Low participation in national health insurance scheme in Central Region OF Ghana: underlying reasons and health seeking behaviour of both insured and uninsured.

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LOW PARTICIPATION IN NATIONAL HEALTH INSURANCE SCHEME IN CENTRAL REGION OF GHANA: UNDERLYING REASONS AND HEALTH SEEKING BEHAVIOUR OF BOTH INSURED AND UNINSURED.

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Abstract

This study investigated the reasons for low participation in national health insurance scheme and health seeking behaviour of both insured and uninsured in central Twifo hemang Lower Denkyira district in Central Region of Ghana. Data were collected from both household heads who are enrolled in NHIS and those who have not been enrolled in the district for the purpose of analysis. The researcher employed interview schedule as data collection instrument used for the collection of the data from the respondents. In total, 400 household heads were interviewed. The study found that the major barrier to national health insurance scheme enrolment is affordability of the premiums. If the annual premium is paid in a lump sum, household heads find it more difficult to pay. Therefore this study recommends that national health insurance scheme annul premium could be paid on instalment basis rather than lump sum. Thus the payment of annual premium could be spread out over the year. Also, government should strengthen policies to enhance income level.

Keywords: national health insurance, household heads, premium

Introduction

Access to effective care is at the heart of the discourse on how to achieve the health-related Millennium Development Goals (United Nations General Assembly, 2000) but according to Nketiah-Amponsah (2009), healthcare financing in developing countries remains an albatross with few countries able to spend the recommended $30 to $40 a year per capita that the

World Health Organisation considers the minimum requirement for basic health care. In Ghana, after the independence in 1957, the government of Ghana provided medical care free of charge to the population at public health facilities. Health care was financed by general taxes and external donor support and attention was directed to developing a wide range of primary health care facilities across the country.

By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax based health financing system and this led to the introduction of user fees (traditionally known in Ghana as "cash and carry"). The user fees created problems of inaccessibility and inequity in healthcare services in Ghana and according to Akazili, Anto, Adjuik, Kanyomse, Oduro, Hodgson, & Anoyoriga (2005), cash and carry at primary health facilities deters low-income households from seeking care until an illness is severe this is likely to aggravate poverty as more advanced illnesses tend to require more expensive treatment.

There was the need to find another source to finance healthcare since financing health care has become major issue and priority for the health sector throughout the world, and particularly in the Sub-Saharan African region (Mwabu, 2007). Due to this national health insurance scheme was introduced in 2003. The aim of the National Health Insurance scheme is to spread the risks associated with health care costs over a group of subscribers. The larger the pool, the greater the likelihood of available funds to support members when they require healthcare. It is also aimed at enabling Ghanaians have access to universal, equitable and acceptable quality health care to all residents of Ghana (Nketiah-Amponsah, 2009).

However, the National Health Insurance 2010 and 2011 annual report shows that the total active membership of National Health Insurance is low as compared to the total population. The active membership in 2010 was 8,163,714 representing 34% of the population and 8,227,823 in 2011. The annual reports also indicated that central region had

the lowest coverage rate in both 2010 and 2011 despite embarking on special registration exercise to increase enrolment. Therefore there is the need to investigate why people are not willing to be enrolled. The purpose of this study is to investigate the reasons why there is low participation in National Health Insurance Scheme in Twifo Hemang Lower Denkyira District in the Central Region.

Objectives of the Study

The specific objectives were to:

1. Investigate reasons why previously insured household heads are not willing to renew their membership
2. Examine reasons why household heads are not willing to be enrolled.
3. Examine health seeking behaviour of both the insured and the non-insured

Methodology

Population

Population is referred to as the complete set of individuals (subjects) or events having common observable characteristics in which the researcher intends to study. The population of the study comprised all the household heads in the four paramountcies in Twifo Hemang Lower Denkyira District . For the purpose of this study, the target population for the study comprised both household heads who have been enrolled in national Health insurance and household heads who have not been enrolled in national health Insurance in the district.

Sample size Determination

The sample size was calculated with a simplified formula provided by Yamane (1967).

$$n = \frac{N}{1 + N(e)^2}$$

Where;

n = the sample size

N = the population size (the total number of households in the district), and

e = the level of precision (proportion of error the researcher is prepared to accept). The level of precision, sometimes called sampling error, is the range in which the true value of the population is estimated to be.

Since the total number of household heads in the district is not known we assumed that every household has a household head and therefore used the total number of households in the district as the population of household heads in the district. The 2000 population and housing census pegs the total number of households in the district at 24178 and the sampling error anticipated for this study was 5%.

Using the formula above the sample size becomes,

$$n = \frac{24178}{1 + 24178(0.05)^2} = 394 \text{ household heads}$$

The sample size of 394 was rounded up to 400 to take care of maximum error. To ensure representativeness, the sample size was distributed according to the population of each community since there was no data on the number of households in each of the community .

Sample and Sampling Procedure

This study was designed to gather data from household head in the Twifo Hemang Lower Denkyira District. Multistage sampling technique was employed in selecting the sample size. With multistage sampling technique, the researcher combines two or more sampling techniques to address sampling needs in the most effective way possible. This involved using a mixture of probability and non probability sampling procedures at different stages in order to select the final sample.

Stratified random sampling procedure was used so that the sample will be consisted of both household heads who have bought health insurance and those who have not bought health insurance. For the purpose of this study stratified sampling technique was also used to divide the district into strata. Since the district consists of four paramountcies (Twifo, Lower Denkyira, Hemang and Ati Mokwaa) , each paramountcy was used as a stratum for the study. Simple random sampling technique was employed by the researcher to select a community from each stratum and the communities selected were Nuamakrom, Morkwaa, Krobo and Baakondidi.

A quota was also given to each town depending on the 2000 population and housing census population of each of the four communities and on the assumption that the larger the community the greater the households. Finally, the simple random sampling technique was employed to select a number of respondents from each community. Table 1 shows the number of respondents from each community for the study. In all, 400 respondents were obtained.

Table 1: Distribution of Respondents by Community

Community	Sample
Krobo	120
Nuamakrom	50
Baakondidi	100
Morkwaa	140
Total	400

Source: Author's construct, 2013

Data Collection Instrument

Structured interview was the research instruments used for the data collection. The interviewer had a standard set / sequence of questions that were asked of all respondents. Interviewers read the questions exactly as they appear on the survey questionnaire. The aim of this approach is to ensure that each interviewee is presented with exactly the same questions in the same order. This ensures that answers can be reliably aggregated and that comparisons can be made with confidence between sample subgroups. Also, household head was adopted as the basic unit of analysis for this study. Information were gathered from both heads of households who have been enrolled in national health insurance and those who have not been enrolled in national health insurance. The household heads provided responses for all questions in the interview schedule. The structured interview was used to gather information from household heads. It is considered to be suitable as some of the respondents are likely to be illiterates.

Also, since most of the household heads were illiterate, the researcher was helped by five (5) research assistants. The research assistants were taken through the process and mechanism of interviewing to obtain the right response from the respondents in order to achieve the objective of the study. The research assistants who were involved in the data collection were chosen base on their educational background, proficiency in the Twi language and their ability to translate from English to Twi.

Results and Discussion

Out of the 400 household heads interviewed, majority of the household heads, thus 153 (38.25%) had no formal education as presented in Table 2. Also, 87 (21.75%) household heads had attended primary education, 72 (18%) attended Junior Secondary School or the Middle School. With the secondary, technical or vocational education level, there were 65 (16.25%) while only 23 (5.75) had obtained one form of tertiary education.

Also Table 2 indicates that, out of 219 males interviewed, 73 (18.25%) had no form of formal education, 57 (14.25%) had attended primary education, while 38 (9.5%) attended Junior Secondary School (or Middle School). There were 38 (9.5%) males who attended secondary, technical, vocational School and 13 (3.25%) had obtained one form of tertiary institution. Among the females interviewed, 80 (20%) out of 181 had no form of formal education, 30 (7.5%) obtained primary education, while 34 (8.5%) attended Junior Secondary School (or Middle School). There were 27 (6.25%) females who attended secondary, technical, vocational School and 10 (2.5%) had obtained one form of tertiary education.

Table 2: Level of Education Attained by Heads

	Male		Female	
Educational level	Frequency	Percent	Frequency	Percent
No education	73	18.25	80	20
Primary	57	14.25	30	7.5
JSS/Middle school	38	9.5	34	8.5
SSS/Tech/Voc	38	9.5	27	6.75
Tertiary	13	3.25	10	2.5
Total	219	54.75	181	45.25

Source: Field Survey, 2013

The study consisted of 40% (160) of insured household heads and 60% (240) of uninsured household heads. The justification is that most people in the district are not registered. Out of the 240 respondents who were uninsured it was found that 112 representing 28% were previously insured and 128 representing 32 percent had never registered or being covered under National health insurance scheme before. This is shown in Table 3.

Table 3: Distribution of Respondents by NHIS Status

NHIS status	Frequency	Percent
Currently insured	160	40
Previously insured	112	28
Never registered	128	32
Total	400	100

Source: Field Survey, 2013

For those who are currently insured, out of 160 household heads 38 household heads had being insured less than a year and majority of the household heads (84) had been insured between 1 and 3 years all inclusive. It was found that 34 household heads who were currently insured had been insured between 4 and 6 years all inclusive, 4 household heads had been insured 7 and above years. Similarly, it was also found that majority of those who were currently insured responded that they waited between 1and 3 months all inclusive before they had their NHIS card. Thus, 92 household heads representing 57.5 percent waited between 1 and 3 months all inclusive before they had their NHIS card.

Although everyone who registers for NHIS is suppose to get a card in three months some of the household heads reported that it exceeded the three months before they had their cards. Out of the 160 respondents who were currently insured, 63 representing 39.37% waited for 4 and 6 months all inclusive and 5 respondents representing 3.13 waited for above 6 months before getting NHIS card.

Apart from the number of months those who were currently insured waited before getting their insurance card it was critical to find out how people perceived the premium

paid. Data on Table 4 shows that a higher proportion, thus 89 (55.63%), perceived the premium as being moderate. However 56 (35%) household heads perceived the amount as expensive while 15 respondents representing 9.37 percent perceived the payment as cheap. The amount paid as premium can affect the demand for health insurance. If more people perceive the premium to be high all other things being equal few people will demand national health insurance and vice versa.

Table 4: Distribution of Respondents by Perception of Premium Paid

Perception of payment	Frequency	Percent
Cheap	15	9.37
Moderate	89	55.63
Expensive	56	35
Total	160	100.0

Source: Field Survey, 2013

Reasons why previously enrolled household heads did not renew their insurance

Table 5 shows the reasons why household heads who were previously enrolled did not renewed their insurance. Out of the 112 household heads who were previously insured, 102 representing 91.07 percent did not renew their insurance because they could not afford renewal payment. Also, 4 representing 3.57 percent of them did not renew their insurance because they were not satisfied with the provider care and 6 representing 5.36% did not renew their insurance because they did not benefit from previous enrolment. This means that majority of the respondents do not have the means to renew their insurance. This is in consistent with Jehu- Appiah *et al.* (2011) study on equity aspects of the National Health

Insurance Scheme in Ghana: who is enrolling, who is not and why?. According to his study, inability to afford renewal payments was cited as the main reason for non-renewal of NHIS , with the poorest households (68%) less able to afford compared to richest households (44%) and also low satisfaction with provider care (6%) was another reason for non-renewal.

Table 5: Reasons for not Renewing Insurance

Reasons	Frequency	Percentage
Did not benefit from previous enrolment	6	5.36
Not satisfied with the provider	4	3.57
Could not afford renewal payment	102	91.07
Total	112	100

Source: Field Survey, 2013

Reasons why some household heads have never registered before.

With regard to why some household heads have never registered before, out of 128 household heads who had never registered or covered under NHIS before, 26 representing 20.31 percent had not registered before because they do not expect to be sick. Also the study found out that 8 representing 6.25 percent of the household heads who had never registered or covered under NHIS before , are not willing to be enrolled because they do not have confidence in the scheme and 94 of them said that they cannot afford premiums. It can be

said that most of the household heads were uninsured because they do not have the means to purchase the national health insurance and also to renew their insurance.

The possible reason why majority of the household heads could not afford premium is that out of the 400 household heads interviewed , 301 responded that their monthly earnings were between GH¢200 and GH¢ 399 inclusive which means that the income levels are generally low in the study area. This is in consistent with a study conducted by Gobah and Zhang (2011). Gobah and Zhang (2011) study shows that for the non-insured, affordability of premium and contributions was mentioned as the major barrier to enrolment (41.9%).The proportion was higher among the rural dwellers (33.8%) than urban dwellers (8.1%). Other reasons mentioned included: NHIS does not cover all my health needs (18.9%), do not need health insurance or not interested (17.6%). Interestingly, 10.8% of the rural respondents do not trust the organizers of the scheme.

Table 6: Reasons why People have Never Registered Before

Reasons	Frequency	Percentage
Do not expect to be sick	26	20.31
Not have confidence in the scheme	8	6.25
Cannot afford premiums	94	73.44
Total	128	100

Source: Field Survey, 2013

Health seeking behaviours

All the respondents reported that they have falling ill during the last 6 months but the frequency of illness defers. It was found that 213 household heads representing 53.25 percent reported that they do not fall ill often. Also, 49 representing 12.25 percent reported that they do fall ill often and 138 (34.50%) out of the sample population reported that they do fall ill

very often. This revelation is important because it clearly shows that, a greater percentage of the sample used for this study were potentially healthcare demanders.

As to the facility visited in times of illness, it was discovered that 272 household heads representing 68 percent out of the total sample, visited formal healthcare facilities when they fell ill during the past six months and 38 percent visited other facilities like herbal centres and prayer camps. One could say that household heads prefer the more formal and more predictive (in terms of treatment outcome) orthodox facilities as opposed to the informal trial and error alternative facilities, even though many respondents did not have formal schooling.

In terms of formal healthcare facilities, it was found that, 112 respondents who were uninsured used formal healthcare facilities and all the insured respondents had visited formal healthcare facilities during the past six months. Out of the 112 respondents who were uninsured 2 representing 1.79 percent responded that they visited the hospital when they fell ill; 109 (97.32%) went to the clinics and 1 (0.89%) went to CHPS compound. Also, out of the 160 household heads who were insured 81 representing 50.63 percent responded that they visited the hospital; 75 (46.87%) went to the clinics and 4 (2.5%) went to CHPS compound. This has been shown in the Table 7. It was discovered that those who were insured prefer to visit formal healthcare facilities when they fall ill and about half of the insured prefer to go to hospital rather than clinics and CHPS compound. Also it can be said that most of the uninsured respondents who visited formal healthcare facility during illness preferred clinics. This conforms with the findings of Jutting (2001) and Gobah and Zhang (2011). Jutting (2001) study on the impact of health insurance on the access to health care and financial protection in rural developing countries example in Senegal found that members of a mutual health insurance have better access to health care services than non-members. The probability

of making use of hospitalization increases by 2 percentage points with membership and expenditure in case of need is reduced by about 50 percent compared with non-members.

Similarly, in terms of healthcare service utilization, it was found that out of the 272 household heads who visited the formal healthcare facilities, 117 representing 43.01 percent utilized OPD service only, 89 representing 32.72 percent In-patient services only and 66 (24.26%) both OPD and In-patient services.

Table 7: Distribution of Respondents by Type of Formal Healthcare Facility Visited .

	Uninsured		Insured	
Health facility	Frequency	Percent	Frequency	Percent
Hospital	2	0.74	81	29.78
Clinic	109	40.07	75	27.57
CHPS compound	1	0.37	4	1.47
Total	112	41.18	160	58.82

Source: Field Survey, 2013

Table 8 also depicts the amount paid by the 112 uninsured household heads who visited the formal healthcare facilities during illness. It was discovered that out of 112 uninsured household heads who paid cash for treatment at formal healthcare facilities, 67 representing 59.82 percent paid GH¢61 and above for treatment, 21 (18.75) paid GH¢30-GH¢ 60 and 24 (21.43) paid less than GH¢30. It can be said that the amount paid for treatment at the formal healthcare facilities within the past six months by all the 112 uninsured respondents were higher than the premium of national health insurance scheme

paid by those who were insured. Although it was found that those who were insured visited formal healthcare facilities more than those who were uninsured but the amount paid by those uninsured household heads who visited the formal healthcare facilities were high.

Table 8: Distribution of Uninsured Household Heads by Amount Paid at Formal Healthcare Facilities

Amount paid	Frequency	Percent
Less than GH¢30	24	21.43
GH¢30- GH¢ 60	21	18.75
GH¢ 61 and above	67	59.82
Total	112	100.0

Source: Field Survey, 2013

For the remaining 128 household heads who did not visit the formal healthcare facilities, the majority of them thus 67 representing 52.34 percent, visited drug store,42 visited herbal clinic and 20 visited prayer camps. Apart from the chemical store, one could say that the next facility that those who are uninsured prefer is herbal clinics.

It was also found that out of the 128 household heads who did not visit the formal healthcare facilities, the majority of them 58 (71.3%) paid between GH¢30- GH¢49 and 48 (12.3%) paid less than GH¢ 30 and 22 paid GH¢50 and above.

Conclusions and Recommendations

It is evidenced in this study that the major barrier to national health insurance scheme enrolment is affordability of the premiums. If the annual premium is paid in a lump sum, household heads find it more difficult to pay. Therefore this study also recommends that national health insurance scheme annul premium could be paid on instalment basis rather than lump sum. Thus the payment of annual premium could be spread out over the year. Also, the Governments should aim at generating sufficient incomes to the people through various employment guarantee schemes.

It was also discovered that those who were insured prefer to visit formal healthcare facilities when they fall ill than those who were uninsured. Half of those who were insured preferred visiting hospital when ill to visiting clinics and CHIPS compounds but those who were uninsured preferred clinics to hospital and CHIPS compounds.

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