

# Identifying the Strengths and Weaknesses of the Administrative and Organizational Structures of the National Health Insurance Scheme, Using Pru and Bawku West Districts

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**Abstract:**-The ability of each country's health insurance to be able to mobilise sufficient funds to finance health care, to allocate these funds and organise health care delivery to produce the much needed health benefits from majority of the people and how to control the cost of health care services depend by and large on identifying the strengths and weaknesses of the administrative and organizational structure of the National Health Insurance Scheme (NHIS). That is the focus of this paper, to explore the strengths and weaknesses of Ghana's Health Insurance Scheme and to advice the way forward. Multi-stage sampling was used, the study areas are first divided into identified communities, where the sample of communities were selected from these clusters, from which sampled households were drawn from each identified community through a sample frame. The survey method of data collection was used, with the questionnaire as the principal instrument designed to collect relevant information from 200 respondents. The primary data was collected through interviews from both closed-ended and open-ended questions, and discussions with key informants such as the scheme managers, as well as management of provider facilities from a special questionnaire that was designed for them. The following strengths were identified in the Insurance Scheme, incentives regime through exemptions for the very young and the aged subsidized through government taxes, allowing for continuous payment of premium by instalments and registration phases across the years, identification of vertical linkages to the Regional and National Health Insurance and horizontal linkages with service providers. On the weaknesses threatening the scheme, the staff situation show the need for more skilled training, poor community participation and poor flow of information also threaten the scheme.

**Key Words:** Strengths, weaknesses, administrative, organisational

## I. INTRODUCTION

Health Insurance is primarily viewed as a means of offsetting catastrophic financial losses associated with severe illness or injury through risk pooling among many people (Joseph Kutzin, 1996). It is a kind of prepayment scheme, where subscribers are made to pool their financial resources together into a common fund, to cater for their unpredictable expenses of health care services.

Health Insurance is said to be an efficient and effective method of health care financing that provides easy access and equity to health care service to people especially the poor and the vulnerable. Since health is a critical and basic human need which affects other livelihood assets, it is important to find measures that will ensure the continuous survival of any mechanism that provides for access to affordable health care. The ability of health insurance as a policy intervention to provide for easy access, equitable, efficient and sustainable health care, will depend on the establishment of appropriate institutional and management structures (the focus of this paper), appropriate premium to cover the cost of benefits based on a risk sharing principle, and adequate coverage to facilitate risk pooling for an equitable and sustainable financing (Martins and Dunlop 2001). Successful implementation would also depend on the nature of the design, level of solidarity, management capacity, and establishing sustainable risk sharing mechanisms that can benefit the informal sector (WHO, 1997).

Health insurance is viewed by its proponents as a policy that is capable of providing universal and equal access to reasonable Health Care Services, keeping health care expenditures at affordable and manageable levels (both micro and macro levels) and to make effective use of available resources with the ultimate aim of achieving poverty reduction. However, the achievements of these objectives and goal depend largely on the sustainability of the Health Insurance Scheme as an effective and efficient development tool. One of the key factors identified by the proponents for the successful use of Health Insurance as a development tool includes the following; the appropriate institutional and Management Structure.

The National Health Insurance Scheme and for that matter the District Mutual Health Insurance Scheme (DMHIS) has very laudable objectives that are aimed at improving the livelihood of most Ghanaians, by making Health care services accessible to all at reasonably low cost. But as to whether this insurance policy especially those in the predominantly rural

communities would stand the test of time as a development strategy to achieve the objective of poverty reduction depends on the implementation strategies and efficiency, given the socio-economic nature of the Ghanaian society.

All developing countries face three major policy issues in health care financing; how to mobilize sufficient funds to finance health care, how to allocate these funds and organize health care delivery to produce much health benefits for the majority of people, and how to control the cost of health care services (William C Hsiao, 2001). These factors depend by and large on identifying the strengths and weaknesses of the administrative and organizational structure of the National Health Insurance Scheme (NHIS).

## II. A BRIEF REVIEW OF LITERATURE

Health care financing involves three basic functions of collecting revenue, pooling resources, and purchasing goods and services (WHO 2000). Policies concerning these functions provide an opportunity to make reforms effective throughout the health sector. *Revenue collection* is the way by which health systems raise money from households, business, and other external sources in order to finance health care. Pooling deals with the accumulation and management of revenues so that members of the pool share collective health risk, and hence, protecting individual members of the pool from unpredictable health expenditures. *Purchasing* refers to the mechanisms used to secure services from public and private providers.

The efficiency and equity elements are critical aspect of any healthcare financing systems. Thus, equity with respect to financial resources, level of payment and pooling, services provision, provider payment and physical access to care. Efficiency concerns - revenue collection, allocation of resources, and technical services production.

Healthcare financing are put broadly into three basic models or methods, they include;

- *National Health Service*, which gives compulsory universal coverage and derives its resources from general government revenue. It has national ownership of health sector inputs.
- *Social insurance*; this also has compulsory universal coverage for only employment targeted coverage under social security in the public sector, and it is financed through employer and employees contributions into a non-profit insurance fund. It has a joint ownership of the public and private sectors.
- *Private insurance* is one model with a profit motive and covers individuals of both the public and private sectors. It is not compulsory and privately owned (Preker and Haring, 2000).

Most developing countries are severely challenged to provide quality and accessible health care to their populations and also to provide financial protection to the majority poor. The challenge is twofold; the task of mobilizing sufficient funds

for operating the healthcare system, and to apply those funds efficiently. Mobilizing funds to finance healthcare interventions is difficult both because health care is costly and because raising revenues in developing countries is not easy (Gottret & Shieber, 2006).

The *National Health Service* is the health financing model that was adopted by most developing countries after independence. However worsening economic conditions in the 1980s and the introduction of Structural Adjustment Programs (SAP) led to the implementation of cost recovery policies in most sectors of the economies of these countries, including the health sector. This brought about the introduction of user fees where out-of-pocket payments are made at the point of service delivery, popularly referred to as “cash and carry” in Ghana. This state of affairs resulted in the deterioration of the health status of most people in these countries, especially the rural poor and the vulnerable most of who died out of curable diseases, because they could not afford to pay for their health care services at the point of delivery (WHO, report 1997).

In recent years, great progress has been made in the effort to securing better access and financial protection against cost of illness through collective financing of health care. Thus, the introduction of health insurance schemes in most developing countries. Experience has shown that, without clear spending policies and effective payment mechanisms, the poor and other disadvantaged people are often left out (Gottret & Shieber, 2006).

### *Theory of Insurance*

Health insurance builds on the ‘law of large numbers’, which states that the average behavior of a group of individuals is more predictable than that of a single individual (Black 1997). In other words, the tendency to behave more systematically and predictably increases with the size of the group. This is the rationale for pooling individual risks, the key function of an insurance fund.

*The four values in health insurance – equity, solidarity, risk pooling, and community empowerment. Community empowerment will take place when the community pays the premium and requests for better quality services. Risk pooling is enhanced when there is risk sharing between not just the healthy and the sick, but also between the rich and the poor. Equity is strengthened when people pay according to their ability and get benefits according to their need. And this is possible only when people are bonded in solidarity. As it is difficult to promote solidarity solely through a health insurance mechanism, it is important that health insurance programmes be piggy backed on existing institutions that have inherent solidarity (Baeza 2001).*

### *The Concept of Health Insurance*

Prepayment and Risk pooling are important for providing financial protection for the poor. Pooling health risks enables the establishment of insurance and improves people’s welfare

by allowing individuals to pay a predetermined amount to protect themselves against large unpredictable medical expenses.

Allison Beatti & Co (2000) in a seminar paper series concluded from their studies that, for a successful implementation of a prepayment scheme (Health insurance Scheme) the following should be taken into consideration during implementation; that there should be: an appropriate institutional Context level and management structure, which should support a level of community participation in the design, implementation and evaluation, which will depend on: the level of the premium in relation to peoples incomes; the imposition of user fees at health centers and referral facilities; the time of payment; the mode of payment the unit of payment (household or individual); the general economic environment; the distance from people's home to Health facilities and associated transportation costs; the quality of services with respect to, supply of drugs, staffing level and qualification, and nature of infrastructure; and the population's awareness and acceptance of the schemes benefits.

They continued to point at the following features as essential for the successful implementation and sustainability of a health insurance scheme;

- a. Integration of the scheme in the health care system, where participation in the scheme as a subscriber assures free services not only at the first point of contact in the health care delivery system, but at other levels based on referral.
- b. Sound financial management based on a decentralized system; the existence of adequate managerial skills, the investment of unused revenue or premium income to preserve the funds value in the face of inflation, and a level of control to reduce fraud and other risks.
- c. The social environment which describes the extent of social solidarity among households and communities where the norm or tradition of the community is that of one being the others keeper. This ensures, and promotes the principle of risk-sharing which is necessary for the success of any scheme.
- d. The economic environment should be stimulating such that, there should be stability in the macro economic variables such as interest rates, inflation etc.

In a World Bank sponsored work entitled "Health financing Revisited"... the following were cited as conditions for implementing social health insurance in developing countries: level of income, size of the informal sector, distribution of the population; labour cost; administrative capacity, quality health care infrastructure, consensus, and political stability.

### III. METHODOLOGY

Multi-stage sampling was used, the study areas are first divided into identified communities, where the sample of

communities were selected from these clusters, from which sampled households were drawn from each identified community through a sample frame-(n/ N) from which a Hundred (100) households was randomly chosen from each of the Two study areas (Pru and Bawku- West) thus, a total of two Hundred (200) households were selected as respondents. This was done to ensure that a sizable and manageable, but representative sample was obtained. More so, purposeful sampling was also used to enable sourcing information from key informants like the scheme management and health care providers.

Table 1 Sample frame PRU DISTRICT

Community (cluster)	Total Number of households	Sample size (N/100*n)
Yeji	3343	66
Sawaba	453	10
Abease	141	3
Prang	1092	21
<b>TOTAL</b>	<b>5029</b>	<b>100</b>

Source: (population census, 2010)

Table 2. Sample Frame- BAWKU- WEST

Community (cluster)	Total Number of households	Sample size (N/100*n)
Zebilla	1354	60
Kusanaba	131	6
Gbantongo	42	3
Binaba	323	15
Sapelliga	131	6
Tilli-Natinga	163	7
Zongoyire	74	3
<b>TOTAL</b>	<b>2218</b>	<b>100</b>

Source: (Population census, 2010)

The survey method of data collection was used, with the questionnaire as the principal instrument designed to collect relevant information from 200 respondents with respect to the characteristic features of the schemes and their implementation strategies and obstacles.

The primary data was collected through interviews from both closed-ended and open-ended questions, and discussions with key informants such as the scheme managers, as well as management of provider facilities from a special questionnaire that was designed for them. Household heads were the sample unit that was also interviewed to ascertain information on basic features of the schemes, the strategies adopted in the implementation of the schemes and their general perception about the schemes. Literate household heads were allowed to respond to the questionnaires personally, while non literates were guided. However, managers of the schemes and management of service providers were interviewed personally

to ascertain some detailed information and their personal perception about the scheme.

The houses were chosen randomly using the enumeration maps provided by the Statistical Department for the 2000 population census. The assemblyman for the various communities helped to locate the houses sampled. Secondary data was also gathered from documentary sources such as annual and quarterly reports of the schemes, government publications, seminar papers and magazines.

Table 3 Variables and Indicators

Variables	Indicators	Techniques
Technical design	<ul style="list-style-type: none"> <li>Revenue collection mechanism.</li> <li>Arrangement for pooling revenue and risk sharing.</li> <li>Purchasing and resource allocation.</li> </ul>	Interviews And records of the schemes
Management	<ul style="list-style-type: none"> <li>Staff</li> <li>Access to information.</li> <li>Culture</li> </ul>	Interviews and records of the schemes
Organization	<ul style="list-style-type: none"> <li>organizational reforms</li> <li>incentive regime</li> </ul>	Records & Interviews
Institutional	<ul style="list-style-type: none"> <li>Governance</li> <li>Insurance markets.</li> <li>Stewardship.</li> </ul>	Records & interviews

Source; Preker and others 2002

Data was collected on design characteristics such as:

- The technical design, where the revenue collection mechanisms, risk pooling and sharing arrangements, as well as purchasing and resource allocation.
- Under management characteristics –quality of staff, culture of community involvement, and access to information were examined.
- With organizational characteristics-organizational forms, incentive regimes, and linkages between schemes, public and private providers
- On institutional characteristics, -stewardship, and governance of the scheme were looked at.

The data was analyzed using cross tabulations, tables, and charts to present the information on analysis.

#### IV. DISCUSSIONS OF FINDINGS

##### Management Characteristics

The analysis of Management characteristics is focused on staffing situation, the culture or management style adopted, and the flow and access to information.

##### Staffing situation of schemes

The staffing situation of the two schemes studied shows that, the schemes need more skilled personnel to contain the quantum of work at their disposal. The table below describes the situation.

Table 4. Staffing Situation of Schemes

	Permanent staff	Professionals	On the job training	Voluntary workers
Pru MHIS	6 (core staff)	3	3	66 (field agents)
Bawku-West MHIS	6 (core staff)	3	3	70(field agents)

Source; Authors' field survey, May 2008

From table 4, the six (6) core staff represents the manager, the public relations officer, the claims manager, the accountant, and two data entry officers. The officers who are professionals include the accountant and the data entry officers. The other three (3) officers including the managers of the two schemes are being trained on the job through workshops and seminars organized periodically by the National Health Insurance Authority. It was revealed from the survey that, there is no defined condition of service or service scheme for the workers with the National Health Insurance Scheme. This serves as a disincentive to most of the workers, for the fear of the uncertainty about their future career with the scheme.

In the case of the field agents who are the voluntary workers, they constitute teachers, Assemblymen, and school drop-outs in the various communities. They are trained to engage in social mobilization and registration of people within their communities. Apart from the six (6) core staffs who receive monthly allowances, the field agents only take a commission of whatever revenue they are able to mobilize from their communities as premium.

his situation lends itself to poor data collection and embezzlement of scheme funds on the part of the community agents as revealed by the managers, since the agents who are engaged in data and premiums collection are not motivated enough by the meagre commissions they collect from the small number of subscribers. More so, they also have to walk long distances around to collect the premiums.

Records keeping of the schemes are reported to have been very poor with the inception of the schemes, since almost all information were manually produced and stored. This was evident when the Bawku-West Health Insurance Schemes found it difficult to retrieve information on renewals. However, all the schemes studied have the necessary equipment to generate, analyze, store and retrieve information to ensure the smooth running of the schemes. Despite this inadequate staffing and capacity profile of the schemes, management of Pru and Bawku- West Mutual Health Insurance Schemes are keeping their respective schemes operating by increasing enrolments, paying claims and educating the people on the health insurance scheme.

##### Culture of management

Community participation in the management of the schemes was measured in terms of the level of subscription, representation, and consultations on major decisions that could affect the registration status of subscribers. Table 5

below shows the level of community participation in the management and decision making process of the schemes,

Table 5: Level of Community Participation

Forms of participation	Frequency		Percentage	
	Pru	Bawku-west	Pru	Bawku west
Participation by representation	66/67	60/63	98.5	95.2
Participation by consultation	10/67	14/63	14.9	22.22
Participation by subscription	44/602	52/706	46.4	46.3

Source: Authors' field survey, May 2008

From table 5, it is evident that, the level of community participation in the management of the Health Insurance Schemes is moderate averaging 54percent. While representation constituted 97.4percent averagely, implying that one agent represented 753 registered people, consultation averaged 18.6percent and participation by subscription averaged 46.3percent. The Agents constitute community health insurance committees that form a General Assembly as the highest decision making body of the Mutual Health Insurance Scheme, and also responsible for the election of Board Members of the schemes. It was however revealed by responses from management that, the directives from the National Health Insurance Authority turn to marginalize the functions of the Management Boards of the schemes, thereby, rendering community participation in the management of the schemes ineffective.

*Access to information*

The existence of a good information system ensures effective feedback on all policies and strategies being implemented for efficient management. In other words, the information flow of

management should be a two way mechanism, that accesses information easily to the people and back to management. In the case of Pru and Bawku-West Mutual Health Insurance Schemes, they do not have any established mechanism to ensure information accessibility to their clients. A sampled population 86.5percent indicated that, no meetings are organized to keep them abreast with the operation of the schemes, and also to get their views about what happens to them, when they visited the clinics and hospitals. The two schemes rely on their field agents to organize meetings and to educate the people in their communities about the operations of their respective schemes, after initial education and promotion drives to increase enrolment.

The interview conducted showed that out of 200 respondents 173 people acknowledged that, neither the scheme management nor their agents organized any meeting with them to educate them on issues concerning health insurance. They however noted that, they visited them to only collect their premiums. Table 5 shows the common sources from which people get information about the health insurance scheme.

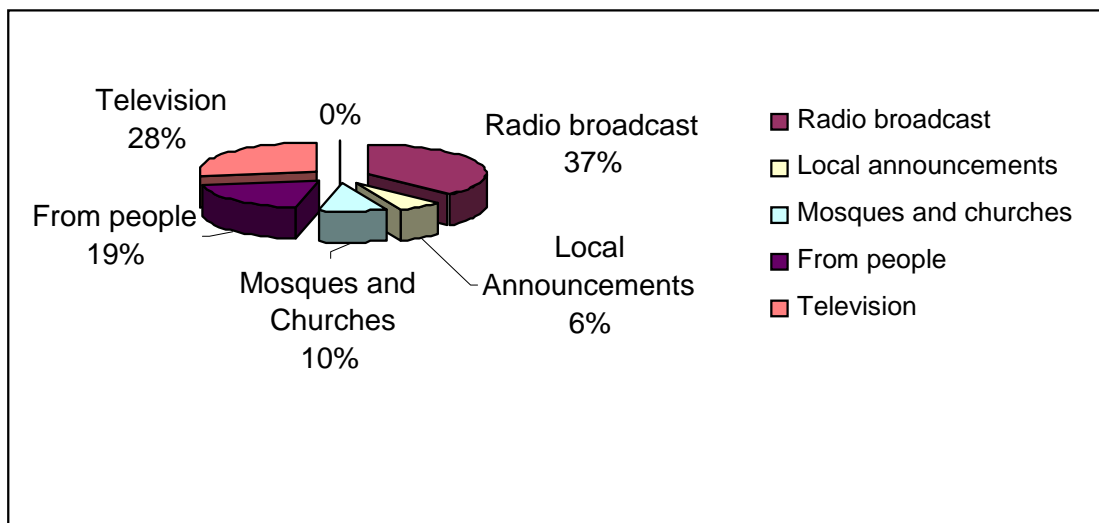
Table 6: Sources of Information about the Health Insurance Scheme

Source	Frequency	Percentage
Radio broadcast	80	40
Local announcements	12	6
Mosques and churches	20	10
From people	40	20
Television	58	29
Total	200	100

Source: Authors' field survey, May 2008

This is illustrated pictorially on figure 1

Figure 1: Sources of Information about Health Insurance Scheme



Source: Authors' own construct from field survey, May 2008

*Organizational Characteristics/ Structure*

Analysis of organizational characteristics measures the level of coverage with respect to the involvement of structures necessary for the smooth implementation of the health insurance policy. Basically, organizational forms, Incentive regimes and linkages are put in place to promote sustainable implementation of the various Mutual Health Insurance Schemes.

*Organizational forms*

The organizational forms identified in the study of the Pru and Bawku-West mutual health insurance schemes include;

*Public-private partnership* is one of the organizational features of the two schemes studied. The Pru and Bawku-West Mutual Health Insurance Schemes like others in other districts of the country are established by Government policy that spells out a comprehensive regulatory frame work within which all health insurance schemes should conduct their activities. However, the schemes are held in trust by the National Health Insurance Authority but managed by the people of each District. Even though the policy endorses private opt- outs, no private scheme is yet established in Pru and Bawku-West Districts. Hence, the Mutual Health Insurance Schemes in the two districts enjoy monopoly in the Health Insurance market. The schemes are using the existing public health delivery system (Hospitals, Health centers, and Clinics) including some private health centers and clinics to which, they have signed contracts with, to provide selected health care services to their subscribers for reimbursements.

Both schemes had organization by employment, where they are able to combined formal and informal sectors under one scheme with different contribution mechanisms. The formal sector workers have their premiums deducted at source, while the informal sector workers pay their contributions directly to their resident schemes. More so, the rural and urban communities are all accepted under the same scheme. The schemes also had inpatient and out patients' organization in their benefit package, which cover all categories of subscribers. This organization gives members of the various schemes access to be treated on 80percentof diseases covered by the scheme.

*Incentive regimes*

The incentive regimes identified among the schemes include categories of people exempted from paying premium and are subsidized for by government through tax. These categories of people include, children under eighteen (18) years of age, the aged over seventy (70) years, and the core poor (indigents).

Continuous payment of premium by instalments and registration in three phases across the year is another incentive instituted by the Mutual Health Insurance Schemes as an arrangement for their members to serve as an inducement for sustaining membership through renewals and as an incentive to prospective subscribers.

*Linkages*

The schemes studied indicate both vertical and horizontal linkages. Vertically, the schemes are linked to the Regional and National Health Insurance Authorities; as bodies they depend on for regulation of their operations and for reinsurance. Horizontally, they are linked to other mutual health insurance schemes, with which they have a mutual relationship that enables them to take care of each other's clients for reimbursement.

Similarly, they also have a horizontal linkage with service providers, with whom they have a contractual relationship. However, the survey revealed that, there are usually delays in the release of reinsurance funds from the National Health Insurance Authority, and also reimbursements of claims from providers. This implies that, the linkages are not working effectively and efficiently, due to administrative lapses and has developed into the lack of confidence among the institutions involved.

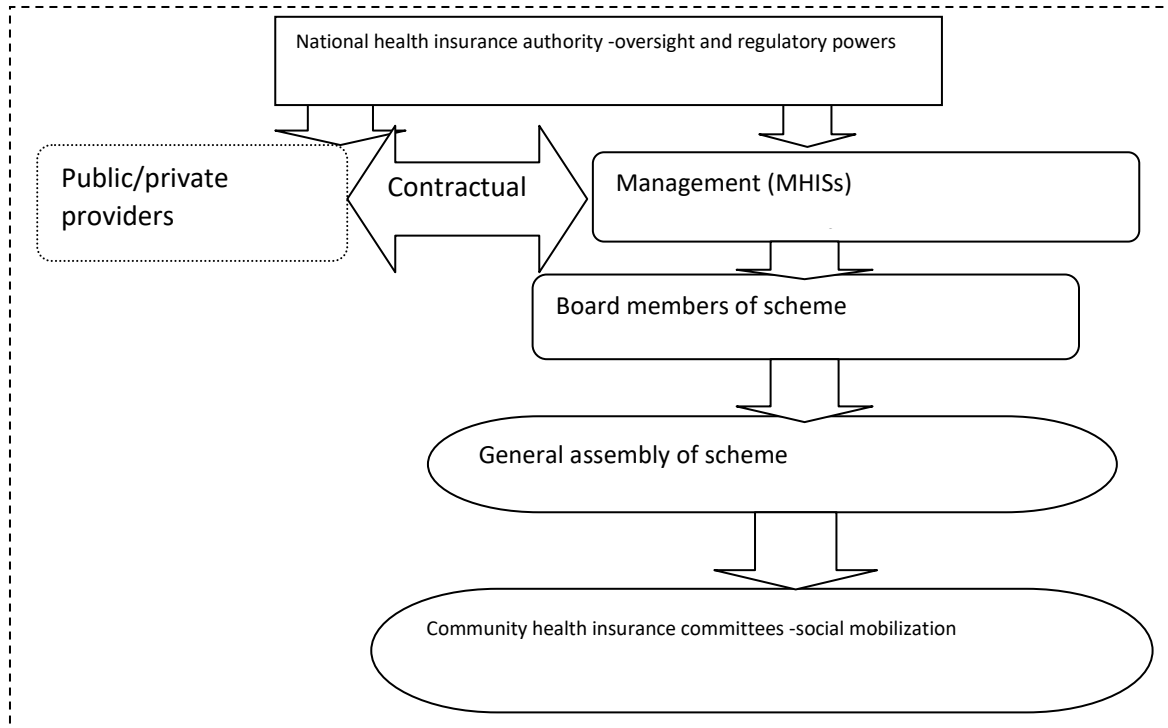
*Institutional Characteristics*

Institutional features here refer to the stewardship function, governance and ownership arrangements, and the insurance market.

Stewardship is in the hands of the government and exercised through the National Health Insurance Authority, which the statutory regulatory body to supervise, monitor and evaluate all activities involved in the implementations of the Mutual Health Insurance Schemes, as well as all health care facilities under its accreditation. The District Health Insurance Boards and Management are also given powers to take decisions on policy, to ensure the smooth running of the schemes at the district level. Managers of the two schemes studied have explained that, they are not given the allowance to be flexible in their operations to regulate some activities of providers. This could lead to a weak oversight function and the creation of a poor regulatory environment, for the promotion of fraud and abuse on the part of providers and hence threaten the sustainability of the schemes.

Ownership and governance arrangements of the Pru and Bawku-West Health Insurance Schemes take the same structure as follows;

Figure 2: Institutional Relationship between Stakeholders and Control



Source; Authors' own construct from survey. May 2008

Information gathered from the field in the Pru and Bawku-west Districts indicates that, the communities have less control and only feel to have a marginalized stake in the mutual health insurance schemes as subscribers, since they were never consulted on any decisions taken or given a forum to take their complains. When asked as to, who owns the scheme, (106) out of (130) registered members interviewed thus, 81.5percent indicated the government as the owner. This is substantiated by management's indication that, the national health insurance authority that represents government regulates almost all activities of the schemes. The District management of the scheme in collaboration with the Board, General Assembly and the Committees for now is concentrating on the implementation of policies and directives from the National authority.

*Purchasing and resource allocation*

The schemes focused basically on the purchase of curative health care for its members. The survey reveals that, the health insurance schemes allocate resources as claims for the payments of only curative health care services that fall within the defined benefit package of the National Health Insurance Authority, for their members. For instance, the Pru mutual health insurance scheme spent GH c 171,434, 436.8 in 2006, and GH¢ 436,665.86 in 2007, as claims for curative medicine provided for its clients by the various facilities. The management of the health insurance schemes and the District Health Management Team indicated that, the schemes have never supported preventive health care services.

Information gathered from the scheme managers and the providers point to the fact that, the schemes signed contractual agreements with both public and private providers, where the mutual health insurance schemes negotiated for prices of drugs and other services, as well as payment mechanisms, which are subject to annual review. The accepted payment mechanism as of now is a monthly reimbursement of providers on claims vetted by a vetting committee of the scheme. Scheme managers however indicated that, the National Health Insurance Authority made some of the negotiations on its behalf and thus, makes it difficult for them to negotiate effectively for special incentives for their clients, from providers.

*Claims management*

Claims management involves procedures that seek to ensure that, claims or bills of insured members at the various accredited facilities (clinics and hospitals) are accurate and not over stated. The claims management procedure identified in the two schemes (Pru and Bawku-West Mutual Health Insurance Schemes) are similar and take the following steps,

Table 7. Claims Management Procedure

Procedure	Data identification requirements
1. Subscriber report at provider's Facility	- provider name - Contact details, facility type, level of care, bank details.
2. Ascertaining subscribers eligibility status	- Members present ID card at facility for services. - Provider verifies member's insurance status.

3. Diagnosis and treatment (services)	- diagnosis information - Service information, cost of service and level of care offered. - Drug information and cost of drugs.
4. Provider submits claims to scheme for payment	- Claims forms provided by District Insurance Scheme should be filled in accordance with agreement between the National Health Insurance authority and the Ghana Health Service. - Drugs and services should be priced based on agreed fee schedules with the National Health Insurance Authority.
5 Claims are sorted and vetted (adjudicated)	- claims are sorted - claims are vetted by a committee - claims are accepted for payment or queried

Source: Authors' own construct, May 2019

Even though the procedure above looks quite comprehensive, management complain of lack of skilled personnel to undertake an adequate vetting of the claims, since most of the services provided by the providers demand technical knowledge. It is also revealed that providers transfer cost of drugs they have not given to clients, to schemes for payments, thereby increasing claims for schemes to pay. This situation arises due to lack of adequate supervision of providers and data collection from members for analysis, in order to make informed decisions; this makes the system susceptible to provider fraud.

On the other hand, providers in Pru and Bawku-West complained about the delays in the reimbursement of claims, which most at times impede the efforts of the providers from purchasing inputs including drugs.

*Challenges of The Scheme*

*Inadequate revenue mobilization*

Inadequate funds to pay for high cost of services provided to clients by health service providers, resulting from low revenue mobilization from premiums. Unstable and low levels of income (revenue) generation by the schemes, the high rate of poverty, affects the ability of the people to pay their premium and registration fees. This keeps the dropout rate increasing.

*The problem of risk management*

The inability to check multiple attendances of members who sometimes visit the hospital to collect drugs for sick relatives who are not ensured (moral Hazard). More so, there is also the issue of adverse selection, where people enrol only sick members of their families to the scheme. There is also the critical issue of provider fraud manifested in multiple prescriptions, and shifting of bills of drugs that are not issued to members to the scheme, resulting in over billing and higher claims.

It was also found out that, the enrolment drive is still very slow and it is difficult to convince some people even the educated ones to join the scheme due to lack of adequate funds and lack of confidence in the case of the later. Hence the majority of members constitute categories that do not make contributions in terms of premiums.

*The lack of skilled and requisite personnel*

This is for the fact that, the scheme is a new concept and hence only a few people have any skills about its operations and the complications involved, especially on risk and claims management resulting in higher claims, and delay in reimbursement of claims.

*Political interference*

Political interference in the implementation and operations of the schemes, serves as another challenge. While the party in government wants to have their members to control the management of the scheme those in opposition see all moves by the scheme in its operations as political, hence, give some destructive criticisms that turn to sabotage registration drive.

*The inadequate and qualified staff in the various Hospitals and Health centers*

To contain the ever increasing workload, resulting from the rising attendance to the various facilities by insurance cardholders.

*The inadequate infrastructural facilities*

Various Health facilities to contain the increased attendance, most health facilities have no enough space within the hospital to accommodate the increased numbers that attend health facilities for treatment as a result of the introduction of the Health Insurance Scheme.

V. CONCLUSION

According to – Arhin-Tenkorang (2002), financial risk protection is measured from the following indicators; affordability, appropriate payment schedule, and a comprehensive benefit package. Taking these inductors into consideration, the Mutual Health Insurance Schemes have provided modest financial risk protection for their people such that premiums are assessed to be affordable to 67percent of the population of the schemes studied, with about 47.5percentof the target population enrolled with the scheme. More so, payment schedule for premiums is considered suitable and appropriate, since payment is allowed by instalment, and registration is done in three phases within a year to allow people to enrol when they are ready within the year. The benefit package is also comprehensive and gives members the opportunity to have access to both out patients' attendance (OPD) and inpatients (admissions) services as and when it is necessary. Thus, it has increases access to health care services to an average of approximately 42.3percent as assessed from out patients' attendance in the Pru and Bawku-WestHospitals.

According to Preker and Carrin's(2003) typology of financial risk protection rating, the Health insurance scheme is at the stage of established insurance pools after it has moved away form out-of-packed payment and Community Health Insurance pools with a National Health Insurance Fund for re-insurance and a framework for the pool management. Thus



according to this rating typology, the National Health Insurance is mid-way through to the achievement of universal coverage.

From the study above, it is important to note that, the National Health Insurance Scheme Policy has so far had a somewhat jerky take off, taking into consideration problems identified by this study which could jeopardize if not collapse an otherwise beautiful scheme. However lessons from experience of other schemes, for a good technical design that includes; formal and informal sectors, public and private participation, coupled with the establishment of subsidy that is supported by a fund from taxation could sustain this scheme.

Additionally, sustainability indicators such as; higher enrolment of premium contributors, effective supervision and monitoring of provider activities, and an effective risk management framework should be enforced to ensure the

growth of the scheme, since it is generally accepted by all people as a good policy.

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