
The National Health Insurance Scheme (NHIS) Of Ghana: A Ghanaian Patient Perspective

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Citation

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Abstract

This is an account of a study of thirty-six patients in the Greater Accra and Volta regions in Ghana. As an IRB-approved qualitative study, structured interviews were conducted at the outreaches of Unite for Sight partner eye clinics around rural Ghana. Patient responses were recorded, organized, and analyzed to gain a better understanding of the patient perspective of the National Health Insurance Scheme (NHIS) of Ghana.

INTRODUCTION

Preliminary results of the 2010 Population and Housing Census estimates the total population of Ghana to be 24,223,431 (51.3% female, 48.7% male) with the majority of individuals (35.6% of total population) living in the Ashanti region or the Greater Accra area¹. It is projected that around 50% of the population lives in rural communities². The GDP per capita (PPP) is estimated at \$1,600 with 28.5% of the population living below the world poverty line (\$1.25/day)³.

Ghana has been overwhelmed with a variety of diseases such as malaria, hepatitis, tuberculosis, typhoid fever, and HIV. Currently there are 1,433 state-operated hospitals and 1,299 private and quasi-government run hospitals, many of which are located in urban areas⁴. In 2005, Ghana introduced the National Health Insurance Scheme (NHIS) to help improve access to existing healthcare systems and ease financial burdens to healthcare by basing the deductible on an individual's annual income⁵.

There are now 145 health insurance districts that have been established in Ghana. Currently, three types of health insurance schemes are provided: district mutual, private commercial, and private mutual⁶. There are currently 15,555,816 total registered members (64% of the total population).

Despite the government's efforts to expand the NHIS, there is still a large number of people who have not enrolled with the NHIS program. A survey of the general population in two rural districts of Ghana observed that "the proportion of

adults who have ever registered with NHIS was lowest in the poorest quintile [...]7". The study also suggests that the main reason for not registering with NHIS, despite the sliding scale deductible, is because the "premium is too expensive."

It isn't surprising to find out that the main reason for non-enrollment in the NHIS is financial. In a country where over a quarter of the population lives below the world poverty line, distribution of finances needs to be carefully measured. However, considering the sliding scale deductible, it should be reasonable to believe that anyone should be able to afford enrollment despite his or her socioeconomic status. This would suggest that there are other reasons, beyond the cost of the premium, for non-enrollment in the NHIS.

In this study, a verbal patient-based survey was employed at village outreaches by Unite for Sight partner eye clinics around rural Ghana. Unite for Sight provides eye healthcare to the most remote parts of Ghana where medical access is limited. It has established itself in many communities and provided access to areas which there exists little international information about. All eye care in these clinics is provided by local nurses, optometrists, and ophthalmologists and is supported by the Unite for Sight organization. This survey was used as a means to explore and discuss other possible reasons for non-enrollment in the NHIS, and to assess the relationship between a patient's demographics and the patient's enrollment and/or satisfaction with the NHIS.

The NHIS covers a wide variety of health problems in addition to some of the ophthalmic conditions encountered at the Unite for Sight outreaches. Ideally, having access to a greater variety of medical clinics would provide a better sample of participants with different medical needs.

However, it was learned that although these patients were at these clinics primarily for eye difficulties, most patients also had many other health conditions such as: hypertension, back problems, malaria, etc.

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METHODS

Data

All patients were interviewed by the researcher with the help of an organized questionnaire. Questions were asked with the help of local translators and the answers transcribed to paper. Participants were randomly selected with the only criteria being that the patient be at least 18 years of age. Participation was strictly voluntary. Care was taken to ensure that the patient understood that no identifiable information would be recorded.

Initially it was proposed to have many participants in this study. However, it was shortly realized that this would not be the case. Although the official national language of Ghana is English, the people in many of these remote communities do not speak English. The vast amount of languages and dialects spoken throughout Ghana, even within local villages, made it exceedingly difficult to interview patients. Although the Unite for Sight organization provided locally trained translators wherever possible, there were still many patients that could not be translated for. In addition, patients sometimes waited several hours for eye care. Therefore, finding participants who were willing to give extra time in order to discuss the NHIS was difficult.

Analysis

First, the demographic of the patient was observed. This included the patient's age, number of persons the patient is taking care of, and number of members in the patient's

household. In order to assess the poverty level of a patient the Simple Poverty Scorecard for Ghana was used⁸. This score is based on things such as: occupation, the material of what a person's roof is constructed of, access to a radio, where drinking water is obtained, and how food is cooked. The range of scores for the likeliness of a patient to possess a poverty status was divided into thirds: bottom, middle, and top to see if there was any correlation between poverty level and the patient's enrollment and/or satisfaction of the NHIS. Poverty Score refers to the economic status of the patient (eg. the lower the score, the more likely to be impoverished). Next, the patient's past medical history was looked at to see if there was any correlation with enrollment and/or satisfaction of the NHIS. This was accomplished by looking at the last time the patients saw a doctor and the total number of doctors' visits the patient had in the past twelve months.

The patient's premium for enrollment into the NHIS and the patient's opinion on what the premium should cost were noted to assess any correlations with a patient's enrollment and/or satisfaction of the NHIS.

Each patient was ultimately placed into one of three categories: (1) not enrolled in the NHIS, (2) enrolled in the NHIS and unsatisfied, and (3) enrolled in the NHIS and satisfied. These questions served as a platform in which to discuss the patient's thoughts about the NHIS program to assess other possible reasons beyond finances for why certain Ghanaians have not enrolled or satisfied with the NHIS.

RESULTS/ DISCUSSION

Thirty-six patients were interviewed in four different locations: three locations in the Volta region and one in the Greater Accra region. Eighteen males and eighteen females were interviewed; gender did not have a significant effect on results. Of the thirty-six participants, 26 were enrolled in the NHIS and 10 were not enrolled. Of those enrolled in the NHIS, 19 participants were satisfied and 7 were unsatisfied with the NHIS.

The mean age of the patients is 58.6 years (Figure 1). The mean number of persons a participant is taking care of is 3.1 and the mean of the total members in a household is 7.5. The average Poverty Score is 48.1 out of 100 (results ranged from 27 to 68). There were 9 participants in the lower third, 17 in the middle third, and 10 in the upper third of scores (Table 1).

Figure 1

Mean age of participants

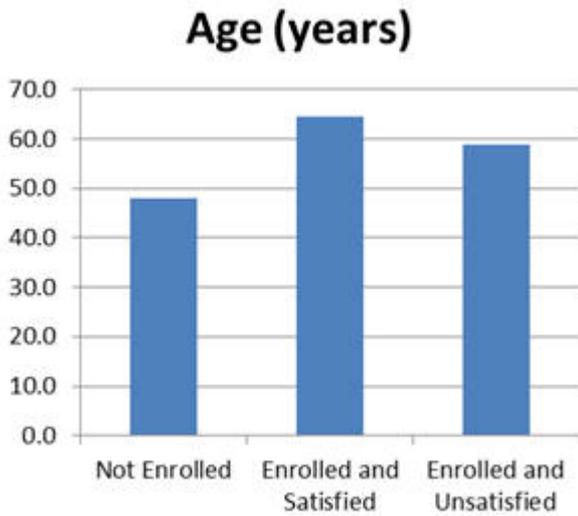


Table 1

Summary Table of Participant Averages

	Unenrolled	Enrolled and Satisfied	Enrolled and Unsatisfied
Number of participants	10	19	7
Age [years]	47.9	64.4	58.9
Persons taken care of	2.0	3.1	4.4
Members in household	6.5	6.9	9.9
Most recent doctor visit (months)	7.6	2.3	8.1
# of doctors' visits in past year	0.5	4.3	1.7
Premium paid for NHIS enrollment (GH¢)	N/A	5.7	7.9
Suggested cost for NHIS enrollment (GH¢)	3.3	4.5	4.9

It is important to note the older age of participants, as seen in the mean age of 58.6 years. This may partially be explained by the setting in which these interviews took place. Because these interviews were conducted on Unite for Sight outreaches, any given participant is more likely to be of an older age since older populations tend to have a greater frequency in eye problems.

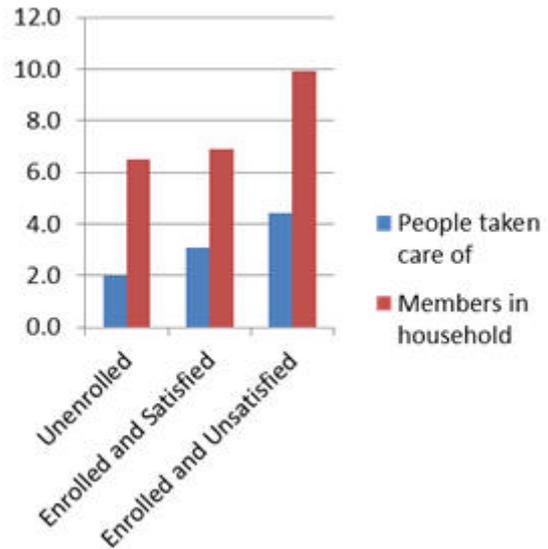
The main criticism amongst all participant groups was that the premium cost is too high. The majority of participants who were not enrolled in the NHIS had some interest in enrolling pending the correction of the problems they saw with the program. Only two participants had absolutely no interest in enrolling in the NHIS.

Participants who were enrolled in the NHIS on average took care of 1.5 persons more than those unenrolled (3.5 persons versus 2 persons). This may be explained by the fact that individuals who take care of more persons are more likely to be of lower socioeconomic status⁸. In addition to a lower

premium for enrollment, taking care of more persons may lead to an increased need to save on medical costs therefore justifying enrolling in the NHIS (Figure 2).

Figure 2

Participant Demographics

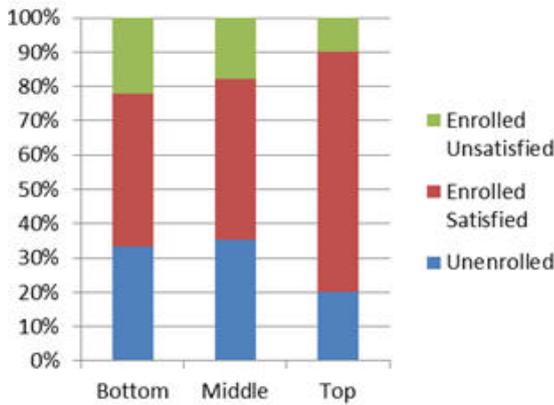


Because individuals who take care of more persons have an increased need to save on medical costs through enrollment in the NHIS, it would be expected that enrolled participants taking care of more persons would be more satisfied. However, those who were enrolled and satisfied with the NHIS on average took care of 1.3 persons less than those unsatisfied (3.1 persons versus 4.4 persons). This suggests that there may be an inherent issue within the NHIS, beyond the costs of the premium, which is affecting the enrollment and/or satisfaction in the program.

By examining the Poverty Scores, it is apparent that the bottom and middle thirds had similar correlations with a participant's likeliness for enrollment and satisfaction with the NHIS. This may be attributed to the differing costs depending on the socioeconomic status of an individual. Additionally, this shows that the implementation of the sliding scale deductible helps make enrollment more affordable, which suggests that the premium costs is not the only factor in determining the enrollment and/or satisfaction in the NHIS. Participants in the top third of Poverty Scores were more likely to be enrolled and be satisfied with the NHIS because of the possibility that participants in the top third may be able to more easily afford these premium costs for enrollment as well as the costs for other medical needs (Figure 3).

Figure 3

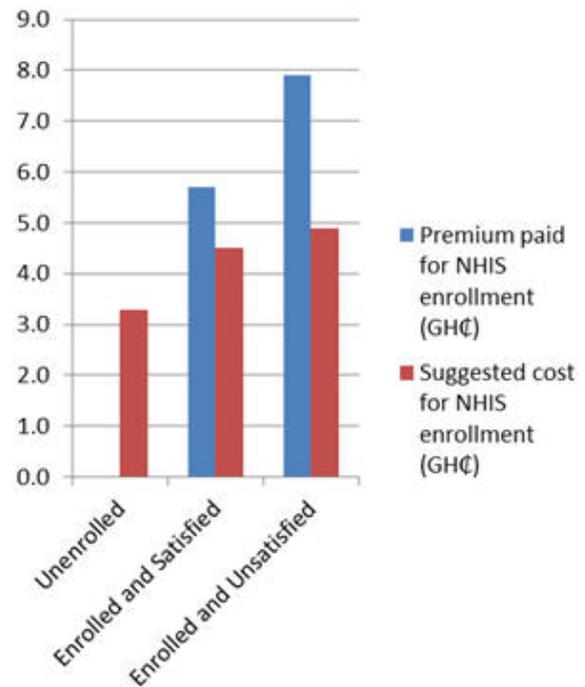
Distribution of enrollment and satisfaction based on Poverty Score



The average premium that was paid for enrollment into the NHIS was GH₵6.4 (approx. \$ 4.2 USD). The average premium paid by those who were satisfied with the NHIS was GH₵5.7 (\$3.8 USD), 27.8% lower than premium paid by those who were not satisfied with NHIS (GH₵7.9 (\$5.2 USD)). When participants were asked about what they thought the premium for enrollment should cost, the average prices of their suggested responses were all less than what they currently paid (Figure 4).

Figure 4

Average premium paid and suggested premium costs for enrollment in the NHIS



However, the actual difference between what patients were paying and what they suggested is not much, considering that the premiums are already low. Even at the highest average costs for enrollment into the NHIS program (GH₵7.9 (\$5.2 USD)), enrollment into the NHIS should not be a problem due to the sliding scale deductible; even those of the lowest economic status should be able to afford enrollment in the NHIS.

Although this survey had a modest sample size, these statistics give a brief window into the relationship between patient demographics and enrollment and satisfaction in the NHIS. These questions provide a platform in which to discuss other issues beyond the costs of the premium which may effect enrollment and satisfaction in the NHIS. Though the main criticism of the NHIS was the premium costs for enrollment, participants also voiced other opinions. Many of these concerns reflect other financial worries not directly related to the premium costs.

One expressed concern was the lack of coverage outside of the area where the patients first enrolled in the NHIS. Patients told stories of times when they were denied medical coverage while traveling to other regions of Ghana other than the region in which they enrolled in the NHIS. In addition to patient concerns about coverage during travels,

not all regions have access to the same specialty medical clinics. If this is true, this may partially explain the lack of enrollment and satisfaction in the NHIS regardless of the affordability of the premium.

However, the idea that a patient is only able to receive care in the region in which they enrolled is a misconception of the current NHIS, as the NHIS provides national coverage regardless of the region of enrollment. This misconception is true for the previous health insurance scheme in place before the NHIS was implemented in 2005. Since these rural communities cannot easily access mass media, a reeducation of the general population about the current NHIS, especially those living in these rural communities, may increase the enrollment and satisfaction.

As a relatively new program, the NHIS seems to have a few internal issues that may add to the reasons for the lack of enrollment and satisfaction in the program. Another major criticism was the poor quality of medication and care patients received. Some patients stated that the wait time to see a doctor was too long and that they frequently received incorrect or low quality medication. These patients felt that they should not have to pay a premium for enrollment into the NHIS if they needed to pay extra for access to quality healthcare. Local health professionals attribute this problem to the delay in reimbursement of doctors for seeing patients covered by the NHIS. Although doctors could not deny a patient from being seen, the doctors did not have any obligation to see patients immediately or provide patients with “quality” medications.

An important observation that was made was the lack of transportation and ease of access to medical clinics. It is difficult for patients in rural Ghana to actually get to certain medical facilities. Most individuals living in these communities pay out-of-pocket for transportation to medical clinics. Thus, no matter how affordable the costs of the premium for enrollment into the NHIS, the expenses of transportation to a clinic may be too much of a financial burden for the patients. This was often demonstrated at the Unite for Sight outreaches where patients were referred for surgery. Although these surgeries were sponsored and paid for by the Unite for Sight organization, many patients forwent the surgery because they could not afford the out-of-pocket expenses for transportation to the eye clinic.

These opinions about the NHIS discussed above may help to explain why in this study as well as the study conducted by Drs. Asante and Aikins⁷ saw the lowest enrollment in the

poorest of populations. Individuals of higher socioeconomic status may be more flexible regarding the distribution of their finances and therefore be more able to afford these premiums for enrollment even at higher prices. However, the sliding scale deductible should allow individuals of any socioeconomic status to afford the premium costs. In addition to the premium costs, it also seems necessary to note that individuals of higher socioeconomic status are also more likely own technological means of communication, such as radios, and thus have better access to the media and the correct information regarding the current NHIS. Furthermore, these individuals may be able to more easily afford expenses not covered by the NHIS such as transportation to medical clinics as well as better quality medications once they reach the clinics.

The implementation of the sliding scale deductible is supposed to make the NHIS an affordable program for anyone regardless of socioeconomic status. Still, there is a large proportion of people who have not enrolled with the NHIS. According to the main criticism regarding the NHIS, an overall decrease in the costs of the premiums should allow for greater enrollment and satisfaction with the NHIS. However, with additional time spent with patients to discuss their thoughts and frustrations about the NHIS, it was discovered that perhaps the lack of enrollment and satisfaction with the NHIS has less to do with the price of the premiums and more to do about the ability to utilize the resources provided by the insurance. Whether it is the misinformation about the NHIS or the inability to get to a medical clinic, no one wants to pay for a program that cannot be utilized no matter how low the costs. This is especially true for those of lower economic status where financial flexibility is limited.

Perhaps better informing the public about the current NHIS, reimbursing doctors more quickly so that they can better provide quality healthcare, and providing accessible and cheap means of transportation will help increase the enrollment and/or satisfaction in the NHIS. From this study it is clear that there exist other factors that cause financial worries which are not directly related to the costs of the premium. Therefore, it is suggested that broader, more comprehensive, in-depth studies be conducted to better understand how the many variables, other than just the costs of the premiums, affect an individual’s enrollment and satisfaction with the NHIS.

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