# Policy Design and Implementation Nexus in Africa: The Experience of National Health Insurance Scheme in Sawla-Tuna-Kalba District of Ghana

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## Abstract

The paper focuses on policy design and implementation linkage in Africa. It specifically examines the linkage between policy design (National Health Insurance Scheme-NHIS) and its implementation with some experiences of policy implementers and the beneficiaries in the Sawla-Tuna-Kalba District in Ghana. The theoretical argument is that. policy design factors may facilitate or impede implementation This study thereby seeks to find out what the situation is in a rural setting of an African state-Ghana. This is the reason for the choice of the qualitative comparative case analysis to solicit the views, opinions, and experiences of policy implementers and beneficiaries on the design and implementation process factors. The implementers are the public and private health providers, while the policy beneficiaries are NHIS subscribers. The implementers' understanding of the policy goals-intent and delivering them to subscribers in terms of access to healthcare services in the rural district and the quality of the services (to address their health needs). Data were obtained through in-depth interviews, review of documents, and on-site direct observations. The findings showed that policy beneficiaries/subscribers have more access to healthcare facilities (healthcare services) due to the involvement of public and private health providers in the district. Also, the findings revealed an improved revenue for both public and private health providers/facilities due to the increased attendance of NHIS subscribers/beneficiaries. It found that the behaviour of health providers was a key determinant of subscribers' choice of health facility. It, therefore, recommends that health providers should treat their clients with utmost care and kindness.

Key words: Heath facilities, quality services, NHIS, Sawla-Tuna-Kalba District, Ghana

## Introduction

Public policy scholars in both developed and developing countries have debated and continue to debate on what happened at the various stages of the policy cycle (Hupe, 2009; Kipo-Sunyehzi, 2020, 2022; Truijens & Hanegraaff, 2023). Some argue that the early stages of the policy cycle (design) matter most. These early stages of the policy circle include agenda-setting, formulation, and decision-making. Thus, the emphasis is on the start of the journey-policy design factors (Schneider & Ingram, 1988). For other policy scholars, the most important stage is the action stage (policy implementation) or the actual execution of the policy. This is where the intent of the policy is realized- the emphasis is on the implementation process factors (Pressman & Wildavsky, 1984; O'Toole Jr 2000). Such a debate among policy scholars continues until a change of direction towards a group of policy scholars known as the synthesizers (a hybrid combination of the design and implementation factors) in the 1990s. These new scholars argue that both the design and the implementation stages matter in the policy cycle (Goggin, et al, 1990; Matland, 1995; Winter, 2012; Sætren, 2014).

### Policy Design and Implementation Nexus in Africa

Policy Scholars in Africa, especially in the 1980s, consider two factors as what matters most, namely the policy content (wording) and context (environment). The elites' pressure may come from the political arena or the bureaucratic arena. These dominated the African policy discourse in the 1980s and 1990s (Grindle, 1980; Grindle & Thomas, 1991).

In the early 2000s, more policy scholars in Africa tend to look more closely at the nexus between the design and the implementation of policies within and across African states. Ayee (2000) made a great contribution to the policy field in terms of why public policies succeed or fail in Africa in his "Saints Wizards Demons and Systems" work/model (Ayee, 2000, p. 14).

Makinde (2005) shares similar views with Ayee (2000) on policy design and implementation nexus. Makinde's main argument is that most public policies in Africa and Nigeria fail to achieve their goals due to inappropriate policy design and implementation factors (Makinde, 2005).

Other African policy scholars look at the design and implementation nexus from the lens of politics. An over-politicalized policy at the design stages has dire consequences for their execution especially when the masses (people) are not well informed about the intent of the public policy. This was the case with value-added tax (VAT) across Africa in the 1990s and 2000s (Osei, 2000, p.258; Kpessa 2011; Kipo-Sunyehzi, 2020b, p. 6; Korongo & Kilonzi, 2023). African policy scholars have also analyzed the nexus between policy design and its implementation in the health sectors of Africa from mental health, health insurance, pediatric and maternal healthcare policies among others (Ridde, 2009; Kipo-Sunyehzi, 2020; Getaneh et al, 2023).

Access to healthcare services/facilities is conceptualized in terms of affordability and availability of healthcare services (Gordon, Booysen & Mbonigaba, 2020). In this paper, it refers to the NHIS beneficiaries' ability to get to healthcare facilities and their ability to access healthcare services with their health insurance card(s) in Ghana. Quality healthcare services are seen as beneficiaries' access to effective and

efficient drugs/medicine in meeting the healthcare needs of the clients or the people (Ataguba & McIntyre, 2012; Atinga, 2012). Some studies in Ghana suggest urban dwellers have more access to quality services than their rural counterparts (Gobah & Liang, 2011; Alhassan & Nketiah-Amponsah, 2016).

## The Design of the National Health Insurance Scheme (NHIS) in Ghana

### *Institutional and Financial Structure*

The National Health Insurance Scheme (NHIS) was established in 2003 by an Act of Parliament (Act 650) to replace Cash and Carry System (CCS) in a way to address the inequity between the rich and the poor Ghanaians. The design of the funding structure of NHIS is that it has a fund (National Health Insurance Fund -NHIF). Money from the NHIF is used to subsidize the cost of the provision of healthcare services to members of district mutual health insurance schemes that are licensed by NHIA. The fund is used to reimburse healthcare facilities accredited by NHIA through district schemes. The largest source of funding is the 2.5% VAT, which constitutes 67% of NHIS revenue, followed by investment income (17%), and SSNIT contributions constituting the third source representing 15.6% (Government of Ghana-GoG, 2003, p. 19).

Scholars argue for the need to broaden the funding sources with an emphasis on tax-based financing to 'offer greater financial protection' and potentially achieve 'universal coverage' of NHIS (GoG, 2003; Jehu-Appiah et al., 2011). Two sources of funding exist at the local level. These are annual premiums and registration fees for new members joining the NHIS. But some people are exempted from paying the annual premium. Such persons include children less than 18 years, pregnant women, core poor (indigents), the aged (70 years and above) and SSNIT pensioners. This is to ensure improved access to healthcare services for these groups of beneficiaries in Ghana. Thus, per the design of the NHIS, it protects the most vulnerable in Ghanaian society as they are insured against out-of-pocket payments (cash payments) at facilities (Kipo-Sunyehzi, 2021; Amporfu, Arthur & Novignon, 2023).

## Theoretical Perspectives

This paper assessed policy design and implementation nexus and associated outputs of public policy (NHIS) at the local level in Ghana. It looks at policy design factors (policy goals/instruments among others) and implementation factors including structures of implementation, the allocation of resources for execution, and the actions of implementers and target groups' behaviors (beneficiaries). Effective policy implementation is conceptualized as 'keeping to the original intent' of the policymakers or public officials who 'ratified the policy' (Howlett et al., 2009). This perspective views implementation from a hierarchical path of policy execution (Van Meter & Van Horn, 1975; Pressman & Wildavsky, 1984; Ayee, 2000). Other policy scholars view implementation from the perspectives of those whose problem the policy sought to resolve (target groups (Hill & Hupe, 2009; Kipo-Sunyehzi, 2020). Lipsky believes street-level bureaucrats are the real policymakers; as such their actions and behaviors are very crucial in implementation (Lipsky, 1980). The mixed approach to policy implementation seeks to end the debate between the top-down and the bottom-up perspectives as it attempts to synthesize the top-down and

bottom-up approaches (Sabatier, 1986; Matland, 1995; Winter, 2012). Winter's heuristic model identifies a cluster of factors or variables namely policy formulation/design, organizational and inter-organizational relations, street-level bureaucrats, and target groups' behaviors towards achieving implementation results (policy performance/output). This study's explanatory factors are shown in an analytical model in Figure 1 (interplay of policy design and implementation).

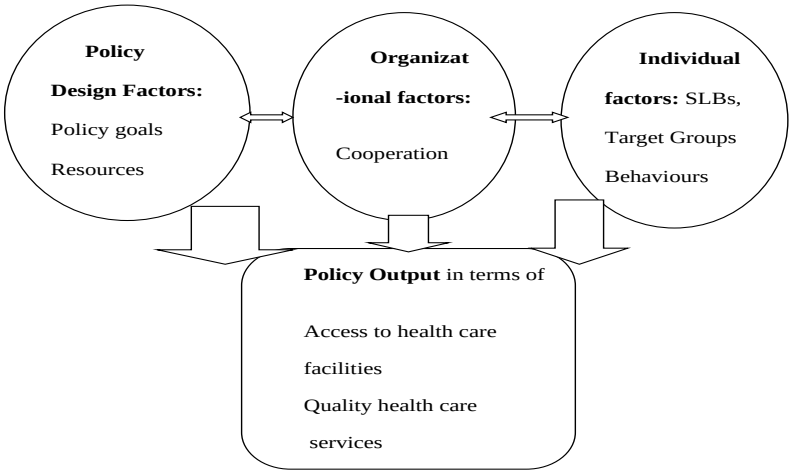


Figure 1: The Analytical Model
Source: Authors' adaptation from policy design and implementation literature

## Research Methods

### Research design

The methods used in the study are informed by the policy design and implementation merger model as advocated by Søren C. Winter in his heuristic model-*integrated implementation model* (Winter, 2012) and the *Saints Wizards Demons and Systems* model by Joseph Atsu Ayee (2000).

### *The Study Setting and Healthcare Facilities*

The study was conducted in a rural setting-Sawla-Tuna-Kalba District (STKD) which is currently part of the Savannah Region of Ghana. It is one of the 28 districts created in 2004 and was among the 170 districts in Ghana (Bening, 2014). Currently, there are 261 metropolitan, municipal and districts in Ghana (Districts of Ghana, 2023).

There is a long history of deprivation of resources and facilities in rural areas of Ghana and healthcare provision is no exception (Asante & Zwi, 2007, 2009). This study, therefore, sought to investigate the implementation of the NHIS and its effect on the healthcare needs of rural dwellers. The district has 14 accredited healthcare facilities; nine owned by the government (public-non-profit), three by the non-profit-private Christian Health Association of Ghana (CHAG) and two private-for-

profit facilities owned by individuals (Sawla-Tuna-Kalba Mutual Health Insurance Scheme (STKMHIS) Accreditation Report, 2009). This study focuses on two healthcare facilities based public-non-profit (Sawla Health Centre-SHC) and private-for-profit (Friends Maternity Home Clinic-FMHC). The two clinics are the biggest healthcare facilities in the district. About 80% of the rural population engages in farming. The district has an estimated population of over 99,000 residents on a total landmass of 4,601 square kilometers representing 6.4% of the total land area of the Northern Region of Ghana (STKD Ghana Health Service (GHS) Annual Report, 2007). Currently, per the 2021 Population and Housing Census, the population of the Sawla-Tuna-Kalba district in Ghana stands at 112,664 (Ghana Statistical Service-GSS, 2021, p. 70).

### *Research Design, Sampling Method, Sample Size and Ethical Issues*

The study adopts a qualitative research design and a case study approach for the comparative analysis of two cases to understand some of the facilitators or inhibitors/barriers. This is in the context of the implementation of NHIS in a rural setting/district (Yin, 2014; Fink et al, 2023). The study participants were 'purposively selected' based on relevant knowledge of the issue of investigation through a simple random sampling technique (Twumasi, 2001; Yin, 2014; Obilor, 2023). The interviews involved thirty-four (34) participants. The ethics of social science research were adhered to, including anonymity and privacy. Also, informed consent was sought from participants verbally and in writing before interviews. Audio recorder and field notes were used depending on the participants' preferred choice (notes writing/use of audio recorder). The 34 participants are illustrated in Table 1.

Table 1: Interview Participants

| **Categories of Persons** | **Public Clinic** | **Private Clinic** | **Total** |
|---|---|---|---|
| Implementers | | | |
| Medical Assistants/Nurses | 3 | 3 | |
| Laboratory Technicians | 1 | 1 | |
| Facility NHIS Officials | 1 | 1 | |
| Record Keepers | 1 | 1 | |
| *STKMHIS Officials | 2 | 2 | |
| Beneficiaries | | | |
| Premium Payees | 2 | 2 | |
| SSNIT Contributors | 2 | 2 | |
| Children | 1 | 1 | |
| Aged/SSNIT Pensioners | 1 | 1 | |
| Pregnant Women | 2 | 2 | |
| Indigents | 1 | 1 | |
| Grand Total | 17 | 17 | 34 |

Note: *STKMHIS Officials refers to national health insurance officials at the scheme office

### Data Collection Instrument, Sources of Data and Data Analysis

The instrument used in the collection of data was an interview guide which was administered by the Lead/First Author. The instrument (interview guide) has open-ended or semi-structured questions that were administered to implementers (health insurance officials and healthcare workers-public-private) and beneficiaries (NHIS exempted groups and contributors). The Lead Researcher/First Author probed for comprehensive answers. Focus Group Discussions (FGDs) were used, which provided the opportunity to obtain information from groups' perspectives rather than relying solely on views from individuals. Each FGD involved six respondents for easy management. Two FGDs took place on market days to get respondents from villages (outside the district capital).

Direct observations revealed information that could not be obtained by interviews. Direct observations further availed the opportunity to get beyond participants' opinions and self-interpretations of their actions,

behaviors, and attitudes (Twumasi, 2001; Bryman, 2016; Schroers, Tell & O'Rourke, 2023). Some observations of queues, services and interactions between clients and workers.

Yin (2014) emphasizes the importance of obtaining data from document sources towards data triangulation. For this reason, some documentary sources of evidence were obtained which include annual reports, healthcare facilities' attendance records, acts, and claims reports among others.

For data analysis, the researchers used thematic and content analyses and meanings and interpretations were made from the text or textual sources (Azungah, 2018). This method of data collection aimed to get a sense of the data and to compare what was obtained from interviews with textual sources of data in a triangulation fashion (Yin, 2014). Recorded audio tapes were transcribed and typed out as well as the use of field notes for analysis. Internal validity was addressed by creating case study data and other sources of data.

## Results

### Policy Design Factors

In the study analytical framework (see Figure 1), the first explanatory variable or factor is the design of the policy (NHIS) and how the design facilitated or inhibited the implementation of NHIS at the local level (Sawla-Tuna-Kalba District-STKD) in terms of NHIS beneficiaries' access to healthcare facilities (services) and the quality of the healthcare services the NHIS beneficiaries received.

One policy design factor analyzed is the accreditation of healthcare facilities. The study found that the public-private design of the policy (NHIS) helped beneficiaries in the rural district to access healthcare from diverse service providers such as Ghana Health Service (GHS), the Christian Health Association of Ghana (CHAG)-mission (GHS (public), CHAG (private-mission) and individual health providers.

Another policy (NHIS) design factor analyzed is the level of knowledge of the NHIS benefits package and medication list. This study found that the two healthcare facilities had adequate knowledge of the NHIS benefits package and medicines list. This was how a medical assistant in the private healthcare facility

commented on the benefits package and medicines list:

The benefits are enormous as health insurance covers 95% of common diseases in Ghana. This notwithstanding we still have problems with tariffs determination, which are mostly below open market prices. This makes it difficult to offer some drugs to subscribers when the tariffs are lower than in the open market. Remember we the service providers don't determine tariffs, rather those at national do so for us. Another problem is some expensive drugs are excluded like HIV retroviral drugs. I think some of these drugs must be added to health insurance to save more lives irrespective of the cost.

A medical assistant in the public health care facility also commented on the NHIS benefits package:

> *"Health insurance is good, it has a broad benefits package for subscribers. There is no doubt it covers most diseases in Ghana. But because prices of drugs and medicines are fixed for longer periods, they often fall below those sold in the open market. If we charge subscribers based on current prices, the insurance authority will deduct it from our monthly claims. Despite these price differences we still try to supply subscribers. Regarding excluded services, I agree some services need to be excluded due to the high cost of treatment".*

Moreover, another policy design factor that was analyzed was the consideration of resources. The financial and human resources of the healthcare facilities were examined as part of the implementation of NHIS. Documentary records have shown that NHIF was the main source of funding. More than 80% of hospitals and clinics in Ghana relied heavily on the NHIF for the purchase of drugs and supplies (STKD GHS Annual Report, 2009). Interviews with staff of Sawla-Tuna-Kalba Mutual Health Insurance Scheme (STKMHIS) and staff of two health care facilities confirmed NHIF as their main source of funding. Several empirical findings support that the National Health Insurance Fund is the main funding source for the implementation of NHIS in Ghana (Alhassan & Nketiah-Amponsah, 2016; Kipo-Sunyehzi, 2021; Amporfu, Arthur & Novignon, 2023). This was what the district scheme (STKMHIS) official said:

The scheme office relied so much on the health insurance fund for payments of services rendered to subscribers. Meanwhile, our internally generated funds from payments of premiums are quite small.

This was what a senior nurse in the public health care facility (clinic) said on NHIF:

> *"I will say the health insurance scheme is doing well in terms of payment of claims. We often submit our monthly claims within a month or two and we get reimbursement on time. We are okay with the health insurance scheme".*

A participant in the private health care facility (clinic) made these comments on funding.

> *"We hail and praise health insurance. We use its funds to buy drugs and medical equipment and to do some repair work among others. Fast reimbursement of claims has helped us to provide quality services to health insurance members in this facility".*

The responses of the study participants suggest that the faster the reimbursement to healthcare facilities, the better the services that are rendered to NHIS beneficiaries (health insurance members) in Ghana.

On financial resource mobilization, the private healthcare facility received GH¢69,626.10 ($46,155.85) from the health insurance scheme as reimbursement while the public healthcare facility received GH¢29,694.98 ($19,685.10). Findings revealed that the private facility received more revenue from NHIF than the public facility in 2009 (STKDMHIS Claims Reports, 2009; 2010). Interestingly, the NHIF constituted over 85% of the revenue for public healthcare facilities and constituted 70% of the private health facility's internally generated funds.

The study found two problems with the management of NHIF. First, the healthcare facility claims are deducted monthly by the insurance authority. The second problem is corruption associated with healthcare facilities which took the form of over-invoicing. The Daily Graphic, a national newspaper reported fraudulent claims of some healthcare facilities in which the NHIA recovered over four million Cedis ($4,640,371) from some health facilities between January 2009 and June 2010 (Daily Graphic, 2010). Similar reports of fraud and corruption or misapplication of funds against the implementation of NHIS in Ghana cost the country especially the National Health Insurance Authority millions of cedis (NHIA, 2017; Auditor-General Report, 2019; Ghana's Sick National Health Insurance Scheme, 2022). As a result of such reported acts of fraud and corruption, the NHIA adopted measures on "blocking all potential leakages" (NHIA 2018 Annual Report, p. 9) as well as "strengthening the internal policing (clinical and internal audit) to detect fraud against the scheme" (p. 35).

On human resources, the staff appears to be another challenge to the local healthcare facilities and NHIS management. The number of medical personnel (medical assistants, nurses/midwives, laboratory technicians, pharmacists, and other health workers) at posts in public (government) healthcare facilities in STKD from 2007 to 2010 was 28, 37, 32 and 37 respectively (STKD GHS Annual Reports, 2007; 2008; 2009; 2010 (Half-Year). The staff shortage is more pronounced when compared, for instance, with the total number of medical personnel as 37 and a district population of 99,863; thus, a ratio of about 1: 2699 using 2010 as the base year. The one medical officer-to-patient/population ratio depicts a human resource deficit. These health staff shortages are attributed to the refusal of health personnel to accept postings in rural Ghana (Okyere, Mwanri & Ward, 2017; Bellerose et al, 2022).

The health insurance office has seven permanent and six non-permanent staff to license, regulate and supervise healthcare facilities in the implementation of NHIS. The lack of vehicles to move across the district to monitor service providers was revealed as a key limitation or an inhibiting factor to NHIS especially moving to remote areas for registrations/renewals and this affected the membership drive.

For the staff of the two healthcare facilities, public healthcare has 10 staff while the private facility has 15. The public healthcare facility has more professionals (8) than the private (6). On professional training and supervision between the two healthcare facilities, a senior nurse in the public facility explained the issues as:

> *"This is the Government of Ghana facility, so we are paid by the government, we do not use our IGF (internally generated funds) to pay professional nurses and other health workers' salaries. The District Health Directorate of GHS is responsible for posting and supervising health professionals here"*

For the private healthcare facility, this was how the senior nursing officer explained their situation:

> *"We recruit our workers. We have to offer competitive prices and better remuneration to attract health workers, especially professionals. We have accommodation for some workers, and this enables them to provide all day and night services to patients".*

The above responses show how the two facilities recruited their staff. While the public healthcare facility relied on the government for the supply of professional medical staff, the private healthcare facility must recruit staff by themselves by offering attractive salaries to workers as well as the provision of accommodation for some health workers towards staff retention (Adzei & Atinga,2012; Sekyi, Asiedu, & Oppong, 2022).

## *Organizational Factors*

The second explanatory variable in the analytical framework (Figure 1) is organizational factors. The researchers looked at how the public-private partnership (Asante & Zwi, 2007) or the cooperation between public and private facilities (Ampong-Ansah et al, 2021) has facilitated or inhibited the implementation of NHIS in the district in terms of whether the beneficiaries have access to a healthcare facility (services) and the quality of services they received in meeting their healthcare needs at the local level (Sawla-Tuna-Kalba District).

One organizational factor is the inter-organizational relations among organizations implementing the National Health Insurance Scheme (NHIS) in the Sawla-Tuna- Kalba District (STKD). Included in the assessment is the level of cooperation, coordination, and collaboration. The Sawla-Tuna-Kalba Mutual Health Insurance Scheme (STKMHIS) is the lead agency. It coordinates the activities of healthcare facilities in the delivery of healthcare services to NHIS beneficiaries. The healthcare facilities also cooperate with STKMHIS by accepting 'treatment notes' from beneficiaries who do not have national Identification (ID) cards. Thus, the public-private healthcare facilities' cooperation or partnerships were confirmed by staff of both healthcare facilities and scheme officials. Evidence to this effect is cited below per transcribed statements from a health insurance scheme (STKMHIS) official:

We facilitate the implementation of NHIS as we liaise with facilities on issues of receiving, vetting and payment of claims as well as accreditation and renewals of facilities. We also help facilities in solving their daily operational problems. Moreover, we register, renew, and distribute subscribers' ID cards to enable them to receive services from clinics, hospitals, and other facilities across the district.

Such a statement affirms inter-organizational cooperation/partnership in areas of claims, working together to resolve operational challenges through periodic visits and exchange of information from the scheme office using circulars or letters.

Despite the evidence of collaboration, some organizational implementation challenges still exist between STKMHIS (scheme office) and healthcare facilities (clinics) regarding the implementation of NHIS in the Sawla-Tuna-Kalba District (STKD). The study found cases of STKMHIS indebtedness to several

healthcare facilities for over three months. Also, healthcare facilities complained of monthly deductions from their reimbursement (claims). This was found to be a setback to the implementation of NHIS by the staff of healthcare facilities. As the healthcare facilities staff or workers or officials were unhappy with such monthly claims' deductions. These challenges have affected the timely delivery of healthcare services to NHIS beneficiaries in the rural district (STKD). While the private facility has a laboratory and a theatre, the public healthcare facility did not have any of these units at the time of the study. Consequently, beneficiaries were often referred to other healthcare facilities, particularly the Bole Government Hospital for diagnostic services and other services including surgical operations. Hence, the public-private partnership helped increased beneficiaries' access to healthcare services within and outside the rural district.

### *Individual Factors*

In this third factor, the study focused on the views, feelings, experiences, or perspectives of individual actors in the Sawla-Tuna-Kalba District (STKD). The two individuals or actors identified are the bureaucrats and beneficiaries of NHIS. Street-level bureaucrats or frontline workers include managers of the district health scheme office (Sawla-Tuna-Kalba Mutual Health Insurance Scheme-STKMHIS). In-depth interviews and FGDs with medical personnel (staff of the two clinics) revealed they offered adequate drugs/medications, rendered more out-and in-patient services, maternity, and oral health care services of good quality to beneficiaries. This resulted in the over-utilization of healthcare services at the two healthcare facilities. A participant from the private healthcare facility expressed her opinion:

> *"Subscribers decide on the facilities to visit for health care when ill and we the service providers all do this to provide them with good services. We are no longer afraid of patients, especially subscribers running away for lack of money to pay their medical bills in our facility since we know that the health insurance scheme will reimburse us for the drugs and services rendered to subscribers".*

A staff of the public healthcare facility (clinic) commented on the same issues.

> *"Health insurance is a blessing to our people; without it, many will die of their illnesses for lack of cash to pay for the cost of health services. Also, many facilities in the district accept health insurance subscribers. This has helped to save them from the hands of untrained ones and poor services".*

The above responses from the implementers indicate the presence of more healthcare facilities and the quality healthcare services being offered to the NHIS beneficiaries. Also, health providers' fear of non-payment of services rendered to beneficiaries is no longer an issue. The fears that clients will run away after treatment for lack of money belong to the past because of health insurance coverage for clients.

Perspectives on NHIS beneficiaries, who are also termed target groups of NHIS were assessed. The target groups (NHIS beneficiaries) had a positive attitude towards NHIS as most of them cooperated with the healthcare facilities and the district scheme officials. This was what an adult beneficiary said on cooperation in the implementation of NHIS:

> *"We the patients need the help of doctors*

*and nurses; whatever they ask us to do we obey them. I tell you we the members of health insurance have also tried our best to work well with health workers".*

Beneficiaries' cooperation with healthcare service providers (facilities) in the implementation of NHIS was confirmed in FGDs with beneficiaries and implementers. On beneficiaries' trust in healthcare facilities for quality healthcare services, findings revealed the majority of the target groups 13 (72%) out of 18 showed more trust for quality healthcare facilities, four indicated average trust representing (22%) and one showed less trust (6%) for quality services they received from health care facilities. There was no significant variation between the two healthcare facilities (clinics) as far as the target groups' perspective on trust for quality healthcare services was concerned as in Table 2.

Table 2 Health insurance scheme beneficiaries perceived trust for quality services from facilities

| **Beneficiaries perceived Trust in Quality Services from Health Facilities** | **%** |
|---|---|
| 13 participants out of the 18 participants show more trust for quality services | 72 |
| 4 participants out of the 18 participants show average trust for quality services | 22 |
| 1 participant out of the 18 participants show less trust in the quality of services | 6 |
| Total | 100 |

On the choice of healthcare facilities, most of the target groups preferred the private healthcare facility (Friends Maternity Home Clinic-FMHC) to the public facility (Sawla Health Centre-SHC). The key factor in their preference for the private facility is the attitude of their staff. Many participants said the private healthcare facility staff were more caring and courteous than their public counterparts. Other reasons identified include the availability of drugs or medication, the distance travelled, the number of prescriptions forms issued, and the referrals made to clients. The outpatient department (OPD) attendance records in 2009 show the public facility recorded 3,987 while the private facility recorded 8,952. Between January and July 2010, the attendance record for the public facility was 3,648 while the private facility recorded 6,838 attendees. These documents/records confirmed interview
evidence that the private healthcare facility was the most preferred for healthcare services to the public facility. The preferences of the NHIS beneficiaries for the two healthcare facilities are in Table 3 as well as the variations in terms of OPD attendance

Table 3 the main kevs that determined beneficiaries' choice of health facilities.

| **Main or Key factors/determinants of beneficiaries' choice of health facilities** | **Ratios Pr v. Pu** |
|---|---|
| The attitude of staff towards beneficiaries is better in the private than the public facility | 5: 3 |
| Private facility staff more caring and more courteous than their public counterparts | 5: 3 |
| More access to drugs in the private facility than the public facility | 5: 4 |
| More issuance of prescription forms and referrals to other health facilities for services | 5: 4 |
| Overall attendance of beneficiaries for healthcare services private 15,790, public 7,635 | 5: 3 |

Also assessed was the rate of enrollment among target groups (NHIS beneficiaries) in the district. It was found that the active NHIS membership in Sawla-Tuna-Kalba District (STKD) was 49,631 in 2010. This represented 49.7% of the total population of 99,863. Further, findings revealed children as most service recipients (56.7%) followed by pregnant women (22.2%), aged (3.3%), indigents (0.2%) and Social Security and National Insurance Trust

(SSNIT) pensioners (0.1%), representing the lowest. The main contributors were represented as premium payees (17.0%) while SSNIT contributors represent 0.3% (Sawla-Tuna-Kalba District Mutual Health Insurance Scheme-STKDMHIS Annual Report, 2010; STKD Ghana Health Service (GHS), 2009; Half- Year, 2010). A similar pattern was observed in 2011.

## Discussion

### *Accreditation and access to healthcare facilities*

The newly accredited Community-based Health Planning and Services (CHPS) compounds in villages like Sanyeri, Kunfusi and Saru 2010 helped increase access to remote parts of the district. (Ghana Health Service Half-Year, 2010). Thus, the public-private accreditation or partnership in healthcare service provision made a wide range of services available to beneficiaries in rural parts of the district. Several findings agree that the public-private partnership is a key facilitating factor as it helped increased beneficiaries' access to healthcare services coupled with referrals/prescriptions in Ghana (Asante & Zwi, 2007; Ampong-Ansah et al, 2021; Kipo-Sunyehzi, 2021).

While the northern regional active membership of NHIS is 31%, the national active membership was 34% in 2010 (Ghana Health Service, 2009). The STKD rate of 49.7% is higher than the national and regional average of active membership of NHIS in 2010. The regional and national records made the STKD records encouraging (Sawla-Tuna-Kalba Mutual Health Insurance Scheme (STKMHIS) Annual Report, 2010). The findings suggest that rural people have more interest in NHIS through registrations and renewals. The increased enrollment in the STKD contrasts with Chankova, Sulzbach and Diop's (2008) findings, which showed lower enrollment in mutual health organizations in rural areas of Ghana (Chankova, Sulzbach & Diop, 2008). However, the rate of enrollment for the core poor (indigents) in society is 0.2% in STKD. This revealed that only a few core poor have access to healthcare services in STKD. This finding on low enrollment of the core poor (indigents) and the most vulnerable is consistent with other studies findings (Kwarteng et al, 2020; Kipo-Sunyehzi, 2021). The low enrollment of the core poor (indigent persons) is partly attributed to the rigorous process involved in the selection of indigents and the problem of affordability of the annual premium.

### *Resource allocation towards effective implementation of NHIS*

The study found exempt groups constituted the majority of beneficiaries (82.5%) in STKD (STKMHIS Annual Report, 2010). The positive findings seem to be short-lived as the study found delays in the reimbursement of healthcare facilities-monthly claims. The findings concurred with Witter and Adjei's work on the challenges of reimbursement of maternal delivery exemption fees due to inadequate funding for policy implementers in Ghana (Witter & Adjei, 2007; Akweongo et al, 2021).

Asante and Zwi identified the "health force shortage" as a big threat to the health system in Ghana and the effective implementation of policies. Coincidentally this human resource issue is more serious in northern Ghana where the numbers of medical doctors get "thinner and thinner". Policymakers at the national level do not want to allocate resources to areas with inadequate personnel to turn those resources into services "for the benefit of the people" (Asante & Zwi, 2009; Okyere, Mwanri & Ward, 2017; Bellerose et al, 2022). These studies' findings are consistent with this study finding in which inadequate human resource allocation to STKD was identified. The worst affected areas are remote villages with no medical personnel to utilize or operate the Community-based Health Planning and Services (CHPS) compounds to increase access to healthcare services. There are vast disparities in the allocation of medical personnel to cities and towns and between towns and villages in Ghana. This geographical inequity has resulted in the worsening plight of NHIS beneficiaries who reside in remote parts of Ghana as those residents do not have access to trained medical professionals to cater for their healthcare needs. Several studies confirmed that there is more access to healthcare services for urban dwellers than for their rural counterparts in Ghana (Gobah & Liang, 2011; Alhassan & Nketiah-Amponsah, 2016).

### *Organizational relations: cooperation, coordination*

The study found effective cooperation and coordination between facilities and health insurance scheme offices which helped to keep healthcare service providers on their toes to improve the quality of healthcare services they provide to NHIS beneficiaries. This inter-organizational cooperation was largely in terms of prescriptions and referrals in the rural district. This was due to a merger between the design-top-down and bottom-up approaches towards the implementation approach on which works better (Sabatier, 1986; Goggin et al, 1990; Matland, 1995; Winter, 2012; Kipo-Sunyehzi, 2020; 2020b).

### *Behaviors of street-level bureaucrats and target groups on quality healthcare*

The attitude of health workers was found to be more influential in determining beneficiaries' choice of facility, followed by the availability of drugs/medicines. Hence, the positive attitude of implementers and target groups is crucial.

## Conclusion

Despite the progress made in the implementation of NHIS in STKD in increasing beneficiaries' access to healthcare facilities, there are still some inhibiting factors and conditions. Some of these include delays in the reimbursement of healthcare facilities after healthcare service provision to beneficiaries, some acts of fraud and corruption, and some health workers' negative attitudes towards beneficiaries.

## Contribution

This paper/study has contributed to the field of policy design and implementation, particularly, NHIS in Ghana in areas of public-private healthcare provision or partnership and how such joint provision of healthcare services has helped increase beneficiaries' access to healthcare services as well as improved the quality of healthcare services in rural Ghana

## . Recommendations

There is a need to grant some accreditation to other diagnostic centers in remote areas (villages). Also, the central government should provide some incentives for health workers who accept postings to rural areas of Ghana. The study recommends some in-service training for some health workers on good attitudes towards their clients, especially public workers (clinicians). Future research may adopt a quantitative approach with a larger sample size and more healthcare facilities across the rural district or elsewhere in Ghana or other countries with similar settings.

## Conflicts of interest

The authors declare no conflict of interest.

## REFERENCES


Adzei, F. A., & Atinga, R. A. (2012) Motivation and retention of health workers in Ghana's district hospitals: addressing the critical issues. *Journal of health organization and management*. 26(4), 467-485.

Akweongo, P., Chatio, S. T., Owusu, R., Salari, P., Tedisio, F., & Aikins, M. (2021). How does it affect service delivery under the National Health Insurance Scheme in Ghana? Health providers' and insurance managers' perspectives on submission and reimbursement of claims. *PloS one*, *16*(3), e0247397.

Alhassan, R. K., & Nketiah-Amponsah, E. (2016). Frontline staff motivation levels and health care quality in rural and urban primary health facilities: a baseline study in the Greater Accra and Western regions of Ghana. *Health economics review*, *6*, 1-11.

Ampong-Ansah, F. B., Maloreh-Nyamekye, T., Otchere, L. N., Boateng, A. K., & Antwi-Boasiako, J. (2021). Partnership and collaboration in healthcare delivery in Ghana. *Journal of Public Affairs*, *21*(2), e2175.

Amporfu, E., Arthur, E., & Novignon, J. (2023). Billing the Insured: An Assessment of Out-of-Pocket Payment by Insured Patients in Ghana. *Health Services Insights*, *16*, 1–9.

Asante, A. D. & Zwi, A. B. (2007). Public-private partnerships and global health equity: prospects and challenges. *Indian Journal of Medical Ethics* 4.4: 176-180.

Asante, A. D., & Zwi. A B. (2009). Factors influencing resource allocation decisions and equity in the health system of Ghana. *Public Health* 123: 371-377.

Atinga, R. A. (2012). Healthcare quality under the National Health Insurance Scheme in Ghana: perspectives from premium holders. *International Journal of Quality & Reliability Management*, *29*(2), 144-161.

Ataguba, J. E., & McIntyre, D. (2012). Paying for and receiving benefits from health services in South Africa: is the health system equitable?. *Health policy and planning*, *27*(suppl_1), i35-i45.

Auditor-General Report (2019). Report of the Auditor-General on the Public Accounts of Ghana, Ministries, Department and Other Agencies (MDAs) for the Financial Year Ended 31 December 2019. Accra: Government of Ghana.

Ayee, J. R. A. (2000). *Saints Wizards Demons and Systems: Explaining the Success or Failure of Public Policies and Programmes*. Accra: Ghana Universities Press.

Azungah, T. (2018). Qualitative research: deductive and inductive approaches to data analysis. *Qualitative research journal*, *18*(4), 383-400

Bellerose, M., Awoonor-Williams, K., Alva, S., Magalona, S., & Sacks, E. (2022). 'Let me move to another level': career advancement desires and opportunities for community health nurses in Ghana. *Global Health Promotion*, *29*(2), 88-96.Bening, R. B (2014). The Creation of Districts and Constituencies in Ghana: Some Pertinent Issues in the Current Dispensation. *Ghana Journal of Geography* 4.1: 1-17.

Bryman, A. (2016). *Social research methods*. Oxford university press.

Chankova, S., Sulzbach, S., & Diop, F. (2008). Impact of mutual health organizations: evidence from West Africa. *Health policy and planning*, *23*(4), 264-276.

Daily Graphic (2010). State Newspaper publication Monday 7 June, p. 7.

Districts of Ghana (2023).Available at: https://en.wikipedia.org/wiki/Districts_of_Ghana#cite_note-1
(accessed on 23/06/2023).

Eilu, E. (2018). Adoption of electronic fiscal devices (EFDs) for value-added tax (VAT) collection in Kenya and Tanzania: a systematic review. *The African Journal of Information and Communication*, *22*, 111-134.

Fink, K., Gaillardetz, E., Théberge, L. B., Zigby, J., & Sanders, J. (2023). Understanding Barriers and Facilitators of Home Death: An Explanatory Mixed-Methods Comparative Case Study of Urban Palliative Care Providers (CS365). *Journal of Pain and Symptom Management*, *65*(5), e573.

Friends Maternity Home Clinic. 2009/2010. *Claims Report*. Sawla. Ghana.

Getaneh, M. M., Bayked, E. M., Workneh, B. D., & Kahissay, M. H. (2023). Satisfaction of beneficiaries with community-based health insurance and associated factors in Legambo District, North-East Ethiopia: a cross-sectional study. *Frontiers in Public Health*, *11*, 1127755.

Ghana Health Service (2009). *Annual report*. Accra: Government of Ghana.

Ghana's Sick National Health Insurance Scheme (2022). Available at: https://thefourthestategh.com/2022/08/05/ghanas-sick-national-health-insurance-scheme/#:~:text=There%20have%20been%20reports%20of,management%20company%2C%20under%20dubious%20circumstances (Accessed on 24/06/2023).

Ghana Statistical Service-GSS (2021). *Ghana 2021 Population and Housing Census: General Report Volume 3 A Population of Regions and Districts*. Accra: Ghana Statistical Service, November 2021.

Gobah, F. F., & Liang, Z. (2011). The National Health Insurance Scheme in Ghana: prospects and challenges: a cross-sectional evidence. *Global Journal of Health Science*, *3*(2), 90.

Goggin, M. L., Bowman, A. O. M., Lester, J. P., & O'Toole, L. J. Jr. (1990). *Implementation Theory and Practice: Toward a Third Generation*. Glenview, IL: Scott Foresman/Little, Brown and Company.

Gordon, T., Booysen, F., & Mbonigaba, J. (2020). Socio-economic inequalities in the multiple dimensions of access to healthcare: the case of South Africa. *BMC Public Health*, *20*(1), 1-13.

Government of Ghana-GoG. (2003). *National Health Insurance Act*, Act 650. Accra: GoG.

Grindle, M. S. (1980). Policy Content and Context in Implementation. In M. Grindle (Ed.), Politics and Policy Implementation in the Third World. Princeton-New Jersey: Princeton University Press.

Grindle, M. S., & Thomas, J. W. (1991). Public Choices and Policy Change: The Political Economy of Reform in Developing Countries. Baltimore: Johns Hopkins University Press

Hill, M. & Hupe, P. (2009). *Implementing Public Policy* (2nd ed). London: SAGE Publications.

Howlett, M. Ramesh M. & Perl A. (2009). *Studying Public Policy: Policy Cycles and Policy Subsystems*. Oxford: Oxford University Press.

Jehu-Appiah C., Aryeetey, G., Spaan E., De

Hoop, T., Agyepong, I., & Baltussen R. (2011). Who is enrolling, who is not and why? an assessment of equity of the national health insurance in Ghana. *Social Science and Medicine* 72: 157-62.

Kipo-Sunyehzi, D. D. (2021). Global social welfare and social policy debates: Ghana's Health Insurance Scheme promotion of the well-being of vulnerable groups. *Journal of Social Service Research*, *47*(1), 73-87.

Kipo-Sunyehzi, D. D. (2020). Making public policy implementable: the experience of the National Health Insurance Scheme of Ghana. *International Journal of Public Policy*, *15*(5-6), 451-469.

Kipo-Sunyehzi D.D. (2020b). Politics of Value-Added Tax Policy in Ghana. In: Farazmand A. (eds) *Global Encyclopedia of Public Administration, Public Policy, and Governance* (pp.1-8). New York, NY: Springer Cham:

Kipo-Sunyehzi, D. D. (2022). Implementation Research in Developed and Developing Countries: an Analysis of the Trends and Directions. *Public Organization Review*, 1-15.

Korongo, S. M., & Kilonzi, F. (2023). Deterrent Factors Influencing Value Added Tax Compliance in Kisumu County, Kenya. *African Tax and Customs Review*, *6*(2), 19-19.

Kpessa MW (2011). The politics of public policy in Ghana: from closed circuit bureaucrats to citizenry engagement. *J Dev Soc* 27(1):29–56.

Kwarteng, A., Akazili, J., Welaga, P., Dalinjong, P. A., Asante, K. P., Sarpong, D., ... & Sankoh, O. (2020). The state of enrollment on the National Health Insurance Scheme in rural Ghana after eight years of implementation. *International journal for equity in health*, *19*(1), 1-14

Lipsky, M. (1980). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Makinde, T. (2005). Problems of policy implementation in developing nations: the Nigerian experience. *Journal of Social Science*, *11*(1), 63–69

McIntyre, D. I., Thiede, M., & Birch, S. (2009). Access as a policy-relevant concept in low- and middle-income countries. *Health Economics, Policy and Law*, *4*(2), 179-193.

Matland, R. E. (1995). Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation. *Journal of Public Administration and Theory* 5.2: 145-174.

National Health Insurance Authority-NHIA (2017). NHIS Fraud sanctions weak – CEO | 5/18/2017. Available at: https://www.nhis.gov.gh/News/nhis-fraud-sanctions-weak-%E2%80%93-ceo-4116 (Accessed on 26/06/2023).

National Health Insurance Authority-NHIA (2018). *NHIA 2018 Annual Report*. Accra: NHIA.

Obilor, E. I. (2023). Convenience and purposive sampling techniques: Are they the same. *International Journal of Innovative Social & Science Education Research*, *11*(1), 1-7.

Okyere, E., Mwanri, L., & Ward, P. (2017). Is task-shifting a solution to the health workers' shortage in Northern Ghana?. *PLoS One*, *12*(3), e0174631.

Osei, P. D. (2000). Political liberalisation and the implementation of value added tax in Ghana. *The Journal of Modern African Studies*, *38*(2), 255-278.

O'Toole Jr, L. J. (2000). Research on policy implementation: Assessment and prospects. *Journal of public administration research and theory*, *10*(2), 263-288.

Pressman, J. L. & Wildavsky A B. (1984). *Implementation*. 3rd ed. Berkeley, CA: University of California Press.

Ridde, V. (2009). Policy implementation in an African state: an extension of Kingdon's Multiple-Streams Approach. *Public Administration, 87*(4), 938–954.

Sabatier, P. A. (1986). Top-down bottom-up approaches to implementation research: a critical analysis and suggested synthesis. *Journal of Public Policy* 6.1: 21-48.

Saetren, H. (2014). Implementing the third generation research paradigm in policy implementation research: an empirical assessment. *Public Policy and Administration*, 0(0):1-22.

Sawla Health Centre, GHS. 2009/2010. *Claims Report*. Sawla.

Sawla-Tuna-Kalba District, Ghana Health Service-GHS. 2007-2009. *Annual Report*. Sawla

Sawla-Tuna-Kalba District, GHS. 2010. *Half Year Report*. Sawla

Sawla-Tuna-Kalba Mutual Health Insurance Scheme-STKMHIS. 2010/2011. *Annual Report*. Sawla.

Schneider, A., & Ingram, H. (1988). Systematically pinching ideas: A comparative approach to policy design. *Journal of public policy*, *8*(1), 61-80.STKMHIS. 2010. *Accreditation Report*.

Twumasi, P. A. (2001). *Social Science Research: In Rural Communities*. 2nd ed. Accra: Ghana Universities Press.

Van Meter, D. S., & Van Horn, C. E. (1975). The policy implementation process: a conceptual framework. *Administration and Society* 6.4: 445-88.

Winter, S. (2012). "Implementation". In *Handbook of Public Administration* eds Guy Peters and Jon Pierre, 255-264. London: Sawla.

Schroers, G., Tell, D., & O'Rourke, J. (2023). Association of external interruptions with increased medication administration duration and self-interruptions: A direct observational study: Empirical research quantitative. *Journal of Advanced Nursing*, 1-9.

Sekyi, S., Asiedu, D., & Oppong, N. Y. (2022). Retention of health professionals in the upper west region of Ghana: Application of partial least square structural equation modelling. *Journal of African Business*, *23*(1), 1-22.

STKMHIS. 2009/2010. *Claims Report*. Sawla.

Truijens, D., & Hanegraaff, M. (2023). It Ain't Over 'Til It's Over: Interest-Group Influence in Policy Implementation. *Political Studies Review*.

Sage Publications.

Witter, S., & Adjei S. (2007). Start-stop funding, its causes and consequences: a case study of the delivery exemptions policy in Ghana. *International Journal of Health Planning and Management* 22: 133-143.

Yin, Robert K. 2014. *Case study research: Design and methods*. 5thedn. London: Sage Publications.