UNIVERSITY OF CAPE COAST

CHALLENGES IN THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME: A CASE STUDY OF UCC HOSPITAL

THOMAS TAMAG

2011

UNIVERSITY OF CAPE COAST

CHALLENGES IN THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME: A CASE STUDY OF UCC HOSPITAL

BY

THOMAS TAMAG

DISSERTATION SUBMITTED TO THE FACULTY OF EDUCATION, UNIVERSITY OF CAPE COAST, IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF ARTS DEGREE IN GUIDANCE AND COUNSELLING

MAY 2011

DECLARATION

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's signature:……. Date…….....

Name: THOMAS TAMAG

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's signature:…… Date……

Dr. (Mrs.) Linda Dzama Forde

ABSTRACT

The study aimed at identifying issues that posed as difficulties in the smooth implementation of the NHIS in the University of Cape Coast Hospital and thereby suggest practical measures that could help improve the operations of the scheme within the university community and the region at large.

A descriptive research design was used to carry out the study. Questionnaires, interviews and non-participant observations were used to collect data for the study. A total of 136 respondents were selected through the quota and purposive sampling methods to form the sample of the study. The target population of the study was students of the university (graduates and undergraduates), staff of the university and the hospital in particular. Inputs were also collated from managers of the insurance scheme as well.

Data collected from the field were sorted out, checked and thereafter coded. The Statistical Product and Service Solutions (SPSS) version 15.0 software was used to key in the data after which simple frequencies and percentages were generated and adopted for analysis of the data.

The unnecessary delays in the registration and issuance of Identification Cards (ID) for new entrants of the insurance scheme, lack of equipment and personnel, with the requisite knowledge and skills in Information Communication Technology (ICT) to capture and process clients data promptly were identified as some of the constraints of the programme. The study recommends a review of the programme that will include the recruitment and training of more personnel with the required ICT skills to manage the schemes nationwide.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude and appreciation to all individuals and institutions who have contributed immensely towards the success of this dissertation. The management and staff of the University of Cape Coast Hospital, for responding to my questionnaires and providing me with documents and useful information to carry out the study. I remain grateful to them all for the support and co-operation extended to me.

The management and staff of the NHIS, Cape Coast Metropolis deserve mention for giving me valuable information on the operations of the NHIS within the region and the UCC hospital in particular. A special word of gratitude to my Lecturer and supervisor, Dr. (Mrs.) Linda D. Forde, who painstakingly read through, corrected and offered valuable suggestions to put this research work together in its present state. I am most grateful for her inspiration, contribution and support to bring me this far in my academic life.

My sincere gratitude to friends and family members who contributed in diverse ways to make this compilation a reality. Special mention is made of Mr. Bagson Ernest and Mary my lovely wife who did some of the secretarial duties for me. Her support and encouragement has been tremendous. She shares the grace with our lovely daughter Bernice for the sleepless nights that they jointly endured. Finally, I acknowledge the contributions of several other persons and institutions whose names have not been mentioned for lack of space, your efforts are duly appreciated.

DEDICATION

This work is dedicated to my parents, Mary, my wife and our lovely daughter Bernice.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

CAM	Carte d Assurance Maladie
CBHIS	Community-Based Health Insurance Scheme
CDI	Center de Development Integral
CHAG	Christian Health Association of Ghana
CHF	Community Health Fund
CWA	Central Water Authority
DHR	Division of Human Resource
DMHI	District Mutual Health Insurance
DMHIS	District-Wide Mutual Health Insurance Scheme
DMHO	District Wide Mutual Health Organization
DUHS	Director of University Health Services
GDHS	Ghana Demographic Health Surveys
GDP	Gross Domestic Product
GOG	Government of Ghana
GHS	Ghana Health Service
GPRS	Ghana Poverty Reduction Strategy
IGF	Internally Generated Fund
ILO	International Labour Organization
IMF	International Monetary Fund
MHO	Mutual Health Organization
MOH	Ministry of Health
NGO	Non-governmental Organization

NHE	National Health Expenditure
NHIS	National Health Insurance Scheme
NHS	National Health Service
OECD	Organization for Economic Co-operation and Development
OPD	Out- Patient Department
POW	Programme of Work
SAP	Structural Adjustment Programme
SHI	Social Health Insurance
SPSS	Statistical Product for Service Solutions
SRMIS	Students Records and Management Information Section
SSNIT	Social Security and National Insurance Trust
UCCH	University of Cape Coast Hospital
UECWA	Union of Employees of the Central Water Authority
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

According to the World Health Organization (WHO), health is a state of complete mental, physical and social well being and not merely the absence of disease, illness or infirmity. The WHO has indicated that many of the world's 1.3 billion people still do not have access to effective and affordable drugs, surgeries and other interventions because of weaknesses in the financing and delivery of health care (WHO, 2000; World Bank, 1993 ,1997).

According to Alexander and Guy (2004), whiles about 84% of the world's poor shoulders 93% of the global burden of disease, only 11% of the $2.8 trillion spent on health care reaches the low and middle income countries. Vaccination strategies of modern health care systems have reached millions of the poor. However, when ill, low income households in rural areas continue to use home-made remedies and resort to traditional or local healers who are often outside the formal health system. The share of the population covered by risk- sharing arrangements in the form of health insurance is smaller at low income levels. Consequently, the rich and urban middle classes often have better access to modern health care facilities.

The flow of funds through the health care system and the private mix is a complete one and different countries adopt different schemes or strategies to fund health care. Generally, a combination of taxation, social insurance,

private health insurance and limited out-of- pocket user charges have become the preferred health-financing instruments for middle and higher income countries where income is readily identifiable and taxes or premiums can be collected at source (WHO, 2000).

In the United States health care is provided by many separate entities under private and not-for-profit health insurance schemes (World Development Report, 1993). The US spends more on health care per person than any other nation in the world. Also, current estimates put US health care spending at approximately 15.2% of GDP. The health care share of GDP in the United States is expected to continue its historical upward trend within the next decade, reaching 19.5% of GDP by 2017. In 2007, the US spent $2.26 trillion on health care or $7,439 per person

According to the Institute of Medicine of the National Academy of Sciences, the US is the only wealthy and industrialized nation that does not have a universal health care system. More so, about 84.7% of citizens have some form of health insurance. The insurance is either acquired through their employers, thus, for those who work, 59.3%, privately purchased by individuals, 8.9% or provided by government programmes, 27.8%. Furthermore, American citizens without health insurance as of 2007 totalled 15.3% of the population or 45.7 million people.

Health insurance costs are rising faster than wages or inflation in the US. US federal law mandates public access to emergency health services regardless of ability to pay. Public funded health care programmes such as Medicare, Medicaid, Tricare, and the Veterans Health Administration provide

for the elderly, disabled, children, veterans and the poor. US government programmes accounted for over 45% of health care expenditures, making the US government the largest insurer in America. The per capita spending on health care by the US government placed it among the top ten highest spenders among United Nations member countries in 2004 (WHO, 2000).

The United Kingdom (UK) National Health Service (NHS) is a publicly funded health care system that provides coverage for everyone normally resident in the UK. The health system is not strictly or essentially an insurance scheme because there are no premiums collected, costs are not charged at the patient level and cost are not pre-paid from a pool. However, it does achieve the main aim of health insurance which is to spread financial risk arising from ill health. The costs of running the NHS estimated at £104 billion in 2007/8 are met directly from general tax levies.

The NHS provides the majority of health care in the UK, including primary health care, in-patient care, long term health care, ophthalmology and dental care. According to the WHO, government funding covered 86% of overall health care expenditure in the UK as of 2004 with private firms' expenditures covering the remaining 14%.

In Canada, the greater part of health insurance is administered by provinces under the Canada Health Act which requires all people to have free access to basic health services (WHO, 2000). Collectively the public provincial health insurance systems in Canada are usually referred to as Medicare. Private health insurance is allowed, but the provincial government allows it only for services that the public health plans do not cover. Canadians are however free to use private health insurance for elective medical services

such as laser vision correction surgery, cosmetic surgery and other non-medical procedures. About 65% of Canadian citizens have some form of supplementary private health insurance. Many of them receive it through their employers (OECD Health Project, 2004). Private sector health services not paid for by the government accounts for nearly 30% of total health care expenditure.

Health care in India is provided through general tax-funded public providers and insurance for the formally employed and through Non-governmental Organizations (NGOs) and charitable institutions (Dave, 1991). The public health system in India serves most poor households, especially those who reside in remote areas where neither government facilities nor private medical practitioners are available. Consequently people in these communities are forced to depend heavily on services provided by local and often unqualified practitioners and faith healers. Where the health facilities exist, they are either dysfunctional or low in quality service. The government's claim to provide free secondary and tertiary care has not been effective. In reality there are charges for various services (Gumber & Kulkarni, cited in Alexander & Guy, 2004).

According to Gumber and Kulkarni, only about 9% of the Indian workforce is covered by some form of health insurance. Most of those insured are in the formal sector of employment. According to Alexander and Guy (2004) public insurance companies hesitate to venture into voluntary medical insurance because of low profitability and high risks as well as low demand. A few Non-governmental Organizations (NGOs) and charitable institutions have helped in delivering health services to the poor and

vulnerable in the Indian communities though their coverage is quite small. There is a greater need to extend services to the socially excluded and ensure that the un-insured get minimum affordable quality services.

The French model of Health Insurance led the WHO to rank French Health Care the best in the world, because it permits a high quality of care and assures almost total patient- freedom (World Bank, 1993). The national system of health insurance was instituted in 1945, just after the end of the Second World War. The insurance scheme is profession–based. All workers are required to pay a portion of their income to a health insurance fund, which mutualizes the risk of illness and reimburses medical expenses. Children and spouses of insured people are eligible for benefits as well. Each fund is free to manage its own budget and reimburse medical bills at rates it deems fit (Ambler, 1993).

The French government has a responsibility of fixing the rate at which medical expenses should be negotiated and it does this in consultation with the ministry of health and drug manufacturers and other experts. The French government also exercises oversight responsibility on the management of the health insurance funds and ensures proper collaboration of the public hospital network.

All citizens and legal foreign residents of France are covered by one of these mandatory programmes which are funded by worker participation (Glasser, 1991). The government also provides health care to those who are not covered by the mandatory scheme. That is, those who have never worked and those who are not students. This scheme, unlike the worker-financed one is funded through general taxation and reimburses at a higher rate than the

profession-based system for those who cannot afford to make up the difference (WHO, 2000).

Health Insurance in Africa

Health insurance is an increasingly recognized tool for financing health care provision in low income countries (WHO, 2000). 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 Wiesman and Jutting (2001), that social health insurance may improve access to acceptable quality health care (Atim, 1999). Authors such as Dror and Jacquier (1999) have also criticized other forms of health care financing and cost recovery strategies such as user fees.

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). It is not certain, however, whether statutory social insurance and commercial insurance schemes alone can increase coverage rates and thereby broaden access to health care especially in rural and remote areas of Africa where incomes are very low.

Within the last decade, in Sub-Saharan Africa and a variety of other countries like Thailand, India, Ghana, Rwanda, Senegal and Uganda, non-profit mutual, community-based health insurance schemes have emerged. These schemes are characterized by an element of mutual aid, solidarity and collective pooling of health risks (Atim, 1998).

These community-based schemes usually operate in conjunction with health care providers, such as hospitals and other health centres in the area. Proponents of community-based mutual schemes argue that, these schemes

have the potential to increase access to health care (Kutzin & Howard, 1992). Other authors such as Bennett, Creese and Monasch (1998) are less optimistic about these mutual health insurance schemes. They argue that, more often the risk pool is small, adverse selection problems arise and more so, the schemes are dependent on subsidies. Consequently, financial and managerial difficulties arise and overall sustainability does not seem to be guaranteed or ensured (Bennett, et al., 1998).

Notwithstanding, the strengths and weaknesses of the mutual health insurance schemes, there abound some potential social benefits of the schemes. These benefits impact greatly on health care access, labor, productivity, and household's risk-management capacity of the communities concerned.

The funding of health systems and health care has in recent times received greater global attention than ever before. This has come about as a result of the world economic crisis and the subsequent restructuring adopted by most countries, particularly in sub-Sahara Africa (Bennett & Nglande-Banda, 1994). According to Atim (1998), most of the countries in the sub-region have found it increasingly difficult to allocate sufficient resources to finance their health care. This has resulted in the need to seek alternative means of funding health care systems in Africa. Health insurance though, a new phenomenon readily emerges as a suitable alternative to addressing health care funding within the sub-region.

The Bwamanda Hospital Community Insurance Scheme in Zaire was started in 1986 by the hospital authorities as a means of mobilizing additional revenue. The aim was to recover the operating and maintenance cost of the

hospital and extend health care access to more people in the community. The insurance scheme covers members or inhabitants of the entire Bwamanda community or health zone. Membership of the scheme is essentially family-based. If one member of the family joins, the rest of the family are encouraged to enroll (Atim, 1998). The patient or insured members of the scheme pay only 20% of cost of services and the insurance scheme pays 80%.

The Bwamanda scheme covers all hospitalizations including deliveries, dental extractions or care and outpatient surgery. The cost of illness treatment at health centres is also covered (Bitran & Giedion, 2003). The scheme is run and controlled by management of the Bwamanda Health Zone and administered by staff of the health centres and hospitals. A series of periodic consultations with the population of the health zone ensures some level of community participation. Atim (1995) contest that, the ultimate responsibility and management of the scheme however, lies with the Center de Development Integral (CDI) a Zairian Integrated Development NGO set up with support from Belgian Missionaries to support social services in the country.

Senegal has had a long tradition of mutual health insurance schemes. According to Alexander and Guy (2004), the first experience began in the village of Fandene in the Thies region in 1990. The insurance scheme in Senegal has been supported by a local health care provider, the non-profit St. Jean de Dieu Hospital. About 16 schemes operate in the Thies area. These schemes are usually community- based and about 90% of them operate in rural areas.

The mutual health insurance schemes have a contract with St. Jean de Dieu Hospital where they get up to about 50% reductions in treatment cost.

The schemes also cover only hospitalizations except the “Ngaye Ngaye” scheme (Alexander & Guy, 2004). The head of any registered household is a member of the mutual insurance scheme and participates in decision making of the insurance scheme. The insured person has a membership card on which he or she can list all members or selected family members as beneficiaries. The membership fee is per person insured.

Health Insurance in Sub- Saharan Africa

Atim (1995) wrote that African countries such as Ghana, Zaire, Mauritius and Benin enjoyed free government funded health care immediately after the Second World War in the 1940s. This system of state funded health care covered mostly the urban sections of the population where modern good quality health facilities existed. The government funded health care service was in effect a disincentive and excluded the vast majority of people who lived in rural areas.

This form of health funding survived in various forms until the early 1980s when the World Bank, the International Monetary Fund (IMF) and other donor partners introduced policies that called for the abolition of free health care in many African countries. Thus, the introduction of the Structural Adjustment Programme in Ghana (SAP) in 1983 among other things abolished free health care in state hospitals and rapidly made Ghana, according to World Bank studies, the sub-Saharan Africa country with the highest “cost recovery” record in the health sector, about 12% in 1987 (Atim, 1995). According to a study by Atim (1995), this merely extended the boundaries of poverty and deprivation without doing much for the under- privileged rural dwellers.

In the midst of these challenges of funding healthcare, voluntary health insurance became one of the options adopted by local communities. Health insurance was recommended by social movements and health care providers to mitigate the effects of collapsed health care services or the abolition of free health care systems.

The Central Water Authority (CWA) workers provident fund in Mauritius is a trade union mutual insurance association set up in 1979 by employees of the Central Water Authority (Atim, 1995). The aim of the fund was to provide some extra services to members of the Union of Employees of the Central Water Authority (UECWA) by pooling the savings of members on the basis of the principles of solidarity and comradeship among the workers. The target group of the CWA Workers Provident Fund was the staff and employees of the Central Water Authority, both members and non-members of the Union of Employees of the CWA.

The government of Burundi in 1984 introduced a National Health Card Insurance Scheme known as Carte d Assurance Maladie. The scheme had the features of the provider insurance model in which government is the organization responsible for both managing the insurance scheme and providing health care. Purchase of a Carte d Assurance Maladie (CAM) Card by a household entitles two adults and all children less than 18 years of age in a household to free healthcare at all public health facilities. The cards are sold at a fixed price irrespective of household size and persons without cards must pay user fees or charges for government health care (Alexander & Guy, 2004).

The user charge per episode of illness treated was determined by the health worker at his or her discretion and generally depends on the quantity

and type of treatment received (Arhin, cited in Alexander & Guy, 2004). All health services provided by the government are covered by the CAM scheme. Hence in theory, CAM card holders who seek health care at government facilities should not pay out-of-pocket expenses. However, due to the shortage of drugs and other inputs, CAM holders, like fee-paying patients were sometimes given prescriptions to purchase drugs on the market.

According to Alexander and Guy (2004), the names of household members entitled to use a card are written on the card at the time of purchase, making it difficult for individuals from other households to use it. The card is valid for one year and may be purchased from a community representative at any time of the year. The cards are however, not accepted by non-governmental health facilities, such as mission hospitals and for profit or private clinics.

In Tanzania, the Community Health Fund (CHF) Strategy for financing rural health services was piloted in Igunga District in 1996. By 1999 it had been initiated in 9 other districts (Atim, 1998). The schemes are governed by district council by-laws and guided by a coordinator located at the headquarters of the Ministry of Health. The scheme receives funding and external technical assistance from the World Bank. The Community Health Fund (CHF) represents a national initiative and thus enjoys central government support.

According to Musau (as cited in Alexander & Guy, 2004), a team of expert consultants designed the CHF and its schemes in 1995. The schemes are managed or run at the sub-district level though the district board has an oversight responsibility over the management of the CHF.

All households in a participating district are eligible to enroll in the scheme and are required to pay a flat rate contribution per household irrespective of household size. The level of contribution is determined by the community at the sub-district by a committee (CHF committee). Contributing households are registered with a public health facility in the sub-district where the household resides and household members are entitled to all the services provided by the facility.

In Ghana, the government through the Ghana Poverty Reduction Strategy (GPRS) has outlined a strategy for dealing with poverty (GPRS-2006). A major component of the strategy is to deliver accessible and affordable health care to all residents of Ghana especially the poor and vulnerable (MOH, 2002). The method of financing health care determines its accessibility and affordability. As a poverty reduction strategy, the government has put in place a policy framework for the establishment of the National Health Insurance Scheme (NHIS) to replace the old cash and carry system which did not favor the poor and marginalized in society. The policy framework allows for the establishment of multiple health insurance schemes with a focus on the social-type known as District Mutual Health Insurance (DMHI) to address the needs of the poor (GOG, Act, 650. 2003).

Health care financing or funding in Ghana like others in the rest of Africa, has had a checkered history. The independence of Ghana in 1957 brought, among others, free health care for all citizens in public health facilities (Aikins, 2003). It meant that there was no direct out-of-pocket payment at the point of consumption of health care. The funding of health care was entirely through the government tax revenue and donor support.

Unfortunately, the sustainability of a free health care system became problematic due to competing demands on the national health budget and the allocation of resources to the various ministries coupled with the economic decline suffered in Ghana during the 1970s and 1980s. Consequently there was a substantial reduction in health care spending between 1975 and 1983. According to the health sector review report (MOH, March, 2002), for instance, in 1983, healthcare spending dropped to less than 2% of the 1975 levels.

This situation continued until 1985 when the Government introduced the "Hospital User-Fee" for all medical conditions except certain specified diseases. According to Aikins (2003) the free health care policy was poorly implemented because although communicable diseases were supposed to have been exempted, in practice no body enjoyed this facility. Moreover, a guideline for implementation was not provided and no conscious system was designed to prevent possible financial "leakages" in the scheme. The introduction of the "Hospital User-Fees" by government resulted in the decline in the utilization of health services in the country. Waddington and Enyimayew (1990) reported that there was acute shortage of essential drugs in all public health facilities with a consequent decline in the standard of health care delivery and utilization.

Notwithstanding these challenges with health funding, Government went ahead to introduce in 1985 full cost recovery for drugs as a way of generating revenue to address the shortage of drugs. The payment mechanism put in place was termed the "cash and carry" system. The implementation of the "cash and carry" system created a financial barrier to health care access,

especially for the poor. The Ghana Demographic and Health Survey (2003) report estimated that out of 80% of the population who required health care at any given time, only 20% were able to access it. This meant that about 80% of Ghanaians who needed health care could not afford it.

According to Aikins (2003) the Government of Ghana in an effort to eliminate the negative effects of the "cash and carry" system on the poor, commissioned various committees to search for alternative ways of funding health care especially insurance based ones. A lot of resources were invested into investigating the feasibility of a NHIS in the 1980s.

Proposals to set up and run a NHIS have been an issue of discussion by governments within the latter part of the late 1970s. Since the early 1980s, various experts, local and international have been contracted by the Ministry of Health (MOH) to study and make recommendations for setting up and running a National Health Insurance Organization. The International Labor Organization (ILO), WHO, the European Union and London School of Tropical Medicine visited Ghana in 1994 and provided technical advice at the request of the Ministry (Atim,1999). In August 1995, the MOH received definite proposals from a private consultancy group entitled "A feasibility study for the establishment of a National Health Insurance Scheme in Ghana". The study proposed that a Centralized National Health Insurance Company should be set up to provide a compulsory mainstream social insurance scheme for all contributors to the Social Security and National Insurance Trust (SSNIT) and all registered cocoa farmers. The report also recommended the piloting of rural- based community financed schemes for the non- formal

sector but gave no details or indications as to how the MOH was to do this. The major emphasis of the report was on the NHIS (Aikins, 2003).

In 1997, the NHIS pilot project was formally launched in the Eastern Region. It was intended to cover the New Juaben, Suhum/Kraboa/Coaltar, South Birim and South Kwahu districts. The objective of the project according to Atim (1998) was to test the grounds, study the performance of existing schemes, identify problems and eliminate them before a nationwide implementation of the scheme.

Within the same period, the people of Nkoranza District of the Brong Ahafo Region assisted by the Catholic Health Service formed the first Community- Based Health Insurance Scheme (CBHIS) to finance their health care cost, (Atim & Sock, 2000). Since then many similar schemes such as the Nkoranza Community Health Insurance Scheme, Dangme West Health Scheme and the Damongo Health Insurance Scheme have been formed especially within the last decade.

The successes achieved by these Community- Based Health Insurance Schemes (CBHIS) have been enormous. According to Atim and Sock (2000), they 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 behavior 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 (Aikins, 2005).

These achievements which are in line with the vision and objectives of the MOH motivated the Government of Ghana to extend the implementation of such schemes as part of the National Health Insurance Policy. A key objective of the MOH is to improve the overall health status and reduce inequalities in health outcomes of people living in Ghana (5-Year Programme of Work, MOH. 2002-2006). One of the Ministry's strategies to achieve the above goal was to ensure that financing does not become a barrier to health services by extending prepayment schemes to replace the cash and carry system.

In August, 2003, the Government of Ghana passed the National Health Insurance Act (Act 650) which aims at improving access and quality of basic health care services in Ghana. According to Stine (2003), the NHIS is a fusion of the concept of Social Health Insurance (SHI) and Community-Based Health Insurance Schemes (CBHIS) that usually covers a whole district. This is otherwise termed as District-Wide Mutual Health Insurance Scheme (DMHIS), a non-profit making scheme. The aim according to the policy framework for the establishment of health insurance in Ghana (MOH, 2002), is to ensure equitable, universal access to quality basic healthcare service to all residents in Ghana without out-of-pocket payment at the point of consumption of service. Thus, the design of the NHIS is guided by principles such as equity, risk equalization, cross-subsidization and quality care. Others are efficiency in premium collection and claims administration, community or subscriber ownership, partnership and reinsurance (Sabi, 2005).

Statement of the Problem

The vision of government in instituting health insurance schemes in the country was to assure equitable and universal access for all residents of Ghana. All residents were to benefit from an acceptable quality of essential health services without, out- of- pocket payment being required at the point of service use. 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 appears that human capital, logistics and existing health infrastructure at the district and regional levels have posed serious challenges to effective provision of the required health services that would make the health insurance scheme a viable and sustainable entity.

Aikins (2003) found that even though some of the schemes were doing well, others had problems with staff who lacked the required analytical skills to effectively manage data and other affairs of the scheme. Sabi (2005) also found that even though most schemes had good management structures which encouraged democracy and grass root participation, the qualifications and experience of people who occupied the various positions could not lead the schemes with good management skills. According to Sabi (2005) schemes managed by people with no or low level of formal education and with little or no knowledge about management of health insurance schemes made the effective management of such schemes difficult.

A more recent review conducted by Sabi (2006) again pointed to the lack of skilled personnel to manage the NHIS as well as inadequate health

personnel to provide the needed health care. The problem was more acute at the district level where the lack of managerial skills was even more evident.

Countrywide, there have been numerous complaints from NHIS subscribers about delays in the issuance and renewal of their membership ID cards, quality of health care provided at health facilities and the general frustration that students and staff of the University go through in accessing the services of both NHIS officials and the health care providers in general. For instance, the inability of some NHIS subscribers to use their membership ID cards to access health care nationwide is a serious challenge to the scheme currently that has been documented by Yeboah (2007). In the University of Cape Coast, students, staff and their dependants are sometimes compelled to pay for the cost of their health care either because they are not registered members of the scheme or the issuance or renewal of their NHIS cards has been unduly delayed (Yarboi, 2007).

The operation of the NHIS is new in the entire country and a critical assessment of the challenges of the implementation would provide an alternative framework for the implementation of the scheme as very little or no research has been conducted regards to this aspect of health insurance. The research findings or results from this research would also contribute to the existing literature on health insurance and provide a basis for further research into other aspects of health care.

The researcher is encouraged and motivated by the knowledge and experience gathered through this academic exercise. More so, other stake holders in healthcare stand to benefit substantially from knowledge generated through this research.

Objectives of the Study

The general aim of this study was to examine the challenges of the implementation of the University of Cape Coast community NHIS. The specific objectives were;

1. To examine the challenges faced by scheme managers and their staff in UCC campus.
2. To identify the problems encountered by students of UCC in accessing the benefits of the UCC campus NHIS.
3. To identify the problems encountered by University workers in accessing the benefits of the UCC campus NHIS.
4. To make suggestions for policy makers and government on ways to improve upon the operations of the scheme on UCC campus.

Research Questions

The study was guided by the following research questions.

1. What problems do scheme managers face with regard to the implementation of the NHIS in the UCC community?
2. What challenges do students of the University face in accessing health care by means of NHIS?
3. What challenges do staff of the University face with the use of their NHIS cards to access health care at the UCC Hospital (UCCH).?
4. In what ways can the operations of the NHIS at the UCCH be improved?

Significance of the Study

The study was an attempt to unravel the various factors that impede the smooth implementation of the NHIS in the UCCH. Findings from the

research would be disseminated to managers of the NHIS in the region, the University Health Management Team and the University community in general. This, it is hoped should inform policy makers and help improve upon the operations of the scheme within the university community.

The concept of health insurance is a relatively new phenomenon in Ghana; hence findings from the study would serve as reference material for students and health care professionals such as nurses and doctors. The findings should also generate debate among students and academia and generate interest for further research into health insurance or health care as the case may be.

The Ministry of Health (MOH) and her development partners should be interested in the recommendations and measures to best improve upon the implementation of the NHIS in the country. The research recommendations would provide some inputs into achieving this goal.

Even though, the research focuses on University of Cape Coast Hospital, other university hospitals in Ghana might consider adopting the research findings to suit their peculiar situations. The findings of the study would add to the existing literature on health insurance and contribute to knowledge in the area of insurance for health care.

Purpose of the Study

The implementation of the NHIS has been marked with enormous challenges at the various levels of its implementation. The study is aimed at identifying the strengths and weaknesses of the schemes and also offers recommendations for efficient operations of the schemes.

The public outcry about poor quality of health care services rendered to NHIS clients across the country needs to be thoroughly investigated. Besides, Health Insurance Schemes the world over have their peculiar challenges that need to be reviewed periodically for improved performance of the schemes.

Delimitation of the Study

The study was limited to the challenges of the implementation of the NHIS on the University of Cape Coast community located in the Central Region of Ghana. It was not possible to study the entire Central Region, for lack of resources to conduct an elaborate and extensive research of the sort. The limited scope of the study also enabled the researcher to complete the study within a specified time.

Limitations of the Study

The study was carried out on the University of Cape Coast campus with the prime aim of examine the challenges of the implementation of the NHIS. The researcher adopted the descriptive research design to conduct the research.

One of the major weaknesses of this research design is that, the research is usually not fact finding per se. In fact, they are susceptible or influenced by distortions through the introduction of biases in the measuring instruments. For instance, errors due to the use of questionnaires or interviews might distort research findings. There is the need to organize and present data systematically in order to arrive at valid and accurate conclusions.

Another shortcoming of the research design is the type of data obtained or collected; self-report responses may be unreliable because people may

provide socially acceptable responses. According to Nieswiadomy (1993), the ability to generalize sample results to the population in survey research design depends on the sampling method. Thus, probability sampling techniques and proper sample sizes are very important in survey research. A sample size of 136 though reasonable cannot guarantee an absolute generalization of the findings to cover the entire country or University community. However, the research could be replicated in other sister Universities.

The researcher also encountered problems with retrieving questionnaires from participants and the reluctance of some interviewees to participate in the study.

These challenges were addressed through persuasion and encouragement of participants to complete the research process.

The instruments used to collect data for the research included questionnaires, interviews and an observation guide. They are probably the most frequently used data collection instruments in nursing or qualitative research, Nieswiadomy (1993). The reliability and validity of data obtained by these instruments is governed by the subject's willingness or ability to produce accurate information. Nevertheless, questionnaires and interviews are extremely important in research and maybe the only instruments for collecting data on certain human responses.

Organization of the Rest 0f the Study

Chapter two reviews related literature. Issues considered here include: the concept of insurance, types of health insurance, features of health insurance policies, inherent problems with health insurance, types and

principles of health insurance schemes in Ghana and a summary of related literature.

The third chapter presents the methods used to carry out the study. Areas considered include the study area, the study population, the research design, sample and sampling procedure or techniques, administration of questionnaires and interviews and data collection. The data analysis is presented in chapter four and chapter five deals with the summary, conclusions and recommendations made in the light of the findings of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter discusses the existing literature related to the topic. It addresses issues such as the concept of insurance, types of insurance, inherent problems with health insurance, types and principles of health insurance schemes in Ghana and concludes with a summary of the literature review.

The Concept of Insurance

Insurance has been given various definitions by different authorities. Nielson (1998) defined insurance as the means by which risk or uncertain events are shared between many people. Paul and Williams (2001) viewed insurance as a process which takes a risk that would be too large for one person and spreads it around so that they become small risks for a large number of people.

According to the Wikipedia Encyclopedia (2008), insurance in law and economics is a form of risk management primarily used to hedge against the risk of a contingent loss. Insurance is defined as the transfer of the risk of loss, from one entity to another, in exchange for a premium. The premium refers to the amount charged for a certain insurance coverage or the price for an insurance policy.

An insurer is the organization, individual or company selling the insurance. The insurance rate is the factor used to determine the premium.

Whiles risk management involves the practices of appraising and controlling risk. Risk refers to the cause of a possible loss, also known as a peril.

Insurance could serve as a legal contract that protects people from the financial costs that result from loss of life, loss of health, lawsuits or property damage. Insurance provides a means for individuals and societies to cope with some of the risks faced in everyday life. (Wikipedia Encyclopedia, 2008).

According to Paul and Williams (2001) almost everyone living in a modern industrialized country buys insurance. For instance, laws in most countries such as France, Germany, England, Japan and the United States of America require people who own cars to buy insurance before driving them on public roads. Lenders require anyone who finances the purchase of a home or a car with borrowed money to insure that property. Some states in America and the United Kingdom provide social insurance, a form of mandatory insurance provided by the government when market failures are so severe that the private market cannot provide adequate coverage. In this circumstance, the government chooses to step in and provide broad and universal coverage for its citizens.

Health Insurance

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). The key actors or stakeholders in any health insurance scheme are usually the subscribers or contributors, the health care or service providers and the managing institution or company.

Health Insurance could also generally refer to instances where officials, a committee, commission, or taskforce formally holds a basket of resources or funds consisting of payments by insurers, which are used to fund all or part of the basket (CHAG, 2002).

According to Kankye (2001) when a group of people come together to contribute towards meeting the cost of their health care needs, then they are said to be operating on the principles of a health insurance scheme. The members contribute an agreed sum into a common "pot". This practice is quite similar to the "susu" groups that exist among certain business circles and occupational groups. However, their operations differ based on principles.

Types of Insurance

Campbell and Stanley (2002) revealed that any risk that can be quantified can potentially be insured. Specific kinds of risk that may give rise to claims are known as perils. An insurance company will usually set out in details which perils are covered by the policy and which are not. A single policy may cover one or several risks depending on the type of insurance. Some types or categories of insurance are; Disability Insurance, Casualty Insurance, Life Insurance, Property Insurance, Liability Insurance, Credit Insurance and Health Insurance.

According to Nielson (1998), disability insurance is a type of insurance which replaces a workers income when an accident or illness prevents them from performing their jobs. Benefits are usually structured to pay a proportion of a person's actual earnings, usually from 40-60%. Short term disability insurance covers up to six months of disability. Coverage for longer than six months is called long term disability insurance.

According to economists Paul and Williams (2001) life insurance is the assumption by an insuring organization of the risk of death of a policy holder. Loss in life insurance is certain to occur and in total. The element of uncertainty is when death will occur. Mortality is subject to the probability and life insurance premiums are usually calculated from mortality tables, which indicate the average number of people in each age and gender group that will die each year.

Property Insurance according to insurance expert Nielson (1998) protects people against losses of and damage to things they have acquired, including houses and valuable items such as appliances and jewelry. Casualty insurance protects people against having their property taken to compensate others in settlements of legal disputes.

Campbell and Stanley (2002) defined liability insurance as the legal and financial responsibility someone has to another person. A person may be found to be liable for causing loss or harm to another person or for having an unpaid debt. Usually, liability claims requires determination of fault for loss or damage whereas other types of casualty claims may not. When someone sustains injuries in, on or caused by another person's property, the property owner may be found legally liable for those injuries.

According to Campbell and Stanley (2002) credit insurance, relates to transactions involving the transfer of money or other property on the promise of repayment, usually at a fixed future date. The transferor thereby becomes a creditor and the transferee a debtor, hence credit and debts are simply terms describing the same operation viewed from opposite stand points. Health

Insurance protects people against the cost and consequences of illness and injury.

Inherent Problems with Health Insurance

The problems with health insurance include adverse selection and moral hazards. These problems are briefly discussed below.

Renowned economists, Campbell and Stanley (2002) identified adverse selection and moral hazards as the common problems of any health insurance scheme. Insurance companies use the term adverse selection to describe the tendency for only those who will benefit from the insurance to buy it. Specifically when talking about health insurance, unhealthy people are more likely to purchase health insurance because they anticipate large medical bills. On the other hand, Paul and William (2001) explained that people who consider themselves to be reasonably healthy may decide that medical insurance is an unnecessary expense. For instance, if they see the doctor once in a year and it cost them $250 that is much better than making monthly insurance payments of $40.

The fundamental concept of insurance is that it balances cost across a large, random sample of individuals (Nielson, 1998). Thus, for instance, an insurance company has a pool of 1000 randomly selected subscribers each paying $100 per month. One person becomes very ill while the others stay healthy, allowing the insurance company to use the money paid by the healthy people to pay for the treatment cost of the sick person. However, when the pool is self selecting than random as in the case with individuals seeking to purchase health insurance directly, adverse selection is a greater concern. A

disproportionate share of health care spending is attributable to individuals with high health costs.

According to insurance expert Nielson (1998) moral hazards occurs when an insurer and consumer enter into a contract under symmetric information, but one party takes action, not taking into account in the contract, which changes the value of the insurance. A common example of moral hazards is third party payment when the parties involved in making a decision are not responsible for bearing cost arising from the decision. An example is where doctors and insured patients agree to extra test which may or may not be necessary. The doctors benefit by avoiding possible malpractice suits, and patients benefit by gaining increased certainty of their medical condition. The cost of these extra tests is borne by the insurance company which may have had little say in the decision.

Other authors such as Aikins (2005) simply view moral hazards as a situation where covered individuals consume services more frequently than necessary to the point of over-consumption (Aikins, 2005). The problem of moral hazard constitutes a major challenge to the sustainability of most health insurance schemes in Ghana.

Health Insurance in Ghana

The obvious challenges and failures of the "cash and carry" system of cost recovery in Ghana`s health institutions necessitated the urgent need for an alternative source of heath care financing. This is because, it is impossible for health care services to be provided free of charge. In addition to the cost to patients in accessing health care in Ghanaian health facilities was also becoming more and more unbearable to the patient (MOH, 2002).

According to Sabi (2006) health care financing may be done through a number of options. These options include the following;

1. Direct out-of- pocket payment at the point of service and personal health account.
2. Risk pooling or sharing through tax revenue and health insurance.

One method that appears to be gaining ground as a possible alternative source of health care financing in the health sector is the Mutual Health Organization (MHO). This is a voluntary, non-profit insurance scheme, formed on the basis of mutual aid, solidarity and a collective pooling of health risks, in which the members participate effectively in its management and functioning (MOH, 2002).

The MHO as a form of health care financing is not uncommon in Ghana. The Catholic Church as part of its efforts to raise funds to support health care delivery established some community - wide health insurance initiatives in Ghana in 1992, at Nkoranza and Drobo in the Brong Ahafo Region, Damongo in the Northern Region and other parts of the country (Stine, 2003).

The choice of a Mutual Health Organization (MHO) was based on the principle that the scheme is operated by a non-profit making organization that is democratic and accountable to its members. The organization further empowers communities with skills to make informed judgment and choices in demanding quality health care services.

This definitely has provided an alternative to “cash and carry” and also complements the government health budget. Health insurance is one of several methods that the government has adopted to finance health care in the

country. According to the MOH (2002) Health Sector Review Report, about 80% of health financing in the public health sector is through tax revenue and donor funds. The 20% is from Internally Generated Funds (IGF) through the "cash and carry" system. By this arrangement, health insurance replaces the "cash and carry" system of payment for health services consumed. This means that tax revenue is expected to continue to form part of the overall health sector financing strategy for some time to come. According to the report, health insurance was not intended to abolish cost recovery but it was simply to replace direct out-of-pocket payment at the point of service use or delivery.

According to the National Health Insurance Policy Framework For Ghana (MOH, August, 2004) the aim of the NHIS was to enable the government achieve its set health goals within the context of the Ghana Poverty Reduction Strategy (GPRS) and the Health Sectors' Five-Year Programme of Work (POW) 2002-2006. It is to spread the cost risks of incurring health care cost over a group of subscribers. The more the subscribers, the more the likelihood of available funds to support members when they require health care. The point is that individuals still make payments for services consumed but in a more humane manner as they do not have to carry the burden of health care cost alone. It becomes a shared responsibility among community members who subscribe to the scheme. This underscores the policy of making it compulsory for every resident in Ghana to belong to a health insurance scheme of his/her choice.

With Mutual Health Insurance Scheme, access to health care is made easier for those who really need it. Nonetheless, access is a function of the location of providers of services, cost of care and ability to pay, quality of care

and socio-cultural aspects of service provision (Dzikunu, Helen, Thorup, Hanne as cited in Stine, 2003). Financial barriers to health care are dependent on the payment mechanism that is put in place at the time of use of service. Out-of-pocket payment at the time of service use reinforces non-access to health care. Prepayment schemes minimize or remove the financial barrier to accessing health care. (Waddington & Enyimayew, 1990). In other words, access to health care becomes independent of the individual's ability to pay out-of-pocket at the time of illness. Direct out-of-pocket payment is regressive in that a higher proportion of income of the poor and lower income group goes into health care. More so, people are expected to pay for services consumed at the time of illness when in fact they are actually non- productive during the said period.

The long term policy objective for introducing health insurance was for every resident of Ghana to belong to a health insurance scheme that adequately covers him or her (MOH, 2002). Thus, people would be protected from the problems associated with having to find money at the time of illness before needed health services can be provided.

Principles or Philosophy of the National Health Insurance Scheme (NHIS)

According to the National Health Insurance Policy Framework for Ghana (MOH, 2004) several conditions apply to the implementation of the NHIS. It is compulsory for instance, for every person living in Ghana to belong to a health insurance scheme type. This reinforces the spirit of solidarity, social responsibility, equity, and a sense of belongingness in the building of a healthy and prosperous nation.

According to the policy framework, every person living in Ghana is expected to contribute according to the principle of ability to pay in order to enjoy a package of health services covering over 95% of diseases afflicting Ghanaians. There is a differential contribution level both in the formal and informal sectors of the society.

According to the National Health Insurance Act 650 (2003) the formal sector is expected to contribute 2.5% of their 17.5% Social Security and National Insurance Trust (SSNIT) contribution, whereas the informal sector will contribute at least GH¢7.2 per annum. The contribution levels have an in-built cross-subsidization mechanism whereby the rich pay more than the less privileged; adults pay on behalf of children, the healthy cover for the sick and urban dwellers pay more than the rural dwellers (GOG, Act 650, 2003).

Contribution levels of subscribers have been categorized based on their socio-economic stratification (GDHS, 2003). The policy proposes 6 main types of categorization. These are; core poor, very poor, poor, middle income, rich and very rich. All these shall pay in line with their ability to pay. The table below illustrates the various categorizations.

Table 1

Informal Sector Categorization of Ghanaians

Social group	Class	Definition
Core poor	A	Adults who are unemployed and receive no identifiable income and therefore unable to support themselves financially.
Very poor	B	Adults who are unemployed but receive identifiable and consistent financial support from the source of low income.
Poor	C	Adults who are employed but receive low returns for their efforts and are unable to meet basic needs.
Middle income	D	Adults who are employed and receive incomes which are just enough to meet their basic needs.
Rich	E	Adults who are able to meet their basic needs and some of their wants.
Very rich	F	Adults who are able to meet their basic needs and most of their wants.

Source: MOH, 2004

According to the policy framework, the design of the proposed NHIS was guided by the principles of equity, risk equalization, cross-subsidization, solidarity, community ownership and reinsurance.

Wagner (2004) explains equity, to mean everybody has access to the minimum benefits package of NHIS irrespective of people's socio-economic status. The poor and rich stand on the same level regarding NHIS benefits. It also means that health insurance should be at the door-steps of every resident

and more so, people should be given the opportunity to register with the scheme. This improves access of the scheme and health care to subscribers all year around.

Risk equalization within the scheme would ensure that disease burden and mortality patterns serve as one of the basis for allocating financial resources to different geographical areas of the country (Aikins, 2004). The cost of care varies depending on the disease burden in the geographical areas. For instance, disease burden within the northern and southern sectors of Ghana differ significantly. Moreover, disease burden correlates positively with poverty. Thus, the higher the poverty levels the heavier the disease burden. A formula for risk equalization shall be developed to make up the cost difference based on the minimum contribution levels.

The design of the scheme according to Stine (2003) was such that contributions were based on the ability to pay. This principle introduced the element of cross-subsidization into the scheme. Thus, the rich pay more while the poor pay less and it should also ensure that all persons contribute and not only have those with the risk of falling ill joining the scheme (adverse selection). Thus, the rich would cross-subsidize the poor and vulnerable, the healthy would cross-subsidize the sick and the economically active adults would cross- subsidize the children.

The main tenet of quality of care is value for money. When clients perceive health services use as value for money their propensity to utilize health care increases (Atim, 2000). Perceived quality of care is also linked to health care access as poor quality of care is a barrier to access. Thus, holding

everything constant people are more likely to use health care that they perceive to be good than one perceived to be bad.

Solidarity according to Aikins (2003) is also a desired virtue in social health insurance. The purpose of the NHIS was to remove financial barriers to health care access which impacts negatively on the health status of the population. More so, our individual health statuses are interlinked in terms of the transmission of communicable diseases which happen to be the main causes of morbidity in this country. The vulnerable groups are the poor, children and the elderly. These groups need the support of the rest of the population in terms of health care access.

Efficiency in the collection of contributions and claims administration is essential for the sustainability of the scheme. The collection of contributions is vital for building a sustainable fund for the social-type health insurance schemes in the country. The problem in Ghana is that most of the potential contributors are in the informal sector of the economy where formal systems of collection of contributions do not exist (GDHS, 2003). Consequently, the NHIS adopted existing informal traditional systems of community contributions that are house to house contributions. In the case of claims administration, the NHIS system reimburses service providers though not on a regular basis. These health care providers depend very much on Internally Generated Funds (IGF) to complement government regular budget. Government budget release often delays and therefore the IGF is used to fill the gap by serving as a revolving fund.

Community or subscriber ownership is vital to ensure the sustainability and viability of the scheme. Within the past decade, community participation

has eluded health care planning and delivery in Ghana (Atim & Sock, 2000). Efforts have been made as part of the primary health care concept to encourage and sustain community participation without much success. Community ownership of the scheme is expected to promote community participation and thereby bring to bear the client's perspective of quality of care on the delivery process.

The scheme would run in partnership with government and other stakeholders to ensure sustainability of the scheme. Based on the fact that the scheme is pro-poor, government would be required to provide central funds to bridge the gap that may result from expected contribution levels and the actual contributions as well as outright payments of contributions on behalf of the poor, children under 18 years and the aged.

Reinsurance as a principle seeks to offer an additional coverage or financial protection against the sudden collapse of any type of insurance. This is especially so in health insurance where schemes may run into the risk of underfunding, debt and other financial difficulties due to unforeseen catastrophic events such as epidemics, embezzlement and natural disasters. A typical example is recent media reports of the NHIS owing service providers in the Ashanti and Northern Regions of the country (Mbord, 2007). When such events occur, central funds needs to be set aside to recapitalize these distressed schemes.

Sustainability of the operations of the schemes at all levels is very crucial especially at the districts. This is essentially about how well schemes are managed especially in the area of risk management, investment and fraud

control as well as the development of human resource capacity, systems and policies that would ensure sustainability of all the schemes in the country.

Types of Health Insurance Schemes

According to Stine (2003) all insurance systems aim to increase the security of individuals who are confronted with risks whose occurrence is unpredictable. They achieve this by pooling the premiums of subscribers together into a common basket. These funds or premiums are usually invested and the proceeds then help to compensate those insured individuals who actually suffer a financial loss from the insured event. Thus, the risk of loss of revenue after a death is covered by life insurance, the risk of illness by sickness insurance.

These insurance policies can either be private, commercial or social and non-profit making. The primary goal of commercial insurance is to make profit for the owners of the firm or scheme, while that of the social or non-profit making scheme is to extend access to good quality health care to members of the target population or subscribers, including its vulnerable members on the basis of solidarity among all members. The following types of insurance schemes were identified by the National Health Insurance Scheme (NHIS) to be operational in Ghana. (GOG, Act 650, 2003).

1. Social -type Health Insurance Scheme
2. District Mutual Health Insurance Scheme
3. Private Mutual Health Insurance Scheme
4. Private Commercial Health Insurance Scheme.

Social -type Health Insurance Scheme (STHIS)

It is a decentralized system that incorporates members from both the formal and informal sectors of the economy. Again, it is social in character because it is not-for-profit and annual dividends are ploughed back into the scheme to reduce contribution levels or increase the benefits package. Thus, every district according to the policy framework was to establish a health insurance scheme to enable residents in that district register as members. The social-type health insurance scheme was designed to ensure transparency, build subscriber confidence and in particular bring health insurance to the door steps of residents. It operates in partnership with government and therefore receives subsidy from government in the form of risk-equalization and reinsurance for catastrophic events.

District Mutual Health Insurance Scheme (DMHIS)

The District Mutual Health Insurance Scheme (DMHIS) is a fusion of two concepts. The Traditional Social Health Insurance Schemes, for formal sector workers who form about 30% of the population of Ghana and the Traditional Health Organizations for the informal sector with a district-wide ownership of the scheme by subscribers who have paid their required contributions or premiums (Aikins, 2003).

Private Mutual Health Insurance Scheme (PMHIS)

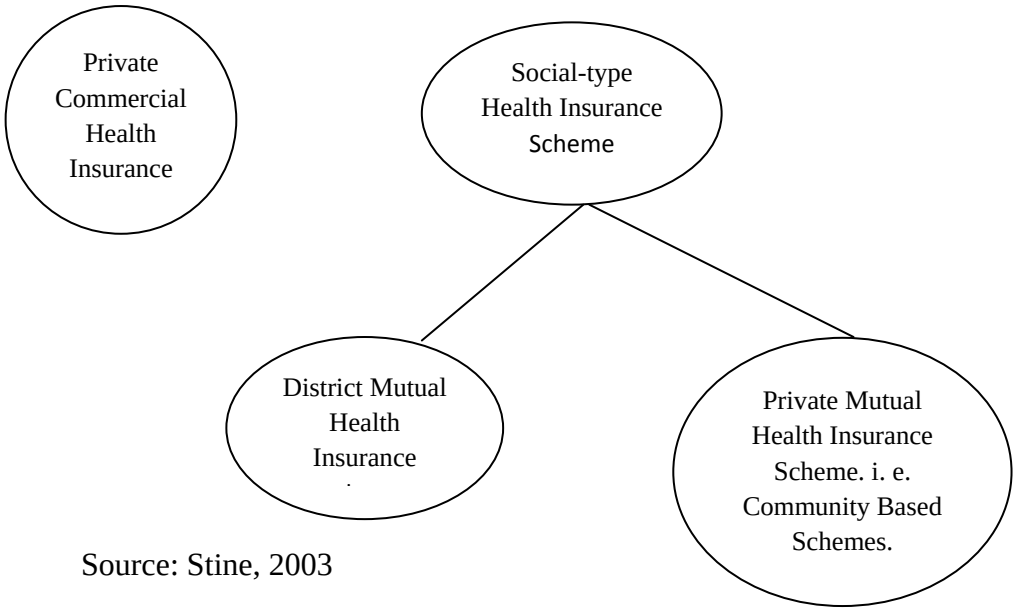
The Private Mutual Health Insurance Scheme according to Atim (1998) was for the purpose of reducing the financial barrier in health care access and improved quality of service. Any group of persons in Ghana may establish and operate a Private Mutual Health Insurance Scheme which may

not necessarily have a district focus or base. It may either be community-based or occupation or faith based. It was also social in character, but this type would not receive subsidy from government. Examples of this type of scheme include the Damongo Mutual Health Insurance Scheme, Nkoranza and Tano District Health Insurance Schemes, the Kintampo Teachers Welfare Fund (Aikins, 2003).

Private Commercial Health Insurance Scheme (PCHIS)

Private Commercial Health Insurance refers to a health insurance that is operated for profit, based on economic or market principles. Thus, premiums are based on the calculated risks of particular groups and individuals who subscribe to it. Those with high risk pay more (MOH, 2002). Usually the management or ownership of the Private Commercial Health Insurance Scheme resides with a company and shareholders and stocks of the company can be traded on the market just like the stocks of the producers of any other goods and services.

The Private Commercial Health Insurance Companies play the role of offering the minimum benefit package and supplementary insurance plans as an add-on for those who desire additional cover for themselves and can afford to pay. This means that private providers willing to participate must abide by the rules and regulations of the National Health Insurance Programme (Stine, 2003).



Source: Stine, 2003

Figure 1: Types of Health Insurance Schemes

The Administrative Structure of the National Health Insurance Scheme

Besides the District-Wide Mutual Health Organizations (DMHOS), the National Health Insurance Council oversees and regulates the establishment of Health Insurance Schemes on a national scale. The Council is a regulatory body and also has monitoring and evaluation functions. The Council is an autonomous body established by an Act of Parliament (Act 650) and is responsible for the creation and monitoring of an enabling environment for the development and operation of health insurance in Ghana (MOH, 2002).

The Council is headed by an Executive Officer or Secretary who has the day-to-day responsibility of ensuring that decisions taken by the council are well implemented. The Council reports directly to the President of the Republic of Ghana through the Minister for Health and also prepares annual reports to government and other stakeholders on the state of the National Health Insurance Scheme in the country. The following units form the

structure of the National Health Insurance Scheme to ensure the effective execution of its functions (GOG, Act 650, 2003).

1. Policy Planning Monitoring and Evaluation unit
2. Licensing and Accreditation Unit.
3. Administration, Management Support and Training Unit
4. Fund Management and Investment Unit.

The Policy Planning Monitoring and Evaluation Unit of the NHIS is responsible for the review and analysis of policy options and advice to the Council on the formulation of policies related to the NHIS. The unit also ensures the development of schemes and budgets for the execution of the Council's decisions and setting of tariffs for payments to accredited providers. Again, preparation of financial analysis on the state of the scheme, research and data management of the scheme.

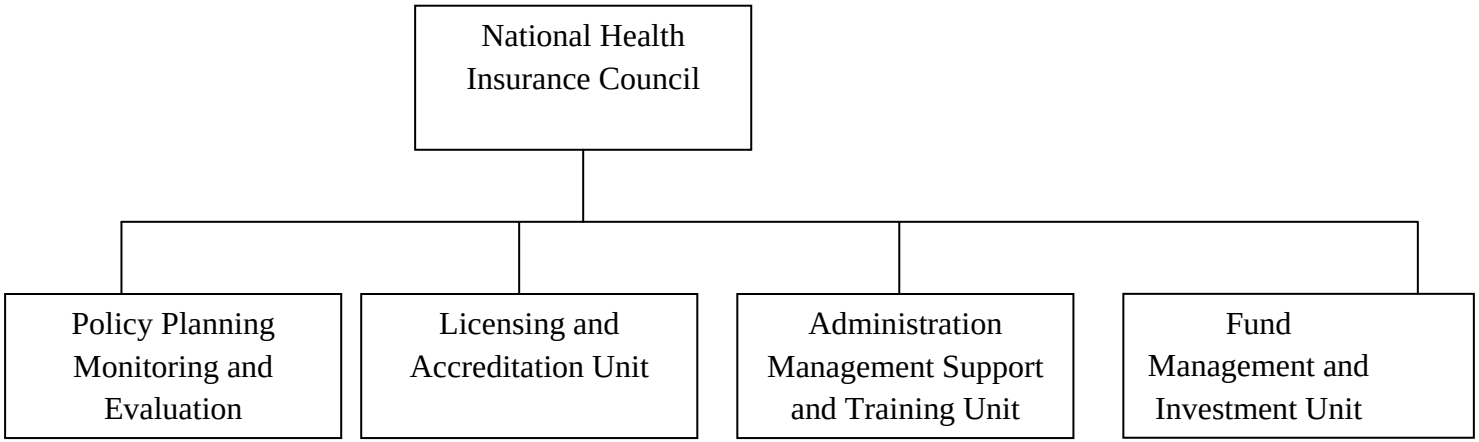
The Licensing and Accreditation Unit according to Aikins (2003) is responsible for licensing and regulating all health insurance schemes in the country. It would also have the power to revoke the license of any health insurance scheme that fails to conform to the law. Again, the unit is responsible for the accreditation of health care or service providers by setting quality of care standards that need to be met by providers in order to be eligible for entering into contracts with health insurance schemes. The unit also negotiates between service providers, professional bodies and the council on regular basis to agree on standard rates to be applied to medical and surgical procedures across the country. The unit is also responsible for monitoring on regular basis the minimum licensing requirements of the

schemes as well as publishing the list of service providers who have met the accreditation requirements.

The Administration, Management, Support and Training Unit of the council, monitor and evaluate the operations of all health insurance schemes in the country and ensure that their efforts are properly coordinated to bring about the ultimate realization of the policy goals of government. It arranges and ensures that the needed technical support and training is made available to all Mutual Health Organizations and other health insurance schemes operating in the country to assist them meet the set standards of operation and management required for legal operation (Aikins, 2004).

The National Health Insurance Fund provides support to District Mutual Health Insurance Schemes to cover the poor and vulnerable groups. It also plays equity and a redistributive role to ensure that equal provision is made for equal need and unequal provision for unequal needs regardless of socio-economic or socio-cultural status. The use of the health insurance fund is reserved solely for the not-for-profit schemes and therefore serves as a re-

insurance for schemes that meet a certain criteria.



Source: MOH, 2004.

Figure 2

The Administrative Structure of the National Health Insurance Scheme (NHIS)

Summary of the Literature Review

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.

The literature examined the concept of insurance 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 discussion is health insurance. This category of 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. After independence, Ghana went through a checkered history as regards 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 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 NHIS to provide accessible, affordable and good quality health care to Ghanaians especially the poor and vulnerable in society.

The vision of government in introducing the NHIS was 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.

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 enjoy 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 DMHIS's were to incorporate members from both the formal and the informal sectors.

The formal sector contributes 2.5% of their 17.5% Social Security and National Insurance Trust (SSNIT) contribution whereas the informal sector

contributes at least GH¢7.2 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. All these should pay in line with their ability to pay. The minimum benefit package of the NHIS 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 NHIS. They were however expected to satisfy a certain accreditation criteria.

Government also instituted by law a 2.5% NHIS 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 NHIS 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.

CHAPTER THREE

METHODOLOGY

This chapter deals with the methods used to carry out the study: areas given consideration in this chapter are, the research design, the study area, and the target population of the study. The sample and sampling procedure, as well as description and administration of research instruments and data analysis form the concluding part of the chapter.

Research Design

The central business of this study was to examine the challenges of the implementation of the NHIS in UCC Hospital. It also involved finding what pragmatic recommendations stake holders in this health sector had on how to fine-tune the implementation and sustainability of the insurance scheme on campus. This required the use of the descriptive survey method. According to Amedahe (2002), the descriptive design determines and reports on issues the way they are. In other words, it is descriptive because issues or phenomena are seen or viewed in their natural setting and reported on as they unfold naturally.

Again, Amedahe (2002) saw the descriptive design as primarily concerned with collecting data in order to test hypotheses or answer research questions pertaining to the current status of the subject of the study. Best and Khan, cited in Amedahe (2002) saw the descriptive research design as concerned with conditions or relationships that exist, such as 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 engaged the use of both qualitative and quantitative data to ensure an effective synergy between the two methods.

According to Patton (1990), qualitative research focuses on gaining insight and understanding about an individual's perception of events and circumstances. The most commonly used methods of data collection in qualitative research are participant observation and semi structured interviews. Qualitative studies produce large amounts of data. The data usually consists of words rather than numbers and may be analyzed manually or through the use of computer programmes. The reliability and validity of qualitative studies are determined differently than in quantitative studies. Quantitative studies are considered valid if the findings reflect reality from the point of view of the subject.

Quantitative research is based on the concepts of manipulation and control of phenomena and the verification of results using empirical data gathered through the senses. The individual's interpretation of events or circumstances is of importance, rather than the interpretation made by the researcher. (Nieswiadomy, 1993).

The qualitative researcher attempts to obtain rich, real and valid data, the quantitative researcher aims for hard, replicable and reliable data. Data for qualitative research is collected through unstructured interviews and participant observation. The researcher searches for patterns and themes in the data rather than focusing on the testing of hypothesis.

The study was cross-sectional in nature considering the relatively short period of time used to carry out the research and more so to ensure maximum

and efficient use of limited resources and logistics for the study. According to Nieswiadomy (1993), a cross-sectional study examines subjects at one point in time. The study data are usually gathered on subjects at one specific time, though the data may be collected from groups of people who represent different ages, time periods or developmental states.

Again, cross-sectional studies are conducted because they are less expensive and easier to conduct than longitudinal studies. The method was suitable for the study as it gave an in-depth assessment of the situation on the ground; it reported on issues as they existed without any biases, doubts or contradictions.

Study Area

According to the 2000 Population and Housing Census Report, the Central Region occupies an area of 9,826 square kilometers or 4.1 % of Ghana's land area, which is 233,588km, making it the third smallest region after Greater Accra and Upper East. It shares common boundaries with Western Region in the West, Ashanti and Eastern Region in the north and Greater Accra in the East. On the south, is the 168km long coast of the Atlantic Ocean (Gulf of Guinea).

The region was the first area in the country to make contact with the Europeans. Its capital Cape Coast was the capital of the Gold Coast until 1877 when the capital was moved to Accra. There are about 32 festivals in the region and the region is also home to historical monuments such as forts and castles. These serve as a boost to the tourism potential of the region.

The region has two Universities at Cape Coast and Winneba. There are other excellent Senior High Schools like, Mfantsipim Senior High School, St.

Augustine's College, Adisadel College, Wesley Girls Senior High School and Holy Child Senior High School. The region also has a Polytechnic, Technical Institution, Colleges of Education and two Nurses Training Colleges as some of the tertiary institutions within the region. In terms of literacy, about 57.1% of the population of the region is literate in at least one language. Male literacy rate is 69.8% and female literacy rate is 46.3%. The Cape Coast Metropolis with a population of 75,554 people has a literacy rate of 20.2% in English only whiles 52.8% are literate in English and a Ghanaian language, 2000 Population and Housing Census. (Ghana Statistical Service, 2000)

Physical features of the region include the coast which consists of undulating plains with isolated hills and cliffs with sandy beaches and marshy areas. In the hinterland, the land rises between 250meters and 300meters above sea level. The region lies within the equatorial zone and moist semi-equatorial zone. Annual rainfall ranges from 1000mm along the coast to about 2000mm in the interior. The wettest months are May to June and September to October while the driest period occurs in December to February. Mean monthly temperatures ranges from 24c^{o} in the coolest month, August to about 30c^{o} in the hottest months March to April. Along the coast is the coastal savannah with grassland and few trees while semi-deciduous forest dominates the inland areas.

The region is also endowed with rich natural resources like gold, bauxite beryl, petroleum and natural gas at Saltpond in the Mfantsiman District, timber in the forest areas, rich fishing grounds along the coast and arable land. In terms of population size, the region is the third smallest region after Upper East and Upper West. The population of the region according to

the 2000 Population and Housing Census was 1,593,823 which was about 8.4% of the nation's population. The population density of the region was 162.2 persons per square kilometer, making it the second most densely populated region in the country after Greater Accra. The Cape Coast Metropolis alone has a population of 118,106 with a male population of 57,365 and female population of 60,741.

The main economic activities are salt mining and fishing along the coast. There are lagoons in addition to the sea which makes fish farming a prominent feature along the coast. There are opportunities for investors in this sector as it has the potential to export fresh and preserved fish to neighboring countries. The forest areas of the hinterland are suitable for the cultivation of large scale palm oil, cocoa, citrus and pineapple, 2000 Population and Housing Census. (Ghana Statistical Service, 2000).

Good health is essential for the development of any nation. Among the factors that promote good health are good housing, nutrition, sanitation, water supply, health facilities and qualified medical personnel. The Cape Coast Metropolis has a well equipped, ultra modern Regional Hospital with a District Hospital and the University Hospital to provide for the health needs of the people of Cape Coast and its environs. All these health facilities are accredited by the NHIS and are therefore accessible to the general populace. There are also personnel available to man these health facilities.

The UCCH is strategically located close to the shore of the Gulf of Guinea, which spans along the west Coast of Africa. Its main entrance is only about 50meters from the Atlantic Ocean. The UCC is surrounded by cluttered settlements of indigenous fishermen and other staff of the University.

Population

The population of UCC and its surrounding villages is cosmopolitan because of the intense interest with which people move into the community for both academic and commercial activities. The population was about 21,359 (GHS, 2009) and includes students both graduate and undergraduate students, University workers, thus, teaching and non teaching staff.

The target population of the study therefore captured the above listed segments of the population in addition to special groups such as the health insurance managers, thus district and regional managers of the health insurance schemes and the Director of University Health Services (DUHS).

Sample and Sampling Procedure

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.

The convenient sampling method was employed in selecting respondents. This is non-probabilistic and perhaps the most common sampling strategy for qualitative research (Patton, 1990). The method allows the researcher to obtain his 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. The methods were used in this case because some staff of the hospital works in three shifts and also enjoy

routine off duty periods. This would have made it difficult reaching many respondents if they were randomly selected.

A total number of 136 people were selected to participate in the study. The subjects were chosen from the population by non-random methods. In non-probability sampling, certain elements of the population will not be included in the sample. 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).

The participants were made up of 74 students of which 27 were graduates and 48 undergraduates. The University staffs were 60 in number, thus 18 teaching and 42 non-teaching staff. The Health Insurance Scheme Manager and the Director of University Health Services were also included in the sample. The quota sampling method was used to select subjects from various categories to make up the sample for this segment of the accessible population. The Quota method of sampling involves dividing the population into homogenous strata and selecting sample elements from each of these stratums.

A total of two strata were established, the general students (graduate and undergraduate students) formed one stratum and out of the stratum a quota was set to get a 0.3% (779) of graduate students and 3.5% (15,483) of undergraduate students. The second category, thus, University staff (Teaching and Non-Teaching) also formed a stratum and within the stratum, a quota was established to select 1.5% (950) of teaching staff and 1.9% (2,850) of non-

teaching staff to form the sample. Sample elements were selected from each stratum by convenience or accidental method to make up the sample. The quota was established to get a fair representation of both students and staff in the study.

With regard to quota sampling, the researcher establishes a desired quota or proportion for some population variable of interest. According to Nieswiadomy (1993), the basis of stratification should be a variable of importance to the study, such as sex, age and educational background. The number of elements chosen from each stratum was disproportionate to the size of the stratum in the total population. Thus, 0.46% (74) of the students' population was selected and the University staff made up 1.6% (60) of the total staff strength. This mode of selection was informed by the fact that students and staff form the core target group of the study.

The Scheme Manager and the Director of University Health Services were reached through the use of the purposive sampling method. Nieswiadomy (1993) stated that, the purposive sampling technique operates based on the assumption that the researcher had knowledge about the population of interest to select specific subjects for the study. In other words, the researcher believed, this particular group had relevant information for the study and more so representative of the accessible population.

Table 2

Numerical Size of Population, Sample and Sampling Techniques

Category	Pop.	Sample	**Sampling Technique**
Students	16,404	74	Quota
Staff	3,800	60	Quota
Scheme managers	2	1	Purposive
Director of UHS	1	1	Purposive
Total	20,206	136	

Source: DHR/SRMIS.2008/ 2009

Data Collection and Administration of Research Instruments

Primary data was gathered through the use of interviews, questionnaires and observation. According to Nieswiadomy (1993) questionnaires and interviews are probably the most frequently used data collection methods in nursing or qualitative research. Observation is also an important method of seeking answers to research questions.

Also the common methods of data collection in qualitative research involve questionnaires, interviews and participant observation. Questionnaires and interviews can be used to measure knowledge levels, opinions, attitudes, beliefs, ideas, feelings and perceptions as well as to gather factual information about the respondents. The validity of data obtained through these methods is governed by the subject's willingness or ability to produce accurate information. Nevertheless, questionnaires and interviews are extremely important in research and may be the only methods of obtaining data on certain human responses.

Secondary data was gathered from reviews of documents which have a direct bearing or link with the objectives of the study. These include textbooks, journals, newspapers, magazines, and records from the Ministry of Health, 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, both documented and undocumented literature.

Questionnaires were used for the university staff (teaching and non-teaching) as well as the students. The questionnaire was divided into two parts, Part one sought for personal data of the participants such as sex, age, level of education and occupation. The second part of the questionnaire dealt with factors that posed as challenges to the implementation of the NHIS. The questionnaires used included the likert scale questions, closed-ended and a few open-ended items. These offered respondents options to choose responses from and also the freedom to express their own 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.

An observation guide was also used. The structured type of observation was used. It was carefully planned, systematic and perceptive. This gave the right focus to the researcher on what data to collect to enhance some related data gathered from respondents and those granted interview.

Frequent visits were made to the hospital to critically observe how individuals or patients, insured and non- insured were treated with regards to their health care needs in the hospital.

Data Analysis

Data collected from the field were sorted out, checked and thereafter coded. The Statistical Product and Service Solution (SPSS) version 15.0 software was used to key in the data after which simple frequencies and percentages were generated and adopted for analysis of the data. As regards close-ended items, responses from respondents were tallied based on data that was gathered from the research questions. The tally was translated into figures and categorized. Tables were drawn for all cases and information converted into percentages and explained or used as basis for discussion. Percentages obtained for frequencies were also rounded off to the nearest whole number.

Responses from open-ended questions were summarized, important themes identified and critical responses from respondents discussed accordingly. In respect of data obtained from observation, critical issues were also discussed in relation to information gathered from the questionnaire and interviews of the selected key management personnel.

CHAPTER FOUR

RESULTS AND DISCUSSION

The study was essentially carried out to assess the challenges of the implementation of the NHIS in the University Cape Coast Hospital. The challenges faced by the staff and students as well as the hospital staff of the University were explored in this research work. The study was also aimed at making recommendations to the NHIS authorities, the University Health Services and other stakeholders in the health sector on ways of improving the implementation of the NHIS. This chapter presents the background characteristics of respondents and a brief analysis of the findings in relation to the objectives of the study.

The instruments used to collect primary data for the research included questionnaires, interviews and an observation guide. Secondary data was gathered from reviews of documents which have a direct bearing or link with the subject matter. These instruments are probably the most frequently used data collection instruments in nursing or qualitative research, Nieswiadomy (1993). They are used to measure the opinions, attitudes, beliefs, ideas, feelings and perceptions as well as gather factual information about the respondents or subjects.

Personal Characteristics of Respondents

A total of 136 respondents took part in the study. This comprised 60, teaching and non-teaching staff of the university, 74 graduate and undergraduate students of the university and the Metropolitan Health Insurance Scheme Manager. Details of the staff and students categories are captured on Table7. Data 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.

Gender of Respondents

The study recognized that the gender of a person could influence the ability and willingness of the individual to register with the NHIS. Of the 136 respondents, 75 (55.1%) were males and 61 (44.9%) were females. The men were slightly more than the women in terms of health care and the utilization of the NHIS. Table 3 shows the gender distribution of respondents.

Table 3

Gender of Respondents

Gender	Frequency	Percentage
Male	75	55.1
Female	61	44.9
Total	136	100

Source: Field data, 2009

Marital Status of Respondents

On the issue of marital status, 113 (83.1%) of the respondents were not married and 23(16.9%) were married at the time of carrying out the research. This gives an indication that most of the students were single and did not have much social responsibilities on them. Table 4 shows the marital status of respondents.

Table 4

Marital Status of Respondents

Marital Status	Frequency	Percentage
Married	23	16.9
Single	113	83.1
Total	136	100

Source: Field data, 2009

Ages of Respondents

As indicated on Table 5, majority of the respondents fell within the age brackets of 25years and below and 26-40 years. Only 6.6% of the respondents were over 40years. Table 5 shows the age distribution of respondents.

Table 5

Ages of Respondents

Age	Frequency	Percentage
25yrs and below	90	66.2
26-40yrs	37	27.2
Over 40yrs	9	6.6
Total	136	100.0

Source: Field data, 2009

Level of Educational Attainment

Table 6 indicates the educational attainment of respondents. From the table, it is clear that most of the respondents 113 (83.1%) had attained tertiary education, 8 (5.9%) had attained Senior High School level education whilst about 11(8.1%) had attained other levels of education that were not spelled out on the questionnaire. Only 4 (2.9%) of the respondents had attained only the Junior High School Level of education.

Table 6

Level of Educational Attainment

Level	Frequency	Percentage
Junior High School	4	2.9
Senior High School	8	5.9
Tertiary	113	83.1
Others	11	8.1

Total	136	100

Source: Field data, 2009

Categorization of Respondents

The categorization of respondents is clearly shown on Table7. For the purpose of convenience, respondents were categorized into teaching and non teaching staff, graduate and undergraduate students. Table 7 shows that a total of 18 (13.2%) teaching and 43 (31.6%) non teaching or supporting staff were involved in the study. Undergraduate students, 48(35.3%) formed a good portion of the respondents whilst 27 (19.9%) of the subjects were graduate students.

Table 7

Categories of Respondents

Category	**Frequency**	**Percentage**
Teaching staff	18	13.2
Non teaching staff	43	31.6
Undergraduate students	48	35.3
Graduate students	27	19.9
Total	136	100.0

Source: Field data, 2009

The next section addresses the research questions raised to guide the study. **Research Question One: What problems does Scheme Managers face with regard to the Implementation of the NHIS in the UCC Community?**

The challenges faced by scheme managers are in terms of personnel, logistics and other equipment which are essential for a smooth operation of the scheme. Table 8 gives a clear picture of the logistical constraints of the scheme.

Table 8

Adequacy of Materials/Equipment

Materials/Equipment	No. Required	No. Available	No. Functioning
Computers	20	15	10
Cameras	10	6	4
Printers	2	1	1
Photocopy machine	1	1	1
Vehicles	3	1	1

Source: Field data, 2009

From Table 8, it is quite clear that logistics and equipments such as computers and cameras were not readily available in sufficient quantities to facilitate the processing of NHIS data. Most of the equipments were not functioning properly or were simply non-functional.

Challenges in Terms of Personnel

Table 9 shows the various qualifications and staffing situation of the NHIS office in the Cape Coast metropolis.

Table 9

Adequacy of Staff

Qualifications	No. Required	No. At Post
Diploma	20	15
Degree	5	1
Masters	1	1
PhD	-	-

Source: field data, 2009

A follow up question on the preparedness of scheme managers in terms of personnel with the required skills revealed that the scheme managers did not have the required 20 personnel with the requisite skills to handle NHIS data. This falls in line with similar studies conducted by Sabi (2005) which stated that most of the schemes were managed by people who lacked the required managerial and ICT skills. The issue of getting the required human and material resources to effectively run the schemes has become a daunting challenge to most of the schemes managers nationwide. This could probably explain why some schemes have run into operational difficulties as a result of fraud, financial malfeasance and mismanagement of their allocated resources.

Research Question Two: What Challenges do Students and Staff of the University face in accessing Health care by means of NHIS?

The challenges faced by students and staff are basically the same and that account for the merger of Research Question Two and Three into one question and discussed under the same table. Table 10 lists some of the

problems encountered by students and staff of the university who use the NHIS cards to access health care in the university hospital.

Table 10

Challenges of the Implementation of NHIS to Students and Staff

Problems with NHIS implementation	**Responses**							
	Agree		**Disagree**		**Not Sure**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Delays in card processing.	94	69.1	28	20.6	14	10.3	136	100
Clients with expired NHIS cards pay for their treatment in the hospital.	100	73.5	23	16.9	13	9.6	136	100
Time spent prior to consultation is too long.	97	71.3	30	22.1	9	6.6	136	100
Prescribed drugs are unavailable in the hospital.	91	66.9	32	23.6	13	9.5	136	100

NHIS card holders are given preferential	8	5.9	100	73.5	28	20.6	136	100
Table 10 continued								
treatment in the								
hospital.								
Lack of public awareness about	92	67.6	31	22.8	13	9.6	136	100
the scheme								
Politicization of the scheme	87	64	29	21.3	20	14.7	136	100

Source: field data, 2009

From Table 10, majority of respondents 94 (69.1%) agreed that there were considerable delays in the registration and issuance or processing of NHIS cards for new entrants. The period of registration and issuance of a new card could take up to six months or more before an individual is given a valid NHIS card. Only 28 (20.6%) disagreed with the statement that there were considerable delays in the registration and processing of cards by the NHIS authorities. The other 14 (10.3%) respondents were however not sure whether there was a delay in the processing and issuance of new NHIS cards. This means that students and staff who fell ill within this period had to pay their

own hospital bills whiles awaiting their NHIS cards to be processed and issued to them for use.

Again, staff and students with expired NHIS cards had to pay their medical bills. An overwhelming majority of respondents 100 (73.5%) agreed with the statement that clients or students and staff with expired NHIS cards were made to settle their hospital bills. Twenty three (16.9%) disagreed with the statement whilst 13 (9.6%) were not sure whether students and staff with expired NHIS cards pay for their medical treatment at the hospital. This reinforces the fact that the insurance scheme would not honor expired cards because there is a fee to pay for the renewal of all expired cards.

Another challenge is the long queues of people in hospitals and health facilities to access healthcare. Certainly with the implementation of the NHIS, OPD attendance at UCC Hospital has increased from 26,452 (2008) to 26,740 (2009). This data was obtained from the Records Unit of the UCC Hospital mid- year performance review 2010. This has a consequential effect on the waiting time to see a doctor in the hospital. As indicated in Table 10, ninety seven (71.3%) of respondents agreed that time spent prior to consultation is too long whilst 30 (22.1%) of respondents disagreed with the assertion that waiting time to see a doctor under the NHIS was long.

The implementation of the NHIS has witnessed a tremendous increase in OPD attendance and admissions in the nation’s hospitals and polyclinics. These increased attendance by clients and NHIS subscribers results in congestion in the hospital wards and Out-Patient Departments of major hospitals in the country such as the Korle-bu Teaching Hospital, Komfo

Anokye Teaching Hospital and the other Regional Hospitals. Other related issues with increased attendance is that, patients' waiting time will increase or there will be general delays in seeing a doctor at the hospital with its consequent increased workload of health personnel and health expenditure.

The issue of delays or spending too much time in hospitals and health facilities in Ghana is not uncommon. A similar study by Stine (2003) of health insurance schemes in Northern Ghana indicated that people refused formal or orthodox medical care because of the delays or long waiting time in such formal health facilities. The general impression was that clients spent some amount of time just to access health care at the hospital. These delays will change if more personnel are employed to deal with the increased client attendance.

Another challenge that staff and students faced with the implementation of the scheme was the unavailability of prescribed drugs in the hospital. Ninety one (66.9%) of respondents agreed with the assertion or statement that most of the prescribed drugs under the NHIS were not available in the hospital, 32 (23.6%) disagreed with the statement and 13 (9.5%) were not sure of the availability or otherwise of prescribed drugs in the hospital. This challenge was corroborated by studies conducted by Arhin (as citied in Alexander and Guy 2004), about the insurance scheme (CAM) operated by the government of Burundi in 1984. In theory, all CAM Card holders who attend government health facilities should not pay for services. However, due to shortage of drugs and other inputs, CAM Card holders like fee-paying patients were often given prescriptions to buy drugs in the open market. The story is

similar to the schemes operated in Ghana, as often times NHIS card holders are given prescriptions to purchase drugs either because such drugs are not covered by the scheme or they are simply not available in the health facilities. Again, a study by Stine (2003) of health insurance schemes in Northern Ghana indicated that some people refused to enroll into the NHIS because of the perception that the hospitals do not stock enough drugs to take care of their needs.

The question of preferential treatment given to NHIS card holders was also assessed. A small minority of eight (5.9%) respondents agreed that NHIS card holders were given preferential or priority treatment in the hospital because of their status as NHIS subscribers, whilst 100 (73.5%) disagreed with the assertion. Twenty eight (20.6%) were however not sure whether priority attention was given to NHIS clients in the hospital. Contrary to the assertion that NHIS clients were given preferential treatment in the hospital, studies conducted by Aikins (2005), about Health Insurance Schemes in the Brong Ahafo Region revealed that people were not willing to join NHIS because the schemes do not guarantee quality of service. More so, poor staff attitude was a disincentive for prospective subscribers of the scheme.

General lack of awareness about the issues and operations of the NHIS was also a challenge to some respondents as indicated in Table 10. A simple majority of respondents 92 (67.6%) agreed with the statement and 31 (22.8%) felt the level of public awareness was alright. Thus, there is the need for education of the populace on the essence of NHIS, to avoid abuse of the system and ensure sustainability of the scheme. The need for subscribers to

pay the premium and fees for renewal of their expired NHIS cards is a measure to ensure that the scheme does not collapse or run into financial difficulties after a few years of operation. The use of enhanced public education has been an effective tool utilized by mutual insurance schemes to achieve the desired membership drive. An evaluation study conducted by Aikins (2005) on the Tano health insurance scheme identified public education as key to a smooth and sustainable running of the schemes.

Also, there were indications of politicization of the scheme by some clients or subscribers within the university community. A good number of respondents 87 (64%) agreed with the assertion that some people play politics with the operations of the scheme. Twenty nine (21.3%) of respondents disagreed with the assertion and 20 (14.7%) were not certain about the politicization of the scheme by some staff and students. Surprisingly, some clients felt the NHIS was the policy agenda of a particular political party and therefore refused to enroll or embrace the scheme because they share different political views.

Research Question Three: In what ways can the operations of the NHIS at the UCCH be improved?

Table 11 shows some ways in which operations of the NHIS can be improved in the University Hospital.

Table 11

Suggested Improvements to NHIS in UCCH

Statements	**Frequency**	**Percentage**
Provide greater variety of medicines.	53	38.9
Increase number and quality of medical personnel.	31	22.8
There should public education on the operations NHIS.	13	9.6
NHIS clients should be given better attention.	39	28.7
Total	136	100

Source: Field data, 2009

A research question was asked to solicit client's views on measures to improve upon the services rendered to NHIS subscribers in the hospital. A fairly good number of respondents 53 (38.9%) recommended 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 are often given prescriptions to buy medicines in town thereby defeating the aims and objectives of the insurance scheme.

Closely linked to this recommendation is the call for NHIS subscribers to be properly taken care of or given better attention whenever they visit the

hospital for healthcare. This has really become a big challenge because of the increase in attendance since healthcare cost has been partly taken up by the scheme. The increase in the number of people seeking healthcare does not match the limited or scarce number of healthcare providers and professionals available to render these services to subscribers. An increased number of patients with limited health professionals affect the quality of care delivered to patients by the health institutions.

Some clients, 31 (22.8%) recommended 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. This recommendation is based on the fact that clients spent a lot of time in the hospital before seeing a doctor or have their needs attended to or solved. It is hoped that an increase in the health personnel in the hospital will greatly ease the delays or drudgery that clients encounter in their bit to access healthcare.

The need for public education on the operations of the insurance scheme was also recommended by some respondents. Thirteen (9.6%) respondents felt the message of the NHIS was not clearly understood by students and staff of the university community. Public education on the benefits of the scheme and clients or subscribers rights and responsibilities to the scheme should be strengthened.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The study was carried out to identify the challenges faced by staff and students of the university with the implementation of the NHIS in the University Hospital. Another aim was to examine challenges encountered by scheme managers and their staff in UCC Campus. The study was also meant to make suggestions for policy makers, the board and management of the university hospital and government on ways to improve upon the operations of the insurance scheme on UCC Campus. A descriptive research design was adopted and a total of 136 respondents comprising 74 students and 60 staffs of the University participated in the study by answering a questionnaire. The Director of University Health Services and the Metropolitan NHIS Scheme Manager were also interviewed using a structured interview guide. The computer software, Statistical Product for Service Solutions (SPSS) was used to analyze the data collected. The final chapter of this study is devoted to summary of the main research findings, conclusion and recommendations.

Summary of Findings

Respondents indicated that they had to wait for at least six months to get their new NHIS cards processed for use. The implication is that staff and students who fell sick within the said period had to settle their own medical

bills whilst in wait for their insurance to mature. On the contrary, respondents revealed that renewal of expired NHIS cards at the University Hospital premises was promptly done.

The study also revealed that staff and students with expired NHIS cards were made to pay their medical bills. This reinforces the statement in the literature review where staff and students were forced to pay hospital bills either because they were not having NHIS cards or their NHIS cards were expired (invalid).

As a matter of policy, the University has since 2007 taken upon itself to insure all staff and students under the NHIS and would therefore not breach policy to pay medical bills on behalf of staff and students who failed to avail themselves of the opportunity. The Hospital Management Team has also taken a decision or policy which ensures that all clients, staff and students inclusive attending the hospital without NHIS cards should pay for the full cost of their treatment, effective this January, 2010. These policies may pose as challenges to staff and students who get busy with their work schedules and fail to register with the NHIS.

The study revealed that clients under the NHIS were dissatisfied with the length of time spent to see a doctor at the university hospital. The indication was that OPD attendance and admissions at the hospital has increased considerably over the years from 26,452 (2008) to 26,740 (2009) without a correspondent increase in staff strength. This explains why patients or clients have to spend more hours to see a doctor or get their needs attended to in the hospital.

An interview was conducted to assess the preparedness of scheme managers in terms of personnel with ICT skills to handle NHIS data. The interaction revealed an inadequate number of ICT personnel. Besides, logistics and equipments such as vehicles, computers, photocopy machines and cameras were not enough to facilitate the collection and processing of NHIS data.

The question on whether respondents were able to get medicines or drugs prescribed for them under the NHIS, indications were that sometimes patients or clients were given prescriptions to purchase drugs in town either because such drugs were not covered by the scheme or were simply not available in the health facility in question. This particular challenge was pointed out in the literature review as a problem experienced by some schemes (Carte d Assurance Maladie) operated in Burundi in 1984. This was certainly expected because not all diseases and medicines are covered by the insurance scheme.

The following were identified as some of the major challenges of the implementation of the NHIS in the hospital:

1. There seems to be a general lack of public awareness about the operations of the insurance scheme. For instance, the rules and regulations of the scheme, benefits and responsibilities of clients are not clearly understood by the public.
2. Again, the study revealed that clients had to wait for well over six months after registration to get their new NHIS cards processed and ready for use.
3. The scheme does not cover all disease conditions in the country.

4. There are also some drugs that are not covered by the scheme as well. Even those drugs covered by the scheme are sometimes not available in the health facilities and clients have to buy such medications on their own without a refund from the insurance scheme.

5. The health facilities also have a heavy task of grappling with large numbers of clients who troop into the hospitals daily to access healthcare. These numbers certainly outstrip the health professionals available to offer health care services to all NHIS clients.

Conclusions

From the findings of the study, one can conveniently conclude that the implementation of the NHIS on UCC campus has various challenges which include material and human resource challenges. It became quite obvious that the public lacked some information and education on the operations of the scheme such as the need to renew the NHIS card annually and pay the appropriate fees for such renewals. 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 bother to them. This clearly is one of the challenges of insurance schemes world over as discussed in the literature. 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 such moral hazards.

Again, the implementation of the NHIS has increased congestion in our health facilities. This increase in attendance therefore put an enormous pressure on the limited health personnel and infrastructure available to provide healthcare. This obviously could compromise or affect the quality of care provided by the health facilities, once demand for service is not proportional to the resources available to deliver that service.

Another issue worth noting is the long hours spent by subscribers in hospitals or health facilities on each visit for their healthcare needs. The situation was compounded by the heavy attendance at the OPD and the limited facilities and personnel available to cope or manage such situations.

Recommendations

The findings revealed some pertinent issues which need to be addressed by government, scheme managers and other stakeholders in healthcare delivery. On the basis of these, the following recommendations are made.

There is the urgent need for government to empower the National Commission on Civic Education to do more public education on the operations of the NHIS. This will reduce the frustrations and drudgery that subscribers go through in an attempt to register for their NHIS cards. The general public should know they have to wait for at least three months after registration for their cards to be ready for use and any episode of illness or sickness within this waiting period is treated on the “cash and carry” basis.

The training of more medical and paramedical staff to man the health facilities and improve upon service delivery to NHIS subscribers and the

public in general. This should ease the congestion and stress on the staff and facilities in our health institutions. The quality of care will also improve if good facilities and well trained personnel are readily available to manage the health institutions. Government could also revise its policy on the current premium paid by subscribers and consider a reduction in the premium to make it more affordable to certain sections of the population especially the informal sector of employment.

It is the researcher's conviction that government's goal of ensuring that every Ghanaian resident should belong to a mutual health insurance scheme of his or her choice can be achieved with a reduction in the NHIS premium. This will also make health care more accessible and affordable as envisaged in the NHIS document and policy guidelines.

The National Health Insurance Authority should also be tasked to provide enough logistics and equipment to facilitate the speedy processing of NHIS cards at all levels. Personnel or staff of the NHIS should be proactive in educating subscribers on operations of the scheme. These could cover issues of registration and payment of premium for new cards, renewal and replacement of lost cards. This definitely minimizes the undue delays in the processing, issuance and renewal of NHIS cards. Again, scheme managers need to scrutinize all claims submitted for payments by health institutions and service providers. The claims should be verified and prompt payments made to the service providers so that subscribers have uninterrupted service delivery. It is also incumbent on all health service providers to stock their facilities with the required drugs and medications so that clients or subscribers do not have to

purchase these medicines from the open market and have value for their money.

The management of the University Hospital should consider expanding its facilities at the hospital and training more medical personnel to deal with the increasing numbers of NHIS subscribers who patronize the services of the university hospital. These measures if implemented will reduce the congestion and client waiting time to access healthcare at the hospital. Also, an orientation course or training sessions for the hospital staff and personnel of the NHIS at the hospital on customer service. This will greatly improve staff attitude towards NHIS clients who attend hospital for services.

Finally, the authorities of the University should be lauded for making it a policy to insure all students and staff of the University. This initiative can be adopted by other public universities, institutions, private organizations, Non-governmental Organizations (NGO) and civil society groups.

Suggestion for Further Study

Since the study was limited to only the UCCH, a similar study could be replicated in other university hospitals in the country and probably extended to cover all the other hospitals in the whole region to make the findings more generalisable to this part of the country. Again, Healthcare financing is quite broad and the researcher would recommend further study into other aspects of health insurance that were not covered by this study.

REFERENCES

Aikins, M. (2003). *Emerging community-based health insurance schemes/ mutual health organizations in Ghana, achievements and challenges.* Accra, Ghana: Danida Health Sector Support Office.

Aikins, M. (2004). *Jaman South Health Insurance Scheme. Brong Ahafo Region, External Evaluation.* Accra, Ghana: Danida Health Sector Support Office.

Aikins, M. (2005). *Tano Health Insurance Scheme Brong Ahafo Region External Evaluation, 2004.* Accra, Ghana: Danida Health Sector Support Office.

Alexander, S. P., & Guy, C. (2004). *Health financing for poor people: Resource mobilisation and risk sharing.* New York: The World Bank.

Ambler, J. S. (1993). *The French welfare state: Surging social and ideological change.* New York: New York University Press. (1993, September 30).

Amedahe, F. K. (2002). *Notes on educational research.* Unpublished text. University of Cape Coast.

Atim, C. (1995). *Towards better health in Africa: A comparative study of community financing and mutual aid insurance.* Belgium: World Solidarity Publishers.

Atim, C. (1998). Contributions of Mutual Health Organizations to financing, delivery and access to health care, synthesis of research in nine West and Central African Countries. Bethesda, Md. *Technical Report 18,* 21-36. Partnerships for Health Reform Project, Abt Associates Inc.

Atim, C. (1999). Social movement and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon. *Social Science & Medicine, 48,* 881-896.

Atim, C. (2000). *Training of trainer's manual for mutual health organizations in Ghana.* Bethesda, Md. Partners for Health Reform plus Abt Associates Inc.

Atim, C., & Sock, M. (2000). *An external evaluation of Nkroranza Community Health Insurance Scheme.* Bethesda, Md. Partnership for Health Reform Project, Abt Associates Inc.

Bennett, S., & Nglande-Banda, E. (1994). Public and private roles in health: A review and analysis of experiences in Sub-Saharan Africa. *Current Concerns Series, ARA Paper (6).* WHO/ARA/CC/97.6 Geneva WHO, Division of Analysis, Research and Assessment.

Bennett, S., Creese, A., & Monasch, R. (1998). Health insurance for people outside the formal sector employment. *ARA Paper 16*. World Health Organization (WHO). Geneva.

Bitran, R., & Giedion, U. (2003). *"Waivers and exemptions for health services in developing countries:* Social Protection Discussion Paper Series. World Bank Institute.

Campbell, R. M., & Stanley, L. B. (2002). *Economics, principles, problems and policies.* (15th ed.). New York: McGraw- Hill/Irwin.

Christian Health Association of Ghana. (March, 2002). *Operational guidelines for the promotion and establishment of community-based health insurance schemes. (MHOs).* Accra, Ghana: Danida Health Sector Support Office.

Dave, P. (1991). Community and self-financing in voluntary health programmes in India. *Health Policy and Planning. 6*(1), 65-69.

Dror, D., & Jacquier, C. (1999). *"Micro insurance: Extending Health Insurance to the excluded."* International Social Security Review *52*(1), 71-80.

Ghana Health Service. (2009). *Health Sector Regional Review Report Central Region.* Cape Coast.

Ghana Poverty Reduction Strategy and Health Sector's Five Year Program of Work 2002-2006; 8.Revised edition.

Ghana Statistical Service. (2002). *2000 population and housing census, Central Region: Analysis of district data and implication for planning*. Accra, Ghana.

Ghana Statistical Service. (2003). *Ghana demographic and health survey.* Accra, Ghana.

Glasser, W. A. (1991). *Health insurance in practice.* San Francisco: Joseph Publishers.

Government of Ghana. (2003). *National Health Insurance Act, Act 650.* Act of Parliament establishing Health Insurance Schemes in Ghana.

Jutting, J. (2001). *The impact of community-based health financing on financial protection: Case study of Senegal.* HNP Discussion Paper. Washington. DC: World Bank.

Kankye, P. (2001). *Handbook on Tano District Health Insurance Scheme.* Accra: Ghana. Danida Health Sector Support Office.

Kutzin, J., & Howard, B. (1992). Institutional features of health insurance programmes and their effects on developing country health systems.

International Journal of Health Planning and Management, 7, 35-42.

Mbord, A. (July 25, 2007). NHIS owing health facilities. *Ghanaian Times.*

Ministry of Health. (March, 2002). *Health sector review report.* Accra: MOH.

Ministry of Health. (August, 2004). *National health insurance policy framework for Ghana.* Revised version. Accra: Policy Planning Monitoring and Evaluation Division, MOH.

Ministry of Health. (October, 2002). *Policy framework for the establishment of health insurance in Ghana.* Accra.

Nielson, N. (1998). *Ethical uses of information in insurance and financial planning as an employee benefit.* htt://www.nchc.org/ -Retrieved on 5-02-09.

Nieswiadomy, M. R. (1993). *Foundations of nursing research* (2nd ed.). Norwalk, Connecticut: Appleton & Lange.

OECD Health Project. (2004). *Private health insurance in Ireland: A case study of Francesca Colombo and Nicole Tapay 2004.* Limerick.

OECD Health Data. (2007). *"How does the United States Compare"*. www. oecd.org/health/healthdata. Retrieved on 15-12-09

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park: Sage Publications.

Paul, A. S., & Williams, D. N. (2001). *Economics*, (17th ed.). New York: McGraw-Hill.

Sabi, W. (2005). *Mandatory community-based health insurance scheme in Ghana: Prospects and challenges.* Accra: Catholic University College of Ghana, Academic Presentations, (Unpublished).

Sabi, W. (2006). *The national health insurance scheme in Ghana; Issues about organization and management.* Accra: Catholic University College of Ghana, Academic Presentations. (Unpublished).

Siegel, A. (1997). *Practical business statistics.* New York: Mcgraw Hill.

Stine, L. (2003). *Health insurance schemes in northern Ghana: A case study of Salamba women's health insurance scheme.* Accra: Danida Health Sector Support Office.

Waddington, C., & Enyimayew, K. (1990). A price to pay part 2: The impact of user charges in the Volta Region of Ghana. *International Journal of Health Planning and Management, 4*, 287-312.

Wagner, R. (2004). Risk equalization within the Ghana National Health Insurance. *Discussion paper,* (*6*). Geneva: ILO.

Wiesman, D. & Jutting, J. (2001). "Determinants of Viable Health Insurance Schemes in Rural Sub-Saharan Africa." *Quarterly Journal of International Agriculture, 4*, 361-378.

World Bank. (1993). *Investing in Health.* World Development Report. New York: Oxford University Press.

World Bank. (1997). *Sector Strategy for HNP.* Washington D.C.

World Health Organization. (2000). "*Health Systems: Improving Performance"*. The World Health Report. Geneva.

Wikipedia Encyclopedia. (2008). *Benefits of Insurance.* htt://en.Wikipedia. org. Retrieved on 15-12-09

Yarboi, T. (2007, October 29). *NHIS asked to clear backlog of ID cards in Central Region.* Ghanaian Times, p.4.

Yeboah, A. (2007, February 8). *Mess at NHIS, over 3million people can't get their ID cards.* Daily Graphic, p.1.

APPENDICES

APPENDIX I

QUESTIONNAIRE FOR UCC STAFF AND STUDENTS

Introduction

This questionnaire is designed to obtain your views on issues related to the implementation of the NHIS in UCC hospital in Cape Coast. Your responses will be used for academic purposes and would inform the University Hospital administration on how to improve on the services rendered to the University community. Your identity will not be disclosed.

Kindly fill in the gap provided or simply tick the appropriate option provided.

SECTION A

1. Gender: Male [ ] Female [ ]

2. Marital Status: Single [ ] Married [ ]

3. Age: 25yrs and Below [ ] 26-40yrs [ ] Over 40yrs [ ]

4. Level of education attained: Junior High school [ ] Senior High school [ ] Tertiary [ ] others Specify……

5. To which of this category do you belong? Teaching staff [ ]

Non Teaching Staff [ ] Undergraduate student [ ]

Graduate student [ ]

6. Which of these categories of clients do you belong to?

Insured students and staffs [ ] Uninsured students and staff [ ]

Insured private clients [ ] Uninsured private clients [ ]

SECTION B

Challenges of the implementation of the NHIS on campus

7. Do you think the NHIS is beneficial? Yes [ ] No [ ]

7. (b) If yes, explain your answer……..

8. How long did it take you to get your NHIS card after registration?

Less than 3months [ ] 3-6 months [ ] Over 6months [ ]

Perception of NHIS

9. The NHIS clients get better health care than the cash and carry Patients/clients in the hospital. 1.Strongly Disagree [ ]

2. Disagree [ ] 3.Not Sure [ ] 4.Agree [ ] 5. Strongly Agree [ ]

10. Why did you choose or join the NHIS?

Because it's a University policy [ ] It is less expensive [ ]

It is convenient [ ] Others Specify……

11. How would you describe the quality of care provided by UCC Hospital?

4. Very Good [ ] 3. Good [ ] 2. Very Poor [ ] 1. Poor [ ]

12. Patients spend too much time at UCCH each time they visit to access health care.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

13. The University Hospital staffs are:

Unfriendly [ ] Friendly [ ] Not Sure [ ]

14. The NHIS has helped you save some money.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

15. It does not take long to renew an expired NHIS card?

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

16. The required NHIS premium is;

High [ ] Moderate [ ] Low [ ]

17. Clients with expired NHIS cards pay for their healthcare services at the hospital.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

18. Do you think it's worth using your NHIS card to access health care at the UCC hospital? Yes [ ] No [ ]

18. (b)If no, explain your answer……

19. Did you have or face any problems with renewal of your NHIS card?

Yes [ ] No [ ]

19.(b)If yes, list the problems……

20. NHIS card holders are given preferential treatment at the hospital.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

Recommendations to improve on the operations of the NHIS on campus

21. What would you like to change about the services rendered to NHIS holders in the Hospital……..?

22. Would you recommend other students or workers of this university to join the NHIS on campus? Yes [ ] No [ ]

2.(b)Why……..

23. What in your opinion can be done to improve upon the operations of NHIS in the hospital ……?

APPENDIX II

QUESTIONNAIRE FOR UCC HOSPITAL STAFF

Introduction

This questionnaire is designed to obtain your views on issues related to the implementation of the NHIS in UCC hospital in Cape Coast. Your responses will be used for academic purposes and would inform the University Hospital administration on how to improve on the services rendered to the University community. Your identity will not be disclosed.

Kindly fill in the gap provided or simply tick the appropriate option provided.

SECTION A

1. Gender: Male [ ] Female [ ]

2. Marital Status: Single [ ] Married [ ]

3. Age. 25yrs and Below [ ] 26-40yrs [ ] Over 40yrs [ ]

4. Level of education attained: Junior High school [ ] Senior High school [ ] Tertiary [ ] Others Specify……

5. To which of this category do you belong? Teaching staff [ ]

Non Teaching Staff [ ] Undergraduate student [ ]

Graduate student [ ]

SECTION B

Knowledge of NHIS

6. What do understand by the concept NHIS?

7. Do you think that your clients understand the concept of NHIS in your catchment area? Yes [ ] No [ ]

7. (b) If yes, explain your answer……..

Perception of NHIS by university staff

8. What is your perception about the NHIS?

A. Good [ ] B. Bad [ ] Not Sure [ ]

9. It is beneficial to join the NHIS.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ]

1.Strongly Disagree [ ]

10. What is your general impression about quality of care/services rendered to you at the hospital under NHIS…….?

11. How long does it take to register and issue an NHIS ID card?

A. less than 3months [ ] B. 3-6months [ ] C. Over 6months [ ]

12. Did you have any difficulty getting your NHIS card?

Yes [ ] No [ ]

12. (b)If yes explain your answer…….....

13. Waiting time to see a doctor in the hospital under the NHIS is too long.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ]

1.Strongly Disagree [ ]

14. It does not take long to renew your NHIS card.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

15. The required NHIS premium is;

High [ ] Moderate [ ] Low [ ]

16. I am able to get most of the drugs prescribed for me at the hospital.

5. Strongly Agree [ ] 4.Agree [ ] 3. Not Sure [ ] 2. Disagree [ ] 1.Strongly Disagree [ ]

17. What is the attitude of the hospital staff towards NHIS clients.

A. Friendly [ ] B. Hostile [ ] C. Not Sure [ ]

Personnel or logistical support

18. Do you have enough personnel to register NHIS clients? Yes [ ] No [ ]

18. (b)If no, explain your answer…….

19. Do you think you have enough people with ICT skills to handle NHIS data? Yes [ ] No [ ]

19. (b) If no, explain your answer…….

20. Do you have enough equipment to carry out the registration of your clients? Yes [ ] No [ ]

20. (b) If no, explain your answer……...

Effects of NHIS on UCC Staff

21. What has been the effect of the NHIS on your work……..?

22. How many hours did you spend at work?

(a) Before the introduction of the NHIS……...?

(b) Now…….?

23. Would you say that you feel more stressed up at work than before the introduction of NHIS? Yes [ ] No [ ]

23(b) If yes, explain your answer…….

24. Has there been any increase in workload since the implementation of NHIS? Yes [ ] No [ ]

24. (b) If yes, what kind of work……

25. What would you say are the challenges of the implementation of the NHIS…….

26. What recommendations do you have for the improvement of the NHIS in the hospital……

APPENDIX III

QESTIONNAIRE FOR NHIS SCHEME MANAGERS AND THE DIRECTOR OF UHS

This questionnaire is designed to obtain your views on issues related to the implementation of the NHIS in UCC Hospital in Cape Coast. Your responses will be used for academic purposes and would inform the University Hospital administration on how to improve on the services rendered to the University community. Your identity will not be disclosed.

Please, you are requested to answer all questions independently and as sincerely as possible. Kindly fill in the gap provided or simply tick the appropriate option provided.

Part 1

1. Gender: Male [ ] Female [ ]

2. Marital Status: Single [ ] Married [ ]

3. Age: 21-30yrs [ ] 31-40yrs [ ] Above 40yrs [ ]

4. Level of education attained.

Diploma [ ] Degree [ ] Masters [ ] PhD [ ]

Part 11

Personnel and logistical challenges

1. What is the required number of personnel to do registration of NHIS clients….?

5. (b) What number do you have now……..

6. Adequacy of materials/equipment.

Materials/equipment	No. Required	Number Available	Number Functioning
Computers Cameras Printers Photocopy machine Vehicles			

7. How long does it take to register and issue an NHIS ID card…….?

8. Adequacy of staff.

Qualifications	No. Required	At Post	
Diploma Degree Masters PhD			

9. Do you have enough people with ICT skills to handle NHIS data?

Yes [ ] No [ ]

9. (b) If no, explain your answer……

Perception of NHIS

10. What is your perception of the NHIS……..

11. The required NHIS premium is; High [ ] Moderate [ ] Low [ ]

12. Do you think your clients understand operations of the NHIS in your catchment area? Yes [ ] No [ ]

12. (b) If no, explain your answer……..

13. What has been the effect of the NHIS on your work schedule .....

14. Would you say that there is any change in your work schedule since the introduction of the NHIS? Yes [ ] No [ ]

14. (b) If yes, explain…….

15. How would you describe the attitude of hospital staff towards NHIS clients in the hospital……...?

16. Are NHIS clients able to use their NHIS cards to assess healthcare nationwide? Yes [ ] No [ ]

16. (b) If no, explain your answer……

17. How do you handle NHIS clients from other districts within the region……?

18. How are finances from the NHIS managed…….?

19. Does re-imbursement from central government come on time……?

Yes [ ] No [ ]

19. (b) If no, explain your answer……..

20. Is the NHIS able to fulfill its financial obligations to service providers?

Yes [ ] No [ ]

20. (b) If no, explain your answer……...

21. What recommendations do you have for the improvement of the NHIS in your area……..?

APPENDIX IV

OBSERVATION GUIDE

Visit the hospital frequently and carefully observe the following;

- How insured and non-insured clients of the NHIS are treated in the hospital
- The facilities available at the hospital to deliver health care to patients
- The level of quality of care given to patients in the hospital
- The attitude of hospital staff towards clients (insured and non-insured clients)
- The attitude and behavior of clients of NHIS towards healthcare