INTERDEPENDENCE AMONG UNITS; CASE STUDY OF GHANA HEALTH INSURANCE SYSTEM

A THESIS SUBMITTED TO
THE INSTITUTE OF SOCIAL SCIENCES
OF
YILDIRIM BEYAZIT UNIVERSITY

BY

EMMA KAMASSAH

IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS
FOR
THE DEGREE OF MASTER OF SCIENCE
IN
THE DEPARTMENT OF MANAGEMENT AND ORGANIZATIONS

APRIL, 2017.

APPROVAL

Approval of the Institute of Social Sciences

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(Assoc. Prof. Dr. Seyfullah YILDIRIM)

Chairman of the Institute of Social Sciences

I certify that this thesis satisfies all the requirements as a thesis of the degree of Master of Science Management and Organizations.

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(Prof. Dr. Tuncer ASUNAKUTLU)
Head of Department

This is to certify that I have read this thesis and that in my opinion it is fully adequate, in scope and quality, as a thesis for a degree of Master of Science Management and Organizations.

_____

(Prof. Dr. Ayşe Elif ŞENGÜN)

Supervisor

Examining Committee Members

Prof. Dr. Ayşe Elif ŞENGÜN (YBU, Management and Organization) _____

Asst. Prof. Dr. Mehmet CAKAR (Baskent University, Management) _____

Asst. Prof. Dr. Murat ULUBAY (YBU, Management and Organization) _____

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ABSTRACT

INTERDEPENDENCE AMONG UNITS; CASE STUDY OF GHANA HEALTH INSURANCE SYSTEM

Emma Kamassah

MSc, Department of Management

Supervisor: Prof. Dr. Ayse Elif ŞENGÜN

April 2017, 111 pages

The study of interdependence help owners of businesses understand how the various sectors, departments or units within their organizations depend on the productivity or performance of others. Some researchers have posited that interdependence and subsequent interaction among individuals and groups are the basis for organization, (Grant,1996). Understanding interdependence also influences the design structure of the organization. It encourages interaction across enterprises, minimizes hierarchical differentiation, and engages organizational tensions.

Thus, organizations require the flow of information and coordination of effort to be effective because inappropriate interdependence can disrupt these basic processes, interfere with productivity, and impact the bottom line, (Alder, 1995).

Effective organizational interdependence is also a salient component of an organization's long-term success, as it is a central component of effective work relationships Van de Ven (1980). This study examines the extent to which one organization’s interdependence on another organization mediates the relationship between them and drives effective coordination and governance of inter-organizational relationships.

ACKNOWLEDGMENT

Prima facie, I am grateful to God for the good health and wellbeing that were necessary to complete this thesis.

I would like to express my sincere gratitude to my supervisor, Prof. Dr. Ayse Elif ŞENGÜN for the continuous support of my MSc study and related research, for her patience, motivation, and immense knowledge. Her guidance helped me in all the time of research and writing of this thesis. I could not have imagined having a better advisor and mentor for my study.

I thank my course mates for the stimulating discussions, for the sleepless nights we were working together before deadlines, and for all the fun we had in the last three years. I am grateful to the examination committee members for enlightening me the first glance of research.

I take this opportunity to express gratitude to all the Department faculty members for their help and support. I also thank my family for the unceasing encouragement, support and attention. I am also grateful to my dependable husband Koranteng who supported me through this venture.

I also place on record, my sense of gratitude to one and all, who directly or indirectly, have lent their hand in this venture.

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LIST OF ABBREVIATIONS

GHIS Ghana Health Insurance Scheme

GHIA Ghana Health Insurance Authority

NHIS National Health Insurance Scheme

CPA Consolidated Premium Account

ID Identification Card

VOI Value on Investments

ROI Return on Investments

MDAs Ministries, Departments and Agencies

MHIS Mutual Health Insurance Scheme

VAT Value Added Tax

SSA Sub- Sahara Africa

SSNIT Social Security and National Insurance Trust

UAHCP Universal Access to HealthCare Program

CPC Claims Processing Centre

CPA Consolidated Premium Account

NHIC National Health Insurance Council

NHIF National Health Insurance Fund

GHS Ghana Health Service

FFS Fee for Service

G-DRG Ghana Diagnostic Related Groupings Method

NDC National Democratic Congress

NPP New Patriotic Party

NGO Non-Governmental Organisation

CBHIS Community-Based Health Insurance Schemes

DEFINITION OF OPERATIONAL TERMS

Interdependence: - A state where factors rely on or react with each other. It's a theory that involves task driven interactions and relationships of an organization.

Sequential Interdependence: - Individual work activities output is directly connected in a linear fashion and each work unit add value incrementally to the overall work in a serial manner. (Van de Ven et al., 1976) also known as dependent interdependence.

Pooled Interdependence: -also known as independently Interdependence, it encompasses task exchanges in which parts contribute independently to the whole and there is no workflow between them. (Van de Ven et al., 1976)

Interdependence Activities: - interaction among groups/units; optimal information flow and the extent of collaboration, cooperation, or structural relationship among groups. (Van de Ven et al., 1976)

Reciprocal Interdependence: - encompass task in which input, conversion, and output activities are inseparable. Also, known as intense Interdependence. (Thompson 1967)

Interdependence Policy: - established task exchanges between different work units in and among organizations.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.0 INTRODUCTION

This chapter provides an overview of the study. It comprises of the importance of the study; a short statement of the problem and the significance of the study. It concludes with the goals and objectives of the study.

THE IMPORTANCE OF UNDERSTANDING INTERDEPENDENCE FOR SUCCESSFUL COORDINATION AND GOVERNANCE

The study of interdependence offers business owners much insight on how the various departments or units within their organizations rely on each other's performance. Some researchers have recommended that interdependence and subsequent relations among individuals and groups are the basis for organization (Grant,1996). Understanding interdependence also influences the design structure of the organization. It encourages the interaction across the enterprise, minimizes hierarchical differentiation, and engages organizational tensions.

As a result, organizations need effective movement of information and coordination of effort because inappropriate interdependence can interrupt these basic processes, obstruct productivity, and influence the bottom line (Alder, 1995).

According to, Van de Ven (1980), effective organizational interdependence is also a significant component of an organization's lasting achievement, as it facilitates actual work relations. This study investigates the scope to which one organization's interdependence on another organization intermediates the rapport among them and drives effective coordination and governance of inter-organizational relationships.

1.3 STATEMENT OF THE PROBLEM

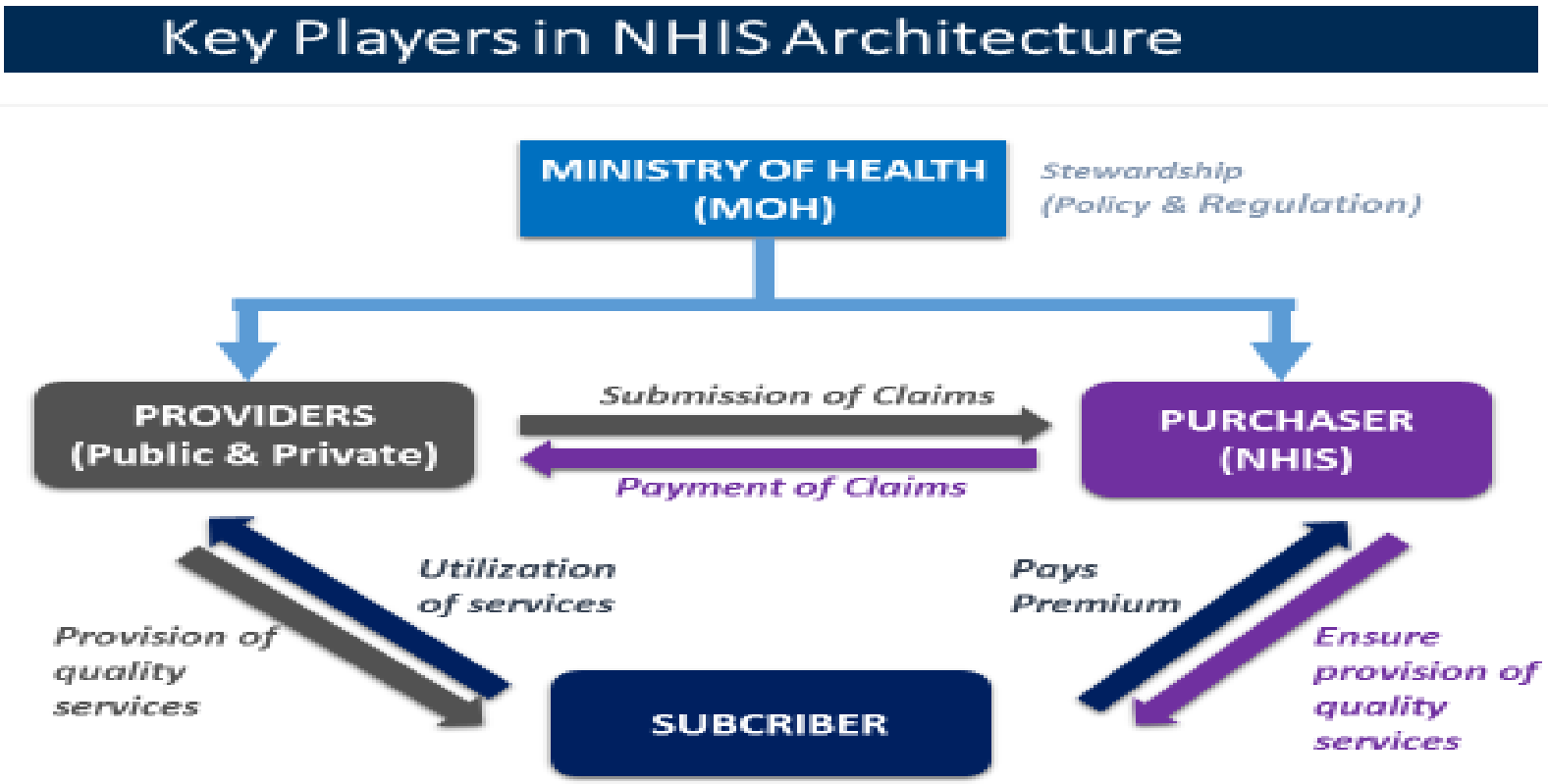
The National Health Insurance Authority (NHIA) was established to govern the operations of the National Health Insurance Schemes (NHIS) and it serves as the National Head Office of the scheme. The basic objective of the Authority is to secure the implementation of a national health insurance policy that ensures access to basic health care services to all residents in Ghana. Its responsibilities included registration, licensing, regulation and supervision of the operations of all types of health insurance schemes. It was also responsible for granting accreditation to health care or service providers, monitoring their performance, and ensuring that health care services rendered to beneficiaries are of good quality. (Agyepong and Adjei, 2008).

Although the National Health Insurance Authority (NHIA) does not directly deal with the service providers, its functions as a coordinator, reinforce the need to understand interdependence relationship among the regional schemes and the service providers. These parts should discuss the importance of understanding interdependence for effective coordination and governance for the Ghana National Health Insurance Scheme.

1.4 SIGNIFICANCE OF THE STUDY

1.4.1 Deductions from literature

Statement of current occurrences speaks of the importance of effective organizational interdependence or the lack of it in the health provision framework in Ghana. Evidence of untimely payment of claims submitted by the scheme to health providers and allegations of over-bloating of financial claims submitted for payments has created lots of tension and mistrust between the scheme and service providers.



Source: National Health Insurance Authority - GHANA, 2013

Myjoyonline, the online extension of Joynews, a creditable media outlet in an expose presented threats by the Society of Medical and Dental Practitioners, Ghana Health Service, Christian Health Association of Ghana and the Ghana Registered Midwives Association to charge cardholders unless cries over debts were settled in the shortest possible time (Myjoyonline.gh, March 2015)

The Daily Graphic (Saturday, April 18, 2015) reported that the Clerk of the General Assembly of the Presbyterian Church of Ghana lamented on the indebtedness of the National Health Insurance Scheme (NHIS) to health institutions making health delivery very difficult.

The Daily Graphic (22nd April 2015) featured a news item in which the President of the Pharmaceutical Society of Ghana made demands for payment of claims over a period of 8 months. A Joy News interview (23rd April 2015) also showcased the same story but with an allegation of the death of a member of the Pharmaceutical Society of Ghana as a result of depression from remittances for health services provided. Such a claim, albeit wanton of verification portrays the extent of tension and mistrust between the scheme and service providers.

Inaccuracies in submission of claims by health providers fall in the category of human errors and fraudulent attempts at duping the state. Instances include calls by the Claims manager of the Nkoranza Municipal Scheme to avoid errors while preparing claim forms to reduce errors (Ghanaweb.com, August 2014) and a claim of the loss of 18 million Ghana Cedis over a period of two years, backtracking from November 2014. (programs.jointlearningnetwork.org, 2014).

These series of reports from the media speaks volume of the dire consequences when interdependence among various units under the scheme are not well coordinated or ineffectively managed. A write up of this nature is very important in aiding to provide suggestions for the way forward in assuring effectiveness of the relationship among the health provision and funding network. Data collection will be geared towards assessing effective interdependence between the entities.

From the above background a study into interdependence among the Ghana Health Insurance Scheme and its service providers could be a significant step in creating awareness on the subject amongst the schemes and the service providers in the country. The study may highlight problems confronting the effective coordination among these organisations. It is also anticipated that the study may reveal what these organisations may be lacking in terms of unmet needs, and can come out with suggestions for them to meet those needs. The study will further aid in formulating future policies concerning the health insurance scheme and its service providers. The study outcomes will therefore be disseminated to the Ghana Health Insurance Schemes and the various service providers in the form of presentations, seminars, workshops and in a peer, reviewed journal, such as the Ghana Health Services Digest. This may enhance the growth of the health sector in Ghana. The study is also important as it may influence health policies within the public and private sector of Ghana.

1.4.2 AIMS AND OBJECTIVES

The main purpose of this study is to investigate interdependence among the Ghana Health Insurance Scheme and the various service providers and to determine the level of

interdependence among them. The aim of the study can be achieved by considering the following points;

- To discover how the constituents of the Ghana Health Insurance Scheme are interrelated,
- To understand the interdependence among service providers.
- To find out the form of relationship suggested as per the type of interdependence among different service providers,
- To identify the types of coordination and governance needed among service providers
- To recommend to these organisations the appropriate forms of governance.
- To assist in achieving the aims and objectives of the study, an extensive literature search is required and this will be provided in Chapter Two.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION - HISTORICAL BACKGROUND

This section provides a general conceptual summary on hıstorıcal background about the Ghana National Health Insurance scheme, its service providers and the literature on organizational interdependence as an organizational construct applicable to the scheme and its providers.

The details include a summary of economic factors along with a historical perspective leading to the setting up of the scheme. Next is a summary of its organizational structure, various stake holders and its funding mechanism. As the major partner of the scheme, health service providers also necessitate an outlook with an explication of the pre-paid mechanism for services rendered to active and registered members who are also known as cardholders. Interdependence, as organizational concept is defined with an analysis of synonyms applied symmetrically as delimitation to discussions. Finally, deductions are made from literature as a summary to the section and again to summarize the attempt at presenting a better comprehension of the theoretical framework surrounding the objectives of the research.

2.1 GHANA HEALTH INSURANCE SCHEME; A HISTORICAL SURVEY

The health insurance is a social mediation that was meant to substitute the “cash and carry system” of health care funding and to make accessibility easier to basic quality health care through the setting up of district-wide insurance schemes in Ghana (International Labour Organization, 2005).

Per Act 650 (2003) of the nationwide health insurance law, the National Health Insurance Authority (NHIA) is mandated to institute the following schemes: District Mutual Health Insurance Scheme, Private Commercial Health Insurance Schemes, and Private Mutual Health Insurance Scheme. Currently, there are 145 district-wide health insurance schemes operating in Ghana of which Brong-Ahafo region has 19 administrative centres of NHIS.

"Per Act 650 (2003), the National Health Insurance Authority (NHIA) has a role of registering, licensing, and regulating health insurance schemes and to endorse and supervise health care facilities working under the schemes. It has a primary function of controlling implementation struggles and managing of the national health insurance finance". (Tenkorang, 2015).

"To organize finances to help enactment of the district and municipal mutual health insurance schemes, the government of Ghana introduced a health Levy of 2.5 percent on particular goods and services manufactured and provided in or imported to Ghana. Moreover, 2.5 percent of the 17.5 percent Social Security Natıonal Insurance Trust (known as SSNIT) payments by formal sector workforces are routinely directed to fund the NHIS. In view of that, formal sector personnel, their families, and SSNIT pensioners are habitually registered in their district scheme and are excused from premiums." (Arpoh-Baah, 2011). Additionally, grants and any other voluntary contribution are made to the Fund (Act 650, 2003).

Ongoing historical debate suggests that challenges within the health sector, with reference to funding of health care cumbered with a concern on Value on Investments (VOI) and Return on Investments (ROI) confronted certain health care facilities, mostly mission hospitals to set up Mutual Health Insurance Schemes (MHIS).

The first of its sort was the Nkoranza scheme started by the Catholic Diocese of Sunyani in 1989 (Owusu, 2010). Later schemes such as the Damongo and Dangme West MHIS were the models for other communities to emulate.

Subsequently, national interest led to the introduction of a National Health Insurance Scheme (NHIS) in 2003 which aimed at addressing limitations in MHIS such as low coverage ın relatıon to population; meaning only members of the community in question where privileged to be covered under this system, it was a district or community managed. It also sought to promote the positive effect of user fees and vital role of public funding in the accomplishment of universal care and curtail concerns arising from VOI and ROI.

The NHIS currently mandates a benefit set that will be used to cover nearly 95% of the disease affliction in Ghana (Uhcc.org.gh, 2013).

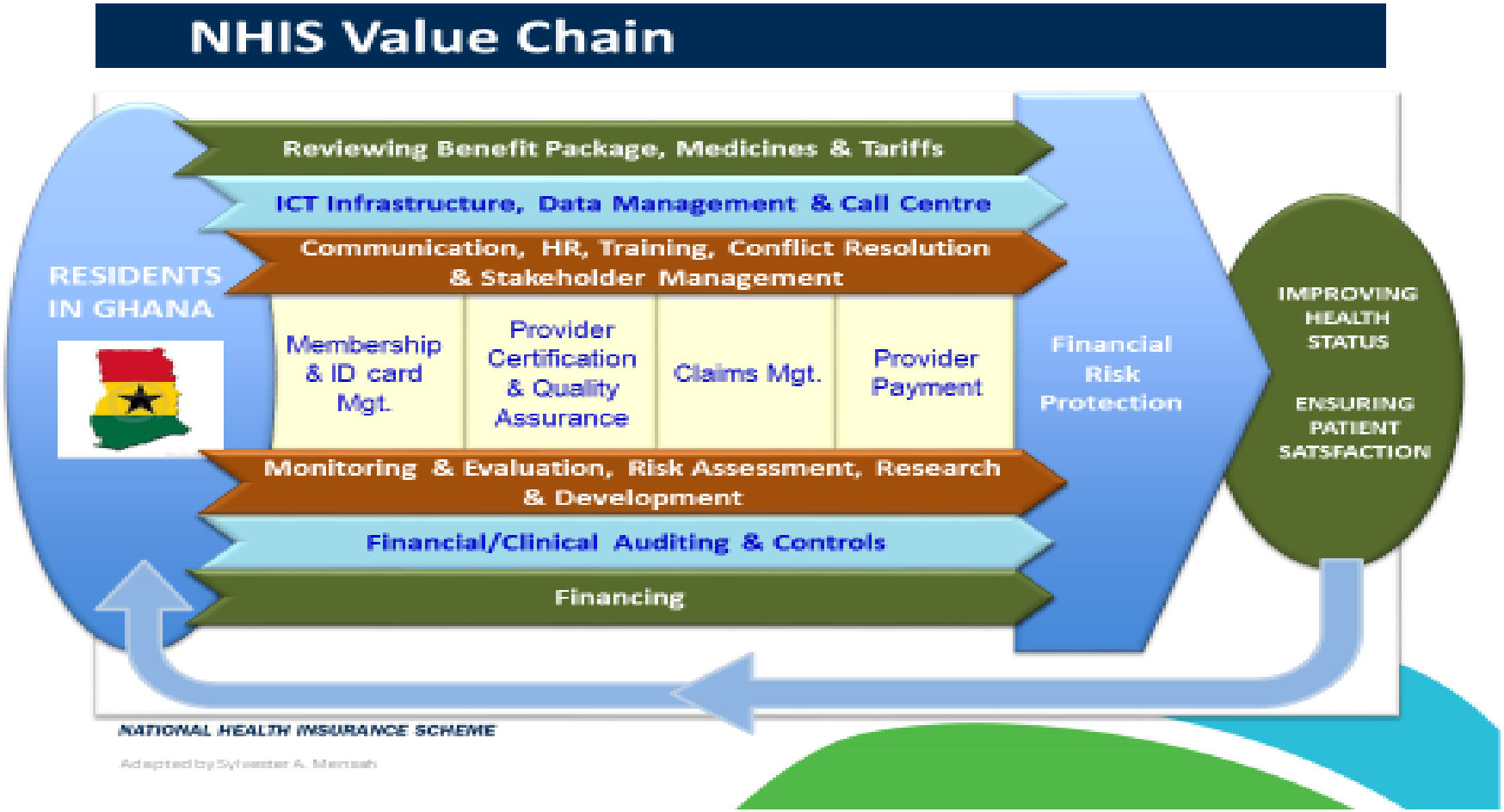
To finance the scheme, specific areas were earmarked; a health insurance tax consisting of a 2.5% addition to Value Added Tax (VAT), monthly pension payments of formal sector workers to the Social Security and National Insurance Trust SSNIT (2.5%), premium payments or contributions from informal sector grownups, money assigned to the fund by Parliament and from savings, grants, aids, gifts and other voluntary donations.

A research project on the evaluation of the scheme over a decade undertaken by the Universal Access to HealthCare Program (UAHCP) in 2013 outlined the following achievements of the scheme:

- Instituting of 145 self-directed schemes in 2003 and further growth as new districts were formed.
- Introduction of 145 autonomous schemes in 2008 with plans for more expansion as other Districts were formed.
- Creation of a Claims Processing Centre (CPC) in 2010.
- Execution of a Clinical Audit in 2010

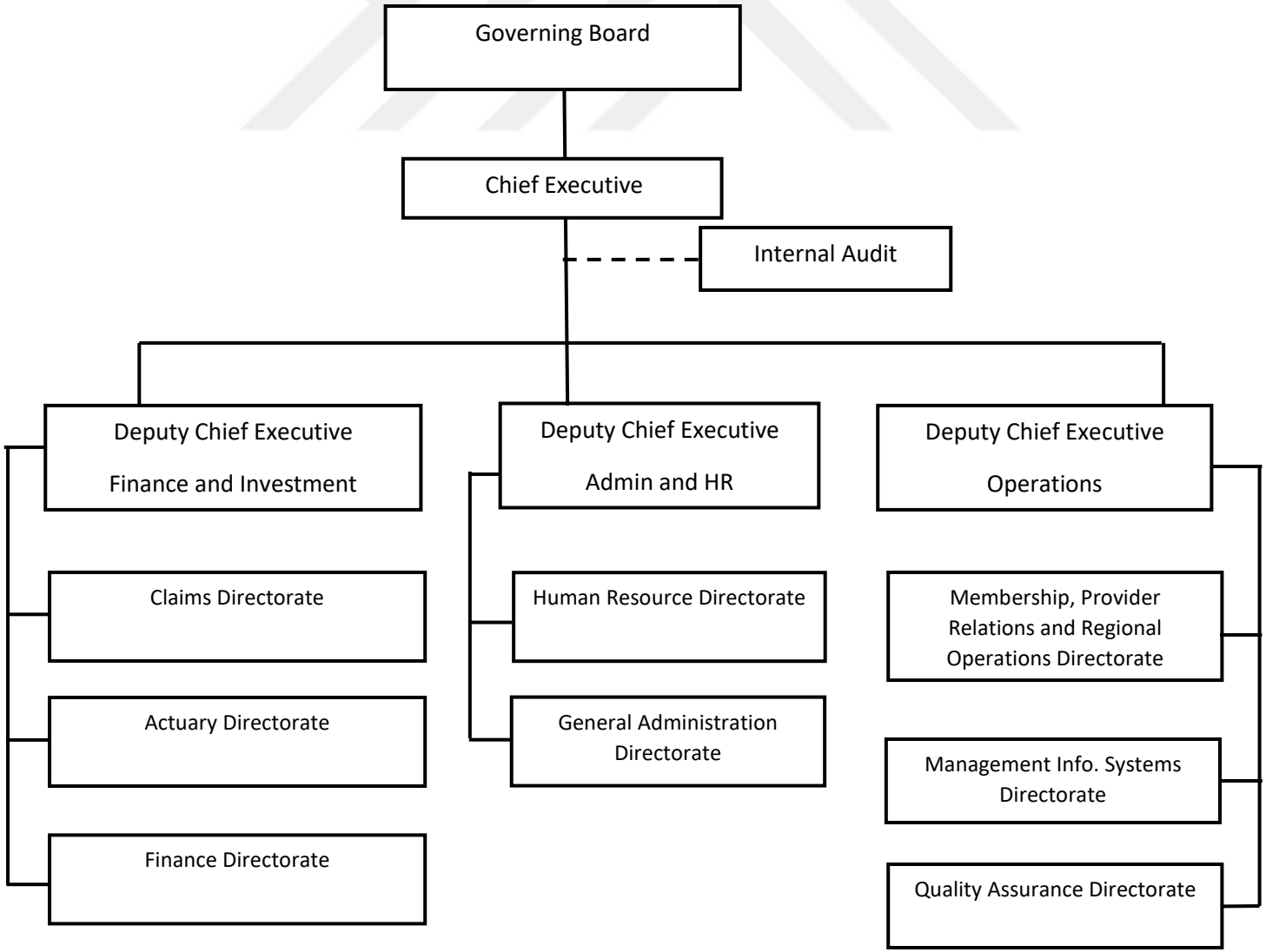
- Institution of the Consolidated Premium Account (CPA) in 2011
- Creation of the NHIS Call Centre in 2012 with current working hours from 6 am to 12 midnights, Mondays to Sundays with trained personnel in English, Akan, Ewe, Dagbani and Hausa
- The issuing of immediate ID cards through an experimental biometric enrollment program. Biometric registration of ID cards is currently a part procedure for all new users and previous users with expired non-biometric ID cards.
- The National Health Insurance Authority (NHIA) is situated in Accra. They have provincial offices deliberated as an extension of the operational division of NHIA and are to supervise and estimate the performance of the administrative centers of NHIS in each region. Brong Ahafo region has nineteen (19) administrative centers of NHIS to monitor and evaluate, and report on performance of each scheme to the head office in Accra.

The most notable international achievement to date across history is the UN award for Excellence and Award in 2010. This award arguably confirms the potentials of Ghana's leadership through the organizational hierarchy of the scheme in coordination with its service providers.


NHIS Value Chain
Reviewing Benefit Package, Medicines & Tariffs
ICT Infrastructure, Data Management & Call Centre
Communication, HR, Training, Conflict Resolution & Stakeholder Management
RESIDENTS IN GHANA
Membership & ID card Mgt.
Provider Certification & Quality Assurance
Claims Mgt.
Provider Payment
Financial Risk Protection
IMPROVING HEALTH STATUS
ENSURING PATIENT SATSFACTION
Monitoring & Evaluation, Risk Assessment, Research & Development
Financial/Clinical Auditing & Controls
Financing
NATIONAL HEALTH INSURANCE SCHEME
Adapted by Sylvester A. Mensah

2.2 ORGANIZATIONAL STRUCTURE

ORGANIZATIONAL STRUCTURE OF GHANA NATIONAL HEALTH INSURANCE SCHEME



-Diagram 2.1- source- Author

The NHIS is controlled by the National Health Insurance Council (NHIC), with its headquarters in Accra. Regional and District offices of the NHIC are being established to devolve the processes of the Scheme. The Council regulates the National Health Insurance Fund (NHIF) through the collection, investment, disbursement, and administration of the Scheme. The role of the Council is also to license, regulate, and accredit the healthcare providers. At the District level, there are Health Insurance Assemblies which consist of all members of the District Schemes in noble positions. District Schemes are administered by Boards of Trustees, Scheme Managers, and District Health Insurance Committees. The managing teams at several Districts commonly consist of an Administrator, Accountant, Publicity and Marketing Manager, Claims Managers, Accountant, Data Control Manager, and Data Entry Clerk" (Arpoh-Baah, 2011).

2.3 STAKE - HOLDERS

Government; through the National Health Insurance Scheme, prepares ethics and rules, while guarding the rights and implementing the commitments of all other investors. Employees come in the second position as the stake-holders by participating in the Formal Sector Social Health Insurance Programme. Their payments (5% of basic salary), made often prior to will assure them and their dependent relative high quality healthcare whenever they need it.

Employers; these are public or private sector businesses commissioning ten (10) or more people who will be obliged to contribute (i.e., 10% of an employee's basic salary). In the Formal Sector, Social Health Insurance Programme, employers are assured high quality health care for their workforces at low-cost rates and a consequential increase in production.

Moreover, employers with internal health facilities will operate them cheaply and earn income by listing them as Providers under the Scheme.

As 2007 ended, the NHIS had certified 800 private healthcare providers along with the government health facilities (Ghana Ministry of Health, 2008). It consists of major entities notable among them the Ghana Health Service (GHS), the Christian Health Association of Ghana, Society of private Medical and Dental Practitioners and the Ghana Registered Midwives Association which provide services varying from the diagnosis of diseases to the prescription of drugs relative to such diagnoses.

The Capitation method is a provider disbursement method which involves the NHIS paying the service providers; comprising healthcare faculties like clinics, lab centers, hospitals, pharmacies and maternity homes in advance at a pre-set fixed rate to deliver a distinct set of services for every individual registered with the provider for a fixed period of time (Amarteyfio &Yankah, 2012). Currently, the capitation method of payment is undergoing a trial project in the Ashanti Region with due prominence by clarifications from the President of the Republic (Dapatem, 2014) and with plans for extension to three other regions from April 2015 (Ghanaweb.com, 2015).

The working relationship between the NHIA and health service providers has been plagued by lots of tension over the years due to disagreements ranging from untimely payment of claims to allegations about inaccuracies of claims. This goes directly to negatively impede trust between these two bodies tasked to oversee the procurement and payment of health services in the country.

2.4 INSTITUTIONAL CHALLENGES FACING THE AUTHORITY

Communication:

Even though electronic means of communication (like telephone and fax) exist among schemes and the regional office, embarking on a physical inspection, sensitization and monitory tour is a challenge because of inadequate vehicles at the regional office of NHIA. Movement through the vase land scape and widely spread district scheme is a major problem for the regional authority.

The regional office of NHIA is faced with a problem of how to carry out a physical inspection tour of district schemes known as administrative centers of NHIS to obtain information about their operational challenges particularly in the entry of health claims unto the nationwide information and communication technology platform of NHIA. Lack of inspection and supervision at these administrative centers to ensure that there was limited number of backlog of claims has necessitated the regional authority to carry out this physical inspection tour of district schemes.

The monitoring and evaluation officers were tasked to embark upon an inspection tour of the administrative centers to check on this operational difficulty and report to the regional manager. They were required to maintain a desirable level of movement to minimize vehicular fuel consumption.

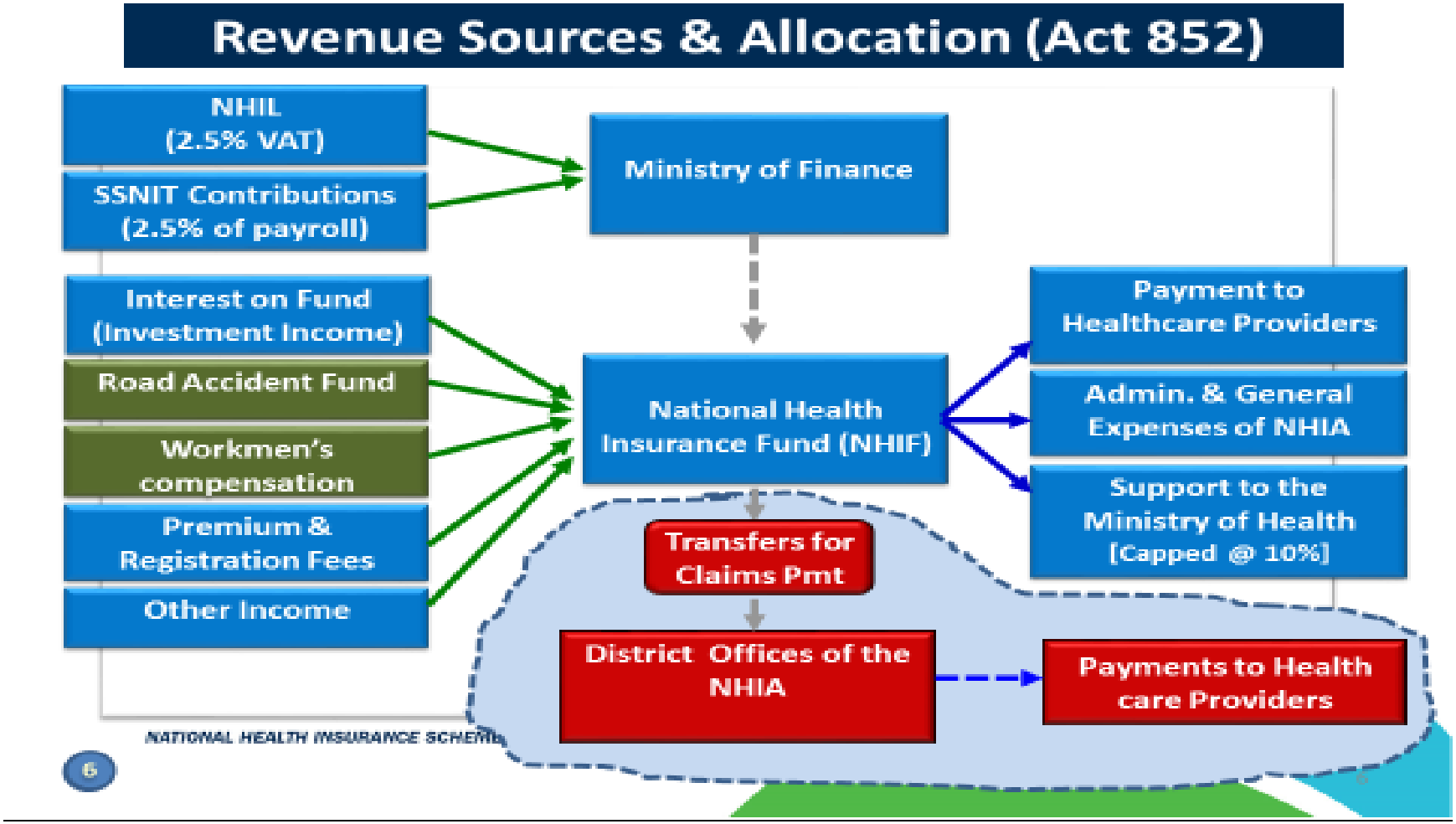
Claim Processing:

The timely inspection tour to district schemes will address concerns on backlog of claims and relatively increase the number of claims entered unto the nationwide information and communication technology platform of NHIA. When this is achieved, it becomes easy for the operations division of NHIA to quickly know the amount to be paid to each health service provider by the end of each month. This will ensure that NHIA pay genuine health claims to

health service providers and reduce fraud in payment of claims. Economically, the nation will save enough money to increase the quality of health delivery countrywide and minimize the rate of maternal and child mortality in the country.

Premiums:

As all insurance schemes, “various kinds of premiums are accessible under the country's NHIS. Ghanaian donors are gathered depending on their income levels. This implies that a Ghanaian contributor must pay a specific premium basing on the group that falls in. This was mainly because of the difference in the socio-economic status of the scheme contributors and the Ghanaian payments was to be reasonable for everyone to ensure that there is no one mandated to go on with the cash and carry system. This implied that Ghanaian payments varied from one district to the other because disease affliction was also uneven in all the districts” (Asafo-Adjei, Birago 2014). “As a way of ensuring that every citizen makes some payments to the scheme, a 2.5% Health Insurance Duty on specific products was enacted so that the taxes paid may possibly be used in the National Health Insurance Fund to sponsor completely paid contributions to the District Health Insurance Schemes.” (National Health Insurance Scheme Magazine: September 2012 – February 2013 Edition).



Source: National Health Insurance Authority - GHANA, 2013

Diseases covered under the scheme:

The state introduced a minimum benefit set of diseases included to be covered by each district-wide scheme for the citizens of Ghana; it would cover about 95% of diseases in Ghana which included among others malaria, diarrhoea, upper respiratory tract infection, skin diseases, hypertension, diabetes and asthma.

Nevertheless, all district-wide schemes were legalized to direct their schemes to pay for the various diseases and services for citizens of Ghana as they wish, as long as it was permitted by the National Health Insurance Council.

Exclusive diseases covered under the scheme:

Certain diseases such as Optical aids, hearing aids, Orthopedic aids, Dentures, Beautification Surgery, Supply of AIDS drugs, Treatment of Chronic renal failure, Heart and Brain surgery, etc. were however exempted from the benefit package because it was deliberated as very costly to cure. Therefore, alternatives had to be taken into consideration to allow Ghanaian citizens have these conditions cured. These forms only 5% of the diseases that have afflicted the citizens.

Scheme coverage controversies and low patronage:

Financial constraints, administration setbacks, bureaucratic procedures in using the system like completion of forms and a lot of paper works connected to using the system and coupled with the fact that members of the opposition National Democratic Congress (NDC), whose members appealed that the scheme was mainly meant for members of the then ruling New Patriotic Party (NPP) has led to a low coverage and patronage. From the time when the scheme was initiated in 2003, there have been lots of misunderstandings encompassing its task and purpose Thus, many members of NDC never enrolled with the scheme making coverage of all Ghanaian populace a little bias. Below is a table showing the percentage of

registered members and active members to the estimated population of Ghana which is not encouraging, as at 2009 the coverage was 48%.

Members of Ghana's NHIS and total percentages of the populace registered 2006–2009

Year	Estimated population of Ghana	Total registered members	Total active members	Percentage of population registered	Percentage of population active
2006	21,876,031	3,867,862	2,422,097	18	11
2007	22,387,911	8,184,294	6,674,270	37	30
2008	22,876,031	12,518,560	9,969,846	55	44
2009	23,416,518	14,511,777	11,132,981	62	48

Note: Reproduced from: National Health Insurance Authority - GHANA, 2013, p.3 Table 2.1

Figure 2.2 Map of administrative centers of NHIS in Ghana.

Source: National Health Insurance Authority - GHANA, 2013

2.5 THE EFFECT OF GHANA'S NATIONAL HEALTH INSURANCE SCHEME ON HEALTH CARE UTILISATION

In Ghana, health care funding initiated with a tax-funded system after independence that offered public health care services free of charge that was meant for all citizens. Later on in 1970 the system slowly became financially unmanageable with the prevailing economic stagnation. This was followed by low user fees which were created mainly for healthcare services to reduce any avoidable use. Further on in 1983, it was followed by the implementation of structural amendment changes in 1983, the Rawlings administration elevated and extended user fees for public hospital services and it was named “cash and carry.” This system enhanced operational proceeds for hospitals, though not planned well, inarticulately implemented, and was discovered to be having aggravated admittance to provide care services for the poor.

Ghana started to pursue alternative methods of funding health care in the early 1990s which included NGO-initiated community-based health insurance schemes (CBHIS). While prevalent amongst members and international donors during the period, the schemes were only directed to specific areas, did not solve primary community insurance concerns, and were not given any support by the governmental revenue to let them provide for the less fortunate. In the long run, the National Health Insurance Scheme (NHIS) was instituted under Act 650 of 2003 by the Government of Ghana to offer a wide variety of hospital services to its citizens via district mutual and private health insurance schemes.

- The main objective of Ghana's NHIS was to render affordable services and to promote the general use of drugs and health services by the less fortunate and most specifically the defenceless populaces. Some studies attempted to examine whether the NHIS attained this goal. Witter and Garshong (2009) noted that there was a sudden

improvement in the number of outpatient appointments per head in Ghana after 2005, when the NHIS operations commenced. Mensah et al. (2010) discovered that the registered expectant mothers in NHIS had higher possibilities of receiving prenatal care, giving birth in a healthcare facility and that there were experts surrounding them during birth. Related results were also discovered in the latest study pursuing health-related behavior in two districts afore and after NHIS rollout.

2.7 ORGANIZATIONAL INTERDEPENDENCE

This section provides a literature review of interdependence in organizational settings. A definition of the subject is considered in a broad term and then the types of organizational interdependence are looked at from the view-point of different researchers. The various coordination mechanisms of organizational interdependence are also considered. The chapter ends with various difficulties of interdependence that should be the focus of senior managers.

Definition

Interdependence is termed by the online psychology dictionary as: ´A state where factors rely on or react with each other. A change in one equals a change in the other´. In economics, it means dependent on others for some needs. This also applies to families, business sub units, organizations, towns and even countries.

As a theory first proposed by Thibaut and Kelley (1959), interdependence is unique among social-psychological theories in addressing questions about how interacting people influence each other's preferences, motives and actions (Reis & B, 2013). In short, "interdependence theory provides a quite comprehensive analysis of outstandingly difficult phenomena: interaction and relationships" (Rusbult & Lange, 2013).

The theory has been used in the study of a broad range of dyadic and intergroup phenomena including negotiating behavior, conflict resolution and the development of intergroup relations" (Bart & Blackburn, 1987). Weick (1979) proposed interdependence's application to the study of organizational processes. Clearly, in any corporation, without smooth intergroup relations or a high degree of intergroup interaction, organizational effectiveness and industrial competitiveness are virtually impossible (Steers & Black, 1994). According to Fisher et al. (1997) task interdependence reflects the interconnectedness of tasks and the extent to which managers' daily work depends on the information, resources and support provided by colleagues in other areas.

According to Steers & Black (1994) intergroup performance or effective interdependence for that matter is largely influenced by the frequency and quality of interaction among groups/units; optimal information flow and the extent of collaboration, cooperation, or structural relationship among groups.

In an organizational setting for example, Thompson (1967) identified three types of interdependence, "which is based on the arrays of work flow that occur between units, each signifying a diverse intensity or level of linkage between units", Bart (1987).

The first type of interdependence is known as pooled interdependence and according to Grandori (1997), "the concept was indistinct in classic organization theory, in that it was considered to be a relationship in which 'every part offers a separate contribution to the whole and each is reinforced by the whole', thereby representing the negligible basic way in which two or more activities/units are connected as they belong to the 'same organization". Every organizational department or unit executes totally separate task or functions. Although departments may not essentially openly interrelate and depend on each other in this type of interdependence model, everyone contribute their individual quota to the same overall task.

Thus, it builds an almost blind, subsidiary dependency on the performance of others hence the failures of one department could result in the failure of the whole process. That is activities are performed independently of one another, people don't rely on others before performing task. Example can be in a university each department works independently but each's effort is pulled by the whole. Thus, the science department functions independently from the business school or the law departments. They do not function or interact directly in any way. Also in a departmental sales shop, each cashier works individually from the other but contributes to the whole and a total collation of their sales becomes the output of the whole departmental sales shop. There are exchanges in which parts contribute independently to the whole and there is no workflow between them. As illustrated in Figure below.

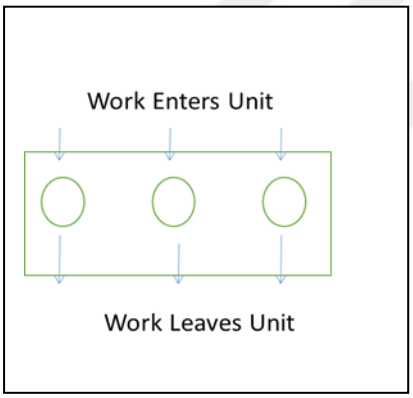


Figure 2.3

Sequential interdependence is the second type. And this exhibits a one-way traffic whereby every department's inputs are the outputs from another unit's inputs. "Sequential interdependence involves using one unit in the whole process to produce an output which is essential for the routine by the next unit. Individual work activities output is directly related in a linear fashion and every work unit adds value to the overall work in a sequential manner." (Van de Ven et al., 1976) Here every task in the set must be readjusted if others deviate from expectations, thus one sequence effect the other. Task here is performed in a

logical series. The action of the employee at the beginning of the production line determines how successfully the next employee can perform his task. The manufacturing process, mass production especially is an example, matchstick industry for instance depends on a sequence of processes to produce it final goods, thus the output of the selecting and polishing of splints units becomes the input for next department, and they in turn dips the splint into wax and chemical and dry it. Then it goes to the next department as input and they box them and sends them to packing department before it finally leaves the industry. Another example of this type of interdependence is an assembly line. As illustrated by Figure below.

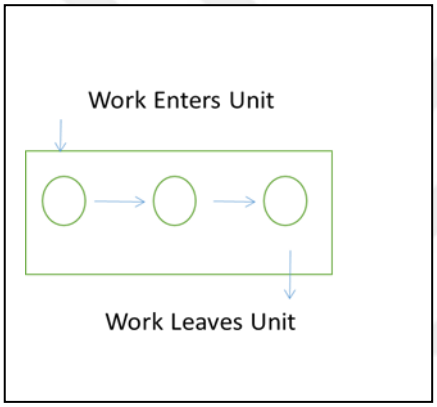


Figure 2.4

The third type of interdependence is known as reciprocal interdependence. “This type denotes a contingent pattern in the work flow where the inputs of every unit become its own outputs, reused through other units” (Victor, 1987). “Just like sequential interdependence, reciprocal interdependence involves the output of one department becoming the input of another, with the accumulation of being cyclical. In this model, an organization’s departments are at their utmost strength of interaction. Reciprocal models are complicated and hard to regulate because a change in one single unit can change the rules and impact everyone else. In this type of independence, “input, interactions, and work flows to and from between works unit for a period of time” (Van de Ven et al., 1976) before it finally leaves the unit or department

as output. Input of a single unit turn into output of the other and vice versa. Inputs, conversions and output activities are inseparable. (Thompson 1967) A typical example is the clerical staff in an organization, his or her activities are fully dependent on other collages and/or department, and others depends on her. Another example is a basket and rugby sports, the activities involved here are unpredictable, therefore the current state of play determines and informs the sequence of moves from one player to the next. The fast pace of actions here requires players to make judgements quickly and get feedback from it before taking the next step. One action effects the other and vice versa. As illustrated by fig 2.5

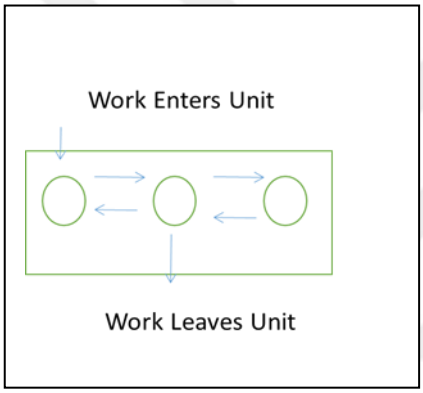


Figure 2.5

Apart from the three main types of interdependence noted by Thompson (1967) above, comprehensive interdependence was added by Wagner & Hollenbeck (2009). This type develops in a well knitted network. It is also the most complex form of interdependence because everyone involved is reciprocally interdependent with one another.

In whatever form, they come, interdependence, - presents organizational challenges in that the firm will still have to competently coordinate its activities to achieve meaningful results. “Thompson speculated that the right way to have the departments in an organization working together efficiently is to structure particular work tasks by strength of interdependence, and then control each of those interdependencies with various coordination methods. For example, a pooled interdependency needs standardization in rules and operating procedures,

while the coordination methods for the other two interdependencies (sequential and reciprocal) is greater than pooled. A sequential interdependency is controlled through mildly adaptive planning and scheduling, while reciprocally interdependent departments are controlled through persistent information sharing and mutual adjustments" (Hall and Tolbert 2009). According to the Proven Models technology typology, "The demand for direction to avoid stoppage and prevent slowdown in sequential interdependency is larger than pooled task interdependence." (James D. Thompsom 1967), Scheduling and planning your organization and resources in a sequential interdependence model is vital to the efficient operations. Grandori (1997) suggested communications, rules, procedures and common staff as the best approach to adopt in the case of a pooled interdependence. "If there are 'time specificities' and difficulties of balancing the flux so that the set of equipment are fully operated, cross-activity programming is an effective and efficient coordination device in the case of sequential interdependence" (see Grandori 1997, and her references there to Thompson 1967; Chandler 1990). In addition, other methods such as physically or administratively separating two groups/units that simply don't work together effectively (decoupling); setting up special task forces as well as special unit within the organization that is charged with overseeing and coordinating the activities of two or more groups can be used to forestall any challenges that may arise in the groups (Steers & Black, 1994).

Other renowned researchers also identified myriad but almost similar mechanisms to effectively manage interdependence which includes: "Mutual adjustment; direct supervision; normalization of work process, work output and worker skills; integrative departments; integrative departments with the primary activity that involves the incorporation of effort among functional departments; permanent and/or temporary cross-functional teams; dependence on direct management contact at all levels of the firm; incorporation through the

formal hierarchy; and integration via a "paper-based" system of information exchange" (Rockart & Short, 1988).

However, Grandori (1997) concludes that the analysis of the coordinated mechanisms governing knowledge-transfer, sharing and integration between and within firms that can be applied to link nodes of differentiated knowledge do not qualitatively differ according to whether the 'nodes', which may refer to firms, units or single actors, are internal to the same firm or not.

Steers & Black (1994) summarizes that the type of interdependence determines in large part the degree of interrelationship that develops among two or more groups. They noted that high interdependence typically requires high intergroup interaction, whereas low interdependence typically requires relatively low intergroup interaction. In other words, the quality of the outcome that accrues to each party in an interdependent relationship is dependent on what both parties bring to the table and the structure of the challenge they face.

The role of technology cannot be underestimated in how it facilitates interdependence of organizational units – it remains a fundamental part of it. According to Steers & Black (1994) information technology is said to be a major impact on the general organizational atmosphere and the working behavior of people. For instance, they indicated that technology influence the nature of social interaction- for example, the size and nature of work groups. Similarly, Rockart & Short (1988) in their analysis of literature on the subject posited that technology has four major classes of impact on organizations: Firstly, they identified that it changes the internal structure of the organization, with importance on change in roles, power and hierarchy. Steers & Black (1994) and Griffin (1999) agreed that, indeed, technology has a significant impact on the structure, design, the nature of workflow, reporting relationships among individuals and effectiveness of the organization.

Secondly, Rochart & Short "found the occurrence of team based, problem-focused, often changing work groups, reinforced by electronic communications, as the key organizational form." Rochart & Short (1988). Thirdly, they also found that organizations are "disintegrating" and at the same time staying connected to each other by the help of cheap and available technology. Lastly, they established that "upgraded communications ability and data availability will result in the system's integration within the business. This, in turn, will result in the immensely enhanced group communications and, more importantly, the incorporation of business processes across traditional function, product or geographic lines". Rockart, & Short, 1988)

To the senior manager who is in charge of managing interdependence, there are certain challenges as suggested by Rochart & Short (1988). For starters, not only is the manager supposed to deal with lines of authority and decision-making which are not clear, but the evolution of organizations is at a rate which is too rapid for them to adjust. Furthermore, the use of task oriented teams in work placed new demands on the managerial skills of senior staff to achieve organizational performance. Moreover, measuring performance and other methods of determining effectiveness/efficiency is a challenge for the individual and sub units in the organization. And while a new measurement approach needs to be devised, a certain lag time fallout where people need to adjust both to a new style of work and to a new measurement process.

Additionally, there is a changed planning process where "technology offers both the base for acquiring data to all appropriate decision makers and, also, provides the ability to spread changes in direction to all parts of the reliant organization impacted by every change".

Lastly, creating an effective information technology infrastructure is seen as an essential key to effective integration. However, justification for these systems is often difficult as their benefits cannot me rationalized.

Interdependence policy is established task exchanges between different work units in and among organizations. They are set of basic principles and associated guidelines, formulated and enforced by the organization, to direct and limit its actions in pursuit of it goals. It entailed mainly claims submitted by service providers to the schemes, acceptable and approved drug list, and services that are approved by the sachems to be rendered by service providers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This part of the study outlines how the research study would be conducted. The chapter will constitute the following headings; Study setting, Research design, Population and Target population, Sampling procedure and sample size, Data collection methods, Data management, and Data analysis and presentation and ethical considerations.

3.2 STUDY SETTING

The study was conducted in the Greater Accra region. The region with its capital Accra doubles as the capital of Ghana. Its location is about 225 kilometers from Kokrobite in the western direction to Ada in the eastern direction. On the administrative front, the region is divided into two complementary structures which are the traditional and political levels. The political administration derives its source from the 1992 constitution of the republic of Ghana and it's structured along the local government system (GSS, 2013). It is administratively divided into 10 districts. The greater Accra region places only second to the Ashanti region as the populous region of Ghana with a population of 4,010,054 with an area of 3,245 square kilometers (GSS, 2013). National Health insurance scheme District Mutual Health insurance scheme (DMHIS) operate in each district within the region. There are several services providers in the region. The region has been chosen for the conduct of this study because it serves as the national capital and emerges as the most cosmopolitan of all the other ten regions in Ghana. Thus the findings of this study will provide a clear overview of the level of interdependence among the DMHIS and the service providers. Fig 1 pictorially presents the region.

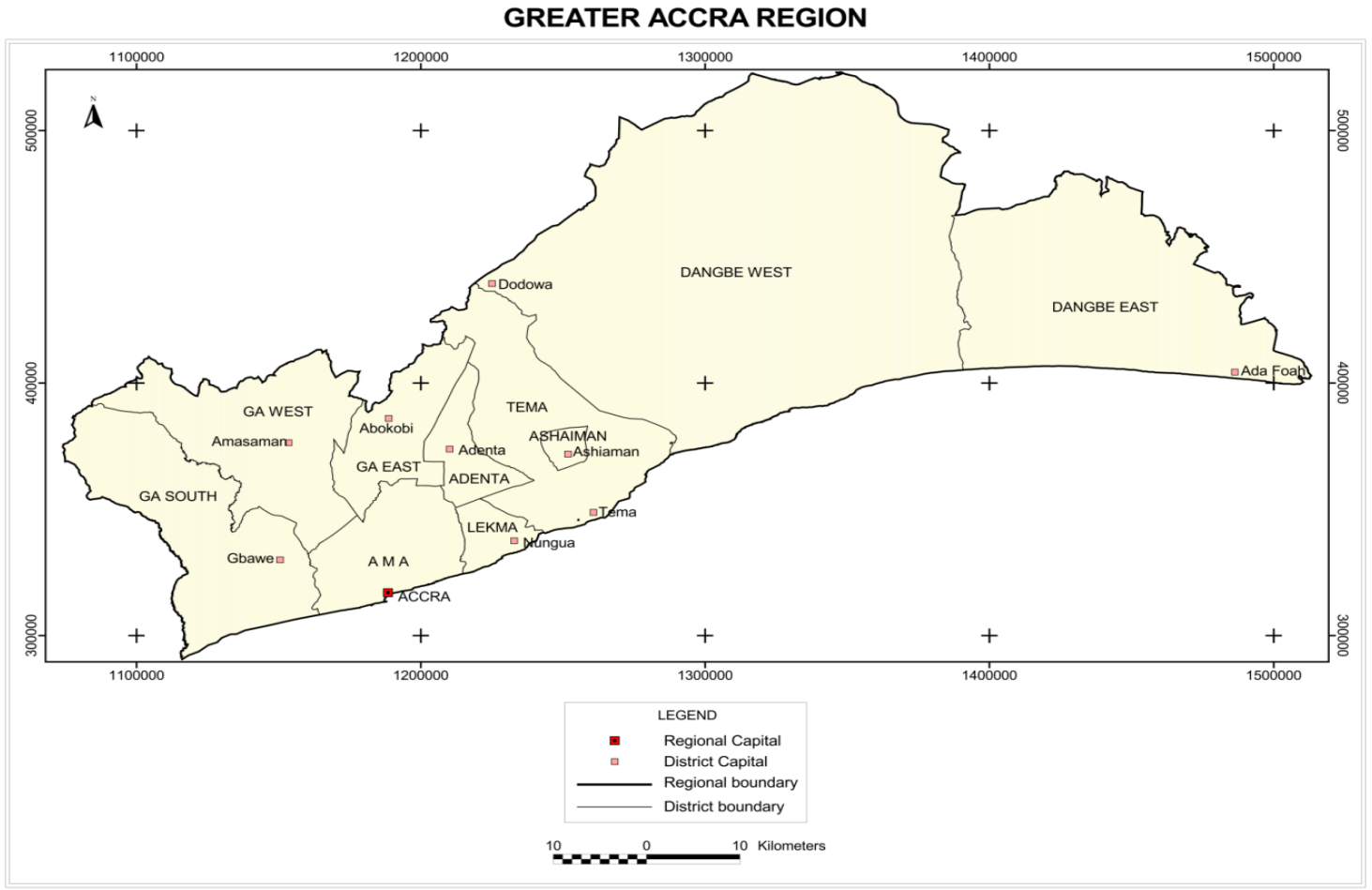


Fig 3.1: Regional Map of Greater Accra region

3.3 RESEARCH DESIGN

The study adopted the qualitative approach in its data collection, data analysis, and data presentation. The method involves philosophical assumptions that guide the direction of the collection and analysis of data. The study design will be case study since, Per Yin (2003) a case study design should be considered when: (a) the focus of the study is to answer "how" and "why" questions; (b) you cannot manipulate the behaviour of those involved in the study; (c) you want to cover contextual conditions because you believe they are relevant to the phenomenon under study; or (d) the boundaries are not clear between the phenomenon and context. The study was interested in examining the in-depth ways, processes of interdependence among the scheme operators and service providers. The multiple case study approach was adopted. This was premised on the fact that, several DMHIS and their services providers was enrolled in the study. Yin (1994) explains that case study design is most applicable and considered most appropriate method when studying a single unit as a case of multiples of cases. The design is best employed for a research study when the researcher is interested in a careful analysis and whole observation of a unit, in this case the DMHIS at one end and service providers at the other end. This study is designed focusing on the real-world problem of interdependence of firms. In this way, the concept of 'bricoleur" as used by (Charmaz, 2006) will, facilitate the identification of factors of interdependence from a constructivist analytical perspective to suit the conduct of this study. This will aid in exploring the limits of interconnectedness, nature, application and challenges and how the two units at different ends of health service provision construct meanings and shapes linkages (Clark, 2005; Ritchie & Lewis (2003). The assumption of this perspective is that "the contingency of several social realities, identifies the common conception of knowledge by the viewer and viewed, and aims toward an explanatory understanding of subjects' meanings" (Charmaz, 2003, p.250)

3.4 POPULATION

The study population included ten (10) permanent staff of four schemes each, making forty (40) and eighty (80) staff from eight service providers (hospitals and pharmacies). Thus, a total of one hundred and twenty (120) staff from twelve institutions formed the population of the study. In other words, the study focused on all the activities of the NHIS and the service providers whether managerial or non-managerial.

3.4.1 Target Population/Unit of Analysis

The target population constitute the direct unit of analysis enrolled in the study. The target population included the Scheme Managers, Accountant, Claims and Data Managers and procurement officers. The target population for the service providers included managers and claims managers. The rationale for deciding on the named target population is informed by the fact that they have adequate information as far as interdependence of the operations are concerned.

3.5 SAMPLING PROCEDURE

The researcher employed multi- stage sampling techniques. A two-stage sampling procedure was used. At the primary stage or stage one, there was adoption of randomization. The simple random sampling was used to select four (4) District /Mutual health insurance schemes within the greater Accra region. The basis for using the simple random sampling will be to avoid bias and to ensure that each District Mutual Health Insurance in the Greater Accra region will have an equal chance of being selected and included in the study. In the opinion of Amin (2005), when randomization is applied, it simplifies in forming equivalent representative groups that are basically the same on all applicable variables imagined of by the researcher. Four (4) principal officers of the randomly sampled District Mutual Health Insurance Schemes will be purposively selected. In addition to that, two service providers

will be randomly selected from the list of all services providers subscribed to each of the District Mutual Health Insurance Schemes. This implies that two service providers will be randomly selected from among the list of numerous service providers subscribed to each of the District Mutual Health Insurance Schemes. The stage two of the sampling process will involve purposively selecting the managers of the service providers subscribed to the DMHIS together with their Claims processing officers. The sampling technique is often applied in situations where there is a pre-defined subgroup(s) with feature(s). The application of the Purposive sampling is because the nature of the study requires that participants that have adequate information are engaged to provide key information or an in-depth perspective on the levels of interconnectedness. In addition, the researcher used one of the DMHIS (the GA DMHIS) as snowball to contact the others thereby making collaboration between the researcher and the participant. Accoring to Baxter, P., & Jack, S. (2008) "one of the advantages of case study approach is the close collaboration between the researcher and the participant, while enabling participants to tell their stories (Crabtree & Miller, 1999). Through these stories the participants can describe their views of reality and this enables the researcher to better understand the participants' actions (Lather, 1992; Robottom & Hart, 1993)". The sample size for the study will be 120. The sample is presented in Table 1.

Table 3.1: Sample distribution of DMHIS and Service providers.

Respondents	Population Sample	Total Population Samples
Schemes	40	40
Service Providers (Hospitals and Pharmacies)	80	80
Total	120	120

Source: Author's construct, 2016

3.6 DATA COLLECTION TECHNIQUES

Data for the study will be obtained from both primary and secondary sources. The secondary data was obtained through information from publicly accessible documents published on the National Health Insurance websites. Other scholarly journal articles that have examined the topic or similar related topics was consulted. Other secondary sources of data that was consulted was reports, memo, and other records and archives from the study participant that was relevant to the study. The Primary data collection was carried out at the scheme management level and the service provider level. Questionnaire was administered to the target population. The key informant was the District Insurance Scheme office managers, and the selected service provider managers and claims officers or any person assigned with that task in the facility. The questionnaire covered the nature of interdependence, the effect it has on service quality, the weaknesses and strengths of the existing level of interdependence if any. The structured questionnaires were closed and open ended items that helped to give the

study a mixed method level of inquiry. The open – ended questionnaire was used to enable respondents to offer their own answers to the questions for the role of attaining the objectives of this study.

3.7 PILOTING OF QUESTIONNAIRE

The researcher piloted the data collection method. This aim is to elicit any inconsistency, errors and ensure clarity. This helped the researcher to get rid of possible encounters before administering the questionnaire. Thus, the time to complete a questionnaire was identified. Questions of ambiguity was cleared in the actual data collection. It should be noted here that the Ga DMHIS mentioned earlier on was used for this purpose.

3.8 DATA ANALYSIS AND PRESENTATION

After the data, was collected, it was compiled, sorted, edited, classified and coded into a coding sheet and processed using a computerized data analysis package known as Statistical Package for Social Science 20.0. The data was analysed descriptively. The qualitative analysis will be based on the constant comparative method (Charmaz, 2006). This involved the deduction of open codes from the transcribed data, field notes and the secondary sources of data from the schemes. The conceptualization of interdependence was highlighted within the questionnaire. The qualitative analysis was performed manually to identify themes, commonalities, and contrasts.

3.9 VALIDITY OF RESEARCH INSTRUMENTS AND RELIABILITY OF INSTRUMENT.

In the opinion of Amin (2005) a researcher can achieve content validity through expert judgment. Therefore, the researcher piloted the questionnaire before the conduct of the

research study commenced. One way to ensure validity is the clarity with which the study methods have been explained. This will enable other scientist to judge the study's quality. The second approach was to examine the validity and the quality of data.

3.10 ETHICAL CONSIDERATIONS

The researcher was complied with the highest ethical standards. Ethical clearance was sought from the Directorate of Health, Ghana. The decision to participate in the study was voluntary and the respondents could terminate from the study at any time. All materials consulted was duly acknowledged. The researcher ensured the anonymity and confidentiality of the information gathered for the study.

CHAPTER FOUR

RESULTS

4. 1 INTRODUCTION

In this chapter consideration is initially given to the response rate of the survey followed by the demographic information gathered. It also regroups and displays responses given to the other sections of the questionnaire. The demographic results (Section 1) are presented with tables or in a narrative form or both as suggested by (Burns and Grove, 2003). The other important dealing with various intergroup performance or effective interdependence issues are collated and displayed using tables, frequency distributions, percentages and graphs for pictorial presentation of information.

4.2 RESPONSE RATE

A total of one hundred and twenty questionnaires (120) were distributed in August, 2016 to selected schemes and service providers using convenient sampling. One hundred and two (n=102) questionnaires were returned completed giving a response rate of 85.0% (n= 102/120). Because of this encouraging response rate and difficulties in reaching respondents there were no follow-up letters urging respondents to complete the rest of the questionnaire.

4.3 PARTICIPANTS' CHARACTERISTICS

This section represents the gender, age, years of working with current organization, ranks and professional qualification of respondents in cross tabulation.

(i)Age of respondents

Table 4.3.1 Gender of respondent * Age of respondents in years Crosstabulation

Count

		Age of respondents in years					
		< 21 yrs	21-30 yrs	31-40 yrs	41-50 yrs	51 yrs and above	Total
Gender of respondent	Male	0	7	38	2	9	56
	Female	2	12	17	10	5	46
Total		2	19	55	12	14	102

Table 4.3.1 shows that men as made up of 54.9 % (n=56) of the total population surveyed and most of the staff were aged between 31-40 years. The table also illustrates unequal distribution of females in each of the age groups. Only two female respondents were below the age of 21 years.

(i)<u>Figure 4.3.1 Age of respondent in years against Gender</u>

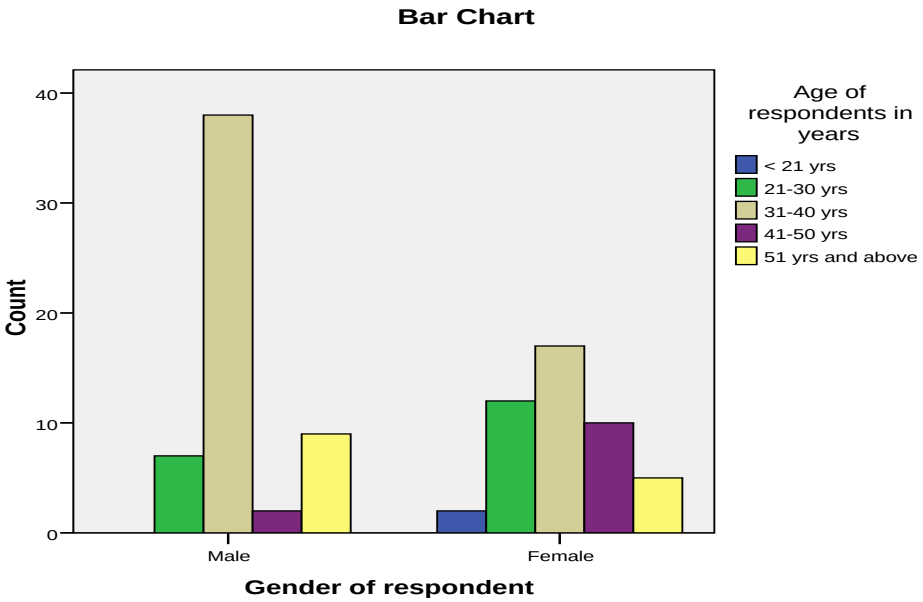


Figure 4.3.1 above illustrates unequal distribution of the respondents in each of the age groups. Majority of respondents, both male and female were between 31-40 year groups.

(ii)Area of work of respondents

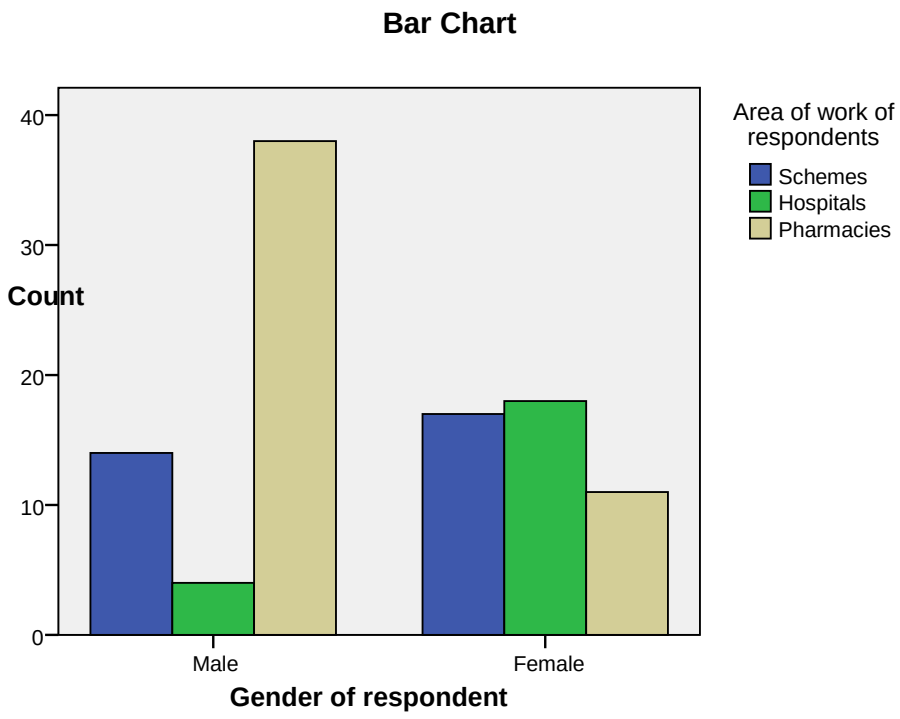
Table 4.3.2 Gender of respondent * Area of work of respondents' Cross tabulation

Count

		Area of work of respondents			
		Schemes	Hospitals	Pharmacies	Total
Gender of respondent	Male	14	4	38	56
	Female	17	18	11	46
Total		31	22	49	102

Table 4.3.2 shows that most of the participants surveyed in the Schemes and service providers were female. The ratio of male to female participant surveyed in the pharmacies was about 3:1.

(ii) Figure 4.3.2 Area of work of respondents



Both table 4.3.2 and figure 4.3.2 show that most of the participants surveyed in the Ministry and Departments were female. The ratio of male to female participants surveyed in the Agency was about 3:1.

(iii) Years of working with current organisation

Table 4.3.3 Gender of respondent * Years of working at current organisation Crosstabulation

Count

		Years of working at current organisation					
		< 1 yr	1-5 yrs	6-10 yrs	11-15 yrs	16 yrs and above	Total
Gender of respondent	Male	0	42	4	2	8	56
	Female	7	19	11	2	7	46
Total		7	61	15	4	15	102

Both table 4.3.3 and figure 4.3.3 show that most of the respondents (n=61) have been working with their current organisation for 1-5 years.

(iii) Years of working with current organisation

Figure 4.3.3 Years of working with current organisation

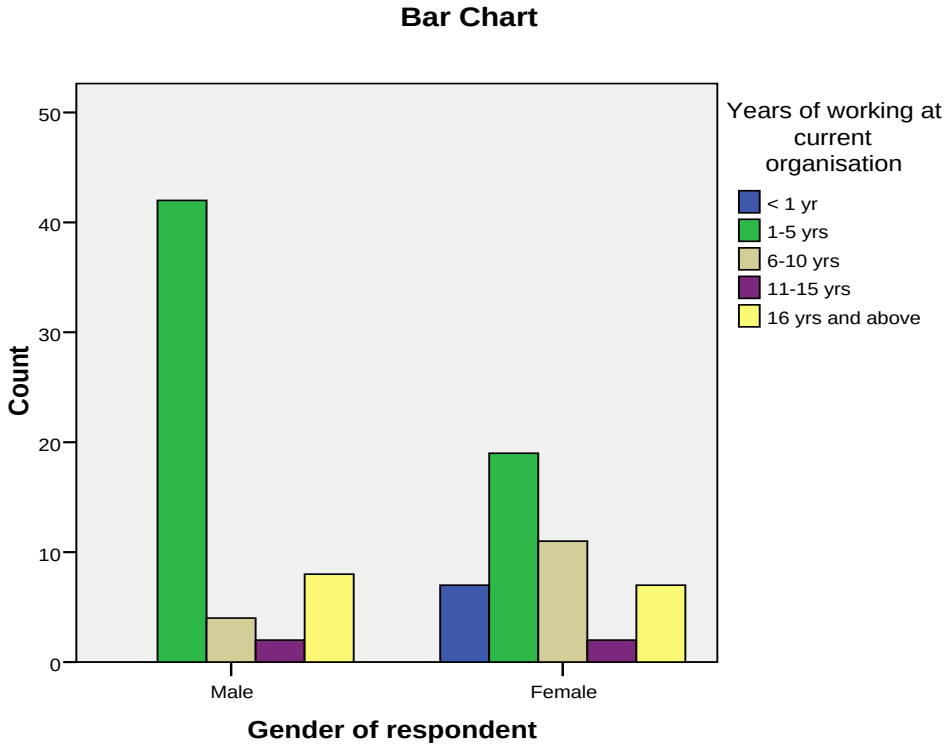


Table 4.3.3 and the bar chart above show that most of the respondents (n=61) have been working with their current organisation for 1-5 years.

(vi) Rank of Participants

Table 4.3.4 Gender of respondent * Category of Rank of Respondents Crosstabulation

Count

		Category of Rank of Respondents			
		Junior Staff	Senior Staff	Management	Total
Gender of respondent	Male	5	43	8	56
	Female	11	33	2	46
Total		16	76	10	102

(vi) Figure 4.3.4 Category of Rank of Respondents

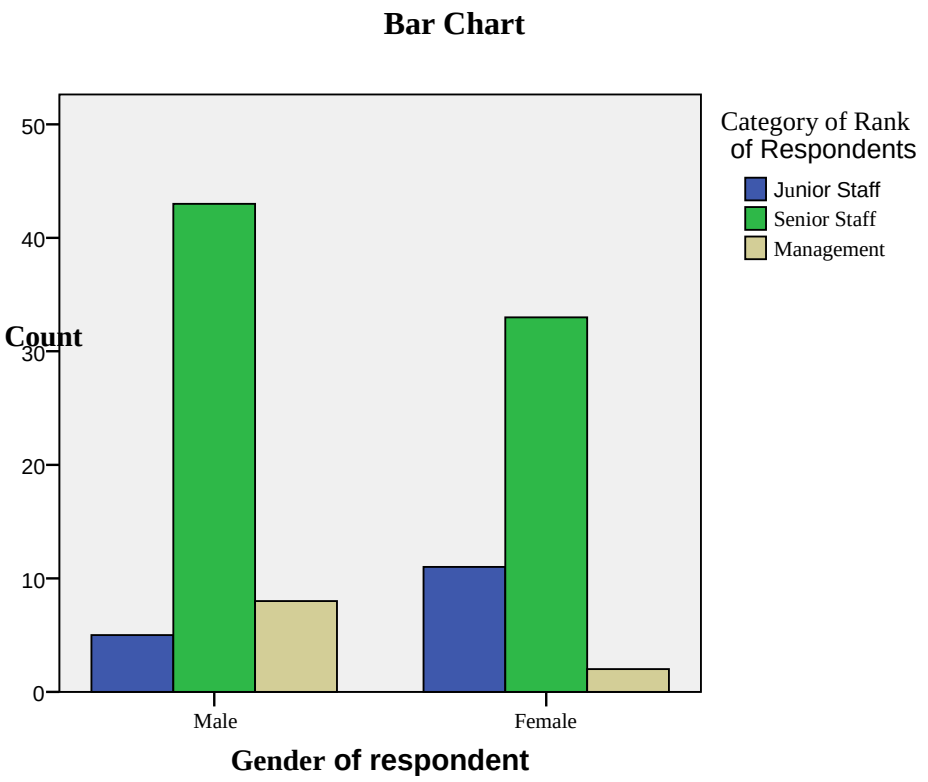


Table 4.3.4 and figure 4.3.4 indicate that 74.5.0 % (76 /102) were in the senior category. The ratio of female senior staff to junior staff surveyed was 3:1.

(v) Professional Qualification of participants

Table 4.3.5 Gender of respondent * Professional qualification of respondent's Cross tabulation

Count

		Professional qualification of respondents						
		G. C.E . 'O' level/ SSS Certificate	Diploma	G.C.E. 'A' Level Certificate	Bachelor's degree	Master's degree	Others	Total
Gender of respondent	Male	2	5	15	28	4	2	56
	Female	13	2	7	24	0	0	46
Total		15	7	22	52	4	2	102

(v) Figure 4.3.5 Professional qualification of participants

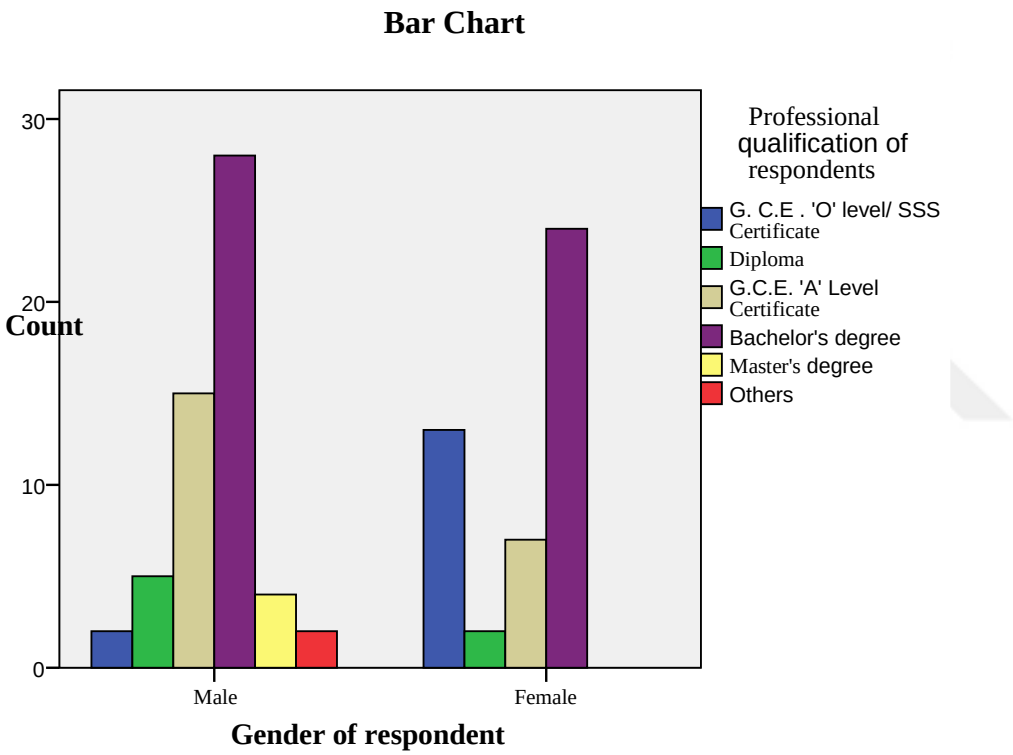


Table 4.3.5 and figure 4.3.5 indicate that 51.0 % (n=52) of the staff surveyed have their first degree. The number of male first degree holders is almost that of their female counterparts. However, only 4 males out of the total surveyed population had their Master's degree.

4.4. Knowledge, Attitude and participants understanding of interdependence

Before responding to this part the concept of interdependence had been explained to the respondents by the researcher with examples of scenarios. It is assumed therefore that the respondent had a rough idea about interdependence. It was also agreed on that interdependence policy entailed mainly claims submitted by service providers to the schemes, acceptable and approved drug list, and services that are approved by the sachems to be rendered by service providers.

(i) Participants knowledge in interdependence

Table 4.4.1 Area of work of respondents * Participants knowledge in interdependence issues Cross tabulation

Count

		Participants knowledge in interdependence issues			
		I know about them	I have no idea about them	I practise them	Total
Area of work of respondents	Schemes	19	5	11	35
	Hospitals	22	3	9	34
	Pharmacies	18	5	10	33
Total		59	13	30	102

Figure 4.4.1 Participants knowledge in interdependence

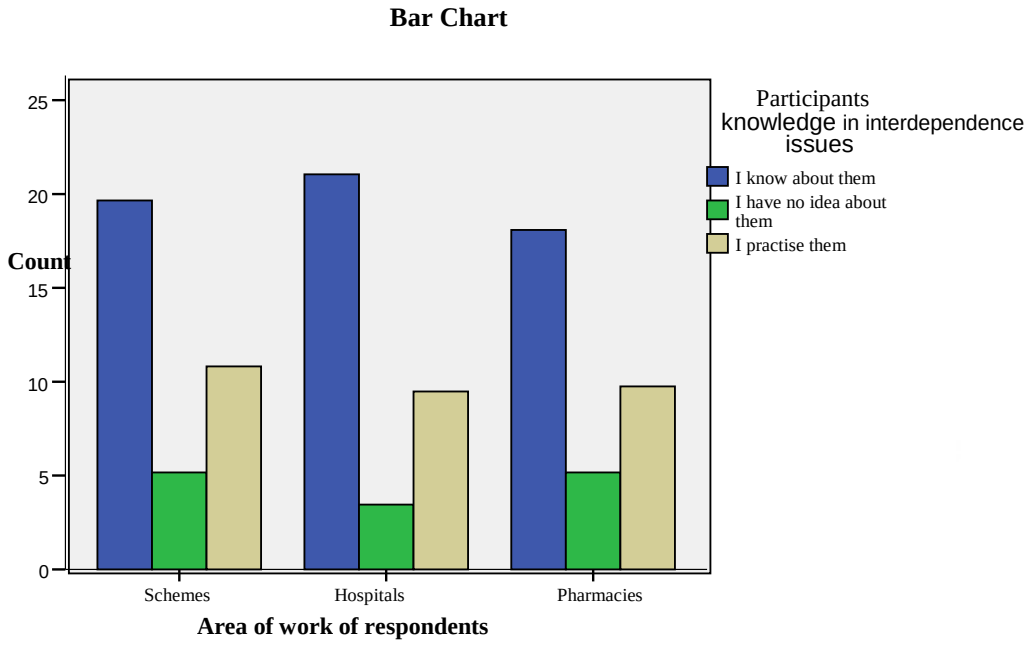


Table 4.4.1 and figure 4.4.1 revealed that the number of the participants surveyed who have knowledge on interdependence (n_1 =59) exceed those who have no idea on interdependence (n_2 = 13). Additionally, only 29.4% (n=30) responded that they practice interdependence.

(ii) Availability of interdependence policy in the organisation

Table 4.4.2 Area of work of respondents * Availability of interdependence Policy in Department. Cross tabulation

Count

		Availability of interdependence Poli Department			
		Yes	No	Not Aware	Total
Area of work of respondents	Scheme	21	6	4	31
	Hospitals	14	1	7	22
	Pharmacies	30	5	14	49
Total		65	12	25	102

Figure 4.4.2 Availability of interdependence policy in the organisation

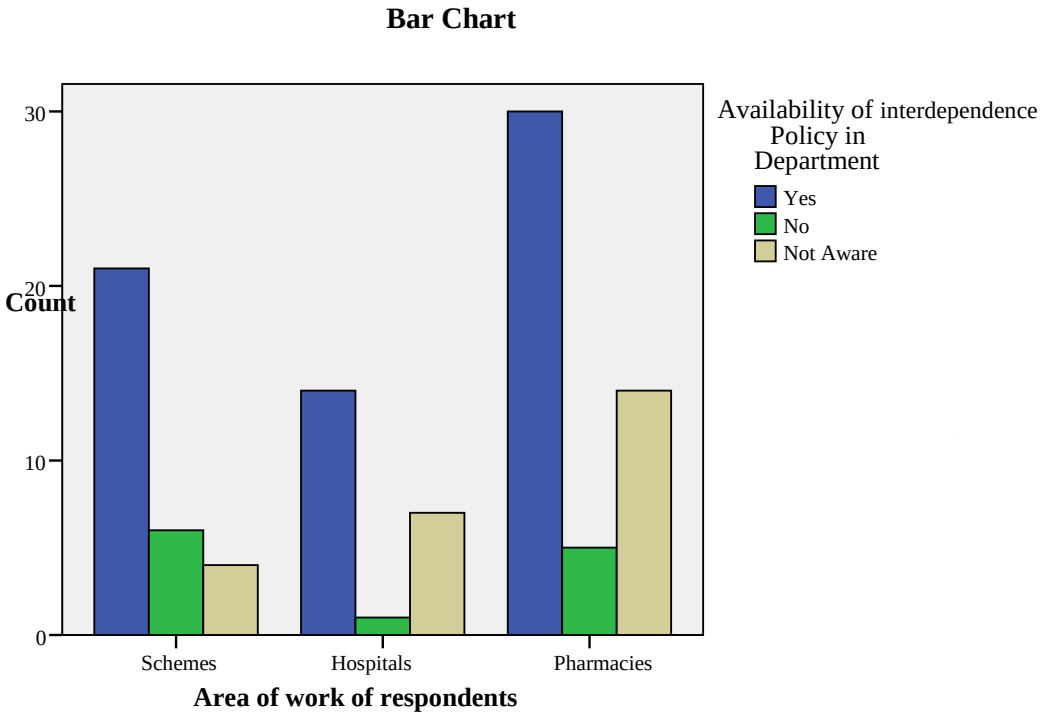


Table 4.4.2 and figure 4.4.2 shows that 63.7 % of the surveyed participants were of the view that their organisation has a policy on interdependence. However, 24.5% (n=25) had no idea that their organisations have policies on interdependence.

(iii). Staff participation in interdependence activities

Table 4.4.3 Area of work of respondents * Staff participation in interdependence **Cross tabulation**

Count

		Staff participation in interdependence				
		Often	Sometimes	Rarely	Never	Total
Area of work of respondents	Schemes	0	19	5	7	31
	Hospitals	6	8	4	4	22
	Pharmacies	6	13	20	10	49
Total		12	40	29	21	102

Figure 4.4.3 Staff participation in interdependence activities

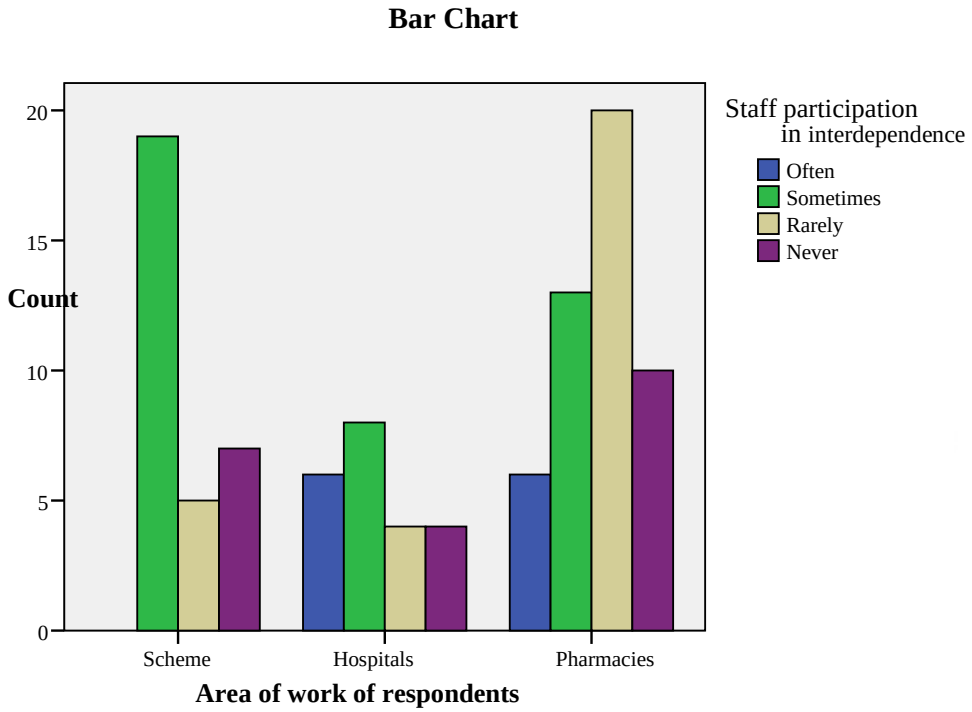


Table 4.4.3 and figure 4.4.3 show that 20.6% of the respondents (n_1=21) have **never** participated in interdependence activities since joining their organisations. Similarly, 28.4 % (n_2 = 29) responded that they **rarely** take part in interdependence activities. Moreover, 39.2 % (n_3 = 40) of the respondents affirmed that they sometimes participate in interdependence activities.

(iv). Staff engaged in Pooled interdependence activity

Table 4.4.4 Area of work of respondents * staff engaged in Pooled interdependence activity

Count

		Pooled interdependence activity				
		Always	Sometimes	Rarely	Never	Total
Area of work of respondents	Schemes	0	2	9	20	31
	Hospitals	0	3	11	8	22
	Pharmacies	0	13	18	18	49
Total		0	18	38	46	102

Figure 4.4.4 Staff engaged in pooled interdependence activity

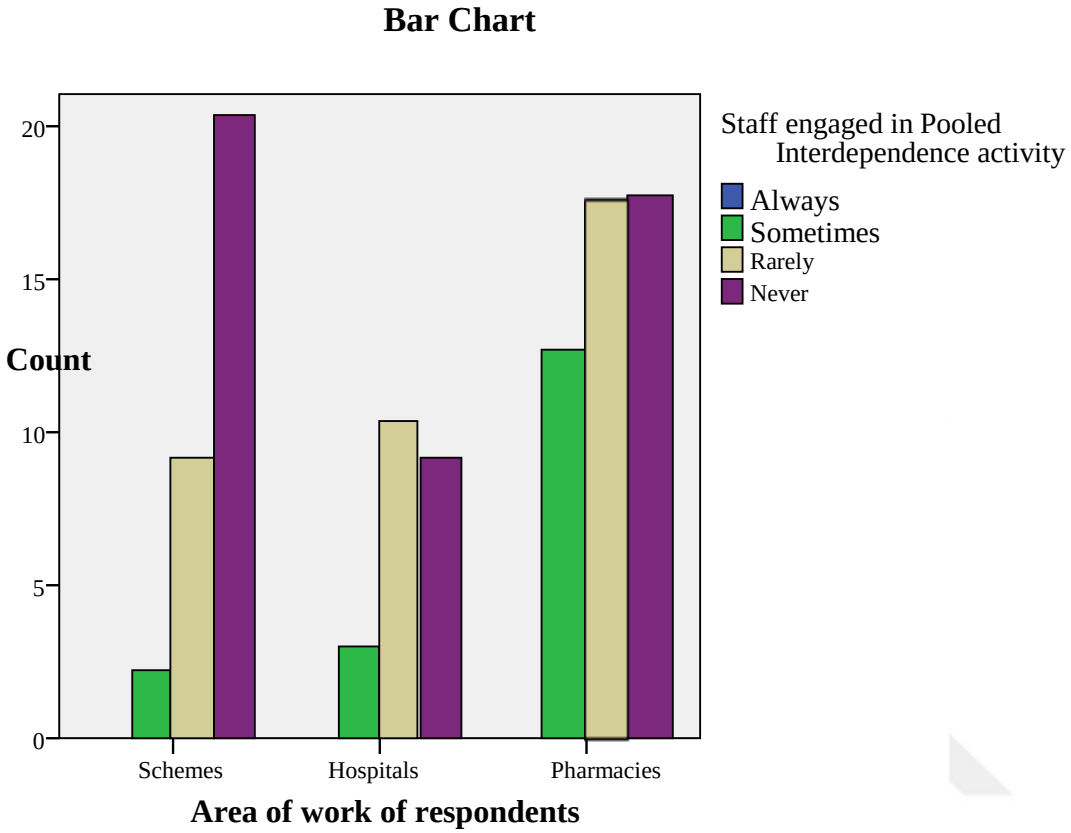


Table 4.4.4 and figure 4.4.4 show that most of the respondents rarely undertake Pooled interdependence activities on the average.

(v). Staff engaged in Sequential interdependence activity

Table 4.4.5 Area of work of respondents * staff engaged in Sequential interdependence activity

Count

		Sequential interdependence activity				
		Always	Sometimes	Rarely	Never	Total
Area of work of respondents	Schemes	9	12	3	7	31
	Hospitals	11	7	1	3	22
	Pharmacies	18	18	0	13	49
Total		38	37	4	23	102

Figure 4.4.5 Staff engaged in Sequential interdependence activity

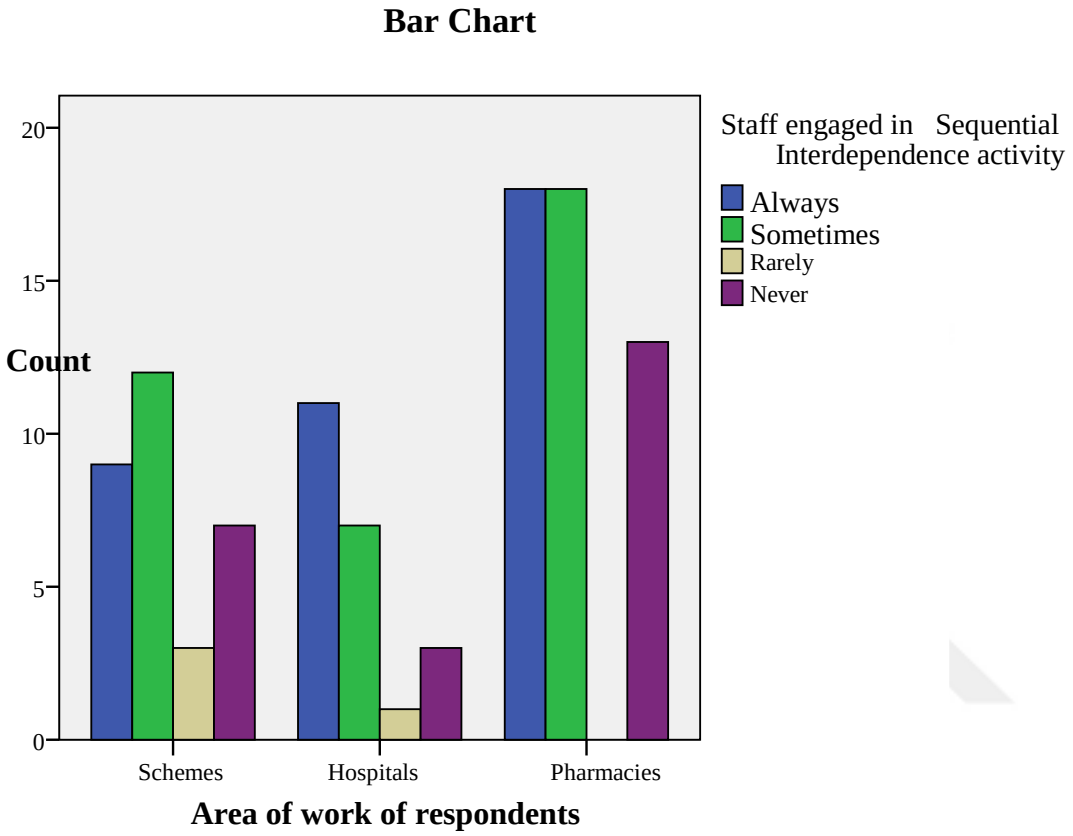


Table 4.4.5 and figure 4.4.5 show that most of the respondents have been sometimes undertaking Sequential interdependence activities.

(vi). Staff engaged in reciprocal interdependence activity

Table 4.4.6 Area of work of respondents * staff engaged in reciprocal interdependence activity

Count

		reciprocal interdependence activity				
		Always	Sometimes	Rarely	Never	Total
Area of work of respondents	Schemes	20	8	0	0	28
	Hospitals	19	9	4	0	32
	Pharmacies	14	2	18	8	42
Total		53	19	22	8	102

Figure 4.4.6 Staff engaged in reciprocal interdependence activity

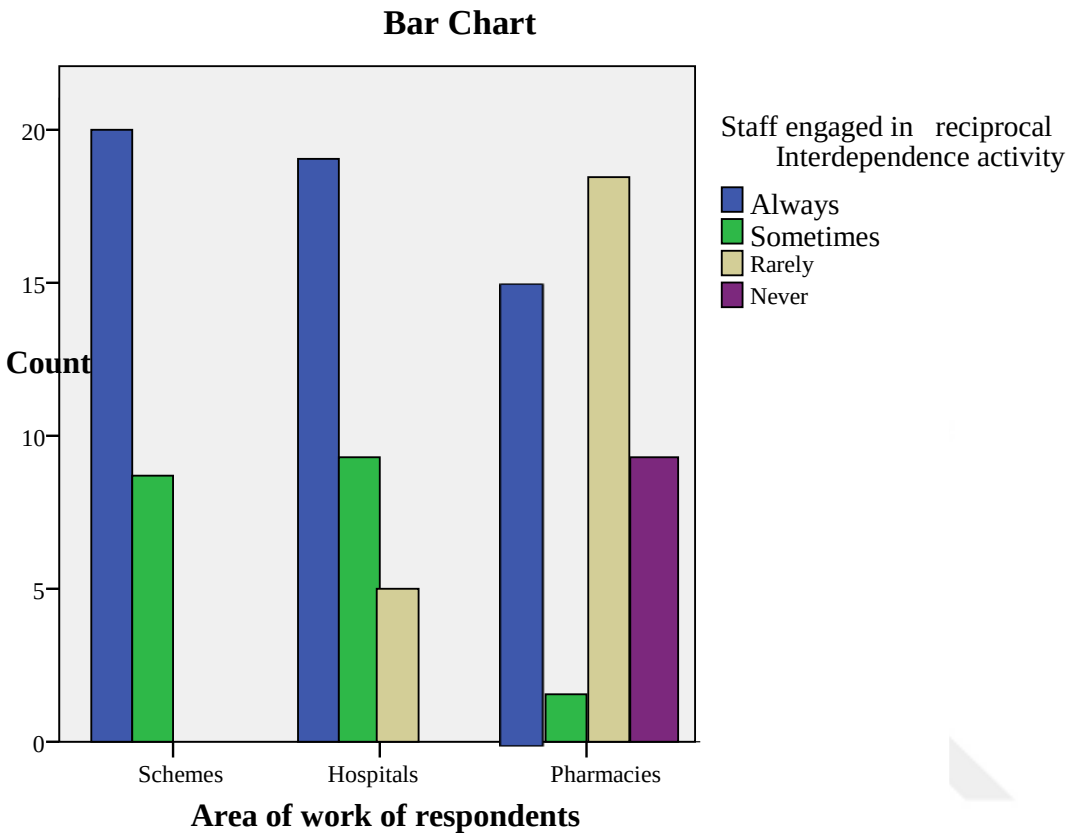


Table 4.4.6 and figure 4.4.6 show that most of the respondents have been mostly undertaking reciprocal interdependence activities at a high rate.

(vii). Contact for information on interdependence activities

Table 4.4.7 Area of work of respondents * Contact for information on interdependence

Count

		Access to information on interdependence activities					
		Professional journals	Colleagues	Workshops	Have no access to information	Other	Total
Area of work of respondents	Schemes	4	4	17	5	1	31
	Hospitals	8	10	4	0	0	22
	Pharmacies	2	16	16	13	2	49
Total		14	30	37	18	3	102

Figure 4.4.7 Contact for information on interdependence activities

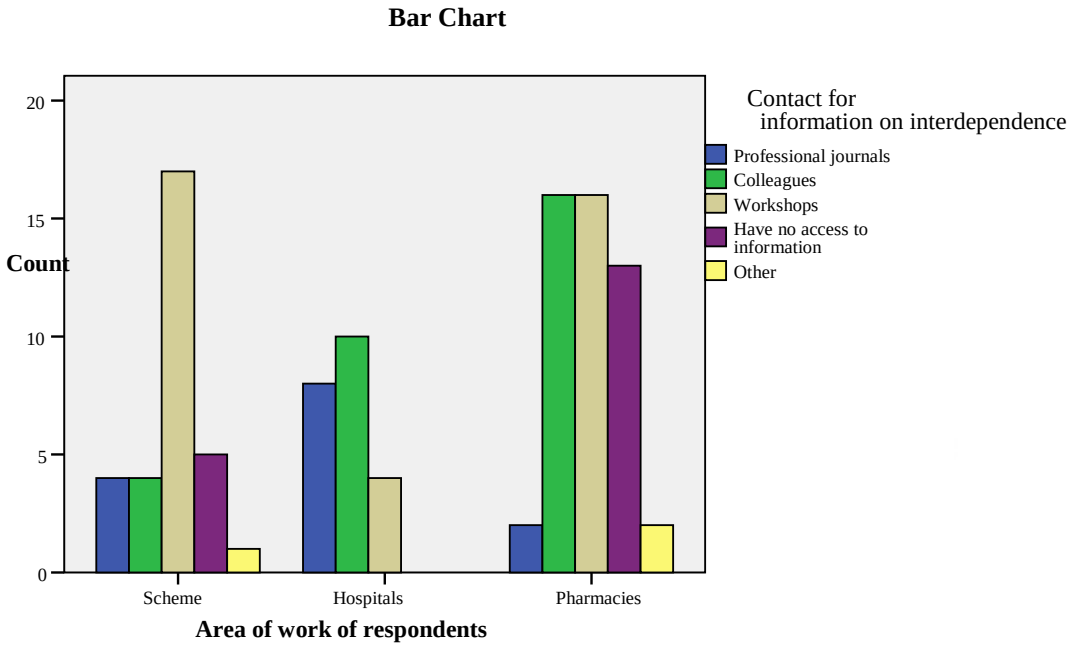


Table 4.4.7 and figure 4.4.7 show that majority of the respondents obtain access to interdependence information through their colleagues (n_1= 30) and attending workshops (n_2= 37). However, 17.6 % (n= 18) of the respondents confirmed that they have no access to information on interdependence activities at all.

(viii). Importance of interdependence among firms

Table 4.4.8 Area of work of respondents * Importance of interdependence Cross tabulation

Count

		Importance of interdependence		
		Very Important	Important	Total
Area of work of respondents	Schemes	24	7	31
	Hospitals	19	3	22
	Pharmacies	41	8	49
Total		84	18	102

Figure 4.4.8 Importance of interdependence among firms

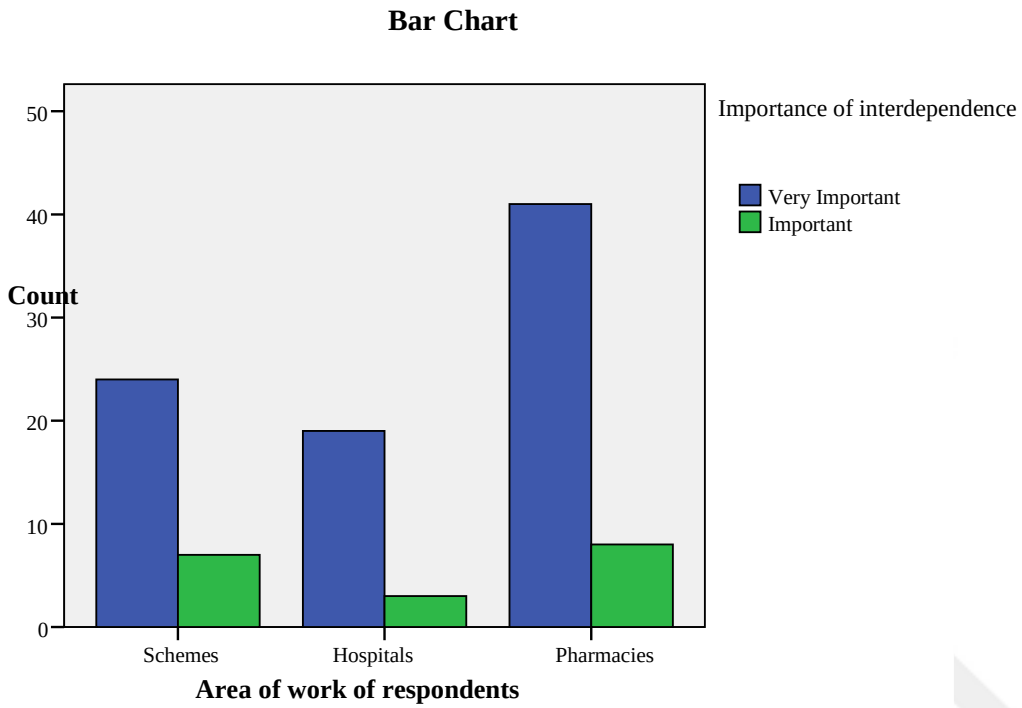


Table 4.4.8 and figure 4.4.8 show that all the respondents hold positive view about interdependence among firms and regard it as important or very important.

(ix). Interdependence to help maintain professional knowledge and skills

Table 4.4.9 Area of work of respondents * Interdependence **to help maintain prof know and skills Cross tabulation**

Count

		Interdependence to maintain prof know and skills			
		Yes	No	Don't Know	Total
Area of work of respondents	Schemes	28	0	3	31
	Hospitals	22	0	0	22
	Pharmacies	47	1	1	49
Total		97	1	4	102

Figure 4.4.9 Interdependence to help maintain professional knowledge and skills

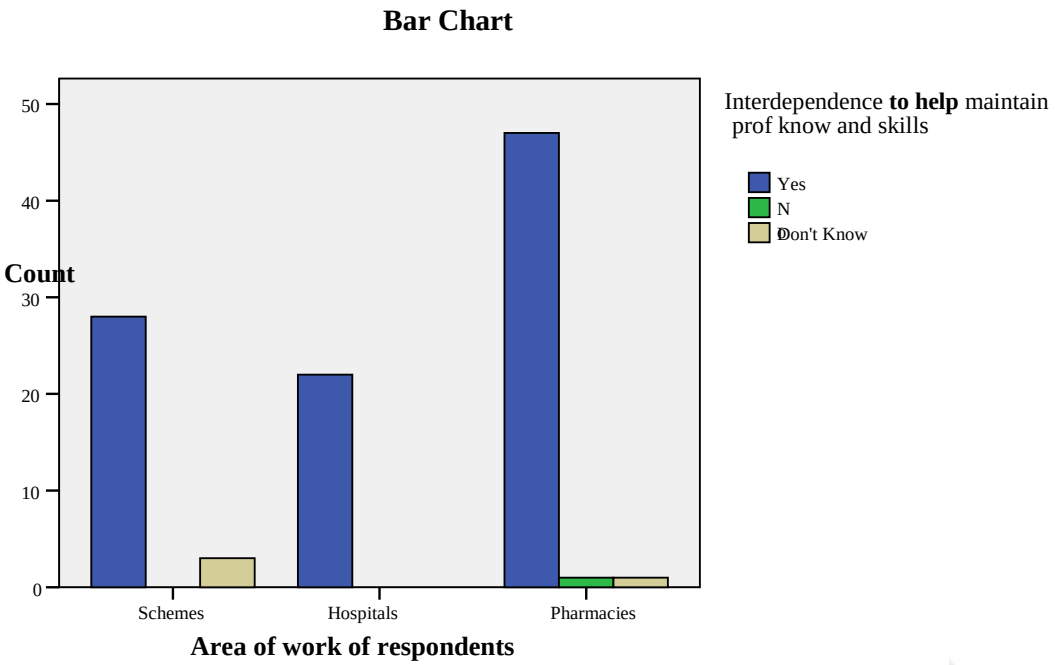


Table 4.4.9 and figure 4.4.9 indicate that 95.1 % (n=97) of the respondents were of the opinion that interdependence help to maintain professional knowledge and skills.

(x) Table 4.4.10 Employers believe in interdependence as important component for professional development

Table 4.4.10 Area of work of respondents * Interdependence **as important part of professional Dev. Cross tabulation**

Count

		Interdependence as important part of professional Dev.			
		Yes	No	Don't Know	Total
Area of work of respondents	Schemes	23	5	3	31
	Hospitals	14	0	8	22
	Pharmacies	37	5	7	49
Total		74	10	18	102

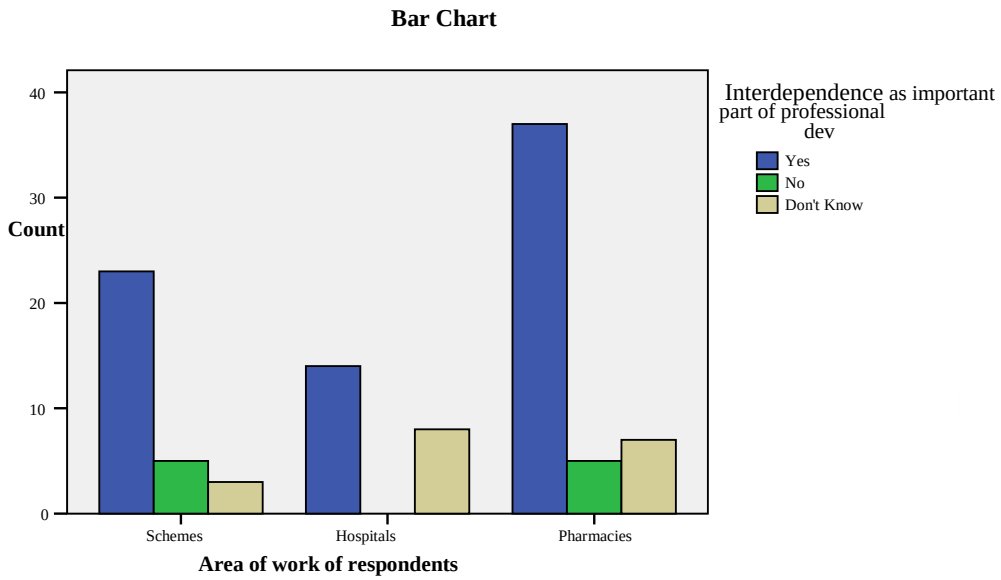


Table 4.4.10 and figure 4.4.10 illustrate that 72.5.0 % (n=74) of the subjects surveyed believed that their employers regard interdependence as important component in professional development.

(xi) Employers interest in interdependence activities

Table 4.4.11 Area of work of respondents * Employer's interest rate in Interdependence **Issues Cross tabulation**

Count

		Employer's interest rate in interdependence issues					
		Very Good	Good	Poor	Very Poor	Don't Know	Total
Area of work of respondents	Schemes	10	13	2	3	3	31
	Hospitals	10	5	1	0	6	22
	Pharmacies	5	33	3	4	4	49
Total		25	51	6	7	13	102

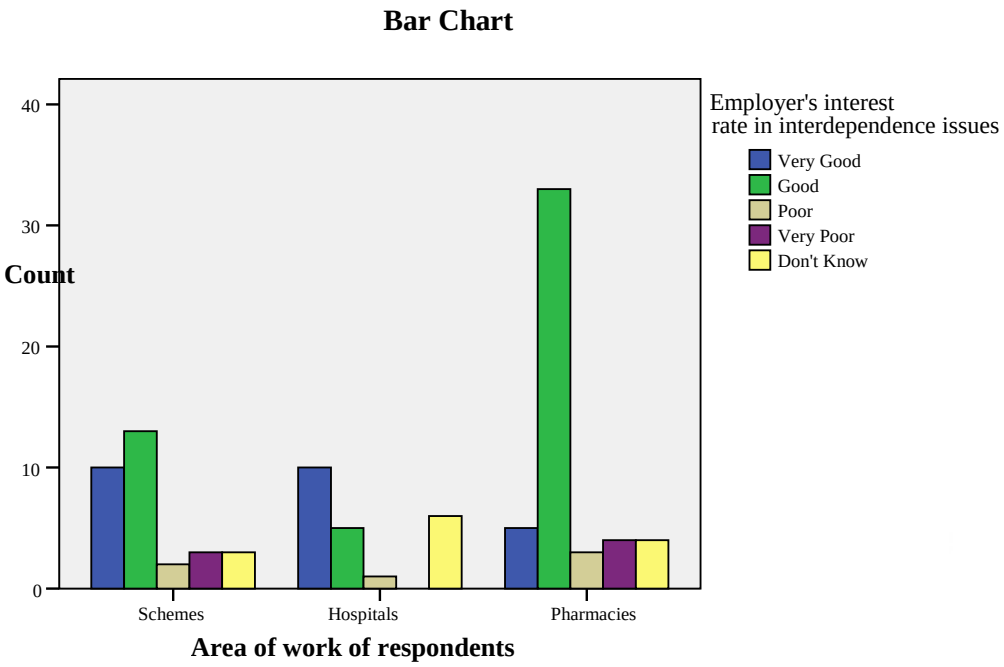


Table 4.4.11 and figure 4.4.11 indicate that majority of the respondents rated high their employers interest in interdependence activities. 50.0 % (n_1 = 51) believe that their employer's interest in interdependence activities is good whiles 25.0 % (n_2= 25) believed their employer's interest is very good.

Forms, organization, Monitoring and barriers to interdependence

Organisation and Monitoring of interdependence activities

Table 4.5.1 Area of work of respondents * Who monitors interdependence **in the department. Cross tabulation**

Count

		Who to organise and monitor interdependence activities in the departmen				
		The organisation	Professional Association	Individual	Have no idea	Total
Area of work of respondents	Schemes	26	0	2	3	31
	Hospitals	19	3	0	0	22
	Pharmacies	41	4	4	0	49
Total		86	7	6	3	102

Figure 4.5.1 Organisation and Monitoring of interdependence activities

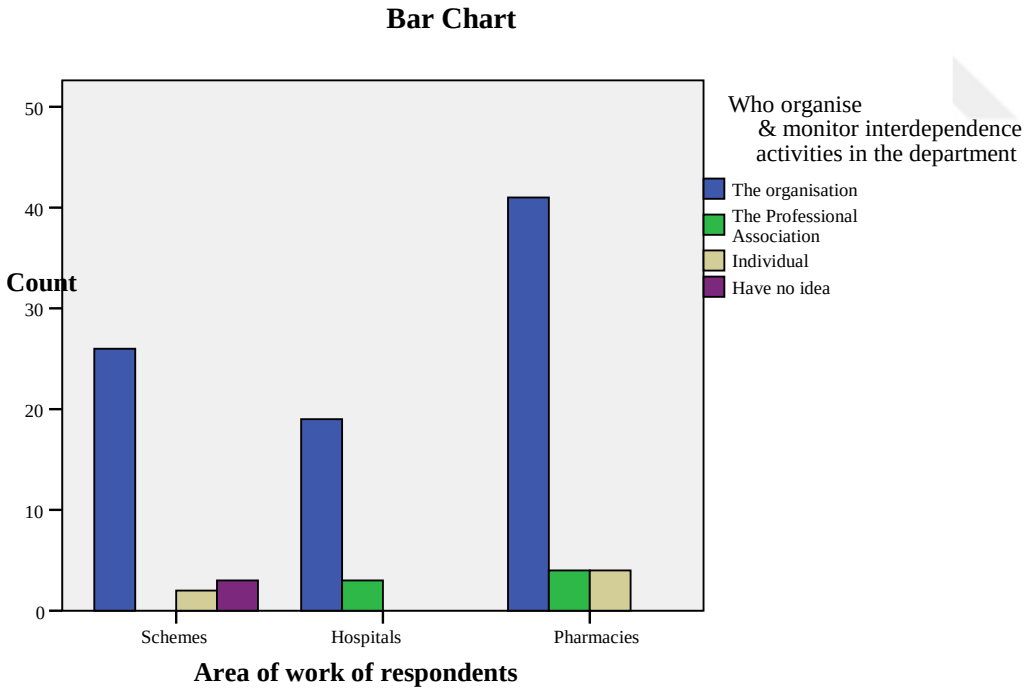


Table 4.5.1 and figure 4.5.1 show that respondents were unanimous, 84.3 % (n = 86) in their opinion that the individual organisations should take lead in the Organisation and Monitoring of interdependence activities.

Financial implications in interdependence activities

Table 4.5.2 Area of work of respondents * Financial implication in interdependence activities

Count

		Financial implication in interdependence activities				
		More Implication	Normal Implication	No Implication	Have no idea	Total
Area of work of respondents	Schemes	11	17	0	3	31
	Hospitals	13	9	0	0	22
	Pharmacies	6	37	3	3	49
Total		30	63	3	6	102

Figure 4.5.2 financial implications in interdependence activities

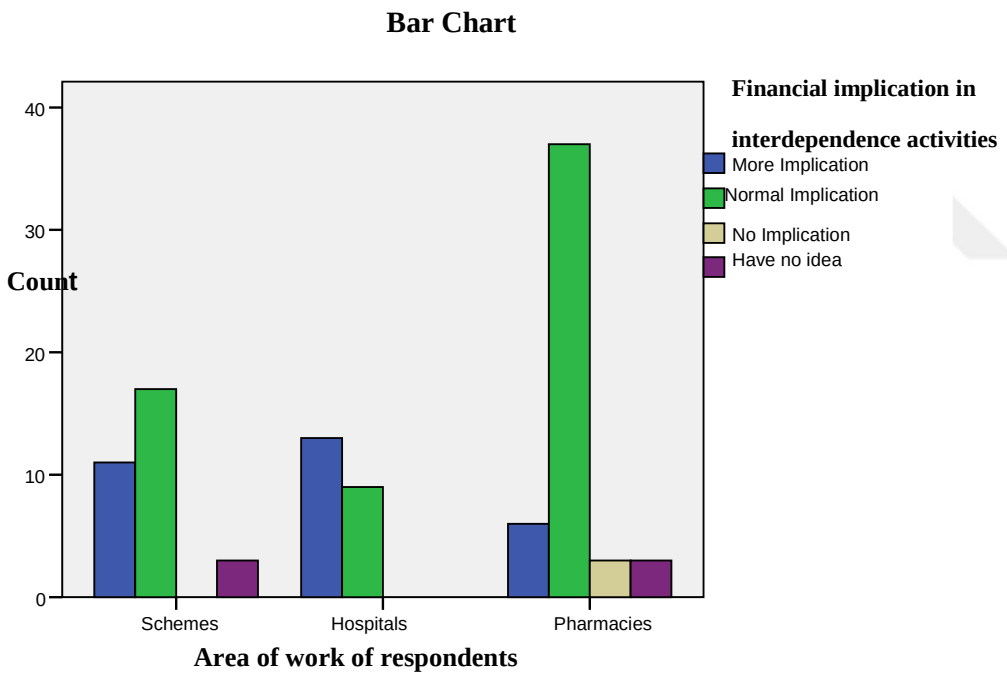


Table 4.5.2 and figure 4.5.2 indicate that majority of the respondents (61.8%) i.e. n= 63 think that there are more financial implications in interdependence activities whiles, 29.0 % felt that there are normal financial implications in interdependence activities. Only 2.9 % think there are no such financial implications.

CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

The main purpose of the study was to examine the interdependence among the schemes of the Ghana National Health Insurance Authority and its various service provides. A descriptive analysis was conducted to identify whether there were interdependence relationships among the schemes and its various service providers. A survey was conducted on the employees of these institutions on the activities of interdependence in their various departments. The research exhibits the various types of interdependence. The data gathered will serve as a base line data for further work. This chapter discusses the findings of the survey.

5.2 RESPONSE RATE

A total of one hundred and twenty questionnaires (120) were administered to section of the employees of some schemes and service providers using convenient sampling. One hundred and two (n=102) questionnaires were returned completed giving a response rate of 85.0% (n= 102/120).

Generally postal surveys can have a low response rate perhaps as low as 20-30% (Burns and Grove 2003). The most important aspect of having a response rate above 50% is that the findings can be generalised (Burns and Grove, 2003). This means that this current survey could be generalised to the population studied. The high response rate may partly be due to the importance respondents attached to the topic. Also, as was stated in chapter 3, before the study was conducted the researcher visited the individual schemes and service providers to explain the study them and asked them to voluntarily participate in this survey and also coupled with the fact that the researcher has worked with one of the DHIS, might have contributed to the high response rate.

5.3 DEMOGRAPHIC PROFILE OF PARTICIPANTS

5.3.1 Gender, age, years of working with current organization, Ranks and professional qualification of respondents.

The respondents were made up of 54.9% (n_1 = 56) male and 45.1% (n_2= 46) female drawn from the three sectors which can be classified as the health sector of the Ghanaian economy namely; NHIS, Hospitals and the Pharmacies. Table 4.3.2 and Fig. 4.3.2 show that most of the female staff are working in the Schemes and the Hospitals Departments with majority of the men working with the Pharmacies. This is so because most of the work within the ministry and departments are mainly clerical which is mainly handled by women. However, in the schemes, there are more men to women because the work involves more of managerial positions which are predominantly occupied by men because of the culture of the country where men are used to studying in higher levels than women. The situation is improving due to changes in attitude towards girls' education in the country. Per the results, the target population which included the Scheme Managers, Accountant, Claims and Data Managers and procurement officers was achieved. The rationale for deciding on the named target population is informed by the fact that they have adequate information as far as interdependence of the operations are concerned.

Table 4.3.1 and fig. 4.3.1 indicates that majority of the respondents, 53.9% (n= 55/102) fall within the 31-40-year group. This situation prevails because until recently, the pre- university education in the country was 17 years. Therefore, before one graduates from the university and completes his / her compulsory national service, he/she may be in the late twenties. With the current educational reforms, which have reduced the pre-university education to 12 years,

it is hoped that people may enter the Public Service in early years. This might explain the reason for the only 2 female staff under the age of 21yrs recorded.

Table 4.3.3 and fig 4.3.3 show that 59.8% (n=61/102) have been working with their current organization between 1-5years compared with the 33.3% (n=34) who have been working with their organization for more than 5 years. In the civil service, remuneration and motivation is often low which does not encourage people to stay on the job for long. Most people start their career with the Public service to gain experience and then leave for the private sector which often has attractive package and incentives. The results relating to the number of years' employees having been working with their organization shows that the respondents are conversant with procedures and activities of the scheme, therefore the probability of them having knowledge about what goes on and around the organization will be high and this is favourable for the research.

Table 4.3.5 and fig 4.3.5 illustrate that most of the surveyed participants 51.0% have their first degree and this explains the reason why most staff fall in the senior staff category in table 4.3.4. The G.C.E 'A' level holders constitute the next dominant qualification in the service because it is the criteria for the selection of clerical jobs in the Public Service. Only two female participants were in the management rank (Table 4.3.4) due to the cultural background explained early. This results indicates that respondents are qualified academically for their positions. For the purpose of the research, this results is good because respondents will be in the position of understanding questioner easily.

In general, the data achieved more significance in diversity as the respondents were from all sectors in the civil service, gender, age groups, and level of seniority as suggested by Gray (2004). The results can also be said to be generalized due to the high response rate.

5.4 KNOWLEDGE, ATTITUDE AND PARTICIPANTS UNDERSTANDING OF INTERDEPENDENCE

It should be noted that respondents had fair idea about interdependence and could identify with examples of scenarios. It is assumed therefore that the respondent had a rough idea about interdependence and interdependence policy which entails mainly how both parties rely on each other for information on how to manage claims submitted by service providers to the schemes, acceptable and approved drug list by both the service providers and the schemes, and services that are approved by the schemes to be rendered by service providers.

5.4.1 Participants knowledge, discussion and availability of interdependence policy and access to information.

Most of the participants, 57.9% (n=59) affirmed that they know about interdependence, whiles 12.8 % (n=13) have no idea about interdependence. However, only 29.4% (n=13) profess that they practice interdependence activities (Table 4.4.1 and fig 4.4.1). This results is quite intriguing because comparing the percentage of those who know what interdependence entails (57.9%) to the percentage of those who practice it (29.4%), it shows that interdependence is yet to be embraced into the fabric of the working culture of the Ghanaian public service. Accumulation of knowledge is important provided the knowledge gained was being practiced by these respondents. Those who have no knowledge on interdependence possibly do not have the inclination to do so or have not had the opportunity because of their circumstances. However, this is worrying because lacking knowledge in interdependence may not only affect their ability to deliver quality service to their clients but could as well affect their personal development.

The situation of lack of knowledge on interdependence activities by middle level educated staff who some time may not see the need to upgrade their knowledge due to lack of motivation.

Table 4.4.3 and fig 4.4.3 shows that 63.7% (n=65/100) of the respondents confirmed that there is a policy on interdependence at their respective areas. Though majority of the respondent affirmed that there are interdependence policies in placed there are still a few of them, 24.5% (n=25/102) who are not aware of such policies. In developing countries like Ghana, policies are easily formulated but the dissemination and implementation of them often is a problem. The people may not be aware of the existence of such policies perhaps there may be effective structures in place to update the staff on interdependence.

Information from professional colleagues was only taken advantage of by few (25%) respondents. This may be partly due to lack of interaction among colleagues on radiation protection issues or there is no colleague to talk to as some of the respondents work alone. Probably, they feel that informal chats are not information gathering or reliable information source. It is therefore recommended that information spreading be intertwined with informal communication in the organisation.

Only 13.7% of respondents have access to information through professional journals which are not common in the public/civil service. For example, only 2 respondents from the pharmacies and 4 from the schemes have access to information on interdependence through journals.

Professional journals were used by less than half of the respondents (Figure 5). Professional journals are generally not common in the country despite their importance in providing current information on interdependence activities to the public/civil servants. There is no evidence to suggest that associations and the organizations subscribe to peer-reviewed

journals for staff to use and this may be the reason why the use of journal is not so common among to respondents. Those who get information from journals do so probably on their own initiatives. The cost of journals also limits the ability of individuals to subscribe to them and therefore have no access to current information.

5.4.2 Staff participation, (Pooled, Sequential and Reciprocal participation)

Table 4.4.6 and fig 4.4.6 illustrates that most of the respondents, 70.6% (n=72) participated in reciprocal interdependence activities within their organisation. This is encouraging and can be cross examined from the number of the participants surveyed who have knowledge on interdependence from table 4.4.1 and figure 4.4.1 that showed 59% of respondents having knowledge.

Respondents explained why they think they are involved more in reciprocal interdependence. They explained that, it is usually difficult to predict their work when it comes to the number of clients (individuals) that they enlist into the scheme in the form of registration within a period. They do not know for certain how many people they will get to register and how many people from the registered will use the health facilities at any given time. Their figures, in terms of client size, to the service providers is not fixed but keeps changing. This, therefore, makes it necessary for a constant communication between the schemes and the service providers, making the rate of correspondence among staff of these organisations very high. Example the total number of people insured today might not be the same number of people tomorrow. In addition, a patient who visited a service provider last week without insurance might walk into the same service provider today with health insurance coverage. This necessitates constant communication in ascertaining information about such clients.

On the other hand, the amount of usage by the insured people can also not be predicted. Thus, the number of times someone visits the service providers is not programmed and the type of treatment seek for is not possible to be predicted. For instance, one client who is insured can utilize health facility on just one visit. There by making his or her claim one time transaction but on the other hand someone can access the health facilities for several times within a year because his or her case is routine and this will put his or her claims in a routine manner too. This means his or her claims will be moving to and fro between the schemes and the service providers throughout the period of treatment.

5.4.3 Training and Developments of Employees Interest

Interdependence to help maintain processional knowledge and skills

Respondents showed positive attitude towards interdependence activities. All of them felt that further training on interdependence was important (Table 4.4.6). In so doing respondents acknowledge the fact that further training could enable them to advance their practice and provide good quality service to their clients.

Majority (95.0%) of the respondent (Table 4.4.7) have access to information on interdependence activities. and they also felt that interdependence activities are essential to the overall success of the organisations (table 4.4.8 and Fig 4.4.8). The employees recognise that further training as part of their professional development is very necessary. The lack of support from stake – holders to sponsor professional development could lead to apathy and low morale among the staff who may not provide quality service to their clients**.**

5.5 PROBLEMS CONFRONTING RECIPROCAL INTERDEPENDENCE

5.5.1 Forms, Organisation, Monitoring, Barriers and Financial Implication to Reciprocal Interdependence

Respondents identified that the major barriers to implementing reciprocal interdependent is financing, as table 4.5.2 and figure 4.5.2 indicates, majority of the respondents (61.8%) i.e. n= 63 hold the view that there are more financial implications in interdependence activities whiles, 29.0 % felt that there are normal financial implications in interdependence activities. Only 2.9 % think there are no such financial implications.

Almost all the participants (84.3%) Table 4.5.1; felt that their organisations Ministries, Departments and Agencies (MDAs) should be organising interdependence activities seminars or programmes which they believed could improve their practice. Less than 7% of the respondents felt that the professional organisations and others should be organising interdependence activities seminars (Table 4.5.1). This is not surprising because indications are that the professional associations within the civil service in the country appears not to be well organised. The suggestion of the respondents can also be interpreted to mean that the public/civil servants are not satisfied with their professional association's involvement in activities that could advance their knowledge. Moreover, financial problems may beset the association if they provide such training programmes which again comes back to lack of support. Individuals may consider their economic situation and may not be willing to contribute from their meagre income to support training programmes for themselves despite the importance of interdependence. It was therefore not surprising that majority of the respondents, 61.8% (n_1=63) felt that their organisations (MDAs) should take the charge of funding interdependence activities as shown in Table 4.5.2 Moreover, 29.4 % (n_2=30), of the respondent also were of the view that the Government should bear the cost of funding

interdependence activities. Since the Government is the major beneficially of the services of the civil servants by relying on them to implement its policies, it will not be out of place that it takes the charge in providing training for the civil servants in interdependence activities.

Although problems associated with training and support from employers may be affecting the performance of the civil servants, individuals could make the efforts to improve themselves.

CHAPTER SIX

CONCLUSIONS AND IMPLICATIONS

6.1 INTRODUCTION

This section of the study discusses the implications of the results of the interview. It forms the concluding part as it summarises and gives constructive conclusion to its findings. It also outlines some recommendations for policy consideration.

The study examined the interdependence among the schemes of the Ghana National Health Insurance Authority and its various service providers. The literature review shows that interdependence enhances the performance of organisations and the participants in their job performance. However, the results show few respondents do not have any idea about the concept of interdependence among firms. This can be partly due to lack of education. Therefore, it is suggested that regular on the job training programs be organised to bring awareness to every member of staff. Knowledge gained must be practiced by employees to help boost the efficiency of the few respondents who have been engaging in interdependence activities at a low pace. The results further illustrate that, employees interest in interdependence activities is rated high and most of the schemes, hospitals and the pharmacies visited have interdependence policies in place.

The major factors explaining the low rate of participation in interdependence activities includes the financial implications, the lack of access to information and the fact that the concept is new in the Ghanaian domain. With the government vision of transforming the Ghanaian health sector to modern status and its realization that the capacity of the work force need to improve, it is hoped that institutions such as the NHIA, mandated to deliver quality and accessible health for all will receive the needed funds to play their role effectively and efficiently. Access to policies in organisations can also be improved if there is a proper

communication channel in place. It will also enable a rise in the level of coordination between departments thereby improving efficiency. According to Galford and Seibold Drapeau-, (2003), outdated managerial features like consistency, communication and a willingness to handle difficult questions are the strong hold of trust. In a broader sense, "building a trustworthy (and trusting) organizational relationship entails close attention to those qualities. A recognized body of research shows the links between trust and corporate performance"-Rose-Ackerman_, (2001). "If there is an organizational trust with their management, they will work through discrepancies. They will take smarter risks. They will work harder, stay with each other longer, contribute better ideas, and dig deeper than anyone has a right to ask". (Galford and Drapeau, 2007, 346-11p).

Thompson identified, 'coordination between departments to improve efficiency. But also, proposed that since a high degree of coordination is more expensive to manage, mutual adjustment replaces programming and standardization as the principal method of coordination. Another strategy that organizations can pursue to reduce the costs associated with intensive technology is specialism, producing only a narrow range of outputs. Finally, he outlined product team and matrix structures to be suitable in operating intensive technologies because they provide the coordination and the decentralized control that: allow departments to cooperate to solve problems.' (Gareth, 2009, 281-3p.)

Over the years the scheme has used standardisation to curtail some of the uncertainty in dealing with its task. Example, agreement has been reached with the service providers to treat all Malaria case with a particular brand of drug. In the case of someone who is allergic to that drug, the provider is forced to give him or her another brand which may not be on the agreed drug list. This is, therefore, one of the major problems which is sorted out through agreement.

The study recommends that, the various institutions involved organize training for its leaders to acquire knowledge in interdependence processes and in using up-to-date techniques and procedures to be able to strategize or outline a suitable strategic plan towards achieving a successful interdependence. This will help aid them to have much control over the institutions performance in the future.

Other sources of funds must be identified and tapped into to help generate enough funds for the schemes to be able to fund the training of their staff without depending on government interventions. The schemes should periodically, organize seminars, workshops and symposiums on the need for interdependence for its employees. This will help contribute to increase interdependence activities resulting in the growth of the schemes.

Through the generation of more funds, executives and managers of the institutions could employ some consultants or experts to train them on how to improve on their interdependence activities to help address the numerous challenges facing the relationships among the schemes and service providers.

Again, the schemes, can also laisse with the other health insurance bodies or foundations and study from them other ways of dealing with interdependence activities for the promotion of a common goal of improving their workings, thus a degree of coordination should be maintained through mutual adjustment.

In addition, when there is funding, employees can comfortable carry out interdependence activities; because communication to and fro will be easy and vehicular movement between schemes and service providers can also be carried out without difficulty.

The study further recommends that more researches are conducted to assess the performance of interdependence activities within organisations in the country to help improving their operations.

The study concludes that, Provision of healthcare for the Ghanaian citizenry and any country is very important. It is therefore very necessary for Governments to develop a national health programme which will furnish adequate public health services and ample medical care facilities for all areas of the country and all groups of people, thus creating adequate physical and financial access to health care in the country. To this end, understanding the various players in the industry and how they interact and interdepend upon themselves will help strengthen the needed trust and co-ordinations among the various players in the industry. Effective organizational interdependence is also a significant component of an organization's lasting achievement, as it facilitates actual work relations.

REFERENCES

Adams, J.S. (1963). Towards an understanding of inequity. Journal of Abnormal and Social Psychology, 67(5), 422-436.

Alder, P. S. 1995. Interdependencies and coordination: The Case of the design manufacturing interface. Organization Science, (62): 147-164.

Alderfer, C.P. (1972). Existence, relatedness and growth: Human needs in organizational settings. New York: Free Press.

Amarteifio, I. Y. ((January 2012)). Understanding the NHIS Provider Payment System and Capitation. Understanding the NHIS Provider Payment System and Capitation. : The Chronicle.com.gh.

Amin, M. E. (2005). Social Science research: conception, methodology and analysis. . Kampala: Makerere University Press.

Arpoh-Baah, Bernard "Assessing financial sustainability of National Health Insurance Scheme (NHIS) in Ghana Case Study: Mpohor Wassa East Mutual Health Insurance Scheme "6-Jun-2011

Asafo-Adjei, Birago "An evaluation of the recruitment and selection policies and practices of the National Health Insurance Authority. A case study of the Brong-Ahafo Region." 25-Jul-2014

Atindanbila, S. (2013). Research methods & SPSS analysis for researchers. Accra: BB Printing Press.

Ayee, J.R.A. (2001). Public service reform in Ghana: A case study of contemporary reform problems in Africa. Africa Journal of Political Science, 6(1), 1-41.

Bart, V. &. (1987). Interdependence: An Alternative Conceptualization. . Academy of Management Review, 486-498.

Capitation", D. A. (2014, February). Dapatem, Donald Ato (February 2014), "Prez explains the use of Ashanti to pilot NHIS Capitation". Daily Graphic. (D. D. Graphic, Interviewer)

Carmel, E., and Tjia, P. 2005. Offshoring information technology sourcing and outsourcing to a glogal workforce. Cambridge: Cambridge University Press.

Charmaz, K. ((2003)). Qualitative psychology: A practical guide to research methods. London: Sage Publications Ltd.

Charmaz, K. (2006). Constructing Grounded Theory: A Practical Guide through Qualitative Analysis. London: Sage.

Clarke, A (2005) Situational analysis: grounded theory after the postmodern turn.: Sage Publications.

Cook, J. & Wall,T. "New Work Attitude Measures of Trust, Organizational Commitment and Personal Need Non-Fulfillment", Journal of Occupational Psychology, 53, 39-52, (1980).

Crewell, J. (2012). Educational research: Planning, conducting, and evaluating quantitative and qualitative research (4th edition). Upper Saddles River, NJ: Peasrson Education.: NJ: Peasrson Education.

Dapatem, Donald Ato (February 2014), “Prez explains the use of Ashanti to pilot NHIS Capitation”. Daily Graphic

Deutsch, M. (1960). The effect of motivational orientation upon trust and suspicion. In Human Relations, 13: 123-140.

Dirks, K.T. (1999) “The Effects of Interpersonal Trust on Work Group Performance,” Journal of Applied Psychology, Vol. 84, pp. 445-455.

Eraut M. (1994). Developing Professional Knowledge and Competence. London: Falmer.

Fisher F, Pankowski ML. (1992) Mandatory continuing education of clinical laboratory personnel. J Con Edu Health Profss; 12: 225-34.

Galford and Drapeau, (2007), An Integrative Model Of Organizational Trust: Past, Present, And Future 346-11p.

Garetti R. Jones (2010); Pearson International Edition Organizational Theory, Design, and Change.

Gareth R. Jones. (2009); Organisational Theory, Design and Change: Six Edition/ Global Edition. Texas A & M University

Ghana Ministry of Health, 2008. Health Sector Programme of Work-2007, Independent Review, Accra: Ministry of Health.

Ghana Ministry of Health. 2004b. Guideline for Designing and Implementing District-wide MHOs in Ghana, Accra: Government of Ghana Publishing House.

Ghana Statistical Service (2013) Regional Analytical Report, Greater Accra Region: 2010 Population and Housing and Housing Census, Accra, Ghana.

Ghanaweb.com. (2014, August 13). Retrieved from programs.jointlearningnetwork.org.

Ghanaweb.com, (2014, August). Retrieved from programs.jointlearningnetwork.org,2014.

Grandori A. 1997 'An organizational assessment of inter-firm coordination modes' Organization Studies 18/6: 897-925 .

Griffin, R. W. (1999). Management. Boston: Houghton Mifflin.

Gyimah-Boadi, E. (2002). Confronting corruption in Ghana and Africa. Ghana Center for Democratic Development (CDD-Ghana), Briefing Paper, 4(2), 1-6.

International labour Organization. (2005). Improving social protection for the poor: ISBN 92-2-117144-2.

Mohamad Idham Md Razak, Siti Hawa Kasim, Raıhan Md Ghazali, Sheela Paramasivam, Dr. Geraldine John Phılıp De Mello. (February 2014). International Journal of Humanities and Social Science Vol. 4 No. 4 [Special Issue – February 2014] 196

Johnson-George, C., & Swap, W. (1982). Measurement of specific interpersonal trust: Construction and validation of a scale to assess trust in a specific other. Journal of Personality and Social Psychology, 43: 1306-1317.

Joseph Mensah, Joseph R. Oppong, Christoph M. Schmidt "Ghana's national health insurance scheme in the context of the health MDGs: an empirical evaluation using propensity score matching" First published: 22 August 2010

JoyNews Television Interview,22nd April 2015

Kelley, T. a. (1959). interdependence theory.

Kumar, K., van Fenema, P. C., & Von Glinnow, M. A. 2005. Intense collaboration in globally distributed work teams: Evolving patterns of dependencies and coordination. In D. L. Shapiro, M. A. Von Glinow and J. L. C. Cheng (Eds), Manageing multinational teams: Global perspectives:127-154. Oxford: Elsevier/JAI.

Kuldeep Kumar, Paul C. van Fenema and Mary Ann von Glinow. Offshoring and the Global Distribution of Work: Implications for Task Interdependence Theory and Practice Source: Journal of International Business Studies, Vol. 40, No. 4 (May, 2009), pp. 642-667: Palgrave Macmillan Journals.

Lawrence, Paul R.; Lorsch, J. W. (1967). Organization and Environment: Managing Differentiation and Integration. Harvard University Press. ISBN 978-0875840642. law, A. 6. (2003).

Miles, R. M. (1979). Organizational conflict and management. In Miles, R. H. And Randolph, W.A., The Organisation Game, pp. 204-21. Santa Monica, CA: Goodyear.

Mayer, Roger C, James H, Davis& F. David Schoorman (July 1995), An Integrative Model of Trust, In The Academy of Management Review, Vol 20, No. 3. pp 709-734.

Myjoyonline. (2015, March 24th). Retrieved from Myjoyonline.com.gh.

Murray, Lotoya. Three Types of Interdependence in an Organizational Structure. Houston. Hearst Communications. 4 December 2012.<http://smallbusiness.chron.com

Owusu - Mensah, Samuel Assessing the clientele satisfaction of the implementation of the National Health Insurance Policy in Ghana: A comparative study of the District and private Mutual Health Insurance Schemes. 18-Jul-2010 Submitted to West Kentucky University

Owusu, A. Y. (2010). National /Mutual Health Insurance in Ghana-Introduction. Pharmaceticals. (2015, April). NHIS and the way forward. (J. N, Interviewer) Practitioners, S. o. (2015, April 22nd). (J. Television, Interviewer)

Paul R. Lawrence and Jay W. Lorsch Differentiation and Integration in Complex Organizations; Administrative Science Quarterly Vol. 12, No. 1 (Jun., 1967), pp. 1-47 Sage Publications, Inc.

Reis, H. T. (2013). Interdependence Theory and Related Theories.

Ritchie, J. L. (2003). Qualitative research in practice: a guide for social science students and researchers. London: Sage.

Rockart, J. F. (1988). Information Technology and the New Organization: Towards More Effective Management of Interdependence. Information Technology and the New Organization.

Rockart, J. F. (1988). Information Technology and the New Organization: Towards More Effective Management of Interdependence. Information Technology and the New Organization: Working Paper No. 2076, 00.

Rockart, John F; Short, James E. Sloan Management Review; Cambridge30.2 (Winter 1989): 7. IT In The 1990s: Managing Organizational Interdependence

Rose-Ackerman, S. (2001) 'Trust, honesty and corruption: reflection on the state-building process', European Journal of Sociology, 42(3), pp. 526–570. doi: 10.1017/S0003975601001084.

Rothwell, R., & Robertson, A.B. (1973). The role of communications in technological innovation. Research Policy, 2, 204—225.

Rusbult, C. E., & Lange, P. A. (2013). Interdependence, Interaction And Relationships. Annual Review Inc, 351–75.

Sabi, W. ((2005)). Ghana National Health Insurance Scheme. ,. University of Cape Town: Unpublished MA Thesis, Department of Public Health University of Cape Town.

Service, G. H. (2015, April 23). NHIS the way forward. (D. Graphic, Interviewer) (2015). The Daily Graphic. (NHIS as it stands.

Tenkorang, K. R. (2015). Automated System For National Health Insurance Scheme (NHIS) Claims (Christian Service University Colleague).

Thompson, J. D. (1967). Organization in Action. New York: McGraw-Hill.

Uhcc.org.gh. (October 2013). Ten Years of the National Health Insurance Scheme in Ghana; A civil society perspective on its successes and failures. Universal Access Health Care Campaign. Retrieved from Uhcc.org.gh,

Universal Access Health Care Campaign. (2013). Ten Years of the National Health Insurance Scheme in Ghana. Accra: Uhcc.org.gh.

Victor, Bart and Richard S. Blackburn.” Interdependence: an alternative Conceptualization”, The Academy of Management Review, 1987

Von Hippel, Eric. "Task partitioning: An innovation process variable". Research Policy. 19 (5): 407–418. doi:10.1016/0048-7333(90)90049-C.

Wagner, John, and Lollenback, John. Organizational Behavior: Securing competitive advantage. Taylor and Francis. 2009.

Wagner, J. A. (2009). Organizational Behavior: Securing Competitive Advantage. London: Routledge.

Worren, Nicolay (2012). Organisation Design: Re-defining complex systems. Pearson. ISBN 978-0273738831.

Yin, R. (1994). Case Study Research: Design and Methods. Thousand Oaks, London, New Delhi: Sage.

APPENDIX

INTERVIEW GUIDE/QUESTIONAIRE

INTERDEPENDENCE AMONG UNITS; CASE STUDY OF GHANA HEALTH INSURANCE

Researcher: Emma Kamassah

Address: Abidinpasa Clav 100

Makro Buyuk , Ankara-Turkey

Tel: Mobile: +905078251775

Home: +905437319580

E-mail: kora_emma@yahoo.com

Thank you for agreeing to participate in this study which will take place from 1st- 31st March, 2016. This form outlines the purposes of the study and provides a description of your involvement and rights as a participant.

The purposes of this project are:

1. To fulfil a course requirement for MA Management and Organization Award at the Yildirim Beyazit University, Turkey
2. To determine the interdependence among firms in the Ghana National Health Insurance.

The study is a survey and the attached questionnaire would be used to collect information which will include demographic data such as gender, age, and employment status as well as your opinion on the Interdependent among Units, the case of Ghana Health Insurance Schemes and the various accredited health care institutions in Ghana. You are encouraged to ask any questions at any time about the nature of the study and the methods that I am using. Your suggestions and concerns are important to me; please you may contact me at any time at the address/phone numbers listed above.

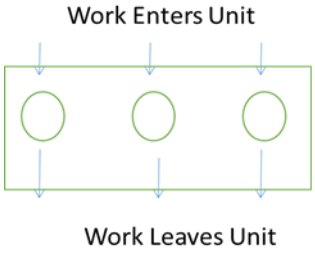
I guarantee that the following conditions will be met:

1. Your real name will not be used at any point during the information collection, or in the written report; instead, you and any other person and place names involved in the study will be given an identification number.
2. Your participation in this research is voluntary; you have the right to withdraw at any point of the study, for any reason, and without prejudice, and the information collected and reports written will be turned over to you.
3. The confidentially of the information that will be collected would be safeguarded and your privacy and anonymity will be ensured throughout the study and publication of the research material.

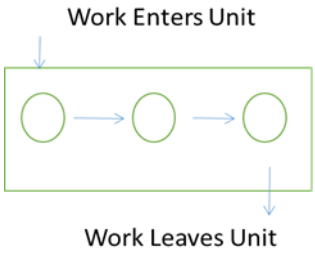
It will therefore be appreciated if you could spare some minutes to complete this questionnaire. The research is purely for academic purposes.

Thank you for participating in this research.

Provided below is a table depicting various scenarios that may possibly illustrate the task exchanges between different work units. I want you to examine each exemplary scenario and the illustrative figure carefully and select the scenario(s) that best describes the EXCHANGES BETWEEN THE NHIS AND THE SERVICE PROVIDERS and explain the reasoning behind your choice(s). There is no page restriction to you explanations; they can be as lengthy as necessary.

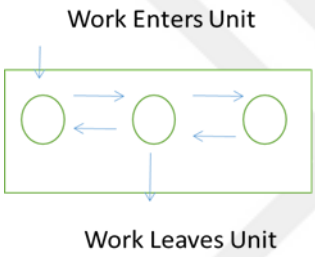
llustrative figures	Scenarios	Please indicate the reason why you picked the scenario(s) in the space beside your choice(s)
	The following scenarios encompass task exchanges in which parts contribute independently to the whole and there is no workflow between them.	
	Scenario No.1: In a supermarket, each cashier works	

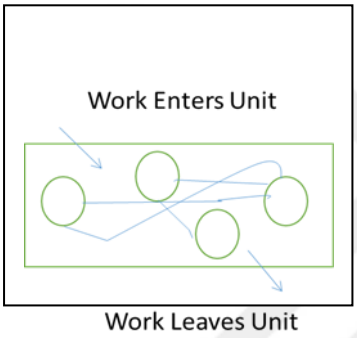
	independently. At the end of the day, each cashier's contribution is pooled…	
	Scenario No.2: In a machine shop, each employer might operate a lathe to produce bolts independently. The action of one dose not affects the other. The overall performance of the manufacturing department is a collation of all individual employees.	
	Scenario No.3: In a bank for example the activities of loan department; the routines involved in lending money have no relations to that of	

	receiving money- checking account department. But the performance of the bank on the whole depends on how each department dose their work.	
	Scenario No 4: A departmental store, like McDonald's Franchise, operates independent from each other, but together all stores determines the performance of the whole organization.	
	The following scenarios encompass task exchanges where individual work unit activities are directly connected in a linear	

	fashion. For example, as in the figure, work unit A's output becomes work unit B's input.	
	Scenario No.1: The frame of an automobile is transferred from one unit and becomes input for another unit where the interior will be installed.	
	Scenario No.2: In th sporting sctor- like foothball, the prformance of one person to a larg extent determines how good or bad the others will perform.	

	Scenario No.3: The case in rugby for example how well the deffence line performes determines how well the offensive can perform. Thus if the deffence is unabl to secure the ball the offensive cannot perform its task scoring points.	
	Scenario No.4: In a bakery shop the finished products depends on the ability of the materials managment department to obtain adequate amounts of high quality inputs in a timely manner.	

	Scenario No.5: Th ability of the sales function to sell finished products depends on the quality of the products coming out of the manufacturing department.	
	The following scenarios encompass task in which input, conversion, and output activities are inseparable. Thus, activities of all people and all department fully depends on one another Scenario No.1: R & D department in a pharmaceutical company.	

	Scenario No.2: A clerical staff's task in a company. His activities and that of his colleges are fully depended on one another.	
	The following scenarios encompass task in which input, conversion, and output activities are intense. Thus activities of all people and all department fully jointed on one another Scenario No.1: A group of members carrying a large sofa together.	

Section A- Demographic information

*Please **tick (✓)** the appropriate box*

1.

a. **Gender**

Male ☐

Female ☐

b. Age (in years)

< 21 ☐

21-30 ☐

31-40 ☐

41-50 ☐

51-60 ☐

c. What is your area of work?

With the Health Insurance Scheme ☐

With the Accredited Facilities ☐

d. How many years have you been with the scheme?

<1 ☐

1-5 ☐

6-10 ☐

11-15 ☐

16 and above ☐

e. Which class of Rank do you belong?

Junior staff ☐

Senior staff ☐

Management ☐

Others (please specify) ☐

If other please specify……

f. Professional qualification/s held.

G. C. E 'O' Certificate/ SSCE ☐

G.C.E 'A' Certificate ☐

Diploma ☐

Bachelor's degree ☐

Master's Degree ☐

PhD ☐

Other ☐

If other please specify……

Section B- Knowledge, Attitude and Degree of Interdependence of Firms

Before responding to this part the concept of interdependence had been explained to the respondents by the researcher with examples of scenarios. It is assumed therefore that the respondent had a rough idea about interdependence.

Please ***tick (✓)*** *the appropriate box*

2. The relationship that exist between the schemes and the accredited facilities is that of a cordial one?

a. True ☐

b. I have no idea about it ☐

c. False ☐

3. How often does the scheme interact with the accredited facilities and vice versa?

Often ☐

Sometimes ☐

Rarely ☐

Never ☐

4. Does your institution have training policy on interdependence for the staff?

Yes ☐

No ☐

Not aware ☐

5. How often do you participate in the dealings of your institution with the scheme/accredited facilities?

Often ☐

Sometimes ☐

Rarely ☐

Never ☐

6. When did you last participate in the dealings of your institution with the scheme/accredited facilities?

< 1yr ☐

1-5yrs ☐

6-10 yrs ☐

11 yrs and above ☐

Never ☐

7. How do you get access to information on the dependence of your institution with the scheme/accredited facilities?

Please you can tick more than one box if applicable.

Professional journals ☐

Colleagues ☐

Workshops ☐

Have no access to information ☐

Other ☐

If other please specify……

8. How important is the dealings of your institution with the scheme/accredited facilities to you?

Very important ☐

Important ☐

Unimportant ☐

Not very important ☐

Don’t know ☐

9. Do you think dependence of your institution on the scheme/accredited facilities requires a professional knowledge and skill to practice?

Yes ☐

No ☐

Don’t know ☐

10. Do you feel that management of your institution believes dependence on other institution is an important part of your professional development?

Yes ☐

No ☐

Don’t know ☐

If your answer is No, can you explain why this is so in the space provided?

……

……

11. How would you rate your institution's interest in depending on other institutions?

Very Good ☐

Good ☐

Poor ☐

Very Poor ☐

Don't know ☐

Section C- Forms, organization, funding and barriers of INTERDEPENDENCE

Before responding to this part the concept of interdependence had been explained to the respondents by the researcher with examples of scenarios. It is assumed therefore that the respondent had a rough idea about interdependence.

*Please **tick (✓)** the appropriate box*

12. Who do you think should spearhead the relationship between your institution and the scheme/accredited facilities?

The Organisation (Management) ☐

The Professional Association (MoH, GHS etc) ☐

The Individual ☐

Have no idea ☐

13. Do you think dependence causes institutions to improve upon?

Yes ☐

No ☐

Don't know ☐

If your answer is No, can you explain why this is so in the space provided?

……

14. Which of the following do you think is a major concern about interdependence among firms?

Time constraint ☐

Financial constraint ☐

Lack of motivation ☐

Lack of access ☐

Others ☐

If your answer is others, please specify?

……

……

15. Who do you think should fund programmes that aim at educating individual firms to adopt good interdependence policies?

The Government ☐

The Organisation (Department/Agency) ☐

The Professional Association (MoH, GHSetc) ☐

Have no idea ☐

17. In relation to the forms of training to adopt good interdependence for organisational development, please indicate in a scale of 1-8, 1 being the most desirable form to you and 8 the least desirable form?

Workshops ☐

Seminars ☐

Lectures ☐

Conferences ☐

Refresher courses ☐

In- service training ☐

Post graduate courses ☐

Correspondence courses ☐

Others (Please specify) ……

Your contribution to this survey is very much appreciated.

Thank you