Journal of Public Policy and Administration
2018; 2(4): 71-83
http://www.sciencepublishinggroup.com/j/jppa
doi: 10.11648/j.jppa.20180204.15
ISSN: 2640-2696 (Print); ISSN: 2640-2688 (Online)

SciencePG
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Public Social Policy Efficacy Assessment: Operational Challenges of the Health Insurance Scheme in Ghana

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To cite this article:

Vincent Ekow Arkorful, Ibrahim Basiru, Latif Amadu, Anastasia Hammond, Sarah Pokuaah, Eric Kwadwo Agyei, Nurudeen Abdul-Rahaman, Edward Arthur. Public Social Policy Efficacy Assessment: Operational Challenges of the Health Insurance Scheme in Ghana. *Journal of Public Policy and Administration*. Vol. 2, No. 4, 2018, pp. 71-83. doi: 10.11648/j.jppa.20180204.15

Received: November 7, 2018; **Accepted**: November 26, 2018; **Published**: December 24, 2018

Abstract: Maintaining the health and wealth of a nation largely depends on the state of health care and policies guaranteeing citizens access to health care. It is the policy that creates the enabling operational environment for the health institutions. The purpose of this paper is to examine the current state of the public social policy program delivery, as well as challenges and prospects in three (3) purposefully selected districts each in the selected case study areas of the three (3) Northern regions of Ghana; The Northern Region, Upper East Region and the Upper West Region. The study employed the case study method. Interviews were conducted in communities in the selected districts in the regions using a semi-structured interview guide. The study relied on primary sources of data. Primary data were obtained through interview schedule and interview guide. The study identified reimbursement delays, widespread poverty among denizens of the study area, human resource constraints, infrastructural challenges and unethical conduct of health professionals. Others include: limited drug coverage under the scheme, logistical constraints, fraud and abuse, and delays in documents processing. The study therefore recommended among others things that, stakeholders, as part of concerted efforts to sustain the policy in the Northern, Upper East and the Upper West Region should integrate social justice, and vulnerability considerations into the policy to favour the poor and the socially marginalized.

Keywords: Public Social Policy, National Health Insurance Scheme, Operational Challenges, Northern Region, Ghana

1. Introduction

Public social policy schemes are increasingly regarded all over the world as effective vehicles for saving vulnerable and deprived societies from a myriad of social challenges. In the face of rising multipronged social quagmires such as deteriorating health of the people, the institution of an effective policy mechanism like the health insurance scheme to serve as a control valve to assuage the pains of populations in developing countries becomes not only critical, but also a much sought-after policy vehicle. Given that health financing is designed to cover formal and informal sectors, rural and urban locations and low and high-income earners, as urgent as it is, it has become a challenge for developing countries who seek to build, implement and operate an effective health financing system that will inure to the benefit of all citizens.

The National Health Insurance policy has proved itself enormously results-oriented to addressing equity, increasing health service utilization and protecting populations against health expenses. It is one of the mediums that could help developing countries in attaining universal healthcare coverage status "[1]". However, owing to financial strings

that have persistently tied the smooth operation of the scheme, the debate of health care financing-related matters somewhat unendingly continues to rage "[2]". In as much as poor households in developing countries regard health insurance as an indispensable intervention, and as such a sine qua non to extending the provision of financial relief to their healthcare expenditures, evidence however suggests that user fees constitute a huge barrier to the utilization of healthcare services and treatment behaviours especially amongst the poor and vulnerable groups "[3]". Osei Akoto and Aryeetey contend that, health insurance scheme appears to provide an antidote to the healthcare financing problem which has been a hindrance to the poor and the vulnerable in accessing healthcare "[4, 5]".

Healthcare financing in Ghana has witnessed a number of reforms over the years. During the pre-independence era, financing of health care was mainly out-of-pocket payments at service points "[6]". Following the introduction of cost sharing as part of health sector reforms in Ghana, user fee exemptions were introduced for poor and vulnerable groups as part of an overall effort to address equity in public healthcare delivery "[7]". Central to the health sector financing reforms, the Government of Ghana passed the National Health Insurance Law in 2003. The proximate rationale was to eliminate the financial barriers posed by the user fees at the point of service and then eliminate the out-of-pocket cash payment to enhance access and improve quality healthcare service "[7]". The policy objective for establishing the NHIS in Ghana states that; *"Ultimately, the vision of the 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. The policy objective is that "within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him / her against the need to pay out of pocket at the point of service use in order to obtain access to a defined package of acceptable quality of health service"* "[5]".

That notwithstanding, the scheme is saddled with operational challenges. To provide reforms to some of the challenges like extending relief to the poor and the vulnerable gave rise to a new era of exemptions where the poor and vulnerable were to be enrolled into the scheme without paying premium. This new policy shifts was not preceded by adequate conceptualization of how to deal with exemptions for vulnerable groups and the poor under the Scheme "[7]". Due to this inadequacy, there was a risk that the poor would be excluded from voluntary social insurance "[8, 6]". Hence, the shift in policy to an "insurance-based system of exemptions gives rise to outstanding questions on how to address equity concerns that the former exemption regimes failed to adequately deal with "[7]". Jehu-Appiah, in agreement with same idea also suggests, the poor and indigent be exempted as a form of greater protection against catastrophic health expenditures in most African countries. "[9]".

While policy makers, analysts and implementing officials and agencies point to a myriad of factors to illuminate on operational challenges, far less attention has been paid to the factors of poverty. Yet, this is crucial to a nuanced understanding of the policy's efficacy. The NHIS has had impressive achievements since its creation, especially in terms of increases in coverage, availability of health services, and utilization of healthcare services. Despite all these achievements, the scheme still has a long way to go to achieve one of its cardinal goals of targeting the poor through poverty consideration selective premium subsidies for the poor indigents who largely make up a community of people characterised by; (1) Employment challenges, (2) Unsustainable source of income, (3) Social services access challenges/constraints and (4) widespread poverty. Although some studies have been done on the scheme, there is a dearth of academic inquisition in terms of the operational challenges relative to the location of health facilities in deprived areas, poverty considerations and how such challenges can be addressed to pluck such societies from their ordeals. This study discusses the internal and external challenges faced by the scheme, including access issues, as well as issues with service providers and clients. This discussion paper contributes to previous studies on the NHIS. For various reasons, this study could help policymakers to initiate programs that will improve on the performance of the NHIS to ensure affordable healthcare services for all, more especially for those in the poverty-endemic areas.

2. Historical Precincts of the Health Insurance Scheme in Ghana

The premier health insurance scheme in so far as the history of Ghana is concerned is the St. Theresa's Catholic Hospital-initiated Nkoranza health insurance scheme. This insurance policy scheme was very instrumental in helping maintain and sustain the collective health of the people. Premised on increasing health quality and improving the health seeking behaviour of the people, it was very helpful in increasing the people's access to health care. It proved indispensable. Later, through a Ministry of Health initiative in the early 1990s, in response to a crushing health system that revolved around a harmful "cash and carry system", vis avis the inability of the larger socially excluded to access their health needs, a unit within the ministry was incepted to inter alia, help with the establishment of the national health insurance scheme. "[10]".

To subject the policy initiative to an efficiency test intended to help identify possible lapses and strengths based on which an informed feed would be channeled into the whole system to further inform a final policy decision, the initiative was commenced on a pilot feasibility studies basis for groups such as those in the formal sector and organized groups as well. Quite unfortunately, the health insurance scheme which had whipped up public interests and confidence among a majority of people within the society suffered a still-birth without any subscription. The failure of

the project could however be ascribed to the lack of leadership, lack of consensus to sufficiently appreciate the difficulties involved in implementing a centralized social health insurance scheme in a low-income developing country "[11, 6]". Given the earlier failures of the scheme as happened in the Eastern region pilot, the Social Security and National Insurance Trust (SSNIT)- a regulatory body charged and entrusted with managing social security finances intervened to fill the void by running another scheme in partnership with the Ghana Health Care Company. Like the earlier scheme, the SSNIT scheme initiative also suffered birth pangs. Despite some expenditures on personnel, feasibility etc., the much-anticipated project scheme never took off.

However, in 1993, under the financial aegis of the United Nations International Children and Education Fund (UNICEF), a feasibility study meant to investigate the prospect of the implementation of a district-wide community health insurance scheme in the Dangme West was conducted. This study earned the interest of the Ministry of Health (MoH) because of the vested interest of the then director of Medical Services. Community members from targeted areas exhibited great enthusiasm about the implementation of a Community Health Insurance initiative. This resulted in the implementation of a planned district-wide Community Health Insurance scheme with the Ministry of Health financing the scheme design and implementation, whiles the European Union (EU) as a project partner bankrolled the monitoring and evaluation "[12]".

Unexpectedly however, the retirement of the head of Medical Service precipitated a slouch in interest of the Ministry in the project. Because this was the situation, subsequent contribution from the Ministry was not forth coming. The EU grant for the evaluation was also not forth coming after the instalment. In the face of these setbacks, local authorities continued with their contribution to the design of the pilot district community health insurance scheme. The district assembly contributed part of their United Nations Development Program (UNDP) poverty-reduction fund to support community mobilization and household register development. The World Health Organisation (WHO) and Danish International Development Agency (DANIDA) provided start-up funding, registration of beneficiaries, and delivery of benefits started in October 2000. Financing to continue with the implementation and evaluation was provided by the Ghana Health Services (GHS) and the MoH "[13-15]". In filling the lacunae created, other community health insurance schemes, mostly supported by faith-based organizations referred to as Mutual Health Organizations mushroomed in Ghana "[16]".

Other key partner organizations from whom support emanated from by way of among other things but not restricted to jointly supporting the preparation of a training manual for mutual health organizations in Ghana comprised the DANIDA, PHR-PLUS (partnership for health reform plus) and the United States Agency for International Development (USAID). The distribution pattern of the MoH outlets were uneven as they were mostly concentrated in the Eastern and Brong Ahafo Regions of Ghana. This was due in part to the presence of technocrats and other bodies in the regions like the Christian Health Association of Ghana (CHAG) represented by the catholic church, the Regional and District directors of health and the District Assemblies who took a centre stage position by playing active role in the development of the Mutual Health Organizations "[10]"

3. Historical Perspective of Health Financing in Ghana

The development and liberalization of health financing in Ghana over the last five decades has been characterized by significant large-scale drastic reforms. Prior to independence, health financing in Ghana was absorbed by the individual. By this, individuals financed their health bills from their pockets "[17]". The phenomenon however witnessed a paradigm shift in the aftermath of independence. The health burden of healthcare in public health facilities in Ghana under the helmsmanship of its first president Dr. Kwame Nkrumah was borne by the Ghana Health Service (GHS) with revenue provided from the coffers of the National government "[18, 6]". This pro-poor system which provided services for all classes of people without medical charges at point of service-unlike the private health service providers, guaranteed and ensured the Ghanaian's easy access to free medical services in any government health institution. Providing services to all classes of people helped save populations from the vagaries of life. It however had shortcomings like engendering the provision of low-quality medical services. It was also discriminative against the rural poor as it rather favored the urban-dwelling elites "[19, 13]".

The plummeting returns in tax revenue that rocked the nation Ghana in the 1970s, against the backdrop of a sagging economy, in the views of Agyepong weakened the foundation of a largely, if not wholly tax-subsistent health financing support structure "[13]". This precipitated the reintroduction of a self-financing out-of-pocket fees in securing and/or procuring medical services particularly in the public health sector during the same period. The economic meltdown that shook the economic foundations proceeded into the 1980s. During this period, its effect was so severe that, it sank the whole economy and drove it to the brink of insolvency.

In this situation, Ghana acquiesced to the demands of the World Bank and the International Monetary Fund (IMF) for the injection of market-driven reforms which centred on the structural shift in the economy from tradeables to non-tradeables. This was tailored to withdraw subsidies, liberalize internal and external trade and push for currency devaluation "[20, 21]". The Structural Adjustment Programme (SAP) of the 1980s which the twin body of the IMF and the World Bank had imposed on Ghana and which Ghana had also readily assimilated dwelled much emphasis on budget balancing and internal and external debt servicing "[20]". Ensuring this resulted into an acute budget cuts on social

expenditures with the health and education sector being the most financially starved.

Under this circumstance, government was compelled to make some policy adjustments that saw to the significant rise in public-sector user fee which became known as the "pay-as-you-go" in 1985. The implementation of the SAP which precipitated the mass drawback effort of the state in providing subsidies on health delivery shifted healthcare expenditure onto patients. The ensuing economic mismanagement then forced government to reduce expenditure. This created a situation of financial scarcity for government. As a result of this, government was unable to service health care bill with revenue generated taxation "[22]".

The reason underpinning the reintroduction of the cash and carry system was to assist government's recovery of at least 15% of recurrent expenditure for quality and health care and to finance other improvements within the health sector. The efficacy of this policy was confirmed in a 2001 published report which corroborated the achievement of the policy target. The report indicated that, though the cash and carry system had its own inherent flaws, in the wake of its reinstatement, there was an improvement in supply and availability of other essential medical supplies "[13]". Contrastingly, the reintroduction of the cash and carry system was to restrain patients who overstretched the benefits of the health system. Prospective patients lacking the wherewithal to finance their medical care were turned away "[23]". This is a defeating evidence to the oft-cited and generalized assertion that, the cash and carry system helped in improving health service delivery. To say the least, the poor were less catered for. So were the vulnerable class of both children and women and the poor masses "[24]".

The impoverishment and devastation pushed these group of people to resort to borrowing, selling their possessions as a means of raising money to procure health care service. The delays in raising money to secure treatment caused deterioration and complications and avoidable deaths. The government as the mother regulator of the sector reserves the right to intervene in the event of a market failure. "[21]". The year 2004, marked an enviable milestone for Ghana's health sector

4. The National Health Insurance Scheme

The build up to the year 2000 political electioneering campaign was a year that witnessed the trading of public social policy manifestoes, especially between the two-major political parties; The National Democratic Congress (NDC) and the New Patriotic Party (NPP). Leading amongst some the messages were largely social policy-based interventions. At the heart of the campaign message of the then opposition party-the NPP was the message that promised Ghanaians the implementation of a health insurance scheme to ensure equitable access and financial coverage for basic health services.

The government of the NPP after winning the election, delivered on its promise. To give the policy a legal framework, the National Health Insurance bill (Act 650) was passed into law by Ghana's parliament in the year 2004. The passage of the bill into law laid the foundation for the establishment of an NHIS at the district level in Ghana "[17]". The rationale behind the policy was to extricate people from the scourge of poverty and financial hardships and remove cost as a barrier to health care access "[25]". From a fledgling policy level, the Scheme has developed into a cornerstone instrument for financing health care in Ghana "[26]". Though the scheme has improved the health seeking behaviour of many people in Ghana, there however remain some challenges which are considered impediments to the efficacy of the policy. It is therefore against this troubling backdrop that this study is conducted "[22]".

5. Funding and Management of the Scheme

The NHIS is basically financed from the National Health Insurance Fund (NHIF). The sources of money to the NHIF as provided under section 41 of the Act includes: The national health insurance levy (NHIL), 2.5 percentage points of each person's 18.5% contribution to SSNIT pension fund, such moneys that may be allocated to the Fund by Parliament. Other sources include grants, donation, gifts and any other voluntary contributions made to the fund, money that accrues to the Fund from investments made by the Authority, fees charged by the authority in the performance of its functions, contributions made by members of the Scheme, and moneys accrued under section 198 of the Insurance Act, 2006 (Act 724). For the purpose of implementing the object of the Fund, section 40 (2) of Act 852 stipulates that the monies from the fund shall be expended as follows:

(1) Pay for the health care costs of members of the National Health Insurance Scheme.
(2) Pay for approved administrative expenses in relation to the running of the National Health Insurance Scheme.
(3) Facilitate the provision of or access to health care services and
(4) Invest in any other facilitating programmes to promote access to health services as may be determined by the Minister of Health in consultation with the Board of NHIA.

The National Health Insurance Authority (NHIA) was first established by the National Health Insurance Act, 2003 (Act 650). In 2012, the Act was repealed and replaced by a new law (Act 852). The object of the Authority under Act 852 is to attain universal health insurance coverage in relation to persons resident in Ghana, and non-residents visiting Ghana and to provide access to healthcare services to the persons covered by the Scheme. Section 39 of Act 852 established the National Health Insurance Fund (NHIF) and places

responsibility of its management on the board members. The object of the Fund is to provide finance to subsidize the cost of provision of healthcare services to members of National Health Insurance Scheme.

The National Health Insurance Authority is mandated by law to secure the implementation of the NHIS. The NHIA is also responsible for the registration, licensing and regulation of health insurance schemes in the country. It is also required to grant credentials to health care providers and monitor their performance for efficient and quality service delivery. The NHIA also manages the NHIF and devise mechanisms to ensure that indigents are adequately catered for under the NHIS "[27]". The governing body of the NHIA is a board consisting of a Chairperson, the Chief Executive and other members drawn from various stakeholder organizations. The board is appointed by the President of Ghana. The responsibility of the board is to ensure proper and effective performance functions of the Authority. The management executive is made up of the Chief Executive and the deputies. There are other technical directors and deputy directors in various departments. Management of the NHIS is decentralized to the regional and district levels to ensure accountability and transparency "[27]".

6. Methodology

The study gathered relevant data from key informants from three (3) National Health Insurance Scheme (NHIS) accredited district hospitals in each of the three (3) selected districts in the purposively selected regions. Data was collected from three (3) health insurance operators in each of the three (3) selected districts in the regions. Eighty (80) insurance subscribers were interviewed in each of the three (3) districts in the selected regions. In total, seven hundred and twenty (720) subscribers were interviewed. Another set of data were collected from managers of Pharmacy, Supply/Procurement and Accounts Department of Hospitals using in-depth personal interview guides. In all, one (1) person was randomly selected from amongst the afore listed group of professionals in each district.

The reason for the large sample size in this study was to ensure representativeness. This was challenging. As the number of people to be interviewed was large, there was the need to establish a rapport with the respondents and institutions under study. This was followed by a reconnaissance survey to map out the strategy on how to sample the population for the study. The selection of the districts in the study regions were purposefully done. Each area was taken against the backdrop of "[28]". In addition to the high poverty incidence rates in the districts as captured in the report for the respective districts in the regions, the hospitals were included in the study due to their location in the study areas.

In the Northern Region, East Gonja, Bole, Kpandai were reported to have 84.2%, 79.4% and 76.9% poverty incidence respectively. In the Upper East, Builsa South, Bawku West and Bongo recorded 84.4%, 68.1% and 67.4% respectively. Wa-west, Wa-East and Sissala West in the upper west region raked 92.4%, 83.8% and 81.2% accordingly [28]. These skyrocketing poverty rates raise a plethora of concerns, including, but not limited to the purchasing power of the inhabitants and their ability to foot their health care related expenses. On the other hand, considering the status of the study areas as food growing areas, and by extension being the food basket of the nation with huge gross domestic product (GDP) contribution to the agrarian-based economy of Ghana, it makes the unhealthy and undesirable situation worthy of attention, particularly with regards to health care.

To achieve what the study sought to investigate, the case study approach was adopted. This was aided by the use of semi-structured interview guide. Most of the interview process was in the form of a conversation due to the relationship established with respondents. This made it possible to make follow-ups to some of the key informants within the study. It also gave the opportunity for probing questions to be asked in order to satisfy the research questions that were under study. All the people who mattered in the study were not left out during the interviews which also included the group of people already mentioned.

6.1. Data Management and Analysis

To put the findings in a proper perspective, the study made use of the inductive process of analysis in order to establish the research themes. Transcription of interviews and observations notes were analyzed with the help of an open codding system. To establish systematic steps in the codding of the data, memos were written to track the process of collection and analysis. After several rounds of going through the transcribed data, there was labelling and naming of concepts which led to the development of the research themes in consistent harmony with the research questions. Initial codes developed included reimbursement delays, widespread poverty among denizens of the study area, logistics and human resource constraints, infrastructural challenges and the unethical conduct of some health professionals.

Others included limited drug coverage under the scheme, logistical constraints, fraud and abuse, and the delays in documents processing. It was evident that the programme is laden with challenges. The process indicated a concern by all who mattered that there was a system error in the running of the policy. The views expressed by stakeholders coupled with beneficiary concerns were compared with other perceptions with relevance to the issue under study. Due to the nature of the subject matter under review, in spite of the initial difficulty encountered in eliciting information from the respondents, they were forthcoming with the right information.

6.2. Study Design

A qualitative based descriptive approach was chosen to

investigate the operational challenges of the health insurance scheme. This qualitative descriptive approach was done using individual in-depth interview. Respondents were given ample time to recollect and reflect before responding. To ensure quality research work, higher research standards were maintained to ensure that questionnaire-based research instruments in the form of in-depth interviews were used to minimize repetitive, duplicated, unwanted and irrelevant stories. After two rounds of piloting, the questionnaire was refined. Before commencing the actual data collection, the interview guide was presented to research experts for final approval and pretested. This was however not included in the data.

7. Findings and Discussions

From the analysis, the emerging themes which underscored the multi-dimensional challenges of the social policy safety net focused on reimbursement delays, widespread poverty among denizens of the study area, human resource constraints, infrastructural challenges and the unethical conduct of some health professionals, limited drug coverage under the scheme, logistical constraints, fraud and abuse, and the delays in documents processing and other related organisational factors constraining service delivery.

These themes are echoed in the following responses.

7.1. Responses from Medical Practitioners

Most practitioners were hesitant to take part in this study. However, upon several visits and interactions, they yielded to express their concerns. An interaction with a medical doctor at the Bamboi district revealed that:

"*The hospital is logistically challenged. We lack sophisticated medical equipment. This compels us to refer emergency cases which we can handle, but for the lack of equipment to the regional hospital. In referring patients, we have no ambulance. So, families and relatives of patients have had to use public transport to transfer their sick relatives*".

This same issue runs through concerns from a Chief medical officer at the Salaga district. In Abrumasi in the East Gonja District and Buya in the Kpandai district, health practitioners expressed similar worrying sentiments.

Another at Viero in the Sissala West district also said that:

"*The hospital does not have enough space and facilities to meet the health needs of the population*" She further stated that, "*the facilities for the past years have not undergone expansion and the increased patient utilisation exerts pressure on the available space*".

At Funsi in the Wa-East district, a respondent touched on insufficient human resource as a challenge to the policy's operation and said that:

"*Given the population of in-patients and out patients, the human resource base of the hospital pales into insignificance. This is compounded by the refusal of practitioners to accept postings into the northern parts of Ghana".*

Another medical practitioner at the Gwollu in the Sissala-West district, stated amongst other things that:

"*Widespread poverty is another challenge to the scheme. This has created a situation of lack of funds. And due to widespread poverty amongst communities, the burden of accessing medical services has become challenging as people cannot afford subscription. Subscribers have difficulty renewing their expired subscription because of money issues".*

At Zoko, a practitioner shared with the research team that;

"Another challenge has got to do with drugs. The limited drugs covered under the scheme restricts drug prescription. We are compelled to operate in a way that doesn't help health care. The scheme decides for us the medication to give. It does not cover essential drugs treating ailments like diabetes which is on a steady rise in Ghana and even omeprazole used for treating peptic ulcer".

Based on the field data, the challenge of logistical constraints, erratic pharmaceutical supplies, human resource constraints, inadequate health infrastructure appears an old recurring one. A study cited the issue of human resource challenges, limited investment in health infrastructure provision, health personnel supply as a challenge to the scheme. And this is regarded to have threatening policy implications "[3]".

7.2. Responses from Scheme Subscribers

From the interactions had throughout the field interviews, it became apparent that the National Health Insurance scheme has gained wider acceptance and patronage among the people in the case study areas. Another thing that became obvious was that, the scheme is bedeviled with challenges. In the interviews, the respondents were consistent in almost all their opinions. Amongst the challenges include: inadequate laboratory health facilities, poor treatment meted to them by health professionals, unprofessional attitudes of health practitioners like charging of illicit fees, verbal abuse of patients, delays in processing of patient's documents. In an interview with a 60-year-old retiree educationist at the Fumbisi-Kunyingsa health facility in the Builsa South district of the upper East region, the nuances of some of the challenges became explicable. Baba Dery had this to say:

"*The hospital of this community lacks basic health facilities and equipment. The laboratory for instance is under-equipped. There are not enough beds. The facility is weakening. You can see the cracks in the building".*

Kasim and Asakinaba, residents of Azuweira and Ngunbeogo number 1 in the Bawku West district in unison bemoaned the unprofessional attitude of some health practitioners and recounted that:

"*There are times I witness medical practitioners verbally abuse patients. Do we go to the hospital to get medication or go to be abused? This is a bad attitude. Some nurses exploit patients by charging exorbitant illicit fees. This is a poor community of farmers. We save little for the family upkeep. Some of these medical practitioners of today have no mercy on us*".

In commenting on the unethical and unprofessional attitude of some practitioners, Issah in Fatchu in the Sissala West district also said that;

"*Though there are good medical practitioners committed to their works, there are equally bad nuts among them. Some of these young nurses seem to be much into phones than the health of the patients. This is very bad*".

Also, others revealed that, sometimes they are given drugs which they think are too basic to be covered by the scheme. Fulera in Tinga in the Bole district of the Northern Region said:

"*The problem most of us contend with is that, you spend all your time in the hospital with the hope of getting medications to the health complications, only to be told either the drugs are finished or aren't covered under the scheme".*

In rehashing same worry, Baniera of Bakamba in the Kpandai district stressed on what patients go through in such circumstances. They stressed that;

"Our hopes get dashed whenever this happens. Given the poverty in this farming community, you could see how difficult it's likely to be for us to afford drugs".

Madam Amina also said that:

"*What the poor majority face isn't the case for the few minorities with the money to pay bills*". She went further to state, "*they are served earlier and better because they are bringing money. And because we are not bringing money, they least care about us".*

Asana on the other also had this to say:

"*We are food producers. we produce food to feed this nation. If our health needs are inadequately catered for, how can we produce food?".*

This finding is confirmed in a study conducted by "[29, 30]". These academic studies confirm that, this is almost a nationwide challenge. As revealed in this study, the study further corroborated that, unethical behaviours by health workers towards scheme subscribers saps the confidence of the Ghanaian in the scheme and goes further deep to discourage them from getting their subscription renewed upon expiration. This may in turn affect the sustainability of the scheme. On the other hand, the lack of the laboratory facilities to expedite health care access and delivery causes undue delays and affects the quality of treatment and diagnoses. The issue of discrimination on the basis of patients' ability to offer an instant out- of-pocket payment for medical services, which in the views of scheme subscribers constitutes a setback against the scheme itself is buttressed in a study of national health insurance scheme accredited facilities where subscribers expressed the view that, the discrimination among patients on the basis of their ability to afford has resulted into poor treatment of the financially challenged patients "[31, 32]".

A separate study in impoverished regions buttressed the revelation of this research with compelling evidence that, apart from the fact that the health insurance scheme is yet to achieve its goal of addressing the need of the poor for insurance against health-related financial risk, the scheme is not as pro poor as originally designed to be, but rather, serves more the needs of the relatively well to do "[33]". From the research, it was revealed that, Ghana's health insurance scheme, particularly as exist and operates in the case study areas as a pro poor scheme is a misnomer at best and a façade at worst.

Other respondents from across communities dotted in the study areas also expressed their worries about what they claim to have gathered from the health authorities as being the basis for the inability of the health facilities to meet their medicinal and other pharmaceutical needs. In an interview with an ailing bed-ridden patient respondent at Kuntolo in the Wa-West captured that:

"*The hospitals are unable to provide us with drugs. For how long are we going to continue coming to hospital without getting drugs? How can a scheme like the health insurance be operated without drug? Anytime we ask, the health authorities tell us they are unable to provide it because government has not paid them. Because of this, they are also unable to pay their suppliers. Government should please try and do something about this for us. Without this scheme, how can somebody like me who has been indisposed for years and been deprived of working ability survive My hope in accessing health care would be the health insurance".*

Madam Luginaah, a resident of Lassia-Toulu in the Wa-West District in an emotional sentiment said:

"One thing I find worrying is the state of the scheme with regards to meeting the medical needs of pregnant women. The scheme's coverage of antenatal care needs to be seriously considered. The inability of the health institutions here to provide the needed care has made people hesitant to visit the hospital. People are losing confidence in the scheme. Stakeholders should sit up".

7.3. Responses from Hospital Administrators

Some of the health administrators interviewed, having witnessed the challenges of the scheme expressed their desire to seeing the scheme reformed to favour the low class. The health administrators are entrusted with major responsibilities. The role of the hospital administrators as the ones responsible for the day to day administration of the health facility may include operations management, financial management etc. When some of the hospital administrators were contacted for this study, it came out that, many of them have challenges about the scheme. Most had same concern throughout the interview. At Zebilla in the Bawku West district, an administrator expressed worry about delays in reimbursement. In an interview, a participant said:

"*We render services all the time and submit records for reimbursement. It takes as long as a year or even more than a year for us to be reimbursed. Meanwhile we have financial obligations to fulfill with suppliers. Currently, we are indebted to our medical suppliers to the tune of huge sums. This has created distrust between the hospital and suppliers. They are no longer willing to supply us essential pharmaceuticals. We have renovation works to do, non-*

mechanized staffers to maintain. How do we do these without money?".

An accounts officer at Fumbisi in the Builsa South district had this to say on the problem of reimbursement delays:

"*We all know that money is everything in management. So anytime there are delays in reimbursement, we are unable to procure logistics, execute projects and take initiatives. It also implies that we wouldn't be able to settle our debts with our suppliers. The effects of all these affects effective administrative work and quality health care".*

Another administrator at Gbedema-Kunkwa commented on the negative ramifications caused by the shortage of essential pharmaceutical drugs. Respondent indicated that:

"*When patients come and we are unable to meet their pharmaceutical consumables demand, we feel bad just as they do. The inability to treat the ailments at the primary stage may cause deterioration of the ailment. The larger part of the population who patronise this facility are largely poor peasant farmers. You can imagine what would happen in times of illness without treatment".*

Gilbert at the Gwollu in the Sissala West district stated that:

"People *hardly accept postings into the countryside because of reasons of the lack of social amenities. They prefer working in the urban areas. This has created a human resource gap. Over here, we have one laboratory technician".*

Similar response was given by at the Kpandai.

The general consensus of opinion as pointed out by a cross section of the key informants formed was that delays in reimbursement and the shortage of human resources have a lot of deleterious implications for the management of hospitals. From the field survey, it is obvious the issue of delays in reimbursement repayments has been a major setback to the smooth operationalization of the scheme.

The issue of delays in claims repayment was cited as a challenge to the scheme and its sustainability. "[34]" The challenge with the human resource as revealed in the study affirms a report on the appalling state of human resources in the health sector in developing countries, particularly Africa "[35]".

7.4. Responses from Pharmacist/Procurement/Supply Officers

The pharmacist interviewed were very cooperative, especially on realizing the subject matter sought to assess the efficacy of the health insurance scheme. When asked about the challenges of the scheme, a pharmacist at the Funsi in the Wa-East district in the Upper West said:

"*The scheme has challenges. Patients have their own skepticism about the scheme especially on pharmaceutical supply issues. Whiles it's true that drug supply constitutes a strong basis of healthcare, it's also true that medical supply is a problem. Under the scheme, not all drugs are covered. There are times we run out of stock for certain drugs*".

This resonated with the worries of an in-charge of pharmaceuticals at the Wechiau hospital in the Wa-West district of the Upper West Region.

In reiterating the above, another pharmacist at Lipileme in the Sissala West further stated that:

"*most of the times, patients rain insults on us when they come here for their prescribed drugs and we tell them we don't have some of the drugs or some of the drugs on their prescription form isn't covered under the scheme. To them we are heartless people who deny them drugs and sell the drugs to patients who are ready to pay. Meanwhile this isn't the case. Left to us, all drugs should be covered. There have been times workers here buy drugs with our pocket money for some patients".*

In another encounter, an in-charge of procurement at the Banda Nkwanta in the Northern Region district of Bole demonstrated her worry about fraud and abuse characterizing the scheme and said that:

"*People come to the hospital with other subscribers' card to access medical services. Others, after a former visit come to the hospital to seek for another medical attention even without completing the full dosage of the drugs given them on their previous visits. This is the side of the abuse am talking about".*

At Kijau Battor, a medical supplier indicated that:

"*The insufficiency of medical supplies doesn't augur well for health care in the community as it deters patients from visiting the facilities".*

It was further stated that:

"This is a community which hitherto weren't interested in modern medical treatment. But now, through education and advocacy, there has been an attitudinal change. So, for drug supplies to be a headache, it is likely they may end up being discouraged from accessing medical care and then revert to the traditional medical treatment which you and I know of the complications involved. The inroads made shouldn't be allowed to go down the drain. Efforts must be exerted by government and alike to resolve the issue".

The views of the interviewees indicated the need for policy makers to revise the scheme and integrate poverty consideration elements to consider the poor regions and their communities. Apart from that, technology should be integrated into Ghana's health system to help create a nationwide database to accommodate all patients. This would help track all this impersonation, abuse and frauds associated with the scheme whiles ensuring the effectiveness and efficiency of the scheme. The abuse factor was confirmed in a study by "[36, 2]". Both studies ascribe the cause of patients abuse and the health practitioners unethical behaviours to excessive workload and exhaustion.

7.5. Responses from Accountants/Finance Officers

The accountants or the finance officers' outfit within the health sector is a crucial one. They are responsible for being in charge of the management of the financial health status of the health facilities. Among other things, they may perform the task of: keeping accurate records for all daily transactions, prepare balance sheets, Process invoice, Record

accounts payable and accounts receivable, update internal systems with financial data, prepare monthly, quarterly and annual financial reports. They may also be responsible for reconciling bank statements, participate in financial audits, track bank deposits and payments, assist with budget preparation, review and implement financial policies. In the series of interviews conducted on the few randomly sampled respondents belonging to the above category of respondents, many had this to say:

"One major challenge faced as accountants/finance officer's borders much on claims management. Periodically, we submit claims for reimbursement and the it takes as long as the distance between the earth and the skies for it to be paid. In times when its paid, it comes trenches, with large sums still held in arrears. This has been a headache for us. It affects our daily routine operations, which invariably affects our efficiency, effectiveness and the overall smooth administration of the healthcare delivery system".

Another set of respondents also indicated the lack of technology utilization in the claims processing. An interview with an accountant at Bongo revealed that;

"One hurdle that confronts us as accountants and finance officers is excessive paper documentation. The claims system is done manually because of the lack of a computer. In some of the areas with computer, they lack electricity. All these add up to delay claims processing".

Another finance officer at Salaga also stressed that;

"*Processing of claims tends to take so many days sometimes beyond five weeks under the manual method".*

In explaining the cause of the delay in claims processing, another finance officer at the Dorimon stressed that*:*

"the delays in claims processing get complicated by the growth in membership of the scheme subscribers and the rising levels in the utilisation of health services across all levels, illegible handwriting, wrong diagnosis and prescription, coupled with heavy workload and incomplete patient data".

In a separate interview with the finance in-charge at Mawia in the Sissala West District of the Upper West Region of Ghana, a statement was made that;

"*Sometimes, confusion over disputed claims ensues between hospitals and insurance authority. And whenever this happens, it results in decline of available funds needed for managerial purposes".*

In a follow up question on the potential source of these unhealthy disagreement between the hospitals and the scheme regulators over disputed claims, the key informants provided a myriad of reasons. Another finance officer cited;

"*Over-billing of drugs and service, prescribing drugs outside the essential drug list covered*, *non-compliance with laid down protocols in delivering healthcare".*

The factor of subscribers' abuse of the scheme, and delayed reimbursement of health providers by the scheme operators is confirmed by "[3]"

7.6. Responses from Scheme Operators

The Scheme operators who are responsible for registering new subscribers and renewing the expired packages of subscribers were very strong in their response to the research topics. When asked about some of the challenges they think constitute a challenge to the National Health Insurance Scheme, an operator at Bole had this to say:

"*We are challenged when it comes to getting materials to produce the cards to prospective subscribers. This unavailability of materials apart from causing unnecessary delays in issuing insurance cards to subscribers also militates against renewal of cards for old subscribers with expired cards, hence poses renewal challenges".*

In another interview with another at Salaga, Catherine lamented the financial difficulty on the part of both prospective subscribers and old subscribers. The respondent said:

"This area is largely populated by predominantly poor farmers who happen to be financially challenged people. Because this has been their situation, it is difficult for new prospective subscribers to pay their subscription premiums. It's equally difficult for old subscribers with expired subscriptions to get their packages renewed"

8. Summary

The proximate reason for the conduct of this research was to assess the efficacy, and the operational challenges of the national health insurance scheme in some selected poverty-endemic districts in selected three (3) northern regions of the Northern region, Upper West region and Upper East region in Ghana. It was expected that the study will help in identifying policy specific relevant issues that would help policy makers to strengthen the scheme, make it effective and efficient in not only in Ghana in general and the study communities in particular, but also to other countries. It was also expected to help provide a sharp sense of policy direction for both government and non-governmental organisations committed and devoted to influencing and driving health needs. The study employed the qualitative approach of data collection. Purposive sampling was used to recruit respondents for the study. The qualitative data was analyzed though explanations, interpretations and direct speech of respondents.

Whiles the finding of the study revealed a greater awareness and patronage of the scheme by the people in the study areas to meet their health needs, it was however obvious that, there still remains lingering policy and operational challenges in the largely farmers populated poverty-stricken study areas. Key among some of the challenges identified revolves around: reimbursement delays, widespread poverty among denizens of the study area, human resource constraints, infrastructural challenges and the unethical conduct of some health professionals. Others include: limited drug coverage under the scheme, logistical constraints, fraud and abuse, and the delays in documents processing.

The findings of this study highlight the fact that the hospitals in the case study areas have not sufficiently tapped into the utilization of technology to bring their institutions in sync with modern trends particularly in so far as health management and administration and health insurance scheme operations are concerned. This is amply demonstrated by the use of less innovative and rudimentary techniques such as manual methods for record keeping and processing of claims. To ensure efficiency and help establish a medium of information, health institutions and the health insurance authority should resort to the deployment and utilization of networking through the use of computer.

This will help facilitate the flow of information across board, and more particularly make it possible for quick administrative actions to be taken on claims and billings, and also help check fraud and abuse which has come to characterise the scheme. The establishment of a computer-based system will help produce feedback instantly as opposed to the manual means. To deal effectively with some of these systemic scheme challenges, it is suggested that concerted efforts needs to be made by key stakeholders such as the health insurance managers, scheme providers, scheme subscribers, policy makers and others alike to make the policy and scheme effective and efficient towards providing better services whiles meeting the health needs of the people.

9. Conclusion

From the foregoing, it is obvious that the national health insurance scheme as a public social policy safety net has come to stay and it would be suicidal for the citizens and the nation to put a stop to the programme or undertake certain things that would contribute to weakening the policy. It is a social policy that has come to gain the acceptance of almost, if not all international communities. This is partly due to the safety net or protection it offers to the poor and vulnerable in communities like the ones in the case study areas. It makes room for the poor to have increased access to healthcare across the country.

The Scheme is also seen as an important mechanism to removing financial barrier to achieving equitable access to health care for all citizens “[25]”. This is the manifestation of the impact of the scheme. However, the scheme which continues to play critical role towards attaining universal health coverage in Ghana is saddled with challenges that could potentially negatively affect the scheme. The question therefore is, given the strong correlation between a nation or a community’s health and productivity and/or production, why has such a scheme been left to be fraught with such challenges? This exposes the laxity on the part of the gatekeepers and stakeholders. Circumventing this possible predicament will largely depend on concerted efforts of key entities such as health insurance managers, service providers, insurance subscribers, policy makers and other stakeholders alike. To better enhance the operations of the programme in order to meet its objectives:

(1) Service providers must eschew all unethical attitudes, do away with dishonest tendencies in their claim submissions on service (s) rendered to subscribers by presenting bills which are true reflections of services rendered. They should not work with the mindset of fleecing the scheme and subscribers to enrich themselves. Service with integrity ought to be made a cardinal principle of engagement.

(2) To maintain trust, preserve public confidence in the scheme and ensure the long term sustainability of the scheme whiles promoting the individuals access to health care, the general public and other stakeholders alike with health-centred interest must hold health care providers (who as stewards are entrusted with the health care issues of the people) more accountable in order not to derail the purposes for which the scheme was set up, and diminish the inroads and/or gains made in the aftermath of the introduction of the scheme. In this regard, service providers ought to hold in high esteem the social contract entered into between the scheme operators, on behalf of subscribers to provide a valuable chain of services to prospective clients in a professional manner.

(3) Heads and management of health institutions should put in place measures to fight graft and fleecing of clients at their health facilities. Measures should be instituted to prohibit the collection of unauthorized levies at the various points of service delivery and revenue collection. In this regard, health authorities should be stern and strict on all professionals who dabble in client exploitation acts which has the potency to result in a monumental loss of confidence in the scheme. When this is done, it will deter others from doing same.

(4) Management of the scheme should team up with other non-governmental organisations in and outside Ghana to assist the socially vulnerable to subscribe to the scheme or renew their subscription upon expiry.

(5) Government, policy makers and advocacy groups should as a matter of urgency prioritize the need to integrate an element of poverty consideration in making the scheme subscriber friendly for the socially and financially vulnerable groups, the aged, terminally ill, physically challenged, mentally ill and to groups who have lost their working abilities

(6) The management of the scheme should be administratively vigilant and go an extra mile to expose bad elements bent on willfully causing financial loss to the scheme, defrauding the scheme and its clients. Other issues of petty stealing of drugs and equipment and pilfering must be seriously checked. Measures to purge the scheme of widespread corruption should also be put in place.

(7) Ghana’s health system, particularly in the study areas should be integrated technologically to check fraud and abuse of the scheme by patients. The manual data entry of client’s details, as observed during the field study amounts to waste of precious working hours

which could be used to attend to another patient. And the manual entry also delays the retrieval of client's records.

(8) It is also recommended that, stakeholders, in partnership with interest parties and policy makers should periodically engage themselves in a national consultative forum to dialogue on the impacts, challenges and possible way forward for the scheme. This would not only help in identifying certain lapses, but also help in gathering feedbacks that would help in taking measures to help sustain the scheme and its policies.

(9) Given the trickle-down impact of health on socio economic development and the strong linkage between health and national production and/or productivity, it becomes critical that government takes health infrastructure development seriously. Relative to this, it behooves government to invest much in providing the various regions, more especially the study areas with modern equipment and other standard health facilities to expedite the achievement of the aims and goals underpinning the inception of the scheme.

(10) Stakeholders should also ensure an equitable and balanced distribution of the national human resource cake without any discrimination. In ensuring the achievement of this aim, stakeholders should prevail upon government to invest in the production of human resources like laboratory technicians, nurses, medical doctors, health administrators and other professionals whose services are very crucial in health care delivery and related services, and by extension the achievement of the goals of the scheme and its sustainability as a whole. Human resource, without which the scheme is likely to flounder, constitutes the cornerstone of the scheme. An improvement in the human resource base should also be made a matter of necessity. Regular training programs should be organized to help bring their expertise in tandem with modern health delivery standards.

(11) From the series of interactions had on field, observations made and data feedbacks gathered from the opinion of the interviewees, this study has established that the inception of the scheme has brought about new managerial challenges to hospitals. The most disturbing and yet perhaps most apparent challenge identified by this study is the problem of weak or poor gate-keeping. Majority of hospitals do not have appropriate technological support systems resource in place to enable them detect abuse and nib fraud in the bud.

(12) The study also suggests that the vulnerable be targeted for social intervention programs. On this score, it is also suggested that studies be undertaken to succinctly set the boarders, basis and requirements for people who meet a poverty measuring standard.

Limitations of the Study

We acknowledge that the findings of the study cannot be generalized beyond the case study areas as the study covered three districts each in the Northern Region, Upper-West Region and the Upper-East region of Northern Ghana, respectively. However, the findings can serve as pointers and provide invaluable feedback lessons to other countries seeking to replicate Ghana's experience. We also acknowledged that policy and implementation processes are complex and can be affected by both endogenous and exogenous factors for which reason factors of uncertainties needs to be incorporated into policy making framework. Findings of the present study offer crucial policy implications for strengthening service delivery in hospitals under the health insurance scheme in general. However, a major limitation of the study is that the themes identified are not holistic enough in explaining the myriad challenges facing the scheme.

Given the much recurring theme of widespread poverty in a largely farming community like the one in the case study areas, future studies should therefore consider expanding the themes to include emerging issues such as the health insurance scheme and sustainable food security in Ghana, Income inequalities and/or poverty and the sustainability of the Scheme in Ghana. Considering the increasing incidence of poverty in the case study areas and the large family sizes, another area of imperative research focus should be on the extension of the scheme to cover family planning and contraception services. The issue of the effects of the scheme on Antenatal care is another area worthy research interest. These are likely research areas that will be the focus of another research to be commissioned after this.

Acknowledgements

The research was made possible by the award of a Chinese Government scholarship by the University of Science and Technology of China. The research team would also like to extend our appreciation to the respondents for their cooperation,

Competing Interests

The authors declare that they have no competing interests.

Authors Contribution

The study was conceived, analyzed and written by Vincent Ekow Arkorful and Ibrahim Basiru. They also handled field data collection in Ghana, data management and analysis and participated in the critical review of the manuscript. Latif Amadu and Anastasia Hammond participated in the study design. Sarah Pokuaah, Eric Kwadwo Agyei, Nurudeen Abdul Rahaman and Edward Arthur participated in the critical review of the paper and offered suggestion that helped shape and restructure the paper. All authors read and approved the final manuscript.

Funding

The research was funded by the Authors themselves.

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