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Assessing the Sustainability of the Operations of the National Health Insurance Scheme: A Case of Oguaa Mansin Health Insurance Scheme, Cape Coast, Ghana

Gabriel Mwinkume
Department of Statistics, School of Applied Sciences and Arts
Cape Coast Polytechnic, Cape Coast, Ghana
Gladys Obuadey
NHIS, Cape Coast, Ghana

Abstract:
This study was conducted to assess the sustainability and challenges of the Oguaa Mansin Health Insurance Scheme (OMHIS) of the National Health Insurance Scheme of Ghana. A descriptive cross-sectional design was employed for this study. Structured questionnaire was used to collect data from 350 subscribers and 10 managers. Majority of managers did indicate that the premium charged on the national health Insurance scheme is cheap but were however of the opinion that registration charges, were expensive. Our multiple regression model explained that a unit increase in premium reduces the over reliance of the expenditure on Government subsidy by 0.14 (14%), suggesting either an increase in the amount of premium or a step-up in the collection of premium from subscribers. It is interesting to know that the scheme's major sources of finance are through government support, employee contributions and, registration and premium payment. Challenges mentioned were maturation time, frustration, card collection, and drugs covered by the scheme. Managers mentioned too many exempts from the scheme and inability to identify the true poor in the informal sector as key challenges. Subscribers recommended that the scheme should be free from politics, diseases covered must be widened, and maturation time must be reduced. How long will Government continue to sponsor the scheme? Alternative but sustainable measures must be found.

Key words: *Challenges, Sustainability, Premium, Government Subsidy, Health Insurance Scheme*

1. Introduction

In 1985, under the guidance of the World Bank, Ghana introduced its first major health cost recovery policy under the Hospital Fees Legislation (1985). Later in 1992, another new cost recovery instrument popularly known in Ghana as 'Cash and Carry' was introduced. With the "Cash and Carry" system, patients were made to pay for the full cost of drugs and some medical consumables whenever they visited any public health institution, while the state was responsible for all other costs including consultations, salaries and emoluments for doctors, nurses and other healthcare workers in state hospitals. It was realized that people went to hospital only when they were very sick and had money to pay for the cost of care. In fact this system of payment arguably constrained a lot of people from accessing healthcare except when they were in dire circumstances. According to Asenso-Okyere, et al. (1998) the implementation of the cash and carry policy, in some instances, led to an increase in self-medication because many people could not afford the out-of pocket user fees demanded at the point of treatment. Again, many citizens increasingly expressed concerns about "inequities inherent in this system known as 'cash and carry" (National Health Insurance Bill, 2003).

To improve access to healthcare the 'Cash and Carry' system was replaced by the National Health Insurance Scheme (NHIS) in August 2003 by an act of parliament (Act 650) to enable Ghanaians have access to basic health care services and medical treatment without the payment of fees at the point of delivery of service. The Act 2003, (ACT 650) ushered in a new healthcare paradigm that allowed Ghana to achieve its healthcare delivery goal of ensuring "equitable access to healthcare for all residents in relation to need rather than socio-economic or socio-cultural status" (National Health Insurance Bill, 2003). With this new policy, came the provision of affordable health coverage for every Ghanaian resident so that seeking medical attention would not depend on one's ability to pay (Aduamah, 2007). According to the NHIS (2010) report, the national average of 8,163,714 members registered with the NHIS, a reduction from 10,638,119 in 2009. According to the National Development Planning Commission (2009), the scheme has shown an increasing level of registration with a total subscription increasing from a low of 1,797,140 in 2005 to 12, 518,560 in 2008.

1.1. The underlying policy of Ghana National Health Insurance Scheme

Blanchet, et al., (2012) described the design of the health insurance in Ghana as being a combination of the concepts of social health insurance and mutual health organisation. It is based on a district-wide Mutual Health Organisation (MHO) approach. The district-wide MHOs provide cover for both the formal and non- formal sectors and the scheme is a multiple-not–for-profit scheme to community level and the non-formal occupational group. MHOs encourage and support the collection of premiums from the non-formal sector into the district–wide MHOs. There is single system at the national level to collect the formal sector premiums. According to Blanchet et al., (2012) the operation includes only two types of health insurance schemes; the district-wide MHOs and private health insurance which are further classified into private commercial health insurance schemes and private mutual health insurance schemes.

NHIS (2010) report indicated that the NHIS policy stemmed from a more general move to reduce poverty through the Ghana Poverty Reduction Strategy (GPRS). GPRS has a major component to provide and deliver accessible and affordable health care to all the citizenry in Ghana. Special concern was for the poor and vulnerable who qualified under previous policies for exemptions. It is primarily poverty Reduction Strategy with its emphasis on the accessibility and affordability. Before its introduction, 80% of health budget in the public sector was realised through tax revenue and donor funds and 20% from internally generated funds through the cash-and-carry systems (Aduamah, 2007). The aim among other things is to enable Government achieve its health goals as enshrined in the millennium development.

The National Health Insurance Policy Framework for Ghana (NHIPFG) (2004) further reiterated that the ultimate intention of government is to replace the out of pocket payments by providing an alternative package of health care which is affordable to all irrespective of the individual's social or financial state. Provision is made for everybody in the scheme the rich or well-to-do paying something slightly higher to subsidize for the poor and disabled. Membership is optional. The target is that within five years after its inception every citizen in Ghana shall belong to one or the other health insurance scheme covering him or her against the effect of the harsh cash-and-carry system. The health insurance scheme is made affordable to all. The benefit package is protection against a wide range of common tropical diseases.

1.2. Operations of the Ghana National Health Insurance Scheme

NHIPFG (2004) explained that the scheme is expected to fall in pattern with more than 287 other schemes reported to be in operation throughout the world. It is basically an insurance scheme in which the individuals have to commit themselves to periodical payments of money (premium) to a centrally controlled agency which has designed a disbursement scheme made up of protection against a set of selected diseases and medical services. The amount the individual pays varies according to age and financial status but the benefit package is uniform for all.

It requires that every person above the age of 18 pays a minimum of 70 thousand old Cedis (7 Ghana cedis) for the non-formal sector and for those in the formal sector, an amount equivalent to 2 .5% of one's $17^{1/2}$% of the SSNIT contribution has been set aside for kick- starting the scheme. A fully paid up member and all his or her children aged up to 17years get the chance of enjoying the minimum benefit package of protection that has been designed. This really suggests that all children from 0-17years are covered by either of his/her fully registered parent. The aged above 72 years of age are covered and qualify for the minimum package of protection. Indigents and other categories of persons as specified by law Funds from the central source shall be allocated to each district to make outright payment of contributions into the District Mutual Health Insurance Scheme (DMHIS) on behalf of such persons. To start enjoying the benefits, one as well as the children would have gone through the registration process. The scheme provides for the existence of two or more types of schemes in operation; the social type which is made up of the district mutual health insurance scheme and the private mutual health insurance scheme, the other is the private commercial health insurance scheme.

1.3. Level of Subscription to the NHIS

Arpoh-Baah (2011) in a survey at Mpohor District in Ghana, of household data indicated that more than half of the Ghanaian population (55.6%) had registered with the National Health Insurance Scheme. Out of this, 47.9% were valid card bearing members of the NHIS, and 7.7% had registered but were yet to receive their valid NHIS cards. Also, one-third (33%) of households in the survey had fully registered all their members, while about a quarter (25.9%) had registered some members of their households. More importantly nearly 41% of the population had not registered under the scheme. The scheme encourages complete registration of household members in order to pool health risk even at the household level. However, the results indicate that more efforts have to be made to reduce the possible high level of selection of individuals into the scheme. There is the likelihood that "high" risk groups could be selected into the scheme given that there is a problem of information asymmetry in developing countries including Ghana.

1.4. National Health Insurance Scheme Membership

The result from the household survey reported by NHIS (2010) shows that the proportions of the population in the Upper West, Volta, Western, Upper East and the Eastern regions who hold valid NHIS cards were higher than the national average. While the proportions of the population who hold valid cards in Central, Northern, Greater Accra and Ashanti Regions were less than the national average. The Central Region had the lowest proportion of the population with valid cards. On the other hand, the Northern Region had the highest proportion of people who though registered had no valid NHIS cards (16.3%), followed by Ashanti (11.9%) and Brong Ahafo (10.5%) Regions respectively, whiles the Upper East Region has the least (1.3%). The report however indicated that significant proportion of individuals interviewed had not registered with the NHIS. This is particularly high for Greater Accra and Central regions

of Ghana where more than half of the population have registered under the scheme. The NHIS (2010) report further indicated that in general, the proportion of individuals registered under the scheme is higher in the urban than in the rural areas. The level of registration is about 10% more in urban areas than in rural areas.

1.5. Financial challenges and Sustainability of the Scheme

Health financing in Ghana has experienced greater transformation in its operation. Under colonial rule, health system was organised to primarily benefit a small elite group of colonial officials and their workers (Arhinful-Tenkorang, 2001). Health care provision occurred mainly through hospitals in urban areas, with direct payment at the point of use. The rest of the population relied on services from a range of providers such as traditional healers and missionary health centres. After independence, the government of Ghana provided medical care free of charge to their population at public health facilities. Health care was financed by general taxes and external donor support, user fees were removed and attention was directed to developing a wide range of primary health care facilities across the country (Ghana Health Service & Abt Associates Inc, 2009). By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax based health financing system (Agyepong & Adjei, 2008).

Not unexpectedly given the voluntary character of health insurance, affordability of premiums or contributions is often mentioned as one of the main determinants of membership. For instance in the Nkoranza scheme in Ghana, the estimated cost of contributions varied from 5% to 10% of annual household budgets (Atim, 1998). It was recognized that such contributions could be a financial obstacle to membership. Contributions are also generally levied as flat sums, which is a disadvantage for the poorest: flat contributions are regressive, a flat-rate contribution as a percentage of income being higher for poor than for the non-poor.

In a related study by Schneider and Diop, (2001) in Rwanda, membership varied from 5.6% to 7.7% in the lowest and highest income category, respectively; yet, this difference was found not to be statistically significant. One indication though in this study that affordability matters, is that large households with more than five members had a greater probability to enrol in the community health insurance (CHIs) than others. The explanation given is that contributions were kept flat, irrespective of household size up to seven members; the average contribution per household member was therefore less than for smaller families, inducing greater enrolment.

1.6. The Oguaa Mansin Mutual Health Insurance Scheme

In 2005, the Cape Coast Municipality started operation of the Oguaa Mutual Health Insurance Scheme with the aim of providing individuals within their community the opportunity to access health services at an affordable cost. The NHIS Act, 2003 (Act 650) allows three types of health insurance in Ghana: the District Mutual Health Insurance Scheme (DMHIS), Private Mutual Health Insurance Scheme and Private Commercial Health Insurance Scheme. The Oguaa Mutual Health Insurance Scheme is an amalgamation of three health insurance schemes already in existence. These are the private commercial health insurance scheme, the private mutual health insurance scheme and the district wide mutual health insurance scheme.

The Oguaa Mansin Mutual Health Insurance Scheme remains relatively young and work remains to be done to ensure their long-term sustainability and their potential to leverage quality improvements in the health sector. Research must be carried out to identify the weaknesses and strengths of the Oguaa Mansin Mutual Health Insurance Scheme so as to make informed and proper recommendations to the management and policy makers of the scheme. Till date no work has been done to critically assess the operations of the Oguaa Mansin Mutual Health Insurance Scheme. More so, according to the directorate of the Oguaa Mansin Mutual Health Insurance Scheme, the scheme is running into distress by their indebtedness to health care providers. This according to the directorate has compelled the health care providers to deny services to card bearing members of the NHIS. Some of the service providers have threatened to withdraw the services of health insurance clients if the amount owed by the scheme is not paid. The scheme also has accommodation problem. Office spaces are too small for workers and there is not enough space to store claims sheets, which is now more than they expected. There is therefore the need to examine the operations of the Oguaa Mansin National Health Insurance Scheme to ascertain the viability and its sustainability. These developments, in line with the recent high outcry of thought about the sustainability of the NHIS nationwide, informed this research to be conducted to examine the operations and sustainability of the scheme.

2. Materials and Methods

The population used for the study were the heads, directors and stakeholders involved in the running of the oguaa mansin health insurance scheme as well as the subscribers. Three-hundred and fifty (350) card bearing members (subscribers) of the scheme were drawn. This number was drawn using the table for sample size determination developed by Krejcie and Morgan (1970). As at the end of the 2012 working year, the number of subscribers was about 49061. All the 10 managers or heads of the providers were also drawn to represent the head/managers of the Oguaa Mansin Insurance Scheme. Subscribers were approached randomly when accessing health care at the health facilities. NHIS card bearers who visit the hospitals were approached to enrol in the study.

The main data collection tool was structured questionnaire. Structured questionnaires were administered to both managers of the scheme and subscribers. Also, secondary data regarding income and expenditure of the scheme was used. Institutional approval for the study was obtained from the authorities of the Oguaa Mansin Health Insurance Scheme. Guarantees of anonymity and confidentiality were ensured.

3. Results and Discussion

3.1. Subscribers Perspective

While majority of subscribers (48.0%) were between the ages 20 and 29 years, only 1.7% of them were either 60 years or above. It was observed that most of the subscribers (56.3%) had attained secondary school education. Those who obtained basic education were the minority (2.9%). Several challenges were mentioned by subscribers. Among the challenges were that maturation time was too long; frustration of subscribers associated with registration and card collection; and the drugs needed are often not those covered by the scheme. Other challenges mentioned by subscribers were; health workers give attention to those who pay cash and the cost of registering is too much.

Also, majority (335 subscribers) representing 95.7% of subscribers agreed that the maturation time is too long. This finding is consistent with Dalinjong and Laar (2012) who indicated that insured clients were not happy about the delay in processing the insurance ID cards after registration, and the yearly renewal of the ID cards. In that study, respondents indicated that they were inconvenienced by the long waiting time to receive their cards after registration to the scheme.

One other major challenge subscribers mentioned was that the health insurance officials make registration and card collection frustrating. This result is similar to the findings by Chankova et al., (2008). According to Chankova et al (2008), all respondents used for the study indicated that they were highly frustrated especially through the registration process and card collection. This frustration was explained by officials of the Oguaa Mansin Health Insurance Scheme that the requirements of the scheme during registration are cumbersome.

It was also noted that 59.4% of the 350 subscribers were of the opinion that health workers give a lot more attention to those who pay cash resulting in long waiting time for subscribers. Providers explained that the differences in waiting times by the insured were due to the processes that the insured goes through in terms of documentation. Given their high attendance rates of the insured, waiting times were likely to be high for them. It would therefore be appropriate if the NHIS or policy makers are able to put measures in place to reduce the documentation process for the insured and help reduce their waiting times. This is in contrast with the assertion by the National Development Planning Commission, (2009) survey which showed that people with valid NHIS card receive high quality health care unlike those who do not belong to the scheme. The finding of this study is also in contrast with the objectives of the NHIS (2010), section 2d of Act 650 which states that the NHIA may ensure that healthcare services rendered to beneficiaries of schemes by accredited health care providers are of good quality and bearers of cards must be giving prompt services.

The result of this study however is consistent with assertions of Criel, and Waelkens, (2002) which indicated that in Guinue-Conakry, several participants preferred not to enrol but rather seek care elsewhere (and admittedly paying more) in order to receive better quality care. Their assertion was as a result of poor health care received. The participants further noted that health care at private health facilities could thus well be preferred to health care offered by the public health facilities associated with the health insurance scheme. According to WHO, (2006) lack of quality of care was cited as the most important cause of non-enrolment in the insurance scheme in Guinea-Conakry. Further, the finding of this research study is consistent with that of Chee, et al. (2002). That study revealed that members of the scheme did not have access to better quality care at mission health facilities which was part of the community health insurance scheme in Tanzania.

Dalinjong, and Laar, (2012) also reported similar assertions by insured clients accessing health care. Their study revealed that about 76% of outpatients who are insured perceived the waiting times to be too long. It is also in line with what Bruce et al., (2008) reported. He identified that clients making outpatient payments for health care services had shorter waiting times than their counterparts who were carrying health insurance cards. In Burkina Faso too, De Allegri et al. (2006) found insured respondents complaining of long waiting times and general poor quality of care when they access health care services.

Further, majority indicated that the cost of registering to join the scheme is too high. This is in line with the findings of Chankova, (2008) who reported that majority of subscribers mentioned high premium rate and the cumbersome registration process as being responsible for their inability to get registered with the NHIS in the Tamale Municiapality in the northern part of Ghana. It is congruent with the findings of Dalinjong and Laar, (2012) where insured clients were not happy with high premium payment for registration. Meanwhile subscribers disagreed that ailments that are covered by the benefit package are too few and they further indicated that very often the drugs needed are not available even though they are covered. The result of this study is in contrast with that of Asensoh, and Wahab, (2007) where 60% of the respondents indicated they had had to purchase prescription drugs on several occasions because the hospital or clinic at which they saw their doctor did not have all the prescribed medications though they are covered by the insurance scheme.

3.2. Perception of Managers on Premium Charges

Majority of the scheme managers (60%) were of the opinion that the premium charged on the national health insurance scheme is cheap. This however was contrasted in the responses of 30% of the managers who said that the premium charged was expensive whilst the remaining thinks that the premium charged is moderate.

3.2.1. Perception of Managers on Registration charges

When managers were asked on their perception regarding the amount charged during registration, it was indicative that half of the managers had the perception that it was expensive. On the other hand it could be realised that 40% of the managers said that registration charged was moderate.

3.3. Main Sources of Funding

One major source of funding to the scheme is registration and premium charges from subscribers. According to the managers, registration paid per subscriber is 4 cedis for new registration and a minimum annual premium amount of 20 Ghana cedis. This result is consistent with the findings of Atim, (2001) that source of income towards health financing schemes in Ghana is through membership payment of annual premiums. The managers also revealed that one major source of funding for the scheme is government subsidy. The government of Ghana has been a major source of financing for the health sector. This is in line with the submission of the Ghana Health Service & Abt Associates Inc, (2009) that after independence, the government of Ghana has provided medical care free of charge to their population at public health facilities. Health care was financed by general taxes and external donor support, user fees were removed and attention was directed to developing a wide range of primary health care facilities across the country. Currently government (tax revenue) and donor funding caters for about 80 per cent of the cost of health care, implying that about 20 per cent of healthcare is financed through out-of-pocket payments popularly known as the cash-and-carry system.

3.4. Financial Contributions to the Scheme

It was revealed in this study that the scheme is also funded partly by the contribution of employees. The National Health Insurance Act (2003) makes provision for the transfer of 2.5 percentage of contribution from the social security pension scheme administered by SSNIT to the National Health Insurance fund. This means a mandatory contribution for all workers is covered under the SSNIT scheme. Payments are therefore made to the various schemes nationwide as subsidy. From 2004, employee contributions were based on 2.5 per cent of salary, computed as the product of the average salary and the number of active contributors of the SSNIT pension scheme and the applicable compliance level.

After managers indicated the sources of income to the scheme, they were further asked to indicate if the current sources of income could sustain the operations of the scheme, and 60% of them answered in the negative. Reasons given by majority of managers who indicated that the current sources of income cannot sustain the operations of the scheme were related to the high claims and administrative expenditure. (Refer: Table 1). On the whole, claims seems to have recorded the highest expenditure over the three years with 2011 and 2010 recording the highest (5853123.46 Ghana cedis) and lowest (4,482,576.12 Ghana cedis) respectively.

Expenditure				Income			
Year	**Administrative**	**Claims**	**Total**	**Premium**	**Registration**	**Government subsidy**	**Total**
2010	159370	4,482,576.12	4,641,946.20	312,976.90	89,183.50	4,031,953.01	4,434,113.41
2011	264955	5,853,123.46	6,118,078.25	356,105.20	202,855.35	5,958,724.00	6,517,684.55
2012	225283	4,915,146.77	5,140,430.23	471,627.00	185,887.10	4,708,794.69	5,366,308.79

Table 1: Income and Expenditure of the Scheme (in Ghana Cedis)
Source: Field data, 2013

As shown in Table 1, revenue generated at the scheme in terms of premium, registration fees and government subsidy revealed that in 2010 the Scheme generated GH¢ 4,434,113.41 which increased in 2011 to 6,517,684.55 but in 2012 the revenue available was 5,366,308.79. The total of the locally generated fund comprising premium and registration fee only, from 2010 to 2012 are 402,160.40, 558,960.55 and 657,514.10 respectively. Meanwhile, considering the expenditure on administrative and claims it would be realised that the locally generated fund could not sustain the scheme. It can also be observed that government subsidy is the major financial source to the scheme. Currently, and according to the data obtained from the National Health Insurance office, the scheme is not sustainable without Government subsidy.

Regressing the Expenditures (Administrative and Claims) on the Incomes (Subsidy, Premium and Registration) of the scheme, at 95% confidence coefficient the fitted model that was relied on to determine the sustainability of the scheme is given as;

Expenditure = (Constant) – 0.14(Premium) + 0.769(Subsidy)

Income from Registration was not significant to sustain the scheme and hence, was eliminated from the model. For a unit change (one Ghana cedi) in Subsidy, the Expenditure is expected to increase by 0.769 (76.9%). However, a unit increase (one Ghana cedi) in the Premium will reduce the average annual overreliance of the expenditure on Government subsidy by 0.14 (14%). This is perhaps happening because higher claims were demanded based on the increasing numbers at the health facilities against a small amount paid by a subscriber (20 Ghana cedis per annum) to include his/her children or aged. Meanwhile, only 2 Ghana cedis is paid per child as registration fee. Granted that in one particular year, no subsidy and premiums were provided, the schemes expected deficit stands at approximately 1,584,127.23 Ghana cedis for the period under consideration. (Refer: Table 2). It was also noted that the contribution of incomes from Registration of members was not statistically significant and hence, was dropped from the model.

Model		Unstandardized Coefficients		Standardized Coefficients	95.0% Confidence Interval for b	
		b	Std. Error	Beta	Lower Bound	Upper Bound
1	(Constant)	1584127.229	.000		1584127.229	1584127.229
	Premium	-.140	.000	-.015	-.140	-.140
	Subsidy	.769	.000	1.001	.769	.769

a. Dependent Variable: Expenditure
b. Predictors in the Model: (Constant), Subsidy, Premium

Table 2: Coefficients of the Fitted Model for the Regression Variables

3.5. Managers Opinion about the Challenges of the Scheme

Among the challenges mentioned were; too many exempts from the scheme, poor healthcare provision to holders of the card and inability to identify the poor in the informal sector. Majority (90%) of the managers agreed that there were too many exempts from the scheme. According to the Legislative Instrument (LI 1809) that accompanied the NHIS, a person shall be exempted from premium payments under four main criteria. These are

- That the person is unemployed and has no visible source of income,
- Does not have a fixed place of residence according to standards determined by the scheme,
- Does not live with a person who is employed and who has a fixed place of residence and
- Does not have any identifiable consistent support from another person (M*inistry of Health, 2004).* These exemptions were thought of by managers as inappropriate the people exempted were too many.

According to the managers, there have been several complaints regarding poor quality of health care provision to holders of health insurance cards. Some of the complaints received include long waiting time for card holders compared with patients that pay money for care to be given. This assertion of the managers is similar to the report of the findings by Dalinjong **and** Laar (2012) that health insurance card holders are given poor health care.

The last challenge mentioned by managers was the difficulty in identifying the poor indicated by 70% of the managers. According to the managers of the scheme, identifying the poor to be exempted is a major challenge of the scheme. This finding was reiterated by Aryeetey et al (2011) that NHIS service uses subjective measures to identify the poor and this implies that the definition of who is poor may vary widely across settings, as sometimes people's expectations about benefits of the identification process and variations in relative perceptions of "poverty" may exaggerate or underestimate the numbers of identified poor. This may provoke in some way unequal exemption policies in a country like Ghana. Aryeetey et al (2011) further indicated that patterns of who is poor varied widely across communities as perceived state of poverty was relative to the context of the communities. In the typically farming (cash crop farming) community for example, households were perceived and ranked predominantly with middle class status contrasting extremely poor perceptions and ranks assigned to households in the typically fishing community.

More so, identification of the poor and the aged found in this study were also mentioned in studies by Agyepong, (1999), Nyonator and Kuntzin (1999) and Russell et al., (1999) as difficult. They indicated in their study that there were gross abuses and side stepping of the exemption clause by policy implementers. The poor and the aged were simply ignored with the implementation agents claiming it was too difficult to adopt, a clear situation of lack of monitoring and supervision. Chankova (2008) also reported similar finding in his research study that the absence of specification of the criteria of the poor makes it difficult to select the poor.

Managers however disagreed that there were inefficient claims management; existence of fraud, abuse and poor ID card management. About 70% of the managers of the scheme noted that there was no mismanagement of claims which is in contrast with mismanagement of claims reported on the 7th of February, 2014, by the Public Accounts Committee (PAC) of Parliament of Ghana, charged managers of the National Health Insurance Scheme (NHIS) to fully retrieve its misappropriated funds (total amount of GH¢28.4 million) with interest, from the health insurance schemes.

Regarding the existence of fraud, 90% of the managers indicated there were no fraud and or abuse in the operations of the scheme. This is in contrast with the operations in certain parts of the country. For instance, Abass, (2011) cited **Ametor-Quarmyne** (2010) that the sustainability of the National Health Insurance Scheme (NHIS) in the Ketu District was under threat, following massive fraud being perpetrated by some service providers. A clinical and financial audit carried out by the National Health Insurance Authority (NHIA) into the operations of the Ketu District Mutual Health Insurance Scheme and five health facilities in the district in March 2010, has led to the recovery of false claims submitted by the five hospitals. It is against this backdrop that the Chief Executive of the NHIS reiterated that in dealing with issues of corruption and mismanagement of fund, that NHIS would review its financial manual to reduce cash payment and place greater responsibility on its centres to ensure that no abuse and fraud occur at the regional and scheme level.

3.6. Subscribers' Recommendations towards the Sustainability of the Scheme

It was further realised that subscribers gave several recommendations to help in the smooth operation of the scheme. Among the several reasons were; the scheme should be free from politics, disease covered must be widened and maturation time must be

decreased. This explains why the Chief Executive Officer of the National Health Insurance Scheme indicated that there is an introduction of an instant issuance of ID cards to address the perennial problem of delays in ID card distribution where individuals register and will have to wait for months.

Other recommendations were that charges on premium and registration must be reduced and permanent cards should be used. The suggestions of the subscribers to depoliticise the scheme, is in line with the assertions by the Chief Executive Officer of the National Health Insurance Scheme (Sylvester A. Mensah) on August 5, 2010, that "it is important to depoliticise health insurance as a social protection policy, and it is becoming increasingly worrying at the rate at which health insurance has become a political punching bag".

Regarding the widening of the diseases covered by the scheme, subscribers think that currently the diseases covered by the scheme are not enough hence some must be included. Although about 95% of the diseases in Ghana are covered under the NHIS some services classified as very expensive are on the exclusion list. Among these are; cosmetic surgery, drugs not listed on the NHIS drugs list (including antiretroviral drugs), assisted reproduction, organ transplantation, and private inpatient accommodation. Diseases covered include malaria, diarrhoea, some respiratory infections, skin diseases, hypertension, asthma, diabetes. (Brugiavini & Pace, 2010).

4. Summary

This study was conducted to evaluate the perception of managers on registration charges regarding the subscription to the Oguaa Mansin Health Insurance Scheme, to also assess the financial sustainability of the Oguaa Mansin Health Insurance Scheme. It also ascertained the challenges associated with the operation of the Oguaa Mansin Health Insurance Scheme; provider and subscriber perspective. It also sought recommendations from subscribers towards the effective operation and sustenance of Oguaa Mansin Health Insurance Scheme. The Oguaa Mutual Health Health Scheme remains relatively young and work remains to be done to ensure their long-term sustainability and their potential to leverage quality improvements in the health sector. Till date no work has been done to critically assess the operations of the Oguaa Mansin Health Insurance scheme.

The study revealed that majority were males and fell within the age category of 20-29 years. It was also found that most of the respondents had attained secondary school education and substantial number (26.6%) of respondents had schooled up to the tertiary level. Of the ten managers, majority, 60% did indicate that the premium charged on the national health insurance scheme is cheap. On registration cost, half of the managers had the perception that it was expensive.

Sources of funds to the insurance scheme found in this study were; contributions from members, via registration, premium payment and government support in the form of subsidy as well as employee contributions. Meanwhile 60% of managers indicated that current sources of income could not sustain the operations of the scheme because of the high expenditure on administrative and claims. It was also clear that income from registration played an insignificant role to sustain the scheme. However, Government subsidy and premium were quite significant determinants of sustainability. Thus, a unit increase in premium (in monetary terms) reduces the overreliance of expenditure on Government subsidy by 0.14 (14%).

Major challenges mentioned by subscribers were; maturation time being too long, frustration of subscribers associated with registration and card collection, the drugs needed are often not those covered by the scheme, health workers give attention to those who pay cash and the cost of registering is too much. The challenges managers exclaimed are affecting the scheme were too many exempts from the scheme, poor healthcare provision to holders of the card and inability to identify the poor in the informal sector. The study also revealed subscribers recommendations that the scheme should be free from politics, disease covered must be widened and maturation time must be reduced.

5. Conclusion

Of the ten managers enrolled in the study, majority indicated that the premium charged on the national health scheme is cheap. Regarding registration charges, it was indicative that half of the managers had the perception that it was expensive. Regarding the financial sustainability of the scheme, the study revealed that the major sources of income to the scheme were contributions of members, via registration and premium payment and government support in the form of subsidy as well as employee contributions. It was also found out that government subsidy is the major financial source of the scheme.

The study also revealed challenges as mentioned by the managers and subscribers. Among the challenges were; maturation time being too long, frustration of subscribers associated with registration and card collection, the drugs needed are often not those covered by the scheme. Other challenges mentioned by subscribers were; health workers give attention to those who pay cash and the cost of registering is too much. Other challenges mentioned were; too many exempts from the scheme, poor healthcare provision to holders of the card and inability to identify the poor in the informal sector.

On the issue of recommendations to help the smooth operation of the scheme, subscribers indicated that the scheme should be free from politics, disease covered must be widened and maturation time must be decreased.

6. Recommendations

It is recommended from the findings of this study that the:

- Government should continue supporting the Scheme because from the study, financial sustainability of the Scheme depends on the government support.
- Government should come up with a strategy to help identify the poor who are exempted from the payment of premium.

- The schemes should intensify public education to sensitize the clients on the cost implications associated with multiple attendances to health care in relation to low premium contributions and inadequate subsidy to the Scheme which threatens its financial sustainability.
- National Health Insurance Authority should further decentralise the registration and card collection process. This has the effect of greatly reducing the congestion that has become characteristic of the operation of the scheme.
- Scheme should consider either reviewing the amount paid annually on premium or pay premium to cover only two children, aged (70 years or above in the family) and a spouse, and a fee paid for the remaining children if any. This in our opinion may sustain the scheme to a large extent.

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