Challenges Facing the National Health Insurance Scheme: Implication on Quality Healthcare Delivery in Ghana

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Abstract. The problem of quality healthcare is much more daunting in the case of developing countries including Ghana. Issues of poor access, longer waiting time and delays are persistent challenges confronting health care in developing countries. These challenges in the provision of quality health care have prompted the government of Ghana to institute the National Health Insurance Scheme to provide accessible and cost effective health care to its citizens. The vision of government in instituting the National Health Insurance Scheme in the country is to ensure universal access to health by all citizens. Given the persistent challenges of NHS within the country this paper focused on the peculiar challenges at the University of Cape Coast Hospital. A total sample of 136 respondents was reached comprising students, University staff, as well as scheme managers. The results showed the challenges faced by the scheme include: non availability of medicines or drugs for patients, increase in out-patients’ department attendance. The study recommended that the operations of the scheme should be re-organised to focus on providing access, affordable and effective healthcare delivery through the provision of adequate drugs and better care for NHIS holders.

Key words: National Health Insurance, challenges, quality healthcare delivery, healthcare funding

INTRODUCTION

The funding of health care or health systems the world over has been of a major concern to various governments. Health insurance is one of the options adopted by different countries to finance their health care.

The concept of health insurance has been practiced for many decades in the Western World. It is somewhat a relatively new phenomenon in Africa and the West African sub-region in general. Insurance takes risks which are too large for one person and spreads the risks around many people so that they become small risks for a large number of people. The business of insurance is usually undertaken by an insurer who is the individual, organization or company selling the insurance for a fee or premium. The concept of insurance takes different forms and these include disability insurance, casualty insurance, life insurance, property insurance, liability insurance, credit insurance and health insurance. The subject matter of this research is health insurance. This has seen several definitions and meanings from various authorities in the field of insurance and health. Some of these definitions which falls within the scope of this study include the definition by Kankye (2001) who intimated that health insurance is when a group of people come together to contribute towards meeting the cost of their health care needs. In that case, they are said to be operating on the principles of a health insurance scheme. This means that health insurance is a system whereby a large number of people contribute small amounts of money into a common pool in order to receive a specific health benefit within a given period of time (Atim, 2000).

After independence, Ghana went through a tested history with regards to health care funding in the country. Different strategies such as “the hospital user-fees,” “the exemptions policy” and the “cash and carry system” were some of the policies adopted by post independent governments to finance health care in Ghana. These strategies did not prove successful and it was against this backdrop of unsustainable health care financing schemes that the Government of Ghana in 2003, introduced the National Health Insurance Scheme to provide accessible, affordable and good quality health care to Ghanaians especially the poor and vulnerable in society. The government of Ghana through the Ghana Poverty Reduction Strategy (GPRS) outlined a strategy for dealing with poverty (GPRS-2006). A major component of the strategy was to deliver accessible and affordable health care to all residents of Ghana, especially the poor and vulnerable (Ministry of Health [MOH], 2002). The vision of government in this regard, was therefore, to ensure equitable and universal access for all residents of Ghana to an acceptable quality of essential health care. This was to protect individuals against the need to pay out of their pockets in order to access quality health care.
care. The government has fashioned out its unique own health insurance strategy based on the principles of equity, risk equalization, cross-subsidization, solidarity, quality care, efficiency in premium collection and community participation. The scheme operates in partnership with government and other stakeholders to ensure sustainability and also enjoys reinsurance from central government.

Again, government in August, 2003, adopted two main types of health insurance regimes to be operational in the country. These were the social type health insurance scheme, made up of District Mutual Health Insurance Scheme and the Private Commercial Health Insurance Scheme. The District Mutual Health Insurance Scheme (DMHIS) was the model adopted by government to deliver quality health care to the poor and under-privileged in society. The model was a fusion of two concepts; the Traditional Social Health Insurance Scheme for the formal sector workers and the Traditional Mutual Health Insurance for the informal sector of the society. Thus, the DMHISs were to incorporate members from both the formal and the informal sectors (Stine, 2003). The formal sector contributes 2.5% out of the 17.5% Social Security and National Insurance Trust (SSNIT) contribution, whereas the informal sector contributes at least GHe7.2 per annum. The contribution levels of the people have been categorized based on their socio-economic stratification. The policy framework proposes six main types of categorizations. These are; core poor, very poor, poor, middle income, rich and very rich. The minimum benefit package of the National Health Insurance Scheme was to ensure that every citizen of this country had access to a level of health care that provides adequate security against diseases and injury and to promote and maintain good health. All service providers within the public, private and mission sectors have been mobilized to provide health care under the National Health Insurance Scheme. They were however expected to satisfy a certain accreditation criterion. Government also instituted by law a 2.5% National Health Insurance Scheme levy on goods and services. Funds accruing from this source shall be used to subsidize the contributions of the under-privileged segment of the society and to pay for the contributions of the core poor and other vulnerable groups.

The National Health Insurance Scheme has been regulated by the National Health Insurance Council through the National Health Insurance Act 650. It also operates under units responsible for Policy Planning Monitoring and Evaluation, Registration, Accreditation and licensing Unit; Administration, Management Support and Training Unit, Fund Management and Investment unit.

According to Atim and Stock (2000), health insurance schemes have been able to improve financial access to health care especially for the poor rural dwellers in the informal sector that were hardest hit by the effects of the “Hospital User-Fees.” It has improved their health seeking behaviour and reduced “under the table charges.” Moreover, the schemes have increased the utilization of health services, community solidarity and indirectly improved health status as well as reduced the cost of health care to the patient.

In the assertion of the World Health Organisation [WHO](2000), health insurance is an increasingly recognized tool for financing health care provision in low income countries. Given the high demand for quality health care services and the extreme under-utilization of health services in developing countries, it has been argued by some health experts such as Jutting (2001), that social health insurance improve access to acceptable quality health care. Health Insurance seems to be the promising alternative as it offers the opportunity to pool risks, thereby transferring unforeseeable health care cost to fixed premiums (Jutting, 2001).

Proponents of community-based mutual schemes argue that, these schemes have the potential to increase access to health care (Kutzin & Howard, 1992). These community-based schemes usually operate in conjunction with health care providers, such as hospitals and other health centres in the area of operation and therefore there is proximity to healthcare centres and residents with registered health insurance cards can easily access healthcare frequently guaranteeing residents easy access to health in general.

Notwithstanding the strengths and weaknesses of the mutual health insurance schemes, there abound some potential social benefits of such schemes. These benefits impact greatly on health care access, labour, productivity, and household’s risk-management capacity of the communities concerned. The fact that some benefits exist for health schemes means that more innovative ways of sustaining these low-cost health insurance schemes should be exploited to grant various categories of individuals’ opportunity to fit into health insurance schemes according to their capacity and ability to afford.

Meanwhile, the strength and focus of this study is on the national health insurance scheme started by the government of Ghana in 2003. Since the inception of the scheme there have been several challenges to the scheme including lack of infrastructure in the various hospitals, skilled personnel and quality of service delivery. Therefore, this study sought to investigate some of these challenges facing the scheme faces in the University of Cape Coast hospital in the Central Region of Ghana.

The vision of government for a health insurance scheme in the country was to ensure equitable universal access for all residents of Ghana and acceptable quality of a package of essential health service without out-of-
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pocket payment at the point of service. The District Assemblies were mandated to facilitate the establishment of health insurance schemes in the districts. At the initial stages, government provided start-up funds for the launch and facilitation of this project. However, it was perceived that human capital, logistics and other health infrastructure at the district and regional levels posed a challenge to the health insurance scheme as a viable and sustainable one (Atk

Also, there have been numerous complaints from National Health Insurance Scheme subscribers about delays in the issuance and renewal of their membership identity cards, quality of health care provided at the various health facilities in the country as well as lack of skilled personnel to manage the scheme. In the same vain, scheme managers, students and staff of the University of Cape Coast equally go through some challenges in accessing the healthcare services from the University hospital. These general observations and challenges gave impetus to this study. For instance, the inability of some National Health Insurance Scheme subscribers to use their membership identity cards to access health care nationwide is a serious challenge to the scheme currently (Yeboah, 2007). At the University of Cape Coast, students, staff and their dependants are sometimes compelled to pay for the cost of their healthcare either because they are not registered members of the scheme or the issuance or renewal of their National Health Insurance Scheme cards have been unduly delayed (Yarboi, 2007).

Meanwhile, the University authorities and management has made it a policy to register all staff and students of the University on to the District Mutual Health Insurance scheme to ensure that members of the University community have access to equitable and affordable health care. Despite all these lofty ideas and efforts, there have been numerous challenges that confronting the scheme. These challenges as indicated earlier on cuts across the broad spectrum of actors and institutions that should make the scheme work for Ghanaians. The study therefore sought:

(a) To examine the challenges faced by University Hospital authorities with the management of the scheme.

(b) To examine challenges faced by the District Mutual Health Insurance scheme managers and their staff at University Cape Coast.

(c) To identify the problems encountered by students and workers of University Cape Coast with the implementation of the NHIS on campus.

(d) To make suggestions for policy makers and government on ways to improve upon the operations of the scheme at University Cape Coast.

The study was also guided by the following research questions.

(a) What problems do the Hospital authorities or management face with regard to NHIS at University Cape Coast?

(b) What challenges do the District Mutual Health Insurance scheme managers and their staff face at University Cape Coast in the implementation of NHIS?

(c) What challenges do students of the University face in accessing healthcare through NHIS?

(d) What challenges do staff of the university face in accessing healthcare through NHIS at the University Cape Coast Hospital?

(e) How can the operations of the NHIS at the University Cape Coast Hospital be improved?

**METHODOLOGY**

The central theme of this study was to investigate the challenges with the implementation of the National Health Insurance Scheme at the University Cape Coast hospital. This requires a simple and effective research design and hence the descriptive design was employed in this study (Amedah, 2002).

Furthermore, Best and Khan (as cited in Amedah, 2002, p.50) saw the descriptive research design as concerned with the conditions or relationships that exist, such as determining the nature of prevailing conditions, practices, attitudes and opinions held by people about issues or phenomena processes that are going on and trends that are being developed. The study also engaged the use of both qualitative and quantitative data to ensure an effective synergy between the two approaches.

**Population of the Study**

The population of study comprised students, staff, and managers of the national health insurance scheme at the University hospital. The population of the study is summarised in the Table 1.

<table>
<thead>
<tr>
<th>Table 1: Target Population</th>
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<tbody>
<tr>
<td>Target population</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>UCC-Student</td>
</tr>
<tr>
<td>UCC-Staff</td>
</tr>
<tr>
<td>UCC-Scheme managers</td>
</tr>
<tr>
<td>Director of University Hospital</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Source: UCC Students Records Section, 2011
According to Siegel (1997), one is free to choose any sample size from an identifiable group of individuals, and there is no requirement that the sample size should be the same for each group but according to the population of the group. Guided by this assertion, the sample sizes of the various categories that constituted the target population were obtained based on the total individuals in each category. A total number of 136 people were selected to participate in the study. The subjects were chosen from the population by non-random methods. The participants were made up of 74 students, graduate and undergraduates, 60 University staff teaching and non-teaching staff the Health Insurance Scheme Manager and the Director of University Health Services.

The first non-random method employed was the stratified sampling method which was used to select subjects from various categories to make up the sample for the study. The stratified method of sampling involves dividing the population into homogenous strata and selecting sample elements from each of these strata. A total of three strata were established and sample elements selected from each stratum. These strata were made up of students, staff teaching and staff non-teaching. According to Nieswiadomy (1993), the basis of stratification should be a variable of importance to the study, such as sex, age, rank and educational background.

The second method employed after the stratified sampling was the convenient sampling method.

This is also non-probabilistic and perhaps the most common sampling strategy for qualitative researchers (Patton, 1990). The method allows the researcher to obtain information from respondents who are readily available and willing to participate in the study. Hence, the sample may not necessarily be proportional to the population. Therefore, in this study the respondents were selected based on the respondent’s convenience. The respondents were selected from the quotas assigned to each category of the population. The method was used in this case because some staff of the University hospital work in three shifts and also enjoy routine off duty periods. This would have made it difficult reaching many of such respondents if they were randomly selected. The choice of non-probability methods or techniques of sampling was informed by the desire to use readily available subjects for the study to save time. The said techniques are also easy to use and less expensive to the researcher as compared to other techniques (Nieswiadomy, 1993).

**Category of Respondents**

The Scheme Manager and the Director of University Health Services were reached through the use of the purposive sampling method. The sampling technique was based on the assumption that the researcher had enough knowledge about the respondents of interest (Nieswiadomy, 1993). In other words, the researcher believed, this particular group had relevant information for the study. Table 2 displays the various categories of respondents selected for the study.

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching staff</td>
<td>18</td>
<td>13.2</td>
</tr>
<tr>
<td>Non-teaching staff</td>
<td>43</td>
<td>31.6</td>
</tr>
<tr>
<td>Undergraduate students</td>
<td>48</td>
<td>35.3</td>
</tr>
<tr>
<td>Graduate students</td>
<td>27</td>
<td>19.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>136</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field data, 2009

Primary data was gathered through the use of interviews and questionnaires. Secondary data was gathered from reviews of documents which have a direct bearing or link with the objectives of the study. These included textbooks, journals, newspapers, magazines, and records from the Ministry of Health (2006), Ghana Health Service and other materials that dealt in part or aspects of the study. The use of both primary and secondary data gave an opportunity to cover all aspects of the study, documented and non-documented literature. Questionnaires were used for the university staff, teaching and non-teaching as well as the students.

The questionnaire sought from respondents the challenges that they faced in their respective capacities when accessing health care from the University Hospital. This mode of soliciting information form respondents was the best because they were all literates and therefore could read and write. Again the questionnaire allowed for many respondents to answer questions. The questionnaire was divided into two parts, part one dealt with personal data of the participants such as sex, age, level of education and occupation. The second part of the questionnaire dealt with factors that pose as challenges to the implementation of the NHIS. Issues captured under this section of the questionnaire pertained to delays in issuing subscribers with identity cards, waiting time to see a doctor at OPDs, inadequacy of health personnel to attend to respondents whenever they visited the hospital and lack of essential drugs at the hospital forcing respondents to purchase drugs outside the

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hospital. The questions included the Likert scale questions, closed-ended and a few open-ended items. These offered respondents options to choose from and also expressed their views on the subject matter. Selected persons such as the Director of University Health Services and the Metropolitan Health Insurance Manager were interviewed. The interview guide was semi structured and solely related to the challenges faced by the scheme operators and other stakeholders. The interview gave these personalities the opportunity to dilate on pertinent issues that were not captured by the questionnaire.

**RESULTS AND DISCUSSION**

This section of the paper takes a detailed look at the results gathered from the field. The discussion under this section was structured to coherently address the objectives set out in the study.

**Characteristics of Respondents**

A total of 136 respondents took part in the study. Details of the staff and students’ categories were captured in Table 2. A research question on personal characteristics was asked because personal characteristics such as age, gender, marital status and educational status or attainment can influence a respondent to either embrace the NHIS or otherwise.

The study recognizes that the gender of a person could influence the ability and willingness of the individual to register with the NHIS. In the same vein the age of a person would also encourage people to register with the scheme. This is because older people would be more willing to register with the scheme as compared to younger people. This is because older people are more likely to predispose themselves to illness and diseases as compared to younger people. Hence younger staff may be reluctant to register with the scheme as compared to older staff of the University. A similar argument could be raised in the case of education with the highly educated been willing to register as compared to the not educated or least educated. Therefore, capturing these variables in this research was relevant.

**Gender Distribution of Out-patients**

Of the 136 respondents, 55.1% are females and 44.9% are males. The women were slightly ahead of the men in of health care participation and the utilization of the National Health Insurance Scheme. This result is in tandem with the statistics from the University Hospital which suggests that more females than males were insured with the use of the National Health Insurance Scheme. Table 3 displays data from the University hospital showing out-patients by gender and National Health Insurance Scheme Utilization.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Insured</th>
<th>Non-insured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11,474</td>
<td>15,214</td>
<td>26,688</td>
</tr>
<tr>
<td>Female</td>
<td>11,877</td>
<td>13,746</td>
<td>25,623</td>
</tr>
<tr>
<td>Total</td>
<td>23,351</td>
<td>28,960</td>
<td>52,311</td>
</tr>
</tbody>
</table>

Source: UCC, Hospital Annual Review 2006-2008

**Demographic Data of Respondents**

On the issue of marital status, 83.1% of the respondents are not married and 16.9% reported they are married at the time of carrying out the study. Meanwhile, the age distribution of the respondents indicates that majority of the respondents are within the age brackets of 25 years and below, whilst a significant number is between 26-40 years. Only 6.6% of the respondents are over 40 years. Therefore, majority of students who took part in the study influenced the basic characteristics of the sample. It is also clear that most of the respondents (83.1%) had attained tertiary education. This is not surprising as most of the respondents are graduates and undergraduates. About 5.9% of the respondents had attained senior high school level education whilst about 8.1% had attained other levels of education such as technical and vocational education. Only 2.9% of the respondents had attained the Junior High level of education.

**Challenges Facing NHIS at UCC**

The study identified the following factors as major challenges to the smooth running of National Health Insurance Scheme at University of Cape Coast:

**Hospital management.** One of the major challenges revealed by the study is the non-availability of medicines or drugs in the hospitals for patients or NHIS clients. When respondents were asked on a Likert scale their opinions on whether they are able to get all essential drugs prescribed for them by doctors, the result indicated that 48.5% of respondents strongly disagreed that they did not get all drugs prescribed for them by doctors, while about 18.4% of respondents disagreed to the assertion. This was further explained by the fact that either the hospital had run out of the drugs, or that they did not have it at all. It is a statement of fact that, not all diseases and medicines are covered by the NHIS. Consequently, subscribers are sometimes given prescriptions to buy drugs that are either not
available in the hospital or covered under the scheme. This definitely is always unpleasant experience to subscribers who had paid their premiums to the NHIS and are constrained to buy drugs in times of illness, because the hospital has either run out of stock or such drugs were not covered under the scheme.

Quality healthcare equally includes having easy access to drugs at affordable cost to the client. The case of the University of Cape Coast therefore poses not only a major challenge to the hospital but to the insurance scheme as well, since this could discourage people from further registering with the scheme.

In an interview with the director of the University health services as regards the lack or non-availability of drugs at the hospital pharmacy, the director attributed the problem to the increase in the number of insured people who seek access to healthcare at the hospital over the period. In the words of the director;

The number of people registered under the NHIS keeps increasing and this is not only for the staff of the University but also other people within the municipality access healthcare at the University hospital. This puts pressure on the available drugs and medicines at the pharmacy. Though we restock as early as possible the increasing numbers constantly creates shortages.

**Out-patient utilization trend.** The director’s assertion can be corroborated with the statistics gathered from the hospital which indicated that the number of insured people who access healthcare at the University hospital has witnessed an increase from 2006-2008. Table 4 displays the out-patients NHIS utilization trend in the hospital.

<table>
<thead>
<tr>
<th>Year</th>
<th>Insured</th>
<th>Non-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>2,992</td>
<td>55,434</td>
</tr>
<tr>
<td>2007</td>
<td>14,576</td>
<td>40,093</td>
</tr>
<tr>
<td>2008</td>
<td>23,351</td>
<td>28,960</td>
</tr>
</tbody>
</table>

Source: UCC, Hospital half-year performance review, 2011

From Table 4 it can be explained that the number of insured subscribers under the NHIS has risen over the period. This suggests corresponding pressure on healthcare at the health facility. As subscribers increase in number, demand for quality healthcare would also be sought.

Another challenge facing the hospital is the increase in Out-patient attendance. The implementation of the NHIS has witnessed a tremendous increase in Out-patient Department (OPD) attendance and admissions at the University of Cape Coast hospital. This also posed a major hindrance to the smooth running of the scheme in the University hospital. About 13.2% of respondents felt the increase in hospital attendance is a major threat to the delivery of services to clients at the University hospital. The increase in attendance by clients and NHIS subscribers has resulted in congestion in the hospital wards and Out-patient Departments. The increase in OPD attendance is shown in Table 5 with the statistics from the University hospital.

The increase in OPD attendance equally throws into the debate the question of quality as the number of health personnel available might be inadequate. It is therefore not uncommon to find one nurse attending to many patients at a time and this trend would eventually be transferred to the doctors. This is because the inadequate numbers of doctors equally mean the few available must work overtime to be able to attend to as many patients as possible. Again statistics from the University hospital demonstrate that the total staff strength is inadequate as compared to the increasing number of people who thronged the hospital to access health daily.

<table>
<thead>
<tr>
<th>Months</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>3783</td>
<td>4071</td>
<td>4658</td>
</tr>
<tr>
<td>February</td>
<td>4228</td>
<td>5205</td>
<td>5286</td>
</tr>
<tr>
<td>March</td>
<td>5467</td>
<td>6154</td>
<td>6234</td>
</tr>
<tr>
<td>April</td>
<td>4933</td>
<td>5259</td>
<td>5115</td>
</tr>
<tr>
<td>May</td>
<td>4382</td>
<td>4408</td>
<td>4987</td>
</tr>
<tr>
<td>June</td>
<td>4247</td>
<td>4942</td>
<td>5581</td>
</tr>
</tbody>
</table>

Total: 26,740 30,041 36,770

Source: UCC, Hospital half-year performance review, 2011

Table 6 displays the population to staff ratio in the hospital. Other related issues with increase attendance at the OPD was that patient waiting time was also increased or delay in seeing a doctor at the hospital with its consequent increase workload of health personnel and health expenditure. This waiting time also created anxiety among patients putting the quality into disrepute (National Health Insurance Scheme, 2010).
Implementation of NHIS. Another challenge with the operations of the scheme to the District Mutual Health scheme managers in the University of Cape Coast was the delays in processing NHIS cards for new subscribers of the scheme. Respondents reported that it took a minimum of 3-6 months to process and issue new NHIS cards for subscribers. This result was confirmed by 43.4 percent of respondents. With a further 15.4 percent indicating it took them more than six months to obtain their NHIS cards. The delay was often blamed on the National Headquarters in Accra where all new cards are processed and delivered to the regions for onward distribution. This equally has consequences for quality of service delivered as subscribers without the cards are not only made to pay for the coast of treatment but stand the risk of not been attended to for fear of nonpayment and cost to the hospital. Again subscribers without cards and needs emergency attention could also be denied treatment as hospital staffs insist on NHIS cards before treatment is offered to clients. Therefore, the period of three to six months is such a long period that access to health for subscribers who may be waiting for their cards within this period would be difficult. The delays in issuing new subscribers with their registered cards was also re-iterated by the International Labour Organisation (2005) that states that notwithstanding the achievements made by, the NHIS is it still confronted with a number of challenges that include administrative bottlenecks such as delay in processing membership and claims.

Table 6: Patient-doctor Ratio at the UCC Hospital

<table>
<thead>
<tr>
<th>Number of personnel</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of doctors</td>
<td>7</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Population to doctor ratio</td>
<td>3051:1</td>
<td>1983:1</td>
<td>1856:1</td>
</tr>
<tr>
<td>Number of medical assistants</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Number of nurses</td>
<td>64</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>Population to nurse ratio</td>
<td>334:1</td>
<td>303:1</td>
<td>303:1</td>
</tr>
<tr>
<td>Number of midwives</td>
<td>16</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Number of community health nurses</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: UCC, Hospital half-year performance review, 2011

Meanwhile, 41.2% of respondents equally indicated that they got their NHIS cards within three months. This generally implies that the minimum waiting period of three months before maturity of NHIS cards is too long and hence put many subscribers who wait for their cards in difficulty as they have to pay cash in order to access health, or even resort to private health care providers and in the worse of scenarios be denied access to affordable health care.

Another revelation from this study which is a challenge not only to the University of Cape Coast hospital but also all other healthcare providers nationwide is the situation where false documentation and claims by individuals and institutions results in financial losses to the scheme. About 8.1% of respondents indicated that certain individuals and health institutions or facilities condone and connive through false documentation to dupe the scheme of huge monies. This was explained to mean that when some drugs prescribed by doctors are purchase outside the hospital the scheme reimburses such clients or individuals and therefore some individuals connive with certain pharmacies where false receipts are issued to such clients which are presented to scheme officials for reimbursement of individuals thus such clients end up cheating the scheme. This definitely does not send a good signal for the survival and sustainability of the scheme. This if unchecked could result in an imminent collapse of the scheme. In an interview with the metro director of the national health insurance scheme he intimated that

The scheme is losing money every month because some clients are finding dubious ways of cheating the scheme as they present false receipts to the healthcare providers who intend submit them for reimbursement of clients. No doubt, this practice threatens the sustainability of the scheme. We are gathering intelligence on that and the public and the healthcare providers should also be vigilant to detect and report such clients to us for necessary action.

Students and Staff. The study also revealed that the general lack of awareness about the issues and operations of the NHIS was also a challenge to some students and staff of the University of Cape Coast. Given the level of education of the respondents, it could be assumed that students and staff should have been aware of the issues and operations of the NHIS. Meanwhile, this study has proved the opposite. Some respondents are of the conviction that the major challenge facing the scheme is the lack of awareness about the issues and operations of the scheme. About 8.8% of respondents called for public education of the populace on the essence of NHIS in order to avoid the abuse of the system and ensure its sustainability. The need for subscribers to pay their premiums and fees for renewal of their expired NHIS cards, are all measures
to ensure that the scheme does not collapse or run into financial difficulties after a few years of operation. The complete processes involved in the NHIS should be made known to the populace.

CONCLUSION

From the findings of the study, one can conveniently conclude that the implementation of the NHIS on UCC campus faced various challenges which include institutional, material and human resource challenges. It became quite obvious that the public lacked some education on the operations of the scheme. Subscribers often get confused or surprised to learn that not all disease conditions and medications are covered by the scheme.

The heavy or increased OPD attendance and admissions reported in health facilities with the introduction of the NHIS is a strong indication that subscribers are taking advantage of the scheme to treat all manner of illnesses which were hitherto not a border to them. This clearly is one of the challenges of insurance schemes worldwide. This requires commitment and due diligence from the service providers and other stakeholders to ensure that the sustainability of the scheme is not compromised due to moral hazards.

RECOMMENDATIONS

(a) The provision of more drugs and medicines in the hospital for clients anytime they accessed healthcare. This could reduce the time and financial burden on subscribers who were often given prescriptions to buy medicines outside the hospital thereby defeating the aims and objectives of the insurance scheme.

(b) NHIS subscribers should be properly catered for or given better attention whenever they visit the hospital for healthcare. This notwithstanding, the increase in the number of people seeking healthcare does not match the limited or scarce number of healthcare providers/professionals available to render these services to subscribers. Hence, an increased number of patients with limited health professionals affect the quality of care delivered to patients by the health institutions.

(c) An increase in the numbers of health personnel would help augment the current situation. Approximately 22% of respondents requested for an increase in the number of doctors or medical personnel in the hospital to cope with the ever increasing number of clients or subscribers who turn up daily to access healthcare in the hospital.

REFERENCES


**Biography**

Dr. Razak Imoro Jaha is a lecturer in the Department of Sociology and Anthropology, University of Cape Coast. He has a PhD in Development Studies with research interest in Migration, Development and Social Policy and Protection

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