Dangme West Health Insurance Scheme
(Dangme Hewaminami Kpee)

Annual Report of the1st Insurance Year
(1st October 2000 – 30th September 2001)

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PREFACE

It has been our privilege in the Dangme West district to be at the forefront of work on health insurance in Ghana. At the time that the planning towards the implementation of the Dangme West health insurance scheme started in 1996, Nkoranza was the only existing health insurance scheme for the non-formal sector in Ghana. It provided insurance for inpatient care only. There was no district wide scheme or a scheme that tried to cover outpatient as well as inpatient care.

Despite its proximity to the Accra Metropolis, the Dangme West district is typical of the kind of poor rural district that makes up 60% or more of Ghana. Poverty is widespread and most residents are engaged in subsistence agriculture or fishing. Primary health care is available from health centres, community clinics, two private midwifes and a private clinic within the district. There are no hospitals and residents have to rely on hospitals surrounding the district for referral care.

The lessons that are being learnt in this district therefore about how health insurance could be effectively organized and administered in a rural district are very relevant to most of Ghana.

It is our pleasure to share some part of our experience and what we have learnt by doing with the rest of the country. It is our hope that in doing so, we are adding to the growing experience in health insurance in Ghana. This way, we will as a district provide our contribution to helping the nation as we take very important policy decisions as to how best to move forward to improve access to and quality of health services in Ghana.

Honorable K.T.K. Agban
District Chief Executive, Dangme West District
April 2002

EXECUTIVE SUMMARY

The Dangme West district health insurance scheme, known locally as the Dangme Hewaminami Kpee started operating in October 2000 with premium collection for the first insurance year and provision of services to registered clients. A long planning and consultation phase of about 4 years preceded the start of the scheme.

Each insurance year covers a 12 month period from 1st October of that year to 30th September of the following year. The scheme provides both inpatient and outpatient cover for registered clients. All outpatient costs are reimbursed by the scheme. Inpatient services are reimbursed up to a maximum of two hundred thousand cedis (C 200,000) per referral episode. The ceiling for inpatient care was set in the first insurance year taking into account the average cost of inpatient care at the referral hospitals and the level of premium people were willing and able to pay. To avoid adverse selection, registration is by household. The premium for the first insurance year was twelve thousand cedis (C 12,000) for every member of the household aged 5 to 69 years, and six thousand cedis (C 6,000) for members under 5 years and 70 years or above. In the year under review, 775 households with a total of 3,081 individuals registered in the scheme.

This report provides detail about the history and background to the scheme and the processes and inputs that went into planning for and actual implementation of the scheme. In addition it provides detail on premium revenue and expenditure as well as administrative support for the scheme.

The objective in providing such a detailed annual report of the scheme is to inform the registered member of the scheme as well as the Dangme West community and the rest of Ghana about experiences and lessons learned. It is believed that this will provide valuable information to help others who are also implementing or planning to implement health insurance in Ghana. It will also provide information for the current policy debates and planning on how best to implement health insurance in Ghana such that the formal and informal sectors are all adequately covered.

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1. INTRODUCTION

1.1 The Dangme West District

The Dangme West district is one of the two purely rural districts in the Greater Accra region. Its location within the region and within Ghana is shown in figure 1. It has an estimated 2000 midyear population of 96,015 based on the results of the 2000 census.

The population is engaged predominantly in subsistence agriculture and fishing. Poverty is widespread. In a study of household incomes in general as well as health expenditure in one sub-district, Arhin 1995[1], found that total annual household incomes after subtracting production costs ranged from negative C 1.8 million ($ 2500)[2] i.e. the household was in debt to C 3.0 million ($ 4167) for 98.5% of households. The mean household income was C 369,800 (US$ 513.61) and the median was C 300,200 (US$ 416.94). About half of the households had annual incomes after production costs of less than C 1.0 million ($ 1389). As many as 28% of households were in debt after subtracting production costs.

Household expenditures on health ranged from C 100 – C 63,000 (US$ 0.14 – 87.50) for treatment actions that did not involve admission into hospital. Costs were skewed towards the lower side with 95% of households spending US$ 0.28 or less for treatment actions that did not involve admission. Transport costs accounted for about 30% of the total expenditure related to non admitted actions. For treatment actions that involved admission to hospital, costs ranged from C 1000 – C 103,000 (US$ 1.39 – 143.05).

Health services are provided in the public sector by four rural health centres and six community clinics. Their location is shown in figure 2. In the private sector services are provided by a private clinic located in Prampram, a private maternity home in Prampram and a private maternity home in Dodowa. Recently a private clinic has also been established in Dawhenya. There are several Chemical shops[3] located in the larger communities in the district. There are no private pharmacies.

In addition to these there are numerous untrained, unlicensed and unregistered providers of biomedical care. This includes in almost every village people who sell biomedical drugs in the market and on tabletops in front of their homes, as well as drug peddlers, injectionsists and other varieties of quacks. In the traditional sector there are Traditional Birth attendants, traditional healers and wansams.

The district has no hospital and people who need to use a hospital travel outside the district to one of several hospitals in the surrounding districts. This includes the Battor Catholic hospital in the Volta region, the Agomanya Catholic hospital in the Eastern

[1] Arhin D.C. (1995) Rural Health Insurance: A Viable Alternative to User Fees? A Review and Evidence from three countries. London School of Hygiene and Tropical Medicine. PHP Departmental Publication No. 19. Series Editor: Tamsin Kelk

[2] At the time of the study 1 British pound was approximately equivalent to C 1,000 and US$ 1 = C 720.

[3] Drug shops run by lay persons who have been licensed to sell over the counter drugs and pharmaceutical products.

region, the Akuse government hospital also in the Eastern region; the Tema General hospital and Ridge hospitals in the Greater Accra region.

1.2 Background of the scheme

Ghana, with a per capita income of about US$ 400 has struggled over the years with the problem of how to adequately finance public sector health care delivery in the face of severe resource constraints.

Pre-independence, user charges were in place in health facilities. Following independence, health services were made free at all levels in the public sector. However over time there were increasing problems with adequate financing of the health services to maintain quality as well as availability of adequate quantities of essential drugs and supplies.

In 1985, the Ghana Ministry of Health introduced significant client out of pocket co-payments at point of service use in the public sector. The aim was to recover at least 15% of recurrent operating costs. Though out of pockets payments at point of service use in the public sector by clients had existed before this time, the amounts paid were minimal and more of a token. The aim of recovery of at least 15% of recurrent costs was met. However, utilization studies also showed a significant reduction in use of health services especially in the rural areas.

In the late 1980s the MOH began to consider the feasibility of health insurance as an alternative to out of pocket payments at point of service use.

In 1991, the Director of Medical Services (DMS) at that time, Dr. M. Adibo, discussed with the District Director of Health Services (DDHS) for Dangme West district, the possibility of the district getting involved in feasibility studies on health insurance for the informal sector in Ghana. Following these discussions, he linked the DDHS to Dr. Dyna Arhin formerly with the planning unit of the MOH/HQ, but then studying for a PhD in Health Economics at the London School of Hygiene and Tropical Medicine to work out the modalities for collaboration. As part of the agreement reached, in 1993 as part of the field work for her PhD thesis, Dr. Dyna Arhin worked with the Dangme West District Health Management Team (DHMT) in the Osudoku sub-district of the Dangme West district to collect empirical data to answer the following questions:

- The preferred specifications of community based risk sharing for health care and the willingness to pay (WTP) – the maximum premiums /contributions that households would be willing and able to pay
- Estimate the community risks, calculated as the proportions of the population in the study area who would seek Western type health care during the dry season and the wet seasons, for serious and mild illness, if such care were physically accessible and affordable
- Estimate average costs for out patient and inpatient episodes in health facilities preferred by households in the study area

- Estimate a fair community rated premium based on the community risks and the average treatment costs
- To estimate the external subsidy from government and /or donor agencies that would be required to make the preferred schemes financially viable

The results of the study suggested that households in the study area were risk averse and were prepared to be part of a solidarity group that collected contributions regularly from members and used the contributions to take care of health care costs at time of illness or members or their family members.

As a follow up to this work, in 1996, the District Health management team decided to work with the District Assembly, community members and Dr. Arhin to design and implement as well as evaluate a district wide health insurance scheme. It was hoped that actually designing and implementing as well as evaluating a district wide scheme would be useful not only to the people of Dangme West but also to other districts in Ghana.
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1.3 The Planning Phase

Between 1996 and 2000 when the scheme implementation actually started, a lot of work was put into thinking through the design of the scheme, consulting with community members and the district assembly as well as providers. The EU provided some financial support for this phase of the work through the London School of Hygiene and Tropical Medicine. Some of the activities carried out in this preparatory and planning phase are described below.

- Census of households

The first census of all households in the district was carried out as a collaborative effort between the district assembly and the District Health Administration (DHA) in 1998. Financial support was provided by part of the EU grant as well as by the UNDP poverty reduction program in the district. The census was to give an accurate idea of the numbers of households in the district and household composition as well as to make it possible to enforce the agreement that had been arrived at that to avoid adverse selection[4], registration would be by household.

The census was updated in 2000 to take account of changes that occur naturally over time in households in the district related to migration in and out as well as births and deaths. The repeat was also to improve the accuracy of the earlier census. The Noguchi Institute for medical research was carrying out some work on malaria in the district at that time and part funded the repeat census.

- Awareness Raising and Consensus Building

Awareness raising and consensus building actually started during the planning and preparatory phase in the form of community discussions, community durbars and

[4] Adverse selection refers to the selective registration in an insurance scheme of more vulnerable groups and people who are potentially at higher risk of being ill such as the elderly and those with chronic illnesses

meetings with the district assembly. This was not a one off exercise but rather a back and forth process until all stakeholders were comfortable with the design of the scheme.

- Health Worker Consultation and Orientation

Several formal and informal meetings were held with health workers to orient them to the scheme, obtain their inputs and suggestions for a better design and to outline their role in the scheme. They were also trained in social mobilization and actively involved in a lot of the social mobilization and awareness raising activities. The field staff among them were trained to carry out education just like the Community Health educators whilst the clinical staff were also trained to carry out education of the patients who visited their health facilities on the scheme.

A final preparatory meeting was held with the health workers to tie up all the loose ends. Issues discussed at the preparatory meeting included the following:

- Preparedness of institutions for receiving members of the scheme
- Dress code
- Management of drugs
- Financial management
- Introduction to codes for submission of returns
- Referrals
- Introduction to books for record keeping on clients who belong to the scheme
- Flow of clients through the clinic

All facilities were then supplied with samples of the ID card and Code book as well as forms for compilation of returns after clarification of all outstanding issues.

- Quality of Care

Quality of care was one of the major issues of concern to clients as well as providers that came up over and over again in the pre-implementation consultations.

Community members were very emphatic at almost every meeting over the fact that quite apart from their problems with financial access to services, the perceived poor quality of services in the public sector was a major deterrent for many of them. They liked the idea of the scheme, but without changes in the quality of care, they did not consider it worth their effort or money to use the public sector services or join any insurance scheme. Their concerns related to:

- Interpersonal relationships between providers and clients
- Availability and quality of drugs. This includes the inconvenience of being given prescriptions to go and look for drugs outside the facility to buy. This often imposed on them time and travel costs in addition to the cost of the prescribed drugs
- Working hours. Specifically people were concerned about getting attention for emergency and other cases after the narrow 'official' working hours (commonly 9.00am – 2.00pm) of most facilities
- Waiting time
- Financial transparency and accountability and under the table charges

- Technical quality of service expressed as the desire for laboratory services, ambulance services and less frequent referrals for what they consider as minor ailments

Providers were concerned mainly about making sure they had readily available the inputs they need to work with including functional equipment. They were also concerned about opportunities to improve their technical skills, the quality of leadership at the sub-district level, issues related to team work and conflict resolutions as well as broader health system issues such as delayed promotions.

Several interventions were planned to improve quality of care. Some were implemented, others could not be implemented because of the lack of resources. Some problems could not be addressed because they were wider health system issues that were beyond the power of the district health administration. An example is delayed promotions or ensuring ambulance services in all facilities.

Interventions that were carried out at various periods over the four year preparatory phase were:

- Conduct of the health workers for change training workshops in Dodowa and Prampram sub-districts. They could not be carried out in the other sub-districts because of resources constraints and also because though the workshop series prompted staff to freely express their problems and frustrations qualitatively it was not having any impact on attitudes and behaviour. This is probably mainly because of the difficulties in addressing many of the problems identified which were related to wider health system malfunctioning and inefficiency. More detailed reports on the health workers can be obtained from the District health administration on request.
- Training in Continuous Quality Improvement for all sub-district health teams and the DHMT
- Training in the management of common illnesses of childhood facilitated by residents from the Department of Child Health of the Korle-Bu Teaching hospital
- Advocacy for basic laboratories to be attached to all the 4 rural health centres in the district as well as ambulances. To date Dodowa health centre and Prampram health centre now have an ambulance each. A basic laboratory now exists in Dodowa. Laboratory technician housemen who rotate through the district under an agreement with the laboratory training school in Korle-Bu run it. Some basic laboratory tests are carried out in Prampram by the disease control officer there who was trained at the Noguchi institute for medical research at the special request of the District Health Administration.
- Work is almost completed in Dodowa to provide an extra consulting room and a night duty room as well as permanent quarters for the laboratory.

- Design Of Registration System

This included the design, pretest and ordering of identity cards. The identity card is basically a photo ID card with a unique number. It contains basic information on the insured person including the name, registration number, area council to which the insured person belongs and the house number. Stamps, colour-coded stickers indicating that premium for a particular year had been paid as well as security seals are included in the design of the card.

Other activities were the design of registration forms (copies attached in appendix 5), and format for recording in notebooks for part payment and full payment as well as receipt books. It also involved the ordering of wooden lockable moneyboxes and wooden photo-frames. Since the scheme's own cameras were not ready, local photographers were recruited and trained on how to take the pictures of family members using the wooden photo frames. A listing of all people in the district was printed out according to community to enable registrars check on the names of all those who came forward to register into the scheme. This was to ensure that complete family registration was complied with and avoid adverse selection. A pilot registration was started in Dodowa a week before the launching of the scheme. This was to learn lessons to improve the effectiveness and efficiency of the registration system before district wide registration started.

- Linking Up With The Referral Hospitals

There are no hospitals in the district and all referrals are sent to hospitals outside the district. The hospital selected for referral depends on the one closest to the primary clinic referring as well as the client's preference. Discussions and briefings were held with the hospital management of the following hospitals to accept insured clients of the scheme referred from primary care clinics in the district. The hospitals involved were:

- Battor Catholic Hospital, Battor, Volta Region
- Tema General Hospital, Tema, Greater Accra Region
- Akuse Government Hospital, Akuse, Eastern Region
- St. Martins Catholic hospital, Agomanya, Eastern Region
- Ridge Government Hospital, Greater Accra region

The discussions involved the fee schedules of the hospitals, administrative procedures that needed to be put in place for referred clients of the scheme to be able to use the facility, and administrative claims and reimbursement procedures. They also briefed about the scheme in general. A briefing brochure (see appendix 5) summarizing all the important points was prepared and provided to the hospitals.

1.4 The Information Management System

Good information management systems are essential for the smooth operation of any health insurance scheme. Early in the planning and design phase of this scheme, work started on exactly what kind of information management system was needed and how to obtain it. Given that the scheme was targeting the whole district and planning to work with several primary care clinics as well as referral hospitals, it was clear that a computerized information management system was needed rather than a manual one.

The second problem was where to get and appropriate system. After much thought and exploration, it was realised that it was not possible to obtain an already designed system that would meet the information needs of the scheme. An IT expert was therefore contracted with to be a part of the Health Insurance Management team and work with the team to custom design a computerized data base that would serve the scheme.

The initial local IT expert and his partner we worked with left suddenly and unexpectedly for Europe while design of the database was still incomplete. The IT experts from SSNIT (Ghana Health Care company) offered to help by adapting their own system for us but also stopped halfway. Finally, Mr. Ekow Weah (Tony Williams) a local IT expert agreed to take up the challenge in his free time and has stayed with the scheme to date. Currently, all registration and premium payment information is computerized. Primary care clinic use and information are also computerized. Work is ongoing to computerize information related to referral hospital use. The set backs earlier experienced have slowed the computerization process, which is the reason why some of it is still ongoing.

The components of the IT system can be summarized as:

- Database of all households in the district from the results of the census. This database is kept separately from the other databases that more directly relate to registration in the scheme and use of services. It is used to cross check the completeness of adherence to the requirement that registration must be by household to avoid adverse selection. It is updated periodically based on changes observed in the field during registration. Information in this database includes:
    - Name of head of household and educational status
    - Members of household and relationship to head
    - Age and sex of head and all members
    - Sub-district, area council and community in which household is located
    - Unique household ID number

- Database of registered households detailing head of household, house address, relationships, names, sex and ages. Each household has a unique ID number and each individual in the household has a unique ID number that relates to the household ID. The design of the unique ID number takes into account the area council, the community and the household number

- Database of primary care facility use. Information on who used the service, when they used the service, the diagnosis, services rendered, drugs prescribed and total cost of service are all available from this database. Codes have been created for the different services, drugs etc. Each participating facility also has a code. A copy of the information management system manual attached as appendix 4 of this document and provides more detail. The forms for reporting by primary care clinics are attached as appendix 6. As has already been mentioned the computerization of records from hospitals is now going to be done and there are as yet no standard forms. Hospitals submit a standard agreed set of data on their

own forms. This data includes diagnosis, whether the patient was admitted on not, if admitted length of stay and total cost broken up into the cost of drugs, cost of services, cost of inpatient stay (bed etc) and any others (specify).

The total amount due each primary care facility is calculated by the system based returns submitted monthly on services rendered and drugs prescribed for insured clients. All the drugs on the essential drug list prescribed at the primary care level are in the database with their unit prices. Whenever the price of a given drug changes it is updated in the database. The costs of services and drugs were standardized with the participation of all the primary care clinics, the district pharmacist and other members of the DHMT. Moreover drug prices will be updated on a quarterly basis at the most unless a very special case can be made. Thus it is possible to calculate directly what is due to each clinic. This was done because it was realized that sometimes the calculation of what is due at the clinic level can be a bit arbitrary. The scheme administrators wanted to work within agreed costs rather than to leave an open fee for service system.

- The referral hospital database is now being developed. As such currently we have had to reimburse referral hospitals on a pure fee for service basis and do the analysis manually. This will change by the end of the current insurance year.

1.5 Setting the premium

The premium for the first insurance year was C 12,000 (US$ 2) per adult and C 6,000 (US$ 1) per child or elderly person (70 years and above) per annum if the whole family registered as required by the scheme. Thus the average family of about 5 to 6 persons was paying around US$ 10 per annum.

These premiums were arrived at using the information from the 1993 study already mentioned (Arhin 1995) as well as consultation and discussion with the community and observation as to where was a reasonable place to draw the line between a financially realistic premium and the ability of people in the district to pay.

1.6 Launching of the scheme

The scheme was formally launched on October 10, 2000 at the Salem Presbyterian Primary School park in Dodowa. Present at the ceremony were local dignitaries like the Honourable District Chief Executive and the Member of Parliament for Shai-Osudoku constituency, one of the two constituencies in the district. Also present was the Regional Director of health Services for the Greater Accra Region, Staff of the Health Research Unit, and representatives of DANIDA and DFID. Others present included Assemblymen, Heads of Department, Area Councillors and representatives of the Traditional Councils. The Guest of Honour was the Honourable Deputy Minister of Health, Dr. Moses Adibo. The programme included the following:

- Processional March by School children with placards through the principal streets of Dodowa
- Community drama on the scheme
- Cultural performance
- Address by Representative of DANIDA, DCE, and the Deputy Minister of Health

The Honourable Deputy Minister of Health Dr. Moses Adibo gave the keynote address and the actual launching was performed by the MP for Shai- Osudoku, Honourable Mike Gizo. A presentation of eleven (11) bicycles was made by DANIDA for the registration exercise. They had previously presented ten (10) bicycles to the DHK making a total of twenty-one.

1.7 Description of the Dangme West Health Insurance scheme

1.7.1 General Description

Health insurance involves the sharing of the risks of incurring health care costs by a group of individuals. Individuals who belong to a health insurance plan or fund contribute money regularly to the fund regardless of whether they are sick or not. This contribution is referred to as a premium. Any time they are sick, money is taken from the fund to which they have contributed to take care of their health care costs. The Dangme West community health insurance scheme is one such arrangement. It is open to all residents of the Dangme West district and any residents of areas surrounding the district who are interested in joining. As already mentioned, many of the target population of this scheme are in non-formal employment or self employed and living at or near the poverty line.

The scheme is non-profit making and has democratic accountability to the members. It is publicly administered on behalf of the members by a District Health Insurance Management team. This is a purely technical team and it is considered as acting technically on behalf of the members of the scheme rather than as owning the scheme.

Currently, the scheme's benefits cover only the use of health services in the public sector. Government, who bears about 80% of the costs, subsidizes these services. The users however have to pay the remaining 20% or so of costs out of pocket at point of service use under the cash and carry system. Payment of health care costs out of pocket at point of service use is proving a significant barrier to access to services especially for the poorest of the generally poor population of this district. The Dangme West community health insurance scheme is trying to replace the need to pay out of pocket at point of service use with insurance. Thus it is only the out of pocket payments that are being insured and not the entire costs of care. Government has been and remains committed to continuing to provide the 80% of costs from general tax revenue and the Donor Pooled Account or Fund[5]. Insurance thus represents a form of pre-payment for out of pocket at

[5] Under what is known as the Sector wide approach, development partners or donors in the health sector put some or all of their funds into a common account. The money is then used as budget support for the

point of service use costs. However it is a form of prepayment in which the whole group involved is showing solidarity by cross subsidizing each other.

The issue of how to cover the use of health services in the legal private biomedical sector is however still being explored. Since these services are not subsidized by government, to cover their use will involve charging higher premiums and studies have to be carried out to determine what kind of premiums would appropriately cover such services, as well as the ability of the population to pay such premiums.

Membership is voluntary, and all residents of Dangme West are encouraged to join. Residents of other districts are also welcome to join provided they are willing to abide by the clause that requests them to use one of the primary care clinics in the district as their first point of service use.

Currently, the services the scheme covers are:

- All Primary Outpatient Clinical Care
- Basic laboratory tests requested as part of primary outpatient clinical care namely, Hb, sickling, full blood count, stool R/E, urine R/E, widal test and blood grouping
- Antenatal care
- Delivery and postnatal care
- Family planning
- Child welfare and immunization. This is in theory free currently, but in practice in most clinics mothers pay a "voluntary contribution" to cover the costs such as transportation for the nurses, cotton wool etc
- Referral to a participating hospital provided the patient consulted a primary outpatient clinical care providing facility first and was referred by the prescriber there. Clients who self refer to hospital will not be reimbursed. This system of gate keeping is necessary to prevent the administrative and financial complications that are likely to be associated with allowing patients to self refer to hospitals outside the district.
- If a client is referred, all fees are paid up to a maximum of two hundred thousand cedis (C 200,000) after which the client has to pay any fee over and above this amount. Cases that are referred as acute emergencies e.g. convulsions; ruptured ectopic pregnancy and other obstetric emergencies are provided transport under the scheme if an ambulance is available. If not private transport such as taxis and buses have to be hired by the relatives. Currently only Dodowa and Prampram have an ambulance.

1.7.2 Long term vision

If the scheme proves successful, it is hoped that over time a way will be worked out to ensure that everybody resident in the district is covered since ultimately the scheme aims for Universality. Universality is defined as making sure every resident in the geographic

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approved plans and priorities of the MOH /GHS. The development partners who contribute to this fund take part in the development and review of the health sector program of work they are supporting through the sector wide approach.

area of coverage of the scheme is insured one way or the other. Health insurance schemes that achieve universality or near universality are much better at promoting equity. Equity is an important consideration in health care for a nation that believes that all its citizens should be entitled to equal care for equal need and unequal care for unequal need regardless of their status.

In addition to universality, the scheme aims at achieving portability. This means that people enrolled in the scheme can be taken care of within any participating facility. Initially, this will be any participating facility within the district. However, once again it is hoped that if the scheme proves successful, a way will be worked out over time to ensure that people enrolled in the scheme within the district could still be taken care of under the scheme if they fall suddenly and unexpectedly ill while outside the district.

Comprehensiveness – An agreed upon package of essential health services will be covered under the scheme. It is important to note however that comprehensiveness does not mean that any and every type of care will be covered. It is doubtful if there is any country in the world that can fully afford to provide all the health care every single one of its citizens thinks they need regardless of cost.

1.7.3 Organization and Administrative structure

It is imperative that the premiums in the scheme be kept low and affordable by the majority of rural households in order to achieve the required high participation in spite of the widespread nature of poverty in the area of coverage. Hence, the scheme has some of the characteristics of provider insurance schemes. This will have the effect of limiting excess utilization arising from moral hazard[6] and lowering administration costs.

The main actors in the scheme are:

a) ***Registered households*** who collectively form the *Dangme Hewanminami Kpee (DHK)* or Dangme Good Health Group or District Health Maintenance Association. They are entitled to health care under the scheme in accordance with its regulations. They are represented by Area Council Executives who they themselves elect. The detailed description of the arrangement for ensuring good community representation is described in the next section (1.2.4). The members of the DHK are considered as the actual owners of the scheme rather than the administrators of the scheme.

b) The health facilities that provide care to registered members using funds received from the members of the *Dangme Hewanminami Kpee.* Participating facilities are collectively referred to as the ***Providers.***

c) ***The District Health Insurance Management Team (DHIMT),*** has representation from the district assembly in the persons of the District Planning Coordinating Officer and one other member of staff from the District Planning and Coordination office of

[6] Moral hazard refers to the abuse of insurance systems by clients or providers through excess and unnecessary utilization of services by clients or payments claims by providers

the District Assembly[7]. In addition, members of the District Health Management Team (DHMT) and some other staff from the office of the District Director of Health Services (DDHS) are part of this team. The DHIMT is responsible for financial and administrative matters including reimbursements to health centres and hospitals using an approved formula /agreed rates and monitoring of performance to ensure that paid up members of the association will have access to good quality health care at hospitals and clinics without paying fees. It is also responsible for the compilation and analysis of routine health management information system data related to the scheme. The details of the computerized routine management information system data that have been developed are described in detail in section 1.5. The DHIMT is not the owner of the scheme. It is only providing the needed technical support to the DHK who are the owners of the scheme.

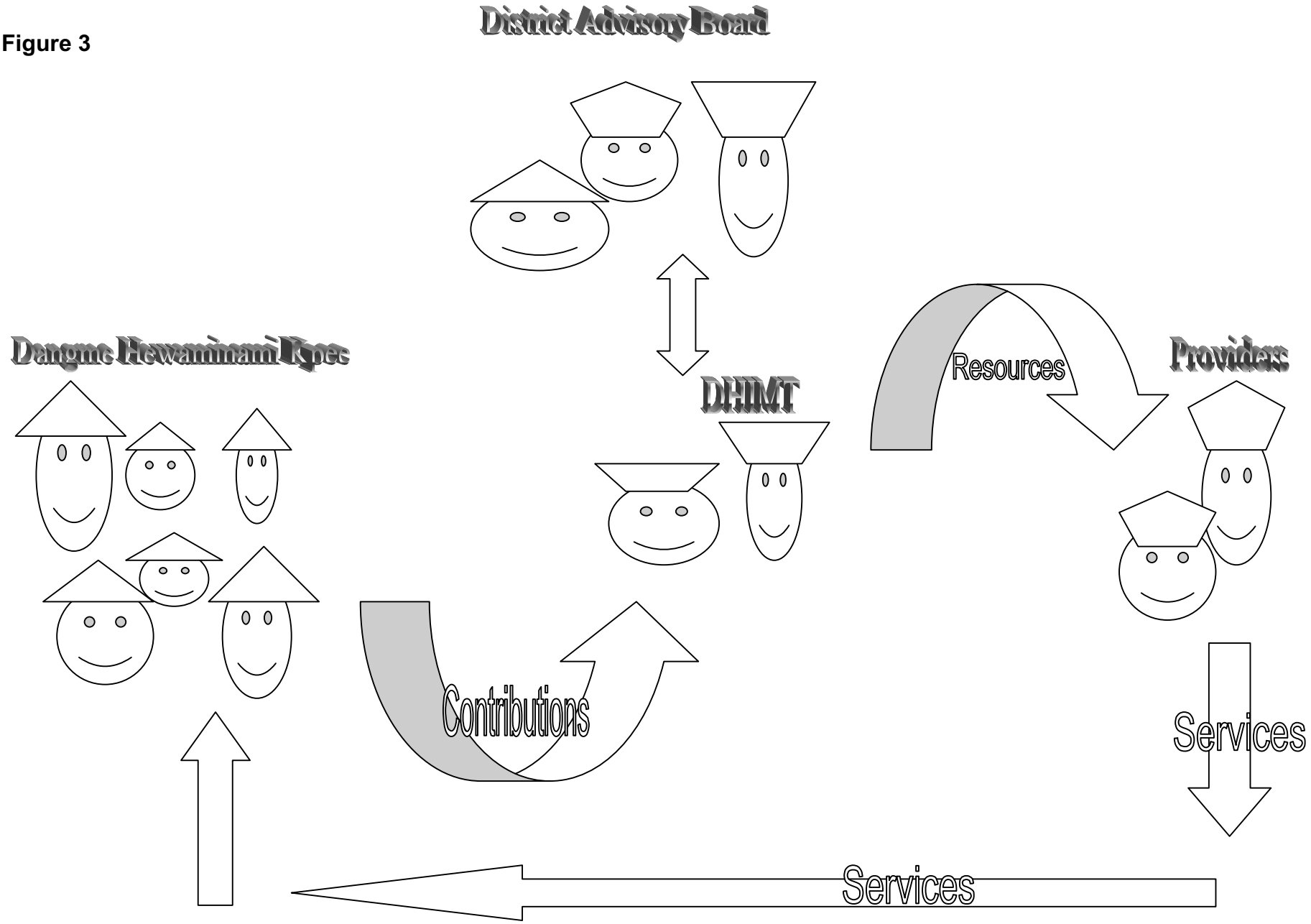
d) ***A District Advisory Board (DAB)*** made up of traditional, political, religious and administrative leaders in the community and district, and regional health leaders (MOH, NGO) and other persons considered as having expertise as well as the interest in the welfare of the scheme. This board is yet to be set up. The delay has been in part related to political changes in the district. It was discussed with the previous administration. However there is now a new District Chief Executive (DCE) and the issue will have to be revisited to ensure that the board is set up. The board is expected to meet twice a year and provide advice in policy related areas such as contribution schedules, exemptions, credit facilities, assuring equity and disciplinary matters.

e) ***Central government.*** As already mentioned, central government through the Ministry of Health provides about 80% of the funding of the public sector health service. Currently it is also bearing the cost of care for exempt categories of patients (under fives, over 70 and antenatal clients). Some of this money is from tax revenue and others are from donor funds through the donor pooled fund or account. However for convenience, it will all be referred to as the Central government provision. Thus indirectly central government is an important player in this scheme since it is vital that it keeps up its share of the financing of the health system. Moreover, it is necessary to keep this awareness alive since people are sometimes afraid that the introduction of insurance means that central government is going to pass on all its responsibility for ensuring the financing of the health care system directly to individuals and households. Central government has moreover provided and continues to provide support funding needed to set up and adequately develop the scheme.

The district organization of the scheme is summarized in figure 3.

[7] The district assembly is the local government governing and administrative body in Ghana.

Figure 3


District Advisory Board
Dangme Hewaamanam Kpee
DHMT
Resources
Providers
Contributions
Services
Services

1.7.4 Arrangements for democratic representation of members

Members of the scheme are represented at the district, area council and community (locality) levels by their elected representatives as described below. At the start of collection of premiums, these bodies had not been put in place though the plan for their establishment and operation had been discussed with the community and district assembly and drawn up. They were set up after the close of registration. This is because during the community discussions and consensus building that preceded the scheme, people expressed as important the need for their representatives to be actually registered members of the scheme. They therefore requested that registration should be completed before the election of representatives were carried out.

The different committees or executives that represent the registered members and they way they function are described below. This is followed by a description of the processes we went through to set them up in the first insurance year. A lot of work was done in the setting up of the committees by the DHIMT that will not be necessary in subsequent years because the committees themselves will now take up these functions.

1.7.4.1 Description of the different committees

- **District level executive or committee**

The district executive is an eleven (11)-member body. Each of the 7 area council committees sends their chairman to represent them at the district level. In addition, 4 other members are selected by consensus among the area council representatives. To ensure that the representation of women is adequate, if the majority of chairpersons are male the four remaining members must be selected such that there are at least four women on the district executive.

The district committee serves a two-year term after which fresh members are to be elected. If for any reason a member of the committee has to leave office or resigns before the two-year term is up, the area council he/she represents will provide a replacement.

Officers who have already served a term can be re-elected provided this is done democratically and there are no unresolved complaints pending against them. The district committee will elect one member as its chairman and one member as its secretary.

Functions

(1) Contribute to policy and planning decisions concerning the direction in which the scheme should go, premiums, quality of care etc
(2) Working with the DHIMT in awareness raising and social mobilization
(3) Ensuring that collection of premiums and management of finances of the association is done in a fair, transparent and equitable manner
(4) Review of annual audit reports of the finances of the scheme
(5) Review of the general annual report of the scheme
(6) Presentation of the views of members of the association on all issues of concern to the District Advisory Board and the Health Insurance Management team and where necessary, through them to the providers

- **Area Council executive**

Each of the 7 area councils in the district elects a minimum of 8-10 and a maximum of 15 representatives from among the registered families in the area council to represent the interest of all the registered families. Election of representatives is done democratically by nomination and voting every 2 years at a joint meeting of all heads /representatives of registered families in the area council. Only members of households registered in the scheme are eligible for membership of the area council committee. The functions of the area council executives or committees are as below.

Functions

(1) Problem identification for members in the scheme
(2) Advocacy for members of the scheme in all areas considered relevant e.g. level of premiums, quality of care, client entitlements etc
(3) Provide the link between the community level and the district level
(4) Social mobilization and awareness raising
(5) Organization of annual members meeting in the area council. These annual meetings will be a kind of stakeholders meeting to brief members on progress in the past insurance year and discuss the upcoming insurance year
(6) Focal persons for organization of collection of premiums within the community
(7) Oversight role:
    a. Which families enrolled
    b. How much collected
    c. Financial status of the scheme
    d. Welfare issues e.g. Families that genuinely need financial assistance to enrol in the scheme and what can be done for them

To enable the area council executive perform its functions effectively, the area council executive is expected to organize regular meetings to discuss issues relevant to their work. The secretary must keep minutes of the proceedings at such meetings. The area council also needs to plan and agree on how to keep in contact with registered members of the scheme.

In relation to item 7(d), there is a line item in the GHS budget to cater for paupers. However the amount is very small and there has been a problem in identifying people who are genuinely destitute (e.g. an old woman living by herself without any family and any financial means of support) so that they can be assisted with this fund. The area and community /locality committees are in the best position to known who in their area is desperately poor and in need of financial assistance. In relation to the definition of desperately poor, it is acknowledged that most people in rural districts such as Dangme West are very poor. However the fund cannot cater for everybody. It is for the few people who are exceptionally poor beyond the ordinary state of everybody else around. The suggestions related to identifying and helping the desperately poor enrol in the scheme include:

1. Have a limited number of poor people who can be catered for in each area council based on the funds available
2. The area committee will have the role of identifying and bringing up desperately poor people who need support
3. The genuineness of each case will be verified by the DHIMT working with the social services department
4. The line item for paupers will be used to provide insurance cover for these people

The area committee should divide up the area council among themselves so that each member covers/is responsible for a defined set of communities.

- **Locality committees**

This will be made up of families living within walking distance neighbourhoods who are enrolled in the scheme. The communities in each area council are grouped together into reasonable clusters and members organized into community or locality committees.

The function of the community level groups is to provide:

(1) Problem identification and Advocacy for members
(2) Linkage between individual members and the area committees
(3) Mobilization and awareness raising
(4) No direct involvement in money collection, but oversight /audit role:
    a. Which families are enrolled
    b. Is financial management of the scheme transparent and efficient and fair

1.7.4.2 The process used to ensure the initial setting up of the committees

All 775 households who had registered in the scheme and their house addresses were printed out from the data base by area council. Letters were then addressed to the heads of households inviting them and their households to a meeting of all registered members. The purpose of the meeting was to set up the representative committees as agreed upon during consultations in the scheme design phase. The dates for the meeting in each of the seven area councils was set based on the 'rest' day for that area. Traditionally each area has a day of rest where people stay in the community e.g. most fishing communities have Tuesday as their day of rest where it is forbidden by tradition to go fishing. The letters were hand delivered with a verbal explanation of the content by staff of the insurance administration. This was to ensure that everyone got the information regardless of his or her ability to read and write.

At each area council meeting, those present were reminded of the procedures that were agreed upon for democratic representation as outlined in the previous section. They were also briefed about how many people had registered and how much premium had been collected. They were also asked about their experience with the scheme to date and any suggestions they had about improvement for the next cycle. They were then asked to nominate representatives for election as members of locality and area council committees

or executives. For each locality at least two or more people were put forward by the members as nominees. The members then voted on the candidates put forward. Selection was by simple majority and voting was by raising of hands. All the locality representatives came together to form the area council committee.

Once the area council committee was elected, the team held a further debriefing with them on their roles and functions as described in the previous section. They went away and voted on who would be their chairman, and secretary. Once this was completed, durbars were held in each of the seven area councils to formally outdoor the area council executives and introduce them to all the people whether insured or not. This was because all the people are potential members of the scheme depending on what they choose in any given year. It also served as a forum for further awareness raising about the scheme.

The chairman automatically became a member of the district committee. The four other persons to join the district executive were elected by consensus from within the area council committees.

2. IMPLEMENTATION AND RESEARCH OBJECTIVES

The Dangme West community health insurance scheme as can be seen from its background described earlier can be strictly said to have originated from the Ministry of Health as Intervention research to provide some answers to questions in the area of health care financing for which very few precedents were available to learn from in Ghana. In relation to this, there were objectives in initiating and supporting the setting up of the scheme from the perspective of the Ministry of health. These are what are described below.

It has been mentioned earlier that one of the foundational principles of the scheme despite the role of the Ministry of health and technical experts in setting it up has been that the ownership of the scheme should actually be with the members rather than the Ministry of Health. This cannot be repeated too often since an erroneous impression is sometimes expressed that because the scheme was initiated by the MOH, it is not possible that there can be any real community ownership.

2.1 General Objective

To implement and evaluate the feasibility and sustainability of a district wide community health insurance scheme as a means of effectively improving financial access to and quality of health services for residents of Ghana whether they are in formal or non-formal employment, in an equitable manner.

2.2 Specific Objectives

(a) To increase financial access to health services for residents of the Dangme West district by implementing a health insurance scheme as a health-financing alternative that will remove the financial barrier created by out of pocket payments at point of service use.
(b) To generate revenue for maintenance of health services and improvement of the quality of care available to residents of the Dangme West district using community health insurance
(c) To evaluate and describe the ability of the health insurance scheme to achieve the objectives of improved financial access and quality of care in an equitable manner
(d) To evaluate and describe the feasibility and most suitable approach to implementing district wide community health insurance schemes that cover the informal sector as well as the formal sector in Ghana.
(e) To discover how best to ensure that health insurance is implemented such that ownership resides with the members and the community rather than technical experts who support the technical development and running of the scheme
(f) To disseminate the findings and lessons learned as widely as possible so that they may inform policy making and implementation related to health insurance in Ghana

3.ACTIVITIES AND PROGRESS IN THE YEAR UNDER REVEIW

3.1 Social Mobilization and awareness raising

Quite apart from all the preparatory work that had been done earlier and has already been discussed, various channels were used to step up the mobilization of people and creating of awareness about the scheme in the run up to actual collection of premiums. Intensive and stepped up social mobilization and awareness raising started in August and was continued through to December when the registration period was supposed to end.
The methods used were:

- District assembly briefings and consultations
- Community durbars in selected communities across the district
- Area council meetings with community members and leaders
- House to house education by trained community volunteers for one on one and group discussions about the scheme
- Use of Public Address system mounted on vehicles
- Nine page health insurance education flip chart used by health staff and volunteers for small group discussions
- A one page information brochure
- Community drama

The use of trained community volunteers for house-to-house education was done in collaboration with the Planning Unit of the district assembly. The Poverty Reduction Program (PRP), which is being implemented by the Planning unit, has an existing group of men and women who have received extensive training on community education in various issues. These have in the past included women empowerment and issues related to Legal Literacy. They have a variety of backgrounds. They include chiefs, community development officers, Opinion leaders, teachers etc. Their job entails doing house-to-house education and organization of radio listener-ship groups in the community. The radio listener-ship groups listen to educative program on radio and discuss the issues that arise. The members of the group are drawn from communities all over the district.

Based on their background and experience and in view of the close collaboration the health administration and the district assembly have, they were thought to be a very useful resource for the health insurance education program. All the volunteers (40) were written to and informed about the education program and asked to indicate their willingness to participate. All 40 agreed to do the job. From the 18th –19th September, the District Health Insurance Management Team trained all 40 volunteers at the premises of the district assembly. They used the nine-page health insurance education flip chart as well as the one page information brochure for the education.

In addition to the household education Public Address (PA) systems were mounted on 7 vehicles and used in the 7 area councils. The announcer had a copy of the brochure and talked to the community based on information from the brochure. Community drama was also organized in the various area councils. The drama troupe was made up of a mix of health workers and community members. The drama was based on 2 scenarios the first one indicating a person who registered in the scheme and the benefits the person

received. The second one was on a person who did not register in the scheme and the problems the family encountered. The drama was performed in 7 selected communities in each of the 4 sub districts in the district making a total of 28 performances. The performances were in the evenings and were followed by question time. They were very interactive in that the community was drawn into the drama.

The original social mobilization and awareness-raising program was to have involved the use of radio. However the Insurance Management team realized that it was necessary to get a better understanding of how best to use radio for education. There are currently a multiplicity of FM broadcasts from stations located in Accra and Tema that reach different parts of the district. In addition there is radio Ada that is located in Ada and specifically targeted at the Dangme speaking peoples. It was necessary to know among other things what the level of radio ownership and use was in the district, the FM stations and kind of programs listened to and preferred as well as the peak listening times. The radio awareness raising programs were therefore postponed. Instead a communication survey was carried out to answer the questions raised. A copy of the report of this survey is available from the district health administration.

The two most listened to radio stations in the district from this survey were radio Ada and Peace FM. Based on the findings from this survey, it is proposed to use radio for education about the scheme. Negotiations are going on with Radio Ada concerning the design of a health digest program that will provide a forum for discussions on health insurance, as well as spots on health insurance. Radio Ada was selected because its broadcasts reach Ningo and Osudoku, it is a very popular station in these areas and they have shown a lot of interest in being involved in the health digest program. We have also initiated discussions with Peace FM whose broadcasts are also popular in the districts.

3.2 Registration of clients

Registration of clients started on 1st October 2000 in the Dodowa sub-district and went on for about a week before it was extended to all other sub-districts. Registration was started during the launching. A registration team was made up of a photographer a registrar and a community mobilizer. The team carried along a notebook, registration forms, receipt books, a wooden money box, a census listing of all people in the area council to which they were assigned as well as a wooden photo frame. There were fixed registration points but in addition the member of the team carrying out community mobilization went from house to house. In addition, each health centre was a permanent registration point.

Once a family came forward to be registered, they had the option of paying in full or in instalments. If a family paid the premium in full, their pictures were taken and their registration forms were then submitted to the Insurance office for processing after which they received their cards and could use the health facilities in the district. Processing of ID cards took about a month and were only issued once payment was completed. If a family paid in instalments, the cards were only processed once payment was complete. Any money paid, no matter how small was acknowledged with a receipt.

Cameras as well as photographic films were provided by DANIDA for this purpose. WHO also donated 2 instant cameras and some film. Because of these donations, photographs were taken for clients registering in the first year free of charge.

Table 1 summarizes the households registered by sub-district and by area council. The 775 registered households represent a total of 3,084 individuals. This gives an average household size of 4 persons. This is one lower than the district average of 5 - 6 persons per household. It suggests that in spite of all our efforts some households did not register all their members. Of the registered individuals, 1400 (45%) were male and 1684 (55%) were female.

The 2000 midyear population of the district was 96,015 according to the results of the 2000 census. This means that in the first year of operation of the scheme, we registered approximately 3% of the total district population. Though this is lower than our ultimate target of 50% or more of the district in the first 5 years of operation of the scheme, we are inclined not be discouraged. The concept is new in the district, this is the first year of operation and some of the constraints faced, which are described in detail under the section on constraints are still being addressed.

Because at the start up of the scheme, the community structures for democratic representation of members had not been set up for the reasons already explained, a mixture of health workers and a handful of community members carried out the registration in the first year. Now that the community representation structures have been set up, the area council executives carry out all the registration. The DHIMT role is now simply the banking of the premiums and the technical management of claims processing and information management.

3.3 Management and administration of the scheme

All monies collected were acknowledged with receipts using MOH General Counterfoil receipt books. The money was deposited in the District Director of Health Services (DDHS) account initially for convenience. Because the money was coming in small bits and pieces it was not immediately easy to open an account specifically for the scheme. Subsequently, however, a specific account for the Dangme Hewaminmi Kpee premiums has been opened with Standard Chartered Bank, Legon branch and all monies transferred there.

A total of thirty five million and seventy five thousand cedis (C 35,075,000.00) was collected in premiums during the registration of the first insurance year from the seven hundred and seventy five (775) households.

3.4 Provision of services to the clients

Once cards were issued, clients were able to access services. However it usually took at least a month to process the card so effectively there was a minimum waiting period of one month.

There was a total of 2705 outpatient contacts among all the insured households i.e. 3084 insured persons. This gives an average of 3.5 outpatient contacts per insured household in the course of the year and 0.9 or approximately 1 outpatient contacts per insured person. Table 2 summarizes the number of contacts per primary care clinic per month over the period. Table 2 also summarizes the total number of outpatient contacts for insured as well as non insured clients over the period.

There was a total number of 51 Hospital (secondary or referral) contacts among all the insured clients. This gives an average of 51/775 referral contacts per insured household and 51/3084 per insured person. Table 3 summarizes the number of contacts per referral hospital per month over the period.

As table 2 shows, utilization of clinics was low at the beginning of the insurance year and only picked up from January onwards. This is because many households did not register at the start of the scheme. They rushed to register in January as the registration window was closing. Utilization is likely to be higher in the second insurance year given that at least half the households who registered in the first year renewed their registration very early on in the second year.

Table 7 summarizes and compares utilization of primary care clinics by insured and uninsured clients. As can be seen from this table, utilization by insured clients was initially very low. The reason for this has already been explained as the late registration of most families in January 2001. Utilization among insured clients picked up rapidly from January 2001 onwards and rose to as high as 8 time utilization among uninsured clients by May 2001. The fall after May is related to the fact that providers in the primary care clinics started to discourage utilization by insured clients. The DHIMT received complaints from the clients concerning this phenomenon. The worst problems were in the Ningo clinic and as can be seen from table 4, in August September no insured clients used that clinic. They went instead to Prampram. Indeed the insured as well as non insured clients were so upset with their treatment by the main prescriber in this clinic that at a community durbar the community elders and members in a group requested removal of the main prescriber. Specifically they complained of insults and rudeness and being turned away.

In the other areas however discussion with the clinical staff revealed that they were uncertain if they would really be paid for services rendered to insured clients. Because of the delay in setting up the computerized system as has been explained elsewhere in this report, there was a long delay in processing payment to the primary care clinics. They already had previous experience of non-reimbursement of bills for clients seen under the exemptions program. They were worried that the bills owed them for seeing insured clients might become bad debts. The fears have been allayed now that the system is working and the money due each clinic has been calculated and paid.

4. INCOME AND EXPENDITURE FOR THE YEAR UNDER REVEIW

The premium fund has been used exclusively for the reimbursement of claims related to use of primary and hospital services by members of the scheme. In some cases direct reimbursement for use of hospital services has been done to members of the scheme for reasons explained below. All the administrative start up costs of the scheme as well as the administrative costs of managing the scheme have been borne out of GOG and DPF budgetary allocations to the District Health Administration, District Assembly funds or special budgetary support from the interested development partners. The details are explained in the sections below.

4.1 Insurance Premiums from Community members

Overall, a total of C 35,075,000 was collected in premiums. Of this amount, C 14,479,469 was used to reimburse use of primary care facilities in the district. C 3,498,900 was used to reimburse use of referral hospitals. A further amount of C 1,655,250 was paid directly to clients as reimbursements for services they had to pay for out of pocket at referral hospitals or drugs they had to purchase themselves. In cases where services had to be paid for by clients out of pocket at the referral hospital, it was because the staff they met at the time they were referred said they were not aware of the scheme and insisted they pay out of pocket. In the case of drugs, it was because they were not available at the hospital. The out of pocket payments are therefore mostly strictly part of the referral hospital payments. Most of the problems of having to pay out of pocket at referral hospitals was because of some initial confusion at the start of the scheme related to recognition of referred clients.

Table 4 summarizes the reimbursements from the premiums collected by month by primary care clinic and table 6 provides the same information by referral hospital. Table 5 summarizes the direct reimbursements to clients.

Expenditure was low in the first insurance year because as already mentioned many families registered late (January 2001). For a new member it took up to a month to prepare and give the family the cards. Thus many families started benefiting from the scheme in the middle of the insurance year rather than at the beginning.

4.2 Development Partner Support for 2000/2001

Special support refers to funds that were specially provided to support the scheme outside of the routine funds supplied to the district health administration to provide health services in the district and outside of the premiums paid by community members registered in the scheme.

4.2.1 Danida support

The total budget received from DANIDA to support the scheme for the 2000/2001 insurance year was sixty three million, two hundred and fifty thousand cedis (C63,250,000) as direct cash transfer. In addition DANIDA provided indirect cash transfer in the form of 6 cameras, rolls of film and 21 bicycles valued at approximately twenty three million, eight hundred thousand cedis (C23,800,000).

4.2.2 WHO /AFRO support

Donation of a computer, 2 instant cameras for passport pictures, instant film and laminating plastic to support the registration and information needs of the scheme was done by WHO-AFRO through the local WHO office. They were valued at approximately US$ 10,000 by the WHO office.

4.3 Support from DHA regular budget (GOG & DPF)

Salaries of all MOH /GHS staff apart from the four research assistants were paid through item 1 (personnel emoluments) of the GOG budget. Since staff gave part of their time to work on the scheme without additional remuneration from any source this represents a subsidy of scheme administration by GOG.

In addition, support has been indirectly provided from the DHA regular budget in the form of:

- Office space and related overheads for utilities such as light and water
- Use of DHA and sub-district vehicles for mobilization and organization including fuel
- Use of office supplies such as paper, toner, photocopier etc

DHA regular budget has also been used for activities related to quality improvements such as staff training and supportive supervision

4.4 District Assembly Support

The district assembly has supported the original census of all households in the district carried out in 1998 and the repeat carried out in 2000. Support in 1998 came from the UNDP poverty reduction grant to the assembly. In addition, the assemblymen were involved in the planning for the census as well as the collection of data during both periods.

5. CONSTRAINTS /CHALLENGES

5.1 General Constraints /Challenges

Our major constraints and challenges have been:

(a) COMMUNICATION /IE&C

Fostering adequate and clear communication links with the community and ensuring community understanding of the scheme has been a major challenge. The district wide nature of this scheme makes it a particular challenge. Despite the fact that it is one district, predominantly inhabited by the Ga-Adangme ethnic group with numerous similarities, there is still a lot of variation among communities socially, culturally and economically.

(b) QUALITY OF CARE

Time and again, community members have made it clear that without an assured basic adequate quality of care they are not interested in using services in the public sector. At the same time, the problem of quality of care in the public sector is a complex one that requires several interventions for which the resources, both manpower and material are not necessarily always available. Also challenging is the fact that the referral hospitals are not under the jurisdiction of the Dangme West district health sector.

(c) REFERRALS

The scheme is working with 10 primary care clinics scattered all over the districts and 5 referral hospitals located in 3 different regions. There is no district hospital. This presents quite a challenge since it requires constant communication and negotiation with a wide variety of actors who are geographically and administratively separate. It is however a challenge that may end up to be one of the strengths of this scheme if it works out successfully. This is because it will provide experiences and ideas as to the way ahead to expand community health insurance schemes to cover more and more of the population in Ghana. It is not going to be possible to cover large portions of the population of Ghana with health insurance without working with a diversity of clinics and stakeholders.

(d) LOCAL GOVERNMENT LEADERSHIP

Given the central role of the district assembly in the effective implementation of this scheme changing political leadership at the district level has been a challenge. Since 1996 when pre-implementation phase started there have been three district chief executives[8]. This a very high turnover of district chief executives. Each time the political leadership changes, the process of briefing the new leadership and getting their commitment has to start all over again.

[8] The District Chief executive is the political head of the local government body (district assembly)

(e) THE GHANAIAN ECONOMY /POVERTY

The general economic constraints in the country as a whole and the health sector in particular does not always make it possible to respond to problems e.g. quality of care issues as rapidly and thoroughly as desirable. This can be discouraging for clients, providers as well as administrators. It requires a lot of staying power to persist in attempting to improve the system in making things work under such circumstances.

(f) THE 2000 ELECTIONS

The closeness of the start of the scheme to the 2000 elections resulted in speculations by some members of the community that perhaps the whole scheme was some kind of political gimmick and as such would not endure. This to an extent affected the willingness of some families to enrol in the scheme

(g) SETTING UP OF A MANAGEMENT INFORMATION SYSTEM

The sudden and unceremonious as well as unannounced departure of the original Information Technology (IT) expert working with the scheme for greener pastures was a severe set back. This brought all the work on the IT system to a halt until another IT expert was found who then had to start designing the system all over again. This is a special problem though it is in part related to the general economic situation in the country and the inability to pay attractive and competitive rates to attract and retain needed experts.

(h) OTHER CHALLENGES

- Communication networks between the primary care facilities, the referral hospitals and the DHIMT are not very easy due to the lack of telecommunication facilities in the district. Though an effort was made to get funding to set up radiophone communication between all these players in the first insurance year it was not successful.
- Lack of transportation was a major challenge and made movement to the remotest parts of the district very difficult.
- Implementing the scheme from scratch was a great challenge since this was the first time that such a scheme was being implemented at the district level.
- In spite of financial assistance in various ways, much more was needed than available. This was because, as the process unfolded, issues, which had financial implications, came up which had not been budgeted for.
- Combining normal district work with implementing the scheme was also a major challenge. This was because there are no permanent staff on the scheme and health staff and staff of the research unit were used in all activities carried out.

5.2 Attempts to resolve constraints /challenges

Health education and communication activities are being intensified. In addition to continued use of all the other methods already discussed, a comic for use in schools to educate JSS and primary pupils as a way of reaching their households has been designed from the flip chart used for community education. Discussions are going on with the Ghana Education Service (GES) in the district as to how best to use the comics in the schools. Negotiations to carry out radio programs have already been mentioned.

Quality of care is a complex problem with many related underlying issues. Currently the issues of reward and incentive systems and supervision are being addressed. There is a per head rate that is being paid as an incentive to each clinic for the registered clients of the scheme they see. There is also a supervisory checklist and schedule for monthly to quarterly support visits from the district level to the sub-district level and from the sub-district level to the community level. A system of clinical seminars has recently been started. Details of the quality of care program can be provided on request.

Work is ongoing to try and improve communication and linkages with all participating facilities through meetings, discussions, letters and memos. During the period under review, two of the referrals hospitals had a change in management. Plans are afoot to start the briefing and negotiation process there all over again. Also important in working effectively with so many facilities is information management. The computerized database developed for use in the scheme is an essential part of this process and work is ongoing to complete it.

Briefing and orientation has been carried out with successive DCE as they came into office. The same process will be continued.

There is very little one can do about the general economic constraints beyond constantly exploring how to maximize the use of whatever little is available and minimize waste. This is a strategy that the scheme has used and continues to use while hoping for an improved economic climate.

Hopefully since there is no election due for the next four years, and the scheme has continued despite a change of government people will have confidence in the neutrality of the scheme as far as political processes in the country are concerned.

6. THE WAY FORWARD

6.1 Lessons Learnt and Implications for the Way Forward

There are several lessons that have been learned from implementation of the scheme in the first year of operation that have implications for the way forward. In many instances, the plans for the second year of operation have been adjusted based on these lessons.

6.1.1 Quality of Care

Quality of Care is key to the sustainability of any scheme. Clients expectations are that the care they receive would improve when they join the scheme. This is not a completely new finding. Before the start of the scheme, consultations with communities and households in the district brought out over and over again that the interest of communities was not just in the removal of financial barriers to care but also in the improvement of quality of care. They saw financial barriers as relative in that if quality of care improved, they would feel more satisfaction with contributing to any scheme. After the start of the scheme the same concerns have been voiced.

Areas clients have been specifically concerned about included the quality and availability of drugs, the dignity and respect with which they are treated by staff as well as the range of services available among others. In the year under review, the insurance administration had to deal with several client complaints related to this issue. It was observed that some clients got offended when they did not see significant changes in the service and talked of not registering in the second year.

Quality of care is however, a function of the inputs required to deliver the service as well as the personnel themselves and as such both areas need to be handled concurrently. In spite of good intentions, if the resources to deliver an acceptable quality of care are not there it may not be possible to rapidly change the situation. The District Health Management team struggled the whole year and continues to struggle with the question of how to rapidly improve quality of care in a situation of systemic resource constraints as well as organizational arrangements in the public sector and an organizational culture that makes rapid change and innovation very difficult sometimes. For example in the public sector, remuneration, job security and rewards are not directly linked to performance and staff may have no real incentive to be outstanding achievers. This is especially so when at the same time the inputs and training to deliver the required standard of service may not be readily available.

6.1.2 Linkages with providers

As has already been mentioned, the hospital services for clients registered in the scheme are provided by five different referral hospitals in three different regions. Moreover some of the hospitals are in the public sector, and others are in the mission sector (private not for profit). This has meant the need to spend a lot of time working on linkages, and collaborative arrangements and trying to work out a system that will be acceptable to all these partners despite their variable modes of administration.

In summary it can be said that it is possible to establish linkages with hospitals in other districts and regions and collaborate with them in health service delivery. The crucial thing is constant dialogue and communication to set up a clear and simple system agreeable to all parties. The importance of dialogue with all relevant stakeholders in the collaboration has been a very important lesson. An important lesson learnt is that for effective collaboration it is important to dialogue effectively not only with the management of the participating referral hospitals but with the frontline staff whose actions can make or break the collaboration. Lessons learnt from the district's collaborative effort could provide useful insights into how the public sector can contract out services to the private sector.

6.1.3 Timing of Introduction of New Programmes

The timing of the introduction of the health insurance scheme and other such programmes is critical. People in general assess issues based on their past experience with other similar issues. The coincidence of the registration period for the first year of implementation with the 2000 National elections affected the scheme because many people had had the experience of political election promises, which never came to pass; as well as programs that die if the government changes. They were uncertain if truly the scheme did not have any political linkages with any of the two major parties in the 2000 election and whether the outcome of the elections would affect its success or otherwise. This is to an extent a special problem, but care needs to be taken to as much as possible carefully consider the timing of the start up of new interventions such as this one with the general political circumstances prevailing.

6.1.4 Communication of messages

Messages on the Health insurance scheme were tailored to the socio-cultural milieu of the different parts of the district. Even though the people are predominantly one ethnic group, they are very diverse in their socio-cultural practices and perceptions. It is also important to find out from the people themselves, the appropriate communication messages to use.

To date several approaches have been used and continue to be used including individual and group discussions, community meetings (durbars), handouts, posters, billboards, gong gong beating, radio, dialogue with political and opinion leaders as well as drama.

Communication is especially important given that health insurance remains a relatively new concept to the average Ghanaian and needs to be well explained and well understood. This takes time and effort. Moreover, the need to create a proper understanding is there regardless of whether you are communicating with community members, providers, members of the district assembly or even technical experts within the Ministry of Health /Ghana Health service.

Though the "susu" and funeral contribution concepts have been in existence in our communities for generations, risk sharing for a period of illness which might never occur is something that people need a bit of explanation to grasp. This is because with the well known 'susu' arrangements as well as funeral contributions, there is always a "collection" period during which one receives in material terms a payback for all that one

has been contributing. They are strictly pre-payment rather than risk sharing schemes in that sense. With health insurance, if an individual does not fall sick during the year, his or her contribution elapses. People kept on asking during the durbars what an individual would receive if he/she did not use the services at all during the year. Towards the middle to the end of the insurance year, there were reports from the clinics of clients who tried to create some reason to use the services and thus gain some benefits despite not having a real need.

Moreover, experience in the year under review clearly showed that to be sure that adequate communication of information has occurred, there is a need to 'over communicate' so to speak though repeated explanations, discussions, publicity, question and answer type of dialogues etc before one can be certain of beginning to make headway. Sub-groups of the community may also be easily overlooked.

An important lesson for subsequent years and indeed for anyone who wants to implement health insurance is to hasten slowly. Apart from the effort already put in to explain the scheme, work is ongoing to dialogue and further explain the scheme to community members. Moreover, this is something that will have to be carried on for several years to come using multiple channels and methods of communication. Like many other interventions in the health sector, the ability to effectively communicate this way is very dependent of the availability of resources both financial and human as well as expertise and know how and the willingness to be in there for the long haul.

6.1.5 The Reality of Fraud

One lesson learnt is that people will always be people and will try to find a way to beat the system. It is essential to spend careful thought in scheme design to try and minimize the success of attempts to cheat and beat the system. Especially of concern are moral hazard, excess utilization, fraudulent claims and adverse selection. Though these potential pitfalls were taken into account in scheme design to try and minimize them, constant alertness and monitoring is still needed.

> *For example, a client who was contacted for re-registration cited non-payment of her claims as the reason for not wanting to register. She had a pile of receipts she wanted refunded. The Insurance office had been keeping records on when people completed their payments and when they received their green cards. This was part of the design of the system to avoid fraud and moral hazard. It turned out when the case was investigated, that this woman had not even registered at the time she attended hospital and obtained those receipts. She was just trying to beat the system and admitted as much when confronted.*

In relation to this efforts continue to be made to ensure that claims are made by the clinics and hospitals rather than by individuals with receipts for refund. Though in the design of the scheme, refunds were not to be made to individuals, there have been some genuine problems that have led to a bending of the rules in some cases. Sometimes drugs have not been available at the clinic or awareness of the scheme at the referral hospital level was low and the client had to pay directly. Dialogue with the clinics and hospitals

have been intensified to deal with these problems. Also being seriously considered is the possibility of negotiating with specific pharmacies to supply drugs that not provided at the clinic so that the scheme administration deals with a few pharmacies rather than the possibility of a few thousand clients.

6.1.6 Reward and Incentive Systems

Rewards and incentive systems in any programme are important to its sustainability as people will not continue to volunteer for ever without the hope of some form of future reward be it material, moral or spiritual. Currently the registrars receive a payment related to how many households they have registered and the number of members in that household. Similarly primary care providers receive a bonus per client.

6.1.7 Start up support and re-insurance back-up

It was difficult to get adequate support for implementation start up. For the first year some support for implementation was obtained from DANIDA and WHO/AFRO. For the second year of operation things have dramatically improved due to a generous grant from the MOH/ GHS out of the donor pooled account (fund).

The size of the target membership of schemes has implications for the start-up capital required to organize and run them. Schemes with target membership of under 1000 are easier to run, does not require so much resources to reach the people with messages and to register them whilst schemes targeting about 50,000 to100, 000 require more funds to reach the people with messages, to meet them, to register them, and to set up a system that can administer the scheme. It is difficult to get such funds from the premiums because it is usually not adequate. Additionally, most schemes run at a loss in the initial years and require re-insurance to enable them stay afloat. It is important that before the National Insurance comes into being or before any scheme begins to operate, a budget is made carefully to ensure that the amount needed to start is available as premiums would not have been collected at the time some of the preparatory activities need to take place.

The scheme has still have not been able to get anybody willing provide re-insurance backup for the first few years of its operation. It is important that the scheme has some backup fund to be able to meet commitments to clients should there be a genuine instance were claims exceed premiums for a given year.

6.1.8 Management and Administration

If a scheme would work, there must be a core of committed individuals who believe in the process, are committed to its success and are prepared to patiently work at it until they see their common vision come into being. With time more and more people must be drawn into thinking and working like that core group to ensure sustainability.

Gradually, over time more people are getting involved and thinking ahead about issues that affect the management of the scheme. They have learnt “by doing” and have gained the capacity to provide solutions to problems that come up without always consulting.

Related to this, it is important to ensure that the scheme delivers on its promises or stated benefits to the members. People get discouraged when they encounter difficulties in accessing the stated benefits for which they have contributed and tend to dissuade others from participating in the scheme.

Dialogue has been kept up through community meetings with members of the scheme to listen to their experiences with the scheme, explain and apologise for lapses where necessary and give them an insight into the background for some of the problems they encounter, request for their suggestions and enlist their support in correcting them. The DHIMT has also tried to change the situations that can be changed such as increasing awareness about the scheme in the referral hospitals to prevent patients being turned back.

Employment of many fulltime staff in the running of schemes is not very beneficial. The important thing is to design systems that require minimal human effort. When the systems are well thought out and efficient, the only peak periods will be the registration period or the beginning of an insurance year when data has to be entered. Several full-time staff leads to high administrative overheads and becomes a drain on the finances of the scheme.

Information management is critical to the success of any health insurance scheme. It is essential to keep accurate records of all documents, discussions, and ideas during the pre-implementation and implementation phase. This helps in documentation and report writing.

In conclusion, things will not always work as initially planned. Scheme administrators must be prepared for planning and re-planning. Things don't always turn out as planned and it is important to recognize this and be ready to plan and re-plan to ensure that the objective is accomplished. People learn by doing and over time, with constant monitoring, evaluation and feedback will learn better ways of doing. There should therefore always be flexibility and preparedness for change over time and in response to changes in the environment. This will ensure continuous improvement in systems and more efficient ways of providing services that are of acceptable quality to members.

6.2 Plans for the 2nd Insurance Year (1st October 2001 – 31st September 2002)

6.2.1 Quality of Care

A compilation of what is required to provide quality of care both from the client and the health providers' perspective has been carried out. Work is ongoing to systematically address the issues. This is a long-term intervention that is not going to be easy. Addressing the quality of care problem requires multiple interventions. Among the interventions proposed are regular on the job training in the form of sub-district clinical meetings. These are to be reinforced by more formalized in-service training. In addition, a current pressing problem in all the facilities is the lack of a complete set of instruments to deal with routine cases and emergencies. This includes suturing instruments,

sterilizing instruments etc. If there are enough sets of instruments, after one client is seen, the next client does not have to wait hours for the instruments to be properly sterilized; or risk cross infection from the use of poorly sterilized instruments.

Apart from instruments there are other needed essential supplies and equipment that have to be provided as funds become available in the coming year.

Last but not least there are also issues that have to be addressed from the systemic level in the GHS and MOH such as promotions, salaries, transfer systems etc. These cannot be addressed at the district level and advocacy is needed.

6.2.2 Linkages

Participating referral hospitals and primary clinics
Regular meetings with referral hospitals and primary care clinics will be held in the course of the year as well as staff durbars with frontline staff to discuss issues of common interest and by so doing improve on a continuous basis collaborative efforts in providing health care for the members of the scheme.

Cost standardization for participating providers
There is a need to revise the rates agreed upon for the primary care clinics last year, and to also make an effort to standardized the hospital rates. Participating in this process, as a new group will be the few private pharmacies the scheme is considering working with.

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Funding agencies that provided specific support in the planning phase, and for implementation in the first insurance year were:

- EU
- WHO/AFRO
- Danida
- UNDP – Poverty Reduction program through the district assembly

Dr. Moses Adibo and Dr. Dyna Arhin were key in the planning phases of this scheme and their efforts and commitment have been invaluable in arriving at where we are today.

Last but not least are the numerous community members and health providers who have been and continue to be a part of this scheme, and whose commitment to its success have been invaluable. Unfortunately they are so many they cannot all be mentioned by name but they are acknowledged with many thanks.

The compilation and editing of this report was done by Irene Agyepong Amarteyfio, Evelyn Ansah and Margaret Gyapong

Appendix 1 – Members of the DHIMT for 2000/2001

(In alphabetical order)

Francis Abofra	District Planning Officer, District Assembly
Irene Agyepong Amarteyfio	District Director of Health Services, DHMT
Evelyn Ansah	Senior Medical Officer, DHMT
Ali Amadu	District Planning Officer, District Assembly
Daniel Ato Ashon	Diseases Control Officer, DHMT
Ebenezer Asiamah	Nutrition Officer, DHMT
Sabina Asiamah	Biostatistics Officer, DHMT
Kingsley Biantey	Insurance Office /Research Centre
Edward Bruce	Insurance Office /Research Centre
Alice Gakpo	Health Education Officer, DHMT
Margaret Gyapong	Senior Research Officer, DWHRC
Nashiru Issaka	Accountant, DHMT
Daniel Y. Mensah	Insurance Office /Research Centre
Richard Nagai	Insurance Office /Research Centre
Solomon Narh-Bana	Insurance Office /Research Centre
Christiana Narh-Dometey	Principal Nursing Officer, DHMT
Jacob Tetteh	District Planning Officer, District Assembly
Ekow Weah (Tony Williams)	IT

Appendix 2 – Elected members of the Area Council Committees and District Executive of the Dangme Hewaminami Kpee

Area Council Committees (Executive)

- **Dodowa Area Council**

Mrs. Gladys Kpabitey
Mr. Ben Kingsley Tetteh
Mrs. Stella Quaynor
Abraham T. Apperkon
Ms. Grace Out
Mr. Christopher Ayebo
Mrs. Amanda Ashon-Dennis
Mr. Emmanuel Lomotey

- **Ayikuma Area Council**

Mr. John Kofi Amuzu
Mr. Jonathan Amenyo
Mr. George Atiogbe Ofori
Mr. Emmanuel K. Addo
Mr. E.O. Mensah
Ms. Grace Osei
Mr. Isaac Adamtey
Ms. Mathilda Teye
Ms. Florence Fiadjogbe
Mr. MacBright Godson

- **Prampram Area Council**

Mr. Daniel Martey
Mr. S.N. Awuley
Mr. Andrews Kudor
Mr. Seth Martey
Mr. Kpakpo Addoquaye
Mr. John K. Akumeni
Mrs. Doris Annie
Mr. Wisdom Narh-Tetteh
Mr. Abraham Narh

- **Dawa Area Council**

Ms. Felecia Larkotey
Mr. Richard Dorho-Addo
Mr. Bright Obodai
Mr. Philip Tetteh
Mr. Edmund K. Duamor
Ms. Esther Yeyo Addo

- **Ningo Area Council**

Mr. Sa Rhack Nartey
Ms. Rose K. Amanor
Mr. Ebenezer Teye Narh
Ms. Rosina Adjewuda
Mr. Emmanuel Amanor Tetteh

- **Osuwem Area Council**

Mr. James N. Akunarh
Ms. Doris Aslevi
Mr. Thomas L. Egbli
Ms. Mary Agbeko
Ms. Francisca Animley
Ms. Stella Appiah
Mr. Samuel Tetteh Kudjoe
Mr. Julius Narteh
Mr. Maxwell Odzor

- **Asutuare Area Council**

Mr. Wisdom Agbovi
Ms. Rosemond Ayertey
Mr. Benjamin Nyavor
Mr. Ibrahim Anyigbor
Ms. Victoria Buernor
Mr. George Adai
Mr. Thomas Ayetey
Ms. Millicent Gador
Mr. Edward Atsu
Mr. James Korwuvi
Mr. James S. Narh

Members of District Executive

	Name	Area Council
1	Christopher Ayebo	Dodowa
2	McBright Godson	Ayikuma
3	Seth Martey	Prampram
4	Sa Rhack Nartey	Ningo
5	Edmund K. Duamor	Dawa
6	Wisdom Agbovi	Asutuare
7	James Akunarh	Osuwem
8	Doris Aslevi	Asutuare & Osuwem
9		Ningo & Dawa
10		Dodowa & Ayikuma
11		Prampram

Appendix 3 – Detailed Tables

Table 1 – Households registered by sub-district and by area council

Sub-District /Area Council (AC)	No. of households	No. of persons	% of all registered households
Dodowa Total	**329**		**42%**
Dodowa AC	193	684	
Ayikum AC	136	632	
Prampram Total	**183**		**24%**
Prampram AC	***183***	731	
Ningo Total	**167**		**22%**
Ningo AC	128	453	
Dawa AC	39	165	
Osudoku Total	**96**		**12%**
Asutuare AC	56	193	
Osuwem AC	40	215	
DISTRICT TOTAL	**775**	**3084**	**100%**

Table 2 – Number of outpatient contacts (insured clients) per primary care clinic and per referral hospital by month over the period

	Oct 2000	Nov 2000	Dec 2000	Jan 2001	Feb 2001	Mar 2001	Apr 2001	May 2001	Jun 2001	Jul 2001	Aug 2001	Sep 2001	
DODOWA													
Dodowa RHC	9	9	9	20	37	65	93	127	103	105	7	7	591
Kordiabe CC	0	0	0	0	0	6	17	30	22	21	27	22	145
Agomeda CC	0	0	0	0	13	28	33	49	52	76	70	64	385
PRAMPRAM													
Prampram RHC	0	0	0	13	52	72	99	158	124	86	94	92	740
Dawhenya RHC	0	0	0	5	7	5	5	11	1	4	6	4	48
NINGO													
Ningo RHC	0	0	0	0	42	54	83	81	87	84	0	0	431
Nyigbenya CC	0	0	0	0	0	0	0	0	0	0	0	0	0
OSUDOKU													
Asutuare RHC	0	0	0	0	0	14	29	38	73	55	30	46	285
Osuwem CC	0	0	0	0	0	7	5	7	2	12	11	3	47
Duffo CC	0	0	0	0	3	3	1	4	4	8	4	6	33
HOSPITAL													
Agomanya	0	0	0	0	0	2	0	3	3	2	3	2	15
Akuse	0	0	0	0	0	4	0	3	7	2	7	6	23
Battor	0	0	0	0	2	0	0	0	0	0	0	2	4
Tema General	0	0	0	0	0	0	0	0	0	0	1	0	1
Ridge	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Reimbursement	0	0	0	1	1	1	3	0	1	4	4	0	15

Table 3 – Total number of Outpatient Contacts (Insured and Un-insured clients) per facility by month over the period

Sub-districts	Oct 2000	Nov 2000	Dec 2000	Jan 2001	Feb 2001	Mar 2001	Apr 2001	May 2001	Jun 2001	Jul 2001	Aug 2001	Sept 2001	Total
Dodowa Subdist													
Dodowa RHC	573	595	408	618	516	452	521	636	647	695	613	536	6810
Kordiabe CC	125	123	108	161	102	59	58	111	91	106	111	106	1261
Agomeda CC	195	211	220	237	181	193	184	203	225	241	209	198	2497
Prampram Subdist													
Prampram RHC	353	350	324	438	403	350	401	579	634	647	486	454	5419
Dawhenya CC	41	32	39	93	60	36	52	107	44	68	66	49	687
Ningo Subdist													
Ningo RHC	217	191	237	251	246	195	192	328	179	372	324	656	3388
Nyigbenya CC	28	19	7	23	28	13	13	27	27	40	48	41	314
Osudoku Subdist													
Asutsuare RHC	230	278	198	302	144	194	190	210	213	193	137	140	2429
Osuwem CC	51	43	36	54	69	33	24	21	13	24	26	22	416
Duffor CC	60	108	71	143	80	55	53	70	101	73	42	49	905

Table 4 – Reimbursements by month by primary care clinic

	Agomeda	Asutuare	Dawhenya	Dodowa	Duffor	Kordiabe	Ningo	Osuwem	Prampram	TOTAL
Oct-00				62,545.00						62,545.00
Nov-00				62,545.00						62,545.00
Dec-00				62,545.00						62,545.00
Jan-01			23,179.00	109,368.00					67,562.00	200,109.00
Feb-01	66,600.00		37,914.00	230,473.00	14,751.00		266,220.00		176,086.00	792,044.00
Mar-01	137,190.00	76,237.00	23,405.00	437,582.00	12,368.00	35,816.00	320,713.00	30,723.00	263,455.00	1,337,489.00
Apr-01	206,728.00	76,237.00	23,405.00	437,582.00	12,368.00	35,816.00	320,713.00	30,723.00	263,455.00	1,407,027.00
May-01	330,957.00	220,361.00	43,909.00	764,066.00	15,294.00	271,986.00	430,774.00	30,200.00	694,931.00	2,802,478.00
Jun-01	270,535.00	398,612.00	2,139.00	639,176.00	18,210.00	123,355.00	455,398.00	8,080.00	788,136.00	2,703,641.00
Jul-01	400,740.00	269,173.00	10,553.00	822,770.00	42,416.00	105,638.00	460,089.00	57,574.00	305,686.00	2,474,639.00
Aug-01	437,931.00	154,814.00	27,110.00	55,457.00	15,716.00	122,520.00	-	57,739.00	386,413.00	1,257,700.00
Sep-01	416,282.00	309,206.00	32,836.00	39,443.00	17,926.00	94,663.00	-	10,870.00	395,481.00	1,316,707.00
TOTAL	2,266,963.00	1,504,640.00	224,450.00	3,723,552.00	149,049.00	789,794.00	2,253,907.00	225,909.00	3,341,205.00	14,479,469.00

Table 5 – Expenditure due to direct patient reimbursements

	Jan 01	Feb 01	Mar 01	Apr 01	May 01	Jun 01	Jul 01	Aug 01	Sep 01	Total
Gladys Nuledjie		67,000								67,000
Florence Agbenyo				56,000						56,000
Vera Modem		200,000								200,000
Comfort Adisey			64,400							64,400
Lewis Pketi	62,500									62,500
Raymond Foli					200,000					200,000
Elizabeth Soti							30,000			30,000
Amenyo Evans								174,000		174,000
Sarah Donkor						187,000				187,000
Vida Tekper							163,000			163,000
Johana Agbenyo								79,350		79,350
Lydia Kwadjo								56,000		56,000
Hannah Tweh									41,000	41,000
Comfort Baidoo							15,000			15,000
Alex Vanderpuye							60,000			60,000
Rosina									200,000	200,000
TOTAL	62,500	267,000	64,400	56,000	200,000	187,000	268,000	309,350	241,000	1,655,250

Table 6 – Reimbursements by month referral hospital

	Jan 2001	Feb 2001	Mar 2001	Apr 2001	May 2001	Jun 2001	Jul 2001	Aug 2001	Sep 2001	TOTAL
HOSPITAL										
Agomanya	0	0	300,000	0	311,000	364,000	39,000	520,500	116,000	1,650,500
Akuse	0	0	200,000	0	106,500	405,500	125,000	432,500	470,500	1,740,000
Battor	0	40,600	0	0	0	0	0	0	53,000	93,600
Tema General	0	0	0	0	0	0	0	14,800	0	14,800
Ridge	0	0	0	0	0	0	0	0	0	0
TOTAL	0	40,600	500,000	0	417,500	769,500	164,000	967,800	639,500	3,498,900

Table 7 – Comparison of Utilization of Primary Care clinics by insured and uninsured clients by month over the period under reveiw

	Oct 00	Nov 00	Dec 00	Jan 01	Feb 01	Mar 01	Apr 01	May 01	Jun 01	Jul 01	Aug 01	Sep 01	Total
All OPD attendance	1873	1950	1648	2320	1829	1580	1688	2292	2174	2459	2062	2251	24126
Insured OPD attendance	9	9	9	38	154	254	365	505	468	451	249	244	2705
Uninsured OPD attendance	1864	1941	1639	2282	1675	1326	1323	1787	1706	2008	1813	2007	21421
Utilization /person (insured)	0.003	0.003	0.003	0.012	0.050	0.087	0.118	0.164	0.152	0.146	0.081	0.079	0.877
Utilization /person (uninsured)	0.020	0.021	0.018	0.025	0.018	0.014	0.014	0.019	0.018	0.022	0.020	0.022	0.231
Ratio of Utilization by Insured to Uninsured	0.15	0.14	0.17	0.48	2.7	6.2	8.4	8.6	8.4	6.6	4.0	3.6	3.8

Appendix 4 – Information Management System Manual

COMPUTERIZED INFORMATION MANAGEMENT SYSTEM

CODES FOR DANGME WEST HEALTH INSURANCE SCHEME

DANGME WEST DISTRICT

OCTOBER, 2000

A. HEALTH FACILTY LIST

CODE	**DESCRIPTION**
KO	KORDIABE COMMUNITY CLINIC
AG	AGOMEDA COMMUNITY CLINIC
DU	DUFFOR COMMUNITY CLINIC
PR	PRAMPRAM RURAL HEALTH CENTER
NI	NINGO RURAL HEALTH CENTER
NY	NYIGBENYA COMMUNITY CLINIC
DA	DAWHENYA COMMUNITY CLINIC
OS	OSUWEM COMMUNITY CLINIC
DO	DODOWA RURAL HEATH CENTER
AS	ASUTSUARE RURAL HEALTH CENTER

B. STANDARDIZED HEALTH FACILITY FEES FOR SUB-DISTRICTS

CODE	SERVICE ITEM	COST IN CEDIS
	Clinical care	
OPI	New OPD card and ID card	2,000
OPC	Additional card	1,000
CON	Consultation	1,000
POF	Filling of police form	2,000
	Antenatal service	
OPC	Card	1,000
CON	Consultation	1,000
TT	Tetanol Immunization	500
	Delivery services	
NOR	Normal delivery fee	8,000
EPI	Delivery with episiotomy	10,000
BBA	Born before arrival	4,000
RRP	Removal of retained placenta	18,000
	Child welfare clinic	
VOC	Voluntary contribution	200
TT	Tetanol immunization	500
IMM	Childhood immunization	200
WCC	Weighing card and cover	1,000
	Non drug inputs	
G/S	Giving set	3,000
GLO	Gloves	1,000
ENV	Tablet envelope	100
SNN	Syringe and needle	1,000
CWS	Cotton wool and spirit	500
DIS	Disinfectant	2,000
MSK	Mask	1,000
DRE	Dressings for fresh wounds	10,000
VGZ	Vaseline guaze	2,500
BAN	Bandages	2,000
GZ	Guaze	1,000
GVP	GV paint	500
PLA	Plaster for wound	500
EUS	Eusol for dressing	500
CC	Cord clamp	1,000

	Family planning	
NEO	Neo Sampoon	500
CEP	Conceptrol	2,500
DEP	Inj. Depo Provera	1,500
IUD	IUCD	5,000
MCO	Male Condom	25
FCO	Female Condom	300
	Laboratory	
HB	Haemoglobin estimation	3,000
SCK	Sickling	3,000
GRP	Blood grouping	4,000
FBC	Full Blood Count	6,000
RHF	Rhesus factor	4,000
SRE	Stool for routine examination	3,000
URE	Urine for routine examination	3,000
BF	Blood film for malaria parasites	3,000
WID	Widals test	

C. DAGNOSIS CODES BASED ON ICD 10 CODES

DiagnoFCOsis code:	Description:
99.3_____	ALCOHOLISM IN PREGNANCY
A00.9	CHOLERA
A01.0	TYPHOID FEVER
A03.9	DYSENTERY BACILLARY
A06.0	DYSENTERY AMOEBIC (ACUTE)
A06.9	AMOEBIASIS
A09	DIARRHOEA / DYSENTERY
A16.9	TUBERCULOSIS (UNSPECIFIED)
A30.9	LEPROSY
A31.1	BURULI ULCER
A33	TETANUS NEONATORUM
A35	TETANUS
A82.9	RABIESA
A95	YELLOW FEVER
AI1	AIDS
B01.9	CHICKEN POX
B05.9	MEASLES
B06.9	MEASLES GERMAN
B19.9	HEPATITIS VIRAL (UNSPECIFIED)
B24	AIDS/HIV
B37.9	CANDIDIASIS
B50.0	MALARIA CEREBRAL
B54	MALARIA
B65.0	SCHISTOSOMIASIS (URINARY)
B74.9	FILARIASIS
B83.9	WORMS INFESTATION / HELMINTHIASIS
C80	CANCER (UNSPECIFIED SITE)
D57.0	SICKLE CELL CRISIS
D59.9	ANAEMIA HAEMOLYTIC ACQUIRED
D64.9	ANAEMIA
E01.2	GIOTRE IODINE - DEFICIENCY - RELATED
E14	DIABETES MELLITUS
E40	KWASHIORKOR
E41	MARASMUS
E42	KWASHIORKOR MARASMIC
E46	MALNUTRITION (UNSPECIFIED)
E96	DEHYDRATION
F03	DEMENTIA SENILE
F10.2	ALCOHOLISM (CHRONIC)
F32.9	DEPRESSION (UNSPECIFIED)
F99	DISEASE MENTAL (UNSPECIFIED)
G03.9	MENINGITIS
G40.9	EPILEPSY

G43.9	MIGRAINE
G82.2	PARAPLEGIA
H26.9	CATARACT
H40.9	GLAUCOMA
H57.9	DISEASE OF EYE AND ADNEXA (UNSPECIFIED)
H66.9	OTITIS MEDIA
H91.9	HEARING LOSS
H93.9	DISEASE OF EAR (UNSPECIFIED)
I10	HYPERTENSION
I50.9	FAILURE CARDIAC
I64	STROKE (CVA)
I84.8	HAEMORRHOIDS (BLEEDING
I84.9	HAEMORRHOIDS
J03.9	TONSILLITIS (ACUTE)
J06.9	INFECTION OF UPPER RESPIRATORY TRACT (ACUTE)
J18.1	PNEUMONIA LOBAR
J18.9	PNEUMONIA
J22	INFECTION OF LOWER RESPIRATORY TRACT (ACUTE)
J45.9	ASTHMA
J98.8	INFECTION OF RESPIRATORY TRACT (RTI)
J98.9	DISEASE RESPIRATORY (UNSPECIFIED)
K01.0	TOOTH EMBEDDED
K29.7	GASTRITIS
K35.9	APPENDICITIS (ACUTE)
K40.9	HERNIA INGUINAL
K42.9	HERNIA UMBLICAL
K61.0	ABSCESS ANAL
K92.0	HAEMATEMESIS
K92.2	BLEEDING GASTRO INTESTINAL
L03.9	CELLULITIS
L30.9	DERMATITIS
L70.9	ACNE
L98.9	DISEASE OF SKIN (UNSPECIFIED)
M13.9	ARTHRITIS
N39.0	INFECTION OF URINARY TRACT (UTI)
N64.9	DISEASE OF BREAST (UNSPECIFIED)
N73.9	DISEASE FEMALE PELVIC INFLAMATORY (ACUTE)
N92.0	MENORRHAGIA
N93.9	BLEEDING VAGINAL
N94.6	DYSMENORRHOEA
O00.9	PREGNANCY ECTOPIC
O06	ABORTION (COMPLETE/INCOMPLETE)
O07.5	ABORTION SEPTIC
O15.0	ECLAMPSIA IN PREGNANCY
O15.9	ECLAMPSIA
O16	HYPERTENSION IN PREGNANCY
O20.0	ABORTION THREATENED

O21.0	HYPEREMESIS GRAVIDARUM
O26.9	DISEASE OF PREGNANCY - RELATED (UNSPECIFIED)
O45.9	ABRUPTIO PLACENTAE ANTE-PARTUM
O46.9	HAEMORRHAGE ANTE-PARTUM: APH
O47.9	LABOUR FALSE
O66.9	OBSTRUCTION LABOUR (DYSTOCIA)
O71.1	RUPTURE OF UTERUS
O72.0	PLACENTA RETAINED (WITH POST-PARTUM HAEMORRHAGE)
O73.0	PLACENTA RETAINED(WITHOUT HAEMORRHAGE)
O80.9	DELIVERY SINGLE (SPONTANEOUS)
O84.0	DELIVERY MULTIPLE (SPONTANEOUS)
O98.6	MALARIA IN PREGNANCY
O99.0	ANAEMIA IN PREGNANCY
P05.1	SMALL-FOR-DATES
P07.3	PRE-MATURITY
P08.2	POST-MATURITY
P15.9	INJURY BIRTH
P21.9	ASPHYXIA BIRTH (NEONATAL)
P22.0	DISTRESS RESPIRATORY SYNDROME IN NEWBORN:RDS
P39.9	SEPSIS OF CORD IN NEWBORN
P59.9	JAUNDICE NEONATAL
P61.4	ANAEMIA CONGENITAL IN NEW BORN
P74.1	DEHYDRATION IN NEW BORN
Q89.9	ABNORMALITY CONGENITAL (UNSPECIFIED)
R00.9	TACHYCARDIA
R02	GANGRENE
R04.0	EPISTAXIS
R10.0	ABDOMEN (ACUTE)
R10.4	COLIC ABDOMINAL
R14	DISTENSION OF ABDOMEN
R31	HAEMATURA
R33	RETENTION URINE
R42	DIZZINESS
R50.9	FEVER (UNSPECIFIED)
R54	AGE OLD / OLD AGE
R55	COLLAPSE
R56.8	CONVULSION
R62.8	FAILURE TO THRIVE
R96	DEATH SUDDEN
R98	DEAD FOUND/FOUND DEAD
S03.0	DISLOCATION OF JAW
S22.3	FRACTURE OF RIB
S42.0	FRACTURE OF CLAVICLE
S43.0	DISLOCATION OF SHOULDER
S43.1	DISLOCATION OF CLAVICLE
S53.1	DISLOCATION OF ELBOW
S62.8	FRACTURE OF HAND

S73.0	DISLOCATION OF HIP
S82.8	FRACTURE OF ANKLE
T10	FRACTURE OF UPPER LIMB
T12	FRACTURE OF LOWER LIMB
T14.0	CONTUSION (UNSPECIFIED)
T14.7	AMPUTATION TRAUMATIC (USPECIFIED BODY REGION)
T30.0	BURN
T60.1	POISONING D.D.T.
T60.9	POISONING PESTICIDE
T61.2	POISONING FISH
T62.0	POISONING MUSHROOM
T62.9	POISONING FOOD
T65.9	POISONING CHEMICAL
T75.1	DROWNING
T88.7	DRUG REACTION
V89.2	ACCIDENT ROAD TRAFFIC
W34	WOUND GUN SHOT
Y05	ASSAULT SEXUAL
Y09	ASSAULT INJURY
Z56.6	STRESS WORK-RELATED
Z73.3	STRESS

D. PRIMARY CARE FACILITY DRUGS LIST AND STANDARD PRICES FOR 2000/2001 INSURANCE YEAR

LIST OF DRUGS AT DISTRICT MEDICAL STORE

			PRICE AT D.M.S.	PRICE AT HEALTH FACILITY
NO.	CODE	**NAME OF DRUG**	**UNIT PRICE**	**UNIT PRICE + 10%**
1	AST	TAB ASPIRIN	7	8.00
2	WFO	OINT WHITFIELD	3000	3,300.00
3	ALT	TAB ALUDROX	10	11.00
4	CQT	TAB CHLOROQUINE	25	28.00
5	PIT	TAB PIRITON	10	11.00
6	SPT	TAB SEPTRIN	30	33.00
7	FET	TAB FERSOLATE	10	11.00
8	FAT	TAB FOLIC ACID	5	6.00
9	MBT	TAB MEBENDAZOLE	25	28.00
10	MUT	TAB MULTIVTE	10	11.00
11	PCT	TAB PARACETAMOL	10	11.00
12	PRT	TAB PROMETHAZINE	60	66.00
13	ENV	TAB ENVELOPES	50	55.00
14	RET	TAB RESERPINE	10	11.00
15	PDT	TAB PREDNISOLONE	15	17.00
16	SLT	TAB SALBUTAMOL	80	88.00
17	MET	TAB METRONIDAZOLE	20	22.00
18	B4T	TAB BRUFEN	40	44.00
19	ORS	O.R.S.	300	330.00
20	V5T	TAB VALIUM 5mg	10	11.00
21	V10	TAB VALIUM 10mg	10	11.00
22	AXC	CAP AMOXYL	120	132.00
23	CQI	INJ. CHLOROQUINE	300	330.00
24	CRP	CRYS PEN	850	935.00
25	TCC	CAP TETRACYCLINE	50	55.00
26	ERI	INJ. ERGOT	1200	1,320.00
27	CPS	SUSP CHLORAMPHENICOL	3000	3,300.00
28	AMT	TAB AMODIAQUINE	75	83.00
29	PPI	INJ PROPEN	2000	2,200.00
30	PRI	INJ PROMETHAZINE	250	275.00
31	WFI	WATER FOR INJ	250	275.00
32	VIK	INJ VIT K	3000	3,300.00
33	LDI	INJ LIGNOCANE	4000	4,400.00
34	PBT	TAB PHENOBARB	10	11.00
35	FAC	MIST F.A.C.	3500	3,850.00
36	HPS	HYDROGEN PEROXIDE	3000	3,300.00
37	AMI	INJ AMINOPHYLINE	400	440.00
38	CPC	CAP CHLORAMPHENICOL	60	66.00

39	RGF	IV RINGERS LACTATE	6500	7,150.00
40	DZI	INJ DIAZEPAN	650	715.00
41	DSF	I.V. DEXT/SALINE	7500	8,250.00
42	D5F	I.V. DEXT 5%	7000	7,700.00
43	NSF	I.V. N/SALINE	6500	7,150.00
44	DIA	DIAGELATES	4500	4,950.00
45	FUN	FUNGITAL	2500	2,750.00
46	CPD	GUTT CHLORAMPHENICOL	2000	2,200.00
47	CPO	OCC. CHLORAMPHENICOL	2000	2,200.00
48	54F	I.V. 5:4:1	6000	6,600.00
49	LXT	TAB LAXIS	15	17.00
50	CPS	SYR PARACETAMOL	5000	5,500.00
51	CQS	SYR CHLOROQUINE	6000	6,600.00
52	MUS	SYR MULTIVITE	8500	9,350.00
53	PIS	SYR PIPERAZINE	8500	9,350.00
54	PRS	SYR PROMITHAZINE	8000	8,800.00
55	SCS	SYR SEDALYN COUGH	9500	10,450.00
56	PSS	SYR SEDALYN PEAD.	9000	9,900.00
57	AXS	SYR AMOXL	3500	3,850.00
58	MMT	MIST MAG. TRICILICATE	3000	3,300.00
59	SPS	SUSP SEPTRIN	3000	3,300.00
60	BBL	SOL BENZYL BENZOATE	25000	27,500.00
61	MSO	METHYISAL OINT	3000	3,300.00
62	HCT	INJ HYDROCORTISONE	1500	1,650.00
63	FLS	SUSP. FLAGYL	3000	3,300.00
64	MES	METHYLATED SPIRIT	12500	13,750.00
65	VID	TAB CAL / VIT D	15	17.00
66	VIB	TAB VIT B' CO	5	6.00
67	GRI	TAB GRISEOFULVIN	75	83.00
68	END	EPHEDRINE N/D 1%	1500	1,650.00
69	POC	MIST POT CIT	65000	71,500.00
70	CXS	SUSP. CLOXACILLIN	2600	2,860.00
71	PEN	TAB PEN V	35	38.50
72	BUT	TAB BUSCOPAN	100	110.00
73	EUS	SOL. EUSOL	3000	3,300.00
74	NFT	TAB NIFEDIPINE 10mg	300	330.00
75	N2T	TAB NIFEDIPINE 20mg	350	385.00
76	VCT	TAB VIT C	20	22.00
77	CXC	CAPS CLOXACLLIN	120	132.00
78	CAL	LOTION CALAMINE	6000	6,600.00
79	NPT	TAB NAPROSYN	850	935.00
80	DFT	TAB DICLOFENAC	185	203.50
81	CFT	TAB CIPROFLOXACIN	2000	2,200.00
82	GCI	INJ GENTAMYCIN	350	385.00
83	VTS	SYR VENTOLIN	6650	7,315.00
84	DFI	INJ DICLOFENAC	1250	1,375.00
85	NOI	INJ NOVALGIN	1750	1,925.00

86	BPI	INJ BUSCOPAN	700	770.00
87	MAT	TAB MATAKELFN	2200	2,420.00
88	CAS	CAMOQUINE SUSP	8500	9,350.00
89	DOX	TAB DOXYCYLLINE	150	165.00
90	GIV	GIVING SET	2000	2,200.00
91	FCX	SUSP. FLUCLOXACILLIN	4800	5,280.00
92	ETT	TAB ERYTROMYCIN	3000	3,300.00
93	CLT	TAB CLOTAN	550	605.00
94	GLA	GLAY	1500	1,650.00
95		SYR. SALBUTAMOL	3000	3,300.00
96		TAB. BRUFEN 200MG	20.5	23.00
97		INJ. XYLOCAIN	4000	4,400.00
98		NYSTATIN VAG PASS	12250	13,475.00
99				-
100				-
		TOTAL		-

Appendix 5 – Referral hospital's briefing brochure

1. All patients referred will have the following:

    - Their green ID card with indication of premium fully paid
    - A Referral card from the referring facility
    - The usual referral letter

2. Members of the scheme referred are to receive free care up to the tune of ¢200,000.00. Any bill above the ceiling will be settled directly by the client.

3. Claims from hospitals are to be made on monthly basis using itemized billing format provided by the scheme with the referral card of the client clipped to it.

4. Members of the scheme are not to be put on "Special/VIP/Seniors" wards etc. The scheme cannot afford to pay for the extra services.

5. Drugs prescribed for clients under the scheme should fall within the **Essential Drug list** of the Ministry of Health.

6. All data on claims once received in Dodowa will be entered into a Data Management system which has been designed to reject claims on self-referred clients and drugs outside the Essential Drug List.

Security Features to Look Out for

1. Green ID card

- Logo of Dangme Hewaminami Kpee embossed on the front of the ID card
- Picture on the first page matching the bearers face
- Dangme hewaminami Kpee seal partly on the picture and partly on the paper of the first page.
- A sticker on the second page in the space beside the current year as well as a "premium paid" Stamp.

2. Referral Card

- The card will be filled in and the office referring will write his/her namke and will not just sign.

2. THINGS TO AVOID

- Tendency to use more expensive drugs and items instead of more reasonably prices ones.

- Tendency to by all means provide services to the tune of the ceiling for each patient referred.

- Tendency to allow to malinger and by scheduling several re-attendances.

N.B. These actions will collapse the scheme. Please assist us in our efforts to provide access to health care for the majority of people in our district.

Appendix 6 – IMS Reporting Forms

List of Acronyms

DCE	District Chief Executive
DDHS	District Director of Health Services
DHA	District Health Administration
DHIMT	District Health Insurance Management Team
DHK	Dangme Hewaminami Kpee
DHMT	District Health Management Team
DMS	Director of Medical Services
DPF	Donor Pooled Fund or Account
EU	European Union
GES	Ghana Education Service
GHS	Ghana Health Service
GOG	Government of Ghana
IT	Information Technology
MOH	Ministry of Health
MOH/HQ	Ministry of Health /Headquarters
NGO	Non Governmental Organisation
Stool R/E	Stool Routine Examination
SSNIT	Social Security and National Insurance Trust
UNDP	United Nations Development Program
Urine R/E	Urine Routine Examination
WTP	Willingness to pay