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DOES MEMBERSHIP IN MUTUAL HEALTH INSURANCE GUARANTEE QUALITY HEALTH CARE? SOME EVIDENCE FROM GHANA

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Abstract

Access to health care and quality of health care are inextricably linked. Not merely is access to health care important, but also its quality: hence the apparent increasing demands for health care services where they are perceived by citizens to be offering quality services. The inverse situation also seems to exist, that is, when health systems are perceived to deliver health services that are of 'poor' quality, attendances at such facilities tend to be low. In light of this, this study seeks to examine the nascent National Health Insurance Scheme in Ghana (NHIS) and how the NHIS addresses the issue of quality health care delivery for its patients. Using mixed methods research; focus group discussions and household surveys, the study compares two groups (insured and non-insured) with respect to the quality of health each group receives in attempt to providing reliable information to policy and decision-makers about the areas that need attention for improvement in quality of healthcare in the Kassena-Nankana District in Northern Ghana. While the household survey results do not establish any difference in the quality of health received by either the insured or uninsured, findings from the FGDs strongly suggest that the uninsured received better quality care than the insured. These findings provide a fertile ground for policy action. It is thus, recommended amongst other things, that health authorities investigate further alleged illegal extortions of monies by some nurses from uninsured patients.

Keywords: *Membership, Quality, Healthcare, Perceptions, Mutual health insurance, Ghana, Kassena-Nankana District.*

1. The problematique of health care services

Over the past 20 years, access to health care has been the focus in developing countries. But access to health care and quality of health care are inextricably linked. Not merely is access to health care important, but also its quality: hence the apparent increasing demands for health care services where they are perceived by citizens to be offering quality services. The inverse situation also seems to exist, that is, when health systems are perceived to deliver health services that are of 'poor' quality, attendances at such facilities tend to be low. Instantiating this claim, Offei, Bannerman and Kyeremeh,(2004:viii) argue that poor quality of health care leads to loss of patients, lives, low morale among health workers, trust, respect, poor recognition of health care providers, and in individual and community apathy towards health services. Importantly, Turkson, (2009:65) argues that if health programmes are to succeed in poor countries, it is imperative to solicit the views of local people in addition to their degree of satisfaction with available services.

The patient's perception of quality of care is fundamental to understanding the relationship between quality of care and utilisation of health services. In the same vein, authors such as Thompson and Sunol (1995, cited in Sharma and Narang, 2011:52) are of the opinion that real improvement in quality of care cannot occur if the user perception is not positively affected. Similarly, Donabedian, (1980) argues that patients' perception is significant as it impacts their health-seeking behaviour, including utilisation of services and provides relevant information to the policy makers to improve the quality of health care services. Accordingly, it can be inferred that quality health care cannot be divorced from access to health care and must thus be given careful attention. This is because a clear understanding of the determinants of patients' satisfaction potentially can aid policy and decision-makers to implement programmes tailored to patients' needs as perceived by them (patients) and service providers. As a result, this study seeks to examine the nascent National Health Insurance Scheme in Ghana (NHIS) and how the NHIS addresses the issue of quality health care delivery for its patients.

Access to health care services in Ghana had hitherto been based on out-of-pocket payments where patients had to directly pay for cost of health care at the point of demanding health care services. This system was commonly known as 'cash-and-carry'. These out-of-pocket payments greatly limited access to health care for the vulnerable and other disadvantaged groups such as the poor. For instance, the Health Systems 20/20 Project, (2009) argues that substantial increase in user charges in 1985 resulted in a drastic decline in health care utilisation, with outpatient visits to hospitals dropping from 4.6 million to 1.6 million persons, that is, a decrease of 65%- a disastrous situation for any developing country.

To limit the negative effects the 'cash-and-carry system' had on the poor, the Ghanaian parliament in 2003 passed the National Health Insurance (NHI) Act, Act 650, promoting the establishment of Mutual Health Insurance Schemes in all parts of the country, as a more equitable and pro-poor health financing policy. The aim of mutual health insurance is to increase access to health care by reducing out-of-pocket payments faced especially by poor households. The scheme gives prominence to Community/District Mutual Health Insurance Schemes (MHIS) as a key strategy for the extension of financial protection of health care services to the poor.

With a focus on communities or districts, Bennett, Kelly and Silvers, (2004), contend that MHIS provide risk pooling to cover all or part of the costs of health care services. They also include an element of community participation in their management or some form of democratic accountability of the management to their members. Generally, the ability of MHIS in providing financial protection in health to the poor is well documented in the literature on health financing (Carrin and Preker, 2004, Jütting, 2005 and Tabor, 2005). For instance, empirical studies by the Health Systems 20/20 Project (2009) in Ghana suggests that as of December 2008, NHIS covered 61% of the population and remarkably reduced out-of-pocket expenditures for outpatients seeking outpatient care in formal health facilities from 21 293 old Ghana cedis [15]in 2004 to 13.748 cedis in 2007.

While the preceding studies have established the potential of MHIS in improving the poor's access to health care, research on the impact of these novel schemes on the quality of health care is limited in the literature. This means, amongst other concerns that there is currently a paucity of systematic evidence about the quality of health care received by insured patients at various health facilities in Ghana. For example, little is known about whether mutual health insurance patients (insured) received better quality health care than people who are not enrolled in the insurance scheme (uninsured). The preceding concerns are some of the lacunae that this paper seeks to fill by answering the following question: Does Membership in Mutual Health Insurance Guarantee Quality Health Care for patients? The research compares the quality of health care received by the insured and uninsured in attempt to providing reliable information to policy and decision-makers about the areas that need attention for improvement in quality of healthcare in Ghana.

2. Conceptualising health care services

In this paper, the need to take into account the perception of patients about the quality of health care they receive has been influenced by, amongst others the works of Paulo Freire and John Friedmann as they both advocate people-centered development. In his seminal work, the "*Pedagogy of the Oppressed*", Freire (1970) contends that the oppressed need be made aware of their living conditions, become conscious of their rights as citizens and mobilise communities to unite to find a way to improve their living conditions. According to Freire's framework, patients will only be able to improve their livelihoods when their perceptions about the quality of health are taken into consideration, how satisfied they are with the care they receive and whether or not they are treated with respect.

John Friedmann (1992), taking the Freirian perspective further, calls for a moral justification for people-centred development (empowerment). Friedmann (*ibid*) states that to defend this alternative development approach has more to do with morality than facts. He highlights three foundations for a morally justified alternative people-centred development: human rights, citizen rights and human flourishing (*ibid*). Firstly, on *human rights*, he defends the Universal Declaration of Human Rights (1948), stressing its civil, political, economic and social dimensions, including liberty and basic needs. He says that a wilful exclusion from these rights is a kind of violence on the person excluded (*ibid*). Secondly, on *citizen rights*, he accents the importance of the citizens' relative autonomy *vis-à-vis* the state, presuming, therefore, a modern, democratic state, where the holders of authority are ultimately accountable to the people organised as a political community (*ibid*). Lastly, his third moral foundation is about *human flourishing*, an evocative and open-ended (*ibid*) term that has to do

[15] Cedi is the official Ghanaian currency. It was redenominated in July 2007 to the new Ghana Cedis. The above figures are quoted in the old currency.

with the possibility of each human being living up to her or his capacity. To Friedmann, people should not only live but also prosper in whatever they do in life. For example, the patient-centered focus can be linked to a drive for greater accountability and transparency in health care governance because accountability has implications for examining patient perceptions of quality. This is because accountability raises the question of who patients would hold responsible for the quality of health care they receive. Amongst other conclusions, this means patients can only flourish as Friedmann suggests when the quality of health care they receive truly meets their health needs.

These preceding discourses have generated a wide range of interest among major development partners such as the World Bank and others to advance people-centered development. For instance, authors such as Aldana, Piechulek and Al-Sabir (2001:512), contend that the World Bank, in recent years, has been advising developing countries to "ensure that limited resources not only have an optimal impact on the population's health at affordable cost but also that health services are client-oriented''. Similarly, the key policy objective for establishing the NHIS in Ghana is to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care services (NHIS 2003:1&7).

Despite the huge interest in quality health care, what constitutes "quality health care" is far from clear, Sofaer and Firminger, (2005). Perhaps, it can be argued that the definition of 'quality' is socially constructed, based amongst others, on the individual's socialisation processes. Thus, given the socialisation and values of health professionals and patients, one would expect a variation in their perspectives and definitions of quality health care. For instance, using qualitative research methods in empirical studies, Sofaer and Firminger (2005:521) contend that patients themselves defined quality through what may be termed patient-centered care approach. For patients in these studies, quality health care, among other things, includes: "having their physical and emotional needs met; having health care providers who respect and know about the patient's health beliefs; having health care providers who show respect for the patient, listen to the patient, and anticipate the patient's needs; and giving equal care for all patients".

In the same vein, Ovretveit (1992 cited in Sharma and Narang 2011:52) identified three "stakeholder" components of quality: patient, professional, and managerial. From the patient's viewpoint, "it is the meeting of the patient's unique need and want at the lowest cost, provided with courtesy and on time. Secondly, professional quality involves the carrying out of techniques and procedures essential to meet the patient's requirement. And thirdly, managerial quality entails optimum and efficient utilisation of resources to achieve the objectives defined by higher authorities" (*ibid*).

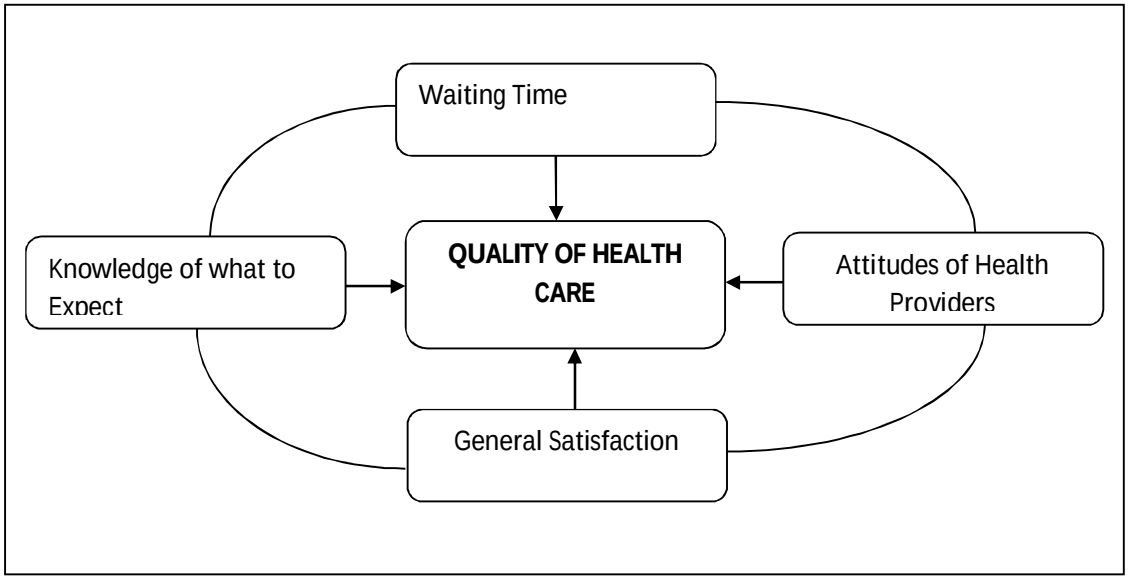
Sofaer and Firminger (2005:518), define and measure quality health care in relation to a patient's satisfaction of the services they receive based on expectation theories. They argue that satisfaction is based on the difference between what one expects and what occurs and that satisfaction is determined by the difference between a patient's standard of expectations, ideals, or norms and the same patient's perceptions of their experiences of care, with satisfaction arising from either confirming positive expectation or disconfirming negative expectations (*ibid*). It is worth pointing out, however, that satisfaction is a relative concept, thus what satisfies one person may dissatisfy another.

Consequently, Donabedian (1980), came up with three criteria for the assessment of quality of health care: structure, process and health outcome. Structure refers to a patient's rating of the physical environment and physical facilities in which the service takes place while process measures refer to the patient's rating of interpersonal interactions with service personnel and of personnel with each other. Examples of process indicators of quality health care include: responsiveness, friendliness, empathy, courtesy, competence, and availability. The third criterion, health outcome, relates to improvements in patient's health (*ibid*).

Similarly, the WHO (2000) conceptualises quality health care in relation to the responsiveness of the health system to the expectation of patients. Some of these expectations include, respecting their dignity, autonomy and confidentiality of information. It also looks at whether patients receive prompt and immediate attention in cases of emergency and reasonable waiting time in non-emergency cases. This view of quality health care is much akin to Donabedian's process indicators of quality health care except that the WHO (2000) goes a step further to argue that a responsive health care system should treat all patients equally without discriminations. The report suggests that often evidence shows that the poor, who are mostly rural people, are less respected for their dignity and are offered poorer quality services than the non-poor who are mostly urban dwellers (WHO 2000:33).

Accordingly, the authors model quality health care using the services dimensions such as a patient knowledge about what to expect at health facilities, average time it takes for a patient to be attended to (waiting time), attitude of health providers towards patients and the general satisfaction about services that patients receive. Along the lines of these empirical studies, drawing extensively from the WHO's conceptualisation of quality health quality, and the Donabedian's process indicators assessment of quality health care as shown on figure 1 below, the following assumptions about health care services in Ghana can be constructed:

FIGURE 1: MODEL OF DIMENSIONS OF QUALITY HEALTH CARE



Source: Authors' Construct

Based on the above conceptualization of quality health care, it is hypothesised that: there is no difference in the quality of health care received by MHIS members (insured) and non-members (uninsured).

3. Research Methodology

3.1 Research Strategy, Sampling Techniques and Data Analysis

The setting of this research is the Kassena-Nanakana District (KND) in the Upper East region of Northern Ghana. KND is one of the 9 districts in the Upper East Region and has Navrongo as its capital. Two communities: Pindaa in the North and Gaani in the South were randomly selected for the research. The research strategy adopted was mixed methods. Mixed methods research refers to the combination of both quantitative and qualitative strategies to collect and analyse data with respect to the quality of health care. The rationale for choosing this strategy is that the weakness of one will be complemented by the strengths of the other. Supporting this choice, Bryman (2008:612) argues that 'each approach has its own limitations or "imperfections", which can be compensated for by using an alternative method'. He asserts further that this strategy is very useful in generating data that is suitable for policy-makers (*ibid*). Drawing from our model above, the variables: waiting time, knowledge of clients about the benefit package, attitudes of health providers towards patients and the general satisfaction of the respondents about the health services provided are used to measure quality of health care. Questions pertaining to the patients' knowledge about the benefit package were asked only during focus group discussions (FGDs) specifically with the insured members.

Random cluster[16], stratified, simple random and purposive sampling techniques were used. Random cluster sampling was used to select the two communities for the study. This sampling technique was found appropriate because the study area is typically rural with dispersed settlement patterns hence random cluster sampling solved the problem of interviewers having to travel the length and breadth of these scattered communities looking for interviewees or respondents. Having selected the communities from which samples were drawn, stratified sampling was used to delineate the population of each community into categories or strata of the insured and non-insured from which samples were drawn. In using stratified random sampling, both groups (insured and non-insured) were proportionately represented in the sample. In this regard, Bryman (2008:179) posits that stratification 'injects an extra increment of precision into probability sampling process, since a possible source of sampling error is eliminated'. Simple random sampling then used to select the required number of households for the household interviews. Purposive sampling was used to selected community members for FGDs. A total of 100 household interviews were conducted in addition to 8 FGDs in both communities. There was however, one non-response - one uninsured household, thus bringing the total sample size to 99. This choice of sample size was informed by the fact that 'decisions about sample size represent a compromise between the constraints of time and cost and the need for precision' (*ibid*). The size of the FGDs also took into account the fact that they are difficult to organise and take longer time to transcribe.

[16] Clusters sampling refers to the groupings or aggregation of population units into identifiable sets or groups.

Data were collected from both insured and uninsured households using a structured questionnaire and FGDs. The structured questionnaire contained specific questions relating to the quality of health care, thus eliciting the appropriate information from households or individuals with. The FGDs were used in the elicitation of a wide variety of different views in relation to the topic from the participants.

A comparative data analysis was done of by comparing the two groups (insured and non-insured) with respect to the quality of health each group receives. The aim of doing a comparative analysis was to seek explanations for similarities and differences between the two groups. Data collected by the questionnaires were analysed using Microsoft Windows SPSS 16.0. Data generated from the FGDs were transcribed and categorised in line with the research question in order to bring out essential patterns. The data was then analysed qualitatively in the form of narratives. Also the Mann-Whitney/Wilcoxon rank sum test was used to our hypothesis: *there is no difference in the quality of health care received by MHIS members (insured) non-members (uninsured).*

The Mann-Whitney/Wilcoxon rank sum test was used to compare the quality of health care received by the insured and uninsured and because the samples are two independent random samples; a two sample test was conducted. The Mann-Whitney/Wilcoxon rank sum test was appropriate for the test because the variable of interest (quality of health care) is ranked in order of magnitude for both the insured and uninsured. The level of significance was 0.05 but this was divided into two equal parts since this was a two-tail test (0.05/2=0.025) so 0.025 is the required level of significance. The P-value must be in the range of (0.000-0.025) in order to be considered significant. The Mann-Whitney U-test has three formulae but for this study, one of the formulae is used: the one for larger samples. This formula is chosen because the samples involved are greater than 20; 51 insured households and 49 uninsured households (n_1, n2>20).

Therefore, the Mann-Whitney U-test is given by the following formula:

$$U_1 = R_1 - \frac{n_1 (n_1+1)}{2} \quad (1)$$

where

n_1= sample size for sample 1, R_1=sum of the ranks in sample 1

$$U_2 = R_2 - \frac{n_2 (n_2+1)}{2} \quad (2)$$

where

n_2= sample size for sample 2, R_2= sum of ranks in sample 2

the sum of the equations (1) + (2) is now computed as follows:

$$U_{1+} U_2 = R_1 - n1\ (n_1+1) + R_2 - n_2\ (n_2+1) \qquad (3)$$

$$\frac{\quad}{2} \qquad \frac{\quad}{2}$$

4. Evaluating Household Survey Results

For the sake of clarity, we measured quality health care using four variables: waiting time, the attitudes of health providers towards patients, knowledge of patients about what to expect (the benefit package) and the general satisfaction of the respondents about the health services provided.

The waiting time simply describes the length of time it takes a sick person to see a health provider at the health facility. Results from the household survey as shown in table 1, indicate that 58.33% of the uninsured receive medical attention or treatment immediately at the health facilities whereas 50.00% of the insured receive attention immediately. Again, 27.08% of the uninsured indicate that they wait for less than 30 minutes to see a health provider whereas 42% of the insured wait for the same time to see a health provider.

Table 1: Waiting Time to see a Health Provider

Waiting Time	**Insured Households (Number/%)**	**Uninsured Households (Number/%)**	**Total (Number/%)**
Immediately	25 (50.00)	28 (58.33)	53 (54.08)
Less than 30 minutes	21 (42.00)	13 (27.08)	34 (34.70)
Between 30 minutes and 1 hour	3 (6.00)	6 (12.50)	9 (9.18)
More than 1	1 (2.00)	2 (4.08)	3 (3.03)
Total	**50 (100)**	**49 (100)**	**99 (100)**

Source: Authors'Fieldwork (2009)

These raw scores suggest that the uninsured are rather attended to more quickly than the insured as 58.33% of the former are immediately attended to at the health facility as compared to 50.00% of the latter. This finding is in contradiction to the WHO's requirement of a responsive health system. The WHO requires a responsive health system to treat all categories of patients equally without discrimination (WHO 2000). On the whole, about 88.78% of all patients are attended to immediately or in less than 30 minutes, which is quite reasonable. These findings are also consistent with other studies in Ghana (see for instance) Turkson (2009:67), who concluded that majority of

patients (83.4%) found the waiting time at health facilities in Komenda-Edina-Eguafo-Abrem (KEEA) District in the Central Region of Ghana to be reasonable.

Households were asked to rank the attitude of health providers towards patients using the following criteria: very good, good, bad and very bad. The detail results are presented in table 2 below.

Table 2: Attitude of Health Providers towards Patients

Attitude of Health Providers	**Insured Households (Number/%)**	**Uninsured Households (Number/%)**	**Total (Number/%)**
Very Good	39 (78.00)	29 (59.18)	68 (68.69)
Good	11 (22.00)	20 (40.82)	31 (31.31)
Bad	0 (0.00)	0 (0.00)	0 (0.00)
Very bad	0 (0.00)	0 (0.00)	0 (0.00)
Total	**50 (100)**	**49 (100)**	**99 (100)**

Source: Authors' Fieldwork (2009)

The results above show that about 69% of the respondents indicated the attitude of health providers towards patients is very good. Whilst 78% of insured household rank the attitude of health providers as very good, 59.18% of uninsured household ranked health providers attitude as very good. Incidentally, neither the insured nor the uninsured ranked the attitude of health providers as bad or very bad. An attempt is made to suggest the possible reason for this state of affairs later in the discussion.

Again, here households were asked to rank their general satisfaction about the services they receive at the health facilities based on the following criteria: very satisfied, somewhat satisfied and not satisfied. The results are displayed in table 3 below.

Table 3: General satisfaction with services provided by the health providers

General Satisfaction	**Insured Households (Number/%)**	**Uninsured Households (Number/%)**	**Total (Number/%)**
Very Satisfied	44 (88.00)	42 (85.71)	86 (86.87)
Somewhat Satisfied	6 (12.00)	7 (14.29)	13 (13.13)
Not Satisfied	0 (0.00)	0 (0.00)	0 (0.00)
Total	**50 (100)**	**49 (100)**	**99 (100)**

Authors' Fieldwork (2009)

Table 3 above shows that 88.00% of the insured indicated that they were very satisfied while 85.71% of the uninsured said they were very satisfied with the services they receive at the health facilities. Only 12.00% of the insured indicated that they were somewhat satisfied with 14.29% of the uninsured being somewhat satisfied. Here again, neither the insured nor uninsured indicated that they were not satisfied with services provided at the health facility.

The results shown in tables 1, 2 &3 do not show any remarkable differences in the quality of health care received by either insured or uninsured. Based on this, the perceptions of the insured and uninsured about the quality of health care was re-coded using two of the variables attitude of health providers and general satisfaction into two categories; very good, good and very satisfied and somewhat satisfied respectively as shown in table 4 below.

Table 4: Perceptions of the Insured and Uninsured about the Quality of health Care

Quality of Health Care	**Insurance Status**			
	Insured		**Uninsured**	
Attitude of Health Personnel	Very Good (78.00%)	Good (22.00%)	Very Good (59.18%)	Good (40.82%)
General Satisfaction	Very Satisfied (88.00%)	Somewhat Satisfied (12.00%)	Very Satisfied (85.71%)	Somewhat Satisfied (14.29%)

Authors' Fieldwork (2009)

Recoding the data as shown in table 4 above still did not indicate any large differences in the perceived quality of health care received by the insured and uninsured hence we cannot draw any informed conclusions based on these raw scores. With the view to allow informed conclusions, we performed quantitative statistical analysis using the Mann-Whitney U-test/Wilcoxon rank test to test the hypothesis:

> H_0: *there is no difference is the quality of health care received by the insured and uninsured.*
>
> H_1: *the insured received better quality health care than the uninsured.*

The results of the Mann-Whitney/Wilcoxon rank sum test are displayed in appendix I. The results show a Sig. (2-tailed) P-value of (0.365). Since this P-value (0.365) is greater than 0.025 (0.365>0.025), the alternative or research hypothesis that assumed that the insured receive better quality health care than the uninsured is rejected in favour of the null hypothesis. These results show that there is no statistically significant difference in the quality of health care received by either the

insured or the uninsured. It can therefore, be concluded based on our sample population that there is no difference in the quality of health care received by the insured and uninsured at the health facilities.

5. Evaluating FGDs Results

Knowledge about what to expect or the MHIS benefit package was only directed at the insured. When asked if they were aware of the drugs and services covered by the MHIS during the FGDs, majority (80%) of insured households indicated that they had no knowledge of the drugs and services covered by the MHIS. Due to the fact that most of the insured do not know the drugs and services that are covered by the MHIS, they are often given prescriptions to buy drugs out of their own pockets because the prescribed drugs are not covered by the MHIS, which they as citizens cannot challenge the health providers. This coupled with the high illiterate population makes it difficult for patients to demand their rights at the health facilities. This has the tendency of negatively affecting patients overall access to affordable health care service since perceived 'good' quality health is positively correlated with patients overall of health facilities. This certainly will not allow the patients to flourish as Friedmann (1992) suggests.

Similarly, results from the FGDs seem to suggest that the uninsured are rather attended to promptly at the health facility, better respected and are generally given quality drugs than the insured. The following quote during one of the FGDs with the insured attests to this assessment:

> *"The MHIS is very good but one thing that we (insured) encounter is that when you have the insurance card and you go to the hospital, you do not receive quick services. The health providers rather treat the uninsured before they attend to us the insured. The health providers get 'something' from the uninsured. With the insured, they know they cannot get anything from you so they will not have that time for you. When you go to the hospital and you don't control your anger, you will surely come home with your sickness untreated. They will shout on you in a way that your own father has never done. They don't regard us the insured at all. ---- Yes, sometime I was sick and went to the hospital. We were in a queue waiting. As we waited the uninsured people just came and they were given immediate consultation, prescription and drugs and we were still sitting. This is because they are going to pay cash. So this is one thing that is bringing back the success of the MHIS".* (Field Interview, 2009)

Furthermore, the FGDs also suggest that some health providers (nurses) intentionally inflate the prices of certain drugs for the uninsured for their own advantage hence tend to give immediate attention to the uninsured. It is also reported that the insured are usually given drugs that cannot even cure headache while the uninsured rather get better drugs. For instance, it was reported during one of the FGDs with the insured that: *"now that we are health insured, paracetamol is our only medicine".*

These findings are in direct contradiction to the findings from the quantitative analysis above because the FGDs show clear differences in the quality of health care received by the insured and uninsured.

6. Towards some provisional conclusions on health care in Ghana

Analysing the empirical findings from the household surveys and the FGDs show interesting patterns. Based on the household survey, the general picture about the quality of health care in the study area could be described as very good from the perspective of both the insured and uninsured. This is because majority (88.78%) of both (insured and uninsured) patients are immediately attended or are attended to within 30 minutes, (68.69%) see the attitude of health providers to be very good and (86.87%) and are generally very satisfied with the services they receive from the health facilities. However, while the quantitative data analyses did not show any differences in the quality of health care received by either the insured or uninsured from the hypothesis testing, the FGDs clearly demonstrate that the uninsured rather surprisingly received better quality health care than the insured. The FGDs show that the uninsured are promptly attended to, are better respected because they have to pay cash for the services, and are generally given quality drugs as compared to the insured that are often given Paracetamol, a common painkiller that can easily be bought over the counter. The FGDs further indicate that majority of insured patients do not have any knowledge about the drugs and services covered by the MHIS, thus cannot demand for their rights at the health facilities and that some nurses intentionally inflate the prices of certain drugs for the uninsured for their own advantage.

These findings are very interesting for two reasons. Firstly, it appears that in assessing the quality of health care, qualitative methods might be better than quantitative methods since the qualitative methods allow the respondents to express their views freely thereby eliciting responses that quantitative methods may not. And secondly, the cultural setting of the respondents also seems to play a role. For instance, in the study area, even when someone is very sick and the person is asked; 'how is your health' the person will say 'I am fine'. The person will never say that 'I am not fine'. Thus, it is likely that because the questionnaire asked directly about the attitude of health providers and satisfaction about the health services provided, both the insured and uninsured decided to say they were satisfied reflecting the cultural values [17]of the study area. The findings further validate our choice of research strategy; mixed methods as both play very important complementary role in the current research.

7. Some health care policy implications

The research findings indicate that there is no statistically significant difference in the quality of health care received by the insured and uninsured despite the fact that the FGDs point strongly to the fact that the uninsured are rather more satisfied with the quality of the services they receive. The reconciliation between the household surveys and the FGDs can only be done with further research. However, the findings provide a fertile ground for policy-makers to probe into some of the very important issues that have been raised:

- **Inflation of the prices of drugs**

It is asserted by FGDs that some nurses inflate the prices of certain drugs for the uninsured for their own benefit. This issue needs to be further investigated by health authorities because these people are probably not insured due to poverty as they cannot afford the annual insurance premiums. Thus extorting monies illegally from them again could worsen their poverty situation thus denying the poor the right to basic health care services. As Friedmann (1992) indicates, the essence of life is not just to live but also to *flourish*, and for each human being to have the possibility of living up to her

[17] Cultural values in this context refers to the societal norms and ethics that govern behaviour.

or his capacity. Indeed, it will be difficult if not impossible for the poor to live up to their capacities if they are wilfully excluded from basic needs such as the right to health care.

- **Knowledge of benefit package**

The majority of insured clients do not know the drugs and services they are entitled to. Hence management of the MHIS would need to educate clients properly on the drugs and services they are entitled to. This corrective action will empower citizens to demand their rights and also hold health providers accountable when their entitlements are not met. It is only when this corrective action is taken that Friedmann (1992) idea of *citizen rights* will have meaning as he underscores the importance of citizens' relative autonomy *vis-à-vis* the democratic state, where the holders of authority are ultimately accountable to the people organised as a political community.

- **Accord all citizen the same courtesies**

Finally, there is the need for policy makers to critically intervene with regards the way health providers discriminate in the treatment they give to patients. Based on the theoretical framework, Freire (1970:34), suggests that the mere perception of a questionable social reality does not automatically translate into changed circumstances. On the contrary, direct action must consciously be taken to transform, that is, fundamentally change a particular reality. Thus, treating the insured with contempt as raised in the FGDs will scare them from any future use of the health facilities with potentially catastrophic effects on the overall health of the citizens.

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Appendix I: Results of the Mann-Whitney Test (Perceptions about Quality of health care and Insurance Status)

Mann-Whitney Test

Ranks

	Insurance Status	N	Mean Rank	Sum of Ranks
Quality	insured	50	47.76	2388.00
	uninsured	49	52.29	2562.00
	Total	99		

Test Statistics[a]

	Quality
Mann-Whitney U	1113.000
Wilcoxon W	2388.000
Z	-.906
Asymp. Sig. (2-tailed)	.365

a. Grouping Variable: Insurance Status