



**Contribution of Mutual Health Organizations
to Financing, Delivery, and Access to Health Care
Ghana Case Study**

USAID/PHR, ILO/ACOPAM, ANMC, WSM

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Introduction

Mutual health organisations (MHOs) are community and employment-based groupings that have grown progressively in West and Central Africa. Their emergence has attracted growing interest from governments, NGOs and international organisations, particularly those interested in new and innovative approaches to the difficult issues of health care financing and access in the subregion.

In the light of this, several international organisations have shared efforts to collaborate from 1997 to 1998, on a research project on the actual and potential contribution of MHOs in the financing, the delivery and the access to health care in West and Central Africa.

The consultative group included the project Partnerships for Health Reform (PHR), supported by USAID, the International Labour Organisation programmes "Appui associatif et coopératif aux initiatives de développement à la base"(ACOPAM) and "Strategies and Tools against social Exclusion and Poverty" (STEP), World Solidarity (WSM) and the National Alliance of Christian MHOs of Belgium (ANMC).

The study deals with nine West and Central African countries and has lead to a database of mutual health organisations in six countries including 22 case studies: Benin, Ivory Coast, Ghana, Mali, Nigeria and Senegal. Methodological guidelines have been addressed for the selection and the analysis of MHOs as case studies.

The research has examined systematically the actual and potential contributions of West and Central African MHOs in the field of the mobilisation of resources, sustainability and the democratic governance of the health sector. It has led to recommendations aimed at the key actors in the development of mutual health organisations. The results of the study have been published and are entitled: "The contribution of Mutual Health Organisations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries".

The study can be considered as a successful example of efficient collaboration between international organisations that have succeeded in sharing human resources, personnel and financing for the realisation of activities of common interest.

This report refers to the case studies in Ghana. It has been produced by Chris Atim, PHR, in April 1998.

Executive Summary

MHO development is a relatively recent phenomenon in Ghana. This is related to the previous tradition of free publicly provided health care, which continues for most employees in the formal sector up to now. There is a trend toward reduction of the amount of free health care cover offered by government and employers to their employees, in efforts to contain health care costs.

The modern concept of insurance is still little understood among the general population, or tends to be associated only with vehicle and other property insurance. Moreover, traditional solidarity tends to lack inclusivity to the extent that such solidarity is frequently limited to clan or ethnic organisations and tends to break down beyond those boundaries.

Meanwhile the evidence examined in this paper indicates that development of MHOs is hampered by lack of suitably skilled personnel and in particular lack of knowledge of the specific risks associated with health insurance and appropriate risk management techniques.

The case study analysis in this research shows that non- or low-participatory schemes such as the West Gonja one appear primarily focused on cost recovery or financial objectives, giving the impression that health improvement is only incidental to their aims, in contrast to participatory schemes (like the Community Partners for Health schemes in Nigeria) which tend to place emphasis on health improvement and quality of care. Some of the problems of the West Gonja Scheme which are aggravated by its non-participatory character include evidence of significant adverse selection and moral hazard.

In this connection, the participatory or ‘complex’ model of community financing seems better placed to respond to these kinds of problems principally due to the significant level of community participation in their management. These latter schemes are also more likely to make a significant efficiency contribution by focusing available resources on PHC services and the health care priorities of the community concerned. The features of the proposed DHIS system in Ghana appear to be based on these lessons and, if implemented, will make a useful contribution to MHO practice in the country.

The health financing aspect of professional organisations such as the teachers association is not well developed, mainly because the members of such organisations typically benefit from subsidised or free health care conditions from the government. But there is considerable potential for these kinds of funds to play a crucial role in health care financing so long as the government continues in its present course of gradually reducing health care benefits for the public sector (although it is also possible that the proposed national health insurance scheme will make their role redundant).

Government plans for introducing a national health insurance scheme by stages will significantly impact on MHO development in the country. But non-profit mutual insurance schemes may still have a comparative advantage in providing for the informal sector (including the large rural population) where Government will have great difficulty devising sufficiently efficient and effective ways of collecting premiums and avoiding abuse. The experience being accumulated by the MHOs in these areas is being closely followed by the

government and it can be assumed that this will not be ignored when thought is given to extending social insurance to the non-formal sectors.

Because of the last point, concentration on the health activities and sectors of the population which will not be covered (at least initially) by the proposed phased introduction of national health insurance scheme (which means mostly the informal sector including rural communities) will be the right direction in which to develop MHO interventions.

The weaknesses of the low participation model (eg West Gonja and Nkoranza schemes) highlighted in the study implies that they could benefit from targeted technical assistance. The areas where such support might be useful would be: lack of independence from the provider, lack of negotiating power, marketing, need for quality control mechanisms, drugs' policy, and lack of preventive/promotional services.

There is need for legislation to enable mutuals to acquire a legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration, and may be some model rules and regulations (drawn up in consultation with existing mutuals) which new organisations can adopt or adapt to their own needs.

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1. Objectives, Methodology and Data Sources

The Methodological Guidelines for this research state that the “overall objective” of the project is to “study the actual and potential contribution of mutuelles to the financing, delivery and access to health care in Africa, with particular reference to WCA countries.” The Guidelines go on to state, more specifically, that the research “aims to evaluate the experience with and potential for mutuelles as a health insurance mechanism.”¹

The fieldwork was aimed at collecting substantial data and information to enable some of the key questions that arose from the stated objectives to be answered in detail. Ideally, four types of non-profit mutual health organisations (MHOs) were to be selected in each country, according to the typology discussed in the Guidelines. But this could be varied if such variation would best contribute to the research objectives.

In Nigeria and Ghana, the research was conducted mainly through interviews with leading personnel of various organisations that are involved in the health sectors and in particular the mutual organisations identified as worth studying in depth.

These interviews were supplemented by literature review of the country’s health and health care fields, discussions and interviews with mutualist leaders, user group discussions, and visits to research and other support institutions that intervene in the health sectors in the two countries.

Most individuals and organisations interviewed were usually open and willing to give information. However, members of traditional mutual organisations were noticeably more reticent about disclosing information particularly relating to their finances. In other cases, with non-traditional MHOs, the quality of the data was sometimes poor due to insufficient, irregular or non-existent records. However, as will become evident, reliable and sufficient data were also available from other schemes, particularly community financing types of scheme investigated. As a consequence, the quality and quantity of data were not even and much care is needed in drawing any comparisons between the various schemes.

It should also be noted that the term “health mutuelles”, used in the Guidelines to refer to the mutual health organisations to be investigated, has been replaced in this paper by the descriptive English term of non-profit mutual health organisations (MHOs). The meaning of this term, based on experience in Anglophone countries, is also wider than is commonly understood by ‘mutuelle’ or ‘mutualité’ in the Francophone countries. The organisations included in this term share the following characteristics: they are non-profit, autonomous, and based on solidarity between, and democratic accountability to, their members, and with a mission to improve their members’ access to good quality health care through any of a range of financing mechanisms including insurance, simple pre-payments, savings and credit, subscriptions, and so on.

¹ Atim, C. 1997. Methodological Guidelines For PHR Field Research On Health Mutuelles In Western And Central Africa (WCA). Maryland: Abt Assocs Inc/PHR.

2. Context

a. Health Indicators for Ghana

Table 2.1 below shows some basic health indicators for Ghana.

Table 2.1: Selected Basic Health Indicators of Ghana

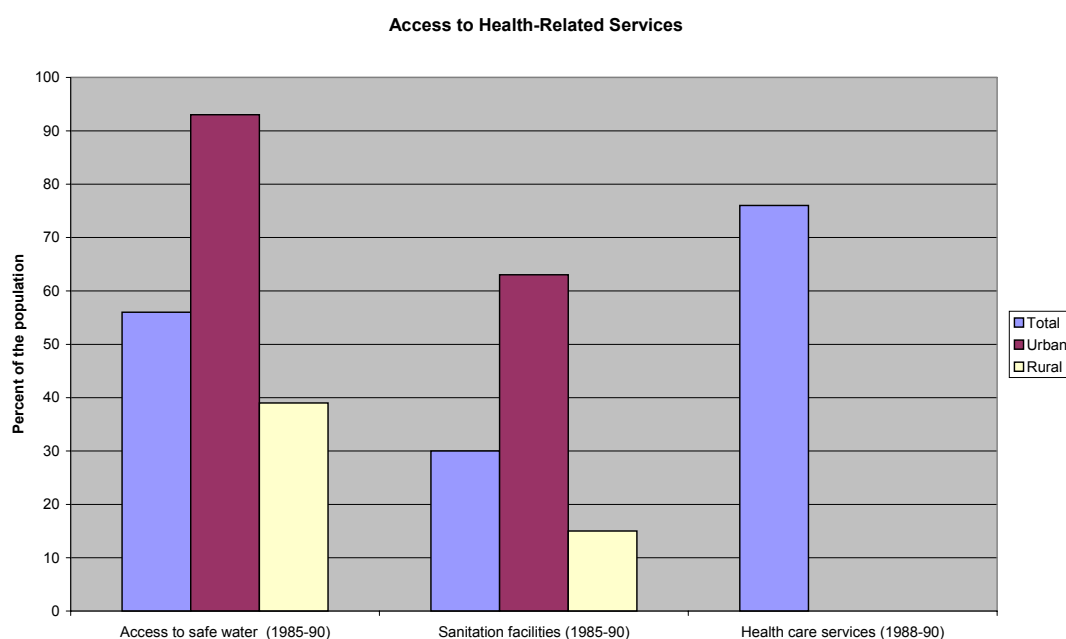
Basic Health Indicators	
Life expectancy at birth (1992)	Male: 53 Female: 57
Infant mortality (1992)	81 per 1000
Under 5 mortality (1990)	170 per 1000

The life expectancy figures are better than the African average of 49 years for males and 52 for females. Infant mortality is also better than the African average of 104 per thousand. The under five mortality figure of 170 is however only slightly better than the African average of 175.

Table 2.2 Access to Health-Related services

	Total	Urban	Rural
Access to safe water (1985-90)	56	93	39
Sanitation facilities (1985-90)	30	63	15
Health care services (1988-90)	76	n.a	n.a.

Chart 1



While 93% of the urban population has access to safe drinking water, only 39% of the rural population have such access. Just 15% of the rural population have access to sanitation facilities, compared to 63% for the urban population.

Table 2.3 Health expenditures (millions of US \$, 1990)

Public:	71.5
Aid flows:	26.9
Private:	105.9
Total:	204.3
Per capita:	14

Source: World Bank (1994), op. cit.

Private health expenditures in Ghana amount to about one and a half times the size of the public one, but this proportion is less than the case in Nigeria for instance, where it is nearly one and three-quarters.²

A national survey in 1987/88 on the health seeking behaviour of individuals who experienced illness found that urban residents with illness consulted medical personnel more than rural ones, ranging from 36% in the rural savannah to 59% in Accra (note that this includes consulting traditional healers). The conclusion was that the “wide variation may probably be due to the fact that people in urban areas have easier access to health facilities than those in rural areas and also the fact that most urban residents can more readily afford to pay for such services.”³

b. The Private Health Insurance Market

The first and only private for-profit health insurance company in Ghana, nationwide Mutual Medical Insurance Scheme, was established in early 1994. It is a joint venture between the Society of Private Medical and Dental Practitioners of Ghana (service providers) and nationwide Mutual Medical Insurance Company (a subsidiary of Vanguard Assurance, a long-established private commercial insurance company in the country). As at October 1997, there were about 50,000 persons (beneficiaries) covered by the company’s policies (representing about 0.3 percent of the Ghanaian population). The turnover of the entire market is currently estimated to be around 250 million cedis (just over US\$110,000) a year, but this estimate is probably a conservative one.⁴

In theory, nationwide sells both group and individual plans but in actual fact, there are less than 10 individual subscribers and the company does not encourage individual subscriptions.

² The World Bank’s publication makes no mention of whether ‘private’ health expenditures include herbalists and other traditional practitioners. But the publication does state that caution is needed in interpreting some of the data.

³ Ghana Statistical Service, *The Pattern of Poverty in Ghana, 1988-1992*, Accra, Nov 1995; p. 71.

⁴ Information obtained from nationwide Mutual Medical Insurance Scheme, November 1997.

Groups currently subscribing to this private insurance scheme include mining and manufacturing companies as well as diplomatic staff in the country.

The benefits package includes, for basic cover, outpatient services such as consultation, prescriptions, basic dental treatment, and diagnostic services (laboratory, radiology, ECG, etc.). Optional higher level benefits are available for extra premiums and include mainly in-patient services (surgical treatment, diagnostic facilities, admission, prescribed drugs, etc.). Maternity care too is an optional benefit but family planning counselling is provided free under the scheme.

The number of beneficiaries per subscriber depends on the collective agreement (service conditions) that the client group has with its employees, but the norm is that coverage includes a spouse and four non-working dependants under 18 years old.

Table 2.4: Basic data about the private health insurance market in Ghana

Companies underwriting health insurance	One (nationwide Medical Insurance Scheme)
Areas of the country covered	Accra, Kumasi, Takoradi, Koforidua, Sunyani, Swedru (the major cities of Ghana, except the last town)
Types of policy sold	Mainly Group, few individual policies
Benefits package	Basic: outpatient services; Optional: in-patient services, maternity
Number of persons covered including dependants (October 1997)	50,000
Number of general practitioners and specialists (private providers) involved in scheme	About 250
Number of pharmacists (private) involved	About 100
Size of the market in millions of cedis (and US\$)	250 (over US\$110,000) per year ⁵

Source: *nationwide Mutual Medical Insurance Scheme, Accra, November 1997.*

nationwide's reimbursement methods are basically 'service' based, according to a 'fee-for-service' (FFS) arrangement with the providers. The service provider submits a claims form after treating a patient. This form indicates the patient's name, age, sex and policy number. It also contains information about treatment given, including diagnosis, tests, prescriptions, hospitalisation dates (if applicable), and so on. After verification by the insurance company, payment is effected by cheque direct to the provider. As there are no co-payments or deductibles, the patient pays nothing personally. The procedure is similar for pharmacists, but they must also attach the original prescription to their claim form.

In exceptional cases, however, cash-indemnity forms of reimbursement are permitted. This happens when a subscriber or beneficiary has to attend a clinic or hospital not listed in nationwide's private provider network (say in an emergency or if the person is visiting a town

⁵ Exchange rate of cedi to dollar in November 1997: 2250 cedis to one US dollar.

where those private providers are not available). In this case, the insured person can attend the nearest health facility and submit an invoice for a cash refund.

Cost control is strict and fairly rigorous. As one illustration of this, all provider claims are subject to thorough verification by a 'vetting committee' of medical practitioners employed by nationwide for just this purpose. Only the vetted amount is paid. It seems that the practice of over-prescribing is so rampant (e.g. instances of 2 or 3 anti-biotics being prescribed for a patient in one visit) that it is normal practice for the paid amount to be less, sometimes significantly less, than what was submitted by the doctor. It appears that some tension has arisen between nationwide and the private practitioners in their provider network. Staff at nationwide attribute this situation to the vigorousness of their vetting procedure which has made the private practitioners, in their view, 'unco-operative'. As a further consequence, it is claimed, the private providers are not keen to promote the insurance scheme to their patients, despite their presumed corporate (as opposed to individual) stake in the success of the insurance scheme.⁶

Cost control is also enforced through strict adherence to the national essential drugs' list (EDL), updated by a supplemental list drawn up by nationwide, which allows certain substitutes on grounds of better efficacy and other factors. Some of these substitutes are patented drugs, which the EDL excludes.

It is not clear how much impact nationwide has on the quality of care dispensed by the providers. But the fact that qualified medical doctors are employed by the insurance organisation means that at least in principle, it has the means to vet the quality of care as well. Whether this is actually insisted on is not known but there is an incentive to do so.

Their clients groups are among the wealthier private companies in the country whose employees are used to good conditions of service. Most have transferred from previous direct arrangements with private providers because nationwide promised them both quality and lower costs (in at least one marketing leaflet seen by the author). To maintain those clients, the scheme would have to deliver on both quality (which the employees can be expected to insist on) and cost (which the employers would insist on). Thus the net effect should be a push towards greater efficiency in the private health sector. While a detailed and specific investigation would be needed to establish if this is actually happening, the alleged 'unco-operativeness' of the private practitioners may well be an indication of resistance to pressure for such change.

In terms of one key indicator of financial performance, nationwide had a medical loss ratio⁷ of 49% in its first year of operation but this rose to around 70% by the end of 1996. This latter figure is still well within what the industry normally regards as the 'safe zone' i.e. below 80%. However, the management considers it as a matter for concern that the rise was that

⁶ This factor may also explain the apparent luke-warm attitude of private providers towards the proposed national health insurance scheme, in contrast for instance to the active interest shown by Nigerian physicians, but part of this difference can be put down to a much stronger private sector in Nigeria that has managed to capture the lead role in the design and implementation of the national scheme.

⁷ That is the ratio of claims to total insurance revenue.

steep, which is blamed on “improper monitoring of benefit utilisation of our clients” as well as on “inadequate computer software”.⁸

c. Experience with other alternatives to user fees

Employer-based insurance schemes for workers in the formal sector were already in force before independence. For the public sector, government generally provides free care for an employee together with a family. Usually this is limited to public health facilities but there are many exceptions where quality of care is the primary criterion, especially for state corporations where management has reasonable autonomy to negotiate conditions with the staff.

In the private sector, wherever the number of employees exceeds five, cover is also provided for employees’ health care expenses, often by arrangement with private clinics. Bigger employers may build and run their own clinics with hired medical staff. More often, this cover takes the form of a service agreement with a hospital or clinic to treat all sick staff and send all invoices plus sickness forms to the employer for direct payment.

The above forms of cover are non-contributory from the employee’s standpoint. It appears to the employee as ‘free’ health care, a fringe benefit of the job. However, in more recent times, both government and private employers are placing limits on the amount that an employee (including his/her family) can spend in a year on health care.⁹ We shall see that this development is pushing some of the professional organisations of employees in the public sector to begin to develop MHO activities alongside their traditional welfare benefits of funeral grants, marriage and birth allowances, etc.

⁸ Interview with Operations manager of nationwide Insurance Company, Accra, November 1997.

⁹ This is similar to the finding of recent developments in this area in Nigeria.

3. Case Studies of MHOs in Ghana

a. Choice and Typology of Case Studies

Three types of health mutuals (MHOs) were found to be in existence in Ghana: the ‘simple’ (or low participation) community financing model, the social movement based kind and the traditional social network. A fourth kind, the ‘complex’ (or high participation) community financing model, had been proposed and was about to see the light of day in the form of four pilot projects supported by DANIDA, at the time of the field work.

Two of the ‘simple’ community financing schemes were investigated because of the different lessons that each brings to the study. However, for reasons further explained below, the focus of this analysis will be on the newer of the two schemes, the West Gonja health insurance scheme, as this case offers more added value to the study. The Nkoranza scheme, the older of the two, is the pioneer of modern mutual health insurance type of organisation in Ghana and this experience has now been well documented.¹⁰ Although it also offers rich material for analysis, this material will be drawn upon only selectively to illustrate points where its longer historical experience is more relevant, to bring out significant design and implementational similarities or differences, and to highlight features that contain important lessons for the study.

The West Gonja Hospital scheme is the newer one of the two but offers valuable lessons because it was explicitly designed to avoid the perceived shortcomings of the first, and the results to date are interesting to evaluate for the study. In addition, this study will be the first ‘outside’ investigation of the scheme and as such the analysis will in itself contribute new material and, in a small way, expand existing knowledge of such schemes in Africa.

The proposed District Health Insurance Scheme (DHIS), which is a big scale project with backing from DANIDA, will, when it eventually takes off, represent what was characterised in the Methodological Guidelines as ‘complex’ community financing schemes, in which there is some participation from the community through representative structures in the running of the schemes. It is targeted at the rural informal sector and though there is no existing case to study as yet, it was judged useful for this study to describe and analyse briefly its principal design features. The basic features have been outlined by the designers of the scheme. Moreover, it is an important initiative in health care financing for which the government is still trying to entice more donors.

The social movement kinds of scheme are currently rather less developed in Ghana. This is partly because the sector where such movements usually take off most easily, that is in the urban formal sector, has continued to benefit from largely free health care funded by

¹⁰ For a fuller description and an evaluation of the Nkoranza health insurance scheme, see the author’s Towards Better Health in Africa: A comparative study of community financing and mutual aid insurance (World Solidarity, Brussel, 1995); and Social Movements and Health Insurance: A critical evaluation of voluntary, non-profit health insurance schemes with case studies from Ghana and Cameroon, forthcoming, *Social Science and Medicine*, autumn 1998. Additionally, various evaluation reports on this scheme also now exist.

government. In addition, the kind of rural focused ‘social entrepreneurs’ who have initiated similar schemes in other African countries, notably Nigeria, do not appear to have put their minds here to the organisation of health insurance schemes based on the many rural social movements in the country (except within the traditional social networks, discussed later).¹¹

However, we did investigate an interesting development where, under the impulse of progressive diminution of the government’s free health care programmes for the public sector, an existing professional association is beginning to add health care support to its members’ benefits package. The teachers’ welfare funds, which cover a broad range of welfare needs of teachers, were studied to see the *potential* that they have for contributing to health goals in the formal sector. The overall purpose of this investigation was to study the potential that these movements offer as an additional source of health care financing as the direction of state health care policy continues to move away from publicly-funded free health care.

Though there are larger traditional social networks in the country, the author decided to investigate a small group outside Accra (the Dagaaba Association in Duayaw-Nkwanta, Brong Ahafo Region) because this latter proved much more accessible and open whereas others were less transparent. The table representing the guidelines reproduced and annotated here (Table 2.5) summarises the types of MHOs studied in Ghana and their characteristics.

Table 2.5: Ghanaian MHO Case Study Typology

MHO type and corresponding case study	Urban Location	Rural Location	Informal sector membership	Formal sector membership	small to medium size	large size
1. Traditional mutual aid association: Duayaw Nkwanta Dagaaba Association, Duayaw Nkwanta, B/A Region	Yes	Members originate from rural areas of Upper West Region	Yes	Is an informal sector organisation but membership includes formal sector employees	Small but linked to other Dagaaba Associations around the country	No
2. Mutual insurance association or social movement type: (#1) Teachers’ Welfare Funds	Yes	Yes: Funds exist in nearly every town, village and hamlet	No	Yes	No	Yes
3. ‘Simple’ Community financing model: (#1): West Gonja Hospital Scheme (#2) Nkoranza Scheme	No	Yes	Yes	No, but individual members may be formally employed	No	Yes

¹¹ That this picture may be changing (and a possible exception to this generalisation) is evidenced by the recent effort by an MP to initiate a mutual health insurance scheme for his constituents in the Bunpukurugu-Yunyoo Constituency of the Northern Region. See “Social Movement and ‘Complex’ Community Health Care Financing Initiatives”, section 3.4.2, for further details.

	No	Yes	Yes	No, ditto	No	Yes
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b. ‘Simple’ community financing schemes: The Community Financing Scheme for Admissions, West Gonja Hospital, with comparative notes from Nkoranza Community Financing Health Insurance Scheme

- ***Background and Objectives***

West Gonja District and Hospital

West Gonja is a rural district situated in one of the poorest regions of the country. An interesting feature of this district is that it contains many settler agricultural communities from different ethnic groups, especially from the relatively densely populated areas further north and east of Gonja. This feature apparently results from the low density of the indigenous population in the area, the availability of vast farmlands and deliberate government policy in the post-war years up to the 1970s to encourage population resettlement and mechanised, co-operative farming in that part of the country. The total population of the district was estimated at about 120,000 in 1995/96.¹² The vast majority of the population are subsistence farmers (engaged in maize and cassava cultivation) but a significant minority are commercial farmers, civil servants (such as the hospital staff and employees of the Game and Wildlife Department) and other salaried workers (e.g. teachers and Ghana Commercial Bank staff).

West Gonja Hospital was acquired in 1954 by the Catholic Church from a farming company, which had established it as a clinic to cater for the needs of its employees. It is managed by the *SSpS* Sisters of the Roman Catholic Church and serves as the district referral hospital for nine health posts, “level B” facilities, in West Gonja. It is medium-sized, with 150 beds and eight in-patient wards. Power, produced from three diesel generators, is provided daily for patients and staff from 6pm till 10.30pm, but on surgery days (Tuesdays and Thursdays), additional power is available from about 8.30 in the morning till after the last operation, usually around 3pm. Water supply is more regular, thanks to a 54-solar panel plant installed with assistance from external donors at a borehole about 1.4km from the hospital to supplement the intermittent supply from the Ghana Water & Sewerage Corp.

Despite its relatively isolated location and the poverty of the district, West Gonja Hospital enjoys a very good reputation for quality throughout the entire northern part of the country, and even further beyond. As a result, patients with particularly difficult or incurable illnesses travel from far distances to patronise it. Anecdotal instances of people coming from as far as the national capital, Accra, where the main national quaternary level referral and teaching hospital is located, attest to this reputation.¹³ The hospital’s own annual report mentions cases

¹² Estimated population figure from Annual Report, West Gonja Hospital, Damongo, 1995/96. The Report claims that this is the largest district in the country.

¹³ However, although the quality of care here is, like some other Church-run facilities, undoubtedly good, it should be pointed out that these are usually cases of self-referral based frequently on desperation and the historical reputation of the hospital.

of patients coming from Tamale (the regional capital) and other far out places where “there are equally good hospitals and qualified medical personnel.” Their reputation for good quality, confirmed repeatedly to this author in focus group discussions in Damongo, is an important factor (and asset) tending to favour the success of the insurance scheme.

Background of the insurance scheme

It is useful to explain from the start that the mission hospitals in Ghana are run by the Christian Health Association of Ghana (CHAG) and not the Ministry of Health (MOH), although the MOH gives them annual subventions and pays most of the staff. In turn, the satellite health facilities are run by the district MOH not CHAG or the Diocesan Health Committees that are in charge of the (Catholic) mission hospitals.

The total revenue of the West Gonja Hospital from all sources in 1996 was 406,532,013.44 cedis (US\$180,681). Of this, 155,533,649.75 cedis (US\$69,126), or 38% of the total revenue, came from Government subventions. Another 17,178,169.95 cedis (US\$7,635), or 4% of the total, came from CHAG. Donations made up 74,085,456.80 cedis (US\$32,927), or 18% of total income. On the other hand, user fees of all kinds including drugs came to 146,088,537.62 cedis (US\$64,928) or 36% of total income, in that year.¹⁴ Assuming that these facts represent either the norm or the trends, and the corresponding figures for 1995 seem to support the latter¹⁵, it can be seen that the hospital is relying considerably on user fees, which make up nearly the amount coming from the Government subvention.

The West Gonja Hospital insurance scheme is partly rooted in the earlier scheme piloted by the Catholic Church in Nkoranza. In 1992, after several years of preparation, the Catholic Diocesan Health Committee and the Senior Medical Officer in Charge of Nkoranza District Hospital launched the Nkoranza Community Financing Health Insurance Scheme with the technical and financial backing of Memisa, an international Church-related NGO in Holland. The scheme was based, at least in principle, on the well-known and relatively successful community health insurance scheme of Bwamanda Hospital in northern Congo-Zaire.¹⁶ The immediate impulse was the desire to find a way to stem the rising tide of unpaid bills left behind by indigent patients at the hospital. It was explicitly regarded by the Catholic Secretariat as a pilot project from which other Catholic Hospitals across the country would be encouraged to draw useful lessons for the design and implementation of similar schemes for their communities.

After about a year of this experiment, the Diocesan Health Committee and management of West Gonja District Hospital at Damongo in the Northern Region took a decision to look at the Nkoranza scheme closely with a view to setting up a similar scheme.

¹⁴ Of this revenue, drug fees came to 74,209,446 cedis and other patient revenues were 71,879,091.62 cedis. See *Annual Report: West Gonja Hospital, Damongo, 1995/1996*, p. 17.

¹⁵ See *Annual Report*, *op. cit.* p. 17.

¹⁶ See Moens, Freddy. “Design, Implementation, and Evaluation of a Community Financing Scheme for Hospital Care in Developing Countries: A Pre-paid Health Plan in the Bwamanda Health Zone, Zaire”, in *Social Science and Medicine*, Vol. 30, No 12.

They were also driven by a need to find an alternative to user fees as rising bad debts threatened the hospital's financial position. People who were unable to afford the cash deposit required before treatment would leave behind personal belongings such as blankets as their guarantee of payment, but many of these did not return to pay the bills and reclaim their personal items. Furthermore, the number of serious illnesses was tending to increase due to the fact that some patients, unable to afford the hospital fees, delayed reporting their illnesses and tended to try self-medication and traditional healers first, only reporting to the hospital after all else had failed. Among other things, this made the cost of treatment even more expensive than might otherwise have been the case.

Two people, the current project co-ordinator and project manager of the insurance scheme, were therefore sent to Nkoranza in June 1993 to study the functioning and lessons of that scheme. They spent a total of three days investigating all aspects of the scheme, both the perceived positive and negative lessons. As a result, they came back with a design for the West Gonja Hospital (WGH) scheme based on the same fundamental principles and mode of operation as Nkoranza but with some significant differences (discussed below).

Backing for this scheme (financial and technical) came from a German Church-related international NGO, Misereor. The Project Manager is a German national previously working with the Catholic Diocese, while the Co-ordinator is a former accounting staff of the hospital. Both have benefited from training courses in Germany designed to improve their technical capacities in the management of community health insurance schemes.

The objectives of the WGH insurance scheme, like the one at Nkoranza, were essentially to achieve cost recovery and to increase accessibility of hospital (inpatient) care to the population of the district. The scheme was operational in October 1995.

- ***Design, Organisation and Management***

Design

The Community Financing Scheme for Admissions, West Gonja Hospital (WGH), like the one at Nkoranza, was designed to cover cases of hospital admission ('catastrophic illness') and the target population in the communities served by this district hospital. However, unlike the Nkoranza scheme, the West Gonja Hospital insurance scheme started coverage of the district in stages, with only the communities within a 10 kilometre radius of the hospital allowed to register in the first year. For the 1996 registration, this radius was extended to 20 km and in October 1997, the third year of registration, this has been further increased to 50 km. Thus farther out places were progressively added as management confidence increased and administrative and other bottlenecks were ironed out.

To appreciate the problems facing the scheme organisers in trying to cover the entire district, it should be noted that this is a district (said to be the largest in the country) that is, by any standards, exceptionally poorly provisioned in road infrastructure. The road network, or what passes for such, is made up of, to quote from the hospital's 1995/96 Annual Report, "poor and unmotorable 2nd and 3rd class feeder sandy roads and about 53% of the district popularly known as 'overseas' are cut off during the rainy seasons."¹⁷ No regular means of transport

¹⁷ Annual Report, West Gonja Hospital, *op. cit.*

links Damongo, the district capital, to the outlying villages, and so the hospital ambulance and other vehicles play a crucial role in transporting patients to and from the hospital. Similarly, the insurance organisers rely on their own VW bus transporter to do their campaigning, education, sensitisation and registration exercises.

Other differences in design and implementation between the West Gonja Hospital scheme and the Nkoranza one are summarised in Table 3.1 below.¹⁸

Table 3.1: Some Design and Implementation Differences Between Nkoranza and Damongo Schemes

Design Feature	Nkoranza health insurance scheme	West Gonja health insurance scheme
1. Registration season	Only open from Oct – January (harvest season)	Open all-year round
2. Family vs. individual registration	Only families can register	Both families and individuals can register
3. Member ID	Up to now, ID numbers allotted plus <i>thumb-printing of membership cards</i> required by each member, but system being changed to use photographs	Photographs of each member with ID number required, no thumb-printing
4. Liaison between scheme and communities	Previously had 3 zonal co-ordinators plus a number of field works in each zone (altogether 130 field works); now zonal co-ordinators and field workers replaced by 21 field officers paid by contract and given specific targets to achieve	Volunteers, chosen in consultation with community chiefs and elders, relied on as contact persons; a mixture of moral and material incentives given
Implementational method		
5. Initial promotional campaign prior to start of scheme	Done for only a few months before scheme officially begun	One full year of sensitisation and promotion before start
6. Identification of insured persons in admission wards	Hang insurance card of patient (which has identifiable colour) together with patient's record chart at the foot of patient's bed	No hanging of insurance cards on in-patients' beds and no way to identify insured in-patients by such means

The justification given for the first design difference, relating to the registration period, were particularly interesting and instructive with regards to the received wisdom on this issue. The usual advice is that the registration period should be strictly limited to a relatively short period, as is done at Nkoranza, not open all year round, as the West Gonja Hospital scheme

¹⁸ Note that comparisons drawn here between the schemes at Nkoranza and Damongo are not meant to reflect on the managerial competence or capabilities of the institutions or individuals concerned, the more so since the initiators of the newer scheme had the advantage, which their counterparts at the older one did not have, of studying the pioneering example in the country, learning where difficulties were encountered and then adapting the design accordingly.

permits. The main reason is to check adverse selection because, with year round registration, there is nothing to prevent individuals from waiting until they are actually sick before rushing in to register to take advantage of the benefits. However, West Gonja Hospital insurance officials counter that:

- With the compulsory ‘waiting period’ of three months, there is no or little danger of adverse selection from this source
- People should be enabled to register as soon as they become convinced of the usefulness of doing so, otherwise, some months later they may have forgotten what made them wish to register. Some of the practical arguments are: (i) With the constant sensitisation campaigns mounted by the scheme, if somebody becomes convinced, they should be able to register then or else they will not do so later when other priorities and problems crop in and the insurance arguments have become a distant memory. (ii) Also, it has been found that many people tend to register only after personal misfortune (serious illness resulting in heavy expenditure) or the misfortune of others, which forces them to concentrate their minds on the solutions. There are many cases of patients rushing to register immediately upon discharge from hospital (too late for the last illness but at least a hedge against future catastrophe).
- Year round registration is convenient for people (like civil servants) whose income is not bunched at a particular time of the year, like farming is, so that everyone can choose a time to register that is suitable for their income or cash flow profile
- Last but not least, year round registration gives a great deal of flexibility to the scheme managers to raise the registration fee at any time during the year if their inflation predictions and budgetary projections at the beginning of the scheme year (October) prove to be too optimistic

This last alleged advantage might well prove the most decisive factor if this design feature turns out to contradict the received wisdom on this matter and to favour scheme success. In this connection, one salient fact that came to light during the fieldwork in Nkoranza certainly augurs well for the West Gonja insurance approach by apparently validating the need for the kind of managerial flexibility conferred by the year round registration. At Nkoranza, the scheme managers were predicting with some certainty that they were heading for a deficit in 1997 because actual medical price inflation, especially drugs’ costs, turned out to be far higher than that built into the subscription fee for last year.¹⁹

It may well be that in similar situations where inflation is unpredictable, the design of community health insurance schemes such as the above may be improved by learning from the West Gonja example, but it is too early to make definitive conclusions from that young experience.

Moving on to the other design features, it was not clear how permitting individual registration (and family registration only as an option) improved the design of the Damongo scheme over the Nkoranza one. It is certainly correct, as was observed, that the requirement for family registration is widely flouted and abused at Nkoranza because a lot of people refuse to

¹⁹ Interview with Simon Unezumeh (PNO and Liaison Officer i/c of Insurance Scheme) and William Sabi (dep. Hospital Secretary), St Theresa’s District Hospital, Nkoranza, November 1997.

register all the members of the family. But this is a weakness in the implementation, not the design, and focus group discussions and observations at Damongo showed clearly that the abuses of the optional registration system are at least as great as those of the Nkoranza system. Many insured openly admitted registering only those members of their family most likely to require health care, leaving out the healthier ones.

The one objection raised to family registration, that of the need to have family registration cards instead of individual ones, is an entirely practical issue, which can be handled in various ways. But even here too, this point tends to ignore one of the important gains that can be achieved with family registrations. That is, an improved Health Management Information System (MIS), making it easier to track family health history through such records, while facilitating the monitoring of any special family-related health problems or needs, thereby possibly contributing to overall health status improvements through cost-effective preventive or promotive interventions.

Time will tell whether the other design differences lead to net improvements in the Damongo scheme as compared to the Nkoranza one.

Management

In other important respects, however, the two insurance schemes (Damongo and Nkoranza) are very similar. In both cases, user participation in management and scheme operation is little or non-existent while their management structures are similar.

At West Gonja Hospital, the insurance scheme is classified as one of the 12 administrative and support services of the hospital. The scheme's constitution also recognises the insurance project as a department of West Gonja Hospital. The project manager, project co-ordinator and a member of the hospital management team together constitute the Management Team of the scheme. There is an Advisory Board to advise and help in promoting the scheme in the area; and a Disciplinary Committee whose functions are to decide on appropriate sanctions for violations of scheme rules.²⁰ In practice, the Diocesan Health Committee (DHC) of Damongo plays a crucial role in overseeing the management and important policy decisions; for instance it must approve all subscription fee increases. The Bishop of Damongo, through the DHC, is the 'owner' of the scheme.

The scheme's finances and accounts are kept separate from those of the hospital, but its management is required to submit quarterly reports to the hospital management and to the DHC.

Organisation

The current membership premiums (as of 1st October 1997) are as follows:

- New member – 4,000 cedis (increased from 2,500 cedis in the previous year)

²⁰ The Advisory Board consists of: the Regional Director of Health Services, the DHC Executive Secretary, the Ghana Commercial Bank Manager in Damongo, the District Veterinary Officer, Director of Education, District Director of Health Services, Senior Medical Officer WGH and the Vicar General. See Constitution of the In-patients Health Insurance Scheme, West Gonja Hospital, Damongo.

- Renewals – 3,500 cedis (from 2,000 cedis the year before).²¹ A renewing member has up to 8 days from the expiry of membership to re-register, after which a one month waiting period is imposed if the member then renews.

Registration is integrated with sensitisation and marketing campaigns, usually at the market places of the villages. In the Muslim communities, registration would be done on Fridays and in the Christian ones, it would be done on Sundays, the days when there is no farm work.

Persons desiring to register will have their details taken down, the membership and ID cards filled in, and their registration fees collected on the spot. Then their passport size photographs will be taken on the spot in groups of six enrollees using a Nikon F801 camera and a wooden frame divided into six windows for each individual's upper portion to fit in, and a card bearing the individual's registration number is affixed to the bottom of each window, enabling the picture to contain this number at the bottom of it. The number corresponds to the one on the ID and membership cards. The pictures would later be attached to the membership cards and kept at the hospital for easy identification of the member.

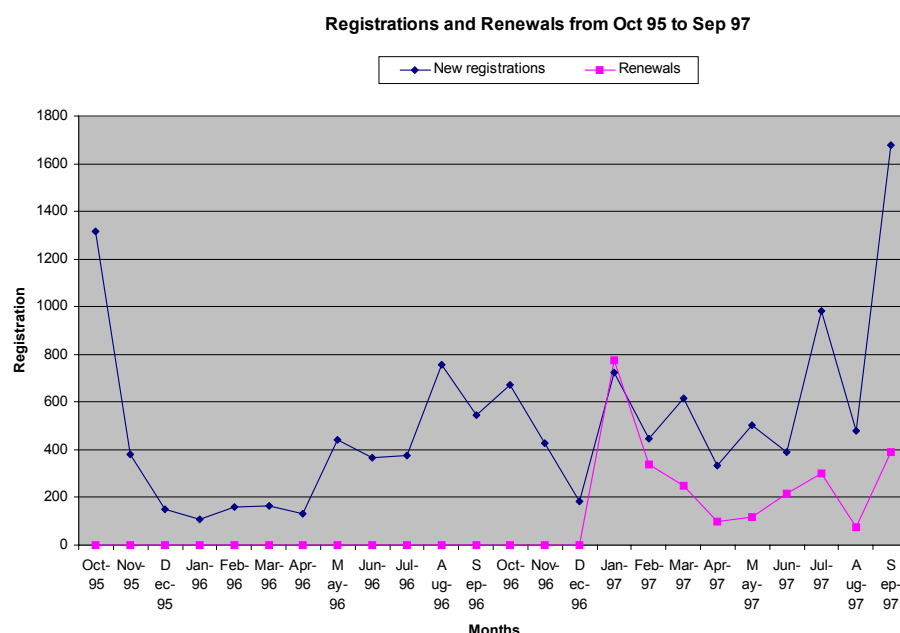
An insured person who is due to be admitted into hospital must present his/her ID card to the hospital staff, who will admit the person without demanding a cash deposit as other patients are asked to do. On discharge, the hospital sends an invoice to the insurance scheme's office containing the name of the patient, insurance (ID) number, hospital number, ward number, date, as well as the diagnosis and treatment offered to the person. The insurance staff usually pays the bill immediately, usually in cash from money received and not yet banked. Apparently security is not a major issue and the bank is about 4 km away. Besides, the staff avoids bank charges by paying from the collections rather than from withdrawals or by cheque, though the latter procedure might improve record-keeping and accountability. At the end of the week, the excess of receipts over bills owing is paid into the scheme's bank account.

Invoices from the hospital are prepared according to a schedule of prices (a fee for service system, over which the scheme has no influence). In cases involving referral to higher levels in the referral chain, the insured patient is entitled to claim the average inpatient bill for the previous year, whatever his/her actual bill at the referral hospital.

As at 12 November 1997, total membership stood at 13,360. After one year of the scheme's operation, i.e. at the end of September 1996, total registered membership was 4,890.

²¹ It is not known how the annual premium levels are practically determined.

Chart 2



Source: Information obtained from West Gonja Hospital Insurance Scheme in November 1997. See Table 1 in Appendices.

The above graph (Chart 2) shows that registration of new members tends to peak around the months of July to October each year. It is no coincidence that in this predominantly farming community, cash for registration seems to be available mainly during the harvest season that those months represent.

- **Resource mobilisation**

It is too early to expect the insurance scheme to have already had a major impact on the financial performance of the West Gonja Hospital, especially as insurance coverage has not yet extended to the entire district. However, considering the age and incomplete coverage of the scheme, its contribution is not insignificant, as shown in Table 3.2.

Table 3.2: Share of Insurance Payments in Hospital Income Jan-Jun 97

Month	Insurance In-patient bill (A) cedis	Total Hospital In-patient bill (B) cedis	Percent A of B
Jan-97	1,110,000	8,748,025	13
Feb-97	1,235,950	7,286,175	17
Mar-97	931,100	6,782,950	14
Apr-97	2,136,700	9,900,875	22
May-97	1,347,900	6,708,250	20
Jun-97	3,669,000	14,180,200	26

Sources: *Hospital In-Patient Bill from: West Gonja Hospital – Damongo N/R, Inpatient Statement of Account*, monthly from January to June 1997; Insurance data from insurance computer records.

Notes to Table 3.2:

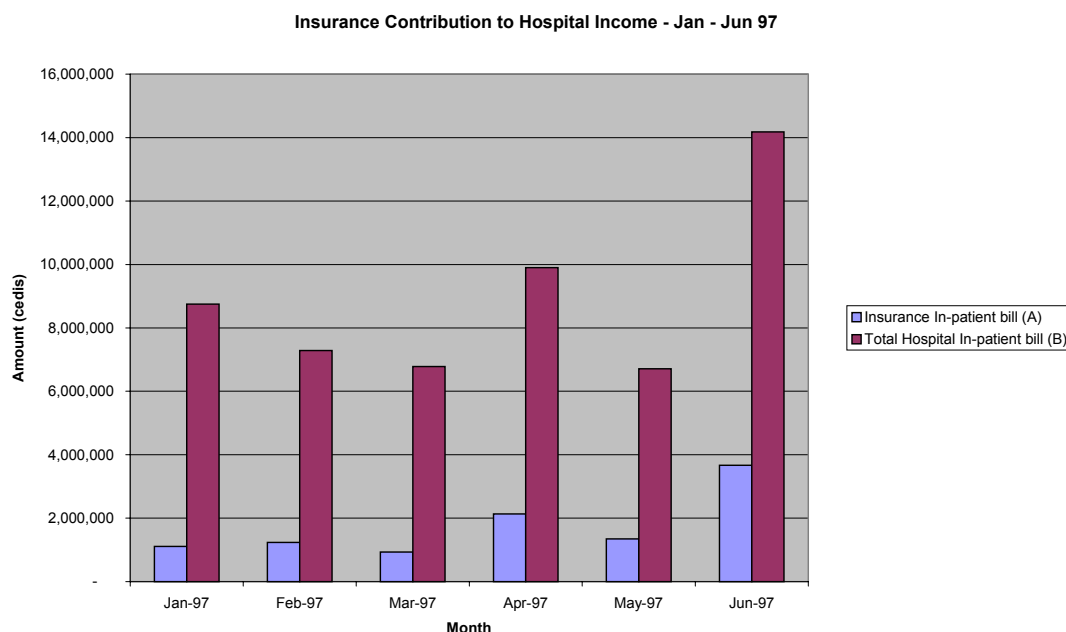
(1) The total hospital in-patient bill includes the insurance in-patient bill, the juxtaposition here is purely to show how much of the total inpatient bill comes from the insurance fund for insured patients.

(2) These are the months for which inpatient bills' data were available for both the hospital and the insurance scheme.

From Table 3.2 above and Chart 3 below, the insurance scheme contributed between 13% and 26% (or just over a quarter) of total hospital inpatient income in the first half of 1997, with a tendency to increase with time, though not consistently. The share of insurance payments in the hospital's inpatient income doubled in the half year shown.

In more global terms, for the hospital's financial year January to December 1996, the insurance scheme paid for 241 patients out of 6,169 insured members, for a total bill of 6,335,220 cedis (US\$2,816, see Table 3.3). The hospital's financial statement for the year does not permit us to disaggregate the share of total revenue that comes from inpatient fees, but the total revenue from user fees for the year was just over 146 million cedis (US\$64,928).²² The insurance fund therefore contributed just over 4% of total patient revenue in 1996.

Chart 3



²² From West Gonja Hospital, *Annual Report*, *op. cit.*

Table 3.3: Admissions and Cost data of insured patients at West Gonja Hospital 1995 - 97

Month and Year	Number of admissions	Total amount of bill cedis	Average bill per insured patient cedis
Oct-95	0	0	0
Nov-95	0	0	0
Dec-95	0	0	0
Jan-96	7	73,200	10,457
Feb-96	9	92,700	10,300
Mar-96	12	432,100	36,008
Apr-96	10	239,700	23,970
May-96	10	392,400	39,240
Jun-96	20	378,900	18,945
Jul-96	27	530,060	19,631
Aug-96	20	620,200	31,010
Sep-96	27	720,960	26,702
1st Year Totals	142	3,480,220	24,509
Oct-96	26	822,900	31,650
Nov-96	38	1,271,600	33,463
Dec-96	35	760,500	21,729
Jan-97	48	1,110,000	23,125
Feb-97	48	1,235,950	25,749
Mar-97	32	931,100	29,097
Apr-97	55	2,136,700	38,849
May-97	43	1,347,900	31,347
Jun-97	63	3,669,000	58,238
Jul-97	57	3,190,800	55,979
Aug-97	69	2,573,900	37,303
Sep-97	67	3,304,900	49,327
2nd Year Totals	581	22,355,250	38,477

Source: Information obtained from West Gonja Hospital Insurance Scheme in November 1997

Note: In terms of admissions, the 241 cases paid for by the insurance constituted around 9% of all admissions for the year (2,807 cases for the hospital in 1996).

The significance of the insurance contribution to hospital revenue cannot be determined only from the absolute figures of payments made. Insurance funds are a more certain or more reliable source of income than user fees, as experience at the hospital before and since the start of the scheme showed.

Examining other indicators of the resource mobilisation capacity of the insurance scheme, one of the most striking is the additional resources attracted to the hospital because of the insurance fund. Besides a new office block donated to the hospital by German NGOs connected to the insurance fund, one of those NGOs is funding what are called “charity registrations” through a 6,000DM (or 6,270,000 cedis) donation received in July 1997. Through this grant, each community covered by the scheme is asked to identify three indigent persons who would be given free registration through this fund. These are individuals who would not ordinarily use the hospital services on grounds of lack of money and so this augments the community’s resources available for health care. Besides indigent persons, this donation is also used to fund a discount of 500 cedis given to students of the Damongo Secondary School who are compulsorily registered in the scheme (by a school edict); finally the donation covers the premiums of all the volunteer contact persons plus their assistants.

Besides the Damongo Secondary School which now obliges all new students to join the insurance scheme (with the insurance contributions collected as part of the school fees and then paid to the scheme), other institutions in Damongo have registered their employees with the scheme. The hospital pays for the registration of its own staff, as does the Catholic parish in Damongo, arguably two instances of leadership by example. The Ghana Education Service and the Ghana Commercial Bank in Damongo also cover their employees by paying their premiums. The Game and Wildlife Department encourages its staff to register and assists the scheme by deducting staff contributions from source and handing this directly to the fund.

Although the numbers involved in all of these instances are not high (with the exception of the secondary school), they still contribute to resource mobilisation for health care in West Gonja. Previously, there were cases when students were rushed to the hospital for emergency treatment, but afterwards they could not pay the bill involved. In the cases of the salaried staff, who must presumably be among the healthiest in the community (good risks), they would probably have less likelihood than most of the rest of the community to need hospital admission. On that assumption, their contribution helps not only to improve scheme viability by bringing in more revenues from healthier persons (improving the risk mix of the scheme) but also to increase the resources available for the community’s health care.

As previously explained, since members can choose to join the scheme whenever they want, they can also thereby choose to pay their dues when it most suits their income profile. This contributes to resource mobilisation because individuals can pay their subscriptions when they are well and have cash available, so that they are not deterred from seeking treatment when they are sick (and perhaps also out of cash).

The 1995/96 Annual Report of West Gonja Hospital shows that bad debt provision declined drastically from 4,411,700 cedis (\$1960) at the end of 1995 to just 12,000 cedis (\$5.33) at the end of 1996.²³ This would appear to be a major achievement, at least on the face of it, and invites comment regarding what role, if any, the insurance fund had in this. However, great caution is advised in interpreting the data. First, the point was argued during interviews with staff that the four million plus figure for bad debt provision in 1995 may be an exaggeration,

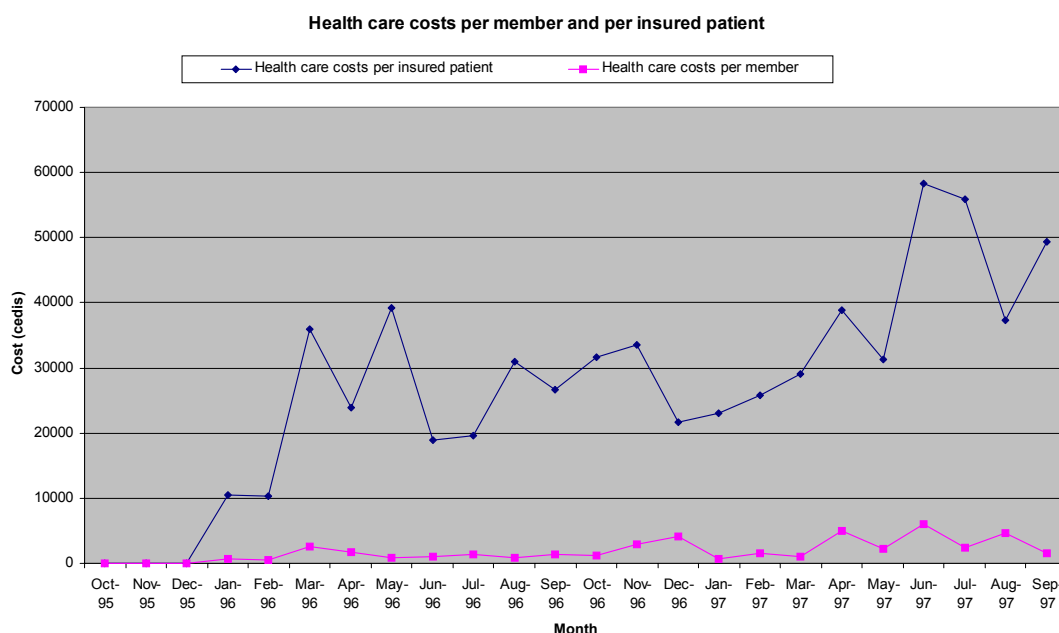
²³ Like most mission hospitals in the country, this hospital does not provide free or uncompensated care, but in general a person in need will not be turned away. In the latter situation, efforts to recover payment after care is not always successful.

and probably partly reflects some debts which were eventually paid in 1996. Technically therefore they were not really bad debts (leave aside the loss of interest income involved.) Although this argument does not explain why or indeed if the apparently vigorous debt collection or repayment exercise in 1996 was not done before in 1995, the vast difference between the two figures in the course of just a year lends some credence to the view that the rubric ‘bad debts’ did not represent the same items in the two years. Having said that, it is also arguable that the advent of the insurance scheme has played some part in reducing bad debts, since an alternative to cash deposit payments and user fees now exists. This proposition can be tested by looking at the income and social profile of insured persons vis a vis the non-insured, to see if those most likely to default on their bill payments were the ones more likely to insure. On this question, the data is scarce and not reliable. What is absolutely certain though, and also relevant from a resource mobilisation point of view, is the fact that no insured person will be among the non-compliant individuals during either of those years.

- **Efficiency contribution**

The efficiency contribution of the insurance scheme can be evaluated by studying a number of indicators, including the evolution of health care costs per member and the per insured patient. The graph below attempts to portray the movements in the first two years of the scheme. However, strictly speaking, the data reflected in this graph are not meaningful unless deflated by the medical price index. This will enable us to see the evolution in real terms. Unfortunately the medical price index was not available (it appears that such an index is not usually constructed in the country). Hence we will try to seize the efficiency contribution out of the nominal cost data.

Chart 4



Source: Information obtained from West Gonja Hospital Insurance Scheme in November 1997

On the other hand, as the trends are important here, it is still possible to partially discount for inflation in a qualitative way by looking for particular patterns or trends in the nominal data: since no one disputes that medical inflation has been high in the period concerned, if the trends nevertheless show that there is no cause for concern as far as evolution of the average costs are concerned, then, all other things being equal, the results must, *a fortiori*, be good for the scheme. Unfortunately, the reverse is not true, i.e. if the nominal trends show that there is cause for concern, it is not possible to tell if this is really so or not without the relevant deflators.

Applying this to the graph, we find a striking fact: the average health care costs per member of the scheme remains virtually flat, i.e. nearly unchanging in the first year of the scheme, and then only very gently rising and then moving along a plateau in the second year. This implies that, if the effects of inflation are taken into account, the real costs per member are probably falling all the time.

But the qualification of ‘all other things being equal’ was necessary because such apparent improvement in technical efficiency may also be a reflection of better ‘case mix’ of admissions, i.e. people being admitted for less expensive conditions (which could reflect health improvements) or, as is far more likely, a better mix of risks associated with the constantly increasing membership of the scheme. It is actually likely that an element of the latter is present in this case, as the scheme is still in its infant, expanding phase, and this will tend to mask the effects of any provider-driven cost inflation, just as the increasing total membership itself, given a less than proportionate increase in insured admissions, probably also does.

Not much can be deduced from the rising trends of average cost per insured patient at the beginning up to May 1996, and then from May 1997. However, it is remarkable again that for the whole year in between May 1996 and May 1997, there is virtually no overall increase, despite much variation. As far as the risk of provider-driven cost escalation of the scheme is concerned, it is arguable that the indicators have been in the right direction so far. But this is not to say that everything is all right on this front as we shall see below.

On the scheme’s risk management techniques, though, there may be room for improvement. There is, as we have seen, a waiting period of three months for new members before they can have access to the benefits, which is a reasonable safeguard against the most blatant form of adverse selection, i.e. when an individual rushes to join only when s/he is sick, in order to take advantage of the benefits (and sometimes promptly withdraw after they have benefited). However, there are other more subtle ways in which adverse selection can take place, and it is arguable that not enough attention has been paid to those areas in the scheme design. An example is the well known phenomenon where people who register with the insurance scheme are those who are prone to fall ill, or who know that they will need the services in the future. If somebody is due for elective surgery, for which waiting times may be very long anyway, three months may be no deterrent but an invitation in the certain knowledge that the benefits will outweigh the costs of registration.

In that connection, the most striking element missing from the scheme is a requirement for families to register as a whole. That this requirement is widely abused in the Nkoranza scheme does not invalidate the importance of such a rule. In the Nkoranza scheme, in actual fact, no incentive is given to individuals to register the whole family. In cases where family

registration is enforced, usually this is accompanied by a reduced fee per head for registering other members of the family (plus an even smaller fee for children) which encourages the main bread winner not to see the other family members as a burden in this regard but to register them for a bargain price especially since they are usually more likely to need expensive health care than the bread winner.

In other cases, there may be an omnibus family registration fee (which may be graded according to family size) which offers other important advantages not sufficiently appreciated in MHO circles. Since a frequent complaint of MHO leaders and promoters is that individuals tend to withdraw after paying their dues for a number of years ‘without benefiting’ (adverse selection), an omnibus family fee may contribute to minimise this problem. It may do this because where the subscription fee is not tied to a particular individual’s name but to the whole family, then the perception of not having benefited will be reduced because it is far less likely that no member of the family will need the services for years. And once a family member benefits, then in a sense the whole family will be seen to have gained, and what is more important, the family itself may feel justified in having insured for the ‘rainy’ day.

Evidence gathered during discussions with focus groups of users and non-users at two communities near the hospital showed that there is a marked tendency towards adverse selection among members, as noted earlier.

Taken together with the fact that the scheme also has no specific mechanism to contain any tendencies toward moral hazard or over-consumption (for instance the lack of member participation in the running of the scheme means that social control or peer pressure cannot be relied on to help checking such dangers), it appears that these two key areas of the scheme’s insurance risk management are rather weak.

No quantitative data were available on the crucial issue of average length of stay in hospital by insured persons vis-à-vis the non-insured, a vital indicator of moral hazard and efficiency. It could also indicate evidence of provider-driven cost inflation if members are staying in hospital consistently longer than non-members, for similar conditions. Though no quantitative data on the matter exists yet, the anecdotal evidence gathered by the author in interviews with medical staff at Damongo indicated that at least some medical staff do take account of the admitted person’s insured status (generally their ability to pay) when deciding on when to discharge. The presumption must therefore be that insured persons (who have no payment problems) will tend to be admitted longer than the non-insured.

Although sufficient data exists to calculate the mortality figures among members of the scheme and hospital patients in general, it was judged that such calculation would not yield information that could lead to any useful conclusions since the young age of the scheme means that there has not been enough time for it to make such a significant health impact, nor for reliable trends to emerge in this area.

The insurance scheme, as explained, is considered as a structure situated under a department of the hospital and so has no independent or corporate existence of its own. This fact coupled with the lack of member participation in the non-financial aspects of the scheme, result in a lack of negotiating power with respect to the hospital management, especially but not only in relation to the fees that insured members have to pay on admission. There might be a case for a discount to be given to scheme members, in return for contributing to a more secure income base for the institution. However, this is not possible under the present arrangements.

Moreover, related to this same issue, there does not exist a mechanism for vetting or checking the quality or appropriateness of care provided to members, nor the pricing of this care. Consequently, the scheme's possible contribution to improving quality of care, while holding down the costs of care (improving technical efficiency) seem minimal.

Similarly, there is no specific scheme policy on generic or essential drugs that the hospital should be required (after consultation, negotiation and agreement) to enforce as a condition for refunds. Instead, what obtains is that the hospital practices its own version of an essential drugs policy, which is based not on the national (MOH/WHO) list, but the pharmacist's assessment of the (cheapest) drugs that are found to be most frequently needed. This should approximate in practice to the essential (generic) drugs list recommended by the MOH/WHO, but not necessarily.

This issue is related to another problem, that is the lack of any package of preventive/promotive services in the scheme's benefits, or of any clear incentives to use the existing ones nearest to where members live. There is no mandatory referral mechanism from the lower level ('level B') health posts to the hospital for the purposes of payments under the scheme. The result is the observation of scheme staff themselves that any member who falls ill, no matter how minor the ailment might be, makes straight for the district hospital and demands immediate admission since that is the way to avoid having to pay anything at all. There is also an incentive for members to exaggerate their symptoms in the hope of obtaining admission, for the same reason.

The effects can be perverse, but the situation (which is similar to what obtains at Nkoranza too) is apparently connected to a deeper structural issue concerning the relationship between mission hospitals (even ones recognised and supported by the MOH as district referral ones such as the Damongo and Nkoranza hospitals) and the satellite government facilities that surround them. As we saw earlier (section 3.2.1.2) the mission hospitals are run by the Christian Health Association of Ghana (CHAG) and not the Ministry of Health (MOH), although it gives them substantial annual subsidies. The fact that, in addition, the satellite health facilities are run by the district MOH and not CHAG results in a lack of proper co-ordination between all the facilities such that the referral hospital run by CHAG is unable to play the full role of the district referral hospital as envisaged under the district-based primary health care system.

- ***Equity features***

The main contribution of this scheme to equity in the health sector lies in the fact that it seeks to improve access to good quality care available at the mission hospital in Damongo for some of the poorest people in the country.

West Gonja is in the northern rural savannah. A national survey on poverty found that while "poverty in rural areas as a whole is above the national average, such poverty is disproportionately concentrated in the northern savannah area... The Rural Savannah locality accounts for around 22 percent of the population, but for around [29 to 32%] of the national incidence of poverty...". Similarly, "households in the Rural Savannah area are much more

likely to be poor than the average household in Ghana, and when they are poor, they are often very poor.”²⁴

Recalling the characteristics of the West Gonja district described earlier, it is clear that the success of the insurance scheme in this respect will have an impact on equity in the health care system as a whole since this is an area of the country characterised by both poor health status and low income levels.

The scheme’s community-rated premiums also mean that a cross-subsidy exists between the better off members and the poorer ones, since the latter tend to utilise the inpatient health services more intensively than the former. This is a contribution to equity in the financing of health care, but the evidence of in-built tendencies toward adverse selection, reviewed earlier, qualifies this. So does the flat rate subscription fee, which, apart from the distinction between new and old members, takes no account of the specific circumstances or earning capacity of members.

No reliable data exists on the imputed current income of subsistence farmers in this part of the country, and this makes it difficult to gauge objectively or accurately the share of the annual premium payment in a person’s income. At the same time, the national daily minimum wage of 1,700 cedis (US\$0.76) has little meaning in this rural district, but it does allow us to note that the current annual premium of 4,000 cedis (\$1.78) for new members is worth 2.4 days’ wages of a person on this wage. Of more significance, perhaps, was the finding from focus group interviews in agricultural settlements around Damongo, especially with non-insured persons, that the level of the premium posed no serious barrier to joining the scheme.

- *Access aspects*

The previous argument about the scheme’s contribution to making health care more affordable to the people of West Gonja also implies that it makes such care more accessible to those people.

In concrete terms, Table 3.4 of registrations per village or town community illustrates the extent to which the scheme has been able to penetrate in each of those target communities. As explained before, the scheme has not targeted the whole district for coverage from the beginning, but rather coverage is being expanded outwards from Damongo in stages. Therefore it has been made possible to improve the access to affordable and quality care of the inhabitants of the villages and towns. It should be noted that since the data in the table was constructed, enrolments in the 16 communities shown have increased and in addition, about 10 new communities have been added to the target list from October 1997.

Table 3.4: West Gonja health insurance scheme registrations per town/village as at 31st Dec 1996

Town/Village	Estimated population	Registered members	
		Figures	Percentage of population

²⁴ Ghana Statistical Service, *The Pattern of Poverty in Ghana*, *op. cit.* p. 17.

Town/Village	Estimated population	Registered members	
		Figures	Percentage of population
Damongo	11,184	2,139	19.13
Canteen*1	2,829	1,766	62.42
Broto/Bonbonto	432	180	41.67
Sori 1-3	1,511	354	23.43
Frafra settlements	731	369	50.48
Nabori	485	136	28.04
Dakpalakura	194	150	77.32
Soalepe	530	39	7.36
Bonyanto	353	21	5.95
Yipala	923	192	20.80
Mole-Game	574	488	85.02
Laribanga*2	1,665	239	14.35
Mempeasem*2	646	26	4.02
Jonokponto*2	1,154	3	0.26
Achebunyor*2	1,463	52	3.55
Kunkunde*2	221	15	6.79
TOTAL	24,895	6,169	24.78

Source: *The Community Financing Scheme for Admissions WGH - Damongo, Annual Report 1996.*

Notes:

*1 Canteen (4 km from Damongo town) is the "home" of the insurance scheme since the hospital and scheme office are cited there.

*2 New villages covered only from Oct 96.

As at the end of 1996, only a potential population of nearly 25,000 was covered, of which just over 6,000 (or about 25% of the target population) chose to enrol or were enrolled on the scheme. This average however masks very wide variations in enrolment from one village to another. The low enrolment percentages shown for the last five villages can be attributed mainly to the fact that the scheme was extended to them only in October 1996, and the data collection for the annual report which Table 3.4 comes from must have been done soon after.²⁵ Of the villages that had been participating for more than a year, registration varied from about 6% in Bonyanto to 85% in Mole-Game (the location of a famous national game park and a tourist attraction). Not surprisingly, the "home" base of the scheme, Canteen

²⁵ The Annual Report gives another reason for these low registration figures: Apparently due to a breakdown of the educational team's TV set, it was not possible to use videos as visual aids during the registration campaign for the new scheme year, affecting mainly those new areas.

settlement, shows a high registration percentage of over 62%, particularly significant because it is the second most highly populated community (2,829 estimated population). In that same connection, the 19% registration figure for Damongo town, the district capital, only 4km away from the hospital, must be considered rather disappointing, even though it has the highest registration in absolute figures. A higher percentage of registrations from Damongo would presumably improve the risk mix of the scheme, on the assumption that the better off population among the target group tends to live there.

It is also of interest as far as gauging the scheme's impact on access goes, to compare the 10 top diseases or conditions catered for by the scheme in 1996 with the top ten similar cases catered for by the hospital's admissions department.²⁶ These data are shown in Table 3.5.²⁷

Table 3.5: Top Ten Causes of Admission – Statistics of Insurance Scheme vs. the Hospital's

Insurance Scheme	Hospital
Malaria	Malaria
Measles	Hernia
Enteric fever	Pneumonia
Pneumonia	Snake Bite
Hernia	Hepatitis
Hydrocele	Kocks
Anaemia	Bronchitis
Hepatitis	Malnutrition
Bronchitis	Gastro-enteritis
Malnutrition	Enteric Fever

Table 3.5 indicates that, apart from a couple of cases, the kinds of ('catastrophic') conditions actually paid or catered for by the scheme are similar to those generally afflicting the rest of the patients (insured and non-insured alike). It can therefore be plausibly surmised from these data that the main risk covered by the scheme, i.e. hospital admission, translates in practice into coverage for the most common 'catastrophic' illnesses in the district as a whole.

Interviews with the hospital pharmacist and users in the community also brought to light the view that drug availability had improved since the scheme was started, but without data on average drug stockout duration both before and after the scheme's establishment, it was

²⁶ The 1996 Annual Report of the insurance scheme gives the 10 top diseases or conditions catered for by the scheme in that year without stating whether this is based on numbers of admissions, or total expenditure per case. However, the context and the fact that the hospital itself collects annual statistics of ten top causes of admission based on the number of admissions per case tend to favour the view that they mean number of admissions per case.

²⁷ Unfortunately, the Annual Report of the insurance scheme, unlike that of the hospital, does not give the number of admission cases per disease, so that further comparison is not possible.

impossible to verify this claim. Moreover, there is need for some caution in attributing improvements in drug supply specifically to the scheme since, as we have seen, the latter's contribution to the hospital's cost recovery, though significant, is not yet decisive.

In terms of other access indicators, the scheme coverage is limited to hospital admissions only as already noted; other types of care are excluded. In focus group discussions, it was felt in particular that the exclusion of maternity care²⁸ from scheme benefits was a limiting factor to better access. There was an unanimous view among both men and women, and young and old in the two communities visited that the inclusion of maternity benefits, even as an option attracting extra premiums and longer waiting times, would significantly increase insurance uptake.

For the inhabitants of the district who live relatively far from the hospital, and especially those living in the parts (called 'overseas') which are regularly cut off from the rest during the rainy seasons, one of the principal health care issues for them must surely be that of geographic inaccessibility of the hospital. Although the problem of unmotorable roads during the rainy season lies outside the control of the scheme's managers, the fact that there is nothing in the benefits package of the scheme which might help to redress the problem is a serious limitation. Measures along this direction could include primary health (especially preventive and promotive) care benefits in the package as well as incentives for scheme members to utilise nearby PHC services rather than the district hospital. This might well mean that the scheme will have to broaden its focus to take in the need to assist first level health care facilities to generate enough revenues (as it aims to do for the hospital) so that they can maintain sufficient equipment and staff to deliver much-needed PHC services.

- ***Sustainability***

Several factors, discussed in the Guidelines, affect the sustainability of the MHO. The West Gonja health insurance scheme was initiated with crucial external assistance. One of the important factors to take into account in assessing its future sustainability is therefore whether its financial, management and institutional practices and likely direction are such as to ensure that it can continue even in the absence of such support in the future. A significant element in this assessment is whether the present assistance is being used in ways that will help secure the future of the scheme, e.g. whether it helps management capacity-building, income generation, sustainable procurement of vital equipment, etc.

Let us note first the scale of the external assistance to the scheme. Apart from the forms of assistance already mentioned, the start-up phase of the scheme was facilitated by a loan of 50,000DM (or over 52 million cedis) from the main donor, Misereor. In addition, Misereor guarantees an annual subsidy to the scheme for the first three years, as follows: 15,000DM each for 1996 and 1997 and 20,000DM for 1998. This yearly guarantee is similar to that given to the Nkoranza scheme by Memisa in Holland.

However, the contrasts in the attitudes of the management of the two schemes towards this 'guarantee' may serve to illustrate both the limitations of certain forms of external assistance

²⁸ The scheme will cover abnormal deliveries, i.e. cases involving caesarean operations or other complications where the mother has to be admitted.

and the positive ways in which management can make use of such funds to enhance scheme performance and long-run sustainability.

In Nkoranza, the guarantee fund was not simply a fixed annual subsidy to the scheme as in the West Gonja case, but a 'guarantee' against deficits, whatever the amount. In practice, this may have contributed to inadequate managerial performance, since this guarantee in effect spared management the need to ensure that current expenditure, especially hospital invoice payments, were covered from current revenue (realistic subscription fees, elimination of waste, etc.). The first evaluation of the scheme found evidence of serious shortcomings in financial accounting, but the effects of such shortcomings were masked by the guarantee fund, which was delivered on schedule annually. Some current difficulties may have a lot to do with this background.

In contrast, at West Gonja, management has elected in effect not to consider the annual subsidy as part of current income. For the first two years of the scheme, only a portion of the subsidy is being used (about 5,000DM or over 3 million cedis, in 1996). The rest is being cumulatively held in an account for the insurance scheme, not to be used unless there is a real emergency. They plan to use the accumulated reserves for some income generating ventures after the third year. In the meantime, every effort is being made to ensure that current spending (especially hospital invoice payments) is financed from revenue generated from subscriptions. While this by itself will not guarantee the success of the scheme, it may be safely assumed that, all other things being equal, the future of the West Gonja scheme is more sound because of this approach.

It should be noted however, that besides financial support, the West Gonja scheme also benefits from other forms of external support. Membership cards for instance, are printed in Germany by a donor; donations of equipment of various kinds, printing of hand-outs, etc.

Moving on to other questions of sustainability, the scheme currently relies on the technical and managerial skills of its two full time staff: the project manager and co-ordinator. These two have benefited from capacity-building courses in Germany and are also learning on the job. They are clearly crucial to the survival of the scheme, as things currently stand, since nobody else has the requisite skills or training to replace them. Only time will tell whether this is actually a weakness of the scheme or not.

An institutional issue, which could affect sustainability, is the scheme's relations with the target communities. In focus group discussions, it came out quite clearly that some of the scheme members do not consider the current relationship to be satisfactory. For instance, some would prefer to be consulted on some matters or to have a regular forum for exchange of views, to be able to ask questions and have their concerns, suggestions and worries transmitted to the management. At the very least, such participation might give members the sense of having a stake in the success of the scheme, and therefore also the incentive to exercise social control or peer pressure on those who would deliberately try to abuse the scheme.

A possible cause for concern, still in connection with sustainability, is the fact that, out of the 4,890 persons who registered in the first year of the scheme, only 2,559, or 52%, renewed

their membership in the second year.²⁹ Once again, this is an indication of adverse selection, a well-known phenomenon, where the healthy members tend to withdraw when they see no personal benefits from continued membership. This may suggest vigorous efforts (including the above suggestions from the focus groups) to sustain interest and loyalty in the scheme. The inclusion of fairly inexpensive primary care benefits (including the universally popular maternity benefits) as options may also be useful measures to enhance renewal rates.

Regular monitoring and evaluation exercises are planned, and these would undoubtedly improve sustainability if these exercises feed into the making and implementation of appropriate policies.

The final set of indicators to examine in this sub-section are the technical financial performance ratios presented in the Methodological Guidelines of this study. But in the absence of a balance sheet or a valuation of the scheme's assets, some of these ratios cannot be ascertained. In addition, some of them, such as mass of dues owed in relation to dues paid, are not relevant to this scheme where 'membership' is defined by those who have currently paid their dues. That leaves three key indicators that can be calculated, and the financial statement of the scheme, reproduced below, will help in their calculation.

**Table 3.6: Financial Statement of West Gonja Hospital Insurance Scheme
Income and Expenditure as at 31st December 1996**

Income	Amount (Cedis)
Membership/Registration Fees	11,948,000.00
Misereor Grant	3,305,929.00
Promotional materials	432,700.00
Photocopy fees	324,600.00
Donation in kind*1	6,270,000.00
Miscellaneous	4,414,989.96
Bank Interest	1,528,040.80
TOTAL	28,224,259.76
EXPENDITURE	
Hospital fees	6,335,220.00
Upkeep of vehicle	885,300.00
Fuel	954,090.00
Office & Administration	469,979.00
Films/Printing costs	451,400.00
Bank Charges	5,613.00
Promotion Materials	-

²⁹ Information obtained by the author from the computer-based statistics of the insurance scheme in November 1997.

Income	Amount (Cedis)
Personal Emoluments*2	4,619,874.96
Travel & transport /Night-outs	240,000.00
Diets and Provision	49,800.00
Miscellaneous	-
Surplus	14,212,982.80
TOTAL	28,224,259.76

Source: *The Community Financing Scheme for Admissions WGH – Damongo, Annual Report 1996.*

Notes:

*1 Salaries and per diem of the manager and co-ordinator not taken

*2 Includes salaries taken by manager and co-ordinator

For this purpose, the surplus at the end of the year is assumed to constitute the scheme's reserves.³⁰ On this assumption, the ratio of reserves to monthly expenses works out at 12, i.e. the reserves will cover 12 months of expenses if they remained at the last year's level. This, on the surface, looks very good indeed compared to the recommended minimum figure of 3 to 6 months reserve cover required. However this calculation is not realistic since this scheme is still in the phase of expanding annually and medical inflation is reported to be high. It would be more reasonable therefore to regard this figure as adequate for perhaps half a year's expenses, which is still well within the recommended values, but not a cause for complacency.

Table 3.7: Financial Performance Indicators

Ratio of net reserves / monthly expenditure	Ratio of dues to expenditure	Ratio of administration costs to income
12	0.85	27%

The ratio of dues to expenditure, 0.85, is below the minimum recommended figure of 1. This ratio would be even worse if the staff had taken all their salary and other entitlements during the year.

The last ratio, administration costs to income, is, at 27%, well over the recommended value of 5% or less. However, it should be noted that the scheme's full subsidy income of over 15 million cedis from Misereor has not been included, which is legitimate as the management of

³⁰ Strictly speaking, the actual reserves of the scheme are the subsidy from Misereor which is being held in a special account on behalf of the scheme, but it was judged more prudent to base the calculations on the details presented in the scheme's financial statement, which are the result of the operations for the year and therefore a better gauge of management performance.

the scheme prefer, precisely for sustainability reasons, not to regard it as part of current income. Moreover, the high fuel and transportation costs reflect the fact that the initial phase involves big bursts of campaigning activity as well as the very bad state of the road infrastructure. Once all parts of the district have been covered and membership of the scheme stabilises, these costs should fall or rise less steeply, all things being equal.

Overall, these indicators show that the scheme's managers do need to watch the evolution of various costs in relation to income, with a view to keeping costs under control and the scheme in a financially healthy state.

c. Traditional social network: The Duayaw-Nkwanta Dagaaba Association

- *Background and objectives*

The Dagaaba are one of the major ethnic groups of the Upper West Region of Ghana. Like many others in this impoverished part of the country, many Dagaaba youth travel to work in the relatively better off Southern, especially the cocoa growing forest, regions of the country. Many of these make annual trips during the dry season in order to earn some cash working on the farms and other seasonal jobs in the South. However, it frequently happens that some of these choose to stay more permanently, some becoming farmers in their own right or moving into other permanent occupations, and bringing over their families to join them. In time, their offspring may become teachers, nurses, artisans, etc. and become even better integrated into the economy of the South, moving into the urban centres, for instance, rather than remaining in the villages where they may have been brought up.

After a while, such more permanently settled people usually discover that the traditional social institutions of mutual support (the extended family, clan, etc.) that they take for granted back in their villages are not available in their new home towns. Such support is vital not only in times of sudden hardship or emergency (e.g. loss of employment or serious illness), but also for more predictable things like funerals, marriages, births and other events where the resources required normally are beyond the means of a single person or family and which therefore call for a communal approach.

It is therefore not surprising that in most urban areas where non-indigenous persons are settled in sufficient numbers, a strong need is felt among these non-indigenes or migrants for some tangible expression of their cultural identity and to stress their continuing links with the original home village or town. This usually takes the form of calls and advice to the young people to foster bonds of togetherness, solidarity and mutual help among themselves. It is out of these kinds of sentiment that many traditional social networks or ethnic-based associations are created.

Apart from this migrant type described above, another, usually much bigger kind of ethnic organisation, is the town development or youth association which is formed by the indigenes of a town or village for the purpose of promoting community development projects such as schools, clinics or roads. and which, like the first kind, often also involve aspects of mutual support. In fact, it is normal for this town or youth association in the home town to be linked directly with the associations formed by indigenes of the village or town who have settled elsewhere (in other words, the first type described above). These links are expressed usually

through joint sponsorship of development projects in the home town or village, co-ordination or co-operation over funeral and festival arrangements.

There are no statistics available on the numbers of such associations nor of their total membership across the country but it can be safely assumed from reliable anecdotal evidence that there are many thousands of such organisations involving hundreds of thousands of people all over the country.

The Dagaaba Association in Duayaw-Nkwanta is one of the first of migrant type. Duayaw-Nkwanta is one of the relatively prosperous towns in the Brong Ahafo Region (upper forest belt) of Ghana. As such, it attracts a fair number of seasonal workers as well as non-indigenous civil servants and others who come there to work or are on transfer from another part of the country. Dagaabas have settled in this town for many years, some for farming purposes, others as civil servants on duty post there. Some of their offspring have remained there and moved into other occupations.

The Dagaaba Association was born in the last few years by these kinds of people who are linked solely by the fact of their being migrants with ethnic origins in the Upper West Region of Ghana. Its membership is open to all Dagaaba living in Duayaw-Nkwanta and its surrounding villages who are 18 years and above. Particularly interesting is the stipulation that Dagaaba females married to members of other ethnic groups “can be members but their husbands cannot”.³¹ This requirement could have an adverse health impact if the scheme purported to run a serious mutual health scheme.

The specific objectives of the Association are to:

- Enable members to interact and to know each other
- Foster unity among members
- Cater for the welfare of members
- Help solve the welfare and financial problems of members.³²

A major factor behind the creation of the association was the “high cost of funerals these days” and the fact that “individually it becomes rather too hard for one to go through without any kind of support.”³³ The association was therefore designed to be a forum where members could assist each other in case of need (mutual support), maintain their cultural identity and facilitate easy identification of each other at public places.³⁴

³¹ Constitution of the Duayaw-Nkwanta Dagaaba Association, p. 1

³² Constitution etc., *op. cit.*

³³ Communication from Messrs David Naaluyele and P Kankye, executive members, Duayaw-Nkwanta Dagaaba Association.

³⁴ *Ibid.* .

- ***Design, Organisation and Management***

The association has 82 full members as at November 1997, plus 78 dependants, making a total of 160 beneficiaries.

Upon registration, all members pay a non-refundable fee of 2,000 cedis each, payable within two months of first attendance of a general meeting. Thereafter the registered member pays 500 cedis a month as dues. Membership is both family and individual based, though it was not clear whether the membership fee automatically covered all family members or whether an additional fee was payable for the family. In addition, the association hopes to raise funds from special levies and voluntary contributions as well as donations from well wishers for special projects or events (such as community development back home or funerals, weddings, parties, etc.).

Benefits of membership, after two months of probation or waiting period, include the following:

Death of a member, member's child or spouse:

- The association buys the coffin but members are asked for additional contributions to pay its cost.
- Additionally, the Association provides initial assistance of not more than 20,000 cedis to the bereaved family for burial and funeral expenses
- Finally, the surviving spouse of the deceased member gets a cash donation of 10,000 cedis.
- In the case of a member's child passing away, a cash donation of 5,000 cedis is paid to the member.
- And in the event of the death of a member's spouse, a donation of 10,000 cedis will be paid to that member.

Sickness

If a member is hospitalised for one week or more she/he receives a cash donation of 5,000 cedis to assist with bills. In addition, it is a requirement of membership that all members will endeavour to visit the sick member in hospital for solidarity.

Transfers

Members who are civil servants on duty posting tend to be rather temporary members, as they can be transferred at any time. In such a case, the members are required to contribute to organise a send-off party for the person leaving.

Natural disaster

If a natural disaster should befall any member, the other members convene to discuss what is the appropriate form and amount of assistance to be offered.

The organisational structure consists of a life patron at the apex, the general meeting of members, the executive committee, and a number of sub-committees for specific tasks such as welfare, finance and audit.

Meetings of all members are held on the first Sunday of every month. Additionally, there is an annual general meeting (AGM) held in December every year, at which financial reports are presented and elections for executive officers are held in alternate years.

The executive committee (consisting of a chairman, secretary, treasurer and other officers) meets as frequently as is considered necessary.

- ***Contribution to health and health sector goals***

The financial statements of the association for the 1995 and 1996 years are shown in Table 3.8, and will be used for the further analysis.

Table 3.8: Financial statements 1995 and 1996

Revenue	1995 cedis	1996 cedis
Dues	106,500	117,300
New members' joining fees	110,000	16,000
Interest received	-	7,595
Total	216,500	140,895
Expenditure		
Office supplies	10,600	5,400
Transport	-	-
Payment of benefits – sickness, funerals, etc.	33,000	17,000
Total	43,600	22,400

Notes: This is a simple organisation with few overheads due to voluntary labour and other services/facilities offered freely by members. The figures for revenue from dues for the two years show that dues payment must be irregular and arrears quite high, since if all were paying, there should be nearly half a million cedis gained annually from the monthly dues alone.

Even on the small scale of operation that this association represents, its contribution to the health of its members is probably insignificant. Between 1995 and 1997, four persons obtained sickness allowances under the association's rules. The total revenue is modest, and the amounts paid out for benefits, 33,000 and 17,000 cedis (about \$15 and \$7.56) respectively in the two years, appears very small indeed. Unfortunately, it was not possible to disaggregate the share of health care benefits within the total figures, but it is obvious in any case that this will be insignificant in relation to the scale of health care needs of even such a small population as this.

The contribution of 5,000 cedis to a person hospitalised for a week or more is not likely to have much impact on their ability to pay the bills since, typically, such hospitalisation will cost considerably more than 5,000 cedis. To get a picture of the financial burden facing a hospitalised member, we can take a look at the charges at the nearby Nkoranza district hospital, which is similar in most respects to the district hospital at Duayaw-Nkwanta. At Nkoranza, a person being admitted for a minor operation will be required to deposit 40,000 cedis (about \$18) before they will be admitted. For a major operation, this deposit rises to between 80,000 and 100,00 cedis depending on the category of operation involved. Even for the common malaria or a normal delivery (i.e. not involving caesarean or other complication) a deposit of 30,000 cedis is demanded.

For the person being admitted, this deposit is in most cases the real barrier to obtaining timely and adequate care, rather than the eventual bill itself. The formal intervention of the Dagaaba association, small as it is, comes too late to be of any help in breaking through this initial barrier. However the stress here is on the formal intervention of the association, for in reality, its role is likely to be felt well before admission if the member is really facing genuine difficulty raising the required deposit for admission. As is well known, in real difficulty of this kind, it is precisely this kind of solidarity network that most hard-pressed people will fall upon for assistance. That assistance will however be an informal arrangement, and may take the form of a loan from a prominent member, or even from the group's account. Unfortunately, it is extremely difficult to assess the size and other details of this kind of contribution, so the analysis will be limited to the formal engagements of the association for which some data are more readily available. But it should also be borne in mind that the contribution of the association to the health of its members, and hence to resource mobilisation for the health sector, is likely to be significantly more than the formal requirements suggest.

The Dagaaba association has no contacts with care providers and so is in no position to make significant contributions to efficiency or quality improvements at these institutions.

The association however certainly makes some modest contribution to equity, and if its financial base was stronger, this could easily be its most significant contribution, since the members include the most disadvantaged and marginalised individuals and families in the Duayaw-Nkwanta township. The assistance it offers them in the area of social and welfare services, as well as social solidarity, could have gone some way towards redressing the social deprivation that is the lot of the majority of the members (especially the farm labourers and peasant farmers among them).³⁵

For the reasons stated previously, this association's contribution to access enhancement is fairly negligible. As far as its sustainability is concerned, the positive aspect is the low overheads entailed because of the voluntary work and services offered by executives and members. On the other hand, the record of dues payments, as indicated by the financial results above, is not encouraging and could be a threat to viability. In this respect, perhaps its

³⁵ In contrast, when the association is not made up of members of a deprived or marginalised community within the town where it exists, or when it is an association of indigenes of the town itself (town development or youth associations), other experience has shown its features can be quite regressive as far as equity even within the ethnic group itself is concerned.

greatest asset is not of a financial nature. As experience almost everywhere else in Africa has shown, principally because of the strength of ethnic solidarity and mobilisation, such associations can be very robust and tenacious and thus survive conditions that might blow away more formal and much bigger types of organisation. The downside of this is that this very strength all too frequently becomes an obstacle to mobilising on a wider social basis or achieving the broader social consensus that is vital for more complex development programmes.

d. Social movement and ‘complex’ community health care financing initiatives: The Teachers’ Welfare Funds and The District Health Insurance Schemes (DHIS)

There are some current developments regarding health care financing in Ghana that, although not yet significant in terms of *actual* contribution to health sector objectives, promise to alter this landscape significantly in the near future and it would therefore be helpful for this study, which aims also to examine the *potential* contribution of such schemes, to describe their features briefly. The three worth mentioning are: (i) the recent direction taken by social movements like the welfare funds of the Ghana National Association of Teachers (GNAT) under the impulse of progressive limitations on the free health care entitlements of public servants over the recent years, and (ii) the proposed District Health Insurance Schemes (DHIS) backed by the Danish co-operation agency, DANIDA, as a complement to the proposed national health insurance scheme for formal sector employees.³⁶ (iii) the proposed *MOTAUK LAFIA* Health Insurance Scheme for Bunpurugu-Yunyoo, Northern Region, which has similarities to the DHIS. Only the first two will be discussed in any detail here.

- ***The Teachers’ Welfare Funds***

The Ghana National Association of Teachers (GNAT) is the professional association that embraces all teachers in the country. It is a very large and powerful organisation because teachers number over 150,000 nation-wide and are found in nearly every town, village and hamlet. We investigated the Kintampo District branch in the Brong Ahafo Region and the national headquarters’ welfare fund in Accra.

The Teachers’ Welfare Funds were originally set up to help members in times of hardship or some social event where financial assistance is needed, especially funerals of members or their close relations. The Funds are totally decentralised, so that each GNAT branch in a district runs its own welfare fund independent of the national association.

In recent times, government has started to place limitations on the total health care bill of public sector organisations, leading to caps on expenditure per person or family and exclusion of some health care services from the free coverage. This has increasingly led some teachers to draw upon their welfare funds to help them fill the gaps, or in some cases, to obtain better quality care than is obtainable at public facilities to which free care is limited.

³⁶ This national scheme is another development that promises to alter the landscape of health care financing even more radically, and is briefly discussed in the next sub-section.

It is reported that for teachers, government now allows a maximum of 25,000 cedis (about US\$11) per family per year for health care expenses.³⁷ Depending on the arrangement in force at the district, the bill for health care is paid either directly to the health care institution concerned, or the teacher pays out of pocket and a medical form is completed by the attending physician and posted/handed over directly to the District Director of Education who will authorise a refund to the teacher concerned (cash indemnity). For those teachers or their family members who are unfortunate to be admitted into hospital, the government's limit will probably be inadequate hence the need to draw upon the welfare fund.

At Kintampo District, it is estimated that there are approximately 1,000 members of the fund (all teachers in the district plus the staff of the GNAT district secretariat). Since 1992, members on admission in a hospital or at a herbal clinic for more than a day but less than a week, qualify for a cash donation of 1,000 cedis (\$0.44) each and if for more than a week, another 2,000 cedis (\$0.89) from the welfare fund.³⁸ These amounts look small, but were fixed in an earlier era when those sums were worth a lot more in real terms. The amounts are currently under review. Moreover, teachers' health care is subsidised by government. The mention of herbal (i.e. traditional medical) clinics among the services illustrates the role of the fund in complementing the care which they already have access to under the government's health care subsidy policy; herbal clinic fees will not be covered by the government's scheme.

The subscription fee for membership of the Kintampo District fund is 500 cedis (US\$0.22) per month, which is relatively small and certainly affordable for all categories of teachers.³⁹ But the resource mobilisation potential of this mechanism really lies in the fact that all teachers from all over Ghana are automatically contributing members of the welfare fund wherever they are stationed. Moreover, this contribution is deducted from their salaries at source and handed over directly to the administrators of the fund (elected officials). This makes the funds potentially large revenue generators, all of which is not of course utilised for health care spending but the potential is there for this share to increase if these funds become the basis for the teachers' participation in the proposed national health insurance scheme,⁴⁰ or for some reason, if they are required to pay more for their health care. For the Kintampo fund, the amount potentially available annually for all welfare expenditure is around 6,000,000 cedis (US\$2667).

³⁷ This figure (of the 25,000 cedis limit) was mentioned to the author by several teachers as well as GNAT officials and is taken here as authentic, but it is important to stress that we could not verify this independently. At the very least, it can be seen as an indication of the trend of government health policy towards the public sector

³⁸ Other benefits include cash donations on the death of a member or close relation, for teachers on transfer and for weddings and outdoorings ceremonies for new babies. Loans, very popular services, are also given to members for a variety of welfare and productive projects, including for building of a house.

³⁹ As the funds are decentralised, the amounts of contribution, as well as the size of benefits, are all decided by the teachers at the district level. The contributions and size of benefits tend to vary widely from one district to another, but the nature of the services tends to be similar.

⁴⁰ There is no such suggestion at this stage to use the funds for this purpose.

The scale of the sums that may be available through these funds may also be glimpsed through the national headquarters welfare fund, where the exact figures were available. This fund has a total membership of about 150 staff (not necessarily or even mainly teachers; membership consists essentially of the administrative staff at the national head office in Accra plus regional secretariat staff in the 10 regions). Each member contributes up to 5,000 cedis (\$2.22) per month as dues for the welfare fund, depending on their salary.

The total contributions to this fund between the years 1995 and 1997, together with the total disbursements for various welfare purposes, are shown in Table 3.9.

Table 3.9: GNAT Headquarters Welfare Fund: Contributions and Disbursements 1995-1997

	1995 million cedis	1996 million cedis	1997 (up to Oct) million cedis
Total welfare contribution	3.50	4.25	3.50
Total disbursement	2.80	3.20	2.70
Surplus	0.70	1.30	Not applicable

The fund is used to cover the following kinds of services to members:

- Health care
- Funerals
- Marriages
- Outdoorings (new babies)
- etc.

In other words, the services are similar to those that teachers in Kintampo District receive from their fund. Unfortunately, it was not possible to desegregate the exact amounts that were spent on each service, nor to give the number of beneficiaries of the services in the years concerned.⁴¹

Another interesting fact revealed by these figures is the amount of surplus the fund appears to be running in the years shown. It was not clear how the surplus is utilised, but it seems likely, as is the fashion among such organisations in the country, that this is invested in treasury bills.

Contribution to health and sector goals

The *actual* health contribution of the GNAT welfare funds could not be ascertained due to the absence of relevant data. However, it is possible to surmise that its *potential* contribution is great, given:

⁴¹ This was due to the impending GNAT congress, preparations for which were actively taking place at the time of the research; staff and resources were over-burdened and pre-occupied with congress work.

- current trends in government health policy towards the public sector
- the number of teachers in the country, and related to this,
- the size of the welfare funds
- the surpluses that appear to be currently available

That contribution will even be further enhanced if the welfare fund administrators establish direct relations with care providers to negotiate favourable terms (especially on quality and prices) for their members. As we have noted, this is a large and powerful organisation with members all over the country, which should give it a lot of clout in discussions with providers.

Teachers, because of their unique role in educating young people and their influence in rural communities in particular, are also potentially important agents of PHC policy, especially with regards to preventive and promotive services (e.g. sex education, immunisations and health education; some of which may form part of the school curricula).

The method of raising the revenue by direct deduction from source, coupled with compulsory membership of the fund by all teachers, makes this, in principle, highly sustainable.

- ***The Proposed District Health Insurance Schemes (DHIS)***

As part of its policy of looking for alternatives to free medical care for the public sector and user fees for the rest, the government has solicited financial support from external donors to “formulate and implement a health insurance policy for the ‘informal’ sector.”⁴² This is to complement the proposed national health insurance scheme which will provide cover for the formal sector (see below).

It is in that context that DANIDA, the Danish co-operation agency, has begun some pilot studies to examine the feasibility of implementing a District Health Insurance Scheme for informal sector workers in the country. The pilot studies will initially be carried out in four of the ten regions, namely, Eastern (where the national scheme is also being tested), Volta, Greater Accra and Upper West regions. One district will be selected in each region for the pilot study, and plans for this appear to be already in progress.

The objectives of the DHIS are similar to those defined by the MOH for the national scheme, namely:

- Achieving universal coverage for primary care
- Making health care economically and geographically accessible to inhabitants of the districts
- Ensuring an acceptable minimum health care at the PHC level
- Generating additional resources for health care.

⁴² JSA Consultants, Draft Proposed District Health Insurance Scheme, unpublished paper.

Its principles are also similar to the national scheme, which are equity, solidarity and self-financing.

Organisation of the DHIS⁴³

The approach envisaged is to base the scheme essentially on informal sector groups and associations such as: local branches of the Ghana Private Road Transport Association, Co-operative Drivers Union, Market Women's Associations, Hairdressers and Dressmakers Associations, Co-operative Distillers Associations, Carpenters Associations, Cocoa/Coffee Farmers Associations, etc. Individuals in the district, including formal sector employees who wish to do so, will however be allowed to join. Many of the targeted groups are already registered with the District Assemblies (the elected political authorities of the districts) and it is intended to work closely with the district political authorities in implementing the schemes.

A scheme will begin with the formation of a District Health Insurance Association (DHIA), under the auspices of the District Assembly, which will serve as the 'cornerstone' of the District Health Insurance Scheme. Organisations and individuals will join the DHIA to gain access to its health care benefits. There will be a co-ordinator of the DHIA, and registrations and collection of premiums will be done by this office in collaboration with representatives of the member-organisations/groups.

The DHIA will have a Board, which will be its highest policy making body. The Board will be composed of the co-ordinator and representatives of the private and public sectors. Groups that would be represented include: insured groups/associations, pharmacists, private medical doctors, nurses, accountants, lawyers, the Department of Social Welfare, Women's groups, the District Assembly's Finance and Administration section, and others.

The Board will have responsibility for policy, planning and development of guidelines for the running of the DHIA. It is also expected that the Board will establish a smaller Management Team that will manage the technical and financial aspects of the DHIA. This includes the tasks of day to day management and co-ordination of the scheme: educational campaigns, authorising expenditures, communication with members, etc.

The DHIA office will carry out educational and registration campaigns in collaboration with the District Assembly, local churches, muslim organisations, schools, and other mobilisation agencies in the district. It will provide membership ID cards as well.

Financing of the scheme

The scheme is to be funded by individual premiums, not family-based fees, and will be backed initially by donor and government support for acquisition of essential inputs such as office equipment. Factors that would determine the level of the premium in any district will be the cost of health services, utilisation rate and annual inflation. The goal is that the schemes should eventually be self-financing at the district level. Before that is attained, the DHIA office and the District Assembly will jointly explore alternative sources of funding.

⁴³ The description of the DHIS is based essentially on the author's discussions with, and write-ups by, DANIDA's health consultants in Ghana, JSA Consultants.

The informal sector groups and associations will be responsible for collecting the premiums from their members, and the office of the DHIA will then collect the funds from these organisations. Contracted field workers will also be given the task of registering and collecting premiums from participating households or individuals not belonging to identifiable informal sector organisations.

It is also expected that premiums will be annual, and registration limited to a specific period during the year, presumably around the harvest time in the particular district. An interesting feature being suggested is to give discounted premiums to members who do not use the services within a given year. This is obviously intended to discourage frivolous use as well as to encourage more healthy individuals to continue renewing their registration annually.

Benefits

A comprehensive service will be offered under the scheme, including all existing in- and out-patient health services currently provided by health centres and hospitals in the district. However, normal deliveries, criminal abortions, and treatment of alcoholism as well as public health preventive and promotional activities will be excluded from the benefits package, as are publicly funded services such as TB and leprosy. This clearly reflects experience gained by the scheme designers from studying the existing community financing schemes at Nkoranza and West Gonja.

The office of the DHIA will also pay an agreed rate to cover transportation for members referred for treatment outside the district, but such referral treatment will not be paid for by the scheme.

Providers will include all government health facilities in the district. Private and non-governmental health facilities will also be eligible to participate under the same terms as the public ones. A mandatory referral system from sub-district level facilities to the district level ones (district hospital) has also been suggested. The office of the District Health Management Team will be responsible for processing and certification of claims of the health providers. The methods of reimbursing the providers that are being considered are capitation, global budgets, fee-for-service and flat-rate-per-household.

Potential contribution

On the basis of the design features proposed and presented above, some comments can be made with regard to the potential contribution of the DHIS concept to health and other health sector goals in Ghana. The design stage of an MHO, probably even more so than many other NGO enterprises, is very crucial to eventual success.

There is no doubt that if this concept takes off and succeeds, it can make a significant contribution to health status in rural areas of the country, especially given the comprehensiveness of the coverage proposed. The design contains many admirable features, and is said to be based in part on the experience of the schemes at Nkoranza and West Gonja. However, optimism must be tempered with a healthy dose of caution.⁴⁴

⁴⁴ Experience in Tanzania offers a salutary lesson that should help temper optimism: there a World Bank sponsored district health insurance initiative was embarked upon with a lot of media attention and high

First, the managerial and technical capacities required for running these kinds of organisation (health insurance, so to speak) are lacking in the country. It does not seem that the kinds of bodies proposed to manage and run the schemes will be properly equipped to appreciate the specific risks and problems associated with running such insurance schemes.

Secondly, the prominent role reserved for the district assemblies, especially in fund-raising and policy making, while it may bring some initial short term benefits in getting the schemes off the ground very quickly, may also expose them to the danger of politicisation and the possible distortion of their goals.

On some specific design details, the recommendation to go for individual as opposed to family based contributions will appear to be a retrograde step, not a valid extension of experience from Nkoranza and West Gonja. (For a fuller explanation of this comment, see the earlier discussion of the West Gonja health insurance scheme.) Coupled with the recommendation to give discounted premiums to individuals who would not have benefited from the services in the preceding year, such a proposal, if implemented, could partially defeat the resource mobilisation, not to mention the proclaimed equity and solidarity, objectives, of the schemes. While the idea of giving discounted premiums is admittedly aimed at addressing an all too familiar problem with voluntary insurance schemes in Africa and is therefore not to be dismissed out of hand, its potential adverse impact on district-wide resource mobilisation and risk-sharing could be reduced if the scheme was at the same time based on family, not individual, membership. This is based on the reasonable assumption that encouraging people to think of whether their family has benefited, rather than whether they had themselves personally benefited, will produce different results than are currently seen from the emphasis on individual registration. Moreover, it would seem that the interests of equity, risk-sharing and health improvement would be better served if the incentives were applied to families rather than individuals.⁴⁵

A final note of necessary caution must also be sounded in relation to the way in which lessons from the pilot projects might eventually be applied to the design and implementation of the follow up nation-wide District Health Insurance Schemes. It must be noted that the commonest danger from 'scaling up' or extrapolating from small-scale pilot experiences to larger scale schemes is the well-known 'fallacy of composition'. The contextual differences and the attendant difficulties that were pointed out by Janovsky and Cassels (1996: 15-16) are germane here.

“...as their scale and scope increases, programmes become more complex; require more co-ordination; greater commitment of resources; and have wider political implications. The context in which they operate changes and new social, political,

hopes but has so far led to a disappointingly slow take-up of insurance by households, and the scheme appeared characterised, at least in the first year, by widespread adverse selection. It is instructive that many villagers are said to be of the view that the scheme ought to be entirely free since a 'rich' donor is putting money into it.

⁴⁵ It is not yet clear what will happen to the government's current policy of free medical care for children and pregnant women when insurance schemes such as the DHIS take off. The presumption from the rhetoric on self-financing status for such schemes, including the national one, is that the government will not continue to offer free care to such persons nor will it pay the premiums for them.

economic and organisational factors affect what can be done. Large scale implementation requires facing the structural and system-wide issues from which small-scale projects are effectively protected.”⁴⁶

The Proposed MOTAUK LAFIA Health Insurance Scheme

It is also worth noting that a new health insurance initiative was on the verge of taking off (in the conscientisation stage) at the time of this research. The MOTAUK LAFIA Health Insurance Scheme is an initiative led by the Member of the Parliament for the constituency of Bunkpurugu-Yunyoo in the Northern Region. Though many details remain to be worked out, the basic framework, the principles on which it will be run, services to be covered, relations with providers and similar areas which have been set out are very similar in many respects to the DHIS system described above, except that this is for a constituency, not the whole district. We will not therefore go into any details about this proposed scheme, except simply to note the context in which the scheme will be launched.

Bunpurugu-Yunyoo is a rural savannah constituency of about 85,000 people in the East Mamprusi District. Farming is concentrated in the three-month rainy season, punctuating a long annual lean season of 9 months. With little opportunities for off-farm employment, this is an area of considerable poverty, malnutrition and poor health. Setting a level of contribution that will be both affordable and realistic enough to be able to cover the health care costs of the expected flood of cases that will attend a sudden lowering of existing barriers to health care access will be a major challenge. It is likely that the scheme will require crucial external support for some time.

⁴⁶ Janovsky, K and A. Cassels (1996). “Health policy and systems research: issues, methods, priorities.” In Janovsky, K. (ed.), Health policy and systems development: an agenda for research. WHO/SHS/NHP/96.1 Geneva: World Health Organisation; cited in McPake, B. and Joseph Kutzin, Methods for Evaluating Effects of Health Reforms. WHO, ARA Paper Number 13, 1997.

4. Institutional, legal, and regulatory framework

Institutional framework

MHO promoting organisations in Ghana are not numerous. The leading one currently is the Catholic Church, through its sponsorship of community financing schemes such as Nkoranza and West Gonja. Externally based donor agencies linked to the Catholic Church have also been playing a crucial role in the development of such schemes, as we have seen in the analysis of the origins of the Nkoranza and West Gonja schemes.

Beyond that, the newest promoter institution is DANIDA and its proposed DHIS programme promises to have an even wider coverage if it takes off as intended. The European Union has also sponsored research work that resulted in a proposal to set up a community health insurance scheme in the Dangbe-West District of Greater Accra Region. It appears that this is being co-ordinated with the DANIDA-sponsored pilot studies.

There are a number of good quality training institutes and centres in the country that, although not currently focused on MHO training needs, could potentially be relied on to participate in developing training programmes for such organisations if the need arises. There is however a general lack of such institutions that have a health or mutuals perspective, reflecting the national experience in MHOs which, as we have seen, is generally not high. There are also a few health research institutes (Accra, Kintampo and Navrongo) that could also offer some technical assistance to MHOs if necessary (for instance regarding statistics of utilisation of health facilities and prevalent diseases or principal health issues of particular areas).

The MOH is apparently keen to support the development of MHOs, especially for the informal and rural sectors, as we have seen with the DANIDA project. But the Ministry has not made clear exactly what role such organisations will play when, as is envisaged, the national insurance scheme is eventually extended nation-wide to embrace all sectors.

The proposed national health insurance scheme is one of the main factors that will shape the institutional environment for the development of MHOs in the country in future. The scheme is designed to be implemented in stages, beginning with the formal sector employees (all current contributors to the Social Security and National Insurance Trust-SSNIT). A pilot project is to be tested in the Eastern Region. This scheme will be extended to the rest of the country. The basic objectives are the same as those enumerated for the DHIS ones above (in fact the DHIS borrowed those aims from the proposed national scheme) since the intention is to harmonise the two kinds of scheme with overall health sector goals of the MOH.

The national scheme will be a “capitation model” with private and public providers equally entitled to participate. Contributions will be collected in the same way as the SSNIT ones, the tried and tested deductions from source. Both employers and employees will contribute to the fund, ensuring a potentially large pool for formal sector health care financing. The goal is to become self-financing, at least as far as recurrent expenditure is concerned. The funds will be transferred to a National Health Insurance Board, which will have regional offices, but will operate with one centralised autonomous fund (based on national solidarity). The benefits’ package will cover all PHC services including in- and out-patient services, diagnostic

services, maternity and reproductive health. For drugs, however, co-payments will be required from beneficiaries and only drugs on the national essential drugs list will be covered.

Legal and regulatory regime

There is currently no specific legislation for MHOs in the country. Nor is there legislation for NGO registration in general. In the absence of these, most of these kinds of organisation have been “registering” with the Department of Social Welfare. It is also possible to register as a company limited by guarantee or as a trust, and this is the route preferred by some organisations.

Currently, there is an ILO study aimed at revising the co-operative laws in the country and it has been suggested that the regulatory framework for mutuals could be incorporated into this revision.

5. Conclusions and recommendations

a. Conclusions

1. Despite a couple of functioning community-based MHOs in the last few years, and much activity behind the scenes aimed at introducing more of these, there is a general lack of public awareness of what these institutions are and what role they could play in their health. MHO development is further limited by the relative absence (and consequent popular lack of understanding) of the modern concept of insurance within traditional socio-economic practice and institutions. Equally important is the very limited character of traditional solidarity (i.e. mutual support systems where the strong have an obligation to help the weak without expecting direct or personal reward in kind) which tends to be found within tight knit clan or ethnic organisations but not much beyond those boundaries.⁴⁷
2. The above observations or findings are not unique to Ghana, it should be noted, but apply equally well to many other African countries known to this author. But in this case, they serve to highlight the lack of any sustained public education on health insurance issues, as well as the relative lack of important pressure groups behind the current initiatives (including the national health insurance scheme). Even doctors, especially those in private practice, who might be expected to benefit greatly from such insurance, are not exhibiting any great enthusiasm for it. This may be partly because of their experience with the existing private for profit health insurance scheme, nationwide Mutual Medical Insurance, discussed earlier. Additionally, donor agencies in the country (with the notable exception of DANIDA and the EU) have not prioritised promotion of such activities in their programmes, and other support institutions (e.g. MHO training centres) are largely absent.
3. Meanwhile the evidence examined in this paper indicates that a clear need exists for alternative sources of health care financing other than user fees. Development of MHOs is however hampered by lack of suitably skilled personnel and in particular lack of knowledge of the specific risks associated with health insurance and appropriate risk management techniques.
4. A general observation flowing from both the Nigerian⁴⁸ and Ghanaian case studies analysed in this research is that while ‘complex’ type of community financing

⁴⁷ These points are important because there is a tendency to assume that ‘solidarity’ exists within African societies and could be a natural basis for designing and implementing mutual insurance programmes. This assumption, though not wrong, is clearly at variance with the often heard complaint from African MHO leaders about individuals who will join the scheme and withdraw (or sometimes demand a refund) when they haven’t personally benefited from the services.

⁴⁸ See the separate study, Non-profit Mutual Health Organisations (MHOs) in West and Central Africa : Nigerian Case Studies.

schemes (as well as social movement types) tend to have strong focus on improving community health, the 'simple' community financing types appear primarily focused on cost recovery or financial objectives, giving the impression that health improvement is only incidental to their aims. This latter is an unfortunate impression which does not help with the legitimization and acceptability of a health insurance project within the community, and it will benefit those projects if their managers pay particular attention to the public image of their schemes (especially if those impressions are unintended ones).

5. The West Gonja MHO examined here appears to be based on good lessons learnt from the Nkoranza one. But some problems that came up during the investigation show that there are inherent shortcomings with non-participatory MHOs particularly when the notion of sharing risks and resources across social and other divisions is not properly understood or accepted within the local traditions and culture. These include evidence of significant adverse selection and moral hazard.
6. In this connection, the 'complex' model of community financing seems better placed to respond to these kinds of problems principally due to the significant level of community participation in their management. These latter schemes are also more likely to make a significant efficiency contribution by focusing available resources on PHC services and the health care priorities of the community concerned. The Nigerian CPHs analysed, and the features of the proposed DHIS system in Ghana, tend to reinforce these points.
7. The health financing aspect of professional organisations such as the teachers association is not well developed, mainly because the members of such organisations typically benefit from subsidised or free health care conditions from the government. However, as the state's commitment to such subsidised or free care is diminishing all the time, the teacher's organisation for instance is finding its welfare funds coming under pressure to support some health care needs of members. For the moment, such support is usually given for cases where the government's free care will not be available (for care above the government's annual limits for teachers, traditional healer's expenses or for quality care for acute conditions at private institutions not covered by the government's scheme). There is considerable potential for these kinds of funds to play a crucial role in health care financing if the present direction of government health care policy for the public sector continues (but it is possible and likely that the proposed national health insurance scheme will make their role redundant).
8. Health care financing support from the small traditional mutual solidarity organisation examined here appears not to be significant. The very small scale of their operation might seem at first sight to reduce their impact on community health as a whole, as well as the scale of their financial contribution to health sector resources. However, because these societies are numerous and many people find it beneficial or socially necessary to belong to their town or ethnic development association, it is possible that the sum total of their contributions may be quite large. But poor record keeping and lack of openness prevent the true significance of such sources of support from being studied.

9. In developing or promoting mutual health insurance organisations in the country, it is important also to take due account of Government plans for introducing a national health insurance scheme by stages. Non-profit mutual insurance schemes may find they have a comparative advantage in providing for the informal sector (including the large rural population) where Government will have great difficulty devising sufficiently efficient and effective ways of collecting premiums and avoiding abuse.

b. Some recommendations from the Study

Areas of intervention which have been highlighted by this study and which will add some value to the experiences of the MHOs in Ghana include:

1. Co-ordination between donors and other interested parties in order to map out the areas of unmet needs and to match available resources to the areas of greatest priority.
2. Training programmes in the principles of non-profit mutual health insurance for the personnel of existing mutuals as well as those considering setting up such schemes will be an important contribution.
3. Concentration on the health activities and sectors of the population which will not be covered (at least initially) by the proposed phased introduction of national health insurance scheme (which means mostly the informal sector including rural communities) will be the right direction in which to develop MHO interventions
4. Technical assistance to existing MHOs to equip them better to manage their schemes (e.g. with the skills to carry out monitoring and evaluation of their work) is another clear area of need.
5. In the area of technical assistance and mutual promotion, it may be useful to bear in mind one of the principal findings of the case studies from Nigeria, namely that the 'complex' or high participation model of community financing appears better attuned to the health care needs of the communities and country health sector goals than either the 'simple' (low participation) type or traditional social network scheme. Social movement based schemes such as the Teachers' Welfare Funds also have great potential.
6. The weaknesses of the low participation model (eg West Gonja and Nkoranza schemes) highlighted in the Ghana study implies that they could benefit from targeted technical assistance. The areas where such support might be useful would be: lack of independence from the provider, lack of negotiating power, marketing, need for quality control mechanisms, drugs' policy, and lack of preventive/promotional services. There was a specific demand from some administrators of the Nkoranza scheme for mutual insurance related training.
7. In Ghana, there is need for legislation to enable mutuals to acquire a legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration. There may be some model rules and regulations (drawn up in consultation with existing mutuals) which new organisations can adopt or adapt to their own needs.

8. Although the government is actively pursuing policies to implement a national health insurance programme for the formal sector, it has also been observed that no or very little consultation with all possible stakeholders has taken place. On the other hand, plans to carry out public education in Ghana on the scheme only propose to explain to the general public through leaflets and media campaigns what it all means to them, so as to win public support for the scheme. The need to include stakeholders in consultation exercises prior to designing such schemes is little appreciated and should be an area where technical support and co-operation agencies can offer assistance and advice. Also, the marketing of such a scheme must go beyond merely explaining to the public what has been decided, but should include consultation and studies to determine user preferences and the way these are likely to evolve in the future.

APPENDIX**New Registrations and Renewals Oct 95 - Sep 97**

Month and Year	New registrations	Renewals	Total number of members
Oct-95	1,318	0	1,318
Nov-95	380	0	380
Dec-95	149	0	149
Jan-96	106	0	106
Feb-96	161	0	161
Mar-96	163	0	163
Apr-96	133	0	133
May-96	440	0	440
Jun-96	368	0	368
Jul-96	374	0	374
Aug-96	755	0	755
Sep-96	543	0	543
Oct-96	670	0	670
Nov-96	428	0	428
Dec-96	181	0	181
Jan-97	724		1,500
Feb-97	446		786
Mar-97	617		864
Apr-97	334	99	433
May-97	504		623
Jun-97	392		606
Jul-97	984		1,285
Aug-97	481	73	554
Sep-97	1,679		2,069

Source: Information obtained from West Gonja Hospital Insurance Scheme in November 1997