

Improving Healthcare Utilization for Low Income Rural Households: Impact Of Social Insurance Policy

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Abstract: This paper underscores the need for all-inclusive social insurance policy for health promotion amongst vulnerable households. It presents experiences from Ghana by analyzing how the National Health Insurance Scheme (NHIS), introduced in 2003 to correct inequities and discrimination in organized healthcare utilization, is making an impact among low income and vulnerable rural households using the specific case of Kintampo Municipality in the middle belt of Ghana where poverty remains high. A sample of 180 households was drawn from NHIS registered households in the study district for data collection using structured interviews, questionnaires and focus group discussions. Data was analyzed around three key parameters: regularity of utilization of healthcare services in times of need, households' expenditure on healthcare,

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and health condition of respondents' households before and after subscription to the NHIS. The paper concludes that holistic social insurance policy should combat affordability, accessibility, and acceptability challenges to healthcare for poor and vulnerable households.

Keywords: Income Poverty, Rural Households, healthcare utilization, NHIS, Ghana

Background to the Study

Good quality health care remains a vital human capital, but not all people have it. Amidst several health policies and programs in many low income countries, the health conditions of poor and vulnerable households have often been dreadful. The need for good quality health care for improving people's living standards and sustaining development has travelled beyond hypothetical situation, perhaps requiring no further verification in theory and practice. Nonetheless, over the past few decades, health sector reforms in many African and other low and middle income countries have increased inequities in access and utilization of healthcare facilities. A growing reliance on out-of-pocket payments at the point of service, and privately organized care has resulted in health care provided on the basis of ability-to-pay. These developments in the health sector usually work against disadvantaged lower income socioeconomic groups, hence, affecting their health seeking behaviors (McIntyre et al, 2008). Though poverty reduction, maternal, and child mortality are prioritized in development policies and programmes, inequality between countries and among different social classes within countries – especially the gap between the rich and the poor – continues to widen (WHO, 2000). According to Gordon (2004), each year over ten million children die mainly from preventable causes which go untreated due to poverty and vulnerability. In his book *The End of Poverty: How We Can Make it Happen in Our Lifetime*, Sachs (2005) reiterates that,

every year over eight million people die around the world because they are too poor to stay alive. These preventable deaths mostly occur in developing countries because victims find it difficult in terms of ability to pay out of pocket to access healthcare (Gill et al, 2007).

Prior to independence, many African countries under colonial rule organized their health systems to benefit only a few elites. This came as an advantage to colonial rulers and their employees and to the disadvantage of indigenous people. Hence, local people resorted to a number of intervening options including self medication, services of traditional herbalists, and available missionary health centers. Since independence, governments and their development partners have sought in various ways to provide an enabling environment and input towards improving health service delivery. In spite of progress made in health sector expansion after independence, quality of health indicators including life expectancy, maternal and child mortality rates, and the prevalence rate of a number of preventable diseases such as malaria, malnutrition, diarrhea, and skin diseases continue to be major developmental challenges saddling these countries. Advancement in the health sector has not translated into improved health conditions for masses of the poor and vulnerable, the majority of whom reside in underserved rural communities. The high cost to utilize health facilities has imposed a large barrier to accessing healthcare. Hence, low income households are denied access thereby increasing the likelihood of health complications.

For well over two decades, Ghana experienced protracted health sector reform due to structural adjustment policies which made access and utilization of organized health care nearly impossible for low income and vulnerable rural households. Underpinned by the high incidence of rural poverty, retrenchment, and removal of subsidies, the 'cash and carry' system that characterized the health sector for the adjustment period of the 1980s made access to orthodox healthcare the prerogative of the urban middle and upper classes, leading to inequities in healthcare utilization countrywide. However, since the dawn of the 21st century,

due to global efforts to achieve improved health for all as enshrined in the health related targets of the Millennium Development Goals, the health conditions of the poor and vulnerable in low and middle income countries have become a major global priority. Against this background, in 2003, the Ghanaian government introduced the National Health Insurance Scheme (NHIS) as an alternative social intervention to the 'cash and carry' system to correct inequities and discriminations in healthcare utilization in favor of low income and vulnerable households. The NHIS is to serve as a means of combating diseases and enhancing quality of life through improved accessibility and utilization of organized health care services for Ghanaians in general and the vulnerable in particular. The NHIS, in an effort to reduce the direct payment system as characterized in the preceding 'cash and carry' system, has attracted a series of intellectual and policy discourse since its inception and implementation in 2003. However, the basis of these debates surrounding the relevance of the social insurance scheme in advancing Ghana's health sector often lack empirical underpinnings, hence, necessitating this study.

The objective of this study is to examine the extent to which the health sector reform through the introduction of the NHIS as a social protection program has improved health conditions of the poor in the study areas as a result of effective utilization of healthcare at reduced cost of service. Even though this study focuses on a relatively smaller geographical scope compared to the spatial extent of the scheme's coverage, the findings of the study analyzed within the specified parameters are relevant for policy on the sustainability of the scheme, particularly for rural health promotion. However, the results discussed in this paper may not be enough for nationwide generalization due to its relatively limited geographical and thematic scope.

Description of the Study Area

The study focused on four rural communities in the Kintampo Municipality of the Brong Ahafo region of Ghana: Gruma Akura, Chiranda, Ashantikwa, and Babatokuma (refer to figure 2). The municipality is located between latitudes 8°45 North and 7°45 North and Longitudes 1°20 West and 2°1 East in the forest, a savannah transitional ecological zone in the middle belt of Ghana (refer to figure 1) in the northern part of the Brong Ahafo Region. The municipality has a surface area of about 5,108km², thus occupying a land area of about 12.9 percent of the total land area of the Brong Ahafo Region of Ghana (39,557km²). The study area shares boundaries with five districts in Ghana namely: Central Gonja District to the north; Bole District to the west; East Gonja District to the northeast (all in the Northern Region) as well as Kintampo South District to the south; and Pru District to the southeast (both in the Brong Ahafo Region). The municipality is strategically located in the middle belt of Ghana and serves as a transit point between the northern and southern sectors of the country. The municipality is sub-divided into four administrative sub-structures (urban and area councils), namely Kintampo Urban Council, Babatorkuma Area Council, Kadelso Area Council and New Longoro Area Council with Kintampo as the capital. These substructures are geographically linked to each other by road.

Kintampo Municipality has an estimated population of 111,122 comprising of 49.1 percent males and 50.9 percent females, with a growth rate of 2.6 percent (Municipality Profile, 2010). The economy of the Municipality can be described as highly agrarian. About 71.1 percent of the residents in the area work in agriculture with the remaining 28.9 percent distributed among commerce, industry, and services. In most parts of Africa where national economies largely depend on agriculture such as Ghana in general and Kintampo Municipality in particular, the need for good quality health status as a precondition for local development cannot be overemphasized as deficiencies in health status tend to affect other sectors including manufacturing and service delivery.

Kintampo North Municipality has suffered reversals in terms of development. This situation has been compounded by such factors as a high illiteracy rate, scarcity of safe drinking water, and inadequate healthcare facilities.

The municipality has only one hospital, two health centers, two rural clinics, one community-based health planning and services (CHPS) compound and one maternity home. These facilities are expected to serve the estimated municipality population of 111,122 people. Though the present number of health facilities has been considered fairly adequate, there is the need to equip the existing facilities with personnel, drugs, and equipment. The top five causes of outpatients admissions as of 2005 in the municipality were malaria, birth deliveries, anaemia, hernia, and gastroenteritis. The fertility rate in the municipality has been put at 5.2 percent as against a national figure of 5.1 percent. Cases of maternal mortality rate remain high (450/100,000) as against a national figure of 214/100,000 while infant mortality rate is at 6.5 percent. Figures 1 and 2 are maps of the Kintampo Municipality in a national context and the Kintampo municipality which show the studied communities respectively.

Figure 1: Map of Kintampo Municipality (the study area) in national context

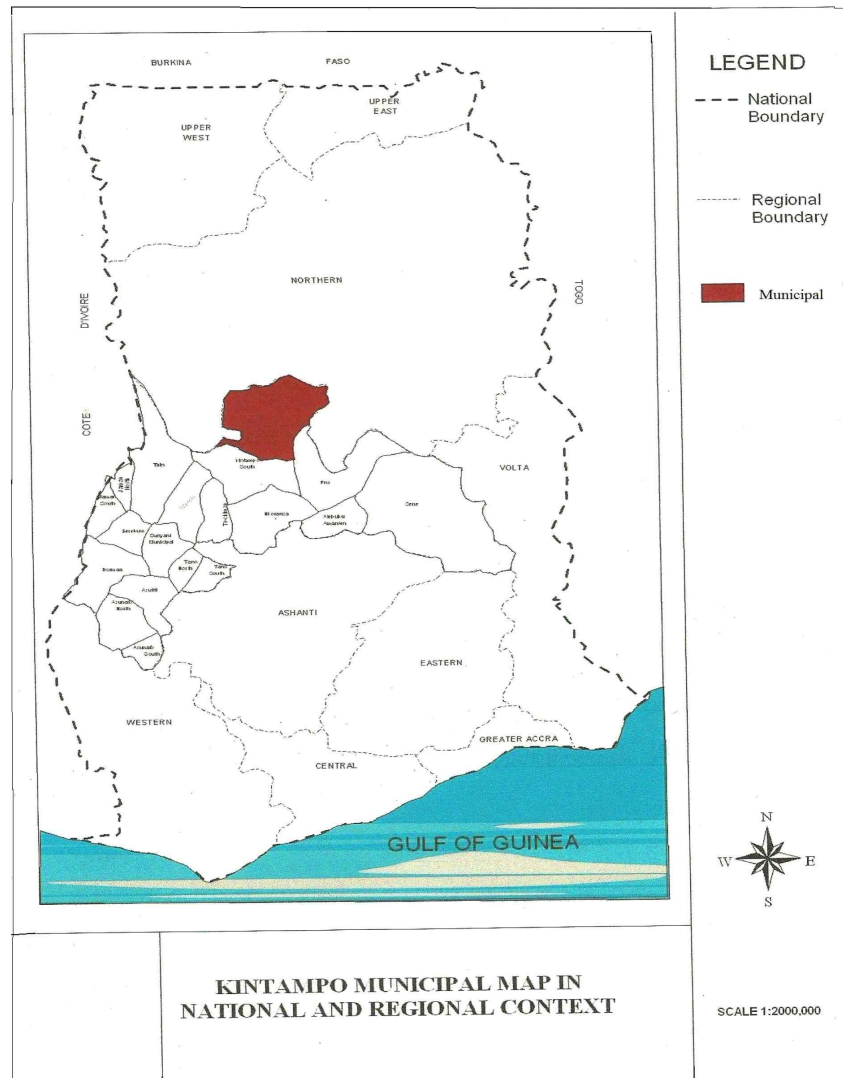
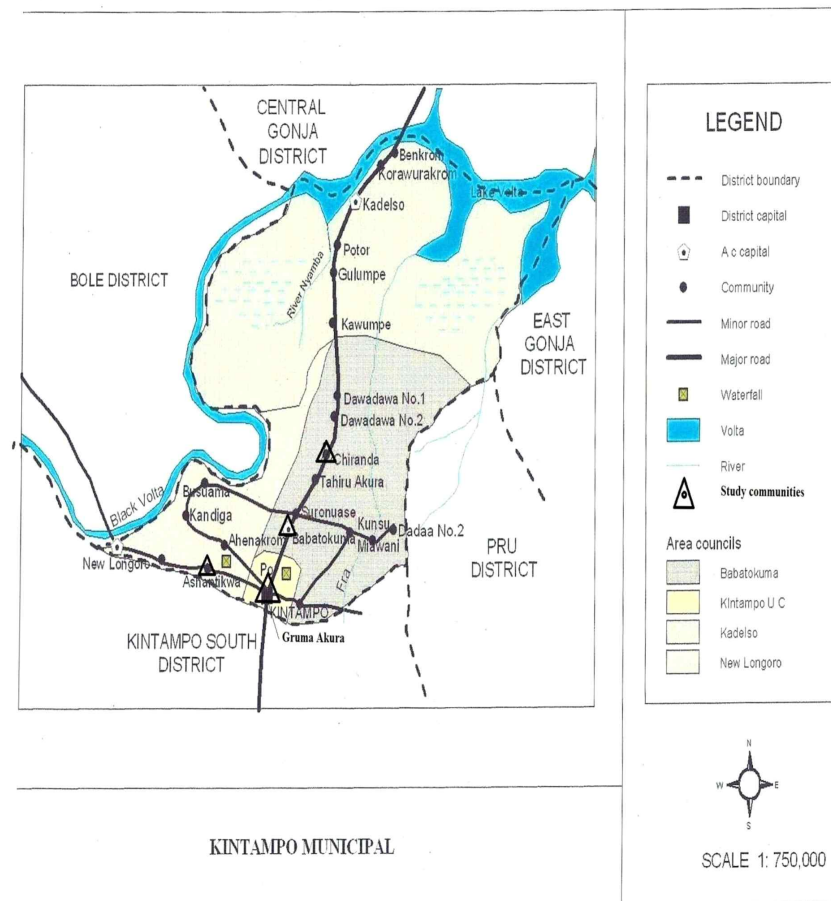


Figure 2: The map of Kintampo Municipality showing the study communities.



Methods of the Study

The case study design was adopted for this study. The study was conducted in 2010/2011 using structured interviews. Questionnaires and focus group discussions for data collection came from a sample of 180 rural households in the four underserved rural communities selected from Kintampo in the Brong Ahafo Region of Ghana (refer to figure 2).

The mixed method approach for data collection allowed for triangulation and authentication of data collected. Both primary and secondary data were collected for this study. Secondary information and data from journal articles, municipal health reports, and books were reviewed to develop a theoretical framework for this study. Primary data from respondents in the study communities were relevant to examining the impact the NHIS has made on the health conditions of vulnerable groups in the study areas. A non-probability sampling technique (purposive) was used for the selection of the study areas as well as the respondents. This sampling technique was necessary for the identification of the specific target group to be included in the study as respondents. The approach ensured that relevant and adequate data were obtained from appropriate primary sources. Heads of households sampled for the study acted as units of inquiry for data collection.

Data were analyzed around three key parameters using both qualitative and quantitative techniques. The parameters were the regularity of utilization of healthcare facilities when necessary, households' expenditure on health, and self-reported cases on the health condition of respondents' households before and after subscription to the NHIS. Qualitative data were analyzed using direct quotations and transcription of focus group discussions. Quantitative data were analyzed using descriptive statistics such as percentages and frequencies together with cross-tabulations. Assessment of the impact of NHIS on beneficiary households' health conditions was done by comparing evidence-based self-reported cases from respondents on their households' health situation before registering with the social insurance intervention and the situation after registering with the NHIS. This was necessary to simplify the results for easy interpretation and application of the results. The quantitative analysis was done using version 16 of the Statistical Product for Service Solution (SPSS) software. Results are discussed and presented in text and figures for clarity of interpretation.

Factors Influencing Healthcare Utilization: A Theoretical Review

Several theories and hypotheses have been developed to explain factors that determine the utilization of existing health facilities in a particular area. However, these theories seem to focus on key supportive factors of affordability, availability, and accessibility as well as acceptability of healthcare services. A review of related literature on this subject helped the study to identify factors that impact access and utilization of health services and the likely consequences on the health conditions of residents.

Humphreys (1998) points out that many rural communities lack the health services they require, hence, small and isolated rural communities struggle to access health care. Humphreys' argument suggests that the accessibility factor, which is the closeness or proximity of a healthcare facility to a patient, is a basic determinant of utilization of that facility. The accessibility factor raised in Humphrey's argument is supported in some research findings. A survey by the Institute of Development Studies (IDS cited in Buor, 2004) revealed that in the Jasikan District of Ghana, distance plays a significant role in determining utilization of health services. IDS discovered that three-quarters of all registered patients come from within four miles and that over 90 percent of the people living within four miles register at the health unit, but only about one-tenth of the population living within more than six miles from a health facility appear to be registered in Jasikan. The implication is that people within communities with no health facilities are less likely to cover relatively longer distances to utilize a facility than if they had a health care facility in their community. Thus, distance is a major determinant for utilizing a health service. Distant locations of facilities as well as poor road and transport systems are among the physical and geographical barriers to utilization of most health facilities in Ghana especially by low income rural households, even though other barriers such as socio-cultural barriers, notably gender issues, are also eminent.

In a separate study, Kissah- Korsah (2004) notes that the use of a

health service is likely to be influenced by availability of means and modes of transport, the existing transport fares, gender, as well as level of education. Further, factors that violate the distance decay mechanism include quality of care provided and the nature of illness. Inferring from Kissah-Korsah's submissions, even though accessibility or availability influences utilization to some extent, patients will be prepared to cover a greater distance depending on the gravity of their health problem and their ability to meet transport cost and health service charges. Thus, the gradients of distance patients will travel to seek health care are relative to the nature of their illness (Girt cited in Buor, 2004). Births attended to by skilled health personnel and life expectancy at birth have been established to correlate strongly with maternal mortality (Buor and Bream, 2004); an argument which suggests that acceptability of services dependent on the quality of service and socio-cultural values and practices regarding service delivery processes also play an important role in the utilization of healthcare facilities.

Even though accessibility and acceptability remain important determinants of healthcare utilization, the use of the healthcare facility is largely dependent on affordability of the service. In a household survey in rural Iraq, Vaughan (1986) observed that the use of health facilities increased substantially with increasing income (Vaughan cited in Buor, 2004). In a related study, Ke-Xu (2003) concluded from a survey on accessibility and utilization of health facilities that low income is a strong barrier to the utilization of modern primary medical facilities even when publicly provided. Poverty has been established in separate studies to be a strong barrier to the utilization of health service (Nyonator and Kutzin, 1999). Rural people tend to rely on intervening options such as self-medication, using traditional medicine, and resorting to 'quack doctors' and pharmacy shops that can result in serious health implications due to inability to meet service charges (Buor, 2004). A number of studies confirm that ability to pay for a healthcare service is a chief determinant of utilization. Aside from physical accessibility, socio-economic status thus influences the use of health service to a larger extent. Using

multivariate models, Montgomery (2005) concluded from his survey that household living standards are closely associated with three health measures: unmet needs for modern contraception, attendance of a trained health care provider at childbirth, and young children's height-for-age.

Considering the role that affordability plays in improving health status through effective health service utilization, health insurance schemes as a social protection program have been an option for many countries through time. Hanratty (1996) studied the impact of Canada's national health insurance program on health outcomes using county-level data on infant mortality and individual-level data on low birth rate and estimated regressions controlling for demographic and economic characteristics. She concluded that, for her study area, the program was effectively meeting its ascribed objectives. Using data from the HIV Cost and Service Utilization Survey, Goldman et al. (2002) found that insurance lowers the probability of six month mortality by 71 percent following the initial round of interviews in their 1996-1997 survey, hence, confirming the effectiveness of the health insurance scheme to improve health conditions. However, Perry and Rosen (2001) observed no difference in health outcomes for self-employed workers compared to wage earners based on their differential employment-based health insurance premiums, hence, establishing a point of departure from the findings of Goldman et. al. (2002) and Hanratty (1996). It is imperative to note that, the varying views on the impact of health insurance programs may be influenced by a number of factors including variation in methods as well as study objectives and scope. However, whether health insurance scheme is a panacea to the affordability challenge and for improving health conditions especially for the poor and vulnerable remains an important research issue needing empirical verification between and within countries.

The NHIS and Health Sector Reform in Ghana

Ghana's health sector has expanded through time for the prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs. Ghana adopted a Medium Term Health Strategy (MTHS) with a 5-Year (1997-2001) Program of Work (POW), which had four sector-wide objectives comprising of: access, efficiency, quality and inter-sector action. A second 5-Year POW (2002-2006) was launched in 2002 (MOH/GoG, 2002) whereupon the Ministry of Health (MOH) sought to review and expand their contractual relationships with the private sector and NGOs. In response to this paradigm, a private sector unit within MOH was set up to coordinate and promote rational public-private collaboration. In a 2007 POW review, the MOH acknowledged the significance of the private sector's contribution and anticipated progressive partnerships with the private sector and NGOs in ensuing years. The 2007-2011 POW was implemented with sector-wide indicators to track progress in health sector financing, equity and collaboration within the health sector.

The difficulties with implementation and the inability of the aforementioned strategies including many others to meet the health needs of most rural households left the government, development partners, and policy makers the task to find more decentralized opportunities to raise the health status of rural communities. This problem is more pronounced in the core rural areas in Ghana in terms of access, cost and effectiveness of health personnel, particularly during night hours. The Community-based Health Planning and Services (CHPS) program was introduced as a solution to the numerous health-related problems saddling the rural poor and vulnerable people.

The CHPS aims to move health services to community locations, developing sustainable volunteer teams and community health action, empowering women and vulnerable groups, and improving community interaction between healthcare providers and vulnerable households.

Health Management Teams try to achieve this by collaborating with District Assemblies and other stakeholders such that healthcare delivery can trickle down to the deprived communities using CHPS. Ashford et al (2006) have commented that, community-based program, especially those using participatory approaches, are capable of improving the health of the poor by involving beneficiaries in program design, implementation, and evaluation. The implication is that the CHPS strategy appears to be more promising in improving the health of low income rural households, but a lot of administrative, financial, and logistical challenges still remain.

For well over two decades, Ghana experienced protracted health sector reform as part of socioeconomic reforms which made access and utilization of organized health care almost impossible, at least for low income and vulnerable rural households. 'Cash and carry' was a system of user charges introduced in the 1980s as part of adjustment policy reforms to form a sort of spring board to create a permanent revolving fund that would be available to replenish supplies of drugs and equipment without constant recourse to public budget. As part of this reform, the government as a policy direction raised hospital bed fees from 7.50 Cedis to 40 Cedis for adults and from 5 Cedis to 20 Cedis for children while general consultation fees were increased from 5 Cedis to 75 Cedis as part of the cost recovery policy (Cedis in 1980s value terms) (Kyei, 1998). The 'cash and carry' system that characterized the health sector for the adjustment period since the 1980s made access to orthodox health care the prerogative of the urban middle and upper classes, leading to inequities in healthcare utilization nationwide (Yeboah, 2008; Wojtusik and Castel-White, 1998). Hitherto to the 'cash and carry' system, health care financing was in line with the socialist philosophy of the government immediately after independence and was virtually free as was education and other social services. However, prior to 2003, the "cash and carry" system, which required on the spot out-of-pocket payment for health care, had been a financial barrier to prompt care seeking behaviour. The Ghanaian health system was largely constrained by accessibility, availability, affordability and acceptability barriers

(GPRS II, 2005). Thus, in 2003, the MOH implemented the National Health Insurance Act (2003), Act 650 and Legislative Instrument, LI 809, intended to improve accessibility to affordable quality health care.

The National Health Insurance Scheme was established under the National Health Insurance Act 2003, Act 650 to replace the “cash and carry” system and offer affordable medical care to millions of Ghanaians as an immediate necessity of a social intervention to address the challenges of inequities and discrimination against some vulnerable and poor households in healthcare utilization. The act established three distinct insurance schemes to be instituted and operated in Ghana. These were the District Mutual Health Insurance Scheme (DMHIS), the Private Mutual Health Insurance Scheme (PMHIS), and the Private Commercial Health Insurance Scheme (PCHIS) (Gill et al, 2007). The DMHIS is the only public scheme that is operational in all of the administrative districts in the country. DMHIS enables all eligible Ghanaians to enroll in the scheme with an annual premium ranging from GHc7.2 to GHc48.0 depending on their income levels, while dependents and indigents receive free insurance as stipulated in the Act. The scheme is funded from annual premiums paid for by subscribers with the central government’s support. The government’s portion of the national health insurance fund is made up of 2.5 percent; contributions from government workers social security contributions and the Value Added Tax (VAT) rate (Frempong, 2009). The government’s commitment to private sector partnership and greater access to health care for all Ghanaians in their best interest created a favourable atmosphere for the smooth operation of PMHIS and PCHIS. The mission statement of Act 650 is to provide financial risk protection against the cost of quality basic health for all residents in Ghana and to ensure that subscribers and stakeholders are enthusiastic, motivated, and empathetic about the professional staffs who share the values of accountability in partnership with all stakeholders. The National Health Insurance Authority was established to secure implementation of the NHI policy to all residents of Ghana.

Impact of the NHIS: The Case of Kintampo Municipality

The Kintampo North Municipality is one of the underserved districts in Ghana as a result of its geographical location, population size, and inadequate employment avenues. Effective utilization of healthcare prior to the inception of the NHIS was a major challenge for most households in the rural communities of the municipality leading to unfavorable health outcomes. With the introduction of NHIS, which aims at providing affordable and quick health care delivery to low income and vulnerable rural households, this study verified the impact of the NHIS in the study area. The study focused on three key factors: of utilization of healthcare facilities when necessary, households' expenditure on health, and health conditions of respondents' households before and after subscription to the NHIS with results shown in figures 3, 4 and 5.

Figure 3: Respondents Out of Pocket Expenditure on Healthcare Before and After NHIS (Source: field survey, 2011)

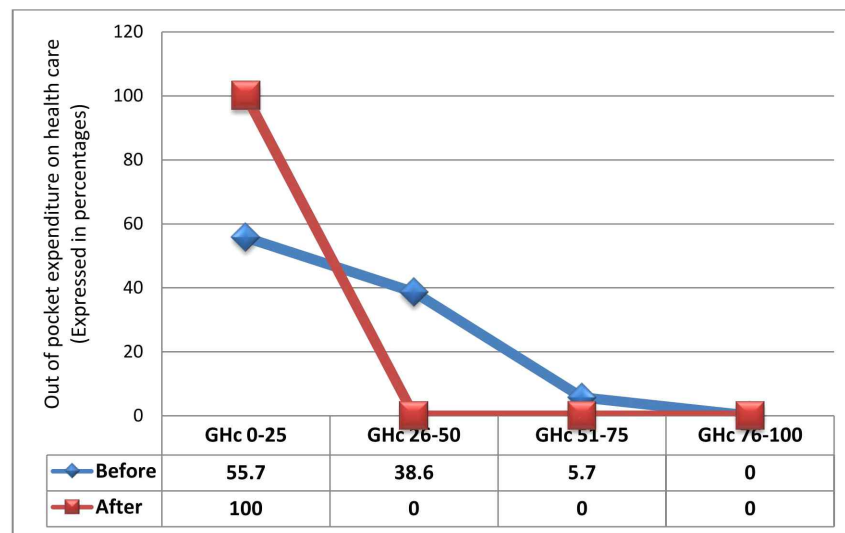


Figure 4: utilization of health facility before and after NHIS
(Source: field survey, 2010)

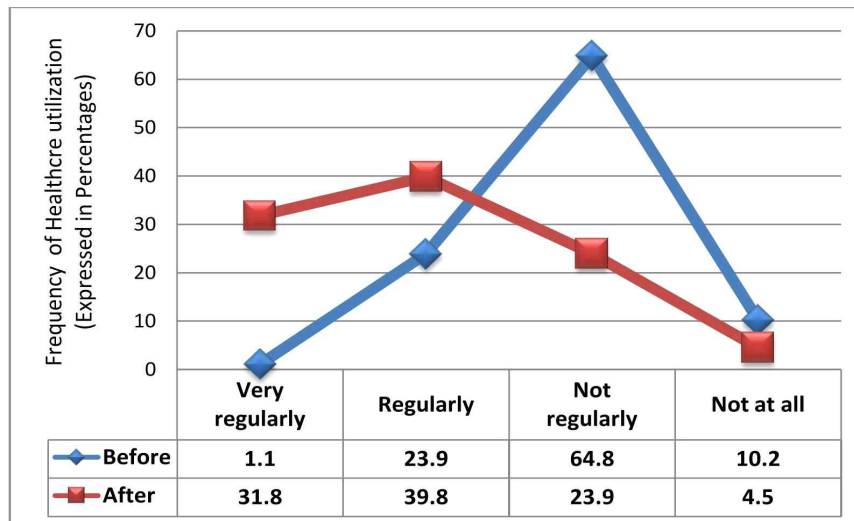
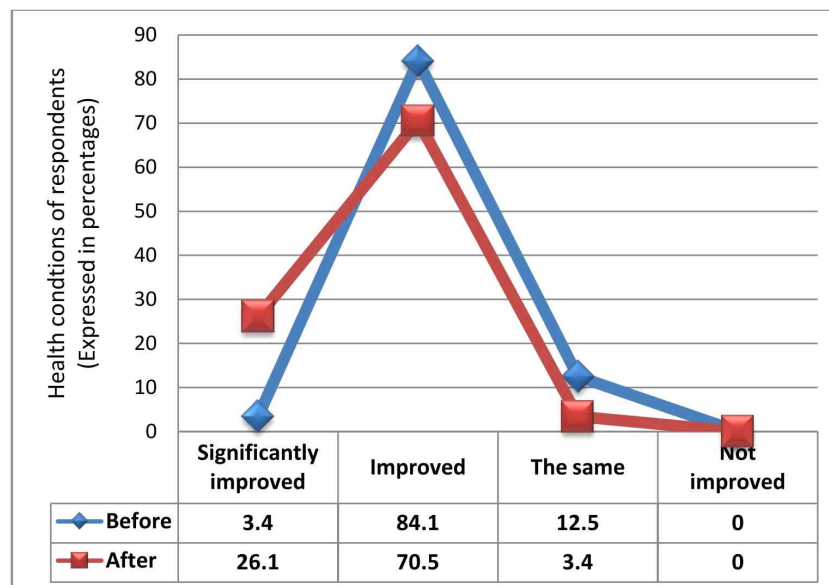


Figure 5: Health Conditions of Respondents Before and After NHIS
(Source: field survey, 2011)



Discussion of Results

Figure 3 depicts the average amount of respondents' household income (expressed in Ghana Cedis- GHc) spent on healthcare monthly before and after the introduction of the NHIS. The results indicate that, prior to the introduction of the NHIS in the study area, 38.6 percent of respondents spent an average amount of GHc26 to GHc50 of their income towards healthcare services, whereas 5.7 percent spent from GHc50 to GHc75 on healthcare services when necessary. Again, 55.7 percent of the respondents for this study were found to spend an average amount of less than GHc25 of their income on healthcare services prior to the introduction of the NHIS in the study area. However, after registration with the NHIS, out of pocket expenditure on healthcare utilization at the point of delivery has reduced to less than GHc25 for all the respondents who were engaged in this study. The implication is that with the relatively lower expenditure on healthcare services at the point of delivery, frequency of use of organized healthcare services for the poor and vulnerable rural households would improve. This was confirmed by this study as shown in figure 4.

Regular visits to health facilities for respondents' households in times of need have also appreciated following registration with the NHIS. Results in figure 4 show that, after registration with the NHIS, the percentage of respondents utilizing organized healthcare service almost always (very regularly) in times of need has increased from 1.1 percent to 31.8 percent; whereas the percentage of respondents' utilizing organized healthcare service often (regularly) in times of need has increased from 23.9 percent to 39.8 percent. The percentage of respondents who are unable to use organized healthcare services regularly in times of need after registration with the NHIS has reduced from 64.8 percent (before registering with the NHIS) to 23.9 percent. Only 4.5 percent of respondents are unable to use organized healthcare services at all even after registration with the NHIS, indicating a reduction from 10.2 percent before the implementation of the health insurance scheme. Thus, for

majority of respondents in the Kintampo municipality, regularity of utilizing appropriate healthcare services in times of need has appreciated due to the reduction in out of pocket expenditure on healthcare services resulting from the introduction of and registration with NHIS. Most NHIS registered households are now able to utilize healthcare services more regularly including rural communities who were unable to meet service charges under the 'cash and carry' system. As a result, the health situation of the majority of people in the study villages has improved based on the respondents' self-assessment compared to the situation during the 'cash and carry' period.

The results shown in figure 5 reveal that the health conditions of respondents improved after respondents registered with the social health insurance scheme. The percentage of respondents who reported significant improvement in the quality of health of their household members following registration with and regularity of utilizing appropriate healthcare services was 26.1 percent, indicating an increase from 3.4 percent before their registration with the health insurance scheme. Respondents whose quality of health remained the same as before registering with the NHIS has reduced from 12.2 percent to 3.4 percent as shown in figure 5. The field results from the study areas within the parameters of this study demonstrate that, with the social health insurance scheme, the affordability constraint to utilization of appropriate healthcare services has been removed for many vulnerable households leading to improved health conditions as a result of increased ability to utilize appropriate healthcare in times of need. Reduced out-of-pocket expenditure has also led to increased access to other household basic needs such as potable water, children's education, food, and housing needs of the poor which together are also necessary for improving quality of life and health.

This study does not negate the need for adequate income as a prerequisite for healthcare utilization (WHO, 2008). It confirms lack of adequate income as an important barrier to appropriate healthcare utilization with adverse effects on the health seeking behavior of poor

and vulnerable households. It also supports Sokrin and Manderson's (2008) findings in Cambodia that lack of income is a barrier to healthcare utilization among rural households. Nonetheless, this study affirms that with a social (health) insurance intervention aimed at improving equities in healthcare utilization and eradicating discrimination against vulnerable and poor households, the affordability constraint can be eliminated to improve the regularity of utilization of appropriate healthcare services by low income and vulnerable households. However, such an intervention may create pressure on existing facilities leading to accessibility and acceptability constraints to healthcare systems. Hence, it is imperative for social insurance intervention aimed at reducing inequities and discrimination against the poor and vulnerable in society to be accompanied with expansion in healthcare facilities. In the Kintampo municipality in Ghana where this study was undertaken, the challenge to healthcare utilization has shifted from the affordability constraints to accessibility and acceptability constraints following the successful introduction of the social health insurance scheme. Accessibility and acceptability challenges manifest in lengthy waiting time spent at service centers to see care providers, short interactive time with healthcare providers, and shortage of essential drugs among others which may warrant further studies.

Conclusion

Poverty and vulnerability adversely affect people's health seeking behaviors. However, poor and vulnerable households are less likely to be poorer in health where social insurance policies tailored to make healthcare services accessible and affordable to vulnerable households are well implemented. It is recommended that policies and programs geared towards improving the quality of health of vulnerable households on sustainable basis need to be directed towards making healthcare not only affordable, but also accessible and acceptable. This would require

expanding health facilities and making insurance schemes affordable to the poor and vulnerable.

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