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Journal of Quality in Health Care & Economics
ISSN: 2642-6250

Healthcare Consumers and Providers' Perspectives on Implementation of Ghana's National Health Insurance Scheme

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Research Article

Volume 7 Issue 6

Received Date: November 21, 2024

Published Date: December 23, 2024

DOI: 10.23880/jqhe-16000427

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Abstract

Background: Health care consumers and providers' behaviors can negatively affect the delivery and demand of health care, and adversely affect a well-functioning social health insurance scheme.

Purpose: The study aimed to assess the effects of health care consumers' and providers' perspectives and behaviours on the implementation of Ghana's National Health Insurance Scheme (NHIS).

Material and Methods: The study used a cross-sectional exploratory qualitative approach guided by Grounded Theory for data collection and analysis. Twelve focus group discussions with insured and uninsured in urban and rural communities, 23 in-depth interviews with private and public providers' staff, managers, directors of NHIS, and a desk review of relevant grey literature were conducted, and analyzed using thematic content analysis, triangulation, and synthesis.

Results: Providers and health care consumers, wholly embraced the NHIS and capitation payment system as a good and efficient system. It could improve health care access, delivery, and outcomes, and quality of care, especially for the poor and vulnerable. However, negative behaviors of consumers such as impersonation, provider shopping, and negative provider behaviors, including poor attitudes, undercover charges, unapproved co-payments, moonlighting, unnecessary and delayed hospitalization of patients, and poor quality of care, were found to affect the effective and efficient implementation of the NHIS. Perception of being healthy, poverty, lack of solidarity, and poor quality of health care services were the main reasons for enrollment hesitancies.

Keywords: Providers; Consumers; Health Insurance; Ghana; Universal Health Coverage; Quality Care

Introduction

Health care consumers and providers' behaviors can negatively affect the delivery and demand of health care if unproperly managed and derail the successes of a well-functioning social health insurance scheme [1,2]. The study aimed to qualitatively assess health care consumers and providers' behaviors and perspectives toward the implementation of Ghana's National Health Insurance Scheme (NHIS).

Ghana's Social Health Insurance Scheme was established in 2004, building on the foundations of the Mutual Health Organizations (MHOs) and Community-

Based Health Insurance Scheme (CBHIS) in the mid-1990s through early 2000s [3-5]. Ghana passed the national health insurance (NHIS) bill into a law in 2003, Act 650, 2003 to establish a Pro-Poor National Health Insurance Scheme for all residents of Ghana. The law was subsequently revised in 2012 (Act 852) to establish the single-purchaser National Health Insurance Authority and insurance scheme [6-8]. The NHIS was established with limited financial resources, mixed opinions, disagreements of the design structure and mode of financing the scheme [9]. Most major political parties in Ghana had promised in their manifestos and campaign messages at the time to establsih a national health insurance scheme [9]. The out -of- pocket user-fees health policy dubbed "cash and carry" which mandated all health care consumers to pay for health care out -of-pocket at the point of need, devastated many health care seekers in Ghana [10]. The NHIS law, Act 650, 2003, permitted the establishment of three types of schemes namely, district mutual health insurance schemes, private voluntary mutual health insurance schemes and private commercial health insurance schemes. Act 650, 2003 established the National Health Insurance Council which regulated and supervised all the schemes across the country. The governance of the Schemes was somehow disjointed due to the semi-autonomous nature of the insurance schemes. The quest for a unified, well organized, and proper governance of the NHIS for a better and strategic health purchasing for its members, the national health insurance law, Act 650, 2003 was replaced with Act 852, 2012 [7]. Under the new law (Act 852, 2012) , all mutual health insurance schemes were unified under a single-purchaser national health insurance scheme with 10 regional offices and more than 145 district offices across the length and breadth of the country. Ghana's NHIS has been domestically and internationally acknowledged as one of the promising social health intervention programs and most generous health insurance scheme in Sub-Saharan Africa, in the country's efforts toward achieving universal health coverage [11]. Despite the numerous challenges of the NHIS, membership, in 2021, stood at 16.75 million members, 54% of Ghana's population.[NHIS2021]https://www.nhis.gov.gh/News/nhia-clarifies-issues-raised-by-the-ranking-member-on-the-parliamentary-select-committee-on-health-5391#:~:text=%2D%20Despite%20some%20challenges%2C%20the%20NHIA's,of%20%2D0.900%25%20from%202020. (retrieved December 9, 2024)

But health care consumers and providers' behaviors have the tendencies to derail the successes the scheme gained over the years. Despite the governance and financial sustainability challenges, the NHIS is recording significant gains in enrollment, a better public understanding of its operations, and increasing access and utilization of health care services by its members.

In Ghana, there are over 3000 healthcare providers including public, private and quasi-government accredited (credentialed) to provide the healthcare benefits package to patients (the insured) under the NHIS [12]. These providers include a mixed of teaching hospitals, regional hospitals, private maternity homes, health centers, community health planning and service (CHPS) compounds, Pharmacies, and drug stores (licensed chemical shops), as known, in Ghana. But the distribution of these health providers is wide and varied across the length and breadth of the country [12].

Materials and Methods

The study used multiple qualitative methods including, Key informant Interviews, In-depth one-to-one interviews, Focus Group Discussions (FGDs), Field Visits, and Document Review, to collect data for analysis, relying greatly on Grounded Theory [13,14]. The study rigorously applied this theory to collect data, produce codes, themes (categories) and sub-themes (sub-categories), social interactions with the study subjects, deduce collective patterns, and synthesized for results (theory) [15].

Study Setting and Data Sources

The methods involved two years of field visits and work, FGDs with health insurance members and uninsured members in selected regions of Ghana (Greater Accra, Volta, Ashanti, Brong Ahafo, Northern, Upper East and Upper West); stakeholder engagement; in-depth interviews with providers; in-depth interviews with selected Districts, Regional Health and National Health Insurance officials and desk review of relevant documents on health insurance in Ghana. Data for this study was collected between the period of June 2015 through February 2017. A total of 12 FGDs with insured and uninsured population in selected urban and rural communities, 23 in-depth interviews with selected private and public providers, staff, managers, directors of NHIS, and desk review of relevant grey literature were conducted to gather relevant data for analysis. Data from various sources were coded and analyzed manually, using thematic content analysis. The results were triangulated and synthesized for consistency and validity.

In-Depth Interviews with Providers

Participants for the in-depth interviews were recruited by pre-appointment through telephone calls or emails; whichever was convenient and appropriate for interviews. All participants in the policy interviews were interviewed at their places of work. Twelve providers (12) including selected district directors of health services administrators and Medical Superintendents of hospitals; and selected staff of Community Health Planning and Service (CHPS)

compounds, in the Northern region, Upper East, Upper West, Ashanti, Volta, Eastern, Central and Greater Accra Regions were interviewed. We selected a mix of private and public providers and a combination of different health provider facility levels: military teaching hospital, public teaching hospital, and regional hospitals, district hospitals, health centers and community health planning and service (CHPS) compounds across the country. This mixture of providers and levels was intended to provide a varied view, experience and perceptions of the issues relating to health insurance coverage and health care service provisions across the country. The interviews also obtained information on the provider-client relations, availability and quality of services, levels of claims as well as provider-payer (National Health Insurance Authority) relations, sustainability issues of the NHIS.

In-depth Interview with National, Regional and District Officers of the NHIA

Further information on the policy direction and strategies for effective implementation of the scheme were solicited from the key personnel of the NHIS at the national, regional and district levels in seven out of 10 regions. Appointments were scheduled with the participants and interviews conducted in an appropriate designated venue selected by the participants in their offices in any appropriate location (quite environment devoid of noise and intruders). Interviews were then conducted with the aid of interview guide. Interviews were both digitally audio-recorded with the consent of the participants and hand-written notes were taken to complement the audio-recordings. The study received ethical approval from Brandeis University Institutional Review Board (IRB).

Results

Demographic Characteristics of Participants

The study participants ranged from the ages of 20 to 60 years. We interviewed both male and female participants.

Insured Members' Perception of the NHIS

Since its inception after the passage of the NHIS law, Act 650, 2003, the NHIS has encountered varied views and perceptions about its operations, benefits package, and its sustainability. Others had different opposing views on the governance of the scheme itself, the provider payment systems and whether it is pro-poor and or pro-rich. But there has been a consensus on its relevance as a social intervention program.

We investigated the public perception about the NHIS in general among the focus group discussants. We unveiled varied perceptions and misconceptions about the scheme among the Ghanaian public and health care providers. We also found that, after more than ten years of successful implementation, there are still varied perceptions among the public. It is perceived among the wider public that these days the NHIS is not working to expectations, and when you are even an NHIS member you are not treated well, you are discriminated against and not given the deserved attention, and you are not given proper medication at the health facilities. Both male and female FGDs in both urban and rural settings confirmed these perceptions. One of the major concerns raised was that most often, NHIS members do not obtain prescribed medications in the health facilities; they are often asked to buy at the pharmacy shops outside of the hospitals. The study also revealed that despite the large number of pharmacists accredited by the NHIS, especially, in the urban centers, many do not accept the NHIS because of delays in payment of claims; and therefore, NHIS members must pay out-of-pocket to obtain the needed medications:

"The NHIS doesn't cover all the drugs, and we are not always happy if we have to buy or pay for the drugs at some point. Besides, some health facilities and Pharmacists do not accept NHIS because they say claims are not paid on time."

Uninsured Patients Perspective on NHIS

The study also solicited information from the uninsured in a FGD with the aim of getting balance views on their perspectives on the NHIS in general; the reasons why they and other people in the community are not insured in the NHIS or any other health insurance. The FGD of the uninsured were conducted in both urban and rural settings, and between adult males and females. The analysis showed that participants perceived themselves to be poor in the rural communities and this perceived poverty level was one of the reasons why some people, especially, households with large families, were not registering with the NHIS. The male FGD participants in the rural setting (Salaga district) said they earned between a minimum range of four hundred Ghana Cedis (GHS 400.00) [USD 100] and a maximum of one thousand and two hundred Ghana Cedis (GHS1200.00) [USD 300] per annum. On assets, half of the male participants said they possessed and lived in their own houses; others owed, at least a motorbike, and all of them possessed an active mobile phone. They were all economically active with mixed professions, including traders, tradespersons, but mostly, farming as the major occupation. Each of them was married with a maximum of two wives and a maximum estimated household size of 10 persons. Notwithstanding the fact that they are not registered with any health insurance scheme, they all agreed that having health insurance is better than paying out-of- pocket for health care at the point of need. There was also a consensus among them that the current

health insurance premium and registration fees were affordable, except in the case of large families. Few of them, however, indicated that they are poor and could not pay to enroll and renew their health insurance every year .See the quotes below from the FGD:

Benefits of the National Health Insurance

"I think the National Health Insurance Scheme is very beneficial."

"If you have insurance and visit the hospital you spend less as compared with one without it."

Uninsured FGD participants also noted that it is less expensive having health insurance than buying medications. However, they were influenced by the public perception that the insured are only provided with lower quality medications and services whenever they visit the health facilities for health care; a situation that discourages them from enrolling in the NHIS. Feeling healthy and not often seeking hospital care or enrolling in the scheme but never benefiting from it discouraged them from enrolling in NHIS. Another concern by the uninsured FGD members, especially farmers, complained about the exclusion of anti-snakebite medications as snakebites are pervasive in their communities. Further responses follow:

"*I used to have health insurance, but I hardly fall sick so when it expired, I didn't see the need to renew it."*

"I have never had it because I don't fall sick."

Waiting Times for NHIS Registration

Uninsured FGD participants also expressed their concerns about the long queues and waiting times and other ordeals community members go through to enroll in the NHIS. Other concerns they raised were the three months waiting period (now only one month waiting period) before accessing health care, as some of the debilitating factors that prevent them from enrolling in the NHIS:

"*There is always a long queue at the schemes office making you to wait for a long time. So, if you don't know anyone there to help during the registration, you can spend the whole of your day at the scheme office.*"

Quality of Care and Attitude of Providers

In addition, the uninsured males expressed their concerns about the perceived bad treatment and discrimination against NHIS members by health professionals whenever they seek health care with their NHIS cards. The selected direct quotes from the FGD participants below confirm the perception expressed:

"I heard that people who have NHIS are not treated well by health workers as compared with cash-and-carry patients because the health workers know they will get something from it."

"I also heard that pregnant women receive free medical care during pregnancy but then the health workers still fill the forms to claim the monies from the government."

User Satisfaction

Poor user satisfaction because of perceived discrimination between the insured and the uninsured coupled with the poor attitude of health care professionals in both private and public health facilities constituted the fourth major reason for the disinterest in enrolling in the NHIS. Providers confirmed the poor attitudes of some health care professionals during health care.

"Some of them are not interested because of the perception that the national health insurance is not working, according to many people I heard from, if you are insured and you go to the hospital, they don't take good care of you like one who is not insured."

Concerns with Drug Cost and NHIS

The study revealed that even though the NHIS covers most essential medications, there are strong perceptions and experiences among health care consumers that they are always provided with inferior medications at the health facilities while the quality medications are often sold to them by the providers or, at best, often prescribed to them to buy from the accredited pharmacy shops of the NHIS. It was also discovered that most of the accredited pharmacy shops do not accept the NHIS because of the delays in claims payment by the NHIS, or deliberately want cash or inflating the medication price. The quotes below from the FGDs confirm the above:

"*People say if you have NHIS and you go to the hospital they give you inferior drugs or Paracetamol because of that it will be better to just gather money and go and buy drugs."*

"Not all drugs are covered by the NHIS; therefore, all the uncovered drugs are always prescribed for health insurance patients to go and buy".

One of the most sterling revelations, which also confirm international conventions in health insurance challenges, is that people refuse to enroll because they perceive themselves

to be healthy or strong and may, therefore, not visit a health facility for any health care. Related to this finding were lack of solidarity and understanding of having health insurance.

The results also suggest that many previously insured members of the NHIS did not renew their health insurance because they had never benefited from the scheme because they never fell ill and never visited any health facility within the valid period of their health insurance.

Consumers' Perspective on the NHIS Premium

In general, respondents had a consensus that the current prevailing health insurance premium (150 -240 Ghana cedis) [approximately USD 38 -60] is affordable, but only with a small family size, but not affordable with a large family size. Participants were very definitive that they would still enroll and renew their membership with the NHIS if even the NHIS premium were increased marginally by 30%.

"If even the premiums were increased to 30%. I will renew my membership because it will be better than "cash and carry" because when you go to the hospital without NHIS you spend so much even more than the premium because just a consulting folder cost GHS20.00 (USD 5) without NHIS at the health center. I see the NHIS to be very beneficial and saves cost."

"I will renew my membership if the premium is increased because the health of every individual is very paramount. Sometimes people just pretend not to have money."

Community Solidarity and NHIS

The FGDs sought to find out whether the community exhibited community solidarity among men in the urban community, as this social value can have a telling effect on enrollment into the NHIS even if one is perceived to be healthy and may not need health insurance. The FGDs among men in the urban community pointed out that very little is done in terms of community solidarity to help one another to register to enroll in the NHIS. The FGD results showed that male participants in the urban community did little or nothing to help each other to register for NHIS, but ironically helped others with firewood, foodstuffs, and sometimes money during weddings, funerals, and naming ceremonies. A male participant of the FGD in the urban community lamented:

"In *this community, everybody for himself and God for us all. We do nothing to help one another to enroll in the NHIS, except from one's own or family income, but we contribute to help during weddings, naming ceremonies, and especially, during funeral ceremonies when one dies."*

The results also revealed that there is some level of solidarity among the community members, but it has not been harnessed and translated into helping each other or the poor in the community to enroll in the NHIS:

"We don't do anything to help each other register for NHIS in this community. But during disasters like a fire outbreak in a community member's house we come out to help quench the fire, and during funerals we help with the burial and other activities, we also help during weddings and 'out-doorings –of babies' (christening). We also help each other to get employment if we are in the position to do so."

"As for sickness it will be difficult to know what is happening in a person's house until you are told, so it is difficult to help each other but then if your family member is sick, the family members can contribute to take the person to the hospital, or they may borrow from someone and take the person to the hospital."

A cross section of participants were, however, conscious of engaging their peers to adopt the social value of community solidarity they show during other social ceremonies, such as funerals and child christening, to contribute money within social groupings and associations to enroll into the NHIS for financial risk protection against catastrophic episode o ill-health and injuries.

Adverse Selection

The results show that adverse selection in NHIS was pervasive. The FGD participants in one urban community noted that given a situation where one had a large family, it was prudent to enroll the vulnerable in the family, especially, women, children, the aged, the sick and those with pre-existing health conditions in the NHIS, for lack of funds to enroll everyone in the family. Additionally, the data showed that the sick, children and women in the household's NHIS membership were renewed first, annually before men and the healthy youth. The quotes below suggests that family heads adversely select the sick or the vulnerable population when enrolling members of the family into the NHIS, which has the long-term consequence of increasing the claims bills:

"*It is like almost everyone in my family's card expires at the same time so whenever it's time for me to renew their cards, I renew for those who often fall sick first then later for the healthy ones when I have enough money.*"

"*We normally select some few people to register because if you have a large family the only thing you can do is to target those who easily fall sick because of the high cost involved in registering everyone."*

"Some people register with the NHIS only when they are sick because that is when they see the need to do so."

Quality of Health Care

The results suggest that the human resource for health situation in the urban centers was better as compared to the rural settings. There were mixed perceptions about the quality of health care among female respondents. While some opined that the health personnel's attitude towards patients were not appreciable, others thought they were reasonable. This is understood because participants visit different health facilities, in most cases.

Access to medicines*:* Access to medicines and consumables is an important component of quality of care. On access to medicines at the health facilities, FGD participants noted that there was limited access to quality medicines; only paracetamol was commonly given to patients. Patients were often asked to pay for other drugs at the health facilities even though those drugs were covered under the NHIS or given prescription to buy from outside pharmacies. They described the situation as discouraging and is leading many insured patients to lose confidence in the NHIS.

Waiting times: long waiting times to receive health care at a health facility affects patients' perception and satisfaction of quality of care. On waiting times, respondents were asked how long they had to wait to get services, whenever they visited a health facility. The data showed that insured patients spent between two hours to a whole day (if laboratory investigations were involved) OPD cases. Participants indicated the long waiting time for health care may explain why people do not want to visit the hospital when they are sick. The doctors, they noted, do not come early to work and yet close early. In general, both insured and uninsured participants were not satisfied with the quality of health care they received.

Providers perspectives on quality of healthcare: Health providers admitted that the attitude of some of their health personnel is appalling. This demotivated patients from visiting health facilities. Providers indicated that patients prefer to buy medicines from the drug stores and pharmacy shops, rather than visit the hospital, because of the awful attitude of health personnel, unavailability of medications, and the long waiting time at the health facilities. According to the providers, these poor health care quality conditions push patients to delay seeking professional health care visits until it is critical. Also, long distances from rural health centers to referral health centers, usually in the urban areas coupled with lack of ambulance, and poor road networks all affect the quality of care and health care outcomes. An administrator in one of the health facilities admitted the poor attitude of health professionals:

"*Once a human institution, you hear of poor attitude of our health professionals, we try to be professional as much as possible, but you will usually hear there are one or two acting unprofessionally towards patients, but we think it has been blown out of proportion.*"

Health Care Consumers' Unauthorized Use of NHIS Cards

In the FGD, we solicited information on unauthorized use of NHIS cards by asking the insured persons how many times they visited health facilities after enrolling in the NHIS and the reasons for the hospital or health facility visit. They were also asked whether they would renew their health insurance membership after it expires. The discussions revealed that people enrolled in the NHIS in an anticipation of benefiting from it, in case of illness and injury. However, if they never had any health condition or illness and as a result had never visited a health care facility before the expiration of their cards, they felt reluctant to renew their membership. The data reaved that community members' NHIS membership helped the sick who did not have insurance to impersonate an insured member by giving them their NHIS ID cards to access health care whenever necessary or attending hospital (OPD cases) to obtain medication for the sick. The quotes below show the extent of consumer unauthorized card use among the insured members in the community:

"There *are a lot of help we offer as members in this community to access health care. In terms of accidents or severe illnesses, we do offer support to the person to go to hospital or give our health insurance cards to the person to seek health care at the hospital, a lot of people without health Insurance cards benefit from that, using others' health insurance cards.*"

"My card has expired, and I have not renewed it, and I don't think I will renew it because I have never used it. I have never used it because I don't fall ill. I don't fall ill so I will not renew it because I will not use it".

"I have always renewed my card every year, but I don't fall ill so I don't use it. The health insurance is cheating me, so I sometimes use my card to go to hospital to get medicines for my family member who fall ill and has no health insurance."

Patients' Experience and NHIS

Both the focus group discussions and the in-depth interviews with selected health care providers illuminated what insured patients encounter at the health care facilities. Among the poor experience indicators were: too long waiting time at the health facilities, non-availability of doctors, and

doctors' absenteeism and lateness. Other variables include poor health professional-patient relationships, inadequate supply of prescribed medicines at the health facilities, doctor moonlightings and diversion of patients to private health facilities. A participant recounted his ordeal, and the ordeals others go through using their health insurance cards to seek heath care below:

"*I don't have much knowledge on the benefits package of the National Health Insurance, but I know it covers certain potent drugs. But the drugs (medications) they give us when we go to seek health care at the health facilities do not treat our illness, they give us fewer effective drugs, usually, paracetamol. Mostly, you buy the effective drugs outside at a drug store or pharmacy at a very high cost. When, you have health insurance, they do not give you much attention, the nurses prefer patients without health insurance. Yesterday, I took my father to the hospital, even though he had the NHIS, I still paid one hundred and fifty Ghana Cedis (GHS150.00) [approximately UDS 38.] on medications*."

Unapproved and Under-Cover Payments

Similarly, the analysis from the FGD indicates that, even though the exempted categories, such as children under 18 years, pregnant women, and the aged 60 years plus, are entitled to free treatment within the health insurance cover with their NHIS membership, providers find a subtle way of charging them some unapproved fees with the reason of delayed payment of claims from the National Health Insurance Authority:

"I also understand that pregnant women are not to pay when they go to the hospital with their health insurance, but the health facilities still charge them and claim the money from the NHIS. They have different terms they use when charging the unapproved fees: some call it 'co-payment, others call it 'top up'."

Dissatisfaction of Healthcare Service

Again, insured patients expressed their dissatisfaction with the health care system, especially, the negative attitude of providers, long waiting times and how some providers deliberately refer patients to their "moonlight" facilities in other to make profit:

"I was sick and when I went to the hospital, I spent too much time, and I was fed up."

"I was once asked to do a laboratory test and the doctor asked me to go to a certain private lab and do it but when I enquired I was told, that lab investigation was covered by NHIS so I went to an NHIS accredited lab and did the test when I brought the results the doctor was furious I didn't run the test at the private lab he asked me to and so he refused to accept the results."

"My child fell in water in a barrel of water, when we got to the hospital, there was a long procedure, and the child was left unattended to till he convulsed again. Nobody seemed to care; unnecessary delay."

Provider Induced demand, Fraud and Abuse

The data indicate that provider-induced demand, fraud, and abuse of the NHIS were pervasive. Providers agreed that there was provider fraud in the health insurance claims among their peers which, they suggest should be checked to forestall the integrity of the health care partnership. Provided indicated that there were fraudulent deals between pharmacists and providers, which resulted in patients being denied their legitimate medications from the health facilities. This occurred in both private and public health facilities. To curb these negative practices, providers suggested the establishment of complaint centers in each health facility to enable patients to report such case of fraud.

The study also revealed that some health facilities, especially, private health facilities, borrowed equipment and personnel to qualify for accreditation (credentialing) after which they go back to render the sub-standard and poor-quality health care to health care consumers. The interview with the NHIS officials of the Clinical Audit Department also revealed provider fraud and moral hazards among some private providers, embarked on cost escalation behaviors such as over-billing and double billing using the itemized billing system; falsifying claims (thus, presenting claims when patients had not actually used any service), and recycling of claims (repeated claims).

Another sterling behavior of both private and public providers, the study unveiled, was abetting or aiding patients to access health care with expired health insurance cards or temporary cards under waiting period; up-coding of drugs for higher tariffs, designing and forging NHIS claims forms, and forging prescribers stamps to produce claims. According to the clinical audit directorate of the NHIS, there were instances where some providers were significantly presenting claims where "men were pregnant" and assessing maternal services in the form of caesarian sections, while others were billed for multiple deliveries and myomectomies *(Interview with Clinical Audit and Claims officials).*

Providers' Perspective on the NHIS Benefits Package and Co-payments

The study suggests that health care providers perceive the NHIS benefits package to be too broad and too generous,

as about 95% of all disease conditions in Ghana are covered under the NHIS. They are, therefore, of the view that the benefits package should be reviewed to reflect the realities on the ground. They also think that, with the current premium of less than GHS 200.00 (USD 50.00 at the 2015 exchange rate) for an average premium per annum and less that 10% of the NHIS funding coming from premiums, the current benefits package cannot be sustained and should be revised down-ward, or realistic affordable premiums to be charged. On co-payment of health care, providers were of the view that it should be introduced, at least 80%- 20% contribution by insurance and patient respectively, to forestall abuse and moral hazards by the insured. The data also revealed that even though there is no formal co-payment under the NHIS law, private providers especially, charge unapproved co-payment fees as a financial security against NHIA delays in claims reimbursement to providers. The study also found that private providers prefer patients to pay out- of -pocket for health care rather than health insurance because reimbursement from the NHIS has continuously delayed, which distorts their budgets because of constant increase in inflation and depreciation of Ghana's currency.

Discussion

The study sought to explore health care consumers' and providers' perceptions and response towards the implementation of the NHIS to improve the NHIS operations. The Government sought to foster public confidence in the NHIS, to increase enrollment and retention of membership, especially among the economically active, the affluent, to enhance the achievement of universal health insurance coverage indicators of United Nation's Sustainable Development Goals (SDGs) in Ghana. Findings from the study suggest that both health care consumers and providers affirm that the NHIS is a paramount social intervention which significantly improves access to health care, but with reservations on its operations.

Health care consumers, especially the insured, were concerned about not getting essential medications from providers, the constant prescribing of medications they needed to buy, and the unapproved fees charged under the guise of co-payment, poor quality of care, poor provider-patient relationships, fraud, and abuse of the NHIS system. Providers, on the other hand, were mainly concerned by delayed payment of claims by the National Health Insurance Authority (NHIA). These concerns were found to play very significant challenges against building public confidence in the NHIS and continuous provision of health care services to the insured, respectively. There is, therefore, an urgent need to address these concerns to build both the public and provider confidence in the operations of the NHIS.

The profit motive of some private providers pushes them to behave in a manner that is detrimental to NHIS members in terms of health care and supply of needed medicines. But businesses must make profits to continue to thrive; therefore, it is rational and fair that private health care providers charge realistic prices to stay in business. However, NHIS needs to monitor and deal with the situations where the private providers deliberately exploit members of the scheme to make supernormal profits. These findings corroborate Dalingjong and Laar's study, which suggests that delayed in payment of claims significantly influenced providers behavior to discriminate against the insured in terms of long waiting times, verbal abuse, non-physical examination of clients and preference for out-of-pocket payment [16].

The result from the FGDs explained that men, especially young men, were reluctant to enrolled in the NHIS for reasons of being strong and healthy and therefore would rather spend their limited resources to enroll the vulnerable, such as women and children. Even though the situation where the vulnerable are mostly those enrolling in the NHIS sounds right, given the object of the NHIS is pro-poor, it engenders adverse selection which defies one of the cardinal principles of health insurance, risk pooling and cross-subsidization between the healthy and the unhealthy.

On quality of care and user satisfaction, the study found mixed results. While certain health care consumers perceived the quality of health care they received because of their health insurance is appreciable, other consumers perceived poor quality of care, discrimination, and poor user satisfaction because of negative attitudes of health professionals and long waiting times of care.

This finding on user satisfaction and quality of care is very consistent with the broader findings of the National Health Insurance Technical Review Committee report. The report indicates that while selected health care consumers expressed their satisfaction about the NHIS and the services providers render to them which have increased their access to health care and reduced untimely deaths, others view the NHIS and the quality of care they received as very poor, and no mechanism for patients to express their experiences for possible redress [17]. These findings are very important in the triple relationship between the patient, the purchaser, and the provider. In this relationship, both are supposed to benefit but, in most cases, the patients suffer because of negative provider behavior and information asymmetry between the provider and the patient. Due to lags in supervision, the purchaser (NIHS) does too little to defend the health care consumers against negative provider attitude and poor quality of care, as it pertains in the NHIS of Ghana. The syntheses of the results from various sources indicate that lack of medications and consumables for the insured at

the health facilities greatly affects public confidence in the NHIS. Additionally, the study found elements of health care consumers unauthorized us of cards, for instance, patients using their family members' insurance cards to access health care and conniving with health personnel to use expired cards to access health care. These unauthorize card uses are not strictly moral hazards but coping strategies adopted by health care consumers to gain access to health care for reasons of not being able to pay.

The study suggests that negative provider behaviors and gaming towards the NHIS and patients are pervasive and lead to increasing cost of the NHIS and loss of public confidence in the scheme. The findings are consistent with large body of knowledge of provider induced demand and claims fraud worldwide. There is, therefore, the need to use the NHIS, as a conduit towards achieving universal health coverage in Ghana. The findings suggest mixed reactions on the effects of politics on the NHIS. The findings also support earlier study by Agyepong, et al. [9] which catalogued the political, and policy processes of the establishment of the NHIS.

Conclusions

The study concludes that health care consumers' perceptions and providers unhealthy behaviors negatively affect the operations and growth of the NHIS. The application of behavioral economics principles is recommended to nudge policy actors, health care consumers and providers, alike, to alter their behaviors to collectively strengthen the NHIS. This can be done thorough intense community and provider engagement to explain the concepts of health insurance and the benefits thereof, especially, the triple-win concept of health insurance (patients/members win, providers win and the purchaser wins). It is further recommended that the NHIA constantly engage providers and the suppliers of essential medicines, using the goodwill and the economies of large-scale purchase to be able to reduce the cost of the essential drugs to the providers and to help them obtain credit facilities at low interest rate to restock their facilities in order not to run out of medication. Also, NHIA needs to strengthen its monitoring and supervisory roles to forestall the gaming and fraudulent activities of providers for the best interest of health care consumers. Further research is needed in the areas of resource and risk pooling to attract the economically active, the affluent and the healthy into the NHIS.

The NHIA should consider trimming some costly and less essential services and medications from its benefit package to ensure fiscal solvency. Then NHIA should borrow, if necessary, to ensure that it pays legitimate claims promptly, especially for drugs. It should set up private complaint mechanisms by which consumers can report instances of rude treatment, unavailable covered medications, or inappropriate requests for top-up payments. Likewise, whistle blower mechanisms should be set up for patients using unauthorized cards. The NHIS should promptly investigate, notify all parties of the outcomes, and sanction through fines, those responsible. Public statistical dashboards should monitor progress.

Acknowledgements

The authors acknowledge the invaluable contribution of the management and various staff of Ghana's National Health Insurance Authority and the Ghana Health Service in the data collection process. They thank the focus group participants in Tamale and Salaga who thoughtfully shared their experiences and opinions. The first author thanks the Ford Foundation International Fellowship Program (IFP), Brandeis University, Heller School Alumni Fund, and the Ghana Education Trust Fund (GETFUND) for their financial contribution towards his doctoral studies on which this article was based.

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