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An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana

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Abstract

The Nkoranza Community Health Insurance Scheme in Ghana, considered the “pioneer” of its kind in that country, was evaluated after eight years of operation. The scheme has proved successful in terms of sustainability and making quality care affordable to a high percentage of vulnerable households in the district. In this sense, it is a model for other schemes. Despite these achievements, certain problems need to be resolved: coverage is still low (30 percent of the population) due to an inappropriate registration period, community misconceptions about the scheme, and massive adverse selection; the benefits package lacks coverage for health center services, in particular, maternal-child care; and the scheme also lacks adequate operational transparency and management skills. This evaluation report recommends ways for the scheme to resolve these problems, including rescheduling the registration period; introducing incentives to enroll entire families; expanding services; and offering training in management and outreach skills to better inform and involve the community.

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Acronyms

AGM	Annual General Meetings
DHC	Diocesan Health Committee
GNAT	Ghana National Association of Teachers
GPRTU	Ghana Private Road Transport Union
IEC	Information, Education, Communication
OPD	Outpatient Department
PHC	Primary Health Care
PHR	Partnerships for Health Reform Project
PROTOA	Progressive Transport Owners Association
TBA	Traditional Birth Attendants
TOR	Terms of reference
USAID	United States Agency for International Development
WHO	World Health Organization

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Our sincere thanks also go to the field assistants and researchers who administered both the household survey and the focus group discussions; and to Mr. Patrick Apoya for logistic assistance to the PHR evaluation team.

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Executive Summary

The Partnerships for Health Reform (PHR) project was invited to undertake an external evaluation of the Nkoranza Community Health Insurance Scheme in Ghana principally because after eight years of existence, the scheme promoters (owners and management) wanted to assess how far they had travelled and in particular, to see if it was possible to advance beyond where they have reached and to determine how to do so. There is a sense that the coverage of the scheme, around 30 percent of the district's population, is not high enough and that there is some unfulfilled potential yet to be tapped.

PHR undertook the evaluation, which was co-funded by the Danish International Development Assistance and the World Health Organization (WHO), in the hope that we could make a contribution to these goals of the scheme's promoters. Especially since the Nkoranza scheme is the pioneer of its kind in Ghana and has since served as an example if not a model for others around the country, it appeared particularly important to shed light on the right lessons from this experience so that others may benefit as well.

The main findings of the evaluation are the following:

- The Nkoranza Community Health Insurance Scheme is, after eight years, surviving essentially on its own resources (i.e., premium income) and has made quality health care affordable for a high percentage of vulnerable households in the district. Moreover, by its mere survival, it has proved sceptics wrong and become an example to all other communities wishing to begin similar initiatives. Its success has also brought fame to the district.[1]

- Despite these achievements, the scheme's population coverage, at 30 percent, remains disappointingly low. Moreover, annual registration figures show no tendency towards an increase in population coverage. The researchers found that the principal reasons behind the low population coverage of the scheme include

  - An inappropriate registration period;
  - Widespread misconceptions in the community about the scheme (reflecting a sense of lack of ownership); and
  - Massive adverse selection (i.e., tendency to enroll only the most vulnerable members of the family). Though the district has high levels of poverty, this was not seen as a major factor behind the poor registration figures.

- Due to its close links to the (private) district hospital, the scheme has not been able to integrate health centre services into its benefits package. More importantly, it has not been able to make use of the potential gatekeeper role that the satellite health centres could have

[1] This is proved by the tremendous interest generated by the seminars in Nkoranza and Accra during December 1999 and January 2000 to present the preliminary findings of this evaluation.

played, in order to encourage efficiency of resource use and keep the costs of the scheme down.

- There was a popular demand, especially from women's groups, for coverage to be extended to Maternal Child Health services and especially maternity care. While respondents were willing to pay extra for these services to be covered, in general there was strong resistance to any form of co-payments or deductibles on the existing (hospitalisation) cover.

- There was widespread and persistent clamour for the scheme to become a community-owned one, i.e., for community participation in management and control of the levers of decision-making. Moreover, it appears that the scheme's promoters have been moving gradually towards this model themselves, which should make it easier to implement the recommendations contained here to address this issue.

- Another matter that most respondents constantly drew our attention to was what they described as the negative attitude of the hospital staff towards patients and here again there were many strident calls for improvements to make the scheme more attractive.

- The researchers' observations show that the scheme's management lacks many skills necessary for running an organisation of this size and nature, such as:

  - Marketing and community participation methods (information, education, and communications, IEC)
  - General management skills, including risk management techniques
  - Negotiation skills
  - Accounting and book-keeping (the scheme presently has no one specifically handling these areas)
  - Computing skills
  - Monitoring and evaluation of a community health insurance scheme including internal (managerial and financial) auditing

Following from these findings, our main recommendations also include:

- The scheme needs to change its main registration period to August–October each year.

- There is a need to introduce more incentives for registering all family members, by having a fee structure which imposes a lower fee per head the more family members a person registers and by offering incentives to those who renew even though they have not used the services the previous year.

- Funding should be sought (possibly from the District Assembly, if not from the scheme's funds) to hold Annual General Meetings (AGM) with representatives from communities and villages, as well as identifiable community groups and associations including the Ghana National Association of Teachers, Nkoranza Traders Association, the Progressive Transport Owners Association, the Ghana Private Road Transport Union, the Traditional Council, District Assembly, District Health Committee, Hospital, Nurses Association, etc. The AGMs will provide an opportunity for the scheme management to report on activities and results for the year, and for external auditors to present the scheme's accounts to the public.

- To instill more community confidence in the motives and actions of management, the scheme should also have a new supervisory organ or oversight committee composed of volunteers from the community.

- A new management structure with community representation is necessary for the same reason as above, and in order to achieve the promoters' expressed desire to see more community involvement in the running of the scheme.

- Specific IEC training for the scheme coordinators and staff with special emphasis on community participatory methods is essential.

- The scheme needs to initiate steps to improve relations between the hospital staff and the community, including seeking an improvement in staff reception of patients.

- Scheme management and staff need to have their skills upgraded in the areas described in the last paragraph of the findings above.

- The scheme should extend cover to include maternity care in order to boost membership.

1. Background, Terms of Reference and Methodology of Evaluation

1.1 Brief Background of Scheme

Following the introduction of the "cash and carry" system into Ghana's health sector in the late 1980s, many patients began to have difficulty with paying for their health care (especially admission) costs. As a result, many did not go to the hospital until it was too late or their illness had advanced to a more complicated phase. Others who were admitted and treated subsequently absconded without paying for their treatment. Many individuals quite simply could not afford to pay for their care.

The population, therefore, had reduced access to hospital services and, in turn, this had a negative impact on the financial performance of hospitals such as St. Theresa's Hospital in Nkoranza. The idea of starting a health insurance scheme was raised at a meeting of Catholic Church hospital administrators in Sunyani in 1989. The idea itself was inspired by the example of Bwamanda Hospital Health Insurance Scheme in the former Zaire.

Approvals for the pilot project in St. Theresa's Hospital at Nkoranza were obtained in 1990/91 under the leadership of Dr. Ineke Bossman, then Administrator and District Medical Officer of Health (DMOH) in charge of Nkoranza.

The Nkoranza community financing health insurance scheme was launched formally in 1992 with a funding pledge from Memisa, a Dutch Christian non-government organization, which promised to meet any expenditure shortfalls (deficits) run by the scheme in its first three years of operation.

The main objective of the scheme as stated in its initial project document was to "reduce the cost per individual hospital admission, thus making services accessible to all within the district."[2]

In the scheme's most recent Annual Report (1998), this same objective was restated:

1) To "encourage the people of Nkoranza to pool their financial resources together … to cater for their hospitalisation bills"

2) To "improve the District population's economic accessibility to curative care by making health care delivery more accessible and affordable."[3]

[2] Project Proposal for Community Financing Scheme for Hospital Admissions in Nkoranza District, 28th Feb 1991; p.1.

[3] See the 1998 Annual Report on the Nkoranza Community Financing Health Insurance Scheme, p. 2.

Although not explicitly stated as an objective, it is clear that improving the scheme would also lead to more reliable revenue for the hospital by, at least, reducing bad debts and attracting more clients.

1.2 Background to the Evaluation

Between January and July 1999, the Catholic Diocese of Sunyani requested and received funding and technical assistance from Partnerships for Health Reform (PHR), a project funded by the United States Agency for International Development (USAID)–supported project, the local office of the World Health Organization (WHO), and the Danish International Development Agency to carry out an evaluation of the Nkoranza Community Financing Health Insurance scheme located in the Brong Ahafo Region of Ghana. The evaluation includes the following steps:[4]

1) The design and administration of a questionnaire;

2) Data entry and analysis of the results;

3) Focus group discussions;

4) In-depth evaluation of the scheme's operations and management; and

5) Stakeholder interviews, including the scheme's relations with St. Theresa's Hospital (owned by the Catholic Diocese of Sunyani and the unique provider of the Scheme).

During the last week of July and the first week of August 1999, the questionnaire, data entry system and sampling methods were designed and field assistants were trained with the help of a PHR consultant. Field assistants administered the questionnaires throughout August and data entry was performed into September. In October, the PHR Regional Advisor arrived in Nkoranza to lead the final stage of the field aspects of the evaluation; focus group discussions, analysis of the scheme's internal operations and management, and stakeholder (key informant) interviews.

1.3 Objectives and Terms of Reference

The objectives of the evaluation and the field research were provided in the first instance by the Catholic Diocese in the terms of reference (TOR). They were to:

> Study the people's priority spending patterns to determine how much people are spending on health and what they are willing to spend on which priority areas, either consciously or otherwise.

[4] The contributions of the three development agencies to the evaluation are as follows:
PHR – design of questionnaires for household surveys, data entry system and analysis of responses, elaboration of focus group themes and analysis of reports by field assistants, training of field assistants for both household surveys and focus group discussions, analysis of the scheme's internal operations, carrying out management and stakeholder (key informant) interviews, writing and presentation of both interim and final reports.
DANIDA – funding for: administration of household surveys and focus group discussions by field assistants, data entry and field-based secretarial support to the evaluation in Nkoranza.
WHO – computer for data entry and motor bike.

- Find out the reasons for higher bills for insured patients against non-insured patients.
- Conduct field studies to determine if poverty is the primary reason for the low registration over the years and, if so, advise the scheme on what measures to take.
- Determine the community members' willingness to accept co-payment and other measures that would likely enhance the progress of the scheme.
- Attempt to determine levels of household expenditures on health by individuals and families within the Nkoranza community to serve as a guide for fixing premiums.
- Determine the level of moral hazards (provider and users) that exist in the scheme's operations and suggest ways of eliminating them.

PHR's initial response was that these terms as they stood (together with the proposed methodology of a household survey) appeared to be designed essentially as a study to find out from both the users and other external sources answers to some specific (albeit vital) questions probably identified by those in charge of the scheme as currently impeding scheme performance rather than an evaluation of the insurance scheme itself. It was subsequently agreed that, while maintaining the original terms of reference, additional questions that could be helpful in an evaluation of the scheme's internal operations, management and impact. as well as its relations with the St. Theresa's Hospital (owned by the Catholic Diocese and sole provider under the insurance scheme) and other key stakeholders. would form part of the evaluation to be conducted by PHR.

A major part of this evaluation has been devoted, within the limits of the methodology and available resources, to throwing some light on the above issues and attempting to answer the questions that are of such interest to the promoters of the scheme.

1.4 Methodology of the Evaluation

The evaluation was carried out by means of:

- A household survey covering all eleven health zones of the district of Nkoranza and based on standard interview questionnaires and random sampling techniques. In all, 3,476 households in the district were covered by this survey, making it probably the largest such survey ever conducted in the area.
- Focus group discussions of representative participant samples from all the health zones, as well as identifiable community groups and organisations in the district. Forty-three focus groups, involving well over 300 individuals were organised.
- Interviews with the management and coordinators of the scheme, some selected contract field workers of the scheme, the management and key staff of Nkoranza's St. Theresa's hospital, the Executive Secretary of the Diocesan Health Committee (DHC) and Diocesan Primary Health Care (PHC) Coordinator. Representatives of other key stakeholders were interviewed, such as the Omanhene and other members of the Traditional Council, the District Chief Executive, District Directing Co-ordinator, the vice-Chair of the Social

Services subcommittee of the District Assembly and the Member of Parliament for Nkoranza, the Regional Health Director and the Bishop of Sunyani.

- Analysis of key documents, records and statistics of the scheme as well as of the hospital.

- The above methods were supplemented by an analysis of socio-economic data and information from previous studies and surveys of the district.[5]

See Annex A for a detailed description of the household survey and focus group discussion techniques.

1.5 The Nkoranza District

The Nkoranza District is one of 13 administrative districts of the Brong Ahafo Region of Ghana (see Figure 1.1). It covers a total area of 2,300 square km and is made up of some 120 mainly rural settlements. The total population of the district was estimated in 1999 at 131,941.

The district lies within the wet semi-equatorial region, in the transitional zone between the savannah woodland of the north and the forest belt of the south of he country. The main occupation of the inhabitants is agriculture, which employs about 95 percent of the economically active population of the district. Food crop farming is the main source of cash for the rural dwellers, and maize farming is the main cash crop grown (26 percent of total cultivated land), followed by yams (19 percent of cultivated land)[6]. In addition, other food crops such as vegetables, cassava, rice, groundnuts, cowpea, cocoyam and plantain are cultivated. Cotton and tobacco are also grown in parts of the district. Nevertheless, 34 percent of the population is also engaged in small scale industry.[7] For purposes of comparison, the corresponding percentages of the regional (i.e., Brong Ahafo) and national labour forces engaged in agriculture for the same period are 71 and 57 respectively.

Nkoranza town is the district capital, with approximately 19 percent of the district's population. This urbanised area has a population made up mainly of traders, civil servants and other government employees, transport operators, small scale industry operators and the like. Many urban dwellers, however, still take up agriculture as at least a minor activity.

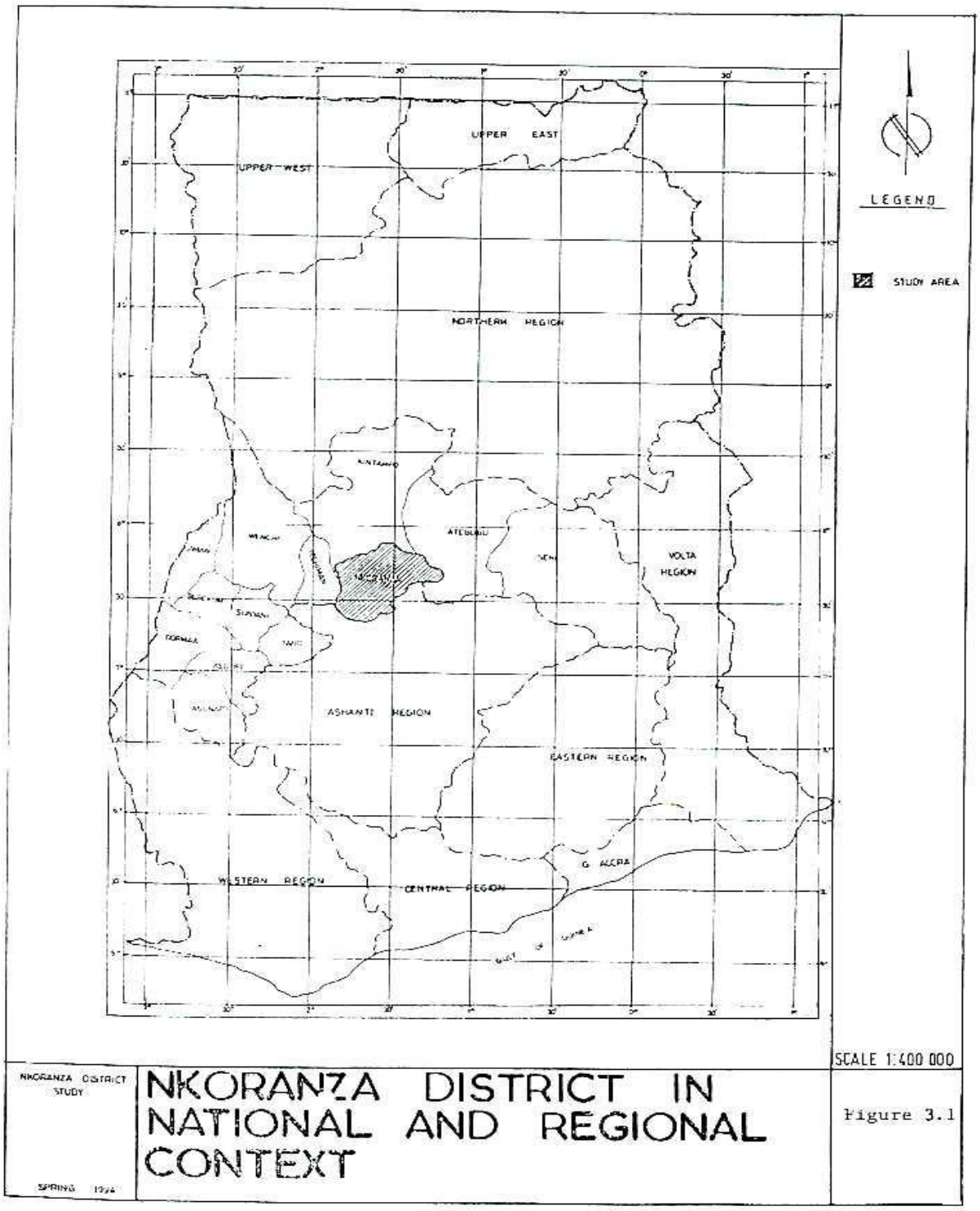
There is only one hospital in the district, the St. Theresa's Hospital, run by the Catholic Diocese of Sunyani, and is the recognised district hospital for Nkoranza. There are currently two doctors at the hospital.

[5] Notably the SPRING Report on the Nkoranza District carried out by a planning team from the University of Science and Technology, Kumasi, between 1993-1994 and survey data published by the Statistical Department in Accra.

[6] Sources: Department of Agricultural Extension Services, Nkoranza, 1993; The SPRING Report, 1994; p. 75.

[7] Source: The SPRING Report, op. cit.

Figure 1.1. Nkoranza District, Ghana



In addition, the district is divided into 11 health zones, each of which has a government-run health centre. Outside the modern health facilities, there are some traditional birth attendants (TBAs) and traditional healers who constitute alternative sources of health care.

2. Findings

The presentation of the evaluation findings is divided into two main sections: (1) a description and assessment of the design features of the scheme as it currently operates, and (2) the findings from the research carried out for the evaluation. This latter section is sub-divided into three sub-sections: (1) principal findings relating to achievements of the scheme and possible reasons for its relatively low population coverage, (2) specific findings related to the original terms of reference given to the evaluation team, and (3) other findings of general interest to the community and the scheme promoters.

2.1 Evaluation of the Design of the Scheme

2.1.1 Set-up and Rules

In terms of the typology of mutual health schemes emerging in Africa, the Nkoranza Community Financing Health Insurance scheme represents a hospital-based scheme where the community served plays no direct role in its management and policy-making. The scheme is, in effect, run as if it were another department of the hospital, with its staff and management subordinate to the hospital's management.

As a result, the scheme enjoys no separate legal status as a corporate body and therefore has had no need for a separate constitution. There are however rules and regulations governing membership and access to its services (which are described as "Scheme Policies"). These are revised annually before the registration exercise and circulated within the community.

The rules (those relating to 1998/99) state that membership is by entire families (unless it is a case of an individual living alone); children born after the annual registration period (December-January) can be registered within 40 days after delivery; and membership is not transferable. (The other regulations are discussed below).

The organisational chart of the scheme (shown below) reinforces the point that the scheme is not separate from the hospital and is not controlled by the community, though some key community persons are present at lower levels of the structure.

The Insurance Management Team (IMT) is made up of:

- All four members of the Hospital Management Team (HMT)
  - Administrator
  - Senior Medical Officer in charge
  - Matron or Principal Nursing Officer
  - Accounts Officer
- District Director of Health Services

- Manager
- Coordinator and Assistant Coordinator of the scheme
- Chairman of the Insurance Advisory Board.

The Insurance Advisory Board, which had been inactive for four years but is now being revived, has some prominent members of the community on it. As both its name and position in the organisational structure indicate, it has no designated authority and no real leverage within the scheme. It does have some moral authority when it is active because the Chairman and members carry out the following functions:

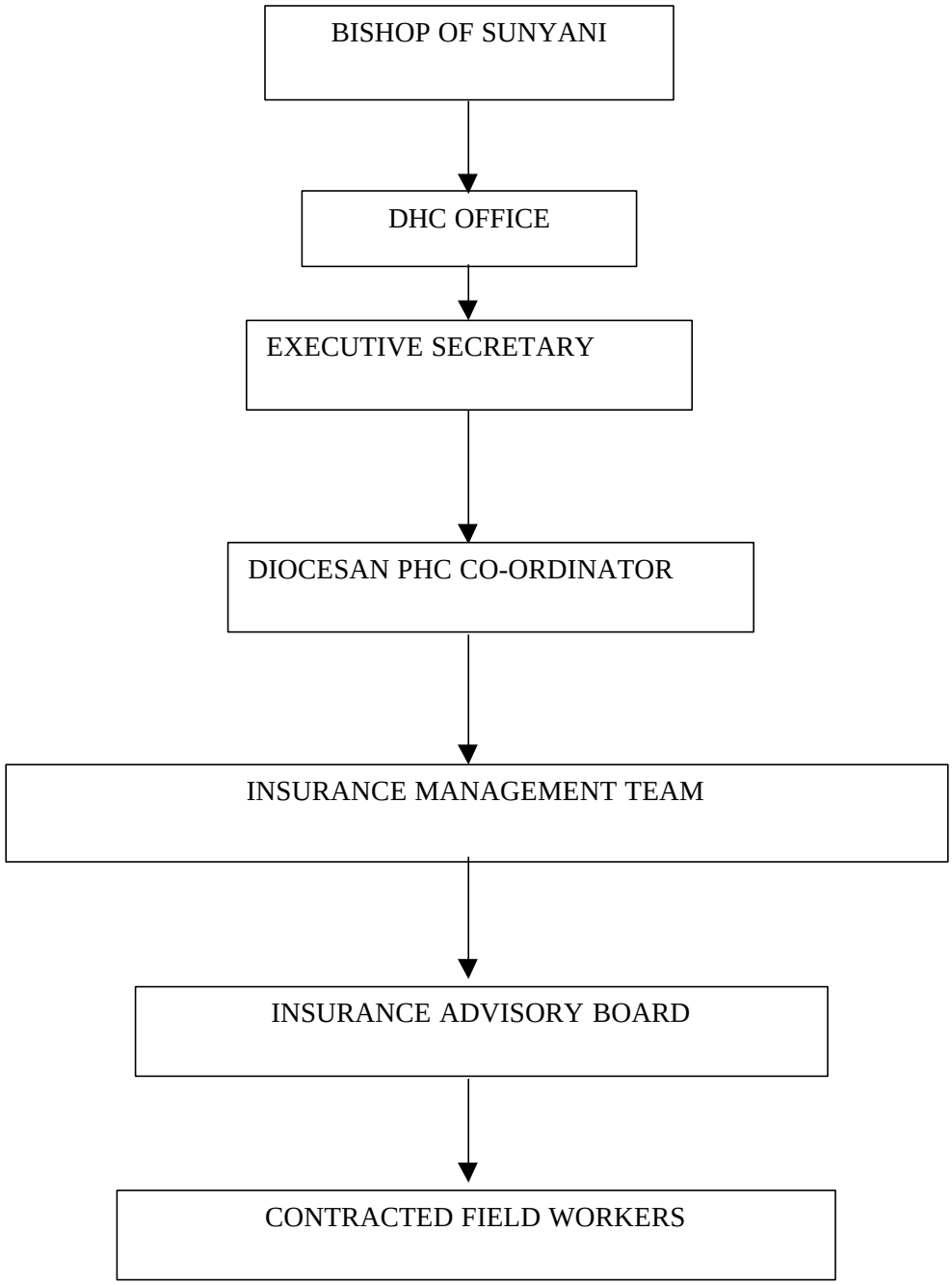
- They assist the scheme by travelling to the communities and using their moral influence to help resolve matters at that level,
- They receive reports from the coordinators of the scheme as well as complaints from members of the scheme on which they can act by requesting a meeting with the HMT to discuss how to resolve them.

In an attempt to reach further into the community, an Insurance sub-Advisory Board made up of Divisional Chiefs in each health zone, assemblymen, unit committee members and opinion leaders of the community has been set up, but it was not possible to ascertain either the effectiveness or the specific role of these bodies.[8]

A notable feature of the scheme is the absence of a specific supervisory organ along the lines of cooperative organisations, which have proved effective elsewhere in providing checks on executive and management bodies. Such an organ would answer only to the supreme decision-making body of the scheme and have powers to investigate complaints and order audits, as well as calling the management (and where appropriate the executives) to account for any act of commission or omission that contravenes the rules and regulations. The absence of a supervisory organ is a consequence of its non-participatory design but it will become increasingly important as consideration is given to effective forms of community participation.

[8] An indication of how effective or ineffective they are may be gleaned from the overwhelming responses received from the community on questions related to community participation, representation and the like, which are analysed later in this report.

Figure 2.1. Organisational Chart of the Nkoranza Community Financing Health Insurance Scheme



2.1.2 The Benefits Package

The scheme began with 100 percent coverage for hospitalisation as its principal benefit. It still offers full inpatient coverage but it also covers:

- Drug refunds for prescriptions which are not available in the hospital itself and therefore mustbe purchased outside by relatives of the admitted member;
- Referral to other hospitals – insured patients on admission who are referred to other hospitals outside Nkoranza for specialist care are paid the average inpatient bill for the month of referral (less the amount already paid by the scheme to St. Theresa's Hospital);
- Outpatient (OPD) bills for snake bite treatment.

The scheme does not cover:

- OPD treatment other than snake bite;
- Normal deliveries;
- Admission bills from any hospital besides St. Theresa's;
- Admission costs associated with "criminal abortion";
- Admission and treatment resulting from alcoholism;
- Patients admitted (in casualty) for less than 24 hours.

2.1.3 Financial Contributions

The scheme charges an annual flat fee or premium per head irrespective of age or sex. This premium must be paid during the single registration period lasting two months from December to January every year (except in the case of newborn babies who can be registered anytime after their birth for up to 40 days).

The evolution of this fee or premium since the beginning of the scheme is shown in Table 2.1.

Table 2.1 Nkoranza Community Financing Health Insurance Scheme – Premium and Renewal Fees per Head (In Cedis) 1992-98

	1992	1993	1994	1995	1996	1997	1998
Premium/head	420	700	1,200	2,100	2,100	3,000	5,000
% increase over previous year		67	71	75	-	43	67
Renewal fee		500	1,000	1,800	1,800	2,500	4,000
% increase over previous year			100	80	-	39	60

Note: The premium per head applies to newly registering members while the renewal fee applies to those renewing their subscription from previous years.

2.1.4 Provider Payment Mechanism(s)

The scheme pays the provider (St. Theresa's Hospital) on a fee-for-service basis. The attending physician or nurse notes the services performed on the inpatient's admission card. If the inpatient is insured, that insured person would hand over his/her insurance card to the person in charge of the ward on arrival, who writes the number of the insurance card on the hospital admission card.

An accounts clerk makes regular rounds to record (from the admission cards) the details of services performed on admitted patients and, in the case of insured patients, the number of their insurance card as well. This information is used by the accounts department to prepare the cost corresponding to the admitted patients, using a price schedule prepared by the Diocesan Health Committee (DHC) annually and distributed to all Catholic Hospitals in the region.

A monthly bill summarising the costs of care provided to insured inpatients is prepared by the accounts department and submitted to the Insurance Manager for payment. This bill details the month, number of inpatients and costs incurred broken down into the following five categories: laboratory, drugs, X-ray, materials and others.

Apart from checking for obvious arithmetical errors, the insurance management does not and has no mandate to check for any other mistakes (e.g., whether the costs entered correspond correctly to the diagnosis recorded and the price schedule of the DHC).

It is worth noting that the fee-for-service payment system is the most expensive option for an insurance system to adopt, though, by the same token, it is the most favourable (financially) for a provider to use. This is because of the built-in incentives to over-prescribe and over-treat, which are financially beneficial to the provider but could be harmful to the insurer. While such over-treatment is not actually taking place at Nkoranza, the problem will be discussed at other points in this report.

2.1.5 The System of Checks and Controls

All insurance systems are open to abuse and checks and controls are required at various levels to minimise or eliminate such abuses. The checks and controls are needed at two principal points – the provider and the patient.

At the provider level, a fee-for-service payment system like the one at Nkoranza, is generally considered to be the method most susceptible in principle to various forms of provider abuse, as already noted. Protecting the system from abuse requires a fairly sophisticated (and expensive) monitoring system to check provider billing and records as well as treatment protocols. Although there is no evidence that such abuse takes place at Nkoranza, no control by the scheme could take place under the present arrangements. Not only does Nkoranza lack the requisite technical and administrative skills, but the scheme's position as a subordinate unit within the hospital structure prevents adequate control systems.

The situation is complicated by the fact that the scheme has no independent accounts officer but must rely on a staff member of the hospital's accounts department to do scheme accounting. He is overseen by the hospital accounts officer who issues the bills to the insurance scheme. The scheme has no ability to ensure that prices have been entered correctly according to both the diagnosis (including prescriptions) and the relevant schedule items.

Another control issue at this level is that of provider-induced moral hazard. If providers (doctors in this case) know the insurance status of their patients, it can influence their prescription and treatment practices, so that insured patients tend to pay higher bills on average than non-insured ones. Evidence to be examined later in this report suggests that this happens (doctors do ask for the insurance status of patients) at Nkoranza, although explanations about why may differ.

At the patient level, the relevant issues are the measures in place to control adverse selection, moral hazard and fraud. The evidence to be examined in this report argues strongly in favour of adverse selection year after year. This principally arises from a high drop-out rate each year and incomplete family registration. In fact, the design of the scheme tends to give rise to the latter phenomenon, since no incentive exists for registering additional family members. As we have seen, the scheme charges a flat fee per head irrespective of age or sex. No family registers exist and members – until now – are not recorded according to whose family they belong to, but rather their household.

The scheme officials' way of dealing with adverse selection is to insist, at the time of admission of an individual, that all the other family members be registered (if they have not been and this is known) before the scheme will pay the fees for the person on admission. It is arguable that insisting on full family registration before cover is given at a potentially traumatic moment for a family is not the best (certainly not the most humane) way to avoid adverse selection. It can lead to hard feelings afterwards, which is not conducive to cooperative behaviour in the future.

Moral hazard is mitigated to some extent in the design of the Nkoranza scheme by the fact that access to its principal benefits – hospital admission and OPD treatment for snake bites – is determined by a qualified medical officer, not the beneficiaries themselves. Nevertheless, there seems to be some evidence, according to the scheme officials, that some insured persons apply whatever pressure they can to gain admission once they are ill, in the hope of getting free treatment.

On the other hand, the scheme's limited benefits and lack of effective referral policies tend also to favour moral hazard by giving incentives for by-passing primary health care facilities and going straight to the hospital.

In terms of checking patient fraud, the control system fails at the point where it matters most; when an admitted person hands over his/her card to the person in charge of the ward, there is no way to determine whether he/she is a genuine beneficiary or a free-rider using another person's card, especially as no photographs were affixed to the cards (this latter problem was being addressed at the time of the survey). Even when photographs have been fixed on the cards, control will depend on the vigilance of the person to whom the cards are handed over on admission, who is not an employee of the scheme and whose incentives for such control are currently not very high.

2.2 The Findings from the Evaluation Research Work

The key findings are presented here in three main sub-sections: the first sub-section presents the principal findings relating to the scheme's performance and population coverage. This attempts essentially to answer the vital question 'why is the scheme coverage apparently so low after eight years of existence?' The second sub-section presents more specific findings in accordance with the above-stated terms of reference originally given to the team by the scheme management. The third sub-section presents further findings representing basically the community's own suggestions, views and proposed solutions concerning some of the problems identified.

2.2.1 Principal Findings Relating to Achievements and Scheme Coverage

As a preface to this section, it should be emphasised that both the household survey and focus group discussions revealed very high levels of satisfaction with the Nkoranza Health Insurance Scheme. For instance, in the household survey, 72 percent of respondents on average throughout the district rated the scheme's services as 'very good.' Nobody apparently wants the scheme to collapse and 67 percent are apparently even willing to accept extra payments to keep the scheme from complete collapse. Although this satisfaction is qualified by certain critical views and suggestions, these findings still represent an extraordinary level of confidence and commitment to the scheme, which is probably its greatest asset and which needs to be nurtured and capitalised on to make further progress.

The following findings and recommendations should therefore be read against this background. They are meant to help the scheme move forward, and above all, to make it more attractive for others to join; they are not meant to diminish the importance of the significant achievements clocked by this pioneering example of community based health insurance in Ghana.

2.2.1.1 Nkoranza Scheme Achievements

There is not enough space in this brief summary report to recount all of Nkoranza's achievements. The most important is that the scheme has made good quality health care (in cases of grave illness or condition requiring hospitalisation or expensive OPD snake bite treatment) much

more affordable to most households of the district (57 percent of households in the district are actually insured on the scheme)[9].

The Nkoranza Community Health Insurance Scheme enjoyed a subsidy from the Dutch non-governmental organization, Memisa, for the first three years of its operations. After eight years, however, it is surviving essentially on its own resources (essentially premium income), which is itself, also a remarkable achievement worth celebrating.

Moreover, by its mere survival, it has proved sceptics wrong and become an example to all other communities wishing to begin similar initiatives. As some people, including members of the Traditional Council noted, the scheme has made Nkoranza famous and has excited a lot of interest both nationally and beyond. Being a pioneer at a time when others were sceptical or less foresighted, and now being vindicated in the sense that even the Ministry of Health has finally abandoned its plans for a state-run national health insurance scheme and come out for community-based schemes like Nkoranza's is a major success.

In order to advance further as desired by the scheme promoters, and as the evaluation terms of reference make clear, it is the areas of dissatisfaction that need fullest attention, and this evaluation has been mainly about throwing light on those areas.[10] We now turn our attention to the important question: why is scheme coverage still apparently so low in relation to the district's population?

2.2.1.2 Possible Reasons Behind the Nkoranza Scheme's Low Level of Coverage

Our analysis of the research data indicate that there are three major factors constraining the scheme: (1) the wrong registration period (December-January instead of August-October, the latter being the main harvest season and preferred by the vast majority of those interviewed), (2) community perceptions about the scheme, and (3) adverse selection. We argue below that there is probably a strong link between community perceptions and the phenomenon of adverse selection.

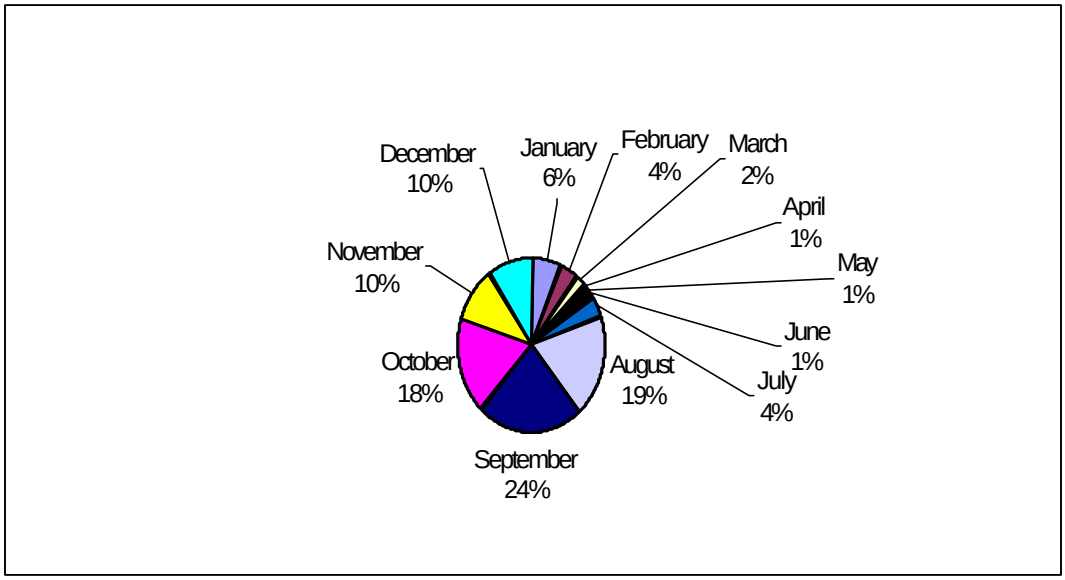
The registration period

The results of the household survey were unambiguous about which months were the ones where community members earned the highest income: September, then August and October, not the current scheme registration months of December to January (see Figure 2.2).

[9] The discrepancy between this household coverage rate and the scheme's much lower population coverage rate will be explained in the sub-section below on adverse selection.

[10] It should be noted in passing that the scheme owners, staff and management, despite their commendable achievement in introducing this pioneering example of affordable health care financing into the country, remain dissatisfied with the state of the scheme. This is to their credit as it implies that they aspire to even higher achievements, all to the benefit of the Nkoranza people.

Figure 2.2. Number of Responses per Month for Which Income is the Highest



The focus group discussions reinforced these results, but a significant minority wanted to continue with the current period of December-January for registrations. Of 24 groups that responded to the question, nine (or 38 percent) preferred the current registration period, while 15 (or 62 percent) would prefer August to October. Thirteen of these (54 percent) would also like year round registration but seven groups (29 percent) disagreed with year round registrations. The most common reason given for disagreement was that this would lead to abuses and procrastination.

Community perceptions of the scheme

The research shows that popular perceptions that the scheme belongs to the hospital and the Catholic Diocese and not to the people (or, expressed differently, that it ought to belong to the people of the district but that they have had little or no say in how it is run) have bred cynicism and strongly held beliefs that the scheme has led to, among other things, the problems below.

- Discrimination against insured people (86 percent of those who discussed the issue in the focus groups agreed with this view, contrary to all available objective evidence);
- Poor quality of care for the insured, as show in the following responses from focus group discussions with 15 non-insured groups:
  - Seven groups specifically said that non-insured people received better care at the hospital than insured people;
  - Six groups complained that staff attitudes to insured were a discouraging factor
  - Six groups said that quality of care for insured groups at the hospital was simply not good;
  - Nine groups, or 75 percent, stated that hospital staff and especially nurses were rude to patients; and
  - Six groups (86 percent) argued that there was discrimination by staff against insured people.

- Î The views expressed above are surprising in the sense that there is no evidence to suggest that insured people are treated differently or worse than the non-insured on any quality indicator;

- > Shorter hospital stays for the insured as compared to the non-insured (the opposite has been consistently demonstrated year after year in analyses of the scheme results);

- > Excessive efforts by staff to make a profit. Discussions reflected the view that the hospital and its staff do everything in their power to economise on their contributions in order to make profits for the hospital (the scheme is non-profit and is just barely able to cover most of its direct costs, while it is subsidised by government payments to staff and the use of hospital office space and vehicles).

These perceptions (described as misconceptions by scheme and hospital managements) have had a negative impact on registration.[11] They are probably fed by the scheme's lack of effective representation in the community and the feelings expressed by some local power centres of effective alienation from the decisive levers of control or influence in the scheme. It is probably not surprising that in such a situation, community members feel little or no guilt about defrauding the scheme or refusing to play according to its rules, such as refusing to register all family members as they are required to do.

An example of how these perceptions have affected the relations between scheme members and the management is illustrated by the controversy surrounding the hospital's casualty policy. Due to a prevailing and pervasive view in the community that the scheme promoters (especially the hospital) are always trying to save money at the expense of insured people, when the hospital initiated what it describes as an unrelated policy of detaining people in 'casualty' for observation during the first day or so of admission, this led to a serious misunderstanding by the population and accusations against the hospital and scheme management.

The uproar happened because of the fact that the insurance scheme does not cover the bills of insured persons who are on casualty admission for 24 hours or less. This policy was one of the single most vehemently denounced actions of the hospital and, by extension, the scheme management that came out of the focus group discussions. Four groups of non-insured persons put casualty detention at the top of their reasons for not joining the scheme (and nearly everyone else showed some concern for the impact of this on the insurance coverage). Three groups specifically qualified their answers on member satisfaction by pointing to the casualty detention as 'a ploy to deny the insured people' their rightful extent of coverage. Unlike most other issues, there was virtual unanimity on this with no one challenging or opposing the prevalent viewpoint in the community. Finally these responses were reinforced by interviews conducted with a cross-section of the scheme's field workers and other key informants during the evaluation research.

If nothing else, these views show that some amount of education still remains to be done to convince people that casualty was not deliberately introduced to reduce the expenses on insurance coverage. In effect, inhabitants of the town accuse the scheme management of a breach of faith in

[11] See the sub-sections below on "Reasons for Non-Insurance" and "Suggestions for Improvement" for the frequency with which these perceptions came up in the interviews.

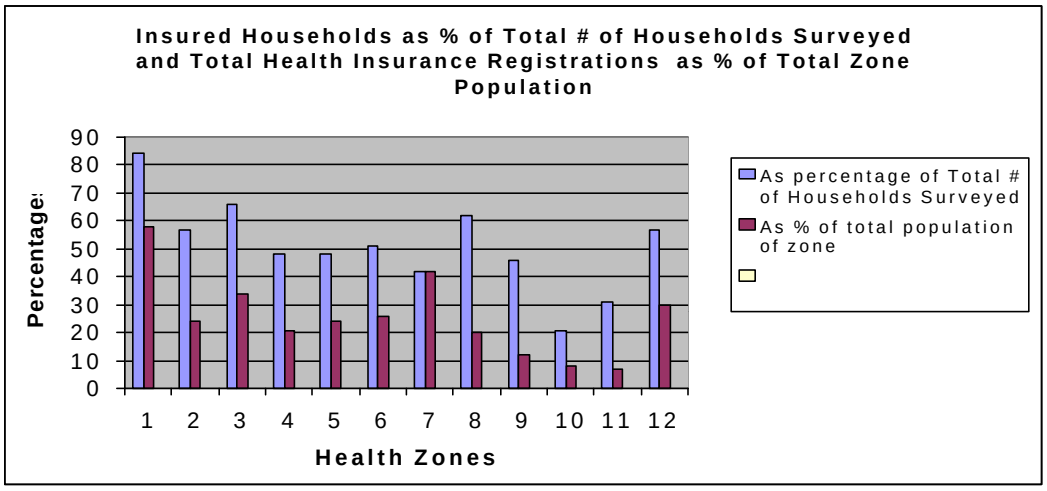
promising to pay 100 percent admission costs and then redefining admission to mean what they want so that they do not have to pay everything supposedly covered.[12]

This accusation, in the context of other similar ideas that the hospital and insurance scheme are in cahoots to cheat the insured people, has a potentially disastrous effect on the image of the scheme in the community. The focus group discussions may, in some ways, account for the low population coverage, but also more importantly for the cynicism of the community and lack of loyalty revealed in extensive adverse selection and such.

Adverse selection

One of the most remarkable findings was that the majority of households (57 percent on average throughout the district) reported that they were insured – but the scheme's estimated population coverage, according to its 1998 Annual Report, is around 30 percent. Therefore, given that the sampling was reasonably reliable, the researchers are left to conclude that most households are incompletely registering their members (by about half).This ties with previous anecdotal evidence that adverse selection (not poverty) is probably the strongest and most consistent factor in the scheme's low coverage rates.

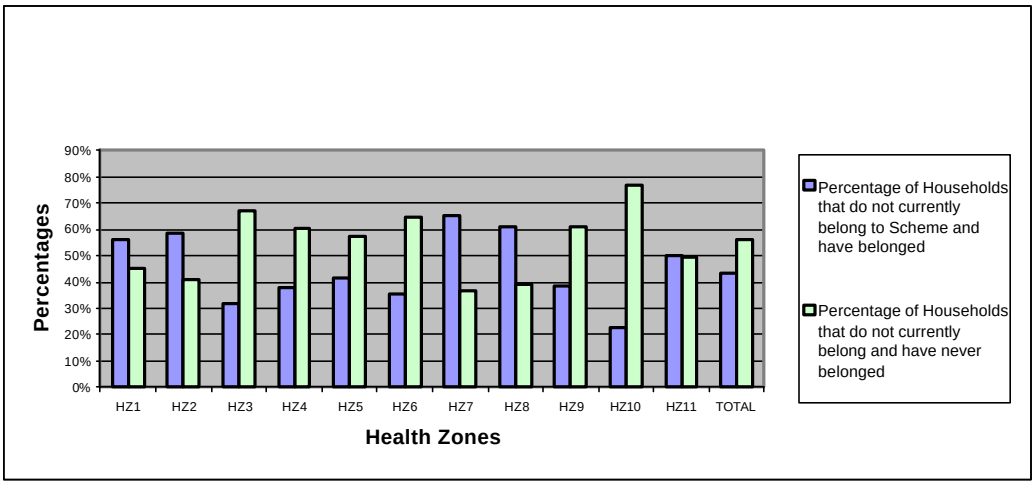
Figure 2.3. Declared vs Actual Scheme Membership



Another indicator of adverse selection is the number of people who fail to renew their membership each year, usually those who have not fallen ill and therefore consider themselves healthy. The chart below shows the breakdown from the household survey of households that do not currently belong to the scheme into the following two groups: 1) those have never belonged, and 2) those that have belonged before but not anymore. This chart gives a graphic indication of the extent of the phenomenon described above. Of the households that do not currently belong to the scheme (43 percent of all households in the survey), over 40 percent have at one time or another belonged. This is a high percentage of non-insured households that used to be insured but no longer are.

[12] It should be noted that there is no vernacular translation of the difference between detention in casualty and hospital admission.

Figure 2.4. Breakdown of Households that do not Currently belong to Scheme



Adverse selection is particularly difficult to combat in voluntary schemes based on community rating because the most effective tools commonly available for tackling this problem are not open to such a scheme: either compulsory membership (as in social insurance schemes where membership is obligated by law) or individual risk-rated premiums tailored to attract the healthier persons into the scheme (which is the normal practice with commercial health insurance companies, but not with community schemes like Nkoranza's). The Nkoranza scheme is both voluntary and community-rated (i.e., the premium is the same for everybody irrespective of his or her actual risk level).

Even with community-rating still in place, it is possible that a different design approach combined with a better skilled management and staff (with good training in modern participatory IEC techniques and a transparent management system might have enhanced the scheme performance and prevented the current situation of 'misconceptions' and adverse selection. However, in this case, community perceptions of the scheme have now become part of its reality, which can no longer be ignored. The research also does suggest what forms of community participation might help to minimise or eliminate the risk of adverse selection. While these suggestions should be considered for integration in the re-design of the scheme, more broadly, a combination of these and other measures would be more likely to improve both the viability of the scheme and population coverage rates, two key objectives of the promoters of the scheme. Some of the additional measures suggested are presented in the recomendations section.

Given the current atmosphere of suspicion of management motives by members of the community, the research also suggests that several of the key reform measures would be likely to succeed only if they were preceded by confidence-building steps, expanding community involvement and management accountability and transparency. In other words, community participation in some form may now be a pre-requisite to significantly advancing the scheme beyond where it is today.[13]

[13] For this reason the researchers have tried to recommend those steps that can be implemented right away, and those that it would be wiser to attempt only after restructuring to bring about greater community participation within some co-management structures (see section 3).

2.2.2 Specific Findings According to the Original TOR Items

Please note that terms of reference items which are similar have been grouped together for convenience.

2.2.2.1 Household Expenditure Patterns and Priorities (TOR items 1 and 5)

Our analysis was based on the household survey and the SPRING Report, which presented the result of a survey carried out in 1993/94. From the latter report, health spending in the district as a whole is 4.8 percent of total spending, after food, clothing, education, transport, energy, and crop farming, but before funerals (which consume only slightly less of household income at 4.2 percent), housing, water, etc. (the case of Nkoranza town is special, see below). Assuming that this order of priorities remains basically similar, the researchers can surmise that health takes no more than 5 percent of the total spending of the average household.

In today's terms, according to the household survey conducted for this evaluation, this percentage represents an average of around 24,000-27,000 cedis per month. For Nkoranza town itself, however, health occupies a slightly higher priority in the SPRING Report, before energy and crop farming which are higher priorities in the district as a whole. Health does, however, constitute slightly less (4.3 percent) of household expenditure, due mainly to greater proportions of income spent on food.[14]

The conclusion from the data is that, for the Nkoranza district as a whole, among the top household priorities, i.e., food, clothing, energy, transportation, education, health, water and housing, health comes near the bottom of the list. However, this classification for the whole district ignores one vital point: health may not occupy the topmost place when looking at expenditure across the district, since only a minority incurs extremely huge health bills annually. For this minority, health probably moves to the highest priority at the moment that an emergency strikes because calamitous health problems usually involve life and death. In other words, the kinds of services provided by the Nkoranza health insurance scheme (hospital admission, complicated births, snake bites) constitute top priorities for the section of the population who are affected.

To state the issue more precisely, the population affected by calamitous health problems is actually more likely to be the vast majority and not merely a minority. Is this a contradiction? Not at all, because no one can predict when calamity will strike, and nearly everyone is potentially at risk. It is the willingness to pay for reducing this uncertainty and the consequences of this risk (i.e., aversion to risk) across the population as a whole that matters, and insurance is of course based precisely on this principle. The ex-poste expenditure patterns cited above are not a reliable guide to determining how many people will purchase health *insurance*, which we suspect is the real issue of interest to the scheme promoters when they formulated this particular point in the terms of reference. It is the community members' aversion to risk that counts, and practically speaking, that aversion can only be determined in two ways: first, take the number of people who have paid for health insurance in the year as a first approximation, and then, secondly, find out what factors prevent others from buying

[14] Compare the 1992 Ghana Living Standards Survey data which found 3.3 percent of urban and 4.9 percent of rural expenditure (4.2 percent for the whole country) going into medical and health items. In that 1992 survey, medical care and health expenses came 6th out of 9 expenditure groups for the rural areas, and 8th out of those 9 groups for the urban areas.

into the insurance scheme so that by removing or reducing them, more people will be able to become insured. The latter is the focus of this evaluation.

2.2.2.2 Reasons for Higher Bills for Insured Patients Against Non-insured Patients (TOR item 2)

The evaluation team found out that scheme promoters already had a working hypothesis; that the costs of normal deliveries in the non-insured population's average bill calculations account for this difference. Generally, insured people are not admitted for deliveries, but rather for general admission to the hospital.

The research team asked for the calculations on which this hypothesis is based. The data are shown in Table 2.2.

Table 2.2 Comparison of Insured and Non-Insured Admission Costs Excluding Normal Deliveries at Nkoranza (excluding normal deliveries)

NON-INSURED ADMISSIONS

MONTH	# Normal Delivery Admissions	Total Cost Deliveries	Average Cost Normal Del	# General Admissions	Total cost General Admissions	Average Cost General Admn.
February	12	375,000	31,250	20	1,702,850	85,143
March	14	358,300	25,593	22	1,410,950	64,134
April	12	308,100	25,675	23	1,986,900	86,387
May	14	391,500	27,964	31	2,250,650	72,602
June	21	482,700	22,986	28	2,876,700	102,739
July	4	127,500	31,875	10	643,500	64,350
TOTAL	77	2,043,100	26,534	134	10,871,550	81,131

INSURED ADMISSIONS

February				92	7,941,843	86,324
March				58	6,837,030	117,880
April				49	4,437,266	90,556
May				61	4,123,698	67,602
June				48	5,274,215	109,879
July				51	2,914,616	57,149
TOTAL				359	31,528,668	87,824

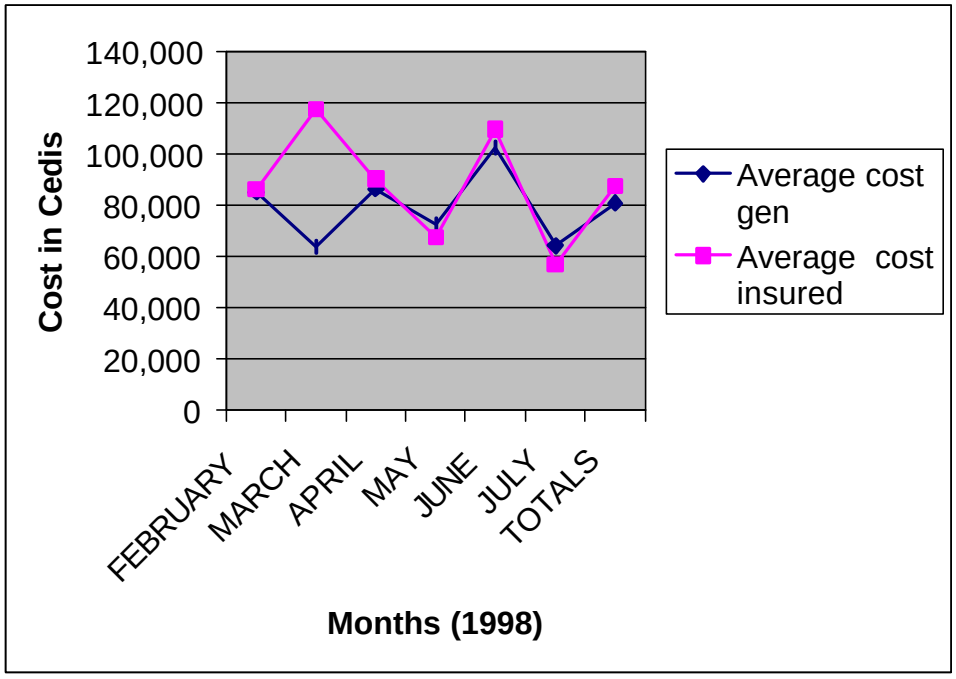
A graphical representation of this data is also shown below. It can be seen from this graph that the average costs of insured and non-insured patients are virtually identical from April onwards, and especially the averages of both over the six months represented by the last data points. This appears to suggest that the reason for the higher average costs of insured over non-insured admission costs boils

down to the normal deliveries component contained in the non-insured admission costs. Such deliveries are excluded from the coverage provided by the insurance scheme and are therefore not reflected in insured admission costs.

A word of caution is needed. This data relates only to a six-month period in 1998, while the scheme has been in existence for eight years. There is nothing to indicate that this period is representative of this entire eight-year era. A similar exercise over a longer period, or over a number of randomly chosen months, would generate greater confidence in the data. The data available to the evaluation team was unfortunately not sufficiently desegregated into normal delivery costs and other costs to enable the team to carry out this exercise.

While it can be said therefore that the available evidence points to no significant differences in cost between insured and non-insured patients, this has to be qualified by noting that this evidence is not sufficiently conclusive to answer the request of the TOR in any definitive way.

Figure 2.5. Comparison of Insured vs Non-Insured Admission Costs



2.2.2.3 Determining the Role of Poverty in the Perceived Low Registration Levels of the Scheme (TOR item 3)

The most reliable poverty profile of the district found during this research was the SPRING Report, which used an approach suggested by the World Bank. The results, shown in Table 2.3, report poverty lines in Nkoranza District and Nkoranza town separately. Those who fall below two-thirds of the average income of the community are described as “poor” (i.e., below the poverty cut off) but those falling below one-third of average income are described as “hard core poor” and are especially hard hit.

Table 2.3: Poverty Lines in Nkoranza District (cedis)

	Poverty cut off (cedis)	% of population	Hard Core Poverty cut off (cedis)	% of population
Nkoranza town	433 667	24	216 833	8
Whole district	315 778	45	147 888	17

Source: SPRING Socio-Economic Survey (1993/94); Table 3.23.

Nearly 45 percent of the district are described by these criteria as poor and 17 percent as hard core poor. In Nkoranza town, however, the situation is better with 24 percent of the households living in poverty and 8 percent below the hard core poverty line. From this data and analysis, the SPRING team concludes that "poverty is more predominant in rural areas than in urban areas".

The hard core poor are presumably a group that could not afford to subscribe to the health insurance scheme, irrespective of their risk aversion and desire to join the scheme. Another method would have to be found to cover the health insurance or health care needs of this category (see the recommendations below). But the real implications of this finding from the SPRING Report are that a sizeable proportion of rural households, 17 percent, and a rather smaller proportion of Nkoranza town households, 8 percent, are not normally insurable because an economic premium rate would likely be outside their reach.

However, these figures for the group of hard core poor cannot fully explain the low level of coverage of the insurance scheme, because if we add them to the insured (17 percent + 31 percent) and subtract the resulting percentage from 100, we are left with 52 percent of the population non-insured which remains unexplained. Our analysis has shown that adverse selection is probably a more convincing explanation of the low coverage rates than poverty.[15]

2.2.2.4 Willingness To Accept Co-Payments, Deductibles and Other Forms of Payment (TOR item 4)

The household survey produced a superficial impression that a majority of the population was in favour of co-payments in order to prevent the scheme from collapsing. On average, 67 percent of households were found to be willing to pay for a portion of their hospitalization fees to keep the scheme from going out of business.

Evidence from the focus groups directly contradicted this finding from the household survey. It turned out that households were only expressing what they might be willing to contemplate in order to save the scheme from total collapse (thus indicating at least a positive commitment to see that the insurance scheme continues to exist at all costs), and not a desire to see such charges introduced, or a willingness to make co-payments. In fact, when asked the same thing in a more open question format,

[15] It may also be of some significance that when the question was posed during the focus group discussions, many participants did not tend to see poverty as a major impediment to registration. Of the groups that discussed the question, five concluded that it would be possible to identify poor people in the community who cannot pay their premiums, but eight groups stated that it was not possible; some even went further out of their way to discourage any consideration of the question on grounds that it should not be the concern of the scheme at all.

most groups vehemently rejected co-payments or deductibles of any kind, preferring an increase in the premiums to such options.

Table 2.4 summarizes the results from the discussions on co-payments and deductibles. Only 5 percent and 15 percent of the groups would be willing to countenance some form of such payments respectively, and 95 percent and 85 percent respectively reject outright the notion of either form of payment.

Table 2.4: Discussions on Co-Payments and Deductions

ISSUE	Number Agreeing/ Affirmative Answer	% Of Total Responses	Number Disagreeing/ Challenging	% Of Total Responses	Total Responding
Do you favour:					
Co-payments?	1	5	18	95	19
Deductibles?	3	15	17	85	20

The evaluation team is convinced that, at present, the opposition to either co-payments or deductibles is strong. This does not necessarily mean the idea should be totally abandoned. The recommendations suggest how this point should be approached in order not to derail the scheme altogether with precipitate fees that are ill-understood.

It is worth noting that when the question was specifically asked whether hernia patients should co-pay for part of their treatment costs, opposition was markedly less vigorous, with 10 groups or 45 percent of respondent groups saying 'yes' and 12 or 55 percent saying 'no.' Moreover, some patients can afford to register for the scheme when they know they have the condition, then schedule their elective surgery and afterwards leave the scheme. (This procedure is relatively expensive.) It seems that the case for imposing some co-payment in hernia cases is morally and financially powerful.

2.2.2.5 The Extent of Moral Hazard (Providers and Users) in the Scheme and Ways of Eliminating Them (TOR item 6)

Normally, given the nature of the benefits offered by the Nkoranza Community Financing Scheme, one would not expect user-initiated moral hazard to be a major problem. Hospital admission, the major benefit, is generally not a patient's decision. There is evidence – although difficult to quantify – to suggest that some people would feign severe symptoms in order to gain admission, as a way of escaping bill payment. There is no evidence of people feigning snake bites (the only OPD benefit), however.

Nevertheless, in interviews and discussions with the scheme promoters, it is clear that user moral hazard is felt to be a serious problem. One way to have gauged the extent of this phenomenon would have been to look at the number of insured people who report with symptoms requiring admission but who are sent home by the doctor in less than 24 hours without treatment. Unfortunately, data concerning casualty detention show no distinction between insured and non-insured persons and so such analysis is not possible. Moreover, there is some controversy surrounding the policy of casualty detention, as explained earlier.

The largest source of user moral hazard comes from another source – the powerful incentives from insured sick people to go straight to St. Theresa's Hospital in the hope of getting admitted rather

than passing through the local health centre first. There are no penalties for doing this. Moreover, many local health centres are in poor shape and people associate the hospital with better care (seeing a medical doctor at all costs). Therefore, few insured people bother to go to a health centre with their health problems. This moral hazard problem, which aggravates inefficient use of resources across the health sector of the district, will remain so long as the incentives for such behaviour exist. The solution is not easy either. Focus group discussions showed that vast majorities would oppose any scheme requiring them to pass through the local health centre first, unless perhaps other prior reforms are undertaken to improve quality at those centres.

If the scheme management is serious about arresting this source of moral hazard, which has the potential to significantly reduce the scheme's expenses, they may wish to experiment with a few health centres by giving the staff of those centres incentives to improve quality. For example, they could help them to constitute revolving drug funds to ensure drug availability and/or link personnel bonuses to clear quality improvement indicators.

On provider moral hazard, there is fairly consistent evidence coming from insured people who have used the hospital that they are regularly asked their insured status before a doctor or nurse prescribes or refers them. It should be noted that the vast numbers of scheme or community members have not been to the hospital. It is not the answers given by the absolute or even relative number of groups or people participating in the evaluation, however, that matters. Rather, the views expressed by those who have been ill and gone to the hospital for care are the most useful. The rest of the community tends to form their views on the basis of the experience narrated by those who have actually gone to the hospital for care. During the focus group discussions, two groups including ex-patients qualified their responses by noting that doctors and nurses constantly ask about their insured status before prescribing treatment. Three other groups, when asked for suggestions for improvement, requested that medical staff stop asking for their insured status.

The insured people are convinced that the only reason to ask for this information is to be able to discriminate against them. Paradoxically, the way provider moral hazard usually works is that once such knowledge is available to the prescribing or attending physician, the latter will tend to discriminate in favour of the insured. They tend to prescribe the most expensive treatment options, use expensive equipment and prolong their hospital stay because they know these people have no difficulty with paying – all directly contrary to what the community has come to believe.

In any case, it has become counter-productive for medical officers and nurses to demand patients' insurance status when such information is not necessary. It is certainly not in the interests of the insurance scheme that such information is known by the prescribing or attending medical officer, and insured patients are vehemently of the opinion that this is not in their interest either.[16]

[16] This phenomenon is particularly curious in light of the fact that insurance organisations around the world tend to fear precisely the opposite; i.e., collusion between patient and doctor, for the latter to give the best possible and expensive care to the insured, to the detriment of the insurance organisation. This illustrates that relations between the insurance scheme and the hospital are breeding an unfortunate atmosphere of suspicion concerning whose interest the scheme really stands for, the insured firmly believing that it is the hospital's interests only that count, and not that of its members.

2.2.2.6 Other Findings of Concern and Interest to the Community and the Scheme

The research also sought the views of the community on particular questions and tested proposed answers to some of the problems identified in order to get a better appreciation of the Nkoranza community's views on these issues. In addition, we wanted to gauge their commitment and readiness to respond to new initiatives aimed at moving the scheme forward. Some of the questions and proposed solutions originated from the scheme promoters, others from the evaluation team, but all were within the scope of the agreed terms of reference. This sub-section presents the findings on these questions and issues. Data for this analysis came mainly from the focus group discussions, which generated a wealth of information that we thought it would be useful to analyse and present in a succinct form for the benefit of the scheme promoters who commissioned the evaluation.

Understanding of insurance

In order to see how extensively the members of the community understood the concept of community health insurance such as Nkoranza's, a number of questions were posed during the focus group discussions by the facilitators regarding various forms of insurance and people's understanding of them.

Twenty out of 24 groups stated that they understood what community health insurance meant (the other four said they had no idea) but of these, 11 gave a definition that reasonably captured the essence of the concept. Two groups were able to draw a distinction between private commercial insurance and community health insurance while 13 could not. Additionally, six groups were able to draw on similar examples from traditional institutions to illustrate the concept of community health insurance. Such traditional examples included susu, funeral contributions, "Abusua Dwatire" and "Abusua Fotoo" to which "one has to contribute before he falls into trouble, otherwise if the trouble befalls the one before he makes the contribution to it the one cannot enjoy immediately (sic)".

It would appear from the discussions that the people of Yefri best understood community health insurance. The general group defined it as "a mutual relationship created by people likely to be affected with a common risk, who contribute to a common fund from which a member is relieved in times of the happening of such eventualities." Paradoxically, even the non-insured (!) in Yefri (Boana) had a better definition than most insured people did. They saw it as a "mutual way of living where members contribute to a common fund from which the members are supported in an event of the occurrence of the very calamity (for) which the money was purposely set aside".

Clearly there is rich material here for the educational campaigns of the scheme, even from the observation of the Kranka (Rural) group which said that health insurance is a form of "lotto"!

Family group registration

In order to contribute to combating widespread adverse selection, the team tested reactions to the idea of changing the system of family registration so that membership would now be based on specific family size categories, with a progressive dues scale so that the more family members registered, the less the fee per head for each person in the family. There was general enthusiasm for this idea, with 19 of 22 groups (86 percent) approving and three (14 percent) against.

In addition, the Nkoranza Traders Association and the PROTOA transport owners group indicated willingness to undertake the group registration of all their members on behalf of the scheme. Modalities need to be discussed with the leaders of these groups.

Results of discussions relating to these and similar issues are shown in Table 2.5.

Table 2.5 Family/Group Registration

ISSUE OR DISCUSSION THEME	NUMBER AGREEING or AFFIRMATIVE ANSWER	% OF TOTAL RESPONSES	NUMBER DISAGREEING /CHALLENGING	% OF TOTAL RESPONSES	TOTAL RESPONDING
MEMBERSHIP BASIS					
Would prefer membership by family groups with progressive dues scale	19	86	3	14	22
Agree there are groups in community which be basis of membership	4	29	10	71	14
Trust their own community people or groups to register them	2	50	2	50	4
Able to identify poor in community who cannot pay premiums	5	38	8	62	13
Would like susu and installment payment for dues	4	100		0	4

Coverage of other services

One of the objectives of the evaluation was to see whether the scheme management could institute certain measures to improve the services of the scheme and its viability into the future. To that end, questions regarding an extension to the present service coverage and extra premiums to cover these were posed, and the results are shown in Table 2.6.

Table 2.6 Potential Changes to Benefits

ISSUE OR DISCUSSION THEME	NUMBER AGREEING or AFFIRMATIVE ANSWER	% OF TOTAL RESPONSES	NUMBER DISAGREEING /CHALLENGING	% OF TOTAL RESPONSES	TOTAL RESPONDING
COVERAGE OF OTHER HEALTH SERVICES					
Increase cover?	9	45	11	55	20
Include health centres?	9	36	16	64	25
Mandatory passage through' health centres?	3	14	18	86	21
Extra premium for more cover?	10	56	8	44	18
Add maternity cover?	8	80	2	20	10

Most groups (55 percent) did not see any need to increase the coverage (with the exception of maternity, see below), and the reason was mainly the fear that this would entail extra payments which they could not afford or were not willing to shoulder. Sixty-four percent of groups also disagreed with extending the cover to include health centres, and again this was principally because people did not trust the quality of services delivered by those centres. This suggests that any plan to extend services to health centres must therefore include a quality improvement component, otherwise it is unlikely to work.

For similar reasons, an even higher percentage (86 percent of the groups) were opposed to any plan to make members pass through health centres as a condition for the scheme covering their care if referred to the hospital. Such a measure, nevertheless, would be essential to arrest moral hazard and reduce costs for the scheme, apart from helping to reinforce the primary care approach which is official policy in Ghana. The same suggestion above about extending cover to health centres applies here too.

It is interesting however to note that most groups (56 percent) agreed that if the cover was to be extended, it would have to be supported by extra premiums. In particular, nearly all women-only groups and some mixed gender groups advocated the addition of maternity care to the scheme's services. This would be a highly popular demand by the women of Nkoranza and it would be worth studying the modalities of adding normal maternity care as an optional benefit for an extra premium to which members who wish could subscribe.

Participation and accountability

One of the ways that the scheme promoters want to improve the scheme is to increase the extent of participation by the community and its accountability to members. During the focus group discussions, this was the theme that excited the most comments and interest. The groups had very definite and firm views of what they thought should happen. The analysis of those discussions is given in Table 2.7.

It should be emphasised that when groups were posed the question as to whom the scheme belongs to, most often, they re-phrased the question themselves into 'to whom should the scheme belong to?' This explains why 20 groups (with no opposing view) declared that the scheme should belong to Nkoranzaman district or its members. The four groups that stated that the scheme belongs to the Diocese/hospital were the ones that literally answered the question as put, but even in those cases, they then added (without exception) that the scheme should belong to the community.

Very impressive majorities would like to have annual general assemblies (90 percent of those responding to this issue) and to have elected representatives in the management (86 percent). Ten out of eleven groups also want to see the accounts and audits of the scheme presented publicly to the members.

Table 2.7 Community Participation

ISSUE OR DISCUSSION THEME	NUMBER AGREEING or AFFIRMATIVE ANSWER	% OF TOTAL RESPONSES	NUMBER DISAGREEING /CHALLENGING	% OF TOTAL RESPONSES	TOTAL RESPONDING
PARTICIPATION AND ACCOUNTABILITY					
Scheme belongs or should belong to Nkoranzaman district	20	100		0	20
Scheme belongs to hospital/Catholic Church	4	100		0	4
Would like to have assemblies	19	90	2	10	21
Want participation in or to elect reps to management	19	86	3	14	22
Want accounting and audits presented to members	10	91	1	9	11
Want to be consulted on issues	4	24	13	76	17
Want to be informed of policy changes	5	100		0	5

Reasons for non-insurance

In seeking reasons for the apparent low coverage of the scheme and in efforts to increase the population coverage, it is clear that the views of the currently non-insured are crucial. Field researchers were instructed to make all efforts to assemble groups of non-insured persons in order to understand their reasons for not insuring themselves and to learn what might be done to attract them to join. The results are displayed below in Table 2.8.

Table 2.8 Non-insured Issues – Reasons for Not Registering

ISSUE OR DISCUSSION THEME	NUMBER OF GROUPS AGREEING or GIVING THIS ANSWER
Financial – premium too high	15
Registration period not good	11
No maternity cover	9
Large family	8
Better care for non-insured at hospital	7
No OPD cover	7
Staff attitudes to insured	6
Bad quality of care	6
Casualty is discouraging factor	4
Increasing coverage to all services	4
No cover for referrals out of St. Theresa's	3
Lack of incentives for healthy members	2
Distance from hospital	1
Lack of cover for other nearby health facility	1
More education required on scheme	1

Not surprisingly, the top reason given for not insuring is financial, that is, the premium is unaffordable. This does not necessarily mean the absolute level of the premium is too high. Especially when one notes that the second most frequent reason given is the period of registration being inappropriate, one may also conclude that the first answer reflects the fact that December-January is not the best period for them financially. Lack of maternity cover again figures high here, especially among non-insured women groups. It is also worth noting from this table that large family size is given as a reason for not insuring. Presumably, these are the honest ones who would like to insure, but scheme rules about insuring all the family prevents them from doing so since it would be unaffordable. This further reinforces the relevance of the approach emphasising incentives, not sanctions, for registering as many members of the family as possible, with the fee per head reducing as family size increases.

Suggestions for improvement

Finally, focus group members were given the opportunity to make any suggestions to the scheme management for improving the scheme in future, and those suggestions are given in Table 2.9 below, by frequency of response.

Table 2.9 Suggestions for Improvement

ISSUE OR DISCUSSION THEME	NUMBER OF GROUPS AGREEING or GIVING THIS ANSWER
Improve hospital staff attitudes	6
More education on scheme required	6
Local representatives on management and board	5
Separate scheme and its offices from hospital	5
Installment/Susu payment	4
Maternity cover needed	4
No asking for insured status	3
AGM needed	3
Go into income generation activities	3
Premium stability needed	2
Newborn children should be automatically covered	2
Annual accounts and audits to the public	2
Additional scheme cover – OPD etc.	2
Better care of patients at hospital	2
Reward those not using services in the year	2
Abolish casualty	2
Obtain District Assembly Common Fund to help scheme	2
Scheme should cover referrals outside St. Theresa's	2
Scheme officers should visit admitted members	1
Distribute scheme profits to health centres as drugs	1
Blood transfusion should be covered	1
Set up Insurance Club – could generate income	1
Hypertension should be covered	1
Scheme should re-insure for big expenses	1
Improve service quality	1

Not surprisingly, many of the top issues have been recurring themes throughout both the household and focus group interviews, as well as other key informant interviews conducted for the evaluation. These issues include improving the attitudes of staff to patients, effective participation of the community and accountability to the members, addition of maternity cover and the notion that doctors should not ask patients for their insured status, etc.

Personnel issues

The evaluation team also met with the scheme's two coordinators (who are the link between the scheme and the community). They appeared to be committed and eager to contribute to the success of

the scheme. However, they felt that they were not being sufficiently valued or appreciated. They complain of not being involved in any decision-making and it appears that communication between them and other members of the scheme management is not very frequent. They are clearly not satisfied with their conditions of service. It would appear that at least a meeting between the Executive Secretary and PHC Coordinator with the two scheme coordinators to discuss their concerns would be appropriate.

In more general terms, we studied the existing skills in the scheme and noted that the staff (at least the coordinators) were not aware of their formal job descriptions. While specific training targeted at each member of the staff is the subject of further technical assistance which PHR has agreed to provide to the Nkoranza scheme, we simply note here the following skills that appear to be either lacking or not sufficiently developed among scheme employees:

- Marketing and community participation methods (IEC);
- General management including risk management techniques;
- Negotiation skills;
- Accounting and book-keeping (in fact the scheme itself has no one specifically handling these areas);
- Computing skills; and
- Monitoring and evaluation of a community health insurance scheme including internal (managerial and financial) auditing.

2.2.3 Key Areas of Concern Identified from Findings

The key problem areas that emerge from the findings and which require solution in order for the scheme to advance are:

- Inappropriate registration period.
- Community misconceptions (and sometimes suspicions) of management's motives. These make it difficult to implement measures that are objectively in the interest both of the scheme and members but that risk aggravating the above problems; examples are casualty detentions and co-payments or deductibles.
- Adverse selection resulting in high household coverage but low population coverage, potentially the biggest threat to the viability of the scheme at the moment.
- Moral hazard resulting from both user and provider behaviour, resulting, among other things, in inefficient resource allocation in the district's health sector.

3. Recommendations

The recommendations here pertain to the main problems emerging from the findings, as well as some suggestions for general efficiency improvements. It would appear to be prudent, based on these findings, for the scheme to base its immediate strategy around the tackling of the erroneous conceptions and widespread cynicism detected among the population of the district. For this reason, we begin here with recommendations concerning the issue of the image of the scheme, including proposals for organisational restructuring to incorporate active community involvement, which were tested during the evaluation.

After the proposals on restructuring, each section of the recommendations section is then arranged in two parts: 1) those actions and steps that can be taken or implemented right away (i.e., *before* the major restructuring), and 2) those that should be undertaken only *after* the restructuring of the scheme.

3.1 Misconceptions and Image of the Scheme

Before Restructuring:

1. The evaluation team believes that specific IEC training for the scheme coordinators and staff (with special emphasis on community participatory methods) is essential because of a top-down and out-dated approach to community education and consultation. This is also necessary because it is one way to address legitimate fears expressed by the DHC that community participation and ownership currently being advocated could turn out to be a bad experience. There are so many other unfortunate examples of community ownership that ended up disastrously, due primarily to organizations being hijacked by a few unscrupulous individuals. The only way to answer those fears is to adopt modern techniques for ensuring effective community participation, the training for which a number of Ghanaian and foreign organisations can offer. For example Kirk Lazell of the USAID Mission in Accra has suggested to one of the authors that the Johns Hopkins Population Communication Services (PCS) IEC project could be of some help in this and other areas. The Catholic Diocese should contact them to see what can be offered to help the scheme in this regard. Contact details are: Mr. Tweedie, Country Director, Email: itweedie@jhuccp.org.gh (Ms. Kirk Lazell of the USAID Mission could give further details if required).

2. Relations between the hospital (especially the nursing staff) and the general public needs drastic improvement. A suggested approach that the scheme staff could initiate is as follows: first, hold a consultation meeting between representatives of nurses and representatives of the community (in this case it would not suffice to meet only with either the Traditional Council or District Assembly but there should also be people directly facing these problems themselves and who can therefore express the grassroots feelings well, for example, a selection of people from community/professional associations of the town and some ordinary insured and non-insured people from each of the villages who can report back to others what happened). The objective would be to discuss common complaints of both sides concerning the other and to seek means of cooperation between the community and the hospital staff to the mutual benefit of all (not just to present grievances against nurses, as patients too can behave rudely at times and disrupt services) and also to put in place a mechanism for resolving future disputes/complaints. After this meeting,

each side undertakes to sensitise their respective organisations or communities on the outcome of the meeting and the mechanism agreed upon. Both sides must then pledge to use only this mechanism for redressing complaints and not to use rumours and blanket allegations. The mechanism should involve investigating complaints and reporting to the appropriate representatives for redress.

3. Casualty should be costed and included in the basic coverage of the scheme. A community consultation exercise could precede implementation of cover for casualty detention in order to sensitise the community on the dangers such cover could bring, and therefore to enlist the community's help to find alternative ways for arresting such abuse should it occur. The scheme could insist on some workable alternative(s) as a quid pro quo for covering the unpopular casualty system.

4. There were numerous calls during the focus group discussions and stakeholder interviews for the insurance scheme to be physically separated from the hospital. That is, the scheme should be moved out of the hospital's premises. There are obviously cost implications to this proposal, but it is also a project that was already envisaged by the scheme promoters and one that the District Assembly is willing to assist. There is no doubt that a physical separation will do a lot psychologically to calm the minds of some members of the public about some of the blatant accusations of the scheme's hospital manipulation.

3.2 Proposed Reforms in Organisational Structure

Before Restructuring:

1. It should be emphasised that we detected a general desire even by the scheme promoters to move the Nkoranza scheme towards a system of greater community accountability. Some even proposed full community ownership. We have not suggested the latter, however, because we believe it is important that the scheme retain the technical competence provided by the Diocese for managing the scheme. Community participation should be reinforced through co-management structures that allow the district population to play a role that would also enhance the accountability and transparency of the scheme. In this way, both parties bring to the table what they do best to the advantage of the whole Nkoranzaman community.

2. The evaluation suggest that funding be sought (possibly from the District Assembly, if not from the scheme's funds) to hold Annual General Meetings (AGM) of representatives from communities and villages, as well as identifiable community groups and associations (including GNAT, Nkoranza Traders Association, PROTOA, GPRTU), the Traditional Council, District Assembly, DHC, the hospital, and the Nurses Association. The scheme management will report on activities for the year and their results, and external auditors will present the scheme's accounts to the public. Proposals for policy changes could be debated here too. This meeting could have a triumvirate steering and convening body drawn from the DHC/Hospital, the Traditional Council and the District Assembly, with the Bishop or his representative serving as the chair (in recognition of their role as initiators of the scheme). The AGM should have power to appoint the coordinators of the scheme, though the manager should continue to be appointed primarily by the DHC (as they have primary responsibility for the technical management of the scheme). In exercising this power, it is advisable to consult with the District Assembly and the Traditional Council to obtain consensus.

3. The scheme should have a new supervisory organ or oversight committee composed of volunteers from the community – mainly representatives from the health zones and identifiable community associations/organisations, especially those organisations that agree to register their members en bloc each year. As in cooperatives, their role would be to investigate and check abuses in the scheme both by the members and the scheme staff, to investigate complaints against the scheme, and to report to the AGM. (As a result of this function, no member of the Supervisory or Oversight Committee can simultaneously belong to any of the other executive or management bodies of the scheme.) They could also be given the power to order audits where necessary but only if the costs of such extra audits can be shared, for example, with the District Assembly or some other organisation.

4. The evaluation team proposes a new management board to replace both the existing one and the advisory board. This will be ideally composed of equal numbers of representatives from the DHC/Hospital, the District Assembly and the Traditional Council (and possibly other key stakeholders too). There should be a clear stipulation that certain fundamental areas such as the dissolution of the scheme cannot be done without the agreement of all parties.

   However, as a way of phasing in this process of community co-ownership, it may be more practical that in the first phase, the new management board should have a majority of DHC/Hospital membership (which is still a vast improvement from the current situation, and especially if both the Annual General Meetings and Supervisory or Oversight Committees are set up involving the community in the scheme as never before).

   The District Chief Executive of Nkoranza had made a commendable proposal that the costs or allowances of this new management board should be borne by the District Assembly and not from the members' contributions. This suggestion is strongly endorsed and recommend.

After Restructuring:

5. Once the restructuring is complete, medical officers should not serve on the management of the insurance scheme except in an advisory capacity. In this respect, they will be able to discuss or advise on specific technical matters relating to their domain but they will not have responsibility for the running of the insurance scheme. There is a potential conflict of interest involved where the medical officer has responsibility both for the financial health of the insurance scheme and the individual health of the insured persons, and the interest of the medical officer is not only to treat people to the best of his/her ability without consideration of the person's insured status nor of the scheme's interest, but to be SEEN manifestly as doing so.

3.3 Inappropriate registration period

Before restructuring:

1. The researchers suggest changing the main scheme registration period to August – October each year. Management may also then wish to consider either allowing registration throughout the year at health centres, with a compulsory 3-month waiting period before access to services is allowed or have a minor registration period from December-January each year. For more robust assurance against adverse selection, those registering in the main registration period should also be subjected to a one-month waiting period.

2. Health centres should be used as registration centres outside the main registration season, with health centre staff being offered the same incentives as for field workers when they register a certain number of persons.

3.4 Adverse Selection

Before restructuring:

1. There is a need to introduce more incentives for registering all family members: The research showed overwhelming support for membership by family groups with corresponding fee categories and declining fee per head as family size increases, as follows:

Family/membership category	Sample Fee per head (in cedis)
Individuals and groups up to 3	X
Family of 4 or 5	X less 10%
Family of 6 or 7	X less 15%
Family 8 or 9	X less 20%
Family of 10 or more	X less 25%

These percentage reductions in fee per head are only indicative and should be modified by the scheme management what is acceptable in accordance with calculations of expected income. This recommendation should ideally be implemented only after a family register has been compiled for the district. It was suggested during the evaluation that Memisa was willing to fund a family registration campaign in the district. If this can be entrusted to an independent census/statistics agency, it would be a very useful tool for managing the family registrations.

The possible challenge is that this system will encourage families to gang together. Such a fear can be met with these responses: (1) if the family register is compiled, it could provide a means of foiling such plans; (2) even if such ganging up still took place, the net result is likely to be a reduction of adverse selection anyway and higher registrations which, if the X fee per single member is fixed at the right level, will still in fact bring in more net revenue.

2. Serious consideration should be given to the suggestion from the focus group discussions that individuals who do not use the services in a year should be encourage to stay on by means of some incentive. Given that it may be difficult to reward all the thousands that would be involved, an inexpensive suggestion from the same discussions that could be studied is that a raffle be held for such people in each village/community.

3. Several occupational groups, such as the traders association and transport owners union expressed willingness to undertake the registration of their own members as groups. Discussions should be started with them to explore the modalities of doing this, emphasising that the scheme objective is 100 percent registration of members and their families. The leaders of those groups should also be asked to exercise some social control over those among them who abuse the scheme.

After restructuring:

4. There should be sanctions for withdrawing from membership and then returning at a later date to join; also for once-only registration (this means significantly higher entry fees for new membership, but significantly lower ones for re-registering – the present gap between the two is not large enough and should be made so by simply raising the initial fee much higher than the renewal fee. Even if a person had been a member before but did not renew on the lapse of his/her membership, they should be considered a new member and thus subject to the new member fee. In addition, they should lose any rights to participate in the raffle draw or other incentives given to loyal members.

5. Community registration targets need to be set at the annual general meetings suggested below. There should be targets set for each village and then for the district as a whole. For example, for the district, 100 percent coverage for children can be sought on the basis of the slogan that no child should be left at risk, irrespective of whether the parent is covered or not. The promotion of safe motherhood can be the basis of similar targets. There is no danger of adverse selection when the coverage sought for any population group is 100 percent.

6. An example worth studying is the case of Tom Village. The chief reportedly assembled the village and advised everyone to register, and that the people should otherwise not expect any help from the community if the unfortunate happens. This could be emulated by other chiefs as well. (This should form part of the pact to be agreed with Nananom in return for the greater recognition they are to be given in the scheme in accordance with the suggestions below.)

3.5 Moral Hazard

Before restructuring:

1. Medical officers should not ask patients for their insurance status.

After restructuring:

1. Co-payments and/or deductibles need to be instituted particularly for those refusing to pass through a health centre before coming to the hospital.

2. Hernia patients should make a significant but not excessive co-payment contribution. Such people are not likely to be deterred from joining because of this, because even with the co-payment, they are still going to pay far less than if they were not insured. The only difficulty, as for co-payment generally, is implementing it in a way that will not exacerbate the suspicions and popular misconceptions of the scheme management's motives. For this reason, the researchers recommend that a co-pay be instituted after restructuring.

3.6 Suggestions for General Efficiency Improvements

Before restructuring:

1. Personnel need motivation and skills upgrading:

There is a need for each scheme staff member to have a written job description. Specific training for each of the personnel based on their revised job descriptions, will form part of the further technical assistance that PHR will provide to the scheme. The researchers believe, however, that every member of the current scheme management can benefit from further targeted training. In particular, the following skills need to be developed or upgraded:

- Marketing and community participation methods' IEC
- General management skills, including risk management
- Negotiation skills
- Accounting and book-keeping (the scheme presently has no one specifically handling these areas)
- Monitoring and evaluation of a community health insurance scheme including internal (managerial and financial) auditing

In addition, the staff members' conditions of service should be reviewed in line with the new responsibilities and structure that is proposed above. If the scheme is to be delinked from the hospital, then the conditions of service should also appropriately receive attention so that they are comparable to what they could obtain in equivalent positions elsewhere.

If this is not already the case, weekly staff meetings with key personnel are recommended. They are an opportunity for people to share their views on the running of the scheme and also a good motivational factor.

The scheme promoters should also note that with the proposed restructuring, the Nkoranza scheme needs to be led by individuals who can be seen as equals by the hospital management and other stakeholders with whom they will deal. This is necessary so that the leadership can effectively represent the scheme before any of these latter bodies. In particular, the scheme manager's skills in management (or economics), accounting and communications should be significantly reinforced.

2. The scheme has no reserve fund, which makes its finances precarious.

As a matter of urgency, the scheme management needs to draw up a plan for constituting a reserve fund in accordance with the norms pertaining to this type of insurance organisation. This will make it more financially stable.

After restructuring:

1. A separate accounts officer is required for the insurance scheme. The recently -issued financial audit of the scheme made critical comments on the quality of the scheme's accounting. This reinforces the need to pay particular attention to this issue.

2. The scheme needs to review the provider payment mechanism to encourage efficiency. Innovative approaches are being developed in provider payment systems to encourage provide efficiency and quality improvements, as well as to enable insurance organisations to contain costs. Some of these innovations may be applicable to the Nkoranza situation. It may be worthwhile for the scheme management to further investigate the methods of provider payment in order to see whether this can be improved. A pilot scheme could test the feasibility of alternatives to the current fee-for-service system.

Annex A: Organisation of Household and Focus Group Discussions

The Household Survey

The household survey was aimed at getting a snapshot of certain characteristics of beneficiaries and non-beneficiaries of the scheme, as well as their views on a range of possible measures for improvement of the efficiency and effectiveness of the scheme.

The terms of reference stated that the survey should cover 10 percent of the target population of 140,000 using simple random sampling and be carried out for three weeks. This seemed a rather large ample and well beyond what might be statistically necessary to be able to draw reasonably valid conclusions. In the course of a meeting of the scheme owners and officials and participating donor organisations, it was agreed that the survey would be administered by 15 field assistants, for a period of four weeks and would cover approximately 7,000 people. However, it was then realised that time period might not make it possible for the field assistants to cover such a large sample and that the sampling size would be derived from the number of questionnaires a field assistant could complete in 20 days, working eight hours a day.

Prior to the beginning of the training exercise, the PHR team presented a copy of the questionnaire to the Catholic Diocese of Sunyani representative, the Scheme Manager and a member of the scheme's management team (see Annex B). Very few suggestions/remarks were made and it was agreed that the field-testing would be used to make corrections, if necessary. It was clearly stated to all participants that the exercise was to remain neutral for exploitable results.

Training activities

The training session for the 15 field assistants, all university students and teachers living in Nkoranza and selected by the scheme management, began on July 2, 1999. The participants were provided with a program (Annex C) and were asked to fill out a registration form to find out their village (this way participants would not be assigned to their own village to ensure neutrality), and their experience in administering questionnaires or involvement in community-based activities (13 out of the 15 field assistants had previous experience in administering questionnaires). After a brief introduction of the representative from the Diocese of Sunyani, the scheme Manager and the PHR team, the field assistants were asked to introduce themselves.

The PHR staff then asked the field assistants to list the different steps in administering a questionnaire, from the preparation required prior to entering a household, to actually entering a household, presenting the purpose of the visit, administering the questionnaire and exiting. The team then presented the *Shannon and Weaver* and the *Schramm* communication models and facilitated three communication exercises involving field assistants to illustrate the models (Annex D). After this exercise, the field assistants were divided into five groups: each group was asked to translate a portion of the questionnaire from English to Twi (the most widely used language in Nkoranza); after this, the Twi translations were interchanged and translated by different teams back into English. The group as a whole then went through the translations, agreeing on terminology and accuracy, as well as making

suggestions on the English phrasing of certain questions (changes were made where appropriate). The results were typed and distributed to the field assistants as a guide (Annex E).

The following day, the field assistants were each given one questionnaire to administer on their own. The field assistants went into the community and administered the questionnaire, and reconvened in the afternoon to share their different experiences with the group. The feedback was very positive from the field assistants. There were no problems with the mechanics of the questionnaire; some suggestions were made as to how to address certain questions based on the responses and reactions they had observed in the morning. This exercise was extremely valuable in stressing the need for neutrality and identifying what is considered promoting the scheme or guiding the respondent's answer. The field assistants also agreed on an average time of 25 minutes to administer one questionnaire (excluding travel time).

Following this exercise, the representative of the Catholic Diocese of Sunyani discussed the administrative and logistical issues. The participants were then asked to complete an anonymous evaluation form (see Annex F for results).

Sampling

A stratified multi-stage random sampling technique was used, as explained below.

During the training seminar, it was suggested that the size of an average household in Nkoranza is 6 people, so that with a population of 140,000, there are approximately 25,000 households in Sunyani; 10 percent of which is 2,500 households.[17] It was decided that this number be used as a sampling size and the duration of the exercise be decreased to 14 days. It was further agreed that the sampling size would be a function of 15 field assistants, for 14 days at 16 questionnaires per day, for a minimum of 3,360 questionnaires.

In order to determine the sampling size per village (the population size per village was not available), the team used the 11 zones for which population size is available. The different villages of a zone were then assigned a size ratio in comparison with other villages (provided by the scheme's field workers who are probably the most familiar with the sizes of the different villages); an approximate village size was then calculated using the ratio of the village relative to the total ratios of the villages of a zone, and extrapolated to the population size of the zone. The percentage of the population of each village in relation to the total population was then used to calculate the number of questionnaires that should be administered in each village, by multiplying the percentage by the total number of questionnaires to be administered (Annex G). To increase randomness, the field assistants were also asked to conduct interviews in every other compound instead of every compound.

One village for which access is difficult was eliminated. The villages were grouped, taking proximity into account, in groups of 230 questionnaires to be administered per field assistant; in some instances, the number of questionnaires to be administered was increased, especially in the case of the townships. The field assistants then picked a random number and were told which group of villages their number corresponded to.

[17] It is worth noting that, if anything, this suggested average household size of six increased the number of households in the survey compared to what would have been obtained using the household size revealed in a previous survey the SPRING team from the University of Science and Technology in 1993/94, i.e., 7.22 average household size (see the SPRING Report 1993/94, Table 3.5).

Also, during the training seminar, the field assistants requested that the authorities be made aware of their presence in the villages and the purpose of the questionnaire. The PHR team requested that this be done in a neutral manner. Prior to departing from Nkoranza, the PHR team along with the representatives briefly visited the District Coordinating Director and the Chief to inform them of the activities of the field assistants. They both gave their approval of the exercise.

Data entry

An Excel table was designed to facilitate data entry (Annex H). A Secretary of the Regional Health Administration with data entry experience and a student from the community were both given an overview on how to enter the data, which is almost entirely coded. Also, a document providing directives for data entry was drafted (Annex I) and transmitted to the representative from the Catholic Diocese of Sunyani for transmission to the two Data Entry Specialists.

The team showed the Manager of the scheme how to number the questionnaires (from 0001). He was also provided with a log of who questionnaires were given to (Annex J), as well as the distribution of the villages/questionnaires (Annex K), to ensure follow-up and control of the activities. It was agreed that the field assistants would pick-up half their questionnaires on Friday, August 6, and would submit them as soon as completed for verification and to begin data entry.

The Focus Group Discussions

The focus group discussions followed after the household survey from October 15 – 22, and were aimed at studying the following: 1) some dynamics of the Nkoranza population (both beneficiaries and non-beneficiaries alike) which are related to the performance and coverage of the insurance scheme. 2) The reasons and factors behind some responses arising from the household survey that were either unexpected or contradicted existing assumptions on which the insurance scheme has so far conducted business with the community. They were also designed to improve the robustness of the survey results, or to find if there are alternative explanations that are consistent with both the survey results and existing assumptions. 3) It was aimed at investigating in greater depth the reactions of the community concerning existing and prospective measures for improving the performance of the scheme, extending the services, increasing participation and coverage and giving members better value for their money. 4) It enabled a better appreciation of the various popular conceptions in the community concerning the insurance scheme, including its relations with the hospital and with the beneficiaries.

Themes/topics for discussions

Themes and topics for the focus group discussions were developed based on the results of the household survey and the objectives and terms of reference for the evaluation (See Annex L). The areas covered included:

- Popular perceptions of insurance in general vis-à-vis community health insurance – are there differences, and what examples from traditional socio-economic life or institutions could be cited to show any similarities?

- Member satisfaction – members were asked to rate the scheme's successes in providing access to health care and improving quality. This topic also elicited popular conceptions about the scheme including criticisms

- The registration period: following the household survey, most people found that December-January was not a good time for registering because they had no money around that time, and overwhelmingly preferred August to October. As a change in the registration period should not be undertaken lightly, it was found necessary to further explore the reasoning behind the revealed preferences.

- Membership basis – to test reaction to changes in the current system of registration to focus more on family groups with built-in incentives to register more, not fewer, family members.

- Participation and accountability – whom does the scheme belong to? Whom should it belong to? How should participation be operationalised?

- Covering extra services – whether people would like to have extra services, and if so, are they willing to pay extra premiums for these?

- Financial questions – attitudes towards deductibles and payments, especially for expensive and easily abused procedures such as hernia operations.

Specific questions were to be posed to non-insured persons, mainly to find out why they were not insured and what could attract them to do so. Women groups were to be asked for their views on the adequacy of maternity cover and the role that women might be able to play in increasing registration and participation in the scheme.

Training

The process started with a training and information session for the facilitators of the focus group discussions. The facilitators were drawn overwhelmingly from the field researchers that carried out the household surveys, and thus included people who already knew the communities well, as well as the background to the exercise. The idea was to constitute focus groups of individuals in the community, as well as of members of identifiable organisations capable of playing a significant role in the insurance scheme, either as avenues for obtaining group registration or whose leaders could significantly affect how many members of the group would register.

It was explained that the key to this exercise was in selecting sufficiently representative focus groups that reflected the character and demographic composition of the community concerned, subject of course to the restriction that all members of a focus group had to be person either in the insurance scheme or capable of joining the scheme. The very young (below 16) were excluded, but students were included because of their unique role especially in villages as people who are capable of influencing their parents' behaviour with regard to all new ideas in the community that originate from educated people in the cities and then have to be explained or translated to rural folk. Being the holiday period, many higher educational students were still at home.

There were 10 field assistants to cover 11 health zones plus four major professional/community associations that were identified – namely traders, transport unions (2), the teachers association (GNAT), and the 31st December Women's Association. Two types of community were to be distinguished – rural and urban, as this would affect the composition of the groups.

The groups were to be constituted taking into account gender, age and occupation, and the proportions of each of these in the community or group concerned. Together, the meeting identified the major occupational categories to be found in rural and urban communities of Nkoranza, and the results were as follows:

- Rural – overwhelmingly farmers, but also teachers, traders and students.

- Urban – traders, civil servants, teachers, hairdressers, tailors/seamstresses, police, fire brigade, and students.

As some health zones contained both urban and rural communities, it was necessary to take into account the different compositions in order to constitute the groups accurately.

Further, it was emphasised that every attempt had to be made to achieve a gender balance. In this case, the opinions of a household head were not enough. Furthermore, such views had no greater weight than others on questions about quality of services, satisfaction with the scheme, understanding of insurance etc. If gender balance could not be obtained for any reason, for example, if women were reluctant to participate with men in a focus group, or if during the discussions women were noticeably less involved, the facilitator was to thereafter constitute a women's only focus group to seek their views on the same issues and those that pertain to the women alone.

Further guidelines were that the facilitator should begin by assuring everyone of the anonymity of the exercise, (i.e., no names would be asked for or written down); the facilitator was not to dominate the discussion but to introduce the themes and facilitate the discussion while encouraging everyone to participate and then listen and record the main points of consensus, as well as those on which there was division indicating the majority view and minority one on the issues. The group was to choose their own chairperson to preside, with the facilitator encouraging women to preside where the group was acceptable to such a proposition. Finally, to ensure randomness, the facilitators were to go to alternative houses to try to find participants from the community. It was recognised that this approach was not likely to be feasible for finding the right number of members of occupational groups, and they could vary this to complete the group with the right number of people from each required category.

Finally, to ensure that the 10 researchers would be able to cover the 11 health zones plus the identifiable professional/community groups, two zones were merged together with nearby ones while somebody was assigned to cover only the professional groups and associations. Apart from the latter person, researchers were assigned to the health zones by means of balloting.

Table A.1
Focus Group Distribution

Health zones/Groups	Busunya	Yefri	D/Nkwanta	Nkoranza	Bonsu	Nkwabeng	Kranka	Ahyiahem	Ayerede	Dromankese	Organised Groups
Number of groups	3	4	5	4	6	4	4	3	2	5	3
Number of women	11	23	21	?	33	21	20	5+?	4+?	31	10
Number of men	11	14	19	?	21	21	14	4+?	3+?	11	18
Total number of people in groups	22	37	40	?	54	42	34	9+?	7+?	44	28
Total number of women only groups (# of women involved)		1 (9)	1 (7)	1 (?6)	2 (16)		1 (16)	1		2 (19)	
Total number of non-insured groups (# of persons involved)	1 (6)	2 (10) + ?	2 (12)	1 (?)	2 (18)	2 (20)	1 (8)	1(?)	1 (7)	2 (10)	

Professions represented in the groups:

Farmer (predominant category)	Tailor
Seamstress	Driver
Trader	Catechist
Teacher	Housewife
Clerk	Student
Business man	Transport owners
Chief	Linguist

Organised groups include: the Traditional Council, Progressive Transport Owners Association (PROTOA), Nkoranza Traders Association, and GNAT.

Annex B: Household Survey Questionnaire

Household Survey Questionnaire

Name of Location (village)	_____
Zone *(Nkoranza (1), Busunyaa (2), Donkro-Nkwanta (3), Akuma (4), Bonsu (5), Nkwabeng (6), Ayerede (7), Ahyiayem (8), Yefre (9), Kranka (10), Dromankese (11))*	_____
Date of visit	_____
Name of Surveyor	_____
Result *(completed questionnaire, partly administered)*	_____
Language of interview	_____
Supervison / quality control (name, date)	_____

Composition of household

Household Head

Name: _____
Sex (M)or (F): _____
Age: _____
Occupation *(farmer (1), salaried worker(2), student(3), unemployed(4), self-employed/business/trader(5), retired (6)) [in case of more than one occupation, tick principal or highest source of income]*: _____
Education Level(none (0),elementary/basic (1) primary (2), secondary(3), above secondary(3), non-formal(5)):_____

Household Head:

Sex ☐
Age ☐
Occupation ☐
Education Level ☐

Number of residents between the ages of (excluding HH Head):

1-17 Male ☐
1-17 Female ☐
18-59 Male ☐
18-59 Female ☐
60-above Male ☐
60-above Female ☐

Actual Household Residents

Relationship of each Household resident to Household head	Sex (M) or (F)

Membership in MHO

1. Have you heard of mutual health insurance organisations that provide health benefits? Question 1
   - (1) Yes (go to next question)
   - (2) No (skip to question 16)
2. Do you and your household members currently belong to the Nkoranza Scheme for health benefits? Question 2
   - (1) Yes (skip to question 5)
   - (2) No (go to next question)
3. Have you ever belonged to the Nkoranza Scheme? Question 3
   - (1) Yes (skip to question 13)
   - (2) No (go to next question)
4. What would you say is the main reason you do not belong to the Nkoranza Scheme? [answer and skip to question 16] Question 4
   - (1) Too expensive
   - (2) Did not have money during the registration period
   - (3) Not sick now
   - (4) Hospital too far
   - (5) Treat elsewhere
   - (6) Does not offer services needed. Please specify:_____

Health seeking behaviour / Willingness to pay: Scheme Member

5. Which year did you first pay your registration fee to join the Nkoranza Scheme? Question 5
   - Year(2000-year): _____
6. How many times/years have you paid your premium since joining? Question 6
   - 8 years
   - 7 years
   - 6 years
   - 5 years
   - 4 years
   - 3 years
   - 2 years
   - 1 year
7. How did you hear about the Nkoranza Scheme? Question 7
   - (1) Through St. Theresa's Hospital
   - (2) Through another health provider. Please specify:_____
   - (3) A radio advertisement
   - (4) A representative of the scheme
   - (5) A relative
   - (6) A member of the scheme
   - (7) Other. Please specify: _____
8. In your opinion, this premium you pay to the Nkoranza Scheme is: Question 8
   - (1) Too expensive
   - (2) Reasonable
   - (3) Inexpensive

9. How do you rate the services from the Scheme?
    - (1) Excellent
    - (2) Very Good
    - (3) Good
    - (4) Fair
    - (5) Poor

Question 9 ☐

10. How do you rate the services you have received from St. Theresa's Hospital?
    - (1) Excellent
    - (2) Very Good
    - (3) Good
    - (4) Fair
    - (5) Poor
    - (6) Never used

Question 10 ☐

11. Would you be willing to pay a higher premium for additional coverage? *[sensitive question]*
    - (1) Yes
    - (2) No

Question 11 ☐

12. Would you be willing to pay for a portion of your hospitalization/admission fees to save the Scheme from going out of business? *[sensitive question]* [answer and skip to question 30]
    - (1) Yes
    - (2) No

Question 12 ☐

Health seeking behaviour / willingness to pay: Former Members of the Nkoranza Scheme

13. When did you first join the Nkoranza Scheme?
    - Year (2000-year): _____

Question 13 ☐

14. How many times/years did you pay your dues?
    - 7 years
    - 6 years
    - 5 years
    - 4 years
    - 3 years
    - 2 years
    - 1 year

Question 14 ☐

15. What is the primary reason you decided not to renew your enrolment? [answer and go to next question]
    - (1) Too expensive
    - (2) Services offered were not used
    - (3) Did not have money during the registration period
    - (4) Access to St. Theresa's Hospital is difficult
    - (5) Unavailable during registration period

Question 15 ☐

Health seeking behavior / willingness to pay: Never enrolled and Former Members

16. The last time you or a member of your household was ill, did you seek care?
    - (1) Yes (skip to question 18)
    - (2) No (go to next question)
17. What is the main reason you did not seek care? [answer and skip to question 30]
    - (1) Sickness will go away
    - (2) Treatment too expensive
    - (3) Health facility too far away
    - (4) Treated illness at home
    - (5) Other reasons: _____
18. Where did you seek care?
    - (1) St. Theresa's Hospital
    - (2) Another Hospital. Please specify:_____
    - (3) Community clinic
    - (4) Health post or center
    - (5) Drug store
    - (6) Traditional healer
    - (7) Other: _____
19. What is the primary reason you chose this provider?
    - (1) Competent staff
    - (2) Have received treatment there before and gotten well
    - (3) Staff friendly and helpful
    - (4) Medicines available
    - (5) Close to home
    - (6) Availability of transport
    - (7) Inexpensive
    - (8) Other: _____
20. What services did you receive?
    - (1) Consultation
    - (2) Tests/lab
    - (3) Medicine
    - (4) Hospitalization/Admission
    - (5) Delivery
21. How much did you pay for the services you received?
    - (1) Consultation
    - (2) Tests/lab
    - (3) Medicine
    - (4) Hospitalization/Admission
    - (5) Delivery
22. Were you satisfied with the care you received from this provider?
    - (1) Yes
    - (2) No

Question 16 ☐

Question 17 ☐

Question 18 ☐

Question 19 ☐

Question 20 ☐☐☐

Question 21 ☐ Cedis ____ ☐ Cedis ____ ☐ Cedis ____ ☐ Cedis ____ ☐ Cedis ____ ☐ Cedis ____

Question 22 ☐

23. Were you referred to the hospital or another provider for treatment?
    - (1) Yes (go to next question)
    - (2) No (skip to question 30)
24. Type of referral facility
    - (1) St. Theresa's Hospital
    - (2) Another Hospital. Please specify:_____
    - (3) Community clinic
    - (4) Health post or center
    - (5) Traditional healer
    - (6) Other: _____
25. Did you seek care at this referral facility?
    - (1) Yes (skip to question 27)
    - (2) No (go to next question)
26. For what reason? [answer and skip to question 30]
    - (1) Sickness will go away
    - (2) Treatment too expensive
    - (3) Health facility too far away
    - (4) Treated illness at home
    - (5) Other reasons: _____
27. What services did you receive?
    - (1) Consultation
    - (2) Tests/lab
    - (3) Medicine
    - (4) Hospitalization/Admission
    - (5) Delivery
28. How much did you pay for the services you received?
    - (1) Consultation
    - (2) Tests/lab
    - (3) Medicine
    - (4) Hospitalization/Admission
    - (5) Delivery
29. Were you satisfied with the care you received from this provider? [answer and go to next question]
    - (1) Yes
    - (2) No

Question 23 ☐

Question 24 ☐

Question 25 ☐

Question 26 ☐

Question 27 ☐ ☐ ☐ ☐

Question 28
☐ Cedis ____
☐ Cedis ____
☐ Cedis ____
☐ Cedis ____
☐ Cedis ____

Question 29 ☐

All Households

30. In total, how much did you spend last month for health care for you and your household members, excluding registration fees and premium paid to the Nkoranza Scheme[if 0 Cedis, skip to question 32]?

31. In your opinion, this amount is:
    - (1) Too much
    - (2) Reasonable
    - (3) Inexpensive
32. Which month is your income the highest?
    January (1), February (2), March (3), April (4), May (5), June (6), July (7), August (8), September (9), October (10), November (11), December (12)

Question 30
Cedis _____

Question 31 ☐

Question 32 ☐ ☐ ☐

Annex C: Household Survey Questionnaire Programme

Household Survey Questionnaire
Surveyors - Programme

Monday, August 2, 1999

7:30	*Breakfast*
8:00	Registration
8:15	Welcome/Introduction of organisers Introduction of scheme and objectives of evaluation and questionnaire
9:00	Introduction of participants
9:15	Components of Communication Feedback/Reading signals in different situations – Exercise
10:45	*Break*
11:00	Introduction of questionnaire
12:30	*Lunch Break*
13:30	Translation exercise
15:00	Role play
17:00	Field test introduction
17:15	*End of session*

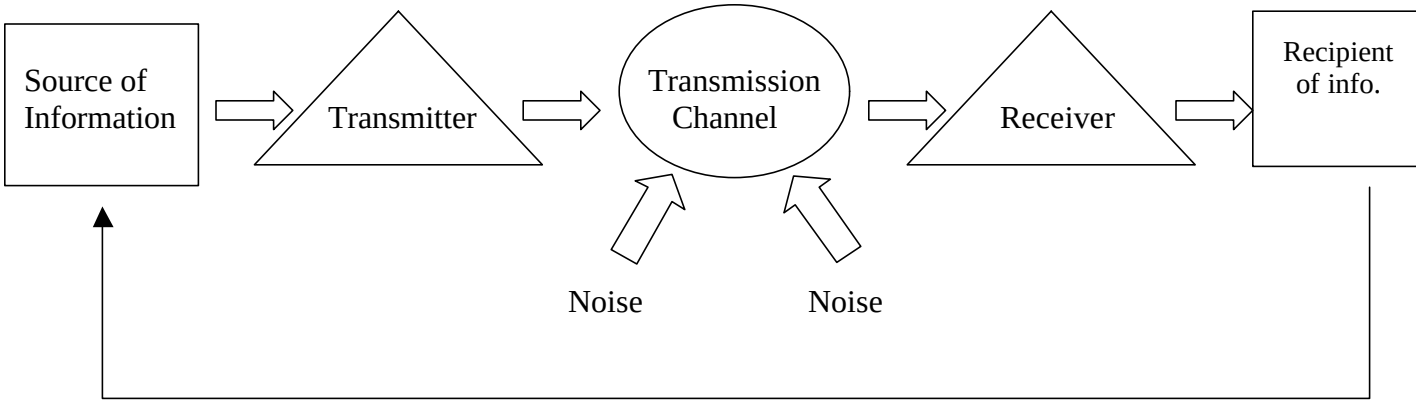
Tuesday, August 3, 1999

8:00	*Breakfast*
9:00	Field testing
12:00	*Lunch*
13:00	Debriefing session and fine-tuning of questionnaire
15:45	*Break*
16:00	Administrative issues
17:00	Evaluation
17:15	End of session

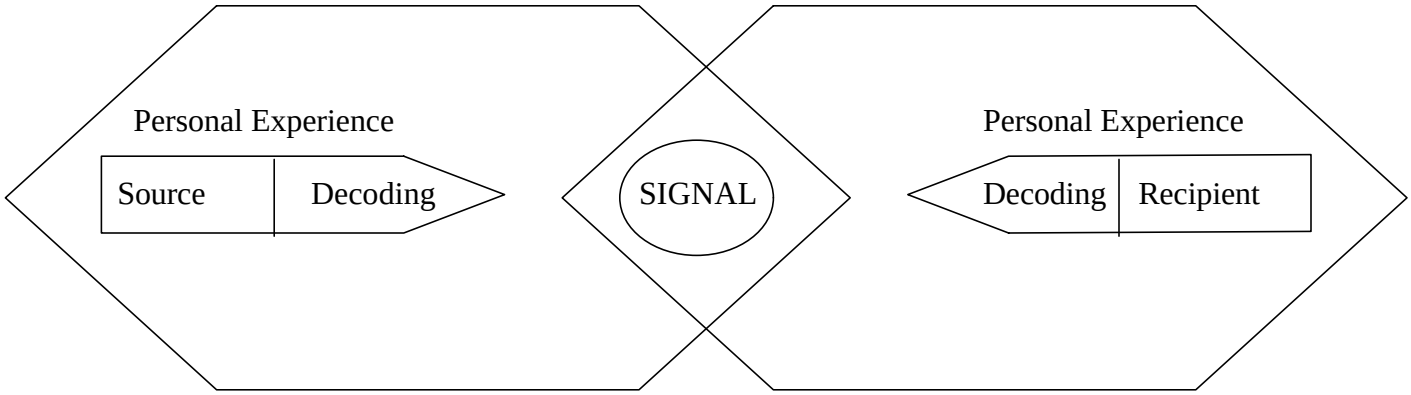
Annex D: Communications Models

Three phases of communication:
1. *Transmission*
2. *Understanding*
3. *Assimilation*

1. Transmission: The Shannon and Weaver Model



2. Understanding: The Schramm Model



3. Assimilation

Annex E: Guidelines for Translation

ME PAWO KYɛW WOWURA NE HWAN?

ME PAWO KYɛW WO DIN DE SEN?

ME PAWO KYɛW WADI MFIE SEN?

ME PAWO KYɛW ADWUMA BEN NA WOYE?

ME PAWO KYɛW WOKOO SUKUU?

PAPA NIPA DODOO, SEN NA OMO HYɛ WASE?

1. MOATE INSURANCE NSAWOSOO KUO A ɛMA YENYA APOOMMUDEN HO MFASOO NO NKA?

2. NTI AFE WEI WO NE WOABUSUA KA SAA AHOBANBO AKUO EWO NKORANZA YI HO SAA BERɛ YI?

3. WODE WO HO ABO NKORANZA KUO NO PEN?

4. DEɛN NTI NA MOMFAA MO HO MMOO NKORANZA AHOBANBO (INSURANCE) KUO NO?

> E BOO YɛDEN

> OMO RETWERɛ DIN NO NA MENI SIKA

> ME NYARE SEISEI

> HOSPITAL (AYARESABEA) NO KWAN WARE

> MESA MEHO YAREɛ WO BAABI FOFORO

> OMO MMA MMOA A YEHIA! KYERA MU

5 AND 13. BERɛ BɛN NA WODE WO HO BOO NKORANZA KUO NO?

AFE BɛN MU NA WODIKAN Yɛɛ INSURANCE NO?

6 AND 14. ɛFIRI SE WOBAA KUO NO MU NO, MPɛN DODO

SɛN NA WATUA WO TOO?

7. KWAN BɛN SO NA WOFA TEE NKORANZA KUO NO NKA?

8. NTOBOA/SIKA A WOTUA MA KUONO, WOHU NO SƐN

> NE BWO Yɛ DEN

ƐYɛ

> NE BOO NYɛ DEN/ƐYƐFO

9 AND 10. Sɛ ANKA WOREKARI MMOA A WOANYA AFIRI KUO NO MUA,ANKA NE GYINABEA NE SƐN?

> ADUTWAM

> ƐYɛ PA ARA

> ƐYɛ

> ƐYɛ KAKRA

> ƐNYɛ

11. Sɛ INSURANCE KUO YI BƐGU, ANAASɛ WOAYARE KA NO. WOBƐTUA KAKRA AMA KUO NO AGYINA NO ANKA WOPɛ DEɛ HE?

15. DEƐN POTEE NTI NA WAGYAE INSURANCE YI Yɛ?

16. BERɛ A ƐTWA TOO KORAA A, WO ANAA WOBUSUANI YAREɛ NO WOHWEHWɛɛ AYARESA ANAA?

17. ADƐN NTIRA

18. ƐHEFA NO WOHWɛɛ WO HO YOREɛ

19. ƐDEAN TITIRIW NTI NA WOFAA SAA KWAN YI SO HWɛɛ WO HO YAREɛ?

20 AND 27. ƐDEƐN NA WOYɛ MAA WO?

21 AND 28. WOANI GYEE DEɛ WOYɛ MAA WO NO HO

WOANI GYEE HO?

22 AND 29. WOHWɛɛ WO NO, WOTUA SƐN?

23. WOKA KYERɛɛ WOSƐKO AYERESABEA FOFORO ANAA OHWƐFOO FOFORO HO KOGYE AYARESA ANAA?

24. BEA FOFORO BƐN NA WOKYERɛɛ WO Sɛ KO?

25. WOKOO SAA BEA HO KOHWEHWɛɛ AYARESA?

26. ADɛN NTIRA?

30. FA NO Sɛ INSURANCE KA NKA HO, BOSOME A ɛTWAMU NO ɛKA SɛN NA WO-WOABUSUA ABO AFA MOAPOMMUDEN HO NE?

31. Sɛ WOHWɛ SIKA A WOTUAEɛ NOA, ɛDOOSO NE KWAN SO ARA NE NO ANAA ɛFO?

32. AFE NO MU, BOSOME BɛN MU NA SIKA BA WO NSAM?

Indeed it has been an exciting experience for the two days orientation program. The only thing I may like to say is next time the time to be used to administer the questionnaire should be agreed upon and be made clear to the participants before hand."

"I find it very interesting and a privilege to be part of such a training seminar. In all it was successful

"In the whole the training given was very good but I wish to suggest that next time the duration should be extended so that we can deal with all issues in details."

"I have benefited immensely from the training. I have also enjoyed the personal and amicable atmosphere in which the seminar went. Such training sessions should be held periodically."

"The program was very successful and the resource persons very innovative."

Annex G: Sampling

NAME OF VILLAGE	RATIOS	POPULATION	% of total population	% of questionnaires
		population of zone/total zone ratio*village ratio	population of village as percentage of total population	population of village as percentage of total population * total number of questionnaires to complete
ZONE 1: NKORANZA		**33,411**		
NKORANZA TOWNSHIP	20.00	19,799	15%	504
ASUOSO	1.00	990	1%	25
TOM	1.00	990	1%	25
ADDOI	1.00	990	1%	25
ASEKYE	1.50	1,485	1%	38
MPEM	0.50	495	0%	13
JERUSALEM	1.25	1,237	1%	32
NYINASE	0.75	742	1%	19
DANDWA	1.50	1,485	1%	38
G'KROM	0.75	742	1%	19
DIMANGO	0.50	495	0%	13
A/DOMASE	3.00	2,970	2%	76
BREMAN	1.00	990	1%	25
TOTAL ZONE RATIO	*33.75*	**33,411**	25%	**851**
ZONE 2: BUSUNYA		16,702		
BUSUNYA TOWNSHIP	5.00	5,302	4%	135
KWAASI	0.75	795	1%	20
AKRUDWA I	0.75	795	1%	20
AKRUDWA II	1.00	1,060	1%	27
FIEMA	1.00	1,060	1%	27
BOABENG	1.00	1,060	1%	27
BOMINI	1.25	1,326	1%	34
BONTE	1.25	1,326	1%	34
ODUMASE	1.00	1,060	1%	27
AKONKONTI	1.00	1,060	1%	27
TIMIABU	1.00	1,060	1%	27
BOAMA	0.75	795	1%	20
TOTAL ZONE RATIO	15.75	**16,702**	13%	**425**
ZONE 3: DROMANKESE		10,750		
DROMANKESE TOWNSHIP	4.00	7,167	5%	183
DIKUMA	1.00	1,792	1%	46
ADUMASA	0.75	1,344	1%	34
AMANA	0.25	448	0%	11
TOTAL ZONE RATIO	6.00	**10,750**	8%	**274**

ZONE 4: YEFRI		10,740		
YEFRI TOWNSHIP	4.00	3,305	3%	84
BOANA	1.00	826	1%	21
PINIHI	2.00	1,652	1%	42
DOMEABRA	1.00	826	1%	21
TANKOR	1.00	826	1%	21
BODOM	1.00	826	1%	21
TANFIANO	1.00	826	1%	21
SENYA	1.00	826	1%	21
KONKROMPE	1.00	826	1%	21
TOTAL ZONE RATIO	13.00	**10,740**	8%	**274**
ZONE 5: KRANKA		10,361		
KRANKA TOWNSHIP	3.00	3,885	3%	99
BAAFI	1.00	1,295	1%	33
SIKAA	1.00	1,295	1%	33
MANSO	2.00	2,590	2%	66
DWENEWOHO	1.00	1,295	1%	33
TOTAL ZONE RATIO	8.00	**10,361**	8%	**264**
ZONE 6: NKWABENG		6,923		
NKWABENG TOWNSHIP	5.00	4,327	3%	110
NTANAASO	1.00	865	1%	22
KRUTU	1.00	865	1%	22
BREDI	1.00	865	1%	22
TOTAL ZONE RATIO	8.00	**6,923**	5%	**176**
ZONE 7: BONSU		6,748		
BONSU TOWNSHIP	3.00	1,557	1%	40
WAGADUGU	0.50	260	0%	7
BABIANI	1.00	519	0%	13
KOFORIDUA	1.00	519	0%	13
DOTOBAA	2.50	1,298	1%	33
AGYEIKROM	2.00	1,038	1%	26
ASONKWAA	2.00	1,038	1%	26
BEPOSO	1.00	519	0%	13
TOTAL ZONE RATIO	13.00	**6,748**	5%	**172**
ZONE 8: AKUMA		**16,865**		
AKUMA TOWNSHIP	6.00	3,776	3%	96
BRAHOHO	3.00	1,888	1%	48
AKROPONG	3.00	1,888	1%	48
ABOONTAM	2.00	1,259	1%	32
ATEKSANO	1.00	629	0%	16
NSUNENSA	2.00	1,259	1%	32
DOMPOASE	2.00	1,259	1%	32
NKUBEM	0.50	315	0%	8
MMETA	0.50	315	0%	8
MMOFSAMFEDWERE	0.50	315	0%	8
PRUSO	0.50	315	0%	8
MAKYMMABRA	1.00	629	0%	16

NBUGUM	1.00	629	0%	16
BEBOANO	1.00	629	0%	16
HWIDIEM	0.50	315	0%	8
AFUNKUM	0.50	315	0%	8
MIM	0.50	315	0%	8
ANAMA	0.10	63	0%	2
DWENEWOKO	0.20	126	0%	3
JOHNKWOM	1.00	629	0%	16
TOTAL ZONE RATIO	26.80	**16,865**	13%	**429**
ZONE 9: AYEREDE		3,201		
AYEREDE TOWNSHIP	3.00	2,134	2%	54
NYAMEBEKYERA	1.00	711	1%	18
NKYINKAMAM	0.50	356	0%	9
TOTAL ZONE RATIO	4.50	**3,201**	2%	**82**
ZONE 10: AHYIAYEM		5,595		
AHYIAYEM TOWNSHIP	4.00	2,356	2%	60
KANTAKANI	1.00	589	0%	15
BREDI	2.00	1,178	1%	30
KONTONSO	1.00	589	0%	15
PRUSO	1.00	589	0%	15
DASAGWA	0.50	294	0%	7
TOTAL ZONE RATIO	9.50	**5,595**	4%	**142**
ZONE 11: D/NKWANTA		10,645		
D/NKWANTA TOWNSHIP	5.00	2,716	2%	69
ASUANO	2.00	1,086	1%	28
BAANOFOUR	1.00	543	0%	14
KYIRADESO	1.00	543	0%	14
SUBODOM	0.50	272	0%	7
KYEKYEWERE	1.00	543	0%	14
YEREPIMSO	0.50	272	0%	7
AKRUDWA	0.40	217	0%	6
MAMPONG	0.20	109	0%	3
SALAMIKROM	2.00	1,086	1%	28
MAMPONG LINE	1.00	543	0%	14
ABOASU	1.00	543	0%	14
KYIREFENE	0.50	272	0%	7
GYEDUASE	1.00	543	0%	14
BREME 1	0.50	272	0%	7
BREME 2	0.50	272	0%	7
APEASUA	0.50	272	0%	7
NWOASE	0.50	272	0%	7
ANAMA	0.50	272	0%	7
TOTAL ZONE RATIO	19.60	**10,645**	8%	**271**

Annex H: Directives for Data Entry

Dear Data Entry Specialist,

Below you will find guidelines to enter the data for the Nkoranza Scheme Evaluation - Household Survey Questionnaire. The data should be entered in an Excel file located on the c: drive of this computer under ***c:/My Documents/Nkoranza Scheme Evaluation/Data entry*** or on a diskette under the same file name**.**

You will also find a copy of the questionnaire and these directives under the same folder as Word documents under the file names *Questionnaire for Ghana – Members* and *Directives for Data Entry*. A copy of a completed questionnaire is attached and entered in the database as a sample.

You will notice that some of the questions ask for precision ("*please specify*") or other options. Please keep a log of the answers provided, including the question number, the Identification Number of the questionnaire and the answer provided (see attached).

Please save your work on the hard drive as well as on a disk.

We thank you for your kind attention to these matters. Your work is very much appreciated.

COLUMN A

Please enter Identification Number located on top of the questionnaire; please enter the four digits (ex: 0005 or 0100 or 3000)

COLUMN B

Please enter the village code using the list that is attached. These are all coded using three letters. In the event that you encounter a village that is not listed, please code it using the first three letters of the village; if the three letters have already been assigned to another village, please code it in an appropriate way making sure the code was not assigned to another village already. Please indicate any new codes when the data will be submitted.

COLUMN C

This is the Zone and should be entered as a code by the Researchers.

COLUMN D

This is the language used during the interview. Please use ENG for English and TWI for Twi. In the event that another language is used, please use the first three letters of that language. Please indicate any new codes when the data will be submitted.

COLUMN E

This is the Household Head's sex and should be coded by the Researcher.

COLUMN F

This is the Household Head's age and should be coded by the Researcher.

COLUMN G

This is the Household Head's occupation and should be coded by the Researcher.

COLUMN H

This is the Household Head's Education level and should be coded by the Researcher.

COLUMN I

This is the number of Household Residents who are Male and between the ages of 1 and 17; this should be coded by the Researcher.

COLUMN J

This is the number of Household Residents who are Female and between the ages of 1 and 17; this should be coded by the Researcher.

COLUMN K

This is the number of Household Residents who are Male and between the ages of 18 and 59; this should be coded by the Researcher.

COLUMN L

This is the number of Household Residents who are Female and between the ages of 18 and 59; this should be coded by the Researcher.

COLUMN M

This is the number of Household Residents who are Male, 59 years old and above; this should be coded by the Researcher.

COLUMN N

This is the number of Household Residents who are Female, 59 years old and above; this should be coded by the Researcher.

COLUMN O

You shouldn't make an entry in this field; the computer will automatically calculate the size of the Household.

COLUMN P

This should be coded by the Researcher.

COLUMN Q

This should be coded by the Researcher.

COLUMN R

This should be coded by the Researcher.

COLUMN S

This should be coded by the Researcher.

COLUMN T

This should be coded by the Researcher.

COLUMN U

This should be coded by the Researcher.

COLUMN V

This should be coded by the Researcher.

COLUMN W

This should be coded by the Researcher.

COLUMN X

This should be coded by the Researcher.

COLUMN Y

This should be coded by the Researcher.

COLUMN Z

This should be coded by the Researcher.

COLUMN AA

This should be coded by the Researcher.

COLUMN AB

This should be coded by the Researcher.

COLUMN AC

This should be coded by the Researcher.

COLUMN AD

This should be coded by the Researcher.

COLUMN AE

This should be coded by the Researcher.

COLUMN AF

This should be coded by the Researcher.

COLUMN AG

This should be coded by the Researcher.

COLUMN AH

This should be coded by the Researcher.

COLUMN AI/AJ/AK/AL/AM

This is question 20 which reflects the health services the person received. Example: if the person received a Consultation and Medicine (coded by the Researcher), enter 1 under the column labeled 1 and 3 under the column labeled 3.

COLUMN AN/AO/AP/AQ/AR

This is question 21 which reflects the amount the person paid for the health services they received (the services are reflected in question 20 and should be restated by the Researcher on the questionnaire). Example: if the person received a Consultation and Medicine (coded by the Researcher), enter the amount paid for the Consultation under the first column and the amount paid for the Medicine under the third column.

COLUMN AS

You should not make any entries in this column. The machine will automatically calculate the total amount spent.Exception: If the Researcher entered a lump sum, please enter that amount in this column.

COLUMN AT

This should be coded by the Researcher.

COLUMN AU

This should be coded by the Researcher.

COLUMN AV

This should be coded by the Researcher.

COLUMN AW

This should be coded by the Researcher.

COLUMN AX

This should be coded by the Researcher.

COLUMN AY/AZ/BA/BB/BC

This is question 27 which reflects the health services the person received. Example: if the person received a Consultation and Medicine (coded by the Researcher), enter 1 under the column labeled 1 and 3 under the column labeled 3.

COLUMN BD/BE/BF/BG/BH

This is question 28 which reflects the amount the person paid for the health services they received (the services are reflected in question 27 and should be restated by the Researcher on the questionnaire). Example: if the person received a Consultation and Medicine (coded by the Researcher), enter the amount paid for the Consultation under the first column and the amount paid for the Medicine under the third column.

COLUMN BI

You should not make any entries in this column. The machine will automatically calculate the total amount spent.Exception: If the Researcher entered a lump sum, please enter that amount in this column. This should be coded by the Researcher

COLUMN BJ

This should be coded by the Researcher

COLUMN BK

This should be entered as an amount by the Researcher

COLUMN BL

This should be coded by the Researcher

COLUMN BM/BN/BO

This is question 32 and asks for preferred months of registration. The maximum that can be entered is 3 months. This should be coded by the Researcher. Enter the number of month codes entered by the Researcher, in ascending order

CODES FOR VILLAGES

ABT	ABOONTAM
ABO	ABOASU
ADD	ADDOI
ADU	ADUMASA
AFU	AFUNKUM
AGY	AGYEIKROM
AHY	AHYIAYEM TOWNSHIP
AK1	AKRUDWA I
AK2	AKRUDWA II
AKD	AKUMASA DOMASE
AKG	AKROPONG
AKO	AKONKONTI
AKR	AKRUDWA
AKU	AKUMA TOWNSHIP
ANA	ANAMA
APE	APEASUA
ASA	ASUANO
ASE	ASEKYE
ASO	ASONKWAA
ASU	ASUOSO
ATE	ATEKSANO
AYE	AYEREDE TOWNSHIP
BAA	BAAFI
BAB	BABIANI
BAR	BAANOFOUR
BEB	BEBOANO
BEP	BEPOSO
BMA	BOAMA
BOA	BOABENG
BOA	BOANA
BOD	BODOM
BOM	BOMINI
BON	BONSU TOWNSHIP
BOT	BONTE
BRA	BRAHOHO
BRE	BREME 1
BRI	BREDI
BRN	BREMAN
BUS	BUSUNYA TOWNSHIP
DAN	DANDWA
DAS	DASAGWA
DIM	DIMANGO
DOA	DOMEABRA
DOM	DOMPOASE
DON	D/NKWANTA TOWNSHIP

DOT	DOTOBAA
DRA	DROMANKUMA
DRO	DROMANKESE TOWNSHIP
DWE	DWENEWOHO
FIE	FIEMA
GRU	GRUMA KROM
GYE	GYEDUASE
HWI	HWIDIEM
JER	JERUSALEM
JOH	JOHNKROM
KAN	KANTAKANI
KOF	KOFORIDUA
KOK	KONKROMPE
KON	KONTONSO
KRA	KRANKA TOWNSHIP
KRU	KRUTU
KWA	KWAASI
KYE	KYEKYEWERE
KYI	KYIREFENE
KYO	KYIRADESO
MAG	MAMPONG
MAK	MAKYINMABRE
MAM	MAMPONG LINE
MAN	MANSO
MIM	MIM
MME	MMETA
MMO	MMOFSAMFEDWERE
MPE	MPEM
NBU	NBUGUM
NKO	NKORANZA TOWNSHIP
NKU	NKUBEM
NKW	NKWABENG TOWNSHIP
NKY	NKYINKAMAM
NOW	NWOASE
NSU	NSUNENSA
NTA	NTANAASO
NYA	NYAMEBEKYERA
NYI	NYINASE
ODU	ODUMASE
PIN	PINIHI
PRU	PRUSO
SAL	SALAMIKROM
SEN	SENYA
SIK	SIKAA
SUB	SUBODOM
TAK	TANKOR
TAN	TANFIANO
TIM	TIMIABU
TOM	TOM

WAG	WAGADUGU
YEF	YEFRI TOWNSHIP
YER	YEREPIMSO

LOG OF OPEN-ENDED ANSWERS

Please specify the answer provided and the Identification Number of the questionnaire in parenthesis. For example, Hope Hospital (0034).

QUESTION 7
(2) Through another health provider. Please specify: _____

QUESTION 7
(7) Other. Please specify: _____

QUESTION 8
(5) Other reasons:_____

QUESTION 18
(2) Another Hospital. Please specify:_____

QUESTION 18
(7) Other:_____

QUESTION 19
(8) Other:_____

QUESTION 24
(2) Another Hospital. Please specify:_____

QUESTION 24
(7) Other:_____

QUESTION 26
(5) Other reasons:_____

Annex I: Log for Pick Up

IDENTIFICATION NUMBER OF QUESTIONNAIRE		TOTAL NO. OF QUESTIONNAIRES	NAME AND SIGNATURE OF RESEARCHER PLUS DATE OF PICK UP
FROM NO.	TO NO.		

Annex J: Geographic Distribution and Researcher Assignments

NAME OF VILLAGE	# OF QUESTIONNAIRES	RESEARCHER
ZONE 1: NKORANZA		
NKORANZA TOWNSHIP (RESIDENCY TO POST OFFICE)	230	FELICITY KYEREWAA
NKORANZA TOWNSHIP (POST OFFICE TO CHIEF'S PALACE)	230	EVELYN ASARE KONAOU BROWN
NKORANZA TOWNSHIP (CHIEF'S PALACE TO SESSIMAN)	149	GEORGE AMOAH
ASUOSO	25	
TOM	25	JOHN ATAABO
ADDOI	25	
ASEKYE	38	
MPEM	13	
JERUSALEM	36	
NYINASE	19	
DANDWA	42	
GRUMAKROM	19	
DIMANGO	13	
A/DOMASE	67	ANTHONY OWUSU
BREMAN	23	
ZONE 2: BUSUNYA		
BUSUNYA TOWNSHIP	130	
KWAASI	10	
AKRUDWA I	20	AMOATENG FOFIE PHILIP
AKRUDWA II	27	
FIEMA	27	
BOABENG	27	
BOMINI	35	
BONTE	40	
ODUMASE	27	
AKONKONTI	27	
TIMIABU	27	ADDO BEKOE SETH
BOAMA	20	
ZONE 3: DROMANKESE		
DROMANKESE TOWNSHIP	183	
DROMANKUMA	42	ERIC BOATENG
ADUMASA	30	
BETODA	11	

ZONE 4: YEFRI		
YEFRI TOWNSHIP	84	
BOANA	21	
PINIHI	42	

DOMEABRA	21	BARIMAH AGYAPONG PAUL
TANKOR	21	
BODOM	21	
TANFIANO	21	
SENYA	21	
KONKROMPE	21	
ZONE 5: KRANKA		
KRANKA TOWNSHIP	104	

BAAFI	33	JOSHUA KRAKUE
SIKAA	33	
MANSO	66	
DWENEWOHO	32	

ZONE 6: NKWABENG

NKWABENG TOWNSHIP	110	SENATOR K. SIAW

NTANAASO	22	JOSHUA KRAKUE
KRUTU	22	
BREDI	22	

ZONE 7: BONSU

BONSU TOWNSHIP	40	SENATOR K. SIAW
WAGADUGU	8	
BABIANI	13	
KOFORIDUA	13	
DOTOBAA	33	

AGYEIKROM	26	OPOKU BOATENG PETER
ASONKWAA	26	

BEPOSO	13	SENATOR K. SIAW

ZONE 8: AKUMA

AKUMA TOWNSHIP	96	OPOKU BOATENG PETER
BRAHOHO	50	

AKROPONG	45	OWUSU-ASANTE TAWIAH

ABOONTAM	32	OPOKU BOATENG PETER

ATEKOANO	16	OWUSU-ASANTE TAWIAH
NSUNENSA	25	
DOMPOASE	25	
NKUBEM	8	
MMETA	8	
MMOFSAMFEDWERE	8	

PRUSO	8	
MAKYINMABRE	16	
NSUGUM	16	
BEBOANO	16	
HWIDIEM	8	
AFUNKUM	8	
MIM	8	
ANAMA	10	
JOHNKWOM	5	

ZONE 9: AYEREDE

AYEREDE TOWNSHIP	84	ASIAMAH KARIKARI DANIEL
NYAMEBEKYERA	18	
NKYINKAMAM	9	
VILLAGE RATIO		
ZONE 10: AHYIAYEM		
AHYIAYEM TOWNSHIP	60	
KANTAKANI	15	
BREDI	30	
KONTONSO	14	

PRUSO	15	MARK NYEWIEH
DASAGWA	7	
ZONE 11: D/NKWANTA		
D/NKWANTA TOWNSHIP	73	
ASUANO	28	
BAANOFOUR	14	
KYIRADESO	14	
SUBODOM	7	
KYEKYEWERE	14	
YEREPIMSO	7	
AKRUDWA	6	
MAMPONG	3	
SALAMIKROM	28	
MAMPONG LINE	14	

ABOASU	14	GEORGE AMOAH
KYIREFENE	7	
GYEDUASE	14	
BREME	7	
APEASUA	7	
NWOASE	7	

TOTAL **3450**

Annex K: Focus Group Discussions – Themes for Facilitators

Introduction

Explain the importance of the exercise in finding out from them how to make the scheme serve them even better in the future, and that the key to lowering the cost of health insurance to all of them lies in two things: first, getting as much of the population to register as possible (healthy people as well), and eliminating abuses and fraud. Until this is done, the scheme stands in danger and the resulting high costs will be borne by those who are left in the scheme, the sick and the vulnerable.

Constituting the groups: Factors to take into account

Representativeness of the community or group concerned is important, in terms of characteristics (the different demographic categories) and numbers (proportion of each category). Thus, gender, age, occupation, literacy, health status (if possible, ask if ever admitted) should be considered. The composition of the group should roughly reflect the numbers of each of these categories within the population.

The facilitator must not dominate or attempt to lead the discussion, just listen and make notes while encouraging those not speaking to do so. Introduce the different themes gradually and try to avoid too long discussions but letting people express themselves freely.

Begin by assuring everyone of the anonymity of the exercise (that is, no names will be asked for or written down and no one's comments will be heard outside the group, only the main points arising will be recorded by the facilitator and summarised in his/her report. Complete freedom of expression is guaranteed and honesty will be appreciated.

Themes and questions to guide the discussions:

Member satisfaction

- Ask group members what they feel in general about the Nkoranza community financing scheme.
- How do group members rate the record of the scheme so far:
  - In giving access to health care (financial and geographical)
  - In improving the quality of health care: have they noticed any improvements in care at St. Theresa's as a result of the scheme? (e.g. waiting times, staff attitudes, drugs availability, over-crowdedness, better or worse treatment for insured people, etc.)
  - In preventing illness or death – any examples?
- What is their understanding of insurance? Do they think there is a difference between other kinds of insurance and a community health insurance scheme like Nkoranza's?

Registration period

> The household survey showed that most people found the current registration period of November to January to be inconvenient from the point of view of their cash availability. People now prefer August- October, but at the beginning of the scheme, a survey found that people preferred the current period – how do they explain this apparent change of preference? What about the school fees being due in September, how do they see this impacting the registration?

> What do they think of the suggestion to open the registration throughout the year, but with the modification that if you register outside the main agreed registration months, then you must wait three months before you can begin to benefit from the services (one month if you register in the main campaign period.?) Facilitator to explain why.

Membership basis

> What is the attitude of the group to the current situation of individual registration versus an alternative where registration is by family groups – i.e., a set fee is offered for registration of a family of 4, or a family of 6, or a family of 8, etc. in addition to individual registration but with the fee per head getting smaller as the number of registered people in the family increases.

> Can they identify some community groups or associations (such as susu, credit unions/coops, clans, etc.) which could become the basis of registration so that their executives or heads could be made responsible for registering every person in the group?

> Are there any people in the community that are too poor to be able to afford their premiums? How should they be identified?

Participation and Accountability

> Whom do they think the scheme belongs to? Whom should it belong to? Why?

> Are they currently consulted on changes and policies of the scheme? How often? Is this satisfactory or not?

> Will they want to see greater member participation in the running of the scheme, i.e., more accountability to the members about how the scheme is run, the use of their monies, who should manage the scheme, etc.? Do they think having members participate by electing representatives to serve on the management will improve the scheme – how?

Covering other health services

> Are there any other services which the group would like included in the package but not currently provided?

> Name which services and why are they important to them?

> Are they willing to pay an extra premium to get these services? Should this extra premium be compulsory for existing members or voluntary?

- Would they like health centre care to be covered by the scheme? Which ones? Do they think the insurance scheme could help the health centres to improve their quality of care? How?

Financial issues

- Premium level – reasonable, too little or too high?

- If, to make the scheme more viable (and therefore assure quality services long into the future), some changes in the financing arrangements had to be made, which would they prefer:

  - a small initial payment for every member when they go for admission (e.g. for the first day only) after which the scheme pays for the rest of the cost? Or
  - a small (say 10) percentage of the cost of every bill to be paid by the member?

(Mention that all the viable voluntary insurance schemes in the world have such fees to prevent bankruptcy.)

- Another possible measure to improve viability is to insist that people pass first through their local health centre and obtain a reference letter before going onto the hospital (so that small ailments are treated at the health centre level, leaving only genuinely serious cases for the scheme to handle), and if somebody goes straight to the hospital without passing through the health centre first, they must pay a small portion of the cost of care. What is their reaction to this? Will their attitude change if the scheme proposes to cover some OPD services at health centres (with extra premiums) and thus help those centres to improve the quality of their health care?

- People are reported from the household survey to be currently paying an average of 25,000 cedis monthly on health care. What is their reaction to this finding – is it true in their experience? If so, is this true for both insured and uninsured people (if not, what are the differences), what kind of services (OPD or admission) are included in these costs and at what health institutions – health centres, St. Theresa's, etc.?

- Hernia operations are reported to cost the scheme a lot, and since people who have hernia can register knowing that they will definitely use the services, what do they think of asking hernia patients to contribute a small portion of the costs of the operation?

Suggestions for improvement

Ask participants to suggest any improvements they would like to see in the insurance scheme to serve them better. Let them ask any questions they may also have and note the questions asked.

Themes for non-insured persons:

- What are the main reasons for not joining the scheme?

- If for financial reasons, what premium levels or other changes to the existing financial arrangements would attract them to join?

- If due to quality of care, what changes would they want to see?

- If due to distance from Nkoranza and nearness of other facilities, would they join today if the insurance extended its services to cover other health facilities nearer to them?

- If treating themselves at home, is it due to lack of confidence in the health services at Nkoranza or financial reasons – if financial, how do they pay the traditional healers and why is more convenient than the insurance?

- Are there some services not covered by the insurance scheme but which could attract them if offered?

- If they have not joined because they think they are healthy, have they ever had a family member sick, what did they do, what would they do if the unfortunate happens and they fall ill?

- If the registration period is not convenient, ask the same questions as for the insured above regarding Registration Period.

- If somebody was a member and then left, ask why they left and what would attract them back?

For women only groups:

- Ask all the above questions (for insured or non-insured depending on the womans's insured situation) and additionally, concentrate on whether the cover for maternity care is adequate, and if not how it could be improved.

- Also, ask how could they participate in getting more people to register in the scheme.