Key Findings from ID-Ghana's NHIS Program Evaluation

Introduction

1.1 Background

The establishment of the National Health Insurance Scheme (NHIS) is considered the most important mechanism to ensuring equitable and universal access to primary health care in Ghana. In 2008, 45% of the Ghanaian population was insured through the NHIS, despite this, concerns have been raised about its pro-poorness and ability to engage the poor.

ID-Ghana a local microfinance NGO had identified from over 11 years in the microfinance industry, that engaging clients in health insurance would minimize business collapse caused from having to spend business capital on emergency health care. They launched their National Health Insurance Program in 2007 with NHIS training and assistance with registration. The program initially involved providing training regarding health insurance and other health topics during the weekly partners meeting. The program also assisted partners to register with a NHIS by assisting them to complete the necessary paperwork and lodge their application.

In 2009, ID-Ghana took yet another step to further encourage patronage of the NHIS. ID-Ghana began subsidizing the premium payable by each partner for themselves and their children by 50%. This arrangement is currently being piloted in 2 out of 7 branches, and will be extended to all branches if the pilot proves successful. For those who have taken up the 50% subsidy in 2009, the subsidy will be reduced to 33% in their second year and to 25% in 2011. ID-Ghana also created a special savings product called the NHIS Savings Product. This enables partners to make weekly savings adding up to 50% of the premium within their first loan cycle of 20 weeks.

1.2 Statement of the problem

ID-Ghana believed they were increasing enrolment of the urban poor in NHIS, though due to a combination of both resourcing and capacity issues, they had not had the opportunity to establish and conduct formal monitoring and evaluation. They contacted SNV after learning of their involvement in NHIS as a capacity strengthening organisation and requested assistance to document the outcomes and impact of their intervention, in order to promote their business case and ensure financial sustainability.

1.3 Methodology

Following two months of discussions between ID-Ghana and SNV a monitoring and evaluation plan was developed, including a plan to conduct a baseline evaluation. Two key assessment tools were used to obtain data for this baseline evaluation. The first was a

questionnaire conducted with a Control and an Experimental Group taken from current ID-Ghana partners (members).

Eligibility criteria for the Experimental Group included having attended weekly ID-Ghana group meetings for at least 6 months and having been offered the range of products in ID-Ghana NHIS Program (assistance with registration, social training, NHIS Subsidy & NHIS Savings Scheme). 40 participants were randomly selected from a pool of 470 eligible partners.

The Control Group consisted of ID-Ghana partners who had not been involved in the ID-Ghana NHIS Program. A random sample of 40 partners was taken from the total population of 460 partners. In order to reduce bias the questionnaire was conducted by four new ID-Ghana staff who had no prior involvement with the participants. The interviews were conducted with the 80 participants throughout August and September 2009. Data from these interviews were collated and analysed using Excel and are available upon request.

The second assessment tool utilised ID-Ghana project records, which recorded the actual number of ID-Ghana partners who were assisted to register with NHIS. This data was collated from November 2007 to June 2009.

Limitations of the Study

Although every effort has been made to eliminate or minimise error and bias, it is possible that several limitations of the study remain. The first is that the results may be confounded by interviewee's accuracy in being able to recall information. This is particularly the case with regards to recalling the number of times respondents had accessed health care in the past six months.

A number of strategies were utilized to ensure the interviewee felt comfortable in providing accurate and honest feedback about the ID-Ghana NHIS program. Despite these attempts it is a possible limitation. Strategies utilized include a coding system to guarantee client confidentiality, and using interviewers who were independent of the findings (i.e. people not directly involved in the ID-Ghana NHIS Program).

Another limitation of the study involves the reality of working in a context where there is a constant ebb and flow of people accessing ID-Ghana's program. Although a range of strategies are put in place to maintain accurate records of current partners, there is the possibility for human error in record keeping.

Finally, the trends observed during this evaluation still need to be confirmed with a larger sample size and deeper longitudinal study over the time of several years.

Findings

2. 1 NHIS Registration

The interviews revealed that more people in the Experimental Group were registered with NHIS than the Control (32 vs 26). These figures show that there was a 23% increase in registrations when ID-Ghana conducted their NHIS Program. Refer to Figure 1 below.

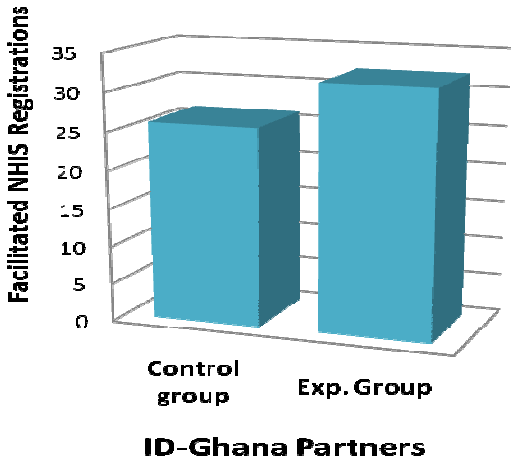

Figure 1. Comparison of NHIS Registrations between Control and Experimental Group

The trend of ID-Ghana's NHIS Program to increase enrolment of its members in NHIS was also confirmed by data taken from project records. This data indicated that the number of ID-Ghana partners who had been assisted to register with NHIS was increasing every year. Figure 2 below shows the average number of NHIS registrations that were facilitated by ID-Ghana each month from November 2007 to June 2009. The figure illustrates that the average number of facilitated registrations per month increased from **21**/month in 2007 to **54**/month in 2008, and to **91**/month in 2009. It should be noted however, that due to the program only being introduced in November 2007 and additional strategies introduced in 2009, there are some limitations with this data. For example, averages were used to compare data due to date only being available for 2 months in 2007 and 6 months in 2009. Additionally, data was only available for 2 branches in 2007 and 2009. For more details of working refer to Annex 1. Despite these limitations it is evident that the NHIS is facilitating enrolment of its members in NHIS.

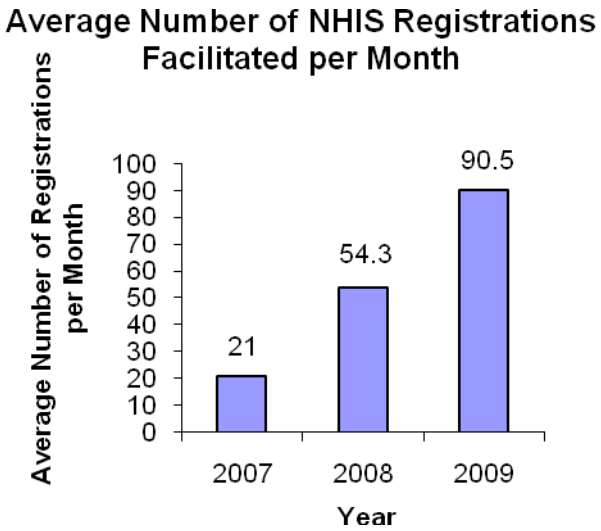

Figure 2. Average Number of NHIS Registrations Facilated by ID-Ghana Per Month

Furthermore, from these figures it is estimated that ID-Ghana has assisted over **1,200** partners to register with NHIS in just over 18 months. The data for 2009 also indicate that 95% of partners who registered, utilised the newly introduced NHIS subsidy. Given the large increase in registrations in 2009 (from 55 to 91 per month) it is possible that the NHIS

Subsidy Scheme is a key incentive to engaging partners in health insurance, however, more evaluation is required to confirm this conclusion.

In summary, this data indicates that the suite of products offered by the ID-Ghana's NHIS program (NHIS registration, NHIS Subsidy, NHIS Savings Scheme & Social Training) is increasing enrolment of its patterns' by 23%.

2.2 Satisfaction with NHIS Registration

Of those who responded to the question regarding satisfaction with registering, 100% reported they were either satisfied or very satisfied with their decision to register. Although all respondents were satisfied, a number of issues were raised predominantly around the length of time taken to receive their NHIS card and that it did not cover all their health expenses.

2.3 Health Services Utilization

All 80 participants (from both the Control and Experimental Group) were asked to recall how many times they had accessed health services in the past 6 months. Out of the 22 participants who did not have NHIS registration there was a total of 13 visitations to health services. This is compared to the 55 participants who had NHIS registration whom reported a total of 49 visitations to a health service. From this information it can be said that for every 100 people who have NHIS registration there will be **89** visits to a health service compared to for every 100 people not registered with NHIS there will only be **59** visits to a health service. This data is represented visually in Figure 3 below. It can therefore be said that people with NHIS are more likely to access health services than those without health insurance. This finding that health insurance plays a significant role in enhancing health service utilization is supported in other literature[12].

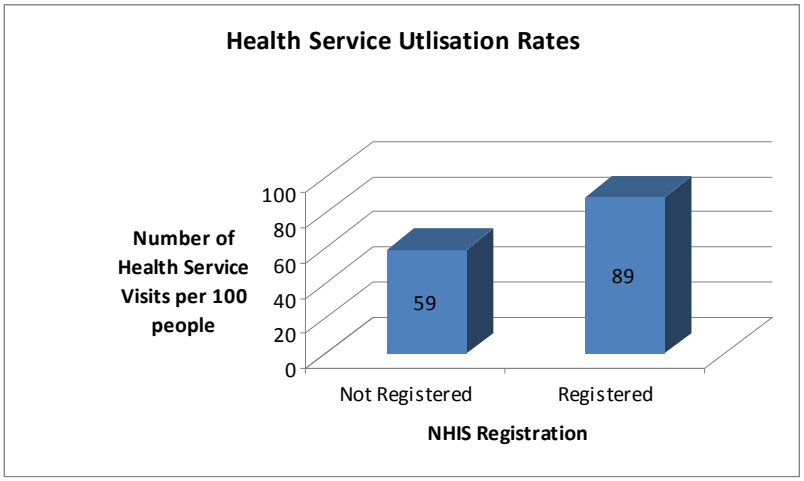

Figure 3. A Comparison of Health Service Utilization Rates of Registered and Not Registered ID-Ghana partners

[1] Abay Asfaw; Johannes P. Jütting. *The Role of Health Insurance in Poverty Reduction: Empirical Evidence From Senegal.* International Journal of Public Administration, 1532-4265, Vol 30(8), 2007, 835 – 858.

[2] Chouvet, D., Dixit, A. and Thuilliez, J., *Survey on the impact of micro insurance and microfinance services on the , families living in deprived areas of Pune, Maharashtra*, Pune, (2008) *(http://www.entrepreneursdumonde.org/pratiques/component/option,com_docman/task,cat_view/gid,227/Itemid,99999999/lang,en/)*.

2.4 Satisfaction with ID-Ghana Social Training

ID-Ghana provides weekly social training in topics such as health insurance, malaria prevention and treatment, HIV/AIDS and Family Planning. From interviews with the 40 participants in the Experimental Group, all of which had received ID-Ghana Social Training, 100% of them were either satisfied or very satisfied with the training they received. Suggestions for improving the training included requests to increase the frequency of training and to spend more time on each topic.

2.5 Health Knowledge & Attitudes

A series of questions assessing health knowledge and attitudes were asked to both the Control and Experimental groups. It was hypothesized that the Experimental Group who had received social training in the above mentioned health topics would have better knowledge and attitudes than the Control group who had not received any training.

The results confirmed this hypothesis, that ID-Ghana partners who had received training (Experimental Group) have better health attitudes and knowledge than those partners who had not received any social training (Control Group). These results are explained in more detail below:

Malaria Prevention:
Respondents in the Experimental Group were able to provide almost twice as many correct responses regarding strategies for preventing malaria (81 vs. 44 responses).

HIV/AIDS
Respondents were asked whether or not 'you can tell someone has HIV/AIDS just by looking at them'. 93% of the Experimental Group provided the correct response versus 70% in the Control Group.

Family Planning (FP)
Participants were asked a series of questions relating to Family Planning (FP) including their attitude towards FP; the benefits of FP; and methods of FP. The results indicate that the Experimental Group consistently had more appropriate attitudes and knowledge regarding FP. For example, 90% of the Experimental Group agreed with the concept of FP vs. 80% in the Control Group. The Experimental Group were also able to identify more benefits of family planning (66 correct responses in Experimental Group vs. 40 correct responses in the Control Group); and more FP methods (98 correct responses in Experimental Group vs. 56 in the Control Group).

In summary, the evaluation revealed that in general those ID-Ghana partners who received social training as part of the weekly group meetings (Experimental Group) displayed more appropriate health knowledge and attitudes than those who did not receive any social training (Control Group). It can therefore be suggested that ID-Ghana's Social Training (including discussions regarding NHIS) is improving health and socially responsible knowledge and attitudes.

Conclusions & Implications of Findings

ID-Ghana has been implementing their NHIS Program since 2007 (with the introduction more recently of the NHIS Subsidy and Savings Scheme) as a strategy for reducing business collapse caused from emergency health care. The key objective of the evaluation was to determine the effectiveness of ID-Ghana's NHIS Program in increasing enrolment of their partners in NHIS. The evaluation also aimed to assess whether the social training included as part of the NHIS Program was improving health knowledge and attitudes and whether NHIS registration was associated with increased access to health services. Two assessment tools were used to collect data. The first was a questionnaire conducted with two groups: a Control Group comprising of ID-Ghana members who had not been involved in the NHIS Program and an Experimental Group who had been involved in the NHIS Program. The second tool utilised project records which recorded NHIS registrations facilitated by ID-Ghana.

The Key Findings are summarised below:

- ID-Ghana's NHIS program is increasing enrolment of its members in NHIS. There was a 23% increase in registrations in the Experimental Group where ID-Ghana delivers their NHIS Program.
- ID-Ghana has assisted over 1,200 people to register with NHIS in just over 18 months
- ID-Ghana members who have registered with NHIS are satisfied with their decision to register.
- ID-Ghana members who have NHIS registration access more health services than those who are not registered with NHIS.
- ID-Ghana's social training is improving health and socially responsible knowledge and attitudes.

The impact of ID-Ghana's NHIS program in terms of improved health and increased economic security was not measured in this study due to limited resources and capacity and the complexities of such research. Despite this, ID-Ghana is currently piloting a Poverty Assessment Tool (PAT) which although will not allow them to measure impact, will assist in observing trends in the evolution of families enrolled in the NHIS program.

This study provides a rare and concrete example of a program that is engaging urban poor in health, by facilitating registration with a National Health Insurance Scheme. Despite the success of this program, ID-Ghana is currently funding the NHIS Program using internal funds which is not sustainable. It is anticipated that the evaluation provides evidence to support the need to continue ID-Ghana's NHIS Program and will enable them to promote their business case and secure financial sustainability of this valuable initiative.

Annex 1. Number of ID-Ghana partners whose registration has been facilitated by ID-Ghana since 2007.

Data Collection Period	Number of branches involved in data collection	Actual number of facilitated registrations	Average Number of Facilitated Registrations per Month	Number Subsidized by 50%
Nov- Dec 2007	3	**42**	**21** (42 registrations/2 months)	Not introduced yet
Jan – Dec 2008	10	**652**	**54.3** (652 registrations/12 months)	Not introduced yet
Jan – Jun 2009	2	**543**	**90.5** (543 registrations/ 6 months)	493 (**91%** of people who registered utilised the offer of the subsidy)
		TOTAL 1,237		