BRIEF REPORTS

The Impact of National Health Insurance Scheme on the Lives of Persons with Disabilities in the Kumasi Metropolis, Ghana

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ABSTRACT

Purpose: *In Ghana, the National Health Insurance Scheme (NHIS) is one of the government's social protection measures to provide healthcare for its citizens. Persons with disabilities and their families, though worthy recipients of such services, are more likely to face challenges in accessing healthcare through the NHIS due to social discrimination. The objective of the study was to evaluate the impact of the National Health Insurance Scheme on the lives of persons with disabilities in the Kumasi Metropolis.*

Method: *A qualitative study was carried out. Purposive sampling was used to select persons with disabilities and NHIA staff as participants. Structured interviews and focus group discussions were employed to collect data from them.*

Results: *Unemployment among persons with disabilities was the major economic factor that influenced access to health insurance and healthcare. Most of the mobility impaired and visually impaired persons were inconvenienced by inaccessible routes to NHIA offices. For the hearing impaired, communication was a major problem since the NHIA staff were unable to understand sign language.*

Conclusion and Implications: *NHIS has been instrumental in providing healthcare for persons with disabilities, and stakeholders must encourage persons with disabilities to register for NHIS. Their unemployment issues should be addressed by aiding their economic ventures. Access routes to NHIA offices must also be made disability-friendly.*

Key words: *Disability, national health insurance scheme, national health insurance authority, health insurance.*

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INTRODUCTION

Health insurance is a financial arrangement in the health sector that is used to pay the medical expenses of insured persons who utilise the services of accredited health providers. It thrives on three factors: the provider, the subscriber and the payer - in the scheme (Gorman, 2006).

Health insurance is well developed in many countries as a social protection policy to provide efficient, equitable and affordable healthcare (Mavalankar and Bhat, 2000). Based on the growing argument, as well as proof, that the introduction of health insurance in poor areas can improve people's access to healthcare (Berk and Monheit, 2001), many countries have adopted and implemented different health insurance schemes which offer affordable healthcare.

In Ghana, the National Health Insurance Scheme (NHIS) is one of the social protection measures undertaken by the government. It was set up under the National Health Insurance Act of 2003, which offered three types of medical coverage plans in Ghana: area shared healthcare coverage, private business healthcare coverage, and private common healthcare coverage. Plans must be submitted to the National Health Insurance Authority, which has the order to enrol, permit, and administer all plans. All general wellbeing offices in the nation are naturally licensed; however, private wellbeing offices need to apply for accreditation by experts. By December 2008, 1,551 private suppliers of various classifications had been licensed (Ghana National Health Insurance Authority, 2008).

Various research works show that the NHIS has impacted positively on the general healthcare delivery in Ghana. With the help of NHIS, individual hospitalisation reduced slightly, from 2.4% in 2004 to 1.9% in 2007. Again, fewer people were detained in hospitals as a result of inability to pay hospital bills, and out-of-pocket expenditure on healthcare has reduced significantly (Sulzbach, 2008). In contrast, Brugiavini & Pace (2011) discovered that the NHIS had not significantly reduced out-of-pocket expenditure on healthcare but had increased healthcare utilisation.

To become a participant, an individual needs to enrol with the closest regional common plan or through an operator. Instalments of suitable premium and enrolment expenses are required for those included. By and large, premiums are intended to be founded on pay and ability to pay, with a broadly decided floor of 72,000 cedis every year. Areas are approved to set premium levels, which run by and by from 72,000 cedis to 480,000 cedis the nation over (Asenso-Boadi,

2009). Persons with disabilities and their families may be considered to be among the worthiest recipients of such social protection measures. There is a growing evidence base on the multi-dimensional relationship between disability and poverty (Mitra et al, 2011; Mont and Cuong, 2011). Every household with persons with disabilities is characterised by low human capital, which results in reduced earning capacity of the family members and their primary caregiver. They are subject to disability-related expenses, such as healthcare and equipment, special dietary and travel requirements, and adaptation to housing, which exacerbate income poverty. Due to social discrimination, they are also likely to experience low levels of social interaction and support which are recognised as important resources, most particularly in developing countries where formal systems of support are limited (Narayan, 2000).

Objectives

The specific objectives of the study were to:

Evaluate the challenges faced by persons with disabilities in the Kumasi Metropolis in accessing NHIS, Assess the challenges confronting NHIA in offering services to persons with disabilities in the Kumasi Metropolis.

METHOD

Setting

Kumasi Metropolis, with an area of 254 square kilometres (25,415 hectares) and a resident population of 2,035,064 (as of 2010), was selected as the study site on the basis of its cosmopolitan nature. As it is centrally located, approximately 270 km north of the capital, Accra, Kumasi is the major transportation hub between the northern and southern sectors of the country. Consequently it has a daytime population of about 3 million.

Sample

A total of 30 persons with disabilities were selected as study participants; of whom 10 each were drawn from the three groups - physically challenged, hearing and visually impaired persons - who had registered with NHIS. There were also 5 officials from NHIA, namely, the district manager, Public Relations Officer and 3 junior staff.

Study Design and data collection

A qualitative data collection technique was used. Interviews and focus group discussions were conducted among people from the 3 disability groups, who had accessed healthcare using the NHIS for a period of time ranging from 1-5 years. Interviews were also conducted with the NHIA district manager, Public Relations Officer and 3 junior staff members.

Data from participants was obtained through interviews, using an interview guide. The interview guide helps in investigating numerous respondents efficiently and thoroughly, and keeps the meeting concentrated on the specific area of interest.

Data Analysis

Discussions were conducted in Twi, the local dialect, and had to be translated to English. Thereafter, the researcher cross-checked the transcripts with the audio tapes and field notes made during the interactions, to ensure that they were accurate in preserving the meanings of participants' words and statements. After the translation and editing, the data was grouped into headings or themes for easy coding, identification and analysis. The researcher guided the categorisation of the edited information into presentable formats based on the various themes developed out of the data, keeping in mind the research objectives and questions. Similar responses were placed under the same headings, based on the various categories.

Ethical Issues

Ethical approval was obtained from the Committee on Human Research, Publication and Ethics at the Kwame Nkrumah University of Science and Technology, School of Medical Sciences.

Respondents were informed that the information retrieved was for academic purposes. They were assured of confidentiality and anonymity. To ensure this, during the interview the researcher did not record identifiers such as names, street and contact numbers of respondents. Participation in the research was voluntary.

RESULTS

The demographic characteristics of the respondents are presented in Tables 1 and 2.

Table 1: Demographic Characteristics of Respondents (Persons with Disabilities)

Variables	Frequency(n=30)	Percentage(%=100)
Age group		
20-29 years	14	47
30-39 years	10	33
40 years and above	6	20
Gender		
Male	16	53
Female	14	47
Religion		
Christianity	20	67
Islam	7	23
Traditional	3	10
Type of Impairment		
Mobility	15	55
Hearing	7	18
Visual	8	9
Educational Background		
Primary	9	26
Secondary	14	40
Tertiary	7	20

Source: Field work (2018)

Table 2: Demographic Characteristics of Respondents (NHIA Staff)

Variables	Frequency (n=5)	Percentage
Position of NHIA Staff		
Senior Staff	2	40
Junior Staff	3	60

Source: Field work (2018)

Demographic information obtained included sex, age, religion, occupation, education, type of impairment, and department or position of NHIA staff. The respondents were, in general, young people, especially the NHIA staff. Most of them were Christians and Muslims, and there were a few traditionalists.

The study participants were from three main impairment groups, namely, persons with mobility, hearing and visual impairments. The NHIA staff consisted of 2 senior and 3 junior members.

Challenges faced by persons with disabilities

There were several factors that were identified as major hindrances to persons with disabilities in accessing the NHIS, and to NHIA staff in delivering services to them. Notable among these were: economic barriers, lack of provision of assistive devices, high cost of transportation, geographic accessibility and inaccessibility of NHIS buildings, communication barriers, logistics and human resources, and infrastructural challenges.

Economic Barriers

Unemployment among persons with disabilities was identified as an economic factor that influences their access to NHIS. They indicated that not only were most of them unemployed and unable to meet their basic needs, but they also did not have money to register in order to attend hospital for treatment when they fell ill. In the hospital one is required to pay money at every stage, so without the insurance card persons with disabilities lack the motivation to access healthcare.

Geographic accessibility and high cost of transportation

Geographic access is an essential factor in obtaining healthcare. For the most part, the health insurance workplaces are located far away and people with disabilities have to travel long distances to access health insurance. Transport facilities are

required to travel from their homes to health insurance offices or to designated posts to register. They complained that transport was a problem as commercial cars are inaccessible, and some drivers refuse to allow them on board due to their assistive devices, especially the wheelchairs. High cost of transportation to the NHIS office negatively influences the enrolment and registration of persons with disabilities.

Infrastructural challenges

Most of the offices of the National Health Insurance Authority are not accessible. Many respondents shared their difficulties and revealed that they had to be carried to the NHIA offices to register, because the buildings lacked ramps or elevators for their wheelchairs. The embarrassment of being carried by other people, either on their back or in their arms, and to be pushed in their wheelchairs, deterred people with disabilities from going to NHIA offices.

Communication challenges between persons with disabilities and health insurance staff

The hearing impaired respondents complained about difficulties arising from their inability to communicate effectively with staff of the NHIA. They are unable to communicate with the NHIA office staff unless they are helped by a sign language interpreter. Additionally, most of the guides are minors and can barely assist in communication or in addressing the needs of the persons with disabilities whom they accompany to the NHIA office.

Challenges faced by NHIA in delivering services to persons with disabilities

The study found that the inability of the NHIA staff to communicate effectively with persons with disabilities was a major inconvenience. Staff were unable to explain what persons with disabilities needed to do to register, particularly when hearing impaired clients were involved. Inability to communicate in sign language was an issue and the use of English language was ineffective since persons with disabilities were, by and large, illiterate.

Lack of accessible routes to office buildings

One major obstacle that prevents the NHIA from reaching out to persons with disabilities is the lack of access routes to most of the office buildings. The structures

are not accessible, and there are no ramps or elevators for the use of persons with mobility impairments.

Logistics and human resources

Due to insufficient human resources and logistics, the NHIA cannot undertake a mobile registration exercise that targets only persons with disabilities so that the latter do not need to travel to the offices to register themselves.

Lack of awareness on registration fees for persons with disabilities

NHIS services are free for all indigent people. Persons with disabilities only require a letter from the Social Welfare Department, stating that they are members of any disability group, and their registration or renewal will be done for free. This covers the person with disability and the entire family. Unfortunately, due to lack of awareness, most persons with disabilities do not know that they need pay no fee for renewal or registration of NHIS cards. Ignorance contributes to the low patronage of the insurance scheme.

DISCUSSION

Unemployment among persons with disabilities was the major economic factor that hindered their access to health insurance and healthcare. Respondents indicated that most of them did not even have money to register in order to visit hospital for treatment when they fell ill. As a result of the high unemployment rate among persons with disabilities, most of them were relatively poor and unable to meet their basic needs, inclusive of quality healthcare.

Unemployed people will not be able to manage the cost of private health insurance. Even employed individuals with impairments might be barred from private health insurance on account of prior conditions, or they might be "under-insured" in light of the fact that they have been denied coverage for a long stretch, or they are rejected from guaranteeing for treatment identified with a previous condition, or should pay higher premiums and out-of-take costs (White, 2002).

Persons with disabilities may have additional expenses for individual helpers or for restorative care or assistive gadgets. In view of these higher costs, individuals with disabilities and their family units are probably going to be poorer than individuals with comparable pay but without disabilities. Debilitated individuals

in low-salary nations are more prone to encounter calamitous wellbeing consumption than non-incapacitated individuals (WHO, 2010).

The study found that the costs involved in making hospital visits without an insurance card scared persons with disabilities away. High unemployment and poverty rates have resulted in their inability to register for health insurance. Most of them indicated that they did not go to hospital regularly due to the costs involved. They were aware of the existence of health insurance but, due to unemployment, the cost involved in accessing the service prevented them from seeking it. Even if one has a health insurance card, starting from the hospital card or folder to visiting the dispensary, at every stage one has to pay money. This finding is not different from the review of the 2002–2004 World Health Survey which uncovers that affordability was the essential motivation behind why individuals with disabilities, crosswise over sex and age gatherings, did not get required social insurance in low-salary nations. For 51 nations, 32– 33% of men and women without disabilities cannot bear the cost of social insurance, contrasted with 51– 53% of individuals with impairment.

Some of the respondents also mentioned that the assistive devices were costly and they were unable to purchase them. They felt that there was no point in getting registered if they would then be told to buy assistive equipment that they could not afford, because the scheme does not make provision for them.

User fees have made the direct cost of healthcare unaffordable for poor households. Poor households have to delay health seeking until the condition of illness becomes serious and this further aggravates their conditions (Nyonator and Kutzin, 1999). The cost of healthcare has plunged some poor households into near-permanent impoverishment. The effect of user fees has been universally and overwhelmingly negative and this has been blamed on poor design, planning and implementation (McIntyre et al, 2008).

The respondents faced many barriers when they accessed health insurance. The respondents that reported to have experienced physical barriers were the mobility impaired persons and visual impaired persons. Also, the medical equipment barriers were mostly experienced by the hearing impaired, mobility impaired persons followed by visually impaired persons. Communication barriers were mostly experienced by hearing impaired persons. The type of barriers experienced among those with physical barriers were inaccessible door entrances, inaccessible staircases, and the absence of elevators, and ramps. In health care, the physical

and social environments often impede access to timely and appropriate health care services for people with disabling health conditions (Dejong et al.,2002).

Delivery of service by NHIA faces many bottlenecks from communication, logistics and human resources, accessibility barriers, etc. These challenges make the service provider unable to deliver service effectively. Persons with disabilities stated that what they required most were assistive devices but these were not covered by insurance. The inability of NHIA staff to communicate with persons with disabilities led to a lot of inconvenience for both staff and clients.

Inaccessible routes, inadequate logistics and human resources also derail or hinder the successful delivery of service by NHIA. Ineffective communication and lack of sign language interpreters make service delivery very difficult. Without sufficient staff, persons with disabilities are forced to join long queues to register. NHIA has failed to inform the various disability groups that NHIS service is free for indigent people, including all persons with disabilities. This has contributed to their low patronage of NHIS.

CONCLUSION

The National Health Insurance Scheme is a social protection policy that has come to replace the cash and carry system. The NHIS has undoubtedly been a lifesaver for most people as the cost of seeking medical care is high for the individual who has not subscribed to any insurance plan. Respondents stated that the scheme had been beneficial to them as they would otherwise have been unable to avail of medical care due to the high fees charged with out-of-pocket payments (OOP). Persons with disabilities and their family members or dependents are covered by the NHIS for free and this has been helpful in meeting their healthcare needs.

However, it has encountered several challenges in making its impact on poor people, such as persons with disabilities whose enrolment is minimal.

Persons with disabilities encountered economic, communication and accessibility challenges while accessing National Health Insurance scheme National Health Insurance Authority in their bid to serve Persons with disabilities also encountered barriers such as Communication, Lack of Human Resources and Logistics and Lack of public education. The NHIS scheme has helped improved the health care needs of PWDs and their families. This reduces the burden of seeking for extra financial muscles to cater for the healthcare needs of PWDs and their dependents.

Stakeholders such as government agencies; Social Welfare Department and NHIA, all Disability groups and NGOs must embark on effective public education to bring to the notice of the general public that NHIS is free for all PWDs to increase the enrolment of NHIS and assessment of healthcare by PWDs and their family members or dependents. National Health Insurance Authority must include assistive devices in their list of provisions to aid PWDs since that is what they require most when they seek medical care.

The Government through its ministries such as Ministry of Health and Ministry of Works and Housing must re-visit existing building regulations and policies to re-design buildings to ensure a more disability friendly healthcare structures that will be accessible to all PWDs.

National Health Insurance Authority must include assistive devices in their list of provisions to aid PWDs since that is what they require most when they seek medical care.

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