders are working with DHIS staff to explain health insurance to us and address our concerns. The nurses' presence in particular showed they support it. Also, holding meetings here and hearing about benefits of insurance from people here convinced me to enrol. In addition, the collector's and volunteer's regular visits to my house, education at schools, churches and the mass registration exercises during the fishing season when we had money was helpful. The more they came to talk to us, the more my children harassed me to enrol them.

A DHIS staff in another FGD explained how they were able to improve enrolment.

The regular meetings made us see the intervention as a collective one and encouraged us to commit ourselves to change community members' attitudes towards health insurance and health providers and DHIS staff's practices that discourage people from enrolling.

These comments and events suggest that bringing stakeholders in leadership and professional roles together to share NHIS related experiences and implementation challenges led to better conceptualisation of the MSPSP and contributed to its success. PSGs' mass registration exercises during fishing and cocoa seasons every fortnight when people had money contributed to PSGs' success in increasing enrolment. These findings underscore the need for collectors to be situated in all communities whether rural, urban or within DHISs' office locations.

The cooperation among these stakeholders built inter-institutional linkages and a synergy that helped achieve positive outcome. The linkages helped mobilise support for the intervention, removed explicit resistance and aided smooth implementation. The synergy that Lasker et al. (2001) point out creates an advantage in collaborations and in the case of the MSPSP it built trust, gave more credibility to the intervention, tapped information about the local environment and made it possible to reach target populations that could not have been reached otherwise.

Robertson & Minkler (1994) observe that treating stakeholders as targets of policies and consumers of problem-solving efforts undermines collaborative effort. The two PSG facilitators who did not involve stakeholders in leadership and professional roles and treated them as objects of the intervention were unable to achieve positive results. This indicates that the significant increase in NHIS enrolment was as a result of the effective engagement of stakeholders in leadership and professional roles.

Trust among stakeholders

The involvement of stakeholders from various levels helps to build ownership and create favourable conditions for the development of commitment to the intervention (Hawkes et al. 2004, Nastasi & Hitchcock 2009). In this study, stakeholder engagement in the PSG intervention fostered changes in behaviour, created confidence in the NHIS and encouraged people to enrol. I observed that the interaction between PSG members and their distribution of tasks to ensure that all parties participated determined their success. Mutual trust among stakeholders seemed to be an im-

portant condition for effective functioning since it reduced the power differentials among the individuals within the PSGs.

Managing tension in PSG intervention meetings

I noticed that the way that PSG intervention meetings were conducted diffused the tension apparent at the beginning that I was worried might lead to confrontation. In one meeting, I observed tension left over from a durbar (organised by the PSG) when people aggressively accused health providers of giving preference to cash-paying patients and malfeasance at the facility. For example, Nurse Julia put up a 'very serious face' before the start of the meeting. She did not smile at any PSG member as she usually does. I could see from her countenance that she was ready to respond in a hostile way if someone said anything negative about health providers. However, the facilitator presented problems identified at all three levels (community, health facility, and national), informed those in attendance about intervention activities that had been conducted so far in the community, and stated that the group was there to listen to the health providers' side of the story. Thus, the tension in the room gradually disappeared. Nurse Julia contributed to the discussion and talked freely about her experience with insured patients.

Supervision of PSGs: regional and local

Supervision of PSGs was instituted to ensure that the facilitators adhered to the MSPSP's general implementation guidelines. NHIA regional managers accepted adding the PSGs' supervision to their routine monitoring of DHISs and DHIS managers or District Director of Health Services (DDHSs)¹ were local supervisors. The supervisors agreed to visit the PSGs quarterly to ensure that they implemented the intervention activities outlined in their action plans at the regional stakeholders meetings organised by the research team.

This monitoring strategy aimed to create linkages between the regional, district and local levels and was informed by Glaser & Taylor's (1973) and Davis & Howden-Chapman's (1996) observations that if an organisational authority structure is bypassed when introducing change, the process can be inhibited. Involving authority structures becomes even more important when the change is initiated from outside the organisation and staff support must be solicited. It was observed in this study that engaging regional and district officials ensured a smooth implementation of the MSPSP and built support across levels. PSG facilitators and members told me that being supervised influenced them to remain committed to the intervention's success. Moreover, since the ultimate goal of the study was to integrate the MSPSP

¹ Only one DDHS was involved in supervising PSGs, and this was because the DHIS manager was the facilitator.

into the DHIS structure, the NHIA regional and DHIS managers' and DDHSs' supervisory roles were expected to make them appreciate the MSPSP and understand how PSGs were formed and functioned so they could facilitate scaling-up if needed. A PSG health provider representative explained why she remained committed to the group:

Our bosses [supervisors] are watching and will be disappointed if we don't achieve positive results. So I have to uphold the confidence they have in me. Also, the Director's presence in some of our intervention activities influenced me to work hard so we could achieve our goal.

Regional supervisors did not perform well

On the part of the regional supervisors, later events indicate that though they accepted monitoring PSG activities, giving them the responsibility over estimated their commitment to the MSPSP. For example, one regional supervisor participated in only one PSG meeting and two intervention activities during the twenty-month period instead of the quarterly visits required. A PSG facilitator shared his thoughts about regional supervisors' performance and reasoned they did not perform their role diligently:

The regional supervisor does not feel personally accountable for the success or failure of the intervention since he does not have to show results. When he came here, he only spoke with Gaby [facilitator and the DHIS manager]. He did not talk to any of us.

I also spoke to one of the regional supervisors to find out why he had not performed his task as expected. He told a research teammate during the course of the intervention that he thought the intervention was over. Though he gave reasons for his inability to visit PSGs, such as not receiving their action plans early enough, I suspect that he did not see himself as personally accountable for the MSPSP's success or failure.

Local supervisors performed well

Local supervisors, on the other hand, showed more commitment and participated in PSG activities regularly. A PSG secretary praised a DHIS manager as follows:

The DHIS manager [local supervisor], compared to the regional supervisor, performed his role better. Unlike the regional supervisor, who only participated in two intervention activities as against the quarterly visits required, he attended meetings and our activities regularly and asked what we are doing. This made us remain committed to achieving our objectives.

These comments suggest that PSG facilitators and members, knowing their supervisors were closely observing them, made a conscious effort to achieve the goals of the MSPSP. However, since enrolment also increased in communities where regional supervisors did not visit, the impression among PSG members was that the regional supervisors did not contribute much to their success. This indicates that more attention should be given to district-level supervision. It is better to engage supervisory authorities closer to the implementation site, in this case the DHIS

managers, rather than those further away to oversee intervention groups. This also gives credence to a bottom-up approach as a major strategy to achieve intervention goals.

Motivation of PSG members

Personal commitment to promote the wellbeing of others was a key motivational factor for the PSGs' success, but monetary incentives were also important. PSG members received a small allowance of GH¢ 8.00 [about US\$5.00] for transport and lunch to encourage them to attend meetings. Nothing was given for participating in intervention activities. I observed that while many PSG members attended meetings regularly and participated in intervention activities, some did not. This raises the question of what actually motivated some to be committed to the MSPSP, while others were not bothered. The following excerpt from a FGD with PSG members reveals what inspired them to participate in the MSPSP and remain committed.

Agnes: Why did you actively participate in PSG activities?

Community representative: Though the allowance of GH¢ 8.00 for attending meetings was important, it was too small to be the main motivator. Nothing was given for planning and carrying out intervention activities. We remained committed because we were seen as capable of ensuring that the intervention succeeds. Also, the marked 'T shirts' by which we were identified sustained our commitment to achieving positive results.

Health providers' representative: We were not given any money for implementing intervention activities, which took many hours. So money was not the main motivator, but recognition of our potential to achieve results. Those who were not active often complained the allowance was too small; they were not bothered whether the intervention succeeded or not.

DHIS facilitator: The fuel I usually buy to come here is more than what I get for attending meetings. But I feel I have to get people enrolled and ensure they receive quality healthcare.

Agnes: What about those who were not regular at meetings and intervention activities?

Community representatives: It is because they were not concerned about the wellbeing of others. In this community, it is common to find individuals organising activities that promote the welfare of others. For example, Baaba [pointing to the volunteer] is not really paid for carrying out activities that promote the health of community members.

Agnes: Auntie Baaba why were you committed to the intervention?

Baaba: Though I'm not paid and only given 'small' money, just like what I do for the hospital, I'm happy to contribute to the community's wellbeing and also happy that the community and health facility recognise my effort as helping improve people's health.

PSG members' levels of participation

I noticed during the course of the intervention that the PSGs devised various ways of making members feel more connected to the group and participate in its activities; unfortunately, insufficient monetary rewards resulted in apathy among some members. Though participation in group activities is often perceived as based on

self-interest (Olson 1965, Ostrom 1990), the findings here suggest that in the PSGs, it goes beyond that and is comparable to what Tocqueville (1840) describes as enlightened self-interest. He observed that though self-interest is seen as primary in people's lives, they commit themselves to social institutions that transcend their private worlds. Tocqueville concluded that both self and social interests are necessary to prevent the pursuit of only private interests to ensure that the weak are not left behind. Thus, the behaviour of non-active PSG members could be described as lack of social interest. They were not ready to sacrifice their time to attend meetings or participate in intervention activities.

Conclusion

Olson (1965) in his analysis of group behaviour observed that most people value social status, personal prestige and self-esteem, which he termed social incentives to group-oriented action that makes the individual contribute towards the achievement of collective goals. In a way, the PSG members' commitment to ensure that everyone enrolled in the NHIS and had access to healthcare was based on social incentives. As PSG members' pointed out, their commitment to the MSPSP was not so much the money they got for attending meetings, but rather the desire of ensuring that almost every community member was enrolled, provided with quality healthcare and not cheated. But underlying this was the value of being recognised among peers and the ability to contribute to the welfare of community members. This notwithstanding, the allowance also contributed to sustaining PSG members' commitment to the intervention. To some, it solved the problem of money for transport to attend meetings. Thus both self-interest and societal interest were necessary to sustain the voluntary spirit and keep people committed to intervention programmes to ensure that the vulnerable in society also have access to collective goods (in this case, healthcare through the NHIS). However, there were others who seemed to see money as their main motivation; hence they were not motivated by the token incentives given to PSG members.

Factors that limited problem-solving groups' achievements

Introduction

The problem-solving group (PSGs) increased overall enrolment in the NHIS. However, disaggregation of the data by community showed that enrolment increased in 11 communities, declined in 2 communities and did not change in 2 communities (see Table A.9, Appendix 2). Thus the intervention failed to achieve positive results in four communities. This chapter examines first which factors might have impeded the functioning of the PSGs leading to some of these disappointing results. In the second half of the chapter, I will reflect on six challenges to health insurance enrolment, which the PSGs failed to improve appreciably.

Factors that impeded the PSGs' functioning

The PSG members attributed their failure to the facilitators' non-adherence to the multi-stakeholder problem-solving programme's (MSPSP) implementation guidelines. Qualitative information revealed four PSG-specific issues that contributed to this failure: (1) facilitator domination of PSGs and lack of trust, (2) stakeholders in leadership and professional roles were not included in activities, (3) no local collectors, and (4) a lack of supervision.

Facilitator domination and lack of trust

Some facilitators down played the importance of making PSG members the designers of the intervention and adopting inclusive decision-making and interdependency approaches in facilitating activities. These facilitators dominated group activities, made decisions without members' consent and did not allow members to play

leading roles. This situation was revealed during my visits to the PSGs where members in a conversation complained about the facilitators' behaviour. A PSG secretary explained the situation in the group as follows:

We lost interest in the intervention because of Gaby's [facilitator, DHIS staff] domineering behaviour. He has turned the intervention into a one-man show. He does not call meetings and do things without informing us and rejects action plans we drew in his absence. This eroded the trust we had in him. Now the group just exists in name. No serious activity is going on.

To check what I had been told, I scheduled a meeting with Gaby and travelled on two occasions to discuss the allegations against him, but he gave excuses so we could not meet. I also sent Gaby a couple of emails about the accusations, but he did not respond or resume the PSG activities. I reported his behaviour to the regional supervisor. Below is an abridged version of an email communication from the supervisor. I changed the names of the community and persons mentioned in the email to protect their identity. Report on my investigation into PSG activities at Mensakrom (abridged version):

Per your request for further investigation into the activities of the PSG at Mensakrom, I made contacts with a number of PSG members to find out first-hand information on their activities. The key observations were:

- Gaby was solely responsible for the activities of the PSG to the extent that when he was not available, decisions and activities planned cannot be carried out. PSG meetings and intervention activities are postponed anytime he is not available.
- Ato [the community facilitator], who is a signatory to the PSG account disclosed that Gaby has about GH¢ 950.00 of the funds for the intervention with him. Gaby corroborated this revelation and pledged to make the money available for PSG activities.

Key stakeholders excluded from the intervention activities

Stakeholders in leadership and professional roles were not involved in the intervention and no activity was organised at health facilities or DHIS offices. An FGD with PSG members at the end of the intervention also confirmed the above observation. The following is an excerpt of their explanation as to why they could not increase enrolment.

Agnes: How can you explain your inability to improve enrolment and retain members in the NHIS?

Community representative: We [PSG members] were ready to work but for Gaby's behaviour. He made the intervention his personal property. We went to his office to complain about the group's inactivity. His behaviour discouraged us so we relaxed. For a long time, no meeting or intervention activity has taken place.

Health provider: We were unable to improve enrolment because we did not follow the intervention guidelines. We did not involve community leaders, health providers and DHIS staff in our activities. Even there is no collector to register those we managed to convince to enrol.

No local collectors

One significant issue was that there were no collectors in two communities out of the seven in the Central Region that registered people who decided to enrol after the intervention activities. Both the health provider above and a PSG community representative in the second group's FGD (the group whose NHIS memberships had declined) below mentioned this problem.

Lack of supervision

Finally, the facilitators' local supervisors – a DHIS manager and a DDHSs – were transferred during the course of the intervention and so did not benefit from supervision. Comments from the abovementioned FGD continue here.

DHIS staff: Our inability to improve enrolment was due to lack of supervision. The supervisors did not do their work well. This made it possible for Gaby to sideline us and do whatever he wants. It was an over expectation on your part that both the regional supervisor and Gaby would perform their task without your supervision.

Further evidence of these four issues related to problem-solving groups' failures

To explore further why the two PSGs out of the seven in the Central Region could not increase enrolment, I engaged members of the second group in an FGD. They also mentioned the four obstacles above as causing their PSGs' abysmal performance. They explained that these problems made people lose interest in the intervention. A PSG community representative explained why they could not improve enrolment as follows:

Our failure was obvious. No regular meetings and intervention activity has taken place for months. Even the few we carried out, health providers and DHIS staff were not involved. No activity was carried out at health facilities and DHIS offices as required. No collector here to register those who we convinced to enrol. The facilitator's domineering behaviour made us lose interest in the intervention.

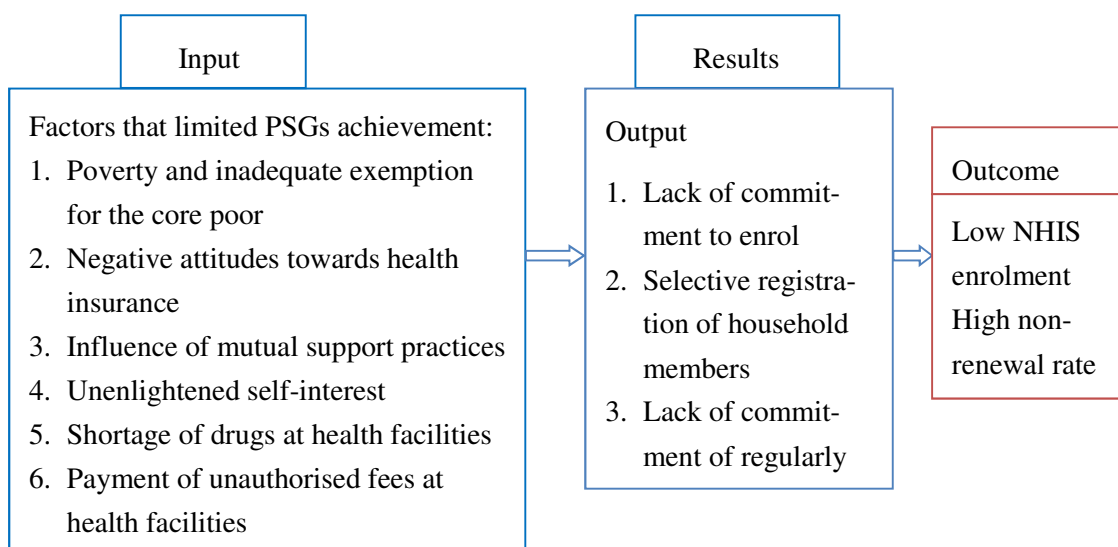
In summary, events in these two communities that did not improve enrolment and the comments illustrate the central role facilitators' played in the intervention. The evidence indicates that the facilitators' dominating behaviour failed to create the trust needed to sustain PSG members' interest in the intervention and eventually stalled PSG activities. Previous findings in similar research have documented that trust is indispensable in collaborative relationships (Gambetta 2000, Currall & Inkpen 2006). Second, the two facilitators' non-compliance with the intervention implementation guidelines largely accounted for the lack of intervention impact. This indicates that supervision was critical to the PSGs' success, since some facilitators are not likely to do the right thing if left alone. As Durlak & DuPre (2008) premise that effective programme implementation is associated with better outcomes. Third, the facilitators failed because they did not follow implementation procedures, engage all stakeholders or make sure that collectors were available.

Finally, they did not promptly address challenges the PSGs faced or motivate them to resume their activities. All of the above mentioned issues could have been managed if the two facilitators had had appropriate supervision. Thus, supervision of facilitators' programme implementation is as critical as the programme's formulation and so must be given equal attention.

Why problem-solving groups failed to achieve maximum impact

This section examines some areas where the PSGs were less successful. The four factors that undermined the PSGs' efforts to encourage significantly more people to enrol and regularly renew their memberships are presented in Figure 8.1. These were poverty and inadequate exemption for the core poor, community members' negative attitudes towards health insurance, the shortage of drugs in health facilities and the requests for unauthorised fees at health facilities.

Figure 8.1 Factors that limited the problem-solving group's achievements



Poverty and inadequate exemptions for the core poor

The NHIS was introduced to ensure equitable access to healthcare particularly for the poor. The law stipulated premium exemptions for the core poor notably identified as indigents. However, literature on NHIS indicates that enrolment among the poor is low (Witter & Garshong 2009, Asante & Aikins 2008, Sarpong et al. 2010). Asante and Aikins (2008) in their study in Eastern and Brong Ahafo Region observed that the poor are not enrolling because the premium was expensive. In this

study, however, the poor indicated that the cost of premium was reasonable and health insurance was better than on-the-spot-payments. So why is enrolment among the poor and the poorest quintile so low? Based on the qualitative information gathered during and after the intervention, two reasons were revealed: people had no or inadequate income to enrol all household members and exemptions were not being granted to the core poor.

The cumulative money required to enrol an entire household was too high for the poor since they have many dependents. One woman explained: “I know insurance is good and the premium is reasonable, but look at me, I don’t get much money from the fish I sell and nobody helps me. How can I insure myself and my five children? I wanted to pay for only the children, but the collector refused.” A boat owner, and community PSG representative, also explained why few poor enrol in the following statement in an FGD.

Many people could not enrol and renew their card because of poverty. These days we go to sea and come back with almost nothing so the small income they get cannot be used to pay for insurance. For the core poor, even money to buy food is a problem. So there are some people who have to be exempted. Look at those people we [PSG members] recommended; only one was exempted. Even that you have to persuade them [the collector and DHIS staff] before they gave it to her.

These comments indicate that the poor’s inability to pay premium is a result of low or no income. For example, the core poor are described as persons afflicted by ‘*ohia buburoo*’ (severe poverty). They did not have regular source of livelihood and engaged in menial jobs that provided an income they could barely live on; therefore, the health insurance premium was beyond their means. There were a few people who wanted to enrol only their children because they felt their children needed to be insured. Some of them came to me asking for help to pay the premium or get an exemption. Others were introduced to me by community leaders for support. Although children are exempted from paying premiums, the NHIRs 2004 (LI 1809: 56) stipulates that they are registered only if a parent or guardian is enrolled. Though this provision has been modified and registration of children 0-5 years of age has been decoupled from their parents and guardians in 2010, parental requests to enrol only their children (below 18 years) was often not granted by collectors.

The poverty literature suggests that the poor remain uninsured because of liquidity and other behavioural constraints, even when they might be better off with insurance. Schneider (2004) in his explanation of low enrolment among the poor in low- and middle-income countries observes that they rely on solidarity from family and friends to smooth out financial shocks related to ill health. However, community support for the core poor in this study during ill health was virtually absent. The reality was often described as follows: “*Abusua dɔ funu sen yarefo*” (The extended family loves a corpse than a sick person). This implies that support is more likely to be provided to extended family members after death for a funeral than during ill

health. Thus, the absence of family support and no or little income to pay insurance premiums make it imperative to grant the poor an exemption to ensure their inclusion in the NHIS. However, like earlier studies, the majority of the core poor in this study did not benefit from exemptions. Witter & Garshong (2009), in their assessment of the NHIS coverage found that exemptions granted to indigents in 2008 formed only one per cent of Ghana's population. Thus, the comments above (combined with our survey results show that 17.6 per cent of the core poor were insured) when compared with the 28.5 per cent of Ghanaians living below the poverty line (GLSS V) indicate that the poor are not benefiting from exemptions.

DHIS representatives often provide explanations as to why they did not grant exemptions to the core poor. They said that the law defines the poor as homeless. PSG members usually rejected this definition. They argued that the criterion was not reasonable, since no one is homeless in their communities, but people were very poor and could not pay the premiums, so they needed to be exempted. Further discussions with DHIS staff and collectors indicated that they were not enthusiastic about identifying indigents for exemptions, but were more interested in revenue generation. DHIS staff's comments and countenance when discussing the issue revealed their unwillingness to undertake activities to identify the core poor who were referred to as indigents in the policy for exemptions. The criteria for identifying the core poor are stipulated in the National Health Insurance Regulations (NHIRs) 2004, LI 1809: 58 as follows:

1. A person shall not be classified as an indigent under a district scheme unless that person
 - a. is unemployed and has no visible source of income.
 - b. does not have a fixed place of residence according to standards determined by the DHIS.
 - c. does not live with a person who is employed and who has a fixed place of residence
 - d. does not have any identifiable consistent support from another person.
2. The conditions under sub-regulation (1) for ascertaining who is an indigent shall be incorporated in the registration form of a district scheme.
3. A person assigned the duty by a district scheme of registering persons for the scheme, shall elicit the information required under the sub regulation (1) for the classification of indigents as part of the registration process.
4. Every district scheme shall keep and publish a list of indigents in its area of operation and submit the list to the NHIA for validation.

Though these criteria are restrictive, the DHISs seemed uncommitted to undertake any activity to identify the poor. Their decision was often based on the financial implications for their offices and not the fact that the core poor could not be identified. As stated in 1b above, the DHISs have the mandate to determine what applies in their district regarding the homelessness criterion. However, they used this criterion as an excuse for not exempting the core poor. The following comment by a DHIS staff illustrates their attitude towards granting exemptions to the core poor.

We use the homelessness criterion, which disqualifies almost everybody, but go to the aid of those who cannot pay their hospital bill when referred to us mostly by the facility authorities. We need money so if we go to communities and tell them about exemption for the core poor, how do we get revenue?

This comment indicates that although identification difficulties exist, the lack of commitment to ensure the core poor's inclusion in the NHIS contributes to their low enrolment. This finding supports earlier work that exemptions in Ghana have not achieved their goal (Nyonator & Kutzin 1999, Garshong et al. 2001, Badasu 2004). In her review of exemptions under the user-fee regimes, Badasu (2004) cited a lack of specificity of identification criteria and financial reimbursement as the main causes of their failure. This study found that the problem is wider. The main problem was DHISs' lack of interest in implementing the policy. They pursue activities to enrol premium-paying members and virtually do nothing to identify indigents thus causing their exclusion from the NHIS. Their emphasis on the homelessness criterion, a situation that does not exist in their districts, and disregard of the local conditions stated in the policy such as unemployment and no visible source of income that could be used to identify indigents, illustrate the DHISs' staff and collectors inattention to the exemption policy. As the manager indicated, they waited until people cannot pay their hospital bill before going to their rescue and granting them an exemption. Throughout my fieldwork, I did not see DHISs' staff or collectors make a conscious effort to ensure that the core poor were identified and enrolled.

To conclude, the condition of the core poor makes it imperative to grant them exemptions to ensure their inclusion in the NHIS. However, it appears that the DHISs focus more on their revenue-generating function to the exclusion of exempting the core poor from premium payments, thereby denying them access to healthcare. The revelation that the NHIS is not reaching the poor, as expected, calls for a rethinking of the exemption policy. Monitoring the implementation process and devising more effective strategies to ensure that the NHIS' goal of removing financial barriers to access to healthcare services, are needed.

Negative attitude towards health insurance

By the end of the intervention, community members generally acknowledged that health insurance protects the insured against catastrophic healthcare expenditures and so perceived the NHIS as better than cash payment at health facilities. There was also the view that they had a better appreciation of the health providers' heavy workloads and that discrimination against insured patients has reduced. As a result of these positive observations, all those who participated in the intervention expressed disappointment about the generally low levels of enrolment and high non-renewal rates. More surprising was the less than 50 per cent enrolment among the rich (46%) and richest (44%) quintiles and high non-renewal rates of 24 per cent.

This indicates that the general low enrolment and retention rates were not because of poverty. Collectors said they were not too surprised and maintained that only a few people renewed their cards promptly; others waited until they needed healthcare. The following excerpt from a FGD with PSG members provides some of the reasons that account for low enrolment despite the PSGs efforts to improve enrolment and renewal rates.

Agnes: Why have some people never enrolled in the NHIS?

NHIS collector: Despite the education about health insurance, many people still say I'm not often sick. As we have been discussing their participation in traditional mutual support groups influence their behaviour. People join only when they are sure of benefitting. We describe it as: 'You reap as you sow'. Men in particular say health insurance is for children and women who often go to hospital.

PSG secretary [health provider]: The low interest in health insurance, though improved, has not changed much. They know health insurance is important, but will not enrol until they have a serious sickness. Many delay and come to the hospital with complications to disturb us.

Agnes: What about those who do not renew their membership?

Community PSG facilitator: Insuring against ill health, we all know, is not part of our culture. What we know is to regularly pay funeral dues because we know we will benefit. This explains why people are reluctant to renew their NHIS card every year, especially if they have not gone to the hospital. When you ask them they say *meretwen kakra* (I'm waiting for a little while). But they will rush to renew when they are sick. Some renew only after they have been admitted to the hospital.

Community representative [GPRTU¹ chairman]: If health insurance was treated like motor insurance all drivers would have been insured. People don't care because nobody is punished for not enrolling or having a valid health insurance card. We would have consistently renewed our cards if we were punished as it is done in the case of motor insurance.

Influence of mutual support practices

I also met a few people at DHIS offices who were renewing their NHIS cards because they were sick and others who came to enrol because they needed healthcare. For example, during one of my routine observational visits to a DHIS office, I met Joe who looked desperate and asked him what was wrong. He responded angrily: "Madam I thought I didn't need health insurance but for this sickness. Now I've registered and my card is delaying." When I queried him further, he said: "I need the card to go to hospital for hernia surgery."

Joe's comment and PSG members' views expressed above reveal that the community members' conceptualisation of the NHIS is still influenced by the traditional mutual support group they participate in. The comments also indicate that although many people accepted the NHIS as better than on-the-spot payment and recognised the need to enrol and renew their membership; this did not translate into action.

¹ Ghana Private Road Transport Union

Hence, there was a pervasive risk-averse attitude towards health insurance and adverse selection (enrolling only family members who appear to be at risk) that made it virtually impossible for the PSGs to get more people to enrol and renew their membership regularly. These attitudes are extensively reported in the literature on health insurance schemes in Sub-Saharan Africa as undermining their expansion (Arhinful 2003, Criel & Waelkens 2003, Kamuzora & Gilson 2007). In their study of a Community Health Fund (CHF) in Tanzania, Kamuzora & Gilson (2007) observed that non-acceptance of paying before falling sick undermines the expansion of the CHF, but they did not explain the reason behind this attitude.

This study found two main reasons underlying people's decision to join or not join and remain in the NHIS. First, and ironically, local insurance traditions do not help convince people to join the NHIS, but rather discourage them to do so. Indeed, traditional mutual support practices have negative influence on people's attitude towards health insurance. Analysis of their operation shows that though they have a health insurance element, their operational guidelines for risk-sharing principles are not the same. In a review of the concepts underlying traditional risk-sharing, Platteau (1997) noted that traditional mutual support schemes are based on balanced or generalised reciprocity, while insurance is based on conditional reciprocity. Under balanced and generalised reciprocity, people receive as much benefit as they contribute. For conditional reciprocity, on the other hand, insured persons receive a return only if they fall sick. The 'reap as you sow' principle observed among traditional support groups facilitates cooperation and exchange of services and obligations among members, but they are largely based on balanced reciprocity and the certainty of benefiting. In many of these groups, such as *nnoboa* and savings and loan arrangements used to manage livelihood activities, the benefits are largely proportional to one's contribution and not need. As already stated, in the case of *nnoboa*, people join only when they need support to sow and harvest crops and weed their farm and pull out from the group until another farming season.

Other groups such as *pataase*, which focus on life events, mainly death, are well patronised because they cover the funeral costs of the members, their spouse, children and parents. So people join and remain committed because they are sure of benefitting. Explanations provided by key informants indicate that they perceive the NHIS' benefit as limited in scope and only for the individual. For example, death is seen as certain so one has to contribute towards it, hence the preference to pay funeral dues. Sickness, on the other hand, is perceived as a random event, which the healthy believe might not befall them, so they are reluctant to enrol and remain in the NHIS. Thus the logic of not enrolling in the NHIS was that it is a risk-sharing arrangement where their investment may not benefit them. This explains why only household members who are likely to need healthcare are enrolled. This practice is

technically referred to as 'adverse selection' and contributed to the low enrolment and renewal rates among the average and rich quintiles.

Many respondents expressed the view that despite complaints of shortage of drugs and payments of unauthorised fees, being insured was still better than cash payment at health facilities. So they rush to register or renew their membership only when they need healthcare. This indicates that they appreciate the benefits of health insurance, but apply the reciprocity principle of traditional support groups. This attitude negates the policy makers' assumption that because many Ghanaians already participate in traditional mutual support networks they will willingly enrol and remain in the scheme. Rather, the incentive for enrolling and remaining in the NHIS is based on individual gains and largely informed by their health status and not a motive of embarking on a risk-sharing endeavour that requires the commitment of all to succeed.

Unenlightened self-interest

Joe's case conveys the pervasive nature of community members' risk-averse attitude towards health insurance. PSG members' assertions that apart from the core poor and poor people with many dependents, anybody willing to enrol all household members and renew their membership can pay a premium of GH¢ 14 [US10.00] and registration fee of GH¢ 4.00 [US2.50] per annum illustrates that the 'wait and see' attitude was not due to poverty. Thus the views and observations above show a pervasive negative attitude towards health insurance. This finding is consistent with earlier work on enrolment in SHISs and CBHISs. In his study, Arhinful (2003) explored the reason why people do or do not enrol in health insurance schemes in Ghana and found that the motive of enrolling is a self-interest goal of averting risk. In another study, Criel & Waelkens (2003) made the same observation when they explored reasons for low enrolment in the Maliando Scheme in Guinea Conakry. They found that poverty was not the most outstanding barrier to enrolment, but rather there were other behavioural constraints. In the current study, a careful appraisal of the discussions suggests that apart from the core poor and the poor, the 'no money to pay' and 'I am waiting for a while' excuses for not enrolling or renewing their membership were socially desirable reasons to cover less worthy motives. The fact that people quickly enrol or renew their memberships when they need healthcare illustrates that though people have accepted that the NHIS is better than on-the-spot payment and appreciate its implementation challenges, they comfortably adopt strategies to derive maximum benefit with minimum financial investment. I call this 'unenlightened self-interest' because eventually the situation will turn out to be less advantageous for the people. They will pay more when they have to access healthcare without health insurance since the cost of treating malaria almost equals the cost of premium. Their action is also a threat to sustainability of

the scheme, which requires regular contributions into a common fund so that those who fall ill will be catered for to ensure individual and societal progress.

Summarising, some people's reluctance to enrol and renew their membership in the NHIS is influenced by their knowledge of traditional risk-sharing arrangements. However, it needs to be pointed out that even in such networks, tendencies for exploitation exist, but sanctions are used to ensure fulfilment of the agreed arrangement based on trust. Mutually agreed sanctions are effectively applied to prevent exploitation for individual benefits. Unfortunately, in the case of NHIS, lack of enforcement of such mechanisms, perpetuates risk aversion and adverse selection practices where people rush to renew their cards only when they needed healthcare without paying penalties. As Putnam (1995: 67) points out: "When economic negotiation is embedded in dense networks ... , incentives for opportunism arise." It is to check such opportunistic tendencies that the NHIRs 2004 LI 1809 59(1)² needs to be applied to sanction defaulters. As a GPRTU chairman indicated, many people did not enrol or renew their membership because there was no sanction to discourage them.

Finally, for any intervention aimed at promoting the NHIS to achieve maximum impact, it is critical to identify issues in the social environment and conditions under which traditional risk-sharing network operate, educate people about the similarities and differences, and enforce regulations that prevent exploitation of the scheme. This suggests that a more practicable way of moving the NHIS towards universal coverage is needed.

Shortage of drugs in health facilities

The shortage of drugs³ was a concern for both community members and health providers. Both saw it as undermining healthcare delivery to insured patients and by consequence limiting the PSGs' efforts to improve NHIS enrolment and retention of members.

In the case of the community members, there was consensus that people enrolled because of the PSGs' assurance that they would receive quality service, which to them included being given drugs at health facilities. So when this expectation was not met, and the community members were given prescriptions to get drugs elsewhere, some decided not to renew their memberships. This situation also discouraged people from enrolling. Insured patients were mostly concerned about going

² The NHIRs 2004 LI 1809 59(1) states that a member of DHIS who defaults in the payment of contribution for a period exceeding three months shall be suspended from the scheme and reinstated after paying all the contributions in arrears, a penalty of 50% of the total contribution that is due. The defaulter is reinstated but will only enjoy benefits after three months from the date of re-instatement.

³ Shortage of drugs may not always be the right term. The problem can also be the inability to obtain certain drugs because they are not on the Health Insurance Drug List. The drugs may be available in the facility but only for those who pay cash.

round looking for accredited pharmacy and chemist shops to fill their prescriptions. I must state that although these shops are supposed to augment the drug supplies at health facilities, they do not exist in all the communities where health centres and hospitals are located. In such cases, patients have to travel to other towns when given prescriptions. In this respect, insured patients blamed health providers and DHIS staff for not doing enough to ease their frustration of looking for drugs outside health facilities. Many of them spoke about how they had to pay for drugs covered by the NHIS in some health facilities and accredited pharmacy shops. One man expressed dissatisfaction about seeking healthcare with the NHIS card and did not renew his card. He explained why he made this decision:

I enrolled because I wanted to live without worrying about how to pay for my healthcare. I expect to get all my drugs at the hospital without payment. I was disappointed when I got a prescription to look for a drug store that serves people with health insurance card. I had to travel to another town. I did so but ended up paying for the drug. That's why I decided not to renew my card. They should tell us the truth so we know what to expect when we seek healthcare instead of telling us 95% of diseases and drugs are covered; yet we end up paying. What then is the advantage of being insured?

In a FGD, a PSG community representative narrated how he had to pay for drugs at a facility as follow:

Though I protested when I was asked to pay for the drug, I had to give in. They explained they got it from a private person and gave me the option to take a prescription. Because of the trouble of going round to look for accredited shop, I decided to pay.

I also observed insured patients' dissatisfaction from their facial expressions when they were given prescription to get drugs from outside health facilities. Their disappointment was about how to go round looking for accredited shops and having to pay for the drugs. The complaint about payment for drugs by insured patients was supported by our survey results which show that the majority (64%) of currently insured respondents in intervention communities agreed that: "Even though one is insured you still have to buy drugs" (Table A.11, Appendix 2).

Giving patients prescriptions is not new in Ghana, but insured patients have an extra burden of spending hours locating an accredited pharmacy or chemist shop to obtain the drugs without paying. Their dissatisfaction increases, especially when they had to travel outside the health facility's location and have to pay. Many key informants argued that the burden of roaming around looking for accredited shops and paying for drugs did not make the economic sense of enrolling in the NHIS and consistently renew their card especially when they did not regularly access healthcare.

In the case of health providers, their concern was that though they strived to improve service delivery, they could not always meet insured patients' expectation of providing all drugs they need at the facility. They attributed the situation to drug administration and acquisition guidelines under the NHIS regime outlined as

follows. Only drugs included in the Health Insurance Drug List are used to treat insured patients. These drugs are purchased from the Regional Medical Stores (RMS) and can only be bought from private suppliers after obtaining a non-availability certificate⁴. They complained that the bureaucracy involved in obtaining the non-availability certificate negatively affected their stock management. They maintained that this arrangement for purchasing drugs in addition to delays in claim payment made it difficult for them to purchase drugs promptly and in enough quantities to meet patients' needs. A Medical Assistant described the situation as follows:

We are expected to buy drugs from the Regional Medical Store and can only buy from private suppliers if we get non-availability certificate. Getting the certificate is not a one-day issue. Sometimes we go there several times before getting it. So it is not possible to buy such drugs immediately to meet patients' needs. Also, though claim payment has improved, sometimes only 60%, 70% or 80% is paid. For example, 60% of the April bill was paid in August and the remaining 40% this month [September]. We are yet to be paid the bill submitted for May. All these make it impossible to get drugs to meet patients' needs and do not help in promoting health insurance.

Our post-intervention survey results confirm the concerns expressed by both insured patients and health providers that shortage of drugs in health facilities leads to dissatisfaction among insured patients. The result shows that an overwhelming majority (83.7%) insured respondents and (90.3%) previously insured respondents indicated that: "Availability of drugs at health facilities should be improved" (Table A.11, Appendix 2). This illustrates the critical role of obtaining drugs at health facilities in determining satisfaction about the quality of service and its contribution to the gap between what insured patients expect and what is actually delivered.

In Ghana, drugs are perceived as a significant component of healthcare delivery. Drugs are symbolic representation of health facilities and their availability creates a positive image of a particular facility and adds value to health provider-patient clinical encounter. As Whyte et al. (2002) point out, drugs are part of everyday life of Ghanaians and important for their survival. They show that drug use is common among Ghanaians and doctors give medicines to satisfy their patients. In another study, Van der Geest et al. (1996) observe that health providers see drugs as indispensable in their encounter with patients while patients also expect to be given drugs to solve their problems. Both studies thus show the significant place that drugs assume in any clinical encounter between patients and health providers in Ghana. Most insured patients in the current study asserted that the essence of enrolling in the NHIS was to seek care at a health facility and obtain drugs for their ailment. Therefore, the absence of drugs reduces the level of satisfaction of the clinical

⁴ The non-availability certificate is given by the Regional Medical Stores to enable public health facilities buy drugs they do not have from private suppliers before they can be paid by the NHIA.

encounter. In fact, both insured patients and health providers' concerns show how absence of drugs undermines quality of service. The finding thus confirms the observation that the shortage of drugs in health facilities eroded the confidence that the PSGs created in the NHIS and undermined their efforts to improve enrolment and retention rates. For many people, enrolling and remaining in the NHIS is determined by whether they were given drugs at health facilities or not. To such people, a single episode of paying for drugs or going round looking for an accredited shop may make them decide not to renew their membership.

Payment of unauthorised fees at health facilities

Though the NHIS has no co-payments, there were reports of payment of fees by insured patients at health facilities. This generated the most heated debates as a factor that limited the PSGs' efforts at improving enrolment and retention rates. According to PSG members, the reason why this practice (though reduced during the intervention) could not be eliminated was because payment of unauthorised fees is a public sector phenomenon and impossible for PSGs to eliminate alone. They asserted that many public sector workers devise ways of collecting such fees for services rendered to clients to earn extra income. They explained the practice helps them 'make ends meet', that is, to be able to meet one's expenditures considering the low salaries. This practice has already been discussed in chapter two and has also been documented by earlier studies (see Agyepong 1999, Armstrong 2006, Gyimah-Boadi 2004, Aryee 2005). Here, I discuss another component of the phenomenon revealed in the course of the intervention and emphasised during FGDs. It was observed that some health providers use the excuse of inadequate resources and delays in claim payment to collect money from insured patients. An insured patient explained the situation follows:

We all know health providers have been collecting unofficial fees from patients under the user fees but people complain less because we are not sure which of the money we pay is approved fee or not. But now we [insured patients] know we don't have to pay, so when I had to pay for drugs covered by the NHIS, I argued with them, but had to pay. I saw it as cheating.

Some health providers, reacting to these allegations cited delays in NHIS claim payments and insufficient logistics as reasons for collecting money from insured patients. Others agreed that the practice is bad and tarnishes their image. Community members and DHIS staff in their reaction did not accept the explanation of inadequate resources and accused health providers of exploiting insured patients. A facilitator, DHIS staff, shared the group's frustration in addressing this allegation as follows:

We could not eliminate the collection of unauthorised fees because it is an open secret that many of them [health providers] benefit from such fees they called welfare, ward funds, doctors' fees and others. We do not have any way of checking whether the money is used to purchase essentials for the facility or goes into their pockets. For us, what we know is that when you have for

example, malaria and you go to the hospital; you don't have to pay anything. So we see it as cheating and this discourages many from enrolling and renewing their card.

Nurse Anas, a PSG member, in her reaction to this allegation, accepted that collection of unauthorised fees is a challenge that could not be resolved by the PSGs alone. She shared her thoughts in the following statement:

We can't deny that we sometimes collect unauthorised fees. Some of those monies are used to purchase certain things we need in the facility. To eliminate the practice, the authorities must provide adequate funds and the NHIS claims paid promptly. If that doesn't happen, then those who hide behind that will not stop. We should also understand that it takes time for such changes to happen.

The above comment indicates that the practice has been going on in health facilities, but was not reported by patients because it was not evident which fees were legal. For insured patients, it is obviously illegal when they are asked to pay for services and supplies that they know are covered by the NHIS. The tag of cheating assigned to the practice indicated that insured patients see the fees as preventing them from enjoying the free service they are entitled to having prepaid. Thus, asking them to pay such fees was a disincentive to register all members of their household, especially those who did not have an immediate need for healthcare. In the case of the poor, such payments discouraged them from spending their meagre income to enrol and renew their membership. These findings indicate that while the NHIS is intended to ensure equity in access to healthcare and protect people against catastrophic expenditure, frontline staff expected to facilitate its implementation make it expensive (especially for the poor) to enrol and remain in the scheme.

To some extent, the health providers' explanations could be a genuine attempt to maintain their stock level while they wait for reimbursement of NHIS claims. But the genuineness of these rationales is a matter of concern and needs to be addressed together with delays in reimbursement to increase confidence in the NHIS and build trust among stakeholders. As Mechanic (1998) observed, patients' trust in health providers to act in their interest is crucial for health insurance enrolment. Failure to do this will make it virtually impossible to sustain confidence in the NHIS. The consensus among PSG members regarding payment of authorised fees was that no matter the genuineness of the intention, the practice added to the cost of enrolment. Illegal fees discourage people, especially those who do not use services regularly, from enrolling and renewing their membership consistently.

As a concluding remark on the PSGs' limited achievements involving local level actors, though effective, could not adequately address all the NHIS implementation challenges within the twenty-month intervention period because some were systemic and needed policy level action. Other challenges were attitudinal and therefore difficult to change and required more understanding of the social environment. Extended time is needed to engage community members and their leaders for any meaningful change to take effect.

Conclusion

A multi-level approach was used to assess the impact of a MSPSP programme on enrolment and retention in the NHIS. The results show that the space the PSGs created for interaction among stakeholders led to significant increase in enrolment, but could not improve retention rates. The bottom-up, inclusive decision-making and interdependency approaches that facilitators employed in conducting PSG activities, monetary and non-monetary incentives for members and supervision of the group contributed to MSPSP's success. These sustained the PSGs' commitment to the intervention. In addition, effective involvement of community leaders and professional stakeholders in the intervention activities built trust between them and PSG members and nurtured synergy, which facilitators utilised to reach all target populations in the intervention. This finding makes it clear that the DHISs acting alone cannot manage the complex mix of problems and build the trust network required to address the issue of low enrolment in the NHIS.

However, the findings reveal multi-dimensional factors that hindered the PSGs' efforts at improving enrolment in the NHIS and retaining members and made it virtually impossible to adequately address all the identified NHIS implementation challenges. Thus involving local level actors though effective, did not adequately address all the challenges. Factors that were identified that limited the PSGs' success included poverty, community members' negative attitudes towards health insurance, shortages of drugs in health facilities and payment of unauthorised fees. These were found to be systemic and their elimination was not possible within the twenty-month intervention period. There is a need for policy-level action to change some aspects of the NHIS operational guidelines. Other challenges were attitudinal and so they were difficult to change within the intervention period. This change requires more understanding of the social environment to develop appropriate intervention activities. Finally, working on the psyche of all actors involved in implementing the NHIS to make accessing healthcare with NHIS card more attractive needs extended time to engage DHIS staff, health providers, residents and their leaders for meaningful change to take effect.

The next chapter is the synthesis of the key findings of the study. I present an appraisal of the MSPSP and discuss why people enrolled or did not enrol in the NHIS, and why they renewed or did not renew their membership. I also provide the conclusions of the study, policy recommendations to enhance NHIS implementation and improve uptake and points out areas for further research.

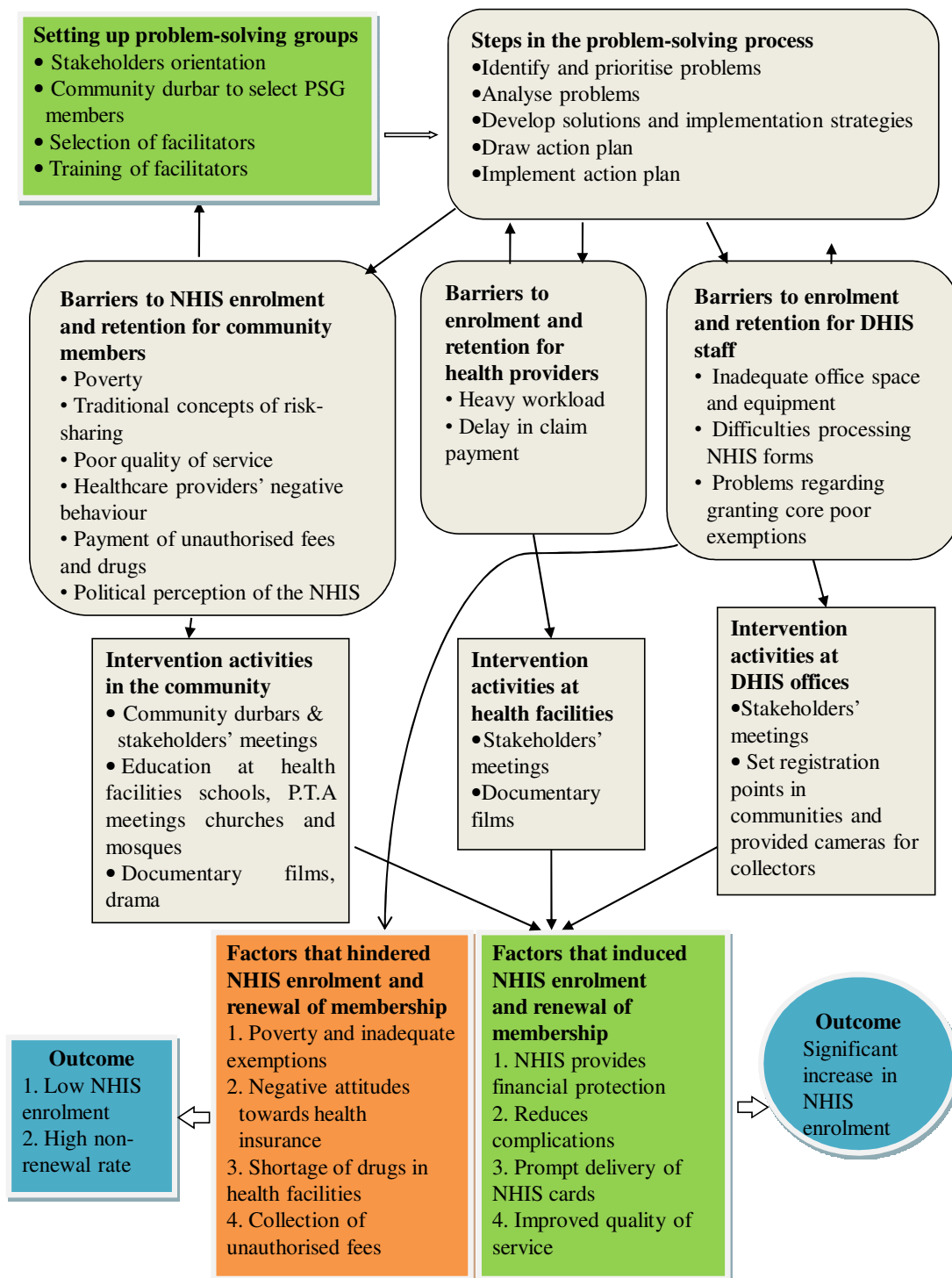
Discussion and conclusions

Introduction

With a shift in health financing policies from fee-free to cost sharing, many countries in Africa are setting up health insurance schemes to reduce inequity in healthcare access. In Ghana, the National Health Insurance Scheme (NHIS) was introduced in 2004 to ensure equity in access to healthcare as the cost of treatment denied many people formal care. However, NHIS' coverage remains low and the poor, who are the primary target, are less represented. This study developed a multi-stakeholder problem-solving programme (MSPSP) to improve NHIS enrolment and retain members, especially the poor. Figure 9.1 presents the pathways of the MSPSP and outcomes. The programme started with the creation of problem-solving groups (PSGs) which consisted of representatives of community members, health providers and district health insurance schemes' (DHISs) staff in intervention communities. The figure also shows the barriers identified by the PSGs at the onset of their work and the various activities carried out to address them. The intervention outcome shows that PSG activities led to a significant increase in NHIS enrolment, but could not improve retention rate due to poverty and inadequate premium exemptions, negative attitudes towards health insurance, shortages of drugs at health facilities and collection of unauthorised fees. This indicates that local stakeholder collaboration to address policy implementation barriers, though helpful, is not the panacea to all the challenges.

In this chapter, I synthesise the outcomes of the intervention in six main sections. I start with theoretical reflections taking up the concepts of multi-level perspective, resilience and trust to discuss factors that influenced people to enrol in the NHIS and renew their membership and how the PSGs were able to increase enrolment. Next, I

Figure 9.1 Schematic representation of the MSPSP and the outcomes



discuss the reasons for persistent low enrolment and high non-renewal rates. Then, I present my conclusions followed by recommendations. I end the chapter with areas for further research.

Understanding the findings

The introduction of the national health insurance scheme (NHIS) in Ghana was part of a social development agenda with the goal of ensuring equity in access to good healthcare. Promotion was based on stimulating solidarity values among community members to inspire them to enrol. In this section, I put the findings into theoretical context using the concepts of multi-level perspective, resilience and trust that were introduced in the first chapter of this book. Each section begins with a brief explanation of the concept and its relevance in understanding enrolment in health insurance and retention of members.

Multi-level perspective

The multi-level perspective (MLP) means looking at issues and events associated with a subject of study across different levels and actors to provide a more complete description and credible explanation. The perspective allowed me to conceptualise the NHIS based on the premise that it is an enterprise with various actors situated at different levels of the healthcare delivery system. These actors are stakeholders and include politicians, policy makers, district health insurance scheme (DHIS) staff, health providers and community members who are active agents involved in the NHIS policy making, implementation and uptake. I conceived the NHIS as a multi-level enterprise because enrolees and DHISs' staff are only linked by premiums and the healthcare providers contracted to provide services for a fee. In this sense, the stakeholders involved in this transaction (the NHIS) strive to maximise their interests thus affecting the success or failure of the enterprise. The MLP helped me to capture stakeholders' interests, behaviour and practices as well as contextual factors that affect the achievement of the NHIS' policy goals. Critical analysis of the NHIS indicated that the interests of various stakeholders interacted to affect enrolment and retention rates. For example, although stakeholders generally accepted the NHIS as better than on-the-spot payment to ensure equity in access to healthcare, the pursuit of their own interests undermined the attainment of policy goals. For instance, politicians, in their desire to win power, rushed to introduce the policy without adequate public sensitisation and education about the scheme's underlying principles. There was little opportunity to build consensus among other stakeholders or to scale up the capacity of health facilities to handle the expected increase in utilisation of healthcare services. These two issues created resentment among some community members and health providers who associated the NHIS with party politics and this undermined enrolment.

The MLP also revealed that a new policy can be introduced by a government to improve the wellbeing of the citizens, but the expected change(s) are affected by several factors from various angles that interact to either hinder or enhance its uptake. Long (2001), in his analysis of development policy, argues that discourses

are introduced by an institution, such as the state, but it is the actors (individuals or institutional representatives) who use, manipulate and transform them. In the case of the NHIS policy, as a new healthcare payment mechanism to improve access to healthcare, the decision to enrol or not to enrol depended on community members' ideas about health insurance despite the fact that all stakeholders appreciated the insurance scheme. Community members' interpretation of the NHIS was often rooted in traditional discourse about risk- and cost-sharing. They applied existing knowledge and held their personal gains above attainment of policy goals. This indicates that targets of public policies are not just objects without agency, but play roles that determine a policy's success or failure. Arhinful (2003: 150) also noted that enrolling in health insurance schemes is based on self-interest. He wrote:

People's motive for participating in an insurance scheme in the present social context is therefore based first and foremost on what they believe would best advance their own self-interested goal of averting a risk or securing a gain for themselves.

In the current study, one can argue that since our post-intervention survey results showed that the majority (59.7%) of the general population did not have a valid NHIS card and 37.3 per cent had never enrolled the NHIS' benefits of ensuring equity in access to healthcare was not appreciated or pursued equally by all stakeholders. As I discuss later in this chapter, the poor – the primary target of the policy – seem not to be the priority of politicians, policy makers, implementers and rich community members. DHISs staff held their institutional interest and personal gains above the attainment of policy goals. They focused on revenue generation at the expense of exempting the core poor. In the case of health providers, while some persuaded people to enrol, others were hostile towards insured patients because of the increased workload that accompanied the NHIS. The rich saw health insurance as a less pressing issue than funeral contributions, so they did not share the NHIS costs by paying premiums according to their incomes. They also did not help poor family members enrol, because it did not bring the same prestige as contributing towards their funerals. All these conflicting interests culminated in low enrolment and retention rates with the poor being the most affected.

A focus on the MLP helped reveal the complexity of health insurance. What seems to be an unambiguous concept to enhance equity in access to healthcare appreciated by all stakeholders can provoke diverse reactions. The MLP helped explain why and how various stakeholders at multiple levels (and sometimes even at the same level), reacted in ways that conflicted with policy goals. Their actions usually benefited the stakeholders themselves and not the objects of the policy goals – the poor. The MLP disclosed the pragmatic realities of the NHIS and provided information on the rather egocentric motives that engulfed it. The lack of enthusiasm to genuinely pursue policy goals and address the actual challenges that implementers and targets of the policy face became apparent.

Finally, implied in the MLP is its contribution to policy change. In this sense, stakeholders must participate in the process of bringing about change or accomplish change through advocacy. The MSPSP and the positive result – an increase in enrolment – demonstrate MLP's relevance in intervention practice especially in anthropological research. In this regard, Scheper-Hughes (1990: 190-196) suggests:

We [critical anthropologists] are to put anthropological knowledge at the service of the power brokers. ... Medical anthropology should exist for us as a discipline and as a field of struggle. Our work should be at the margins, questioning premises, and subjecting epistemologies that represent powerful, political interests to oppositional thinking.

Taking such a stance and pursuing this agenda means advocating for the poor and projecting how the interest of politicians, policy makers, service providers and community members undermine the attainment of NHIS' equity agenda. We must engage these stakeholders to discuss the NHIS implementation challenges that arise and devise activities to improve their behaviour and practices. Such interventions should be multi-level-oriented, involve stakeholders and aim to: (1) develop community-oriented mechanisms to pursue the NHIS' equity agenda and (2) improve the quality of healthcare service by making health providers and community members' concerns the basis of reform. The long-term effect will undoubtedly be a reduction in health providers' workload, improvement in their behaviours and quality of service and an increase in the exemptions granted to the core poor. At the community level, the continuous inclusion of all stakeholders in discussions is likely to result in positive attitudes towards health insurance, a reduction in adverse selection and ultimately move the NHIS toward universal coverage.

In conclusion, the earlier chapters have shown that the MLP provided an in-depth understanding of the factors that influenced enrolment and retention in the NHIS. It revealed the multiple layers of the NHIS and the need to use a critical medical anthropological lens to identify and address the challenges. It proved a useful approach for interpreting the stakeholders' interests, behaviours and practices and the social context in which the health insurance scheme operates. The MLP thus proved an effective tool for PSGs to address the stakeholders' conflicting interests and build an equitable health insurance scheme. This knowledge might help develop appropriate intervention activities to improve the implementation and uptake of health insurance in Ghana and other countries.

Resilience

Resilience refers to the ability to maintain normal functioning despite exposure to adversity. Niehof (2008: 217) in her analysis of the concept of resilience describes it as follows:

The concept of resilience overlaps that of vulnerability. The vulnerability context is an important factor in people's ability to 'bounce back' when faced with adversity and it is the context in which entry points for supportive policies and programmes should be identified

In the context of ill health, resilience refers to people's strength to reduce their vulnerability to sickness and recover from or live positively with their disease. This strength is conditioned on both personal strength and a supportive environment. These two dimensions of resilience, inner power and external factors, interact to strengthen patients to regain their health or cope with their sickness. Thus people's purposive action to harness external support is important in the development of resilience. The monetisation of healthcare has made economics a prominent feature for resilience during the therapeutic process especially in patients with chronic diseases. This makes resilience relevant in a health insurance discourse.

In Ghana, the NHIS was introduced to provide a fall-back position for people who were ill. From this perspective, I conceive the NHIS as an important mediating factor in the interface between vulnerability and resilience when someone is sick. Sickness often leads to a depletion of resources and decline in wellbeing; so, external support is needed to strengthen patients' recovery from or ability to cope with their disease. Given the focus of this study – reaching the poor in the NHIS – the question is whether the NHIS is helping sick people mitigate the adverse effects of ill health? The concept of resilience is thus useful to address the question of whether or not the NHIS strengthens the poor and vulnerable to manage the adversities of ill health and maintain normal functioning. Resilience provides a framework to examine two main issues: why people enrol and remain in the NHIS and what contributes to low enrolment among the poor and core poor.

First, I interpreted the community members' responses and actions in regard to the NHIS using the concept of resilience. This approach revealed that people enrolled and remained in the NHIS because it helped them address the adversities of ill health. It was apparent that the NHIS provides people who are ill with the security of healthcare and fills the gap of inadequate or no support from extended family members. In the past, seeking healthcare did not involve much money and payment could be in kind. Therefore, it was easier for extended families to arrange treatment for sick members and offer them material and emotional support (see Arhinful 2003). But this support has dwindled and is now virtually absent in Ghana. Kumado & Gockel (2003), in their study of social security in Ghana, also reported a breakdown in traditional social and economic support provided by the extended family for vulnerable members and called for a state-sponsored form of social security. Traditional support that helped build resilience during ill health in the past has lost its value due to the monetisation of healthcare. As the cost of healthcare increases, more financial resources are needed to support sick family members. Nuclear family members, who now bear the burden of caring for sick members, might be in a precarious economic situation and unable to provide the needed financial support to enable sick people to seek healthcare and enhance their resilience during ill health. Health insurance is expected to replace the traditional family as

a source of economic resilience in times of illness. As Arhinful's (2003: 120) study in Ghana indicates, people had a favourable perception of health insurance: "Community people conceptualise the value of health insurance in terms of its economic, psychological and social support attributes." Key informants mentioned similar attributes of the NHIS in the current study. People enrolled and remained in the NHIS because it guaranteed them access to treatment without catastrophic healthcare payments and helped them mitigate the worst effects of sickness. Health providers also mentioned that insured patients had fewer complications than the uninsured; thanks to early reporting. Our post-intervention household survey affirmed these observations and showed that the NHIS reduced household out-of-pocket healthcare expenditure by 86 per cent (see Aryeetey 2012). The post-intervention survey also indicated that insured poor suffering from acute illness were 5.5 times more likely to use primary healthcare out-patient department compared to the uninsured poor and 2.7 times at the secondary level (district and regional hospitals) (see Jehu-Appiah 2012). Other studies in Ghana have also reported that health insurance improves access to healthcare and leads to better health outcomes (Mensah et al. 2010, Durairaj et al. 2010, Amporfu 2011). Mensah et al. (2010) observe the dramatic differences in maternal and infant health indicators of insured and uninsured persons due to more preventive check-ups and out-patient attendance and prenatal care. Durairaj et al. (2010) also reported that the NHIS provides social and financial protection to insured patients and contributes to a decline in hospital deaths among the insured due to early treatment. These observations indicate that health insurance provides a safety net for community members and strengthens patients' resilience to manage the disease.

Key informants suffering from chronic diseases mentioned characteristics of the NHIS that demonstrated its resilience-enhancing role. They reported that the NHIS provides quick and regular access to healthcare thereby strengthening them to manage their condition. In Ghana, like many African countries, local aetiological discourse holds that prolonged sickness is often not a natural episode but linked to some wrongdoing. For example, diseases such as HIV/AIDS, diabetics and hypertension may be socially interpreted and the patient often blamed for his or her predicament. The patient is usually accused of immoral behaviour or committing a crime (see Dapaah 2012) and often isolated by family members while financial support is withheld. This phenomenon leads to what a key informant described as a feeling of shame (*Eye animguase*). An insured patient describes the NHIS' resilience-enhancing role as follows:

Health insurance has removed the shame. My husband nearly divorced me because I spent all our money on treatment. With health insurance I no more spend much money on treatment and he has stopped blaming me. So I don't worry anymore about the diseases and have resumed my trading.

It is clear that people enrolled and renewed their membership because by taking care of the economic burden, the NHIS strengthened them not only to manage the debilitating effects of prolonged illness, but it also provided a safety net to offset the negative impact of accusations from family members and others. The insurance strengthens the sick not to succumb, but to see beyond the disease and live positively with their condition.

In theory, the NHIS is pro-poor, as discussed later in this chapter, but not in practice. From the perspective of health insurance as a resilience-enhancing tool, one would expect that the poor would be the most eager to join. However, the opposite proves to be the case. I do not want to revitalise Lewis' (1971) much criticised concept of 'culture of poverty', but the low rate of poor NHIS members suggests that poverty may have affected people's inner strength and reduced their ability to plan their life. Poverty not only reduces the external resources of resilience, but also the internal ones; it demoralises the families who cannot afford to pay the premiums for all members of the household. Thus they chose to practice adverse selection or wait until the last minute to buy insurance when they are in dire need of healthcare.

To conclude, this discussion has shown the relevance of resilience in the health insurance discourse. It shed light on the resilience-building attributes of the NHIS as a safety net that gives financial relief to patients and strengthens them not to be overwhelmed by adversity, but to see beyond their disease, reorganise their lives and bounce back to normalcy. Consideration of resilience provides an in-depth understanding about people's exposure and response to the adversities of ill health. However, enrolment in the NHIS among the poor and core poor remains low. Apparently more is at stake than the mere need for resilience. The next section looks at trust and mistrust as concepts that may shed more light on people's reaction to health insurance.

Trust

Many developing countries promote social health insurance to improve access to quality healthcare services. However, the low demand for health insurance has been shown to be based on a lack of trust in the promises of health insurance (cf. Criel & Waelkens 2003).

Trust is the expectation of honest behaviour by all agents to promote the interest of those involved in a transaction. In health insurance, trust is the assurance that the premiums that are paid will guarantee access to decent healthcare. The decision to enrol is based first and foremost on trust (Schneider 2005). The concept of trust thus helped me understand the conditions that stimulate enrolment in the NHIS and retain members and the ones that create distrust and discourage people from enrolling.

I employed the concept of trust based on the premise that people might enrol and remain in the NHIS because they are sure of access to quality healthcare when sick

(trust). Conversely, they might not enrol if they have doubts that their NHIS card will be promptly delivered to enable them to benefit from the premiums they pay (mistrust). Mechanic (1998) argues that trust in insurance is multi-dimensional with aspects varying in importance depending on the circumstances: (1) patients' trust in providers, which is based on their ability to diagnose and treat illness and to act in the patients' interest; (2) trust in insurers, based on their reputation of improving access to healthcare; and (3) trust generated by regulations and control mechanisms for the legal enforcement of commitments like contracts. As a result, personalised trust develops between insurers, health providers and insured patients and generalised trust between community members and the institutions involved in implementing the NHIS (DHISs and health facilities) and their employees. People may therefore decide to enrol with the expectation that the institutions and their staff will fulfil their promise of providing quality healthcare as stated in the NHIS policy.

In the current study, building trust was both a systemic and behavioural issue. Examining statements of insured patients and those who did not renew their membership, two main trust-building factors at the level of each stakeholder emerged. These were financial protection by the NHIS and good quality healthcare services. Poor quality services created distrust between community members and health providers and undermined confidence in the NHIS. However, creating trust-building conditions was a major challenge for DHISs. Delays in issuing national ID cards after the three-month mandatory waiting period prevented clients from accessing healthcare nationwide. Trust also depended on drug acquisition and administration guidelines, and the National Health Insurance Authority's (NHIA) ability to promptly pay NHIS claims to enable health facilities to maintain their stock levels. These actions were beyond the health providers and even the health system's control. Also, health providers' workload, as a result of increased healthcare utilisation and lengthy completion of NHIS forms, undermined the quality of service and weakened trust in the NHIS.

With the challenges mentioned above, building trust in the NHIS was driven by the PSGs' recognition of distrust among stakeholders of the NHIS. PSGs believe that trust between NHIS' stakeholders (community members, health providers and DHIS staff) is fundamental in improving enrolment and retention rates. Therefore, they set out to first and foremost build trust among them to elicit their cooperation and commitment to achieve the intervention goal. As Gilson (2003) observes, trust facilitates collective action to achieve common goals. The trust concept revealed that participation in collective activities depended on asking group members to lead intervention activities. This elicited cooperation and ensured the PSGs' effective functioning and the commitment to achieve intervention goals. PSGs then engaged stakeholders to devise approaches to improve trust in the NHIS. The main strategy the PSGs used was to engage health providers, insured community members,

opinion leaders and DHIS staff to project NHIS' benefits, discuss challenges they faced in providing healthcare to insured patients and address their concerns. Insured community members shared their experiences regarding the NHIS' protection from catastrophic healthcare payments compared to when they were not insured. They showed that NHIS' benefits far outweighed the inconvenience of delays at health facilities, roaming about looking for prescribed drugs and the possibility of unfriendly interactions during clinical encounters. Health providers also explained the benefits of health insurance and discussed the challenges involved in providing healthcare to insured patients during clinical interactions and other intervention activities.

These friendly interactions did not only make people appreciate the benefits of the NHIS and the challenges involved in providing healthcare to insured patients, but also bridged the power differential gap between health providers and community members. The interactions influenced the former to eschew negative behaviours and practices that led to distrust. Though PSGs improved trust in the NHIS and convinced people to enrol, they could not solve the practical problems that should have retained people and encouraged many more to enrol even if they did not need healthcare. For example, key informants mentioned that the basis of trust in the NHIS was the guarantee of treatment, which reduced their worries about the disease and helped them lead normal lives. However, this trust is lost if their experience does not reinforce it.

Thus, trust helped explain the pre-condition for enrolment in the NHIS and membership renewal. These included: the NHIS' attributes of financial protection, health providers' competence in providing treatment and appreciation of health providers' constraints in providing insured patients treatment (not necessarily the quality of services delivered). However, what constituted trust was fraught with ambiguities and contradictions. There were contradictions in what key informants mentioned as the basis of their trust and what actually influenced them to enrol and renew their membership. Key informants said they did not enrol or renew their membership because of health providers' disrespect, request for unauthorised fees, and the burden of roaming to get prescribed drugs from accredited private pharmacy and chemist shops, and extra payments for drugs and other supplies.

Insured patients who had pre-paid for their healthcare felt they had greater entitlement to quality service, and drugs were the most important component for them. Thus, the policy makers' assumption that private pharmacies and chemist shops would augment drug supplies at health facilities and satisfy insured patients totally missed the point of what would create trust in the NHIS. Instead, this assumption caused discontent about clinical encounters. So, although PSG activities improved trust in the NHIS, their inability to resolve the practical problem of ensuring that all benefits stated in the NHIS policy were delivered reduced the level of trust. This

contributed to the limited increase in enrolment and no improvement in retention rates. As Gambetta (2000) suggests, we can limit the extent to which we need to trust agents in cases of distrust. This implies that even when there is distrust, some level of trust still persists to keep agents in the transaction. In this study, though there was distrust, some insured members remained in the scheme because it served their interests; the NHIS gave them access to cheaper healthcare. An example is as follows. Some insured patients paid for drugs covered by the NHIS at health facilities. Although this created some distrust, they still had faith in the NHIS and perceived the payment as a problem that health facilities could not resolve. They preferred to pay instead of receiving a prescription since they could avoid the burden of roaming to obtain the drugs in accredited shops. They rushed to enrol or renew their membership only when they needed to go to the hospital. Thus, the benefits of the NHIS are still attractive to those who need healthcare.

In conclusion, the concept of trust helped to understand and explain barriers to enrolment and retention in the NHIS. It also revealed that the pre-conditions of trust depended on the social context in which the scheme operates. Though I have emphasised that health providers' expertise in providing regular access to healthcare and the financial protection of the NHIS as the basis of community members' trust, in resource-poor countries where providing quality services is a herculean task, trust can be improved and distrust reduced if structures are put in place for regular interaction between stakeholders of the scheme. However, if services promised in the policy are not delivered, it becomes difficult to attract many more people to enrol and to retain them. In the next section, I will focus on the four main obstacles to expanding NHIS' coverage. I shall illustrate these with the concepts I just discussed – multi-level perspective, resilience and trust as well as mistrust on the enrolment and retention of members.

Re-examining low enrolment and retention

Community members generally acknowledged that the NHIS was better than on-the-spot payment at health facilities and the premium was affordable, but this did not naturally translate into the decision to enrol and remain in the scheme. Our post-intervention household survey results showed a less than 50 per cent enrolment among the general population (41%), the rich (46%), and richest (44%) quintiles and high non-renewal rates (22.4%). More worrying was the less than 30 per cent enrolment (between 15.3% and 25.1%) in five of the 13 communities that had improved enrolment. These results are striking against the backdrop that the premium is heavily subsidised from value added tax. The cost of premium is GH¢ 14.00-GH¢ 48.00 (US\$10.00-US\$35.00) per annum and GH¢ 4.00 [US\$2.50] as a registration fee to join the NHIS per person and GH¢ 1.00 administrative fee to renew membership. Exemption is provided for vulnerable groups: children below 18 years,

SSNIT pensioners, older people above 70, pregnant women and the core poor. With the exception of pregnant women, people in all exempt categories pay the registration fee. In fact, all those who participated in the intervention were disappointed about the outcome. The reasons for their limited achievement were attributed to 'missing links' and contradictory expectations of various stakeholders. The missing links are differences in the stakeholders' interests in the NHIS policy and expectations regarding what would stimulate enrolment and retain members and thus move the NHIS towards universal coverage.

For this concluding chapter, I have selected four important factors that discourage people from enrolling or remaining in the NHIS for further discussion because they deserve special attention if the NHIS is to move towards universal coverage. These are healthcare service delivery challenges, the politicisation of the NHIS, a lack of commitment to reach the core poor with the NHIS and adverse selection. Each of these challenges, which reduced the ability to achieve policy goals, will be addressed below.

Challenges to healthcare delivery

Policy makers often consider the NHIS as a panacea to the existing inequity in access to quality healthcare. The assumption is that the NHIS will provide adequate funds for health facilities to improve the quality of their services. However, a vital but often underestimated constraint is the limited capacity of health facilities to implement the policy. So the expectation that the NHIS will provide adequate funds promptly to enhance quality of healthcare was not evident. A key finding of this study was that policy makers did not sufficiently consider the details of what was necessary to enhance service delivery, build trust in the NHIS, stimulate enrolment and retain members to achieve universal coverage within five years as stated in the National Health Insurance Policy Framework (see chapter one). In this section, I discuss two main factors that I describe as missing links that undermine the quality of service and achievement of NHIS policy goals. These include health providers' increased workload as a result of the introduction of the NHIS and the shortage of drugs on the National Health Insurance Drug List at health facilities.

Increased workload

This study found that the NHIS was implemented within a health system already overburdened with patient numbers without providing the adequate resources to cope with the increase in the utilisation of services. As critical medical anthropologists observe, new health policy initiatives introduce problems into healthcare delivery systems. For example, Pfeiffer & Nichter (2008), in their critique of global health initiatives, noted that the introduction of narrow interventions usually undermines the expected benefits when inadequate effort is put into institutional

building. NHIS policy makers focused on stimulating enrolment and not much was done to increase the health facilities' capacities to handle the growing number of patients. As expected, many people, who hitherto had not had access to formal healthcare or cut treatment short because they could not pay under the user fee regime (Asenso-Okyere et al. 1998, Nyanator & Kutzin 1999, Osei-Akoto 2003), do have access now. Though the increase is desirable, indicating that the NHIS is achieving its goal of improving access to healthcare, the result has been a heavy workload and long working hours that has undermined health providers' ability to provide quality service. Consequently, insured patients experience delays and hostile treatment. Boakye (2008) made a similar observation in his evaluation of the Nzema-East District Mutual Health Insurance Scheme in Ghana. He found that increased workload affected the quality of service and patients waited for long hours before being attended to.

Following the increase in utilisation of services, health providers exercised substantial discretion and devised strategies to implement new policies while adopting ways to manage the burden. They categorised patients into insured and uninsured to address the increase in patient numbers and completion of the NHIS forms. Generally, clinicians are used to hurriedly writing only a few words or phrases and not spending time filling out long and complicated forms. The additional task of completing the NHIS forms for the many insured patients they attend to psychologically drew a negative reaction to these patients. In this respect, two types of health providers were identified during the intervention based on how they treated insured patients. One group of health providers explained the benefits of the NHIS and persuaded patients to enrol. Others were hostile, used defamatory language when interacting with insured patients, demanded cash payments from them and gave preference to uninsured patients. Insured patients described these practices as cheating, which created distrust between healthcare professionals and community members since the idea of enrolling in the NHIS was not to pay money at a health facility. The negative practices eroded confidence in the NHIS. Health providers are not a homogenous category in the way they treat insured patients and some of their actions conflict with the NHIS policy goal of providing access to quality healthcare and free treatment. Thus the NHIS does not automatically lead to better services. This finding supports Ekman's (2004) findings. In his review of the literature on non-profit making community-based health insurance schemes (CBHIs) in low-income countries, he observed that these schemes have weak or no effect on quality of service. His findings and my observation further strengthen the argument that both CBHISs and SHISs do not necessarily lead to quality service.

Shortage of drugs

Another missing link and contradictory expectation relates to insured patients' conceptions about quality service. I observed that the quality healthcare service needed to build trust in the NHIS did not depend on health providers alone; it also depended on national level actors. In this respect, there was a misunderstanding about what insured patients expect, what will enable health providers meet their needs and what policy makers' thought would satisfy the patients. Insured patients expected to receive all their prescribed drugs from the health facilities. Health providers anticipated prompt payment of NHIS claims to maintain their stock levels and meet insured patients' drugs requirements. Policy makers on the other hand, felt that accredited pharmacies and chemist shops could augment drug shortages at health facilities and satisfy insured patients' needs. Clearly, this illustrates a significant misunderstanding about what insured patients considered crucial to quality services and what policy makers considered reasonable. Community perceptions are often quite different from what policy makers have in mind.

Anthropologists have extensively studied the meaning of medicines and shown that providing drugs is a major issue in the appreciation of a clinical encounter (e.g. Whyte & Van der Geest 1994, Van der Geest et al. 1996, Senah 2002). A doctor or nurse without medicines is a contradiction in terms, like "a bar without beer" (Van der Geest, personal communication). In this study, the unavailability of drugs at health facilities led to patient dissatisfaction about the clinical encounter and by consequence discouraged people from enrolling and renewing their membership. Van der Geest et al. (1996: 156) writing on the value of drugs in the clinical encounter note: "Medical practitioners see pharmaceuticals as indispensable means in their encounter with sick people who come for help and advice. ... patients and their relatives expect medicines to solve their problems."

In the current study, both health providers and patients saw medicines as an essential commodity in health facilities and a critical component of quality service. Their availability leads to satisfaction with care among all parties. Their shortage not only frustrated patients, but also health providers. Arhinful (2009) also identified a similar problem in his survey on the general pharmaceutical situation in health facilities in Ghana. He found that only 80 per cent of key drugs were available in public facilities and called for an improvement in the distribution of drugs. This indicates that shortage of drugs is not a problem only for insured patients.

To insured patients, the symbolic role of drugs in their clinical encounters clashes with drug shortages at health facilities. Almost all insured patients mentioned the shortage of drugs as a factor that reduced their confidence in the NHIS. This raises the question whether policy makers' decision to contract with private shops to augment drug supplies at health facilities was sufficiently deliberated with regard to the expectations of insured patients. The shortage of drugs and risk of additional

payments discouraged people from enrolling and renewing their NHIS membership. The burden of roaming and looking for accredited pharmacies and chemist shops to obtain prescribed drugs forced some patients to buy from non-accredited shops. A recent study indicates that households' ability to access healthcare does not only depend on wealth, but also on perceptions about the quality of healthcare. Information that only poor quality service is available is likely to deter households from seeking healthcare. Conversely, if services are viewed as high quality, significant resources might be spent to access them (Save the Children UK 2008).

In the case of health providers, their concern was that drug shortages undermined their attempt to provide good service. They anticipated prompt reimbursement of fees charged to maintain their stock levels. This would allow them to have control over the treatment episode. Health providers know that the absence of drugs not only affects the quality of services in the eyes of the patient, but it also has a negative impact on treatment since some patients do not buy all prescribed drugs. Thus, health providers' wish to provide good care during the clinical interaction explains why some facilities buy drugs from private sources without a non-availability certificate to maintain their stock level and sell them to patients.

Our survey results showed that 64 per cent of patients buy drugs despite being insured. For the poor, payments for drugs and other supplies was a burden on their meagre income and so discouraged them from enrolling and renewing their insurance membership. Thus, while the NHIS is intended to ensure equity in access to healthcare and protect the poor against on-the-spot payments, the lack of prudent planning to ensure its effective implementation makes healthcare expensive even for insured patients. This shows how macro-level policies targeted at the poor are bound to fail without adequate measures to achieve their goals.

Politicisation of health insurance

The popular discourse in Ghana, especially among health experts and national level stakeholders of the NHIS, was that service delivery to insured patients has not improved because the NHIS has been politicised. As discussed earlier, the policy-making process was dominated by the political allies of the then government. Despite the bickering that went on in and outside Parliament in protest against the National Health Insurance Bill, the bill was passed into law under a certificate of urgency. As a result, the NHIS was perceived by many as a tool to build political capital (see chapter one). This induced resentment towards the scheme instead of creating the perception that the NHIS was a social security scheme that would enhance the health of Ghanaians. As a result, the then opposition (now in government) capitalised on the protests by organised labour groups and discouraged potential members not to join. There were also accounts that some villagers, who were sympathisers of the opposition party chased DHIS staff out of their communi-

ties. They accused them of being government supporters. Another political issue raised by key informants was the lack of improvement in DHISs operations and poor quality healthcare services. They believed that this was largely due to a lack of collaboration among the three institutions involved in the NHIS policy formulation and implementation: the National Health Insurance Authority (NHIA), the Ministry of Health (MoH) (the policy-making body) and the Ghana Health Service (GHS) (the implementing body and main healthcare service provider). According to key informants from the MoH and the GHS, the improvements that should occur as the NHIS grows are not happening as expected because the NHIA does not involve the MoH or the GHS in efforts to improve the scheme. They mention that the NHIS is missing some of the critical implementation challenges. They asserted that the NHIS has been politicised and there is no transparency in their activities. One of the key informants described the situation in the following statement.

Very little information on the situation of the DHISs filters into the public domain and that has been the situation since the NHIS was introduced. No joint planning between NHIA and us [MoH and GHS] for monitoring and evaluation of DHISs and health facilities. This doesn't help build systems that will improve service delivery, hence the numerous complaints. The typical example is piloting of ICT software to authenticate NHIS membership being carried out without involving GHS as the main service provider. The computerisation of health facilities with an internal network to be connected to DHISs' system is taking much longer time than projected.

Presently, the capitation system of provider payment¹ being piloted in the Ashanti Region is being opposed by some service providers (The Society of Private Medical and Dental Practitioners and the Ghana Registered Midwives Association), interest groups (The Asante Development Union and Asante Students Union) (Domfeh n.d.) and the main opposition party (the New Patriotic Party) (Ennin n.d.) due to a lack of consensus. The coordinator of the Asante Development Union expressed their reservations as follows: "Understanding of the policy is very minimal. ... the policy is complex and technical and therefore requires much understanding before starting. ... Stakeholders should be brought on board for consensus building and proper education done." Thus history seems to be repeating itself. The situation where the NHIS policy-making process was highly centralised and dominated by political associates of the government and the bill was passed in the midst of severe criticism by the opposition and civil society organisations (see Agyepong & Adjei 2008, Rajkotia 2007) to fulfil a campaign promise before the pending election. At the moment, the agenda appears to contain costs with or without stakeholders support.

¹ Capitation payment system is a method of payment in which physicians are paid a fixed prearranged amount for each patient for a defined set of services within a specified period regardless of any treatments offered. The advantages are: it is less expensive to administer and cost of treatment per patient is lower. Its disadvantages include: the patient's choice of primary healthcare provider is limited to a particular physician or group of physicians and optimal treatment may not always be delivered since physicians are required to keep costs down to make more profit (Agyepong & Yankah n.d.).

This seems to be based on the need to prove the regime's legitimacy and the continuity of the NHIS policy that has a significant political 'aroma'. This supports the key informant's observation that there is no collaboration between stakeholders. Decisions on the NHIS were primarily based on political expediency. This posture by policy makers does not build confidence in the NHIS as a public good expected to promote the public's wellbeing. In essence, the NHIS agenda seems not to be driven by concerns about public well-being, but rather by accumulating political capital. Clearly, this does not build trust in the scheme nor improve service delivery that could stimulate enrolment; hence the poor quality service being experienced by insured patients and the challenges health providers face implementing the policy. The excessive documentation, drug administration and acquisition difficulties and delay in claim payment, drug shortages, collection of unauthorised fees and inadequate exemption granted the core poor have been discussed in the public domain since the NHIS was introduced; but, these issues have not been given the attention required by politicians and policy makers.

Not reaching the poor

In Ghana, the NHIS was introduced to address the problem of inequity in access to healthcare that characterised earlier user-fee regimes. The NHIS was linked with the country's poverty reduction strategy and expected to reach the poor first. This explains why the premium is heavily subsidised by a tax and formal sector workers' Social Security and National Insurance Trust (SSNIT) contributions and why there is an exemption provided for the core poor. Ironically, this study found that the poor and the core poor were the least enrolled. Our post-intervention household survey results show that only 31 per cent of the poor and 18 per cent of the core poor were enrolled. Witter & Garshong (2009: 5) found that exemption for indigents in Ghana fell from fewer than four per cent of the population in 2005 to one per cent in 2008. This indicates that the inequity in access to healthcare persists and even grows. In fact, throughout my fieldwork I did not see the DHISs organising any activity to identify the core poor for premium exemptions. Why this is so, is examined in this section.

For the poor, the inability to pay the NHIS premium was the most important barrier to enrolment and renewal of membership. According to the respondents, although the premium is reasonable and the benefits far outweigh the costs of becoming sick without insurance, they did not pay because of poverty. Appraisal of their situation revealed that due to the social responsibility of caring for parents and other close relatives in Ghana, the poor also have a large number of dependents to enrol. The heads of households (usually the men) had to enrol their wives, children, their own relatives and those of their spouses and other dependents. Given their low income, enrolling all these family members was beyond their means. In addition,

extra payments for healthcare services and drugs discouraged some insured poor from renewing their membership. This supports the observation by Save the Children UK (2008) that poor families face barriers in accessing basic healthcare. The authors mentioned that compulsory or voluntary informal payment were a barrier to healthcare for poor families. They reported that about 25 per cent of the healthcare users in Ghana made informal payments to public health providers.

The inequality trend in enrolment was worst for the core poor because they were strapped because they have no stable source of income. Their low enrolment indicates that the exemption is fundamental to ensure they are not excluded from the NHIS. In a discussion of community-based health insurance schemes in developing countries, the World Health Organisation (2003) also points out that exemption for the poor are crucial to ensure they are enrolled. However, the exemption provided to prevent their exclusion is not reaching them. This defeats the purpose of the NHIS as a safety net, which is expected to provide the poor with access to healthcare and free them from expensive healthcare costs.

Though the NHIS has performed relatively well in providing protection against expensive healthcare payments among the general population, the mere 18 per cent enrolment amongst the core poor indicates that little attention has been paid to the equity goal. Critical analysis of the implementation gap revealed that it is not simply a problem of identification. The gap has other dimensions already mentioned in previous chapters. Further discussions and observations revealed other dimensions of the problems that will be considered in this discussion, because the situation cries for attention to ensure the NHIS reaches the core poor. I discuss two main dimensions of the implementation gaps: the lack of commitment of DHIS staff and collectors to pursue the equity agenda of the NHIS and government's lip-service to ensuring that the core poor are exempted.

Lack of commitment

The exemption implementation gap can be explained as the DHISs' inability to balance the two roles of the NHIS: to generate revenue and pursue equity in access to healthcare (McIntyre et al. 2003, Ekman 2004). As McIntyre et al. (2003) point out, there should be trade-offs to achieve both goals. However, in the case of the NHIS, DHISs' staff and collectors, who are to pursue both policy goals, have gradually drifted their focus in favour of revenue generation. Less attention is paid to the NHIS' equity goal. The DHISs' mandate to vigorously apply the exemption policy as implementers of the pro-poor NHIS has been relegated to the background. Like previous exemption policies under user-fee regimes that could not fulfil their goal (see Nyanator & Kutzin 1999, Badasu 2004, Aikins & Arhinful 2006), the NHIS has also failed to provide the core poor access to healthcare. These studies mentioned problems of identification of the poor and the governments' delay in

reimbursing health providers as the main causes of failure. In this study, the DHISs' staff thought that the reasons they gave for the poor not being exempted were morally acceptable excuses to cover up for their lack of commitment to ensure that the core poor were not excluded from the scheme. Critical observation of DHIS staff and collectors' countenance when discussing the issue and the NHIA's inaction to resolve the identification problems demonstrated the lack of commitment to the policy goals. As Criel (1999) observes, the effectiveness of SHISs is the ability to reduce genuine exclusion. Thus, the NHIS's inability to reach the core poor questions its viability as a health insurance scheme aimed at protecting the vulnerable. It must be noted that although children are exempted, those above five years are only registered if a parent or guardian is enrolled. This means lack of exemption to the core poor affects their children as well.

The main explanation for the DHISs' stance is the requirement to generate revenue to meet some of their recurrent expenditures. This has influenced them to make revenue generation a priority. As a result, the DHISs use the most restrictive criterion, homelessness, which does not apply to the core poor in these communities – to disqualify potential beneficiaries. The local condition of unemployment, no visible source of income and inconsistent support from another person stated in the policy, are all criteria that apply to the core poor and yet are ignored (see National Health Insurance Regulations 2004, 58: 1-3). A key informant explained: "If we tell them [community members] about the other criteria and they come demanding exemption, how do we get revenue?" As stated in chapter three, apart from mad people everybody including those identified as core poor, lived in family houses, dilapidated structures or with friends. I did not find a single normal homeless person in the ten intervention communities (seven in Central Region and three in the Eastern Region) I visited during my fieldwork. In farming communities, the poor generally had no stable source of income. Some did menial jobs for friends and neighbours, some were farmers, but did not have a regular income. In fishing communities, some were engaged by boat owners as labourers only during the bumper harvest while others were totally unemployed and usually lived on the occasional kindness of family members or neighbours while struggling to survive. Thus, apart from homelessness, other community indicators share commonalities with what is stated in the policy, but are rarely considered by the DHISs.

At this point, it is necessary to mention that the study communities, just like many rural and urban communities in Ghana, are closely knit with many households living in one structure. In this living arrangement, the core poor are not difficult to find. They are not ashamed to seek help. Their neighbours, the community and opinion leaders often look for assistance so they can afford formal care. But, unfortunately, requests for exemptions during the intervention were often not granted on the basis of the homelessness criterion. In some cases, I had to intervene to get a poor person

enrolled to prevent a fatality since they were seriously sick and needed to go to the hospital. The irony was that collectors and DHISs' staff who were supposed to facilitate the exemption process were PSG members, but often reluctant to follow through. This showed their lack of commitment. The question then becomes, whose interest is the NHIS policy supposed to serve, the poor or the rich? If the former, then why use a criterion that excludes them? As social scientists posit, poverty is a social construct whose understanding requires a contextual approach (Hulme et al. 2001, Aryeetey et al. 2010, Aryeetey 2012). In their study of community concepts of poverty in the Central Region of Ghana, Aryeetey (2012) also observed that the national level indicators of poverty are inappropriate from the community perspective. They suggest that in developing such a policy, it is necessary to engage communities to ensure that there is an understanding of their situation and perspectives to inform the process.

The lack of interest from the collectors, who were expected to recommend the core poor to the DHISs to be certified as qualified for exemption, may have been to do with the fact that they were not paid for registering the exempt group. So, they usually do not disseminate information about exemptions. If they did give exemption information, then it was normally about homelessness. Thus, unlike other exemption categories with indisputable criteria such as age and pregnancy, the core poor's exemption depended on the discretion of collectors to recommend them and ultimately the DHISs' approval. Clearly, this stance by DHISs' staff and collectors demonstrates a lack of commitment to prevent the exclusion of the core poor from the NHIS.

The findings of this study show how policies that target the poor are experienced and how the intended impact is not often achieved due to implementers' attitude. In an analysis of the behaviour of frontline public service workers in the United States of America, Lipsky (1980:13) refers to street level bureaucrats and observes that they generally exhibit a high margin of discretion in resource allocation decisions especially in resource-constrained systems. He observes that the actions of the frontline workers then "effectively become public policy rather than the objectives of the documents and statements developed at the policy level." Although Lipsky's study was in another social context, the nature of public service in essence seems to be the same in most countries. The DHISs and collectors can be described as street level bureaucrats who use their discretion regarding which aspects of the NHIS policy need to be emphasised and pursued: revenue generation or exemption. They found the latter less appealing, which made the policy largely pro-rich. These bottlenecks attest to the evidence in the literature that many healthcare interventions targeted at the poor, do not actually reach them as envisaged (Con & Walford 1998, Basaza et al. 2008, Kamuzora & Gilson 2007). In their study in Tanzania on the exemptions of the Community Health Fund, Kamuzora & Gilson (2007) also

observed that the targets of exemptions did not know about their existence because of managers' negative attitudes. They noted that the managers felt that the exemptions would erode their financial base and often refuse requests for exemptions.

Lip service

The homelessness criterion as the basis for granting the core poor exemption raises some intriguing questions about why it was put in the policy. Was it just a matter of a wholesale transfer of policies from other social contexts such as Western Europe and the United States of America where homelessness is a condition of the core poor? Or were policy makers not familiar with the reality at the local level in Ghana? Analysis of these questions reveals hidden insights regarding the motivation to establish a criterion that eliminates potential beneficiaries. Contrary to general opinion that the implementation gap is mainly due to identification difficulties, I think the explanation runs deeper. I point out the lack of commitment at the policy level to ensure that the core poor are enrolled as a factor. I put forward two possible explanations. First, if policy makers were genuinely committed to exempting the core poor, they would have paid collectors for enrolling them just as they do for the premium-paying category. This would motivate the collectors to pursue the NHIS' pro-poor agenda and identify the core poor. Second, if the policy makers were really committed to running a pro-poor NHIS, some groundwork would have been done to ensure that all the criteria reflected the conditions of the target group. I explain why these actions were not taken by looking at the political situation at the time that the NHIS was envisioned and the financial implications of granting exemptions to those who would qualify as core poor. As mentioned earlier, setting a condition that eliminates the target equals a lack of interest in achieving the set goal. The question that comes to mind is why was such a condition set? From this perspective, I argue that setting such a condition could have been a strategy to lessen the financial burden of enrolling all core poor while also serving as propaganda to accumulate political capital for the election that was due in a few months before the NHIS was introduced. The scheme was introduced nation-wide in March 2004 and elections were held in December of the same year. Meanwhile, the financial implication of enrolling all the exempt categories was too significant for the country, so a criterion that would reduce the financial burden was needed.

One may question this explanation, but a critical analysis of the financial implications provides insight and strengthens my argument. The NHIS has a large exemption group (about half of Ghana's population). For example, in the two regions used for the study, our household baseline survey showed that children (0-17 years) form

46.6 per cent of the population and people above 70 years form 3.6 per cent.² The figure for pregnant women could not be computed from our data. In the case of the core poor, a recent Ghana Living Standard Survey shows that about a third (28.5%) of Ghana's population live below the poverty line (Ghana Statistical Service 2007). The Ministry of Finance pays GH¢ 14 for each person exempted per annum to the National Health Insurance Authority (NHIA). Considering the core poor alone, it means that the government would have to pay premiums for about 2.5 million people. This equals a total cost of about GH¢ 35 million (US\$25 million) per annum, which would be a significant demand on the country's budget. A country with a cross-national per capita income of US\$520 in 2006 (World Bank 2010) and already over stretched with unfulfilled needs in other sectors of the economy, such as education and roads, means that the money to cover the exemptions is not easily available. The International Labour Organisation (2006) made a similar observation in their financial assessment of the NHIS. They cautioned that with the large exemption group in relation to income, the National Health Insurance Fund might not remain viable over the medium to long term. For example, by the end of 2008, the National Health Insurance Authority owed health facilities about US\$34 million (see Witter & Garshong 2009).

Thus considering the financial burden, there was nothing to lose if in practice the homelessness criterion eliminated almost all potential beneficiaries while appearing to be fulfilling the government's moral obligation to the poor and showing the international community they were committed to ensuring equity in access to healthcare. The politics of the NHIS policy-making process has been described as characterised by political rhetoric (Rajkotia 2007, Agyepong & Adjei 2008). Witter & Garshong (2009) also observe that the original objective of introducing the NHIS was essentially political. Thus, what was important at that time was to win votes for the pending election. The practicalities of its implementation were overlooked, probably intentionally. If this was not the case, and the politicians were truly committed, whose definition of the core poor should have counted; the one by policy makers or by the community? The government had the option to set a criterion that reflected the realities of the core poor in Ghana. As Agyepong & Nagai (2011: 232) point out: "A policy is only as good as its implementation arrangement." Poverty needs to be defined by the community. Aryeetey et al. (2010), in their analysis of various methods of identifying poor households, observe that the community criteria of classifying the poorest members correlated with mean testing and the proxy mean testing considered as the gold standard. This view starts from

² These figures roughly agree with the nation-wide figures. The 2008 Ghana Demographic Health Survey reported that 41% of Ghana's population was below 15 years. The 2000 population census reported that 5.3% were above 64 years (Ghana Statistical Service 2002).

the assumption that opinion and community leaders understand local conditions of poverty and are in a better position to devise effective guidelines that could be used to identify them.

The argument is strengthened when one considers the fact that the non-applicability of the homelessness criterion has been discussed in the public domain since the inception of the NHIS, but both past and present governments seem not to be concerned and no solution is in sight. This is not to say that nothing is being done to improve the applicability of the exemption policy and enrolment of the core poor, but the moral urgency required on the part of both the DHISs and the government seems to be lacking. This is often the case when reforms are introduced and the economy is too weak to support implementation. These reflections underscore the need for civil society groups to look at programmes that target the poor with a lens that sees beyond the policy document and effectively monitor implementation. Otherwise, social security programmes targeted at the poor will not reach the majority since they have no voice to make demands. The poor are voiceless; they are the silent ones in society who cannot challenge DHISs for not granting them exemptions even when all indicators show that they qualify. Clearly, this shows that even if the implementation arena is littered with other barriers, it is ironic that policy makers' professed goal of ensuring equity in access to healthcare is not being given the urgency it requires.

“I'm not often sick”: Adverse selection

Contrary to the philosophy of social health insurance schemes (SHISs) that requires people to enrol and consistently renew their memberships, whether they benefit or not, the NHIS is beset with pervasive adverse selection. The mutual cooperation that was expected to stimulate voluntary enrolment was absent. Many people enrolled with just the motive of benefitting and not of sharing the risk or cost. This is reflected in the less than 50 per cent enrolment among the general population (40%) after the intervention. The intriguing aspect was the enrolment level among the rich quintiles: rich (46%) and richest (44%) and high non-renewal rates (22%) within the same groups. This tendency contradicts the policy goal of attaining universal coverage by the end of five years against the backdrop of a heavily subsidised premium. The improbable reason given by the majority of all respondents was their inability to pay the premium. The majority (67%) and (73%) said they did not renew their membership and never enrolled because they could not pay premium (Table A.10, Appendix 2). Almost all key informants gave the same reason as their first response when I asked them why they did not enrol or renew their membership. But, as I engaged them in further discussion, their real intention emerged. They said: “I'm not often sick” and “I'm waiting for a while.” This indicates that the decision

to enrol and remain in the NHIS for most people is not poverty, but rather a rational calculation.

The situation observed was that many household heads enrolled only those who needed healthcare and renewed their membership only when they had to go to the hospital. This contradicts the crucial assumption by policy makers that the solidarity principles exhibited by the rich kinsmen's generous contributions to the funerals of the poor would be transferred to secure them against ill-health as well as motivate them to enrol and remain in the NHIS. In Ghana like other African countries, the NHIS was introduced based on the assumption that traditional norms that oblige kinsmen to support poor members will motivate people to enrol (see also Arhinful 2003, Sommerfeld et al. 2002). In contrast, people merely appreciated the NHIS' benefits as reducing the financial burden of expensive healthcare costs. The need to share the costs and risks for their mutual benefit did not seem to impact people's decisions; rather many looked for ways and means to get the maximum benefit with minimum contribution. As Arhinful remarked, the 'solidarity' that existed in community-based health insurance scheme (CBHIs) in Ghana was the unintended consequence of self-interest. People are not willing to pay for people they do not know, as would be the case in a national health insurance, because it will not produce social capital for them. Arhinful (2003: 150) states:

In the emerging mutual insurance setting, a contract that asserts payment of a fixed voluntary premium is the only social tie that binds members together. For most of these people there is no sense of emotional attachment to other members of the group, apart from the few that they probably know and live with. The absence of opportunities for the accumulation of social capital thus diminishes the binding feeling of solidarity and for that matter the binding force of reciprocity underlying such schemes.

This lack of solidarity to share the risks and costs that Arhinful noted was also observed in the current study. The risk- and cost-sharing principles only 'worked' for SSNIT contributors whose premiums were (forcibly) deducted at the source. Non-SSNIT formal sector contributors and informal sector workers were not willing to pay premiums based on their income. Almost everybody paid the minimum and in many cases discontinued paying if they did not benefit. For example, boat owners paid the same premium as their employees when they enrolled them. They enrolled their employees because fishermen are prone to accidents and need regular access to healthcare. However, the higher premium the boat owners were expected to pay because they earned more than their employees was rejected. The owners insisted on paying the minimum. Arhinful (2003) refers to this as: 'solidarity of self-interest': joining a group with a minimum contribution to satisfy personal needs. Other researchers also commented on people's low interest in health insurance. In their analysis of declining subscriptions in a mutual health organisation in Guinea-Conakry, Criel & Waelkens (2003) attributed low enrolment in health insurance schemes in Africa to a lack of risk perception. I have argued that the situation is

more complex in Ghana. People perceive they are at risk, but wait until they need healthcare before rushing to enrol or renew their membership. A similar observation was made by Adusei-Asante (2009) in his study of a rural district in the Eastern Region of Ghana. He found that only mothers and their children and people with chronic sicknesses, who needed regular healthcare, enrolled and renewed their membership in the NHIS routinely. They opted out when their need for medical care was over.

Also, a nation-wide survey by the Ghana Statistical Service in 2008 found that Private Commercial Health Insurance Schemes covered less than one per cent of Ghanaians (Ghana Statistical Service 2009). These findings question the general notion, and the assertion of key informants of this study, that people will enrol in an insurance scheme if they are confident they will receive quality service. Like private enterprises, healthcare services to private insurance enrolees are provided by well-equipped health facilities with good quality service, positive staff attitudes towards insured patients and only rare incidences of drug shortages. The low patronage of private health insurance schemes confirms the observation that many Ghanaians have not yet accepted the conditional reciprocity embedded in health insurance. Nor do they use it as protection against ill health. Thus, the intervention outcome was influenced by the low interest in the NHIS, which was a country-wide phenomenon.

These observations indicate that the minimum solidarity needed to drive people to enrol and remain in the scheme was absent. People tended to enrol if they were certain to benefit; they did not accept cost redistribution and risk-sharing in health insurance. The selective enrolment of household members reveals an adverse selection and negative risk-averse attitudes towards health insurance as implied in the “I’m not often sick” and “I’m waiting for a while” reasons for not enrolling or renewing their membership. This indicates that these people fully perceive the risk of not being insured as more expensive, but wait and rush to enrol or renew their membership only when they need healthcare.

A more distressing finding was that these actions were encouraged by the lack of sanctions against defaulters and ‘back door registration’. Some people managed to enrol and access healthcare without waiting for the three-month mandatory period. This unscrupulous behaviour perpetuated by some DHIS staff and collectors was largely due to ineffective monitoring. According to some collectors, they did it as a favour for a small fee. This gave more people the hope of manipulating the registration process and so they did not enrol until they were sure of benefitting. Putnam (1995: 67) calls this a “dilemma of collective action” when people want to benefit from collective goods with minimum input. He notes that the dilemma of collective action can only be resolved when civic engagements foster sturdy norms and social trust. But, I argue that for the intriguing phenomenon of mutual benefit being subsumed by individualistic tendencies, the problem can only be addressed when the

rules are strictly enforced and effective monitoring mechanisms put in place. Otherwise, the NHIS will continue to suffer from parochial interests and the goal of attaining universal coverage will remain a mirage.

The problem of low achievement of health policy, in spite of massive support, has also been observed by critical observers of other health issues. Van der Geest et al. (1990: 1025) examined why Primary Health Care (PHC) so rarely worked, although there was “unanimous approval of PHC” at Alma Ata in 1978. They attributed the failure of PHC to the diverse interests that multiple actors at various levels had in the policy so the idea of using PHC as a strategy to attain health for all by the year 2000 was not accomplished. In their study, the authors mentioned the low financial appeal of PHC to health providers, inadequate funding by governments and the community’s cultural values that led to the acceptance of some of the proposals and rejection of others. In the same vein, although all stakeholders accepted that the NHIS improved access to healthcare and reduced complications among insured patients, the various interests undermined the achievement of the NHIS’ goal. Politicians saw it as a tool to secure electoral victory, so they did not wait to expand the health facilities’ capacity to handle the expected increase in patient numbers before introducing the scheme. They did not seriously consider what constitutes quality service to insured patients and also paid lip service to the exemption policy. Health providers saw it as increasing their workload, and hence were hostile to insured patients and charged extra fees. Community members thought that they could benefit with minimal financial investment, while the DHISs were more interested in revenue than granting exemptions to the core poor to ensure the equity agenda was achieved. These distinct – and often conflicting – interests converged to limit the PSGs’ efforts at improving enrolment and retention rates.

Conclusions

This study set out to generate evidence to show that local stakeholders can collaborate to improve enrolment in the NHIS and retain members. The study aimed to prove that in-depth information can lead to a better understanding of health insurance decision-making in Ghana. Three researchers (including the author of this book) set up a multi-stakeholder problem-solving programme (MSPSP) that engaged local NHIS stakeholders to identify barriers to enrolment and retention of members and developed and implemented solutions to expand coverage. I used a multi-level perspective as a conceptual framework and methodological tool to analyse and explain challenges to enrolment in health insurance and retention of members. I described the MSPSP and examined the approaches that the facilitators employed in implementing the intervention. I examined the outcome of the intervention and factors that led to increase in enrolment and studied reasons for the PSGs’ limited success by employing quantitative and qualitative research methods. The

results show that many factors mediated the effect of the intervention; therefore, drawing a decisive conclusion about the outcome is difficult. However, the following key conclusions are presented.

The study has shown that stakeholders' engagement in the educational and advocacy activities in communities and health facilities stimulated enrolment in the NHIS. This approach led to a better understanding of the barriers to enrolment and increased confidence in the NHIS. For example, insured opinion and community leaders shared the benefits they derived from the NHIS with community members and convinced people that it was a viable alternative to on-the-spot payments. Health providers educated community members and their patients on the benefits of health insurance and persuaded them to enrol. In contrast, the PSG facilitators who dominated PSG activities and made unilateral decisions created distrust, stifled intervention activities and could not sustain the group through the intervention period. These facilitators did not engage stakeholders in intervention activities, so they could not establish the trust relationships needed to increase confidence in the NHIS. Hence, they failed to achieve a positive outcome. This finding demonstrates that the bottom-up, inclusive decision-making and interdependency approach that most facilitators employed in PSG activities and interactions among stakeholders created trust and ensured the stakeholders' effective participation. This approach also sustained the facilitators' commitment to achieve positive results.

The study also found that people (apart from the core poor and some poor households with many members), enrolled in the NHIS because the cost of the premium was affordable and relieved them from expensive healthcare expenditure. It also strengthened community members' resilience to manage the adversities of ill health. However, quality service is yet to be the basis for enrolling and remaining in the NHIS. Almost all insured patients complained about the poor quality of healthcare services. Prominent complaints included delays at health facilities, disrespect, extra payments and the burden of roaming to obtain prescribed drugs from accredited private pharmacies and chemist shops due to the shortage of drugs on the National Health Insurance Drug List in health facilities. These issues all caused discontent, created distrust and eroded the confidence that the PSGs had built in the scheme. This shows that the NHIS is not the cure for poor quality healthcare service. Conscious efforts must be made to resource health facilities and position them to meet the expectations of insured patients. In addition, 'back door' registrations due to inefficient monitoring systems gave some people the hope that they could obtain the NHIS card to access services without waiting for the three-month mandatory period.

The PSGs' limited achievement was attributed to the social and institutional context in which the NHIS operates. Community members were influenced by the generalised reciprocity embedded in traditional risk-sharing arrangements. This undermined the acceptance of the conditional reciprocity of health insurance and led

to adverse selection as many household heads enrolled and renewed NHIS cards only for members who needed healthcare. Others did not regularly renew their memberships because of the lack of sanctions against defaulters. They rushed to renew their membership only when they needed healthcare. This finding contrasts the policy makers' assumption that participation in traditional mutual support groups stimulates enrolment and the commitment to remain in the scheme.

For health providers, the NHIS can be described as a paradox; on the one hand, they saw it as reducing complications, which would encourage people to enrol. On the other hand, it was perceived as increasing their workload due to increased utilisation of healthcare and completion of NHIS forms. As a result, two categories of health providers were observed. One devised strategies to cope with the burden of work by being hostile to insured patients and giving preference to uninsured patients. Others charged insured patients to compensate for their heavy workload and to avoid filling out the NHIS forms. The second category treated insured patients well and persuaded people to enrol because the NHIS reduced complications among patients.

In the case of the DHISs, inadequate equipment especially cameras adversely affected their output of work. It created difficulties in processing of registration forms and resulted in delays in issuing NHIS cards. So collectors were provided cameras to take photographs as they simultaneously registered people. This facilitated registration processes and led to prompt delivery of NHIS cards, which influenced people to enrol.

I started this study to explore if PSGs could identify barriers and develop and implement intervention activities to improve NHIS enrolment and retain members. However, during the intervention, the focus was expanded beyond PSGs to cover a wider context and higher level actors involved in the NHIS. Issues arose that exposed more linkages that needed to be explored.

The findings indicate that although local level stakeholders can collaborate to increase enrolment, more understanding of the barriers is needed and national-level interventions are required to improve enrolment (especially among the poor) and retain members. Nonetheless, each of the three concepts – multi-level perspective, resilience and trust – employed in this study enhanced the understanding of health insurance decision-making and the reasons behind low enrolment and retention rates in Ghana. The findings without doubt contribute to the discourse about the potential of multi-stakeholder collaborative groups in helping reduce barriers and improve coverage of social health insurance schemes in developing countries.

Recommendations

This study has shown the potential of using local level stakeholders of Ghana's NHIS to reveal and address the multidimensional factors that interact to undermine

enrolment and retention of members. However, the PSGs' achievement was limited because of the social environment in which NHIS operates and reservations about quality of healthcare service delivery. The practical and policy concerns are apparent from the preceding discussions on how to limit or eliminate adverse selection, improve enrolment of the poor and core poor, improve quality of service and scale-up problem-solving groups and ensure their effective functioning.

Policy implications

Kinsmen and the entire community provide support during funerals. Cash and other donations are given to the bereaved family to enable them give the dead a befitting burial. This support did not transform to communal solidarity to share risk and cost of ill health. Relying on solidarity as a virtue to motivate people to enrol in the NHIS and consistently renew their membership does not seem realistic. Rather, policy makers should move away from the solidarity principle to promote health insurance and devise pragmatic intervention activities that emphasise enlightened self-interest and project the benefits of health insurance to the individual and immediate family. Overall solidarity will be the unintended de facto result of such self-interest (Arhinful 2003). Extensive education and promotion is required to convince Ghanaians that health insurance is first advantageous to themselves and their families.

The study also highlighted the adverse effects of self-interest and tendency of some community members and DHIS staff to manipulate the registration process to their advantage. Moreover, the PSGs' intensive education and promotion had a limited impact on voluntary enrolment and renewal of NHIS membership. This makes it imperative for the DHISs to strictly apply the National Health Insurance Regulations, 2004 (LI 1809, 59: 1) and sanction defaulters to wait for three months before accessing healthcare services upon renewal of their membership. This will deter people from adopting the wait and see strategy and consistently renew their memberships.

History yields important lessons about how to address low enrolment in voluntary health insurance schemes. The initial stages of social security in Western Europe, where health insurance was made compulsory to all wage earners, indicate that some coercive action is required to compel all residents in Ghana to enrol. Some might argue that since it is more expensive to access healthcare without health insurance, there is no need to coerce people to enrol because without it, they pay more. Uninsured patients experience more complications and higher risks of death than the insured do because of delays at home and lack of access to healthcare. Since the economic cost of prolonged illness does not only hinder an individual's wellbeing, but the country's development as well, it makes economic sense to ensure that all citizens are healthy. The following forms of coercion are recommended. One, a

premium for formal sector workers who do not contribute to Social Security and National Insurance Trust (SNNIT which is a government pension scheme in Ghana for most formal sector workers) should be deducted at source. Two, NHIS enrolment should be made a requirement for obtaining voter identity cards, driving licenses, passports, marriage certificates and admission to educational institutions. At the same time, heads of health facilities and DHIS managers should institute measures to stop frontline staff that looks for opportunities to manipulate the system for personal gains.

The revelation that the NHIS is not reaching the poor and the core poor calls for strategies that will reduce their exclusion. In the case of the poor, the decoupling of the registration of children less than five years from their parents or guardians should be effectively implemented to reduce fatalities among them. For the core poor, the homelessness criterion should be removed from the exemption policy since it does not reflect reality. Since the NHIRs 2004 LI 1809, 58: 3 mandates DHISs to assign the duty of eliciting the information required for the classification of indigents according to standards determined by the scheme to collectors, the DHISs' staff and collectors should engage opinion and community leaders to develop indicators that reflect their reality rather than national documents prepared by people who are usually not familiar with local conditions. Moreover, this study revealed that the core poor are not difficult to find. Community members described them as persons afflicted by '*ohia buburoo*' (severe poverty) (see also Aryeetey 2012). Removing the homelessness criterion will be a first step in making it possible for the core poor to demand exemptions with the support of opinion and community leaders. This will force the DHISs to pursue the equity agenda of the NHIS.

Enrolling and remaining in a health insurance scheme is largely influenced by trust, which depends on health facilities' ability to provide quality healthcare to insured patients. This requires the creation of an improved image for the NHIS that resonates with quality healthcare service and makes it easier and faster to obtain healthcare and not the reverse. This means that health facilities need to be strengthened to provide services that are responsive to patients' needs. Since drugs are essential component of quality service, the priority should be to provide insured patients drugs at facilities with no extra payment. In the short term, the NHIA should allow health facilities to purchase small quantities of the drugs they need urgently from private suppliers without the non-availability certificate to reduce the incidence of drug shortages. Also, supervision at health facilities should be strengthened to check the collection of unauthorised fees and the selling of drugs covered by the NHIS to insured patients and to make sure that the staff performs their tasks diligently. In the long run, the on-going electronic network to connect DHISs to the NHIA should be expanded to cover all accredited hospitals and health centres nation-wide for easy claim processing and payment. This will reduce the time spent

treating insured patients and ease health providers' workload. Since the fees charged will be reflected in the DHISs' system, claims will be promptly paid to enable health facilities maintain their stock levels. These measures will build trust among insured patients and health providers and boost confidence in the NHIS. This will influence people to accept the NHIS as better than cash payment at health facilities. It will also make the compulsory enrolment more bearable and influence both the rich and the poor to enrol so that the cost and risk are shared.

For the above measures to be effective, stakeholders should be continuously engaged in identifying and addressing their concerns through conversations and key informant interviews. To achieve positive results, these measures should be seen as part of the quality assurance activities undertaken to reveal the NHIS' implementation challenges across regions and districts, and efforts made to address them. The evaluation outcome should be incorporated into both the National Health Insurance Authority (NHIA) and Ghana Health Service's (GHS) annual review reports. These reports should be discussed at joint annual review meetings by the NHIA and GHS at national, regional and district levels to provide a platform for sharing ideas that will lead to improvement in healthcare service and DHISs' operations.

How to scale up PSGs and make them more effective

The results of this study confirmed that collaboration by local stakeholders leads to increase in enrolment. I therefore recommend that PSGs should be scaled up nationwide and used for intensive education and advocacy activities. When carried out over a long period, these activities will reduce the negative practices among stakeholders that undermine enrolment in the NHIS and retention of members.

The NHIA's proposal that every DHIS should be divided into Health Insurance Communities and Community Health Insurance Committees (CHICs) was a laudable idea, but not implemented. The CHIC was to promote community ownership of the NHIS and ensure their efficient operations. They were supposed to oversee the collection of premium and registration fees and to ensure that monies collected were deposited in the District Health Insurance Fund. I recommend that the CHIC agenda be revisited and the membership expanded to include health providers and DHIS staff. Thus, PSGs should be established in every town. A number of small villages could collectively form a single PSG to save costs, since those communities patronise the same health facility and DHIS. The DHISs should facilitate the formation of PSGs and provide a small budget for their activities. The procedure for selecting members is described in chapter four. Lessons learnt show that consultation with opinion and community leaders and institutional heads to devise a selection approach, which ensures that only committed representatives are selected, is critical. Also, the low representation of women in PSGs and exclusion of the poor highlight the need to develop additional strategies to ensure that both are fairly represented in

the group. Health providers and DHISs' representatives should not be selected based solely on their work schedule; being an effective PSG member requires a specific set of skills and a volunteering spirit that not all employees have. Therefore, heads of health facilities and DHIS managers should engage their staff in a discussion and give them the option to accept or decline their nomination. In addition, all nominees should be confirmed or rejected by their colleagues through secret voting since they are likely to have better insight into the above mentioned characteristics. Facilitators should be selected at the first PSG meeting through secret voting and the DHIS manager should facilitate the meeting. These procedures will ensure that only people committed to promoting the welfare of others become PSG members and facilitators. This is important because the allowance paid for participation is usually not enough to keep those who do not have the spirit of volunteerism to be committed to the intervention.

Since how a programme is presented and run determines its success or failure, appropriate strategies at each stage of the life span of a programme must be developed. Five measures are recommended to make PSGs efficient. First, all PSG members should be given adequate orientation to ensure that they understand well the rationale of the intervention and their task from the onset. Second, a nurturing environment that creates space and effective mechanisms should be developed for community members, health providers and DHISs' staff to freely express concerns about problems they face without looking over their shoulders. This means stakeholders need to be sensitised to accept the work of PSGs as part of quality improvement initiative that requires their commitment to succeed. The involvement of health providers and DHISs staff should focus on building trust between them and PSG members to encourage open and dispassionate discussion of issues. With trust in place, the PSGs can pursue the interest of all stakeholders and openly discuss challenges that undermine enrolment in the NHIS and retention of members, and develop intervention activities to reach all target groups. For example, the DHISs' reluctance to grant exemptions to the core poor because of the homelessness criterion could be taken up by PSGs and engage them in discussions to develop locally tailored criteria to identify the core poor. Third, DHIS managers should not be part of PSGs. They should be supervisors who spend funds and closely monitor PSGs' activities and ensure the money given out is spent on the intervention. Fourth, there should be an annual review meeting for PSG members, facilitators and DHIS managers at the district level. The meetings should be used to evaluate their activities, share experiences and learn about best practices to help improve their work and address their concerns. This will also motivate community members and facilitators to remain committed and work harder to achieve positive results. Accountability on the part of facilitators will also be ensured. Finally, the NHIA regional managers should play an oversight role and incorporate PSG activities into their programme of

work and reports. As mentioned earlier, PSG activities should be discussed at joint review meetings of the NHIA and GHS at the district, regional and national levels.

These recommendations when implemented will reduce the NHIS's implementation challenges and stimulate enrolment and retain members. It will also ensure that the poor and the core poor are not excluded from the NHIS.

Implications for future research

The MSPSP, as a pilot project, provided insight into factors that enhanced and limited PSGs' achievement at improving enrolment in the NHIS and retaining members. However, more qualitative research is needed to understand the specific factors to develop effective intervention activities for addressing them. For example, more understanding of local discourses on informal risk-sharing arrangements and how this affects enrolment is required. This will generate more knowledge to help develop effective intervention activities that will influence people to accept health insurance as a state social security policy that needs their support to ensure everybody has access to healthcare.

More research is also needed to develop appropriate criteria for exempting the core poor and how to cultivate the political commitment to include them. In the case of the poor, ways should be explored on how to ease the heads of households' burden of many dependents.

Further research is also needed to find ways to reduce the bureaucracy involved in treating insured patients and thus, reduce the health providers' negative behaviour towards them. In addition, more efficient registration processes and effective monitoring mechanisms need to be developed to make DHISs more efficient.

Further, the lack of transparency in the policy making and implementation process as a result of lack of collaboration among national level actors – MoH, NHIA and GHS – was identified as a hindrance to the development of efficient systems to build confidence in the NHIS. In this respect, further studies are needed to explore inculcating the notion of participatory, transparent and bottom-up approaches to policy making and implementation in politicians, policy makers and implementers. This will help improve collaboration among stakeholders to develop systems to improve DHIS operations and the quality of healthcare services to insured patients and make the NHIS more attractive. Moreover, intervention science is an underdeveloped yet crucial academic subject requiring theory building through empirical research, so further research on PSG formation and functioning is needed to inform policy makers and programme officers in the field.

References

- ADUSEI-ASANTE, K. (2009), The National Health Insurance Scheme in practice: Motives for joining and modes of use in the Afram Plains, Ghana. Master's Thesis, Vrije University of Amsterdam.
- AGYEPONG, I.A. (1999), Reforming service delivery at district level in Ghana: The perspective of a Ghanaian District Medical Officer. *Health Policy and Planning* 14(1): 59-69.
- AGYEPONG, I.A. & S. ADJEI (2008), Public social policy development and implementation: A case study of the Ghana National Health Insurance Scheme. *Health Policy and Planning* 23(2): 150-160.
- AGYEPONG, I.A. & R.A. NAGAI (2011), "We charge them; otherwise we cannot run the hospital". Front line workers, clients and health financing policy implementation gaps in Ghana. *Health Policy* 99 (3): 226-233.
- AGYEPONG, I.A. & B. YANKAH (n.d.), Understanding the NHIS provider payment system and capitation. www.nhis.gov.gh/Uploads/dbsAttcahedFiles/12.pdf. Accessed on 3/3/2012.
- AIKINS, M. (2003), *Emerging community health insurance scheme organisations in Ghana: Achievements and challenges*. Accra: Sakva Company.
- AIKINS, M. & D. ARHINFUL (2006), Review of exemption policy: A report on the annual health sector review 2005. Ghana: Ministry of Health.
- AIKINS, M. & G. OKANG (2006), Utilisation and cost of healthcare under district health insurance: A case study of Brong Ahafo and Eastern Regions. Accra: JSA Consultants.
- AMPORFU, E. (2011), Private hospital accreditation and inducement of care under the Ghanaian National Insurance Scheme. *Health Economics Review* 1(13): 1-9.
- ANDERSEN, H.M. (2004), "Villagers": Differential treatment in a Ghanaian hospital. *Social Science and Medicine* 59 (10): 2003-2012.
- ANSAH, E.K., S. NARH-BANA, S. ASIAMAHA, V. DZORDZORDZI, K. BIANTEY, K. DICKSON, J.O. GYAPONG, K.A. KORAM, B.M. GREENWOOD, A. MILLS, C.J.M. WHITTY (2009), Effect of removing direct payment for health care on utilisation and health outcomes in Ghanaian children: A randomised controlled trial. *Plos Medicine* 6(2): 0048-0058.
- ARHINFUL, D.K. (2003), *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana*. PhD dissertation, University of Amsterdam. Leiden: African Studies Centre.
- ARHINFUL, D. (2009), WHO pharmaceutical situation assessment – Level II: Health facilities survey in Ghana. Ghana: Ministry of Health.
- ARHIN-TENKORANG, D. (2001), *Health insurance for the informal sector in Africa: Design features, risk protection and resource mobilisation*. Geneva: Commission on Macroeconomics and Health, World Health Organization.
- ARMSTRONG, A.E. (2006), Towards a strong virtue ethics for nursing practice. *Nursing Philosophy* 7(3): 110-124.
- ARYEE, J.R.A. (2005), Public management in Africa. Economic Research Paper Working Series No. 82. African Development Bank.
- ARYEETEEY, G.C. (2012), *Targeting the poor in Ghana's National Health Insurance Scheme and benefits of enrolment*. PhD Dissertation, Radboud University, Nijmegen.
- ARYEETEEY, G. C. JEHU-APPIAH, E. SPAAN, B. D'EXELLE, I. AGYEPONG & R. BALTUSSEN (2010), Identification of poor households for premium exemptions in Ghana's Health Insurance Scheme: Empirical analysis of three strategies. *Tropical Medicine and International Health* 15(12): 1544-1552.
- ASANTE, F. & M. AIKINS (2008), Does the NHIS cover the poor? DANIDA Health Sector Support Office, Ghana.
- ASENSO-OKYERE, W.K., A. ANUM, I. OSEI-AKOTO & A. ADUKONU (1998), Cost recovery in Ghana: Are there any changes in healthcare seeking behaviour? *Health Policy and Planning* 13(2): 181-188.
- ATIM, C. (1998), *The contribution of mutual health organisation in financing delivery of access to healthcare: Synthesis of research in nine West and Central African countries*. Bethesda: Abt. Associates Inc.
- BADASU, D.M. (2004), Implementation of Ghana's health user fee policy and the exemption of the poor: Problems and prospects. *African Population Studies Supplement A* 19: 285-302.

- BAER, H., M. SINGER & J. JOHNSON (1986), Towards a critical medical anthropology. *Social Science and Medicine* 23(2): 95-98.
- BAILEY, A. & S. VAN DER GEEST (2009), Introduction: Bringing health research to practical use. *Medische Antropologie* 21(2): 215-221.
- BAILEY, D. (1992), Using participatory research in community consortium development and evaluation: Lessons from beginning of the story. *The American Sociologist* 23(4): 71-82.
- BALLARD, D.J., B. SPREADBURY & S.R. HOPKINS (2004), Health care quality improvement across the Baylor Health Care System: The first century. *Baylor University Medical Centre Proceedings* 17(3): 277-288.
- BARTLE, P. (n.d.), Modernisation and the decline in women's status: Covert gynocracy in an Akan community. <http://www.scn.org/rdi/kw-gyn.htm>. Accessed on 1/7/12.
- BASAZA, R., B. CRIEL & P. VAN DER STUYFT (2007), Low enrolment in Ugandan community health insurance schemes: Underlying causes and policy implications. *BioMed Central Health Services Research* 7(105): 1-12.
- BASAZA, R., B. CRIEL & P. VAN DER STUYFT (2008), Community health insurance in Uganda: Why does enrolment remain low? A view from beneath. *Health Policy* 87(2): 172-184.
- BENNET, S. & L. GILSON (2001), Health financing: Designing and implementing pro-poor policies. Development for International Development. Health Systems Resource Centre, London.
- BITRAN, R. & U. GIEDLON (2003), Waivers and exemptions for health services in developing countries. Social Protection Discussion Paper No. 0308. Washington D.C.: The World Bank.
- BLAS, E. & M.E. LINBAMBALA (2001), User payment, decentralisation and health utilisation in Zambia. *Health Policy and Planning* 16(2): 19-28.
- BOAKYE, K.B. (2008), National Health Insurance in Ghana: Evaluation of Nzema-East District Mutual Health Insurance Scheme. Master's Thesis. Vrije University of Amsterdam.
- BOUDREAU, V. (1996), Northern theory, southern protest: Opportunity structure analysis in cross-national perspective. *Mobilisation* 1(2): 175-190.
- BRANTLINGER, E., R. JIMINEZ, J. KLINGNER, M. PUGACH & V. RICHARDSON (2005), Qualitative studies in special education. *Exceptional Children* 71(2): 195-207.
- BRINKERHOFF, D.W. (2004), Accountability and health systems: Towards conceptual clarity and policy relevance. *Health Policy and Planning* 19(6): 371-379.
- BROWN, W. & P.S. MUELER (1970), Psychological function in individuals with amyotrophic lateral sclerosis. *Psychosomatic Medicine* 32(2): 141-152.
- BRUCE, K.S., A. NARH-BANA & I.A. AGYEPONG (2008), Community satisfaction equity in coverage and implications for sustainability of the Dangme West Health Insurance Scheme. Ghana Dutch Collaboration for Health Research and Development.
- BRYCE, J. (n.d.), UNICEF program failed to save children. <http://www.cbc.ca/health/story/2010/01/12/unicef-africa.html>. Accessed on 1/04/10.
- BUOR, D. (2004), Gender and utilisation of health services in the Ashanti Region, Ghana. *Health Policy* 69(3): 375-388.
- BUTT, G., M. MARKLE-REID & G. BROWNE (2008), Interprofessional partnership in chronic illness care: A conceptual model for measuring partnership effectiveness. *International Journal of Care* 8: 1-14.
- CHAMBERS, R. (1983), *Rural development: Putting the last first*. London: Longman.
- CHAMBERS, R. (1992), Rural appraisal: Rapid, relaxed and participatory. IDS Discussion Paper 311. Brighton, UK: Institute of Development Studies, University of Sussex.
- CHAMBERS, R. (1994), Participatory Rural Appraisal (PRA): Challenges, potentials and paradigm. *World Development* 22(10): 1437-1454.
- CHANKOVA, S., S. SULZBACH & F. DIOP (2008), Impact of mutual health organisations: Evidence from West Africa. *Health Policy and Planning* 23(4): 264-276.
- CLACKSON, S. (2008), Ronald Dworkin's "Prudent insurance" ideal for healthcare: Idealisations of circumstance, prudence and self-interest. *Health Care Anal* 16(1): 31-38.
- CON, C.P. & V. WALFORD (1998), An introduction: Designing and implementing pro-poor policies, Department for International Development, Health Systems Resources Centre. London.
- CRIEL, B. (1998), *District health insurance schemes in Sub-Saharan Africa. Part II: Case studies*. Antwerp: IGT Press.
- CRIEL, B. (1999), *District-based health insurance in Sub-Saharan Africa Part I: From theory to practice*. Antwerp: IGT Press.
- CRIEL, B. (2000), Local health insurance systems in developing countries: A policy research paper. Institute of Tropical Medicine, Antwerp, Brussels.

- CRIEL, B. & M.P. WAELKENS (2003), Declining subscriptions to the Maliando Mutual Health Insurance Organisation in Guinea-Conakry (West Africa): What is going wrong? *Social Science and Medicine* 57(7): 1205-1219.
- CURRALL, S.C. & A.C. INKPEN (2006), On the complexity of organizational trust: A multi-level co-evolutionary perspective and guidelines for future research. In: R. Bachmann & A. Zaheer, eds, *Handbook of trust research*. Cheltenham, UK / Northampton, MA, USA: Edward Elgar Publishing.
- CUSACK, K. (1999), Defining violence. In: D. Coker-Appiah & K. Cusack, eds, *Breaking the silence and challenging the myth of violence against women and children in Ghana: Report of a National Study on Violence*, pp. 14-33. Accra: Gender Studies and Human Rights Documentation Centre.
- D'AMBRUOSO, L., A. ACHADI, A. ADISASMITA, Y. IZATI, K. MAKOWIECKA & J. HUSSEIN (2008), Assessing quality of care provided by Indonesian village midwives with a confidential enquiry. www.elsevier.com/locate/midw. Accessed on 7/6/2009.
- D'AMOUR, D., F. FERRADA-VIDELA, L.S.M. RODRIGUEZ & D.M. BEAULIEU (2005), The conceptual basis for inter-professional collaboration: Core concepts and theoretical framework. *Journal of International Care* 1: 116-131.
- DAPAAH, J.M. (2012), *HIV/AIDS treatment in two Ghanaian hospitals: Experiences of patients, nurses and doctors*. PhD Dissertation, University of Amsterdam. Leiden: African Studies Centre.
- DAVIDSON, J.O. & D. LAYDER (1994), *Methods, sex and madness*. London: Routledge.
- DAVIS, P. & P. HOWDEN-CHAPMAN (1996), Translating research findings into health policy. *Social Science and Medicine* 43(5): 865-872.
- DAVIS, S. (1993), Are coping strategies a cop out? *IDS Bulletin* 24(4): 60-72.
- DE ALLEGRI, M. & R. SUERBORN (2007), Community-based health insurance in developing countries. *British Medical Journal* 334(7607): 1282-1283.
- DEATON, A. (1997), *The analysis of household surveys: A micro econometric approach to development policy*. Washington D.C.: The International Bank for Reconstruction and Development and The World Bank.
- DEATON, A. & S. ZAIDI (1999), *Guidelines for constructing consumption aggregates for welfare analysis*. Working Paper. 192. Princeton University Research Program in Development Studies: Princeton, NJ.
- DE SWAAN, A. (1988), *In care of the state: Healthcare, education and welfare in Europe and the USA in the modern era*. Cambridge: Polity Press.
- DOMFEH, K.A. (n.d.), Group demonstrates against health insurance capitation in Ashanti. <http://edition.myjoyonline.com/pages/news/201202/80991.php>. Accessed on 15/3/12.
- DONNER, A. & N. KLAR (2000), *Design and analysis of cluster randomised trial in health research*. London: Arnold Publishers.
- DUNCAN, C., K. JONES & G. MOON (1998), Context, composition and heterogeneity: Using multi-level models in health research. *Social Science and Medicine* 46(1): 97-117.
- DURAIRAJ, V., S. D'AMEIDA & J. KIRIGIA (2010), Ghana's approach to social health protection. World Health Report Background Paper No. 2. Geneva: WHO
- DURLAK, J.A. & E.P. DUPRE (2008), Implementation matters: A review of research on the influence of implementation on programme outcomes and the factors affecting implementation. *American Journal of Community Psychology* 41: 327-350.
- EKMAN, B. (2004), Community-based health insurance in low-income countries: A systematic review of the evidence. *Health Policy and Planning* 19(5): 249-270.
- ENNIN, K.A. (n.d.), NPP joins protestation of NHIS Capitation. <http://edition.myjoyonline.com/pages/news/201202/81571.php>. Accessed on 3/3/12.
- EVANS, M. & J. DAVIES (1999), Understanding policy transfer: A multi-level, multi-disciplinary perspective. *Public Administration* 77(2): 361-385.
- EVANS-PRITCHARD, E.E. (1976), *Witchcraft, oracles and magic among the Azande*. New York: Oxford University Press.
- FARMER, P. (2005), *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley: University of California Press.
- FERLIE, E.B. & S.M. SHORTELL (2001), Improving the quality of healthcare in the United Kingdom and the United States: A framework for change. *The Milbank Quarterly* 79(2): 281-315.
- FIELD, A. (2009), Logistic regression. In: A. FIELD, ed, *Discovering statistics using SPSS*, pp. 264-315. London: Sage.
- FRENK, J. (2006), Bridging the divide: Global lessons from evidence-based health policy in Mexico. *The Lancet* 368(9539): 954-961.

- GAMBETTA, D. (2000), 'Can we trust trust'. In: D. Gambetta, ed., *Trust making and breaking cooperative relations*, pp 213-237. <http://www.sociology.ox.ac.uk/papers/gambetta213-237.pdf>. Accessed on 1/2/12
- GARSHONG, B., E. ANSAH, G. DAKPALLAH, I. HUIJTS, & S. ADJEI (2001), "We are still paying": A study on factors affecting the implementing of the exemption policy in Ghana. Ghana Health Service Research Unit, Ministry of Health, Accra.
- GHANA STATISTICAL SERVICE (2002), *2000 Population and housing census. Summary report of final results*. Accra: Ghana Statistical Services.
- GHANA STATISTICAL SERVICE, NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH & ORC MACRO (2004), *Ghana Demographic and Health Survey 2003*. Calverton, Maryland: GSS, NMIMR and ORC Macro.
- GHANA STATISTICAL SERVICE (2007), *Trends and patterns of poverty in Ghana 1990-2005: Report of Ghana Living Standards Survey*. Accra: Ghana Statistical Service.
- GHANA STATISTICAL SERVICE, GHANA HEALTH SERVICE & ICF MACRO (2009), *Ghana Demographic and Health Survey 2008*. Accra, Ghana: GSS, GHS and ICF Macro.
- GHANA STATISTICAL SERVICE (2012), Ghana Statistical Service releases census results. <http://www.ghanaweb.com/GhanaHomePage/regional/artikel.php?ID=240661>. Accessed on 2/7/12.
- GILSON, L. (2003), Trust and the development of healthcare as a social institution. *Social Science and Medicine* 56(7): 1453-1468.
- GILSON, L. (2006), Trust in health care: theoretical perspectives and research needs. *Journal of Health Organisation and Management* 20(5): 359-375.
- GLASER, E.M. & S. TAYLOR (1973), Factors influencing the success of applied research. *American Psychologist* 28(2): 140-146.
- GLASSER, M. (1988), Accountability of anthropologists, indigenous healers, and their governments: A plea for reasonable medicine. *Social Science and Medicine* 27(12): 1461-1464.
- GOODMAN, H. & C. WADDINGTON (1993), *Financing healthcare*. Oxford: Oxfam UK and Ireland.
- GOVERNMENT OF GHANA (2003), The National Health Insurance Act: Act 650. Accra: Ghana Government.
- GREEN, L., M. DANIEL & L. NOVICK (2001), Partnerships and coalitions for community-based research. *Public Health Reports* 116(1): 20-31.
- GREEN, J. & N. THROGOOD (2005), *Qualitative methods for health research*. London: Sage Publications.
- GYIMAH-BOADI, E. (2004), New anti-corruption governments: The challenge of delivery. Excerpts of meeting co-organised by the Government of Kenya, TI-Kenya and TI Secretariat held in Nairobi, Kenya in October, 2004.
- HALL, M.A., E. DUGAN, B. ZHENG, & A.K. MISHRA (2001), Trust in physicians and medical institutions: What is it, can it be measured and does it matter? *The Milbank Quarterly* 79(4): 613-639.
- HARRINGTON, B. (2002), Obtrusiveness as strategy in ethnographic research. *Qualitative Sociology* 25(1): 49-61.
- HAWKES, S., S. MILLER, L. REICHENBACH, A. NAYYAR & K. BUSES (2004), Antenatal syphilis control: People, programmes, policies and politics. *Bulletin of the World Health Organisation* 82(6): 417-423.
- HAWKINS, J.D., R.F. CATALANO & M.W. ARTHUR (2002), Promoting science-based prevention in communities. *Addictive Behaviours* 27(6): 951-976.
- HENNERKENS, C. & J. BURING (1987), *Epidemiology in medicine*. Boston: Little Brown and Company.
- HENNEMAN, E.A., J.L. LEE & J.I. COHEN (1995), Collaboration: A concept analysis. *Journal of Advanced Nursing* 21: 103-109.
- HIGGINS, D.L. & M. METZLER (2001), Implementing community-based participatory research centres in diverse urban settings. *Journal of Urban Health* 78(3): 488-492.
- HOSMER, D.W. & S. LEMESHOW (2000), *Applied Logistic Regression, 2nd edn*. New York: Wiley and Sons, Inc.
- HUCKMAN, J.B. (1987), The design of teams: In: J.W. Lorsch, ed, *Handbook Organisational Behaviour*, pp. 315-342. Englewood Cliffs, NJ: Prince Hall.
- HULME, D., K. MOORE & A. SHEPERD (2001), Chronic poverty: Meaning and analytical frameworks. Chronic Poverty Research Centre Working Paper 2, International Development Department, United Kingdom.
- INTERNATIONAL LABOUR ORGANISATION (2006), Financial assessment of the National Health Insurance Fund. Geneva: International Labour Organisation.

- JEHU-APPIAH, C., G.C. ARYEETEEY, E. SPAAN, T. DE HOOP, I. AGYEPONG, R. BALTUSSEN (2011), Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why? *Social Science and Medicine* 72: 157-165.
- JEHU-APPIAH, C., E. SPAAN, G.C. ARYEETEEY, I. AGYEPONG & R. BALTUSSEN (2012), Reaching the poor in Ghana's National Health Insurance Scheme: Equity aspects and strategies to improve enrolment. PhD Dissertation, Radboud University. Nijmegen.
- JENKINS, R. (1992), *Pierre Bourdieu*. London: Routledge.
- JUTTING, J.P. (2004), Do community-based health insurance schemes improve poor people's access to healthcare? Evidence from rural Senegal. *World Development* 32(2): 273-288.
- KÄÄRIÄINEN, J.T. (2007), Trust in the police in 16 European countries: A multilevel analysis. *European Journal of Criminology* 4(4): 409-435.
- KAMUZORA, P. & L. GILSON (2007), Factors influencing implementation of the Community Health Fund in Tanzania. *Health Policy and Planning* 22(2): 95-102.
- KELTNER, J. (1989), Facilitation: Catalyst for group problem solving. *Management Communication Quarterly* 3(1): 8-32.
- KIEFER, C. (1971), Medical Anthropology. *Newsletter* 3.1.
- KINSMAN, J. (2008), Pragmatic choices: Research, politics and AIDS control in Uganda. PhD dissertation, University of Amsterdam.
- KITANO, M.K. & R.B. LEWIS (2005), Resilience and coping: Implication for gifted children and youth at risk. *Roepers Review* 27(4): 200-205.
- KOTOH, A.M., C. JEHU-APPIAH, E. SPAAN, D.K. ARHINFUL & I.A. AGYEPONG (2009), Manual for facilitators of problem-solving groups. Accra: SHINE Ghana Project.
- KPUNDEH, S. (2004), Process intervention versus structural reforms: Institutionalising anticorruption reforms in Africa. In: B. Levy & S. Kpundeh, eds, *Building state capacity in Africa: New approaches, emerging lessons*, pp. 257-282. Washington D.C.: International Bank for Reconstruction and Development and the World Bank.
- KROEGER, A. (1983), Anthropological and socio-medical healthcare research in developing countries. *Social Science and Medicine* 17(3): 147-161.
- KUMADO, K. & A.F. GOCKEL (2003), A study on social security in Ghana. <http://library.fes.de/pdf-files/bueros/ghana/50022.pdf>. Accessed on 14/4/2009.
- KYAKUWA, M. (2011), *Going the extra mile: An ethnography of care-giving and care designing among nurses in Uganda*. PhD Dissertation, University of Amsterdam.
- LAPAN, S.D. (2004), Evaluation Studies. In: K. deMarrais & S.D. Lapan, eds, *Foundations for research methods of inquiry in education and the social sciences*, pp. 235-248. Mahwah, New Jersey/London: Lawrence Erlbaum Associates.
- LASKER, D.S., E.S. WEISS & R. MILLER (2001), Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Milbank Quarterly* 79(2): 179-205.
- LASKER, R.D. & E.S. WEISS (2003), Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health* 80(1): 14-47.
- LAUER, H. (2006), The contribution of women's traditional leadership to enlightened governance and national development in Ghana. In: I.K. Odotei & A. Awedobo, eds, *Chieftaincy in Ghana: Culture, governance and development*, pp. 622-650. Accra: Sub-Saharan Publishers.
- LEWIS, O. (1971), The culture of poverty. In: M. Pilisuk & P. Pilisuk, eds, *Poor Americans: How the white poor live*. pp. 20-26. New York: Transaction, Inc.
- LINKAGES & PARTNERS (2003), Lessons learned in promoting better infant and young child feeding in Northern Ghana. http://pdf.usaid.gov/pdf_docs/Pnadh494.pdf. Accessed 2/04/11
- LIPSKY, M. (1980), *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russell Sage Foundation.
- LONG, N. (2001), *Development sociology: Actor perspectives*. London: Routledge.
- MANTOURA, P., S. GENDRON & L. POTVIN (2007), Participatory research in public health: Creating innovative alliances for health. *Health and Place* 13(2): 440-451.
- MCLNTYRE, D., J. DOHERTY & L. GILSON (2003), A tale of two visions: The changing fortunes of social health insurance in South Africa. *Health Policy and Planning* 18(1): 47-58.
- MECHANIC, D. (1998), The functions and limitations of trust in the provision of medical care. *Journal of Health Politics, Policy and Law* 23(4): 661-686.

- MENSAH, J., J.R. OPPONG & C.M. SCHMIDT (2010), Ghana's National Health Insurance Scheme in the context of the health MDGs: An empirical evaluation using propensity score matching. *Health Economics* 19: 95-106.
- MERCIER, C. (2002), The discourse of Maendeleo and the politics of women's participation on Mount Kilimanjaro. *Development and Change* 33(1): 101-127.
- MINISTRY OF HEALTH (2002), Policy framework for the establishment of health insurance in Ghana. Accra. Ministry of Health.
- MINISTRY OF HEALTH (2004), National Health Insurance Policy Framework for Ghana, revised edition. Accra: Ministry of Health.
- MINISTRY OF HEALTH (2008), Independent review health sector programmes of work, 2007 Draft Report. Accra: Ministry of Health.
- MULEMI, B.A. (2010), *Coping with cancer and adversity: Hospital ethnography in Kenya*. PhD Dissertation, University of Amsterdam. Leiden: African Studies Centre.
- NASTASI, B.K. & J. HITCHCOCK (2009), Challenges of evaluating multilevel interventions. *American Journal of Community Psychology* 43(3-4): 360-376.
- NATIONAL HEALTH INSURANCE AUTHORITY (2008), Ghana' National Health Insurance Review: A quarterly magazine. Accra, The National Health Insurance Authority.
- NATIONAL HEALTH INSURANCE REGULATIONS (2004).
<http://www.ilo.org/gimi/RessShowRessource.do?ressourceId=11967>. Accessed on 1/6/08.
- NIEHOF, A. (2008), Introduction: Dimensions of resilience in a context of health-related adversity. *Medische Antropologie* 20(2): 217-226.
- NYONATOR, F. & J. KUTZIN (1999), Health for some: The effect of user-fee in Volta Region of Ghana. *Health Policy and Planning* 14(4): 329-341.
- NYONATOR, F.K., K. AWOONOR-WILLIAMS, J.F. PHILIPS, T.C. JONES & R.A. MILLER (2005), The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. *Health Policy and Planning* 20(1): 25-34.
- NUTBEAM, D. (1999), The challenge to provide 'evidence' in health promotion. *Health Promotion International* 14(2): 99-101.
- OAKLEY, A., V. STRANGE, C. BONELL, E. ALLEN, J. STEPHENSON & RIPPLE STUDY TEAM (2006), Process evaluation in randomised controlled trials of complex interventions. *British Medical Journal* 332(7538): 413-416.
- O'BRIEN, R. (2001), An overview of the methodological approach of action research. In: R. Richardson, ed., *Theory and practice of action research*. <http://www.wem.cal-robrien/paper/arfinal.html>. Accessed on 02/04/08.
- OKELY, J. (1984), Fieldwork in the home counties. *RIAN* 61: 4-6.
- OLSON, M. (1965), *The logic of collective action: Public goods and the theory of groups*. Cambridge/Massachusetts: Harvard University Press.
- OOSTERHOFF, P.P.J. (2008), "Pressure to bear": Gender, fertility and prevention of mother to child transmission of HIV in Vietnam. PhD Dissertation, University of Amsterdam.
- OOSTERHOFF, P. (2009), Observation on action research with HIV-positive women and state service providers. *Medische Antropologie* 21(2): 257-275.
- OSEI-AKOTO, I. (2003), Demand for voluntary health insurance by the poor in developing countries: Evidence from rural Ghana. CEA 37th Annual Meetings: May 29-June 1, 2003. Carleton University, Ottawa, Canada.
- OSTROM, E. (1990), *Governing the commons: The evolution of institutions for collective action*. New York: New York University Press.
- PATHMAN, D.E., E. CHUANG & B.J. WEINER (2008), Effectiveness of a grant programme's efforts to promote synergy within its funded initiatives: Perceptions of participants of the Southern Rural Access Programme. *BioMed Central Health Services Research* 8(263): 1-11.
- PFEIFFER, J. & M. NICTER (2008), What can critical medical Anthropology contribute to global health? A health systems perspective. *Medical Anthropology Quarterly* 22(4): 410-415.
- PILLSBURY, B.L.K. (2008), Applied anthropology and executive leadership. *NAPA Bulletin* 29(1): 131-151.
- PLATTEAU, J.P. (1997), Mutual insurance as an elusive concept in traditional rural communities. *Journal of Development Studies* 33(6): 764-796.
- PORTER, P.G., L. ROSS, R.W. CHAPMAN, N.D. KOHATSU & P. FOX (2007), *Medicine and public health partnerships: Predictors of success*. San Francisco, CA.: Institute for Health and Aging.

- POTTER, J. & M. WETHERELL (1987), *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- POTTER, J. & M. WETHERELL (1994), Analysing discourse. In: A. Bryman & R. Burgess, eds, *Analysing qualitative data*, pp. 47-66. London: Routledge.
- POTTER, J. & M. WETHERELL (1995), Discourse analysis. In: J.A. Smith, R. Harre & L. van Langenhove, eds, *Rethinking methods in psychology*, pp. 80-92. London: Sage.
- PRESS, I. (1990), Levels of explanation and cautions for a critical clinical anthropology. *Social Science and Medicine* 30(9): 1001-1009.
- PUTNAM, R.D. (1995), Bowling alone: America's declining social capital. *Journal of Democracy* 6(1): 65-78.
- RAJKOTIA, Y. (2007), *The political development of the Ghanaian National Health Insurance System: Lessons in health governance*. Bethesda, MD: Health Systems 20/20 project. Abt Associates Inc.
- ROBERTSON, A. & M. MINKLER (1994), New health promotion movement: A critical examination. *Health Education and Behaviour* 21(3): 295-312.
- ROLAND, M. & D.J. TORGENSEN (1998), Understanding trials: What are the pragmatic trials? *British Medical Journal* 316: 285.
- RONDEAU, K.V. (1998), Managing the clinic wait: An important quality of care challenge. *Journal of Nursing Care Quality*: 13(2): 11-20.
- RUSSEL, S.S. (2004), The economic burden of illness for households in developing countries: A review of studies focusing on malaria, tuberculosis and human immunodeficiency virus/acquired immunodeficiency syndrome. *American Journal of Tropical Medicine and Hygiene* 71(2): 147-155.
- SARPONG, N., W. LOAG, J. FOBIL, C.G. MEYER, Y. ADU-SARKODIE, J. MAY & N.G. SCHWARZ (2010), National health insurance coverage and socio-economic status in a rural district of Ghana. *Tropical Medicine and International Health* 15(2): 191-197.
- SAVE THE CHILDREN, U.K (2005), The unbearable cost of illness: Poverty, ill-health and access to healthcare – evidence from Linda Rural District. Tanzania: Department for International Development. http://www.savethechildren.org.uk/sites/default/files/docs/Helping_Children_Survive_1.pdf. Accessed on 2/3/12.
- SAVE THE CHILDREN, U.K. (2008), Helping children survive: Supporting poor families to overcome barriers to maternal, new born and child health services. http://www.savethechildren.org.uk/sites/default/files/docs/Helping_Children_Survive_1.pdf. Accessed on 2/3/12.
- SCHENSUL, S.L., R.K. VERMA & B.K. NASTASI (2004), Responding to men's sexual concerns: Research and intervention in slum communities in Mumbai, India. *International Journal of Men's Health* 3(3): 197-220.
- SCHEPER-HUGHES, N. (1990), Three propositions for a critically applied medical anthropology. *Social Science and Medicine* 30(2): 189-197.
- SCHEPER-HUGHES, N. (1992), *Death without weeping: The violence of everyday life in Brazil*. Los Angeles/London: University of California Press.
- SCHNEIDER, P. (2004), Why should the poor insure? Theories of decision-making in the context of health insurance. *Health Policy and Planning* 19(6): 349-355.
- SCHNEIDER, P. (2005), Trust in micro-health insurance: An exploratory study in Rwanda. *Social Science and Medicine* 61(7): 1430-1438.
- SCHWARZ, R. (2006), Using the facilitative leader approach to create an organisational culture of collaboration. In: S. Schuman, ed., *Creating a culture of collaboration: The International Association of Facilitators Handbook*, pp. 281-303. San Francisco, CA: Jossey-Bass.
- SCOTT, S., F. MILLER & K. LLOYD (2006), Doing fieldwork in development geography: Research culture and research spaces in Vietnam. *Geographical Research* 44(1): 28-40.
- SENAH, K.A. (1997), *Money be man: The popularity of medicines in a rural Ghanaian community*. PhD Dissertation, University of Amsterdam.
- SENAH, K.A. (2002), "Doctor- talk and patient talk." Power and ethnocentrism in Ghana. In: S. van der Geest & R. Reis, eds, *Ethnocentrism: Reflections in Medical Anthropology*, pp. 42-66. Amsterdam: Aksant Academic Publishers.
- SERRAT, O. (2009), The five whys technique. <http://www.adb.org/documents/information/knowledge-solutions/the-five-whys-technique.pdf>. Accessed on 13/5/09.
- SHADISH, W.R., T.D. COOK & D.T. CAMPBELL (2002), *Experimental and quasi-experimental designs for generalised causal inference*. Boston: Houghton-Mifflin.
- SIMMEL, G. (1990), *The philosophy of money*. London: Routledge.

- SINGER, M. (1989), The coming of age of critical medical anthropology. *Social Science and Medicine* 28(11): 1193-1203.
- SOMMERFELD, J., M. SANON, B.A. KOUYATE & R. SOUERBORN (2002), Informal risk-sharing arrangements (IRSAs): Lessons for the development of community-based insurance (CBI). *International Journal of Health Planning and Management* 17(2): 147-163.
- SPRADLEY, J.P. (1980), *Participant observation*. New York: Holt, Rinechart and Winston.
- SULZBACH, S. (2008), Evaluating the impact of National Health Insurance in Ghana. Accra: Health System 20/20.
- SULZBACH, S., B. GARSHONG & G. OWUSU-BANAHENE (2005), Effect of National Health Insurance Act in Ghana: Baseline report. Bethesda, Maryland: ABT associates Inc.
- THORP, R., F. STEWART & A. HEYER (2003), When and how far is group formation a route out of chronic poverty? Presented at Staying poor: Chronic Poverty and Development Policy Conference, Chronic Poverty Research Centre, University of Manchester, United Kingdom. 7-9 April 2003.
- TOCQUEVILLE, A. DE. (1840), *Democracy in America* (2 volumes, 1835-40). Translated by H. Reeve. London: Saunders & Otley.
- TONES, K. & J. GREEN (2004), *Health promotion: Planning and strategies*. London: Sage Publications.
- TURNER, J.H. & J.E. STETS (2006), Sociological theories of human emotions. *Annual Review of Sociology* 32: 22-52.
- UK DEPARTMENT OF HEALTH (2004), Patient and public involvement in health: The evidence for policy implementers.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082334.pdf. Accessed on 1/3/2010.
- VAN DER GEEST, S. (1975), Appearance and reality: The ambiguous position of women in Kwahu, Ghana. In: P. Kloos & K.W. Van der Veen, eds, *Rule and reality: Essays in honour of André J.F. Köbben*, pp. 50-65. Amsterdam: Antropologisch-Sociologisch Centrum.
- VAN DER GEEST, S. (1992), Is paying for healthcare culturally acceptable in Sub-Saharan Africa? Money and tradition. *Social Science and Medicine* 34(6): 667-673.
- VAN DER GEEST, S. (1997), Money and respect: The changing value of old age in rural Ghana. *Africa* 67(4): 534-559.
- VAN DER GEEST, S. (2003), Confidentiality and pseudonyms: A fieldwork dilemma from Ghana. *Anthropology Today* 19(1): 14-18.
- VAN DER GEEST, S. (2008), Resilience and the whims of reciprocity in old age: An example from Ghana. *Medische Antropologie* 20(2): 297-311.
- VAN DER GEEST, S. & K. FINKLER (2004), Hospital ethnography: Introduction. *Social Science and Medicine* 59(10): 1995-2001.
- VAN DER GEEST, S., D.J. SPECKMANN & P. STREEFLAND (1990), Primary Health Care in a multilevel perspective: Towards a research agenda. *Social Science and Medicine* 30(9): 1025-1034.
- VAN DER GEEST, S., S.R. WHYTE & A. HARDON (1996), The anthropology of pharmaceuticals: A biographical approach. *Annual Review of Anthropology* 25: 153-178.
- VAN GINKEL, R. (1994), Writing culture from within: Reflections on endogenous ethnography. *Etnofoor* 7(1): 5-23.
- VIOLANTI, J.M., D. PATON & C. DUNNING (2000) *Post-traumatic stress intervention: Challenges, issues and perspectives*. Springfield, Ill: Charles C. Thomas
- VISWANATHAN, M., A. AMMERMAN, E. ENG, G. GARTLEHNER, K.N. LOHR, D. GRIFFITH, S. RHODES et al. (2004), Community-based participatory research: Assessing the evidence. Evidence report/Technology assessment No. 99. North Carolina: AHRQ Publications.
- WADDINGTON, C.J. & K.A. ENYIMAYEW (1989), A price to pay. Part 1: The impact of user charges in the Ashanti-Akim district, Ghana. *International Journal of Health Planning and Management* 4(1): 17-47.
- WADDINGTON C.J. & K.A. ENYIMAYEW (1990), A price to pay. Part 2: The impact of user charges in the Volta Region of Ghana. *International Journal of Health Planning and Management* 5(4): 287-312.
- WHYTE, S.R. & S. VAN DER GEEST (1994), Injections: Issues and methods for anthropological research. In: N.L. Etkin & M.L. Tan, eds, *Pharmaceuticals: Meanings and contexts*, pp. 137-161. Quezon City: HAIN.
- WHYTE, S.R., S. VAN DER GEEST & A. HARDON (2002), *Social lives of medicines*. Oxford: Oxford University Press.
- WIEGERS, E.S. (2008), Resilience and AIDS. Exploring resilience in the case of AIDS among female-headed households in Northern Zambia. *Medische Antropologie* 20(2): 259-277.

- WILLIAMS, M. (2001), In whom we trust as an affective context for trust for development. *The Academy of Management Review* 26(3): 377-396.
- WITTER, S. & B. GARSHONG (2009), Something old or something new? Social health insurance in Ghana. *BioMed Central International Health and Human Rights* 9: 20.
- WORLD BANK (2010), World development indicators database. <http://data.worldbank.org/country/Ghana>. Accessed on 1/8/10.
- WORLD HEALTH ORGANISATION (2003), *Community-based health insurance schemes in developing countries: Facts, problems and perspectives*. Geneva: WHO
- ZAMAN, S. (2005), *Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh*. Amsterdam: Aksant.

Appendix 1: List of acronyms

CEA	Census Enumeration Area
CHIC	Community Health Insurance Committee
CHAG	Christian Health Association of Ghana
CHPS	Community-based Health Planning and Services
DDHSs	District Director of Health Services
DHD	District Health Directorate
DHIS	District Health Insurance Scheme
GHS	Ghana Health Service
GLSS	Ghana Living Standard Survey
GoG	Government of Ghana
GPRTU	Ghana Private Road Transport Union
GSS	Ghana Statistical Service
IGF	Internally Generated Fund
LI	Legislative Instrument
MLP	Multi-level Perspective
MSPSP	Multi-stakeholder Problem-solving Programme
NHIL	National Health Insurance Levy
NHIR	National Health Insurance Regulations
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
PRO	Public Relations Officer
PSG	Problem-solving Group
SSNIT	Social Security and National Insurance Trust
UNICEF	United Nations Children Fund
VAT	Value Added Tax
WHO	World Health Organisation

Appendix 2: Tables

Table A.1 Profile of households and individuals in intervention and control communities

	Overall		Intervention communities		Control communities	
	Baseline	Post-intervention	Baseline	Post-intervention	Baseline	Post-intervention
Overall (households)	3301	3152	1646	1562	1635	1590
Overall (Individuals)	13857	12810	7234	6790	6623	6020
<i>Age</i>						
0-17	46.5	46.3	48.0	48.1	44.9	44.4
18-69	49.8	49.7	49.1	48.5	50.7	51.1
70+	3.6	3.9	2.9	3.4	4.4	4.5
<i>Sex</i>						
Male	47.8	47.5	48.1	47.6	47.5	47.0
Female	52.2	52.5	51.9	52.4	52.5	53.9
<i>Highest education</i>	<i>n=3299</i>	<i>n=3152</i>	<i>n=1646</i>	<i>n=1562</i>	<i>n=1653</i>	<i>n=1590</i>
None	26.2	26.3	26.0	27.9	26.3	24.7
Primary	22.0	20.6	26.7	21.7	17.3	19.6
Secondary	42.4	44.4	40.8	44.1	44.1	44.7
Higher education	9.4	8.7	6.6	6.3	12.3	11.0
<i>Marital status</i>	<i>n=3299</i>	<i>n=3152</i>	<i>n=1646</i>	<i>n=1562</i>	<i>n=1653</i>	<i>n=1590</i>
Single	16.3	15.9	16.0	14.4	16.6	17.4
Married	63.9	62.7	65.9	66.2	62.0	59.2
Divorced	19.8	21.4	18.1	19.3	21.4	23.4

Table A.2 Profile of key informants in each study and the national level

Stakeholders	Position / employment	Number
Community members	Fishermen, farmers	3
	Traders, farmers, unemployed	3
	Traditional and opinion leaders	3
	Religious leaders	2
Health facility staff	Staff nurse	1
	Community health nurse	1
	Midwife	1
	Medical assistant	1
District health Directorate staff	Disease control officer	1
	Hospital administrator	1
	District director of health	1
District Health Insurance Scheme staff	Accountant	1
	Manager	1
Total		20
	National Health Insurance Authority staff	2
	Ministry of Health staff	1
	Ghana Health Service staff	1
Total		4
Grand total		24

Table A.3 NHIS status of households and individuals in 30 communities in Central and Eastern Regions (%)

Communities	Poverty incidence	Households (N = 3301)			Individuals (N = 13857)		
		insured	Currently insured	Previously insured	insured	Currently insured	Previously insured
Elmina (U)	10.9	31.8	2.7	65.5	41.8	3.4	54.8
Amama (R)	28.4	29.4	4.6	66.1	27.3	3.8	68.9
Moree (U)	28.8	21.6	16.2	62.2	14.7	11.1	74.3
Anomabo (U)	32.1	9.2	10.1	80.7	4.8	11.3	83.8
Apam (U)	39.8	23.0	23.9	53.1	16.8	33.3	49.9
Winneba (U)	11.8	14.5	14.5	70.9	8.7	12.4	78.9
Nyakrom (U)	14.5	12.7	10.0	77.3	6.3	8.2	85.4
BremanAyipey (SM)	38.9	25.9	13.0	61.1	27.3	26.0	46.7
Kokoben (SM)	43.6	18.2	19.1	62.7	15.3	16.9	67.7
Assin Achiano (R)	43.6	19.1	10.9	70.0	20.5	12.7	66.9
Jukwaa (U)	10.9	35.5	9.1	55.5	28.8	8.1	63.0
Dunkwa-on-Offin (U)	29.1	33.6	13.6	52.7	41.3	13.7	45.0
Assin Akrofuom (SM)	24.5	39.1	16.4	44.5	41.6	20.4	38.0
Afoso (SM)	29.1	50.0	12.7	33.3	56.1	11.9	31.9
Akim Akroso (U)	18.2	17.3	10.0	72.7	20.1	11.2	68.7
Asamankese (U)	14.5	37.3	10.0	52.7	40.5	12.0	47.5
Alafia No. 1 (R)	23.6	24.5	22.7	52.7	23.3	32.1	44.6
Kokoso Aboabo (R)	31.8	13.6	15.5	70.9	12.0	12.9	75.1
Akim Apapam (SM)	24.8	47.3	8.2	44.5	47.6	4.5	47.9
Akyem Hemang (SM)	30.6	33.9	17.4	48.6	32.7	22.2	45.1
Koforidua (U)	0.0	50.9	26.4	22.7	56.1	22.7	21.2
Ntoaso (R)	27.9	16.2	26.4	54.5	14.1	18.5	67.4
Adawso (SM)	20.9	29.	16.4	54.5	16.7	16.7	66.5
Burukum Maumi (R)	56.4	33.6	13.6	52.7	31.0	11.5	57.5
Nuaso (SM)	8.2	40.0	25.5	34.5	48.6	20.6	30.8
Akosombo (U)	11.9	32.1	27.5	40.0	35.7	33.6	30.6
Pitiku (SM)	31.5	26.1	5.4	68.5	31.9	3.3	64.8
Kwakese (R)	34.8	26.8	26.8	46.4	26.0	34.2	39.7
Bunso (SM)	23.6	53.6	27.5	43.6	57.8	2.9	39.3
Oframase (SM)	29.4	56.9	4.6	38.5	66.2	5.2	28.6
Total		30.1	14.3	55.6	30.0	15.7	54.3

Rural = R, Semi-urban = SM, Urban = U

Source: Fieldwork, baseline household survey, March 2009.

The poverty line used is according to GLSSV report: Lower poverty line is GH¢ 288: minimum amount of money needed to meet nutritional requirements of household members for a year. Upper poverty line is GH¢ 370: total amount of money needed to meet food and non-food consumption requirements of household members annually. All households whose monthly per capita expenditure falls below GH¢ 30.8 are considered poor.

Table A.4 Reasons for enrolling, not renewing membership and not enrolling in the NHIS

	Overall (N=3301)	Anomabo (N=109)	Achiano (N=110)
<i>Reasons for enrolling</i>	<i>n=1007</i>	<i>n=9</i>	<i>n=20</i>
Financial protection against illness	76.2	100	75.0
It is better than cash and carry	20.2	0	23.0
The school insured my child	0.5	0	0
A relative asked me to join	1.5	0	0
Community opinion leader asked me to join	0.3	0	0
Employer paid	1.4	0	0
<i>Reasons for not renewing registration</i>	<i>n=422</i>	<i>n=11</i>	<i>n=11</i>
Cannot afford cost of premium	61.4	81.8	63.3
Did not use services last year	7.1	0	0
Not satisfied with provider	6.4	0	0
Difficulty of accessing service	3.3	0	0
Facility too far	4.5	0	0
No transport money	0.2	0	0
Inappropriate timing of premium payment	4.5	0	0
Had to buy drugs outside the facility	1.2	0	0
I believe I was given poor quality care	0.7	0	0
Covered elsewhere	0.2	0	0.3
Other	10.4	18.2	27.3
<i>Reasons for never enrolling</i>	<i>n=1736</i>	<i>n=88</i>	<i>n=72</i>
Cannot afford cost of premium	72.5	86.4	80.6
Mostly healthy do not need to insure	8.6	2.3	1.4
No confidence in the NHIS	6.6	6.8	1.4
Registration point too far	2.1	0	5.6
No close facility	1.1	0	5.6
No scheme in the area	0.5	0	2.8
Covered elsewhere	0.1	0	0
My employer pays for me	0.5	0	0
Have private insurance	0.2	0	0
Never heard of NHIS	0.1	0	0
Other	7.6	4.5	2.8

Source: Fieldwork, baseline household survey, March 2009

Table A.5 Benefits of NHIS derived by the insured

Benefits of NHIS	Agree	Neutral	Disagree
<i>30 communities (n=933)</i>			
NHIS saves money from paying hospital bills	89.7	7.0	3.3
Did not need to borrow money to pay hospital bills	87.1	9.0	3.9
HI makes me independent, I don't need to ask for money from elsewhere when ill	88.6	8.4	3.0
<i>Anomabo (n=10)</i>			
NHIS saves money from paying from paying hospital bills	70	0	30
Did not need to borrow money to pay hospital bills	60	10	30
HI makes me independent, I don't need to ask for money from elsewhere when ill	60	40	0
<i>Achiano (n=21)</i>			
NHIS saves money from paying from paying hospital bills	95.2	0	4.8
Did not need to borrow money to pay hospital bills	85.7	4.8	9.5
HI makes me independent, no need to ask for money from elsewhere when ill	71.7	19.0	9.3

Source: Fieldwork, baseline household survey, March 2009

Table A.6 Opinions associated with the NHIS and quality of service delivery

	Currently insured			Previously insured			Never insured		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
N=3298									
Three months' probation period for receiving service is adequate	17.5	11.9	70.6	11.7	14.0	74.3	12.2	20.2	67.7
Even though one is insured you still have to buy drugs	47.5	9.6	42.9	41.6	8.7	49.7	38.7	14.7	46.6
Attitude of health staff should be improved	81.7	13.1	5.1	81.5	11.5	7.0	80.9	15.0	4.1
Availability of drugs should be improved	87.7	9.6	2.7	90.2	7.4	2.3	84.7	13.1	2.2
N=3297									
Expect prompt attendance at the facility	86.1	14.0	0	82.2	17.8	0	22.8	17.9	59.3
It is good to be a member even if I don't fall sick	89.0	2.7	8.4	74.5	15.1	10.4	65.6	6.3	28.1

Source: Fieldwork, baseline household survey, March 2009

Table A.7 Profile of PSG members in the two case study communities

Achiano	Anomabo
Community members	
Chemist shop owner, volunteer (facilitator)	Volunteer
Cocoa purchasing clerk, farmer	NHIS collector (facility)
A community elder	Secretary to the traditional council
Mobile banker / farmer	Trader, volunteer
Teacher / NHIS collector	Teacher
Cocoa purchasing clerk / farmer	Fisherman
Cocoa purchasing clerk	GPRTU chairman
Kushea Health Centre	Anomabo Health Centre
In-charge / midwife	Community Health nurse
Biostatistician	Health assistant
Praso Health Centre	Nurse
Medical Assistant	District hospital
Dispensary Assistant	Focal person on health insurance at the District Hospital
DHIS	
Public relations officer (Secretary)	Public relations officers (facilitator)
Data entry operator	Management information system officer

Table A.8 Profile of PSG facilitators

	No.	Role/Position
Community members	3	Assemblymen
	1	NHIS collector
	5	Health volunteers in central
	1	Traditional birth attendant
	3	Self-employed
	2	Farmers
	1	Medical Assistant
Ghana Health Service staff	1	Focal person on health insurance at the District
		Hospital
	1	Principal field technician (Disease control unit)
District Health Insurance Scheme staff		
Central	1	NHIS manager
Central	5	Public relation officers
Eastern	1	Claims managers
Eastern	5	Public relation officers
Total	30	

Table A.9 Changes in NHIS status of individuals in intervention communities after the MSPSP

Intervention communities	N		Currently insured (%)					Previously insured (%)				
	2011	2009	2011	2009	Δ%	P-values	χ ²	2011	2009	Δ%	P-values	χ ²
Akosombo	452	468	53.1	36.0	17.1	0.000	27.42	24.6	33.4	-8.9	0.003	8.74
Akyem Hemang	439	486	47.6	32.7	14.9	0.000	21.35	17.1	22.2	-5.1	0.050	3.84
Anomabo	445	520	15.3	4.8	10.5	0.000	30.20	18.7	11.4	7.3	0.001	10.20
Apam	452	501	16.6	16.8	-0.2	0.943	0.005	40.7	33.3	7.4	0.018	5.55
Asaman-kese	386	358	53.4	40.5	12.9	0.000	12.34	30.6	12.0	18.6	0.000	37.73
Assin-Achiano	459	528	49.5	20.3	29.2	0.000	93.45	19.6	12.7	6.9	0.003	8.79
Assin Akrofuom	475	524	63.2	41.4	21.8	0.000	47.18	15.6	20.4	-4.8	0.047	3.94
Breman-Ayipey	540	578	50.0	27.3	22.7	0.000	60.70	13.2	26.0	-12.8	0.000	28.86
Bunso	438	445	48.9	57.8	-8.9	0.008	7.02	29.7	2.9	26.8	0.000	116.48
Elmina	368	446	32.3	40.9	-8.6	0.011	6.40	26.9	3.8	23.1	0.000	88.22
Kokoso-Aboabo	481	434	35.8	12.0	23.8	0.000	69.77	15.4	12.9	2.5	0.283	1.15
Ntoaso	398	426	25.1	14.3	10.8	0.000	15.28	26.1	18.3	7.8	0.007	7.31
Oframase	451	441	67.6	66.2	1.4	0.654	0.20	17.1	5.2	11.9	0.000	31.50
Pitiku	639	639	23.6	31.9	-8.3	0.001	10.96	21.9	3.3	18.6	0.000	100.63
Winneba	367	437	21.3	8.7	12.6	0.000	25.48	25.1	12.4	12.7	0.000	21.69

Source: Fieldwork, March 2009 and March 2011

Note: 'Δ' means change

Table A.10 Reasons for enrolling, not enrolling and renewing membership in the NHIS

	Intervention communities
<i>Reasons for enrolling</i>	<i>n = 657</i>
Financial protection against illness	75.2
NHIS is better than cash and carry	23.6
The school insured my child	0.8
A relative asked me to join	0.0
Community opinion leader asked me to join	0.1
Employer paid for me	0.3
<i>Reasons for not renewing registration</i>	<i>n = 538</i>
Cannot afford cost of premium	67.3
Did not use services last year	7.7
Not satisfied with provider	7.8
Difficulty of accessing service	5.4
Facility too far	0.6
No transport money	0.2
Inappropriate timing of premium payment	1.7
Had to buy drugs outside the facility	0.7
I believe I was given poor quality care	0.9
Covered elsewhere	0.7
Other	7.2
<i>Reasons for not enrolling</i>	<i>n = 826</i>
Cannot afford cost of premium	73.2
Healthy do not need to insure	12.3
No confidence in the NHIS	6.2
Registration point too far	1.1
No close facility	0.4
No scheme in the area	0.4
Have private health insurance	0.7
My employer pays for me	0.1
Other	5.6


Source: Fieldwork March 2011

Table A.11 Opinion about NHIS and quality of service expected in intervention communities after the MSPSP

	Currently insured			Previously insured			Never insured		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
N=3297									
Health personnel treat patients with insurance cards in an equal way	66.0	7.5	26.5	48.5	9.9	41.7	38.1	22.0	39.9
It is good that scheme does not register children without their parents	32.7	10.4	56.8	20.7	11.4	67.9	20.7	18.3	61.0
District scheme personnel are trustworthy	75.4	13.0	11.6	53.4	26.9	19.8	49.4	36.4	314.2
Even though one is insured you still have to buy drugs	64.0	11.6	24.4	58.2	10.8	31.0	50.0	19.8	0.2
Attitude of health staff should be improved	76.6	14.7	8.7	87.0	9.6	3.4	74.7	18.3	7.0
Availability of drugs should be improved	83.7	11.2	5.1	90.1	7.1	2.8	78.6	17.7	3.7
Expect prompt attendance at the facility	75.8	11.4	12.8	68.8	18.5	12.7	64.7	21.6	13.8

Source: Fieldwork, March 2011

Appendix 3: NHIS form filled by healthcare providers on insured patients



NATIONAL HEALTH INSURANCE SCHEME

Claim Form (Regulation 62) Form no. _____
 HI Code: _____

Important! The form should be completed IN CAPITAL LETTERS using a BLACK or DARK BLUE ballpoint/fountain pen. Characters and marks used should be similar in the style to the following:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0 ☒ ☑

Scheme Code* _____ Month of Claim* _____

CLIENT INFORMATION

Surname * _____ Gender: Male Female

Other Names _____

Date of Birth _____ Age _____ Member Number* _____

Hospital Record No. _____ Card Serial Number* _____

SERVICES PROVIDED (to be filled-in by all health care providers)

<p>Type of Services <i>select only one</i></p> <p>(a.) <input type="checkbox"/> Outpatients <input type="checkbox"/> In-patient <input type="checkbox"/> Pharmacy <input type="checkbox"/> Diagnostic</p> <p>(b.) <input type="checkbox"/> All Inclusive <input type="checkbox"/> Unbundled</p> <p>Outcome:</p> <p><input type="checkbox"/> Discharged <input type="checkbox"/> Died <input type="checkbox"/> Transferred out <input type="checkbox"/> Absconded/Discharged against medical advice</p> <p>Type of Attendance:</p> <p><input type="checkbox"/> Chronic Follow-up <input type="checkbox"/> Emergency/Acute episode</p>	<p>Date(s) of Service Provision:</p> <p>1st Visit/Admission _____</p> <p>2nd Visit/Discharge _____</p> <p>3rd Visit _____</p> <p>4th Visit _____</p> <p>Duration of Spell (days) _____</p>
--	--

Specialty Code: _____

PROCEDURE(S) (to be filled-in by health care providers who have provided out or In-patient services)

Physician/Clinician Name _____ Physician/Clinician ID _____

#	Description	Date	G-DRG
1		_____	_____
2		_____	_____
3		_____	_____

* Mandatory Field

NHIS Claim Form

Form no.

DIAGNOSIS(ES) (to be filled-in by health care providers who have provided out or in-patient services)

	Description	ICD-10	G-DRG
1		<input type="text"/>	<input type="text"/>
2		<input type="text"/>	<input type="text"/>
3		<input type="text"/>	<input type="text"/>
4		<input type="text"/>	<input type="text"/>

INVESTIGATIONS (to be filled-in by health care providers providing diagnostics services only)

	Description	Unit Price	Date	G-DRG
1		<input type="text"/>	<input type="text"/>	<input type="text"/>
2		<input type="text"/>	<input type="text"/>	<input type="text"/>
3		<input type="text"/>	<input type="text"/>	<input type="text"/>
4		<input type="text"/>	<input type="text"/>	<input type="text"/>
5		<input type="text"/>	<input type="text"/>	<input type="text"/>

MEDICINES (to be filled-in by health care providers who have dispensed medicines)

	Description	Price	Qty	Total Cost	Code
1		<input type="text"/>	<input type="text"/>		<input type="text"/>
2		<input type="text"/>	<input type="text"/>		<input type="text"/>
3		<input type="text"/>	<input type="text"/>		<input type="text"/>
4		<input type="text"/>	<input type="text"/>		<input type="text"/>
5		<input type="text"/>	<input type="text"/>		<input type="text"/>

CLIENT CLAIM SUMMARY

Type of Service	G-DRG/Code	Tariff Amount
In-Patient	<input type="text"/>	<input type="text"/>
Out-Patient	<input type="text"/>	<input type="text"/>
Investigations		<input type="text"/>
Pharmacy		<input type="text"/>

Name

Signature

(Health Facility Insurance Officer)

TOTAL



Scheme Use Only

Date Received * <input type="text"/>	Action 1 <input type="text"/>	Date <input type="text"/>	Signed <input type="text"/>
Signed <input type="text"/>	Action 2 <input type="text"/>	Date <input type="text"/>	Signed <input type="text"/>

*Mandatory Field

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Summary

This study presents the outcome of a multi-stakeholder problem-solving programme (MSPSP). It aimed at improving enrolment and retention in the National Health Insurance Scheme (NHIS) in Ghana. The NHIS was introduced in 2004 following criticism that on-the-spot payments denied vulnerable groups access and did not achieve the overall benefit of quality healthcare. The aim was to improve the quality of service and ensure equity in access to healthcare. However, despite the heavily subsidised premium and exemption for vulnerable groups, enrolment among the general population has remained low and the poor, who are the target of the policy, are the least enrolled. The primary aim of this anthropological study was to assess if and how problem-solving groups (PSGs) could increase enrolment in the NHIS and retain members.

Chapter one is an introduction to the study, which is part of a larger multidisciplinary project involving economic and anthropological approaches. The chapter presents the research objective and questions and some relevant theoretical concepts. The theoretical foundation of the study is situated within critical medical anthropology based on the idea that medical anthropologists have both professional and moral obligation to explore and address the socio-economic, cultural and political contexts in which health inequities manifest. Taking note that many stakeholders are involved in the NHIS policy – politicians, policy makers, implementers, healthcare workers and community members – I employed the multi-level perspective (MLP) as a conceptual framework and methodological tool to describe and analyse how the multiple (sometimes conflicting) interests, views and practices of these various actors affected the policy uptake. My other standpoint was that stakeholder collaboration often fails because they do not effectively engage implementers and the target population of the policy from the onset.

Chapter two presents the study design, relevant information about the study sites, data collection tools, analytical techniques and a reflection on the researcher's role as a participant observer in the intervention group. This study draws on data from qualitative research in seven intervention communities in the Central region including: Anomabo and Assin Achiano, which I used as case study communities, and five others I visited during the study. Pre- and post-intervention household surveys were also conducted, in March 2009 and March 2011, respectively in 30 communities in the Central and Eastern Regions of Ghana.

To show the depth of the problem to be addressed, chapter three discusses barriers and enablers to enrolment in the NHIS and retention of members. It presents the

experiences of users and implementers of health insurance within and outside PSGs. It also looks at the historical context in which the NHIS was introduced, which affected people's decisions to enrol or not and the work of the DHISs. Community members mentioned poverty, traditional concepts of risk-sharing, disrespect of health providers towards insured patients, delays at health facilities, difficulties in obtaining prescribed drugs, collection of unauthorised fees and national politics. Health providers faced problems of heavy workloads as a result of the increased utilisation of healthcare, bureaucratic red tape and delays in claim payments leading to shortages of drugs. Staff of the DHISs complained about inadequate equipment, difficulties processing NHIS forms and granting exemptions to the core poor. The NHIS was perceived by many as a tool to build political capital, so some political opponents of the then government decided not to enrol.

Chapters four and five focus on the problem-solving intervention programme. Chapter four describes processes followed to set up the intervention group, PSGs, and the selection of facilitators. Four main themes are discussed. First, stakeholders' were sensitised about the problems of low enrolment in the NHIS and high membership non-renewal rates and the purpose of the intervention. This raised their interest in the intervention and made them willing to work together for change. How they were involved in the setting of PSGs forms the second theme of the chapter. I describe how community members, health providers and DHIS staffs were mobilised to assume the responsibility of forming PSGs. Heads of health facilities, District Health Directorates and the DHISs selected their staff based on their work schedules while community members devised an open election process. Opinion leaders and research assistants led events at community durbars to select their representatives. This strengthened trust among stakeholders, and laid the foundation for the intervention and a commitment to achieve set objectives. However, the low representation of women and exclusion of the poor indicate that unless extra strategies are developed to include them, the open election processes reduce participation to abstract theory. The third theme is the selection of facilitators for PSGs. Facilitators and secretaries were selected from PSG members to form the leadership. The fourth theme is facilitators training. Facilitators were the catalysts for PSGs functioning and were equipped with special skills in a three-day workshop. The workshop helped the facilitators provide the required leadership to create a shared vision among PSG members and stakeholders, facilitate meetings and mobilise the PSGs to effectively participate in intervention activities to achieve positive outcomes.

Chapter five discusses the tools and participatory approaches the PSGs employed to identify barriers to enrolment and retention of members, and develop and implement intervention activities to improve NHIS coverage. Barriers experienced by the community included: poverty, collection of unauthorised fees and traditional

concepts of risk sharing. Health providers mentioned the heavy workload and delays in claim payments while the district health insurance staff complained about inadequate equipment and difficulties faced processing NHIS forms. Intervention activities developed and implemented to redress these barriers were durbars, documentary films, drama, and community leaders' and stakeholders' meetings, education at health facilities, churches, mosques, schools, lorry stations, setting registration points in the community and provision of cameras to collectors to take pictures immediately as they registered people.

Chapter six presents the outcome of the problem-solving intervention programme. Overall, PSGs significantly increased enrolment by 10.6 per cent from 29.7 to 40.3 per cent but could not improve retention rates. Probit model analysis showed that residents in intervention communities were 17 per cent more likely to enrol compared to control communities. Ten communities showed significant increases in enrolment, two had no change and three recorded significant decreases. PSGs however, failed to influence the poorer and poorest quintiles to enrol. They had the lowest enrolment rates – poorest 17.6 per cent, poor 31.3 per cent – compared to the 46.4 and 44.4 per cent among the rich and richest quintiles. Disappointingly, membership non-renewal rates increased among the general population: from 15.5 to 22.4 per cent. Nonetheless, probit model analysis showed that residents in intervention communities were five per cent less likely to drop out of the NHIS compared to those in the control group.

Chapters seven and eight examine factors that enhanced the PSGs' functioning and factors that limited their efforts at improving enrolment and retention rates. Chapter seven discusses factors that stimulated enrolment. These were the awareness that NHIS provided prompt access to healthcare and financial relief from catastrophic payment and reduced complications among patients. The advocacy role of opinion and community leaders and health providers to promote the NHIS was another stimulating factor. Insured opinion and community leaders sharing the benefits they derived from the NHIS convinced people that it was a viable alternative to on-the-spot payment. Health providers educated community members and their patients on the benefits of health insurance and persuaded them to enrol. These health providers had a greater impact on community members than the regular education by DHIS staff and collectors. Rather than the traditional practice, where health providers and community members are considered only as implementers and consumers of the NHIS policy and excluded from planning and executing intervention activities, their involvement in this intervention led to increase in enrolment. Chapter eight revealed that contrary to the popular notion that the NHIS would ensure equity in access to quality healthcare services was not evident. The PSGs' achievements were limited by their inability to resolve some of the barriers identified in chapter three: poverty, inadequate exemption for the poorest quintile,

negative attitudes towards health insurance, unenlightened self-interest, shortages of drugs at health facilities, collection of unauthorised fees at health facilities and payment for drugs covered by the NHIS.

The study concludes with a discussion of the key findings in chapter nine. I argue that although the NHIS improves access to healthcare, provides financial relief and reduces complications among patients, a range of factors including politicians, policy makers, implementers and targets of the policy continued to undermine equity and improvement of quality service goals. Politicians saw health insurance as a tool to secure electoral victory and failed to expand health facilities' capacity to handle the expected increase in patient numbers before introducing the insurance scheme. They also did not seriously consider what constitutes quality service to insured patients, so there were missing links and contradictory expectations among the various stakeholders at multiple levels regarding what would improve quality of service and stimulate enrolment and retain members in the NHIS. The politicians only paid lip service to the exemption policy by setting homelessness as a criterion for poverty, a condition that rarely exists in Ghanaian communities, thus denying the core poor their exemption. Health providers who saw the NHIS as increasing their workload tended to be hostile to insured patients and charged extra fees. Community members thought they should benefit with minimum financial investment so usually enrolled only household members who needed healthcare. The DHISs staffs were more interested in revenue generation than granting exemptions to the core poor. They emphasised the homelessness criterion that eliminates almost all potential beneficiaries and ignored other criteria stated in the policy that more accurately reflect the status of the core poor in their districts. The DHISs' staff and collectors pursued activities to enrol premium-paying members and made no effort to prevent the exclusion of non-paying poor from the NHIS.

The multiple – and often conflicting – interests converged to limit the PSGs' efforts at improving enrolment and retaining members in the NHIS. Although the intervention could not achieve all objectives, by situating barriers and enablers at the level of local stakeholders and highlighting their concerns, the reality involved in implementing the NHIS policy and uptake is made clearer to policy makers. This study adds ethnographic information to the growing literature on social health insurance in Africa and sheds light on how to identify and address barriers to achieve policy goals.

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