KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

ASSESSING FINANCIAL SUSTAINABILITY OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) IN GHANA

CASE STUDY: MPOHOR WASSA EAST MUTUAL HEALTH INSURANCE SCHEME

BY

BERNARD ARPOH-BAAH
BACHELOR OF COMMERCE (Hons.)
PG3041309

COMMONWEALTH EXECUTIVE MASTER OF BUSINESS ADMINISTRATION (CEMBA)

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A THESIS SUBMITTED TO THE SCHOOL OF BUSINESS KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF

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CERTIFICATION

I hereby declare that this submission is my own work towards the MBA and that, to the best of my knowledge, it contain material previously published by another person nor material which has been accept for the award of any degree of the University, except where due acknowledgment has been made in the text.

MR. BERNARD ARPOH-BAAH - PG3041309	**……..**	**…….**
STUDENT' S NAME AND ID	**SIGNATURE**	**DATE**

CERTIFIED BY:

MR. ANTHONY AGYEMANG	**……**	**……..**
SUPERVISOR'S NAME	**SIGNATURE**	**DATE**

CERTIFIED BY:

PROFESSOR I.K. DONTWI	**….....**	**…… ……**
DEAN, IDL	**SIGNATURE**	**DATE**

DEDICATION

I dedicate this work to my lovely wife and daughter and also my parents, brothers and sister for their prayer and contribution made toward my education.

ACKNOWLEDGEMENT

No vision or great work is accomplished without help from other people. Many individual have supported and contributed to this work and I am grateful to each of them.

Firstly, I am grateful to the Almighty God who has kept us until now, equipped us with his wisdom and understanding.

Secondly, I would like to say a big thanks to you my wonderful supervisor Mr. Anthony Agyemang for his pieces of advice, constructive criticisms and the time he had to supervise this work in spite of his busy schedule.

Again, I am grateful to Mrs Mariama Arpoh-Baah for her immense contribution and support in one way or the other toward the completion of the long essay.

I thank all my staff members who either offered suggestions upon reading the project work or wished me well in the course.

I cannot mention all those who have influenced the execution of this work but I am grateful.

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ACRONYMS

NHI - National Health Insurance

NHIA - National Health Insurance Authority

NHIS - National Health Insurance Scheme

NHIC - National Health Insurance Council

NHIL - National Health Insurance Levy

MHO - Mutual Health Organization

GPRS - Ghana Poverty Reduction Strategy

MDGs - Medicine Diagnosis Groupings

SSNIT- Social Security and National Insurance Trust

OOP – Out -of- pocket

DRG - Diagnosis Related Grouping

ABSTRACT

The study was conducted in Mpohor Wassa East National Health Insurance Scheme (NHIS) in the western region to assess the financial sustainability of the scheme. A content validated questionnaire, interview guide and observation techniques were used to seek the needed information from the scheme management in the District, the accredited provider and the NHIS clients.

The research design used in this study was descriptive research.

The targeted population for the study was the National Health Insurance Scheme (NHIS) Mpohor Wassa East District, providers and clients in the Mpohor Wassa East District and the sampling technique used was simple random and quota sampling. Data collected were analyzed using the Statistical Package for Social Science (SPSS) through descriptive analysis and frequency distribution table.

The main finding of the study indicated that about 95% of the claims payment is being financed by the government through taxes levied on the Ghanaian in the form of VAT system. The study also revealed that the scheme incurs high administrative cost which increased in an alarming rate.

Again, the study showed that, the internal generated fund for the scheme is not encouraging. However, the study finally revealed that government needs to increase the NHIL so as to mitigate the low premium and registration fee being paid by the subscribers. It was concluded that, proper internal control procedures should be adhere to in the scheme to check expenditures. Again, since the internal generated funds are is not encouraging, the scheme manager should intensify education to attract more members to register.

Also, government should continue its support for the scheme in whatever way possible and practicable. However Mpohor Wassa East Mutual Health Insurance Scheme cannot sustain financially without government support (subsidies).

Finally capacity building and refresher courses should be organized for both providers and the scheme to minimize waste in the scheme. And the clients in the communities should be educated on the usage of the NHIS Card in accessing the health care to reduce cost per attendance.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Health Insurance is a pre-payment plan providing services or cash indemnities for medical care needed in times of illness or disability" (Encyclopedia, Britannica 2003). From the above, National Health Insurance could be identified as a prepayment health scheme established by the government of a country, on a national scale, that gives members access to health care services in times of need. Health financing or general taxation or social health insurance is generally recognised to be powerful methods to achieve universal coverage with adequate financial protection for all against health care costs. These systems intend to respond to the goal of fairness in financing, in that beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to need; in tax funded systems, the population contributes indirectly through taxes, whereas in social health insurance systems, workers and enterprises generally pay in through contributions based on salaries.

According to Vineberg (2002), Community Based health Financing is a health plan organized and managed by members of a community as a reciprocal means of paying for the health care needs of members in times of illness. The significant difference of Community Based Health Finance Schemes from other health insurance programs is that it is developed and managed by the members of the community in accordance to their needs and not by government regulations. Germany was the first country to adopt National Health Insurance. The German chancellor Prince Otto von Bismarck received approval for a compulsory sickness-insurance law in 1883, which was financed by state subsidy (Aaron, 2005). NHI has its root in the mutual aid societies called *Jyorei*

that started in Japan in 1835 (Ogawa *et al*; 2003), but health insurance law was enacted in Japan in 1922 (Ministry of Health and Welfare, 2000). Mention can be made of some of the countries that practice social health insurance as Europe: Germany, France, Switzerland, Netherlands and Hungary; Asia: Japan, Taiwan, Korea, Philippines and India; Latin America: Mexico, Argentina and Brazil; Africa: Tanzania, Kenya, Nigeria, Zimbabwe, Uganda and Ghana. Despite existence of NHI policy, implementation has not been easy for most developing countries due to huge resources and technical capacity required. (Ramesh and Dileep, 2000).The fact that both countries Zimbabwe and Uganda share similar economic and socio-cultural characteristics shows that while resource and technical capacity are important prerequisite to successful implementation of NHI other issues like political priorities of a country also play vital roles. African countries mentioned above are currently experimenting different approaches to Health Insurance System including Ghana. As these schemes are still young and evolving, few have yet been systematically evaluated. This is focused on the recent experience of Ghana, where a National Health Insurance Scheme (NHIS) was passed into law in 2003 and fully implemented in 2005 (Agyepong and Adjei, 2008; Abekah-Nkrumah et al., 2009). Ghana's health reform has passed various transformations which started in the early 1970s, there were no out-of-pocket payments in these facilities and care was financed solely from tax revenue in Ghana. However, this was not sustainable in the light of the needs of other sectors of the economy, and the government had to find alternatives to this financing mechanism.

In the health sector there were shortages of essential medicines, supplies and equipment, and poor quality of care. Therefore, in 1985 Ghana initiated health sector reforms as part of broader structural adjustment programs aimed mainly at reducing government spending to address budgetary deficits, introducing cost recovery mechanisms through user fees (traditionally known in

Ghana as “cash and carry”) and liberalizing health services to allow private sector involvement. The financial aim of the reform was achieved and shortages of essential medicines and some supplies improved. However, these achievements were accompanied by inequities in financial access to basic and essential clinical services (Waddington and Enyimayew, 1990).

During the 1990s several community health insurance schemes, popularly called Mutual Health Organizations (MHO) developed in Ghana with some external funding and technical support. Specific example was most MHO focused on providing financial protection against the potentially catastrophic costs of a limited range of inpatient services. The last but not the least reform is the National Health Insurance Scheme (NHIS) which grew out of an election promise made in 2000 by the incoming New Patriotic Party to abolish the “cash and carry” system and to remove financial barriers to utilization of health care. Hence, the establishment of National Health Insurance Act, 2003 (Act 650) with the aim of increasing access to health care and improving the quality of basic health care services for all citizens, especially the poor and vulnerable. The law establishing the scheme allows for the concurrently operation of District-Wide (Public) Mutual Health Insurance schemes in the one hundred and forty five (145) Metropolitan, Municipal and District Assemblies in Ghana. Also, Private Mutual Health Insurance schemes and Private Commercial Health Insurance schemes are covered by the Act. However, the schemes would only financially support District-Wide (public) Mutual Health Insurance Schemes. The initially defined benefit package under the scheme includes inpatient hospital care, outpatient care at primary and secondary levels, and emergency and transfer services. Each district mutual health insurance scheme also uses its discretion to determine additional benefits a scheme could provide. Beneficiaries for the schemes receive care from accredited service providers including government health facilities, quasi-government, mission and private health facilities.

1.1 **PROBLEM STATEMENT**

Effective and affordable health care delivery has over the years been the dream of governments of both the developed and the developing countries. The National Health Insurance Scheme seeks to offer accessible affordable health care to the people especially the vulnerable and also an alternative to the cash and carry system of health care. The introduction of the Health Insurance Scheme has achieved it intended aim by providing accessible and affordable health care to the people of Ghana and this has increased attendance rate tremendously at the health facilities. Claims payment is the major cost driver accounting for over 85% of NHIS expenditure in 2009.

Total disbursements (subsidies and reinsurance) for claims payment increased from GH¢ 7.60 million in 2005 to GH¢35.48 million in 2006 showing an increase of 367%. The payments increased from GH¢79.26 million in 2007 to GH¢ 198.11 million in 2008 and increased to GH¢308.15 million in 200 (NHIA, Annual Report 2009). It is in this light that this study finds it necessary to assess the financial sustainability of the National Health Insurance Scheme in the Mpohor Wassa East District.

1.2 OBJECTIVE OF THE STUDY

General Objective

The general objective of the study is to assess the financial sustainability of National Health Insurance Scheme in the Mpohor Wassa East.

Specific Objectives

In order to achieve this aim, the study addresses the following specific objectives which include;

1. To investigate the NHIS claims payment system.
2. To find out the utilization rate of both NHIS clients and non insured clients who access health care.
3. To investigate the gate keeper system of care on clients from sister schemes who access health care in Mpohor Wassa East District.
4. To identify other sources of funds to sustain the Mpohor Wassa East Scheme among Schemes.
5. To assess the average cost per out-patient and in-patient services by the facilities on claims for NHIS clients.
6. To examine Scheme's sustainability in terms of premium against cost of services on NHIS clients of Mpohor Wassa East.

1.3 RESEARCH QUESTIONS

To be able to achieve the objectives of this study, the following research questions need to be stated to aid in finding answers to the research problem.

1. What are the provider payment mechanisms used by the Mpohor Wassa East Health Insurance Scheme on claims submitted by the providers?
2. What are the sources of funds available for the scheme?
3. What are the average cost and utilization rate for both out patients and in patients' attendance?
4. How can the gatekeeper system contribute to the abuse of health care by the NHIS clients?
5. What are the ways and means of Ghanaian Government to sustain national health insurance scheme?

1.4 JUSTIFICATION OF THE STUDY

In the late 1980's, many patients began having difficulty with paying for the health care under the cash and carry system. As a result, many did not go to hospital until their illnesses had advanced to a more complicated one. Furthermore, public health facilities also suffered from poor management, low quality service and weak financing. This made private health facilities very expensive in order to allow only the rich to have access to good quality health care services. This also made most of the vulnerable within the country die from curable diseases at various hospitals. Therefore the government has to find an alternative payment system to the cash and carry system, hence the introduction of NHIS.

Again, the study will help us to know if the premium charged is too high and as such people do not have access to affordable health care services. Yet again whether premiums paid by clients is enough to sustain the scheme.

Finally, the study will help to educate the people on how to sustain financially the National Health Insurance Scheme for Mpohor Wassa East District.

1.5 SCOPE OF THE STUDY

Mpohor Wassa East District is in the Western Region and lies within the forest belt. It covers an area of 11,959 km and lies on the altitude average of 150 metres above the sea level. It is bordered on the north-east and south-east by central region (Twifo-Hemang Lower Denkyira and Komenda Edina Eguarfo Abrim District respectively) and on the north-west and south by the Wassa West Municipal Assembly and Shama Districts. Also it is bordered by Ahanta West on the south-west. The District is enriched with gold a mineral which mined by Golden Star Wassa Mine which

employs indigenes. The District is also blessed with the biggest oil palm plantation (Benso Oil Palm Plantation Company Limited) in Ghana and also employs indigenes.

The District Mutual Health Insurance Scheme was piloted in the Mpohor Wassa East District in January 2004 and the full implementation began in October 2004. The District has a total population of about 122,595 (2000 census). To date the Scheme has registered a total of 68,081 people and over 46,000 ID cards have been issues to clients/members. The Scheme has 20 accredited health care providers which comprises one mission hospital (Ahmadiyya Muslim Mission Hospital) which serves as a District hospital and fourteen (15) community clinics, two (2) maternity homes and two(2) chemical sellers.

1.6 LIMITATIONS AND EXPECTED SOLUTION OF THE STUDY

The major constraint to this study is that NHIS is yet to be implemented in most developing countries especially in Sub-Saharan Africa. Hence the experience is not well reported, restricting the researcher for detailed experience to countries in Europe and Asia.

Again, the results of the study may be confounded by interviewee's accuracy in being able to recall information. This is particularly the case with regard to recalling the number of times respondents had accessed health care in the past six months. A number of strategies would be utilized to ensure the interviewee feeling comfortable in providing accurate and honest feedback about the NHIS. Strategies utilized include a coding system to guarantee client confidentiality, and using

interviewers who were independent of the findings (i.e. people not directly involved in the NHIS program).

Another limitation of the study involves the reality of working in a context where there is a constant ebb and flow of people accessing NHIS in Mpohor Wassa East District. Although a range of strategies are put in place to maintain accurate records of current partners, there is the possibility for human error in record keeping.

Finally, the trends observed during this evaluation still need to be confirmed with a larger sample size and deeper longitudinal study over time of several years to have a wide range of materials for comprehensive report.

1.7 ORGANISATION OF THE STUDY

The National Health Insurance Scheme (NHIS) was established in 2003 to provide financial access to healthcare services. Currently, 145 District Mutual Health Insurance Schemes are operating across the country. Ten regional offices have been set up to supervise and monitor operations of the district schemes. The mission of the Scheme is to provide financial risk protection against the cost of basic/ standard quality healthcare for all residents in Ghana, and to delight our subscribers and stakeholders with an enthusiastic, motivated, and empathetic professional staff who share the values of honesty and accountability in partnership with all stakeholders.

The aim of the health insurance is to spread the risk of incurring health care costs over a group of subscribers. Thus, the larger the subscribers the lower the risk burden on an individual. The vision is to be a model of a sustainable and equitable social health insurance scheme in Africa and beyond. The long-term policy objective for introducing health insurance is for every resident of Ghana to belong to a health insurance scheme that adequately covers him or her. Thus, the design of the health insurance scheme is guided by equity, risk, equalization, cross subsidization, quality care efficiency in premium collection and claims administration and community or subscriber ownership.

Based on these principles, a multiple-fund health insurance programme to provide health care insurance for all residents of Ghana is implemented through multi-fund schemes. It is largely not for profit schemes at the district level. However, private schemes will be allowed to provide for profit schemes as an additional insurance cover for those who wish to take on additional insurance cover for themselves. This means that private provider willing to participate must abide by the guiding rules and regulations of the health insurance programme.

The scheme has a cumulative membership base of 14,511,777 representing 62% of the estimated national population as of December 31, 2009. 1,930 health facilities had been accredited to provide services to insured members. The total volume of in-patient and out-patient visits was 17,603,216 and GH¢308.15m had been paid in respect of claims as at December 31, 2009.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

The section will explore as much as possible both empirical and theoretical literature review available that has to do with the topic "Assessing Financial Sustainability of The National Health Insurance Scheme of Ghana''.

2.1 HISTORY OF HEALTH CARE FINANCING IN GHANA

To sustain various government health policies and strategies, an adequate financing mechanism becomes imperative (Ansa, 2005). This has been grossly inadequate, due to poor attention given to the health sector in the past. Recent ideas on health as an investment good rather than a consumer good has increased attention to the health sector and hence increased attention to health sector financing (ILO, 2000). Health financing in Ghana has experienced greater transformation in its operation as discussed below; under colonial rule, Ghana, as many other African countries, organized its health system primarily to benefit a small elite group of colonial officials and their workers (Arhinful and Tenkorang, 2001, 2003). Health care provision occurred mainly through hospitals in urban areas, with direct payment at the point of use. The rest of the population relied on services from a range of providers such as traditional healers and missionary health centres. After independence, the government of Ghana provided medical care free of charge to their population at public health facilities. Health care was financed by general taxes and external donor support, user fees were removed and attention was directed to developing a wide range of primary health care facilities across the country (Ghana Health Service & Abt Associates, Inc 2009: 1). By the early 1970s, general tax revenue in Ghana, with its stagnating economy, could not support a tax

based health financing system (Agyepong et al. 2007). In the health sector there were shortages of essential medicines, supplies and equipment, and poor quality of care. In 1985 Ghana initiated health sector reforms as part of broader structural adjustment programs aimed mainly at reducing government spending to address budgetary deficits, introducing cost recovery mechanisms through user fees (traditionally known in Ghana as "cash and carry") and liberalizing health services to allow private sector involvement. The financial aims of the reform were achieved and shortages of essential medicines and some supplies improved. However, these achievements were accompanied by inequities in financial access to basic and essential clinical services (Waddington and Enyimayew, 1990). During the 1990s several community health insurance schemes, popularly called Mutual Health Organizations (MHO) developed in Ghana with some external funding and technical support. Most MHO focused on providing financial protection against the potentially catastrophic costs of a limited range of inpatient services. The National Health Insurance Scheme (NHIS) grew out of an election promise made in 2000 by the incoming New Patriotic Party to abolish the "cash and carry" system and to remove financial barriers to utilization of health care. The NHIS was launched with the National Health Insurance Act (Act 650), passed into law in 2003, with the aim of replacing out-of-pocket fees at point of service use and of making health care affordable, improving access and health outcomes. The implementation of the NHIS in terms of access to benefits began in autumn 2005.

2.2 ESTABLISHMENT OF NATIONAL HEALTH INSURANCE IN GHANA

The development of the human resources of the country has been identified as one of the key priorities of government. Under the Ghana Poverty Reduction Strategy (GPRS I: 2003 - 2005), a number of measures were initiated in the medium term to enhance access to, and delivery of health services. Considerable investments were made in the provision of health care facilities, with positive outturn on a number of health indicators. However by the end of the implementation of GPRS I, a significant proportion of people still did not have adequate access to quality health services with regional and socio-economic disparities. These variations in health status were attributed, in part, to geographical barriers, financial barriers, service delivery constraints and broad socio-cultural barriers, including gender. The "Cash and Carry System" of paying for health care at the point of service was observed as a key financial barrier to health care access for the poor. To remove the financial barrier to health services and ensure affordable and sustainable health care arrangement for the poor, the government initiated the National Health Insurance Scheme in 2003 aimed at abolishing the "Cash and Carry System" and limiting out of pocket cash payment at the point of service delivery.

The National Health Insurance Act, 2003 (Act 650) established the National Health Insurance Scheme (NHIS) with the aim of increasing access to health care and improving the quality of basic health care services for all citizens, especially the poor and vulnerable. The law establishing the scheme allows for the concurrently operation of District-Wide (Public) Mutual Health Insurance schemes, Private Mutual Health Insurance schemes and Private Commercial Health Insurance schemes. However the schemes would only financially support District-Wide (public) Mutual Health Insurance Schemes. The initially defined benefit package under the scheme includes inpatient hospital care, outpatient care at primary and secondary levels, and emergency and transfer services. Each district mutual health insurance scheme also uses its discretion to determine

additional benefits a scheme could provide. It is envisaged under the GPRS II that access to quality health care will improve with the establishment of affordable health care financing arrangement, while creating the necessary environment for the attainment of the health MDGs namely, the reduction in child and maternal mortality, and the combating of HIV/AIDS, malaria and other diseases.

Additionally, improving the health status of especially women and children will contribute significantly to the reduction of extreme poverty. The NHIS is financed mainly through taxes on selected goods and services, retention on workers' Social Security and National Insurance Trust contribution and premium payment through membership registration. The NHIS Act, 2003 (Act 650) imposed a 2.5% VAT levy on selected goods and services in the country to finance the scheme, in addition to 2.5% of workers contribution to the Social Security and National Insurance Trust (SSNIT) which is deducted at source as their contributions to the scheme. Thus all SSNIT contributors are exempted from paying a premium, though they are required to register in order to benefit from the scheme. On the other hand, all informal sector workers are required to pay a premium, based on the income level of subscribers, in order to have access to basic health services under the NHIS. A portion of total mobilized funds for the scheme is repackaged as an 'exemption fund' and channeled through district implementing bodies to cater for the poor and vulnerable groups as defined under the scheme. Due to anticipated teething problems related to adverse and risk selection issues, and also due to low incomes, the framework innovatively established this fund to provide buffer for district mutual health insurance schemes licensed under the NHIS Act and to subsidize the cost of providing health care services to the exempted group. The fund implicitly subsidizes families by exempting children (under 18 years of age), whose parents fully

pay their annual premiums. Generally, the introduction of contributory health insurance has implications for tax burden on low income groups, labor market costs, and even international competitiveness. Literature from developing countries has demonstrated that voluntary health insurance is associated with both benefits and risks. Notably, it is an area where market imperfections are particularly acute and where some of the negative features can have a particularly adverse impact on both patients (adverse selection) and the health system (fragmentation in financing and cost escalation). Therefore, a better understanding of these aspects of NHIS for different income groups in Ghana will allow policy makers to introduce mitigating policies to deal with their effects. (McIntyre 2007)

2.3 PROVIDER PAYMENT SYSTEMS

The provider payment system easiest to administer would be a capitation system where a gatekeeper provider with whom all insured persons would register would be paid a lump sum amount per year for each insured person. This could logically be a primary care provider, i.e. a clinic or a health centre, or a physician in private practice. Inpatient treatment could be paid on a per day or per case basis upon referral by the primary care provider. However, as long as the population coverage is not complete a parallel fee-for service fee schedule would have to be maintained for the non-insured users of health care facilities. That fee-schedule might be used to calculate the capitation payments (even if less than full fees might be taken into account in the calculations).

The payment of private providers - should they be allowed to participate – will be a key steering element in the overall system. If their fees are too high they are likely to lure staff away from public sector facilities or alternatively push up indirectly staff cost in public facilities. If their fees

are too low, the private sector will probably charge under table payments that could have the same effects. The staff crowding-out-effect will not be completely avoidable. However, a minimum supply of medical professionals in the public sector could possibly be achieved by a minimum bonding of professional after their publicly financed professional education. (Cichon, (ILO 1999).

2.4.0 NATIONAL HEALTH INSURANCE SCHEME TARRIF SYSTEM IN GHANA

The sustainability of the NHIS depends to a large extent on a well designed provider payment mechanism which allows providers to achieve reasonable income, provide quality services and avoid wastage and unnecessary service provision. With a view to supporting the scheme's long-term sustainability, the National Health Insurance Authority (NHIA) has taken critical steps to pursue reforms in the provider tariff payment.

In 2004, a memorandum of understanding regarding services to be provided and prices to be charged was agreed on by the NHIC and service provider representatives. This memorandum now forms the basis of all contracts between the health insurance schemes and providers (Grub, 2007). Claims are made by the health services and the district schemes pay providers on DRG basis. Drugs are paid on a fee for- service basis (McIntyre *et al*., 2008). Claims processing is a manual process, with some automation in enrollment verifications and claims documentation.

2.4.1 THE OLD PROVIDER TARIFF SYSTEM

One of the most important linkages in health insurance is the payment system link between the insurance schemes and service providers. Service providers, like most organizations, are interested in maximizing their income. They would like to provide as many tests and treatments as possible, asking patients to come back several times even when it is not necessary, needlessly using

expensive equipment they have purchased in order to recover cost. It has often been suggested that without a well designed provider payment system to curtail these supply-induced demands, any insurance scheme, however well conceived, might break down.

There are many different methods for paying providers; each one has different effect on quality of health care services, cost containment and administration. The commonly used provider payment methods include the following:

- Fee for services or itemized per case costing,
- Daily (per diem) payment,
- Capitation and
- Case payment (e.g. Diagnosis Related Group).

At the inception of the NHIS, a provider tariff system, which was based on 'itemized per case costing' was adopted for implementation. Under this system, providers were paid a fee for each service, procedure or act provided to patient- consultation fees, accommodation, non-drug consumables, x-ray, laboratory, feeding and so on. The administration of this tariff system, however, faced a lot of challenges.

One of the challenges was the fact that the volume of information required to be provided by the providers brought about prolong vetting of claims and delay in the reimbursements. Another was the issue of proliferation of tariffs among the schemes resulting in great variability of the cost of treatment for the same condition in related facilities. The delay in the reimbursement and the fact that diverse prices were charged for similar procedures and investigations provided in similar facilities in the same or in different regions obviously threatened the sustainability of the NHIS.

Another dimension of the problem was that some providers particularly private ones did not find the NHI tariff attractive and therefore those who otherwise would have applied for NHI

accreditation did not do so. Acceptable rates were important for increasing provider participation, thus reducing congestion at current NHIS accredited facilities.

2.4.2 THE NEW PROVIDER TARIFF SYSTEM

The new tariff system is based on Diagnosis Related Group (DRG) concept. The DRGs are standard groupings of diseases that are clinically similar, have comparable treatments or operations and use similar healthcare resources. Under this tariff system, service providers are paid an already decided all-inclusive flat payment for a patient's treatment according to his/her diagnostic group irrespective of the costs. This payment system has tremendous administrative benefits, as the scheme does not have to scrutinize individual bills. Again, despite the fact that the system can compromise quality of care, as providers may actually skip on relevant treatment to make profits, the incentive for the providers to prescribe extra services is quite limited.

One other benefits of the new tariff is that it provides the service providers, opportunities to earn a reasonable income which, if well managed, will go a long way to bridge the current funding gap in the public health facilities. Unlike the previous one, the new tariff is made up of estimated direct and indirect/overhead costs of providing the various services to each patient depending on the patient's diagnostic related group and level of care. The direct cost includes direct consumable cost for investigations, anesthesia and direct patient care while the overhead cost consists of maintenance of buildings & equipment, vehicle running & maintenance cost, utilities, housekeeping, general administration and indirect labour (casual labour). The details of the components of the overhead costs are as follows: Building & equipment maintenance cost (minor repairs on official & residential buildings, drive ways, grounds, equipment/plant/machinery),

vehicle maintenance and running cost (fuel and lubricants and maintenance of official vehicles), Utilities (electricity, water and telephone), Housekeeping (cleaning materials, sanitation charges), General administrative and office expenses (printing and photocopying, purchase of publications, bank charges, refreshment, training and conferences, stationery and other office consumables, and indirect labour (casual labour).

It is important to point out that, the new tariff covers the full cost of the estimated direct consumables for direct patient care, anesthesia and investigations, and about 80% of the estimated overhead cost for the public health facilities. The implication is that the insurance schemes, in addition to paying for the full cost of the direct consumables for the treatment of the insured patients, also pay a substantial amount for the estimated cost for overhead cost including building and equipment maintenance, housekeeping and utilities in the various public health facilities. In the case of the private and quasi-government facilities, the new tariff covers the full estimated cost of both the direct and overhead costs.

2.5.0 FINANCIAL PROTECTION AGAINST THE COST OF HEALTH CARE

This section looks at the economic burden of health care in general and examines the role of insurance schemes in the process of accessing health care for general health conditions a survey conducted by (National Development Planning Commission, 2009).

2.5.1 ECONOMIC BURDEN OF SEEKING HEALTH CARE

The greatest expectation of Ghanaians about the NHIS is to reduce the burden of health care cost on households. The survey has established that access and use of health care facilities have increased with NHIS membership. The data shows that households registered with the NHIS

benefit in terms of out-of-pocket (OOP) expenditures at health care facilities compared to those that are not registered. It has also revealed that less than 30% of persons who hold valid NHIS cards spend cash at health facilities. This is far less than the 90% of persons who are not registered with the scheme. Persons with NHIS valid cards may incur OOP because of two things: (i) illness that is not covered by the scheme (even though by regulation about 95% of all conditions are covered); (ii) an illness that may involve other medications that are not covered by the scheme. Despite these individual MHOs have operational challenges that tend to serve as barriers to beneficiaries to getting the needed assistance. Members of the scheme may also use facilities that are not accredited out of convenience.

Another important observation from the study deals with the differences between the cost of treatment of diseases or ailment for households which are not NHIS subscribers and those that are NHIS subscribers, the cost of treatment for individuals under the NHIS was estimated to be GH¢20 while cost of treatment borne by individuals who are not insured was estimated at GH¢15. It is likely that people with valid NHIS card use high quality health care unlike those who do not belong to the scheme who may use low quality health care due to lower cost. However it is important to caution against the possible abuse of the scheme and "overuse" of services, in order not to deplete the scheme's resources. The NHIS managers need to be encouraged to thoroughly review claims to avoid possible provider induced claims. Overall, the average cost of deliveries estimated from the survey is GH¢31 per delivery. However, responses from NHIS card holders, show that it costs the scheme nearly GH¢39.70 to take care of the cost of delivery per an individual, compared to GH¢27.32 by Non-NHIS card holders. This again raises concerns about possible over use and possible provider inducement. It is however important to observe that individuals without

NHIS cards before the introduction of the exemption policy for maternal care were not using certain health services because of the cost involved.

2.5.2 NHIS AND PAYMENT FOR GENERAL HEALTH

The findings of the survey conducted showed that the costs of health care accessed by 83.5% of households that are not insured were borne mainly by households, whereas for households with some members insured (partially insured) and for those with all members insured, only 33.1% and 29.7% respectively bore most of the costs. The implication is that the burden of the cost of health care on households is very high when they are not insured with the NHIS.

By regional breakdown, the Central Region recorded the highest proportion of households who bear most of the cost of health care themselves, followed by Greater Accra and then Western Regions respectively from the study. The next region is Northern Region, then Volta Region and Eastern Region, with the rest following in the order. Relatively few people pay for their health care by other means (not specified). This result reflects both the level of membership of and level of usage of the NHIS in the various regions. Based on this, it can be said that the level of usage of the scheme is lowest in the Central and Greater Accra Regions.

The proportion of rural people whose health care costs are borne by the NHIS is higher than those in the urban areas even though uptake of the scheme is higher for urban households. This is not surprising because for most rural areas available health care facilities with qualified personnel are mostly public and accredited by the NHIS.

The results also indicate that more people with lower socio-economic status have their health care costs paid for by the NHIS than those with higher socio-economic status. This is a positive development in view of the fact that the NHIS is expected to provide affordable health care

financing arrangement for the poor. More efforts should be made to get more people in the lower socio-economic group to register with the scheme so that they can equally benefit from the NHIS.

2.6.0 DEMANDS FOR NATIONAL HEALTH INSURANCE

This section discusses two aspects of demand for National Health Insurance in Ghana. The overall level of subscription by individuals across various localities, and subscription by households in different socio-economic groups are analysed. (Nyman, 2003).

2.6.1 OVERALL LEVEL OF SUBSCRIPTION TO THE NHIS

Analyses of the household data suggest that, at the time of the survey more than half of the Ghanaian population (55.6%) had registered with the National Health Insurance Scheme. Out of this, 47.9% were valid card bearing members of the NHIS, and 7.7% had registered but were yet to receive their valid NHIS cards. Also, one-third (33%) of households in the survey had fully registered all their members, while about a quarter (25.9%) had registered some members of their households. More importantly nearly 41% of the population had no household member registered under the scheme. The scheme encourages complete registration of household members in order to pool health risk even at the household level. However, the results indicate that more efforts have to be made to reduce the possible high level of selection of individuals into the scheme. There is the likelihood that "high" risk groups could be selected into the scheme given that there is a problem of information asymmetry in developing countries including Ghana. The survey shows an increasing level of registration under the scheme with a total subscription increasing from a low of

1,797,140 in 2005 to 12, 518,560 in 2008. There are significant variations in the proportion of the population registered under the scheme across geographical areas and socio-economic groups in the country. The scheme encourages complete registration of household members in order to pool health risks even at the household level but the findings show that more work will have to be done to reduce the effects of selecting high risk individuals into the scheme that has the potential to over-burden its resources.

2.6.2 NATIONAL HEALTH INSURANCE SCHEME MEMBERSHIP

The result from the household survey shows that the proportions of the population in the Upper West, Volta, Western, Upper East and the Eastern regions who hold valid NHIS cards were higher than the national average. While the proportions of the population who hold valid cards in Central, Northern, Greater Accra and Ashanti Regions were less than the national average. The Central Region had the lowest proportion of the population with valid cards. On the other hand, the Northern Region has the highest proportion of people who though registered had no valid NHIS cards (16.3%), followed by Ashanti (11.9%) and Brong Ahafo (10.5%) Regions in that order, whiles the Upper East Region has the least (1.3%). However institutional data from NHIA records and also from data on 58 schemes covered as part of this survey suggest that Ashanti, Brong Ahafo and the Northern Regions have the bulk of the population registered under the NHIS nationwide. Significant proportion of individuals interviewed has not yet registered with the NHIS. This is particularly high for Greater Accra and Central regions where more than half of the population is still not registered under the scheme.

The survey shows that in general, the proportion of individuals registered under the scheme is higher in the urban than in the rural areas. The level of registration is about 10% more in urban areas than in rural areas.

These findings reflect in the high level of satisfaction of the performance of the scheme as expressed by respondents of the survey. Households with all members insured are particularly pleased with the performance of the scheme with 59.8% indicating they are satisfied and a further 31.7% indicating that they are very satisfied. It is hoped that more people will enroll in the scheme if a number of challenges identified in this report are addressed.

2.7 FINANCIAL CAPACITY OF NHIS

A country's financial capacity for funding health insurance is a function of its current and expected economic status (gross domestic product per capita), the size of the formal sector economy that can be taxed and/or contribute to employer-based health insurance, the opportunity to find efficiencies in the current health system, and the current level of household health expenditures, some of which might be tapped to finance health insurance. Financial capacity is also a function of the country's organizational and operational capacity to collect, pool, and spend funds efficiently and effectively. Ministries of Finance and Health must work together to determine the government's capacity and commitment to finance health insurance. Economists, actuaries, and accountants can inform this process by analyzing different scenarios of the country's financial capacity and insurance design. (WHO 2000)

2.8 SERVICE AVAILABILITY, QUALITY AND PROVIDER CAPACITY

Service availability and provider capacity affect feasibility at two levels:

1. The physical presence of health workers and facilities near enough to target populations and their capacity to deliver quality services covered by insurance (do they have the skills, equipment, and supplies?). If policy makers fail to address gaps in service availability and quality, they risk making existing inequities worse if insurance funds will flow to the providers already in place in wealthier, urban areas.
2. Providers' willingness to participate in the insurance program. Providers may not be willing to participate if, for example, the insurance payments are perceived as too low, patient volume increases significantly while health worker salaries stay the same, or insurance reduces user fee income (either formal or informal). In Vietnam, providers began refusing to provide services to those enrolled in the insurance scheme because the reimbursement rates were much lower than their actual costs and providers were losing money servicing the insured. In Ghana, the combination of high patient volume and flat income led health workers to strike in 2005. (WHO 2000).

2.9 INCOME SOURCES

I. Employee Contributions

The National Health Insurance Act (2003) makes provision for the transfer of 2.5 percentage points from the social security pension scheme administered by SSNIT to the National Health Insurance fund. 37 This means a mandatory contribution for all workers covered under the SSNIT scheme. From 2004, employee contributions were based on 2.5 per cent of salary, computed as the product of the average salary and the number of active contributors of the SSNIT pension scheme and the applicable compliance level. 38 Over the projection period, SSNIT active membership and average salaries were projected by applying scheme-specific growth rates.

II. Government Funding/Donor Support

Government and donor funding have been a major source of financing for the health sector. Currently government (tax revenue) and donor funding caters for about 80 per cent of the cost of health care, implying that around 20 per cent of healthcare is financed through out-of-pocket payments popularly known as the cash-and-carry system.

The total public sources of finance considered in this model include funds from general tax revenues and the proposed health insurance levy of 2.5 per cent on all expenditures and transactions. The latter is also provided for in the Act, starting in 2004. It is assumed here that the present level of government financing (from general taxation) is maintained in the future. Values for 2003, 2004 and 2005 are taken from the Medium-Term Expenditure Framework and are thereafter assumed to grow with GDP. It is also assumed that this includes the Government premium subsidy for the poor.

Donor financing for health care delivery for 2003, 2004 and 2005 are likewise taken from the Medium-Term Expenditure Framework, and are assumed to be driven by inflation throughout the projection period as of 2006.

It should be noted that the 90 million US$ World Bank release for the Health Sector have not been taken into consideration in these calculations.

III. Insurance Premiums

Insurance premiums were based on membership of MHOs and a minimum annual premium amount of 36,000 cedis. 39 A survey of health financing schemes in Ghana conducted in 2001 by Atim 2001, 40 revealed that the total membership of MHOs in Ghana was about 86,822. This figure was assumed to have increased by 20 per cent in the year 2003. The annual premium was

projected to grow by medical inflation, computed as the mean of inflation (consumer price index) and wage inflation.

- 2.5 per cent of the contributions of SSNIT workers translates to about 0.4375 per cent (17.5 per cent* 2.5 per cent) of the salaries of workers which may be inadequate to meet government expectations of health insurance contributions from workers. It is therefore clear that the statement is referring to 2.5 percentage points of the contributions, which is equivalent to 2.5 per cent of gross earnings.

- Not all covered members of the SSNIT scheme pay their contributions. The compliance rate shows the proportion of the expected covered members who pay contributions. Beyond 2004, the compliance rates applied conform to the targets set by SSNIT (Strategic Plan).

- The model does not assume that additional premium shall be paid by SSNIT members to cover their family when the 2.5 per cent of the salary is smaller than the premium for spouse(s) and children above 18, as it is believed that few people will fall into that category.

IV. Investment Income

Investments were based on the current year balance and the reserve from the previous year. In the base year and throughout the projection period, income from investments was based on a 2 per cent real rate of return. Investment income can also be negative. This means that if the overall Government budget is negative- the Government would have to borrow money to fulfill its

obligations. The interest on the emerging debt would be interpreted as “negative returns” in the model. (Atim. 2001)

2.10 COVERING THE POOR IN PERU THROUGH MEANS-TESTED SUBSIDIES

From 1997 to 2009, Peru’s health financing system has evolved from several targeted insurance programs aimed at specific segments of the population to a universal system including the poor. Since the 1930s, the Peruvian Health Social Security Agency (EsSALUD) has provided health care coverage to formal sector workers and their dependents (spouse and children under 18), pensioners, and some self-employed persons. EsSALUD is financed through a 9% payroll tax levied on employers. Pensioners and the self-employed have to contribute to premiums, though other formally employed workers do not. As of 2006, the combined contributory coverage of EsSALUD, the Armed Forces, and the police reached 5.8 million persons, i.e., around 20% of Peru’s population. These were mainly non poor families.

In 1997, the Peruvian Ministry of Health took the first step to extending public health insurance to the poor, which they referred to as “subsidizing demand for health care.” The initiative started with an easily identifiable group, school children. The Free School Health Insurance program (Seguro Escolar Gratuito) provided exemptions from the cost of consultations and medicines to all children ages 5–17 enrolled in public schools. To extend coverage further, the Maternal Child Health Insurance program was launched in 1998 and provided a package of free basic services to pregnant women and children under 5. This was started as a pilot project in five districts at first and expanded to eight districts in 2000. The programs merged in 2001 to create the Integrated Health Insurance Program (Seguro Integral de Salud, or SIS) and coverage was extended from the eight pilot districts to the whole country. The program was targeted to those who could demonstrate

financial need through a screening process that was improved in 2004. Eligibility expanded to include all children under the age of 18 (whether enrolled in school or not), pregnant women, and adults in need of emergency care, if they passed the means test. In 2009, eligibility was extended to include entire families earning less than a certain income, as long as they had no other insurance coverage. Coverage is free of charge for those who are considered in a state of poverty and available at a subsidized rate for those with eligible incomes (under approximately $200 per month individual income or $500 per month family income. SIS, funded predominantly through tax revenues, grew from covering 5,860,000 beneficiaries in 2002 to 10,350,000 in 2008, out of a population of 29 million.

In 2009, Peru passed a Universal Health Insurance Law, which established an overall framework for health insurance reform in Peru. This policy comprises a two-pronged strategy: 1) increasing the breadth of insurance coverage by expanding the number of people with effective access to quality health services and protection against financial risk, with an emphasis on the poor; and 2) increasing the depth of insurance coverage by expanding the range and quality of health benefits according to the current and future demographic profile and epidemiological needs of the population.

2.11.0 NHIS BENEFITS PACKAGES AND COST CONTAINMENT

The benefits package is usually a list or table of general categories of care (e.g., outpatient care and hospital care) with details regarding the level of coverage in each category. The details can include the type of provider, specific services or conditions covered or excluded, limits on services (e.g., number of days in the hospital), and any co-payments or deductibles). The National Health Insurance Scheme (NHIS) currently provides coverage for basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and cesarean), eye care, dental care, and emergency care. Initially, certain public health services were excluded from the benefits package because they were considered "essential public goods" and were provided free by the government. These services include family planning and immunizations. As of July 2008, all pregnant women became eligible and exempt from premium contributions. (Smith and Fairbanks. 2008) In September 2008, all children under 18 became eligible regardless of whether their parents were enrolled. Women are entitled to free prenatal care services, free delivery care (for either normal delivery or cesarean), as well as free care for their babies up to one year of age (women are able to also receive family planning services at the same clinic, but must pay out-of-pocket). Recently, the government and other stakeholders have considered the costs of including family planning in the benefits package, including long-term and permanent family planning methods as well as injectables. A recent cost-benefit study found that if family planning is covered in 2009, by 2011 NHIS will save almost $11 million that year alone and save up to $17 million by 2017 (cost savings would come from decreased fertility, averted births, and lower costs associated with birth).

In 2001, the Commission on Macroeconomics and Health (CMH) recommended four criteria to choose essential health interventions to be included in benefits packages: "(1) They should be technically efficacious and can be delivered successfully; (2) the targeted diseases should impose a

heavy burden on society, taking into account individual illness as well as social spillovers (such as epidemics and adverse economic effects); (3) social benefits should exceed costs of the interventions (with benefits including life-years saved and spillovers such as fewer orphans or faster economic growth); and (4) the needs of the poor should be stressed." In addition to the CMH criteria, policy makers must also consider the priorities of the population groups that are providing most of the financing, who may withdraw their political support for an insurance scheme that does not cover services that they value.

2.11.1 THE BENEFITS PACKAGE CONTAINMENT

The goal of cost containment is to make the insurance scheme solvent and financially self-sustaining. As part of the benefits package, cost-containment methods can discourage unnecessary, wasteful spending so there are more funds for needed health care services. Some methods can promote quality, while others can possibly erode quality and must be closely monitored. There are costs incurred when implementing cost containment. Most methods are annoyances to beneficiaries and providers and require administrative systems and labor to implement. Policy makers must confirm that the cost containment method is saving more money than the cost of implementing and monitoring compliance with the method.

The benefits package design process itself can contribute to cost containment. Many health insurance plans control costs through deductibles and co-payments as these mechanisms control the tendency to overuse health services (moral hazard). These deductibles and co-payments, however, may be unaffordable to the poorest groups. Some schemes set a ceiling on the benefits an individual may be paid within a given time frame, such as a year, although such maximums may leave beneficiaries at risk of catastrophic expenditures. Many insurers exclude expensive services

such as organ transplants and dialysis. Insurers may cover only generic drugs, or use an essential drugs list. Clear and rational processes, based on evidence of cost effectiveness, should always be followed for modifying the benefits package and reviewing new interventions, products, and technologies for possible inclusion.

Other cost-containment methods can include the following:

- Mandatory enrollment and eligibility policies that diversify risk and combat adverse selection, for example, requiring that the whole family enroll not just the sick and elderly.
- Waiting periods for beneficiaries to use certain benefits to prevent people from enrolling just after diagnosis or when a service is needed.
- Provider selection and payment methods that reward quality and efficiency
- Assigning a gatekeeper, often a primary care physician, responsible for authorizing the insured person's access to specialized tests and services covered by the insurance scheme; and gatekeeper determining whether the patient has met the conditions to be referred for specialized services, what is the appropriate level of service, and sometimes where the services should be provided.
- Effective communication among stakeholders, such as the insurer, beneficiaries, and providers, so they understand roles and responsibilities, rights under the scheme, and ways to collaborate to avoid wasteful spending. Controlling fraud or abuse by the beneficiary, the provider, or both.
- Promoting the use of protocols or clinical guidelines among providers to standardize service delivery for certain diagnoses or types of care to contain costs and improve quality.
- Case management of chronic diseases to promote health and avoid inpatient admissions.

2.12.0 FINANCIAL PROCESSES AND MANAGEMENT

Financial management is critical to ensure adequacy of financial resources to cover operating costs, keep the health insurance funds in financial equilibrium, and ensure transparency for sound monitoring, management, and viability. This includes maintaining an adequate operating reserve to cover known costs, risks, and unforeseeable short-term risks. When there are several stakeholders involved in the implementation of health insurance and potentially multiple sources of income for the scheme (individuals, employers, and government), it is vital that the management and integrity of these funds be maintained to optimize efficiency and effectiveness to ensure it sustainability.

The financial management system should have the following three main elements:

- A budgeting system to plan for and understand all costs related to the health insurance scheme.
- An expenditure tracking system to ensure the proper internal controls to manage the flow of funds.
- A cost management system to ensure payments and costs are in line with what is budgeted for financial viability.

2.12.1 BUDGETING SYSTEM

The budgeting system refers to the planning and budgeting of expenses related to the health insurance scheme. These expenses include administrative costs, marketing costs, legal costs, and claims or benefits costs. It is essential during the planning phases of health insurance that all costs are estimated and planned for to ensure that the revenues collected are adequate to meet the needs of the insurance scheme.

If the budget reveals a funding gap, it is crucial that the gap be addressed; this can be done by revising the benefits package, revising premium amounts, reducing administrative costs, and/or taking other actions. These changes are not easy to make and often take considerable time to address because of contractual obligations and other variables.

2.12.2 EXPENDITURE TRACKING SYSTEM

The expenditure tracking system refers to the internal systems in place to manage the flow of funds. This includes robust accounting and cash management systems, as well as internal controls to receive and document the flow of funds and accounts payable. A well-functioning expenditure tracking system is essential for monitoring the use of funds, detecting fraud, and determining areas for cost containment.

The expenditure tracking system will also likely be the system that pools all incoming financial resources and manages the use of the resources to finance the insurance scheme. For example, collections made from the beneficiaries, employers, and government will all be pooled and tracked in the expenditure tracking system.

2.12.3 COST MANAGEMENT

Cost management refers to the mechanisms by which a health insurance scheme can manage and control resources that are being expended. It is the feedback loop to ensure that expenses are staying within the budgets forecasted. Effective cost management is critical to ensure the viability of the health insurance scheme and includes utilization management, expenditure tracking and reporting, and financial adjustments during implementation of the scheme.

Once a health insurance scheme is established, health care utilization rates will likely increase because of moral hazards and the effectively lower cost to health care consumers. Moral hazard is inevitable when a traditionally costly service for which there is unmet need becomes financially accessible. It is very difficult to forecast the amount of moral hazards a new health insurance scheme will experience, which is why it is critical to manage expenses after start-up and maintain the flexibility to revise program benefits and payment arrangements; adjustments will probably have to be made along the way to stay within budget. For example, a scheme may need to institute co-payments or co-insurance to help generate revenue and limit utilization, or alter the mode in which providers are paid to discourage overprovision of services.

While many stakeholders will provide inputs into the financial management system, it is important that the main managing entity of the scheme (the "owner" of the scheme) be responsible for the overall financial management of the scheme, managing and controlling costs, and making necessary changes to maximize efficiency without compromising quality. When multiple stakeholders are involved in the implementation of the insurance scheme, the managing entity must develop systems for collecting the relevant data on a timely basis. This includes financial data (expenses for services, administration, human resources, etc.), as well as claims and utilization data.

2.13 MARKETING AND COMMUNICATION

Communications about the health insurance scheme can serve several purposes. They can be used to educate the population about the scheme to generate demand for enrolling (marketing). They can be used to educate the beneficiaries about what benefits they are entitled to, the process for using the scheme, and their rights within the scheme.

Different stakeholders may take on the function of marketing and communications, depending on their interests. For example, where health insurance schemes are predominantly private, the government may have an incentive to educate beneficiaries about their rights under the schemes. Stakeholders responsible for enrollment may have an incentive to market the health insurance scheme to generate demand for enrolling. Marketing and communications become particularly important in a voluntary scheme if beneficiaries are expected to contribute to the premium, in which case generating demand and persuading the population to join becomes a high priority. It may be necessary to regulate marketing and communication strategies to ensure that beneficiaries understand their rights and coverage. A state-led health insurance scheme in India was launched to cover all of the people living below the poverty line. The state government fully subsidized the premium and contracted an insurance company to cover this population. However, the insurance company was required to do very little marketing and communications. After one year of implementation, there were few claims because beneficiaries did not know they were covered by the health insurance program.

Some countries have very strict guidelines for marketing insurance schemes. For example, when the U.S. government introduced the Medicare prescription drug benefit, it put in place strict guidelines for how pharmacies and others could market the benefit to the population. In fact, the Center for Medicare and Medicaid Services contracted with a third party to establish the marketing guidelines and monitor compliance with those guidelines.

2.14 COLLECTION OF FINANCIAL CONTRIBUTIONS

Premium collection is the gathering of financial contributions for participation in the health insurance scheme. It is a critical function that can be very difficult to manage in low-resource

settings. Depending on the insurance model being used, premium contributions can be collected through general taxes (sales, income, real estate, import/export, and other taxes), payroll deductions, or directly from individuals enrolling in the scheme. Tax-based and payroll-based insurance financing depend on a reasonably well functioning tax system and a substantial formal sector that is willing to contribute.

In countries with a small formal sector (few registered companies) or effective tax system, contributions must be collected directly from beneficiaries. Reaching beneficiaries in dispersed, rural areas presents logistical challenges. For example, this is done door-to-door in rural Rwanda. Many subsistence farmers only have cash income on a seasonal basis and will not be able to contribute except around harvest time. Families living close to health facilities are far more likely to be willing to pay than those living further away, although the most remote inhabitants often have the greatest need for health care services.

Typically, it makes sense to collect financial contributions at the same time as enrollment. It may be administratively easier and more cost-effective to collect annually for a one-year subscription to the health insurance scheme, and this may work well in farming communities if contributions can be collected at harvest times when families are most likely to have cash. However, in many resource-poor communities, paying for a year of health insurance in one lump sum may be cost-prohibitive and discourage families from enrolling. Some countries have been able to link health insurance collections to microfinance organizations, allowing families to access credit to cover their health insurance contributions and manage smaller payments on a regular basis. The fact that there is already a mechanism in place for debt payments facilitates this process. Overall, strong communications plans are critical to ensure that the population fully understands what they are paying for.

2.15 CLAIMS ADMINISTRATION

Claims administration refers to the process of receiving, reviewing, adjudicating, and paying claims. In many health insurance schemes, the payer is not in a position to manage the claims process, so it is essential that another entity is hired to administer the claims. Claims administration will also vary depending on the model of insurance and provider payment system being implemented.

In insurance schemes where there are claims to be processed, the responsibility for claims submission can fall either on the patient or the provider. In a cashless system, the beneficiary receives a covered service from a provider and does not pay the provider (other than a possible co-payment or for items that the scheme does not cover). The provider then submits a claim for that service to the claims administrator for payment. In a reimbursable arrangement, the beneficiary seeks services and pays the provider out-of-pocket. The beneficiary then submits the receipt(s) and a claim for that payment to the claims administrator for reimbursement.

Beneficiaries generally prefer the former (cashless) option because the reimbursement option does not remove the financial barrier to accessing care and requires careful tracking of paperwork. Providers prefer the reimbursable arrangement because it reduces their administrative burden and allows them to be paid immediately (rather than waiting for reimbursement from a third party, which can take time).

However, reimbursement is much less feasible in resource-constrained settings where the ability to pay up front and submit a claim to an insurer may present logistical challenges. Considering the advantages and disadvantages of each option is essential to deciding on and developing your insurance scheme design. Whichever submission option, the claims administrator must determine

if the claim is an eligible expense under the health insurance policy. This is an area of potential fraudulent behavior. Therefore, the claims administrator must have very clear guidelines on which claims are allowable. Further, the claims administrator often needs to employ physicians or health care professionals to determine if a service was medically necessary and identify mutually exclusive claims. For example, a claim submitted for payment for both a normal, institutional delivery and for post-abortion care for the same individual should raise a red flag, because one person does not need both services for the pregnancy. The claims administrator must investigate to ensure that the right claim was submitted and that fraudulent activity did not occur. Claims investigation is the process of obtaining all the information necessary to determine the appropriate amount to pay on a given claim.

Depending on the model of insurance, the payer and providers will generally agree upon a rate schedule. A rate schedule is the set of fees determined by an insurer or payer to be acceptable for a procedure or service, which the physician agrees to accept as payment in full (this takes into consideration any copayments, co-insurance, or deductible that may be applied). Sometimes the rate schedule includes individual rates per individual service. In other cases, there are fixed, packaged (or case-based) payment rates (such as DRGs) that "prepackage" services. For example, for a woman delivering by cesarean section, the fixed package rate includes all the services needed to perform that procedure (blood, surgery, anesthesia and other drugs, etc.). Packaged payments require more sophisticated actuarial, accounting, and payment systems but are often preferred for cost-containment purposes. To minimize the number of claims that must be investigated, some insurers require pre-authorization for each service. This is when the provider must solicit the insurer's authorization to deliver the service to a beneficiary and will be guaranteed payment, assuming no other questions arise. Further, to facilitate claims administration, it is necessary to

establish a coding system by which the provider labels health care services with a numerical identifier that will be recognized by the payer or insurer. There are many different coding systems. Regardless of the system chosen, providers will require training in filling out the claims paperwork to ensure accuracy and efficiency.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

The chapter focuses on the procedures adopted in carrying out the study. These over the research design, data collection, population, sampling procedure, research instrument and data presentation and analysis.

3.1 RESEARCH DESIGN

The descriptive method of research was used for this study. To define the descriptive type of research, Creswell (1994) stated that the descriptive method of research is to gather information about the present existing condition. The emphasis is on describing rather than on judging or interpreting. The descriptive approach is quick and practical in terms of the financial aspect. Moreover, this method allows a flexible approach, thus, when important new issues and questions arise during the duration of the study, further investigation may be conducted.

Descriptive research on the other hand is a type of research that is mainly concerned with describing the nature or condition and the degree in detail of the present situation.

In this study, the descriptive research method was employed so as to identify the role and significance of using personality questionnaire in assessing the financial sustainability of NHIS during the time of research. The researcher opted to use this research method considering the objective to obtain first hand data from the respondents. The descriptive method is advantageous for the researcher due to its flexibility; this method can use either qualitative or quantitative data or both, giving the researcher greater options in selecting the instrument for data-gathering.

The research is using households, workers of health care facilities, scheme manager and patients exit as respondents to gather relevant data; the descriptive method is then appropriate as this can allow the identification of the similarities and differences of the respondents' answers.

3.2 DATA COLLECTION

For this research, two types of data were gathered. These included the primary and secondary data types. The primary data were derived from the answers the participants gave during the survey process. The secondary data on the other hand, were obtained from published documents and literatures that were relevant to personality questionnaire. With the use of the survey questionnaire and published literatures, this study took on the combined quantitative and qualitative approach of research. By means of employing this combined approach, the researcher was able to obtain the advantages of both quantitative and qualitative approaches and overcome their limitations.

Quantitative data collection methods are centred on the quantification of relationships between variables. Quantitative data-gathering instruments establish relationship between measured variables. When these methods are used, the researcher is usually detached from the study and the final output is context free. Measurement, numerical data and statistics are the main substance of

quantitative instruments. With these instruments, an explicit description of data collection and analysis of procedures are necessary. An approach that is primarily deductive reasoning, it prefers the least complicated explanation and gives a statement of statistical probability. The quantitative approach is more on the detailed description of a phenomenon. It basically gives a generalization of the gathered data with tentative synthesized interpretations.

Quantitative approach is useful as it helps the researcher to prevent bias in gathering and presenting research data. Quantitative data collection procedures create epistemological postulations that reality is objective and unitary, which can only be realized by means of transcending individual perspective. This phenomenon in turn should be discussed or explained by means of data analysis gathered through objective forms of measurement. The quantitative data gathering methods are useful especially when a study needs to measure the cause and effect relationships evident between pre-selected and discrete variables. The purpose of the quantitative approach is to avoid subjectivity by means of collecting and exploring information which describes the experience being studied.

Quantitative methods establish very specific research problem and terms. The controlled observations, mass surveys, laboratory experiments and other means of research manipulation in qualitative method makes gathered data more reliable. In other words, subjectivity of judgment, which is not needed in a thesis discussion, can be avoided through quantitative methods. Thus, conclusions, discussion and experimentation involved in the process are more objective. Variables, both dependent and independent, that are needed in the study are clearly and precisely specified in a quantitative study. In addition, quantitative method enables longitudinal measures of subsequent performance of the respondents. Fryer (1991) noted that qualitative researchers aim to decode,

describe, analyze and interpret accurately the meaning of a certain phenomena happening in their customary social contexts. The focus of the researchers utilizing the framework of the interpretative paradigm is on the investigation of authenticity, complexity, and contextualization, mutual subjectivity of the researcher and the respondent as well as the reduction of illusion.

Contrary to the quantitative method, qualitative approach generates verbal information rather than numerical values (Polgar & Thomas, 1995). Instead of using statistical analysis, the qualitative approach utilizes content or holistic analysis; to explain and comprehend the research findings, inductive and not deductive reasoning is used. The main point of the quantitative research method is that measurement is valid, reliable and can be generalized with its clear anticipation of cause and effect (Cassell & Symon, 1994). Being particularistic and deductive in nature, quantitative method is dependent on the formulation of a research hypothesis and confirming them empirically using a specific data set (Frankfort-Nachmias & Nachmias, 1992). The scientific hypothesis of a quantitative method holds no value. This means that the researcher's personal thoughts, subjective preferences and biases are not applicable to this type of research method.

The researcher opted to integrate the qualitative approach in this study due to its significant advantages. The use of qualitative data gathering method is advantageous as they are more open to changes and refinement of research ideas as the study progresses; this implies that qualitative data gathering tools are highly flexible. Moreover, no manipulation of the research setting is necessary with this method; rather than employ various research controls such as in experimental approaches, the qualitative data gathering methods are only centered on understanding the occurring phenomena in their naturally occurring states. Aside from these advantages, researchers use qualitative data-gathering tools as some previous researchers believe that qualitative data are

particularly attractive as they provide rich and well-grounded descriptions and explanations as well as unforeseen findings for new theory construction. One of the notable strengths of the qualitative instruments is that they evoke a more realistic feeling of the research setting which cannot be obtained from statistical analysis and numerical data utilized through quantitative means. These data collection methods allow flexibility in conducting data gathering, research analysis and interpretation of gathered information.

3.3 POPULATION AND SAMPLE SIZE

The targeted population for the study was made up of all the accredited health care providers, all the NHIS staff and all NHIS members (card bearers) in Mpohor Wassa East Mutual Health Insurance Scheme. However, the sample size used for the study was 76 made up of 16 accredited providers, the Scheme Manager and 59 NHIS Clients.

3.4 SAMPLING PROCEDURE

Simple random sampling was done for the sample selection. This sampling method was conducted in each of the two categories (accredited providers, and NHIS members) of a population where all has an equal opportunity to become part of the sample. As all members of the population have an equal chance of becoming a research participant, this is said to be the most efficient sampling procedure. This sampling technique was adopted after the researcher had developed quota sampling for the population. Quota sampling was used to assigned quota to each of the categories of the population. The Scheme Manager was interviewed due to his indebt knowledge about the scheme and also being the head of scheme.

3.5 RESEARCH INSTRUMENT

The research instruments used for this survey were opened and closed ended questionnaires, interview guide and observation**.** There were two sets of questionnaire – one for the clients and providers. Both questionnaires were divided into two main sections: a background and the actual survey. The background contains characteristics of the respondents such as age and educational background. The actual survey explored the assessment of NHIS on questionnaire, particularly on its financial sustainability. In designing the questionnaires, adequate measures were taken to ensure that good, unbiased, non leading and accurate questions were developed. To this end, questions that required a 'YES' or 'NO' response were followed up with further questions to reflect research questions and objectives of the study. Interview schedule was chosen because the scheme manager was only person to provide the needed information for the study.

After the questions have been answered, the researcher asked the respondents for any suggestions or any necessary corrections to ensure further improvement and validity of the instrument. The researcher revised the survey questionnaire based on the suggestion of the respondents. The researcher then excluded irrelevant questions and changed vague or difficult terminologies into simpler ones in order to ensure comprehension.

3.6 DATA PRESENTATION AND ANALYSIS

Statistical Package for Social Science (SPSS) was used for the data analysis to determine the frequency distribution table and percentage distribution rate of the respondents.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF RESULT

4.0 CHARACTERISTICS OF SURVEY RESPONDENTS

4.1Clients Survey

The survey covered the entire District of Mpohor Wassa East, divided into Zonal areas. Table 1 shows the unit of analysis of the NHIS Clients and a total of 59 members were tasked to fill a questionnaire. The total number of respondents was 59 of which 10.2 % were below the age of 18-25,11.9% were under the age 26-30 years, 11.9 % were 36-40 years 16.3 % were under the age 36-40 years, 20.3 % were 41-45 and 20.30% were 46-50 years and 8.5% were under the age 51-60 years. This signifies that the client respondents were concrete and well informed information decision making.

Table 1: Age distribution

AGES	PERCENTAGE (%)
Below 18-25	10.2
26-35	11.9
31-35	11.6
36-40	16.9
41-45	20.3
46-50	20.3
51-60	8.5

TOTAL	100

Out of the total respondents of 59 clients 35 were female and 24 were male, this result implies that there were more female respondents' than male.

Health Care Provider's Survey

A total of 16 questionnaires administered were conducted with providers of health care services during the survey. The objective of this interview was to gather information on the use of health facilities by NHIS card holders and non-card holders. It also helped to gain insight into the claims payments mechanism, ways to sustain NHIS financially in the district and ways to improve the smooth operation of the scheme. Out of the 16 respondents who administered the questionnaires 3 were medical assistants, 8 midwives and 5 community nurses. All the respondents were qualified personnel in charge of the various facilities.

National Health Insurance Scheme Survey

The operation of the National Health Insurance Scheme at the district level falls within the mandate of the various district-wide schemes established in the ten regions of Ghana. They are responsible for educating the public on the benefits of the scheme, registration and renewal of membership, collection of premiums, management of claims and ensuring the sustainability of the scheme. The study, discusses sources of funds to the scheme, claims payments systems and how to sustain the scheme.

The Scheme manager was interviewed for information relating to the claims payment, sources of funds and expenditure pattern and how the scheme can be sustained financially, the categories of registered members of the scheme and their payments and ways to improve the scheme's

operations. The information gathered from the scheme thus has a high level of reliability and could confidently be used for assessing the study. The scheme commenced operations in 2004 and 2005 following the passage of the National Health Insurance Scheme Act, 2003 (Act 650).

4.1 ANALYSIS AND DISCUSSION OF PROVIDERS PAYMENT MECHANISMS

A question was posed to find out how often the scheme reviews its NHIS payment system. The results reveal that, the scheme reviews its payments system bi-annually and annualy. This implies that, the scheme is conscious about the trend of the market prices on both drugs and other consumables used at the facilities.

Table 2: Review of payment system by the providers

Time	Frequency
Annually	6
Bi-annually	10
Total	16

The same question was also posed to the providers on how often the scheme reviews its payment system. A study of table (2) reveals that, six of the providers responded annually and ten of the providers responded quarterly. Both respondents agreed on the same result which buttress what (Grub 2007) stated that, ' the sustainability of the NHIS depends to a large extent on a well designed provider s payments mechanism which allows providers to achieve reasonable income, provide quality services and avoid wastage and unnecessary service provision'. With a view to support the scheme's long term sustainability, the NHIA has taken critical steps to pursue

reinforcing in the provider tariff payment bi-annually and annually. Grub (2007), stated that, there are many different methods for paying providers; each one has different effect on quality of health care services, cost containment and administration. The commonly used provider payment methods include the following: Fee for services or itemized per case costing, Daily (per diem) payment, Capitation and Case payment (e.g. Diagnosis Related Group).

The mode of payment reveals under the study was cashless system, whereby the beneficiary receives a covered service from a provider and does not pay the provider (other than a possible co-payment or for items that the scheme does not cover). The provider then submits a claim for that service to the claims administrator for payment. According to Atim C. et al (2001), the mode of payment is cashless system and a reimbursable arrangement, where the beneficiary seeks services and pays the provider out-of-pocket. The beneficiary then submits the receipt(s) and a claim for that payment to the claims administrator for reimbursement.

A question was asked to find out the internal control measures used by the scheme to check claims payment. The study reveals that the scheme has processes and procedures which are followed before a claim could be paid. The claims have to be received by the scheme to check on its authenticity through vetting, query the problematic claims before approval is made for payment. This claims investigation is the process of obtaining all the information necessary to determine the appropriate amount to pay on a given claim. The scheme manager later, stressed that if this internal control measures were strictly followed fraud and misappropriation of scheme funds would be controlled.

4.2 ANALYSIS AND DISCUSSION OF SOURCE OF FUNDS

A question was posed to find out the sources of funds for the running of the scheme. The study showed that the source of funds was through registration fees and premium contributions of the clients and also the subsidy for the exempt administrative support which is released by the government. The study also reveals that about 95% of the claims payments are being financed through taxes levied on Ghanaians through the VAT system. The premium contributions by clients cannot sustain the scheme expenses as revealed by the study. 98% of the total claims fund is from the government in the form of National Health Insurance Levy (NHIL) and the scheme funds the remaining 2%. This coincides with Chris Atim et al, 2001.

According to NHIS Act, 2003 (Act 650) which states that, government has imposed 2.5% VAT levy on selected goods and services in the country to finance the scheme, in addition to 2.5% of workers contribution to the Social Security and National Insurance Trust (SSNIT) which is deducted at source as their contribution to the scheme. Thus, all SSNIT contributors are exempted from paying a premium, though they are required to register in order to benefit from the scheme. On the other hand, all informal sector workers are supposed to pay a premium, based on the income level of the subscribers in order to have access to basic healthcare under the NHIS.

Further question was asked to find out the categories of clients who pay registration fees and premiums. The study revealed that children below the age of 18 years, SSNIT contributors and SSNIT pensioners and ages above 70 years only pay registration fee of GH¢4.00 whilst the informal sector of the population pay premiums depending on their income level which the district collects GH¢15.00 across all income levels. The extremely poor in the district pay no fee for registration and also no premium contribution.

With regards to the frequency and amount of subsidy received from the government, the result reveals that, the scheme within the study area receive government subsidy on monthly basis and the amount is based on the indebtedness submitted for that particular month. This shows that government has a great commitment in ensuring financial sustainability by providing monthly assistance in the form of financial subsidy.

Table 3: Administrative Expenditure Trend

Years	Cost GH ¢	% increase
2008	112,320	-
2009	169,580	51%
2010	264,471	56%

A question was posed on the expenditure trend of the scheme both administrative and claims. The result of table 3 reveals that, the scheme incurred high administrative expenses which increased from 51% in 2008 to 2009 and later increased to 56 % margin. These high expenses were as a result of weak internal control measures of tracking cost and scattered nature of district which has been divided by the River Pra makes the scheme spend high cost of fuel and vehicle maintenance and also night allowances for the staff contributed to such expenditures. The study later reveals that the Scheme is indebted administratively to an amount of GH ¢150,000.00 (One Hundred & Fifty Thousand Ghana Cedis) as at December 31, 2010.

Table 4: Claims Expenditure Trend

Years	Cost	% increase

	GH ¢	
2008	492,472	-
2009	837,202.40	70
2010	1,590,684.56	90

Again, a study of table (4) reveals that, the claims expenditure increased at the rate of 70% from 2008 to 2009 and increased further to 90% from 2009 to 2010. This increase signifies that more people are joining the scheme which shows a positive sign and the gate keeper principle is not being adhered to by the Scheme.

Table 5: Revenue generated for 2008, 2009 and 2010

Years	Premium GH ¢	Registration GH ¢	Claims(Subsidy) GH ¢	Administrative GH ¢
2008	127,274.00	180,000.00	302,835.32	
2009	222,444.00	130,000.00	587,238.00	
2010	116,484.00	190,000.00	677,376.00	9,000.00

A critical examination of revenue generated at the scheme in terms of both premium and registration fees reveals that in 2008 the Scheme generated GH ¢ 307,274.00, 2009 – 372,444.00 and 2010 – 306,484.00. This implies that the schemes internally generated funds are not encouraging which is threatening the financial sustainability of the scheme.

Again, the study also shows the amount released by government to support payment of claims and administrative expenses. The table 5 reveals GH ¢ 302,835.32 in 2008, GH¢ 587,238.00 in 2009 and GH¢ 677,370.00 in 2010. This support implies that, the scheme can only be sustained financially with the assistance from the government. According to Legal Instrument (L.I) a benchmark for the minimum contributions could be an amount equal to 2.5% of the minimum wage as that is the minimum contribution that has to be paid on behalf of a SSNIT member and 2.5 % of VAT as NHIL as subsidy to the schemes.

4.3 ANALYSIS AND DISCUSSION OF SUSTAINABILITY OF THE SCHEME

In the quest to find out the financial sustainability of the scheme, the study reveals the following;

1. Government should increase the NHIL so that the subsidy to the scheme can be reflected.
2. Premiums should be increased to mitigate the financial non-sustainability of the scheme.
3. Education should be given to the people of the community to understand the importance of NHIS and its operations.
4. Clients should be educated on the frequency of accessing health care.

Table 6: Average Cost of OPD attendance

OPD Cost per attendance	Frequency	%

19.50	4	25
20.50	4	25
11.10	3	18.8
12.36	3	18.8
13.19	2	12.5
Total	16	100

A closer look at the table 6 indicates that the highest OPD average cost per attendance was GH ¢20.50 by four respondents facilities and the lowest cost per attendance was GH ¢11.10 represented by three respondents. This agrees with the National Development Planning Commission, (2009) survey, it revealed that cost of treatment for NHIS clients was estimated to be GH ¢ 20.00 and for non clients estimated at GH ¢15.00. This implies that people with valid NHIS card receive high quality health care unlike those who do not belong to the scheme who may have low quality health care due to lower cost. However, it is important from the study to caution against the possible abuse of the scheme and over use of services in order not to deplete the scheme's resource which in the long run can affect it sustainability financially. The NHIS manager needs to be encouraged to thoroughly review claims to avoid fraudulent claims. Overall, the average cost of delivery estimated from the summary is GH ¢ 39 to take care of the cost of delivery per an individual compared to GH ¢27.32 by non NHIS card holders. This again raises concern about possible overuse and possible provider inducement. All of them are in line with the objectives of cost attendance identified from the research. Again, the survey contradict a report by (WHO 2000) which stated that, in Vietnam, providers began refusing to provide services to those

enrolled in the insurance scheme because the reimbursement rates were much lower than their actual cost and providers were losing money serving the insured. This implies that the average cost of attendance was lower than the actual cost incurred on clients which was collapsing the facilities.

Table 7: Indebtedness to the facility

Number Provider	Percentage (%)
Yes 4	25%
No 12	75%
16	100

A study of table 7 reveals that 75% responded that the scheme does not owe them whilst 25% responded that the scheme owes their facility. This coincide with the response given by the Scheme Manager when asked how much does, the scheme owes its facilities to a tune of GH ¢ 151,732.15 as at December 31, 2010.

Table 8.a: Gate keeper Principles of NHIS

Response	Frequency	%
Yes	2	12.50
No	14	87.50
Total	16	100

A study of table 8.a. reveals that, 14 respondents representing 87.50% responded had no idea of Gate keeper system whilst 2 respondents representing 12.5% responded had idea of gate keeper system. The main reason for gate keeper system is for the client to access health care at the

primary health care and get referral to secondary/tertiary, level facilities. Under the NHIS payment system secondary / tertiary level facilities have higher charges irrespective of the condition. Therefore, it could be better to educate the clients to access health care at the primary level facilities to save cost which can threaten financial sustainability of the scheme.

When asked the same question, the scheme manager responded having knowledge about gatekeeper system. The study reveals later that, the NHIS has developed a strategy to roll out all the facilities to be abreast with the gatekeeper system so as to control the cost per attendance to sustain the scheme. According to Atim, C. (ed.) (2000) assigning a gatekeeper, often a primary care physician, responsible for authorizing the insured person's access to specialized tests and services covered by the insurance scheme; and gatekeeper determining whether the patient has met the conditions to be referred for specialized services, what is the appropriate level of service, and sometimes where the services should be provided.

Table 8.a: Knowledge of Gate keeper principle

Classes of Health Care	Frequency	%
Primary Health care	18	30.5
Regional Hospital	39	66.1
Tertiary	2	3.39
Total	59	100

With reference to the findings in the table 8.b. 18 respondents representing 30.5% NHIS client responded that, they access health care at the primary facility and 39 respondents representing 66.1% responded Regional Hospital (Secondary care) whilst 2 respondents representing 3.39%

responded tertiary health care. The result indicates that, majority of the respondents (clients) access health care at the secondary facilities which has higher charge for the tariff instead of primary care which gives the same treatment at a minimum cost. This result reveals that the scheme pays higher claims amount which can affect the scheme's sustainability financially because the scheme can continue to be indebted to the facilities to a time that the system cannot contain.

Table 9: Suggestions to improve NHIS

Suggestions	**Frequency**	**Percentage (%)**
Deductions must be stopped communicated to the facility	1	6.2
Claims must be paid promptly	2	12.5
NHIS should educate health personnel	5	31.2
Staff capacity should be increased	4	25.0
Refresher courses should be organize for NHIS staff	4	25.0
Total	16	100

A critical examination of the result in table 9 reveals that, 4 respondents representing 25% mentioned that refreshed courses should be organized for NHIS staff, 4 respondents representing

another 25% mentioned staff capacity should be strengthen (increased) whilst 5 respondents representing 31.2% also mentioned NHIS should educate health care personnel.

Moreover, 2 respondents representing 12.5% mentioned claims must be paid promptly whilst I respondent representing 6.2% mentioned deductions must be communicated to the facility. This implies that capacity building and refresher courses could assist the scheme to reduce certain costs to ensure the Scheme's financial sustainability.

Table 10: Frequency of accessing health care

NUMBER OF TIMES	FREQUENCY	PERCENTAGE (%)
Twice a month	17	28.8
Twice a week	8	13.60
10	9	19.60
Once a year	24	40.70
Total	59	100

A close examination of the result in table 10 reveals that, 17 clients representing 28.8% respondents and 8 clients constituting 13.6% respondents, twice a month and twice a week respectively in accessing health care. The study also shows that 8 of clients representing 16.9% and 24 clients representing 40.7% responded once a week and once a year respectively. This shows that majority of the clients' use their cards to access health care wisely. This is a good indicator for the NHIS sustainability in the district. This will reduce the scheme's burden on the huge claims paid to the facilities.

Table 11: Quality of Services Provided

Quality	Frequency	%
Good	44	74.6
Average	14	23.7
Poor	1	1.7
Total	59	100

A critical look at the table 11 shows that 44 (74.6%) of the respondents described their rate of health care service as good 14 (23.7%) described their rate of health care service as average while 1 (1.75%) described it as poor. It can therefore be deduced from the analysis, that a substantial number of clients have better quality of care.

A further question was asked on whether premium paid merit the quality of care. 46 (78%) responded YES whilst 13 (22%) of the respondents answered NO. This shows again that, NHIS clients are satisfied with the type of care given. But in the report by (WHO 2000) which stated that, in Vietnam, providers began refusing to provide services to those enrolled in the insurance scheme because the reimbursement rates were much lower than their actual cost and providers were losing money serving the insured. This is not the same in Ghanaian implementation of NHIS.

Table 12: Ways to Improving NHIS

Responses	Frequency	%

Health personnel should be trained	9	15.3
Premium for informal should be reduced	15	25.4
Government should increase its subsidy	22	33.9
Claims should be paid promptly	15	25.4
Total	59	100

A study of table 12 reveals that, 9 respondents representing 15.3% clients responded Health care personnel should be trained and 15 respondents representing 25.4% clients responded premium for informal should be reduced. Again 20 respondents representing 33.9% of the respondents stated that, government should increase its subsidy whilst another 15 respondents representing 25.4% also responded that claims should be paid promptly. The result shows that if government increases its subsidy it can mitigate the premium reduction for informal sector. Also, premium contribution of the informal should be reviewed downward to attract more members to join the scheme.

Table13: Financial Sustainability of NHIS

Responses	**%**
Administrative cost should be controlled	10
Claims should be vetted well	9
Control of fraud	10
NHIL should be increased	30
Total	59

A critical look at the table 13 as implies the ways to sustain the scheme financially shows that, 30% clients responded NHIL should be increased and 10% clients responded Administrative costs should be controlled in the scheme. Again, the study reveals that 9% clients responded claims should be vetted well before payment whilst another 10% client responded fraud should be controlled. This result indicates that majority of the respondents were of the view that government should increase the NHIL to mitigate the high attendance cost of accessing health. Again, administrative measures should be looked at carefully to control fraud in the Scheme.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.0 INTRODUCTION

These chapter in made up of the findings from the study, conclusions drawn and recommendations are made based on the findings of this study as well as recommendations for further studies.

5.1 SUMMARY OF FINDINGS

National Health Insurance Scheme (NHIS) was designed to offer affordable medical care, especially to the poor and vulnerable among Ghanaians population. The main aim of the Scheme is to provide a solution for the health care sector and serving as an alternative to the outdated cash and carry system. On like the cash and carry system, the NHIS is an important step toward preventing unnecessary deaths from curable diseases because it ensures that all important Ghanaian residents regardless of their income have access to quality health care.

In recognition of the potential of NHIS to eliminate user fees and increase access to health care, Ghana enacted the National Health Insurance Act in 2003, mandating the establishment of district wide health insurance scheme.

The general objective for study was therefore to assess the financial sustainability of NHIS in the Mpohor Wassa East District. In order to achieve this aim, the study addresses the following specific objectives which included, investigating the NHIS claims payment system, to identify other sources of funds to sustain the Mpohor Wassa East Scheme among Schemes, to assess the average cost per out-patient and in-patient services by the facilities on claims for NHIS clients, to examine Scheme's sustainability in terms of premium against cost of services on NHIS clients of Mpohor Wassa East.

The sample population for the study was made up of all the accredited health care providers, the NHIS staff and the NHIS members (card bearers) in Mpohor Wassa East Mutual Health Insurance Scheme. The total population used for the study was 76 respondents. Data were obtained by the administering of questionnaires and the use of personal observation. Descriptive analysis was used to report findings. Percentage and frequency distribution tables were used to summarize the data of the main findings.

Summary of major findings:

The study revealed many findings with respect to the financial sustainability of NHIS in the Mpohor Wassa East District. Notable among these finding are as follows:

1. The result indicated that, the scheme reviews its payments system bi-annually and annually and also receives claims from the providers on monthly basis.

2. The mode of payment reveals under the study was cashless system, whereby the beneficiary receives a covered service from a provider and does not pay the provider (other than a possible co-payment or for items that the scheme does not cover). The provider then submits a claim for that service to the claims administrator for payment. The claims have to be received by the scheme to check their authenticity through vetting, query the problematic claims before approval is made for payment.

3. This study according to the scheme manager stressed that if this internal control measures were strictly followed, fraud and misappropriation of scheme funds would be controlled.

4. The study finds that the source of funds was through registration fees and premium contributions of the clients and also the subsidy for the exempt administrative support is released by the government.

5. The study also portrays that about 95% of the claims payment is being financed through taxes levied on the Ghanaian through VAT system.

6. The study points that children below the age of 18 years, SSNIT contributors and SSNIT pensioners and ages above 70 years only pay registration fee of GH¢4.00 whilst informal sector of the population pay premium depending on their income level which the district collects GH¢15.00 across all income levels

7. The study reveals that, extremely poor cannot pay fee for registration and also premium contribution.

8. This study reveals that government has a great commitment in ensuring financial sustainability by providing monthly assistance in the form of financial subsidy.

9. The study further reveals that, the scheme incurred high administrative expenses which increased from 51% in 2008 to 2009 and later increased to 56% margin.

10. The study later reveals that the Scheme is indebted administratively to an amount of GH ¢150,000.00 (One Hundred & Fifty Thousand Ghana Cedis) as at December 31, 2010.

11. A critical examination of revenue generated at the scheme in terms of both premium and registration fees reveals that in 2008 the Scheme generated GH ¢ 307,274.00, 2009 – GH ¢ 372,444.00 and 2010 – GH ¢ 306,484.00.

12. Find out the financial sustainability of the scheme, the study reveals the following;

    i. Government should increase the NHIL so that the subsidy to the scheme can be reflected.

    ii. Premium should be increased to mitigate the scheme.

    iii. Education should be given to the people of the community to understand the importance of NHIS and its operations.

    iv. Clients should be educated on the frequency of accessing health care.

13. The result reveals that, people with valid NHIS card receive high quality health care unlike those who do not belong to the scheme who may have low quality health care due to lower cost.

14. This result reveals that the scheme pays higher claims amount which can affect the scheme's sustainability financially because the scheme can continue to be indebted to the facilities to a time that the system cannot contain.

15. The result shows that if government increases its subsidy it can mitigate the premium reduction for informal sector.

16. This result indicates that majority of the respondents were of the view that government should increase the NHIL to mitigate the high attendance cost of accessing health.

17. Again, administrative measures should be looked at carefully to control fraud in the Scheme.

5.2 CONCLUSION

Based on the findings the research as far as this topic is concern, the following conclusion can be drawn.

This result reveals that the scheme pays higher claims per cost of the attendance coupled with the small amount of premium contribution can affect the scheme to financially since the scheme would continue to be indebted to the facilities. Also Scheme is heavily indebted to its creditors and the study shows that, it will continue to the same in subsequent years. However, the result also shows that if government increases its subsidies for the exempt it can mitigate the low premium and registration fees contribution by the informal sector. The study revealed that, capacity building and refresher courses should be organized for both the Scheme and the providers to reduce certain cost to ensure it financial sustainability.

The study reveals that, if the internal control measures were strictly followed fraud and misappropriation of funds in the Scheme would be controlled.

Finally, Mpohor Wassa East Mutual Health Insurance Scheme cannot sustain financially without government support (subsidies).

5.3 RECOMMENDATIONS

1. The NHIA which is the regulated body of the Scheme should make it a policy to review both the tariff and medicine list annually so as to meet market price changes.

2. As a measure to check fraud and inefficiency in claims management, re-imbursement of claims should continue be written in the facilities name and received by the authorized person from the facilities as a form of internal control mechanism for the Scheme.
3. Government should continue supporting the Scheme as a financial sustainability of the Scheme depends on the government support who contributes no fund to the Scheme.
4. Government should increase NHIL to mitigate the low premium and registration fees being collected from informal sectors and indigents.
5. Public education should be intensified by the Scheme to sensitize the clients on the cost implications associated with multiple attendances to health care in relation to low premium contributions and inadequate subsidy to the Scheme which threatens its financial sustainability.
6. Government should organized regular and intensive capacity building for both the Scheme's staff and staff of the health care facilities to minimize cost on inefficiencies in claims management to reduce huge claims indebtedness which is seriously affecting the Scheme's sustainability.

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APPENDIX A

SCHEME'S INTERVIEW GUIDE

The objective of the study is to assess the financial sustainability of National Health Insurance Scheme in the Mpohor Wassa East.

This study is for academic purposes therefore any information given will be treated strictly as confidential.

Please read through the following questions and answer all questions as best as you can.

Tick [ ] where appropriate and supply the needed information where applicable.

SECTION A

BIO-DATA

Name of the Scheme: ……

Region: ……

District: ……

SECTION B

CLAIMS PAYMENT SYSTEM

1. How often do you review NHIS tariff module?
    a. Monthly [ ]
    b. Annually [ ]
    c. Bi-annual [ ]
    d. Quarterly [ ]
2. How often do you receive claims from the providers.
    a. Monthly [ ]
    b. Annually [ ]
    c. Bi-annual [ ]
    d. Quarterly [ ]
3. Do you have internal controls for claims payment?

a. YES [ ] b. NO [ ]

If YES what are the controls?

a. ……
b. ……
c. ……
d. ……
e. ……

4. What is the mode of payment of the claims?
   a. By cheque [ ]
   b. By cash [ ]
   c. Both [ ]

5. Does the Scheme owe the facility?

   a. YES [ ] b. NO [ ]

   If YES how much does the scheme owe to the facilities?

   GH ¢ ……

SECTION C

SOURCES OF FUND

1. What are the sources of funds to the Scheme?
   a. Premium [ ] b. Registration [ ] c. Government Subsidy [ ]

2. What are classes of clients who pay premium and registration fee to the Scheme?
   a. ……
   b. ……..
   c. ……..
   d. ……..
   e. ……

3. How much do you charge for each of the categories in question 2 above?
   a. ……
   b. ……
   c. ……
   d. ……

4. How do you describe the premium charged?
   a. Cheap [ ] b. expensive [ ] c. moderate [ ] d. others specify:…….

5. How do you describe the registration being charge?
   a. Cheap [ ] b. expensive [ ] c. moderate [ ] d. others specify:……

6. How much does government pays on the exempt?
   a. GH ¢ 12.00- GH ¢ 20.00 [ ] b. GH ¢ 25.00 - GH ¢ 30.00 [ ] c. others specify: ……..

7. What is the total expenditure made for the following years?

YEAR	**ADMINISTRATIVE**	**CLAIMS**
2008		
2009		
2010		

8. What is the total revenue generated for the following?

YEAR	PREMIUM	REGISTRATION	GOV'T SUBSIDY
2008			
2009			
2010			

9. How often does the Scheme receive subsidy from Government.
   a. Yearly [ ] b. Monthly [ ] c. Quarterly [ ] d. others specify:……

10. Which classes of people are exempted from payment of premium?
    a. Under 18 [ ] b. above 70 years [ ] c. indigents [ ] d. others specify:……

11. In your opinion, what can be done to sustain the operations of the scheme in this district?

    1. ……
    2. ……
    3. ……

4. ……
5. ……

12. In your opinion what are the challenges the scheme is facing?
    a. ……..
    b. ……..
    c. ……..
    d. …….
    e. …….

13. What do you suggest can be done to remedy the challenges in 18 above?
    a. …….
    b. …….
    c. …….
    d. …….
    e. …….
    f. …….

APPENDIX B

QUESTIONNAIRE (CLIENT)

The objective of the study is to assess the financial sustainability of National Health Insurance Scheme in the Mpohor Wassa East.

This study is for academic purposes therefore any information given will be treated strictly as confidential.

Please read through the following questions and answer all questions as best as you can.

Tick [ ] where appropriate and supply the needed information where applicable.

SECTION A

BIO-DATA

1. Age of the client
   - Below 18 – 25 [ ]
   - 26-30 [ ]
   - 31-35 [ ]
   - 36-40 [ ]
   - 41-45 [ ]
   - 46- 50 [ ]
   - 51-60 [ ]
   - Above 60 [ ]
2. Educational Background
   - BECE [ ]
   - MSLC [ ]
   - SSSCE [ ]
   - TERTIARY [ ]
   - ILLITERATE [ ]

SECTION B

HEALTH CARE ATTENDANCE

1. How often do you access health care facility
   a. Twice a month [ ]
   b. Twice a week [ ]
   c. Once a week [ ]
   d. Others specify: ……

2. How do you rate the services provided by the facility?
   a. Good [ ]
   b. Average [ ]
   c. Poor [ ]

3. Does your premium paid merit the treatment given?
   a. YES [ ] b. NO [ ]

4. Do you spend additional money on accessing health care?
   a. YES [ ] b. NO [ ]

SECTION C

GATE KEEPER PRINCIPLE OF HEALTH CARE

1. Which facilities do you access health care most?

   a. Primary Health Facilities (District Hospital, Health Centre, Clinics, Maternity Home and Chp Compound) [ ]
   b. Regional Hospital [ ]
   c. Teaching Hospitals [ ]

2. How often do you access Regional Hospital/Teaching Hospital instead of Primary Health Care?

   a. Once a week [ ]
   b. Twice a week [ ]
   c. Once a month [ ]
   d. Others specify : ……

SECTION D

SOURCES OF FUNDS

1. How much did you pay as a premium?

   a. GH ¢ 10.00 [ ]
   b. GH ¢ 15.00 [ ]
   c. GH ¢20.00 [ ]
   d. GH ¢25.00 [ ]

2. Did you pay registration fee aside the premium?

   a. YES [ ] b. NO [ ]

3. Do you pay the same rate every year?

   a. YES [ ] b. NO [ ]

SECTION E

1. In your opinion what do you suggest can be done to improve the NHIS?

   a. ……
   b. ……
   c. ……
   d. ……
   e. ……

2. In your opinion what do you suggest can be done financially to sustain the scheme

   a. ……
   b. ……
   c. ……
   d. ……

APPENDIX C

QUESTIONNAIRE (HEALTH CARE PROVIDER)

The objective of the study is to assess the financial sustainability of National Health Insurance Scheme in the Mpohor Wassa East.

This study is for academic purposes therefore any information given will be treated strictly as confidential.

Please read through the following questions and answer all questions as best as you can.

Tick [ ] where appropriate and supply the needed information where applicable.

SECTION A

NAME OF THE SCHEME: ……..

DISTRICT: ……..

SECTION B

CLAIMS PAYMENT SYSTEM

1. How often do you submit claims to the Scheme?

   a. Bi-annually [ ]
   b. Annually [ ]
   c. Others specify: ……..

2. How much do you submit averagely to the Scheme per month for?

   a. OPD GH ¢ …….
   b. IPD GH¢ ……..

3. Does the Scheme pay your facility all the claims submitted?

   a. YES [ ] b. NO [ ] c. NOT ALL CASES [ ]

4. What happened to the rejected claims if any?

   a. ……..
   b. ……..

c. …….
d. …….
e. ……..

5. How often does the scheme re-imburse your facility?

   a. Monthly [ ]
   b. Quarterly [ ]
   c. Annually [ ]
   d. Others Specify: ……

6. What is the mode of payment of claims submitted?

   a. Cash
   b. Cheque
   c. Both

7. Does the Scheme owe your facility?

   a. YES [ ] b. NO [ ]

If YES how much? GH ¢.....

8. Does the amount owe by the Scheme has an impact on the services provided?

   a. YES [ ] b. NO [ ]

SECTION C

ATTENDANCE RATE (UTILISATION)

1. What is the average attendance per month for?

   OPD: …….
   IPD: ……..

2. Do you attend to non-insured clients?

   a. YES [ ] b. NO [ ]
   If YES what is the average attendance per month for?

OPD: ……..
IPD: ……..

3. Does your facility give equal treatment to both insured and non-insured members?

   a. YES [ ] b. NO [ ]

SECTION D

COST OF ATTENDANCE

1. What is the average cost of attendance per month for?

   OPD: ……
   IPD: …….

2. Does the amount paid by the NHIS commensurate with the services provided?

   a. YES [ ] b. NO [ ]

3. How often does the scheme review its payment system?

   a. Annually [ ]
   b. Quarterly [ ]
   c. Others specify: ……

SECTION E

GATE KEEPER PRINCIPLE

1. Do you have any idea of gate keeper principles of NHIS?

   a. YES [ ] b. NO [ ]

SECTION F

1. In your opinion what do you suggest can be done to improve NHIS?
   a. ……..
   b. ……..