ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG,
EASTERN REGION, GHANA

FINANCIAL SUSTAINABILITY OF GHANA'S NATIONAL HEALTH INSURANCE SCHEME; THE WAY FORWARD

by

NICHOLAS NYAGBLORNU

A Thesis submitted to the Department of Community Health in the Faculty of Public Health in partial fulfilment of the requirements for the degree

MASTER OF PUBLIC HEALTH

June 2016

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CERTIFICATION/DECLARATION

I, Nicholas Nyagblornu, declare that this submission is my own work towards the MPH and that to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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ABBREVIATION/ ACRONYMS

CBHIS	-	Community-Based Health Insurance Schemes
CHIS	-	Community Health Insurance Schemes
DMHIS	-	District Mutual Health Insurance Schemes
DMHO	-	District Mutual Health Organizations
DOTs	-	Directly Observed Therapy short course
FMCP	-	Free Maternal Care Programme
LEAP	-	Livelihood Empowerment Against Poverty
MHO	-	Mutual Health Organizations
MOF	-	Ministry of Finance
MOH	-	Ministry of Health
NGOs	-	Non Governmental Organizations
NHIC	-	National Health Insurance Council
NHIC	-	National Health Insurance Council
NHIL	-	National Health Insurance Levy
NHS	-	National Health Service
PCHIS	-	Private Commercial Health Insurance Schemes
PHIS	-	Private Health Insurance Scheme
PMHIS	-	Private Mutual Health Insurance Schemes
SHI	-	Social Health Insurance
SSNIT	-	Social Security and National Insurance Trust
THs	-	Teaching Hospitals
WB	-	World Bank
WHO	-	World Health Organization

ABSTRACT

Health Insurance is a formal contractual arrangement between the insurer and the insured to the effect that the insurer provides cover for part or all healthcare cost of the insured as agreed between the two parties for a period of time. Ghana since 2003 has been implementing a National Health Insurance Scheme. Currently, the NHIS is facing financial sustainability issues. The scheme is heavily indebted to the service providers on average of 7 months claims reimbursement with some service providers resorting to charging unapproved fees in cash and occasional denial of services to the scheme members.

Funding to the scheme has remained unchanged over the years despite evidence suggesting otherwise. In the absence of political will to take necessary far reaching decisions, it has become critical to review the operations of the scheme to determine what can be done to improve its financial sustainability. The NHIS laws, operational data and relevant documentations were reviewed.

Fifteen key informants were interviewed for the study. It was found out that the revised NHIS law, Act 852 has exposed the NHIS to extreme financial burden relative to Act 650, membership improvement drive were focused mainly on enrolling persons in the exempt categories, delays in claims reimbursement to service providers and perceived low quality of services offered to scheme members has created enabling grounds for perpetuating frauds and abuses against the scheme and weak implementation of some policies in the health sector has not been supportive of the NHIS cost containment measures.

The study recommended to the NHIS to engaged its stakeholders to reviews the provisions on exemption, the Ministry of health to provide and ensure enabling policy environment and the government of Ghana to make additional budgetary allocation to support persons exempted from premium payment.

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CHAPTER 1

1.0 INTRODUCTION

1.1 Background Information

Health Insurance is a formal contractual arrangement between the insurer and the insured to the effect that the insurer provides cover for part or all healthcare cost of the insured as agreed between the two parties for a period of time. According to Doetinchem et al (2010), Social Health Insurance (SHI) is one of the possible organizational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance community insurance, and others.

Ghana since independence has tried various health financing models. The National Health Service (NHS) post independence provided free health services to all Ghanaians and was financed through budgetary allocation as documented by Owusu-Sekyere and Bagah (2014). The sustainability of the NHS was therefore linked to the continuous economic fortunes of the nation. As economic fortunes declined with associated budgetary constraints, NHS sustainability was threatened and it was short-lived.

In 1971, user fees were introduced for hospital procedures and overhead cost thereby ending free health service delivery. As economic conditions continued to worsen coupled with political instability, budgetary allocation to the health sector declined. Consequently full cost recovery was introduced when government gradually withdrew subsidies including those in the health sector dwindled in early 1980s (Owusu-Sekyere and Bagah, 2014). Although exemptions policies were implemented

to support the poor for essential services, they did not work, the full cost recovery policy rather put more financial burden on the poor and served as a major barrier to healthcare (Asenso-Okyere et al, 1997). The current National Health Insurance Scheme (NHIS) was the result of extensive design and piloting of models of Community Health Insurance Schemes (CHIS) with satisfactory results from Nkoranza in 1992 and Dangme West in 1993 (Arhin-Tenkorang, 2001).

By the year 2001, CHISs also called Mutual Health Organizations (MHO) became popular especially in Brong Ahafo and Eastern regions mainly because they hosted the initial pilots and are home to many Catholic Mission Hospitals (the designers of the Nkoranza pilot). With support from health development partners and the Christian Health Association of Ghana, the Ministry of Health (MOH) developed training manuals to guide the running of the MHOs and actively promote the establishment and growth of many more MHOs. While the MOH was promoting the MHOs in the districts, it was also working on a legislative document – National Health Insurance Law - to create government sponsored District Mutual Health Organizations.

National Health Insurance Act, 2003(Act 650) was passed and it mandated all residents (excluding those in the military and police service) to enroll with the government District Mutual Health Insurance Schemes. The new health insurance Act passed in 2012 (Health Insurance Act, Act 852) seek to consolidate the District Mutual Health Insurance Schemes (DMHIS) into National Health Insurance Scheme (NHIS), remove administrative bottlenecks, introduce transparency, reduce

opportunities for corruption and gaming of the system, and make room for more effective governance of the schemes (NHIA, 2015).

Ghana since 2003 has been implementing a National Health Insurance Scheme (NHIS) - a social health insurance - to provide financial protection for all and toward ensuring universal health coverage. The scheme is funded mainly from indirect taxation, social security fund, contribution from members and budgetary allocations. The scheme has a benefit package that is generally thought to be generous and covers services at all levels of the Ghanaian health care system. Over a decade of the introduction of the NHIS, the scheme seems to be having sustainability issues requiring interventions to save it from collapse.

1.2 Problem Statement

Currently, the NHIS has reached a stage where the cost of providing health care for subscribers is growing faster than its annual financial resource. This has placed the scheme under severe financial pressure. In a recent statement to the Parliament of Ghana, the honorable Minister of Health stated that NHIS has consequently experienced persistent annual deficits since 2009 and therefore heavily drawn on its investment cover from about 9 months in 2008 to less than one month in 2015. The scheme is heavily indebted to the service providers on average of 7 months claims reimbursement resulting in occasional denial of services to its members. Some service providers have also resorted to charging unapproved fees in cash to enable them continue operations since their funds were locked up with the scheme.

The funding sources - indirect taxation, social security fund, contribution from members and budgetary allocations - for the NHIS have remained unchanged since its inception in 2005; although there are overwhelmingly evidence supporting the need to review the funding mechanisms of the scheme. Since the NHIS is one of the best social and pro-poor intervention in recent times in Ghana, issues surrounding its operations are highly political and the prospects of making some objectives especially increasing premium payment to the non exempt category are less likely at this time. In the absence of political will to take necessary far reaching decisions, it has become critical to review the operations of the scheme to determine what can be done in the interim to improve its financial sustainability.

1.3 Rationale of the Study

Ghana's NHIS like any other SHI is a reliable means of raising and pooling resources to finance the health care system and also provide financial risk protection to significant proportion of the population towards the future attainment of universal health coverage. The NHIS at the moment is threatened and its financial sustainability is at stake. It has been in financial deficit since 2009, indebted to service providers for over 7 months and has investment cover of less than 1 month.

The collapse of the Ghana NHIS would put many people within the vulnerable population at a risk of experiencing catastrophic healthcare expenses. Currently, the NHIS provides free cover for some categories of the population considered vulnerable and the collapse of the scheme would expose them to high healthcare expenses. It is therefore very important and urgent to assess the operation of the NHIS and make recommendations on interim measures to strengthen the financial

position of the scheme, while long term measures requiring political will are being considered.

1.4 Conceptual Framework for NHIS Financial Sustainability

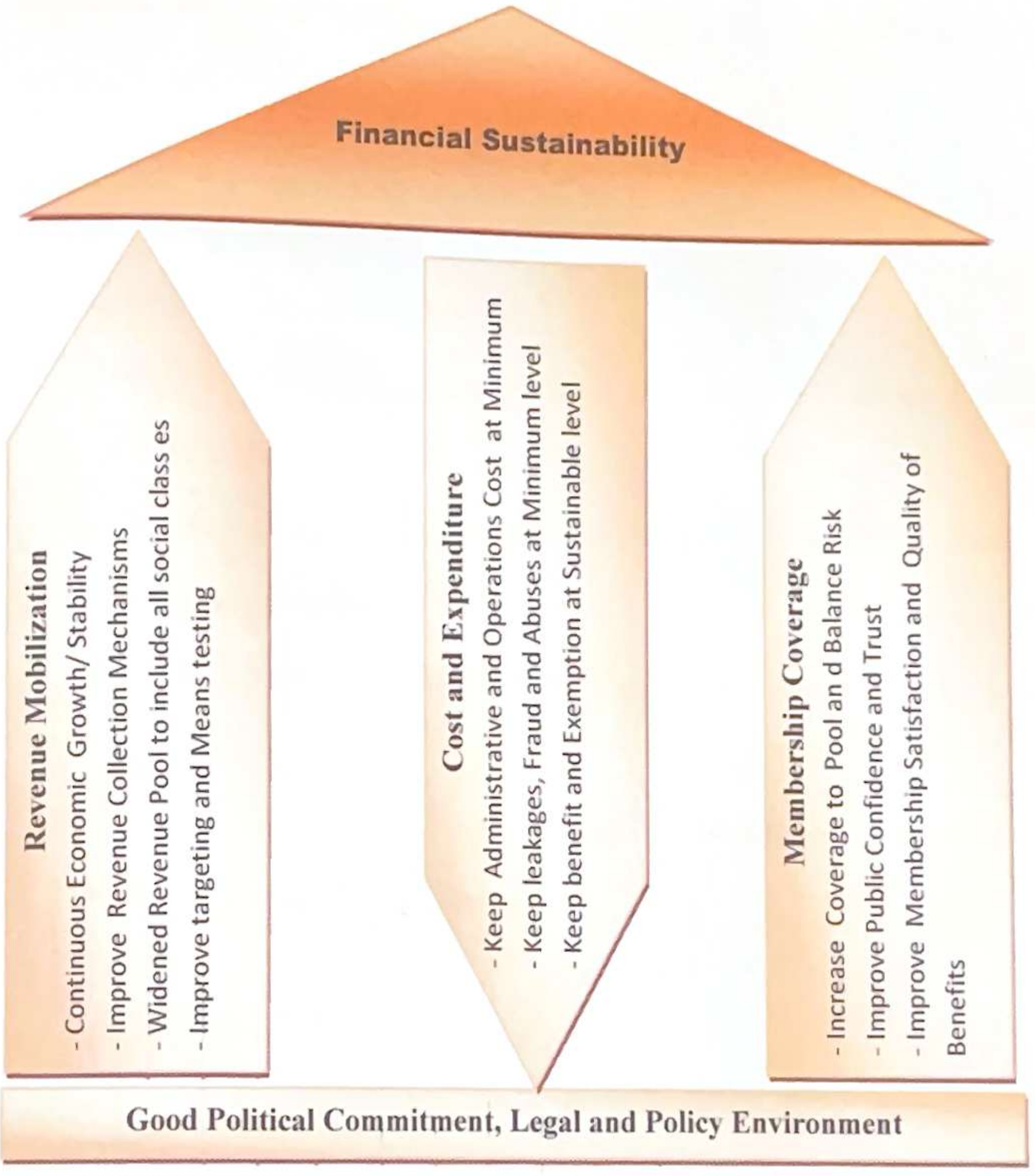


Figure 1-1, Framework for Financial Sustainability

This framework for financial sustainability recognized four groups of factors; enabling environment, Revenue Mobilization, Cost and Expenditure and Membership Coverage. A strong foundation with appropriate political commitment

and support in a favorable legal and policy environment is required to effective manage other factors to attain financial sustainability. To attain a financial sustainability, efforts aimed at revenue mobilization must be strengthen and inclusive of majority of the population. Again, there must be conscious effort at increasing membership to pool and balance risks. Factors likely to increase cost must be kept at minimum and efficient.

1.5 Research Questions

The study seeks to answer the following:

1. What are the weaknesses inherent in the NHIS law which imposes financial burden on the scheme?
2. Why is NHIS not able to attract the working class and non-exempt category to register as members?
3. Are there fraud and abuses perpetuated against the scheme resulting in high expenditure?
4. For the next five years, what measures can be adopted by the NHIS to strengthen its financial position?

1.6 General Objective

The general objective of the study was to assess the current operations of the NHIS and make recommendations to help strengthen its financial sustainability.

1.7 Specific Objectives

1. To determine weaknesses inherent in the NHIS law which imposes financial burden on the scheme.

2. To determine reasons why the NHIS failed to attract the working class and non-exempt category to register as members?
3. To determine if fraud and abuses are been perpetuated against the scheme
4. To determine possible cost-saving measures to strengthen the financial position of the scheme
5. To make recommendations to improve the financial sustainability of the NHIS

1.8 Scope of Study

The scope of this study does not include economic analysis and estimation of financial viability of the national health insurance scheme. The study was limited to the operational issues and how some of these practices are affecting the financial sustainability of the scheme. Data on enrollment, revenue sources and expenditure were reviewed. In-depth interviews were done to determine the reasons for the current challenges of the scheme and measures to mitigate the challenges.

1.9 Organization of Report

The report is organized in 6 chapters. Chapter 1 provides background to the study, defines the problem and explained the rationale for the study. Chapter 2 reviewed the relevant literatures of the subject matter while chapter 3 outlined various methods and procedures employed to execute the study. Chapter 4 and 5 covered the results and discussions of the results respectively. Conclusions and recommendations of the study are covered in chapter 6 of the report.

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 Global Healthcare Financing

All governments have the difficult task and challenge of dealing with how to generate financial resources, ensure proper allocation and use of such resources in their health system to improve health outcomes. The desire to attain universal health coverage and commitments to achieve the just ended Millennium Development Goals have forced many countries to consider reliable sources of financing healthcare. Wang et al (2012) documented that globally, health insurance has been considered and promoted as the major financing mechanism to improve access to health services and provide financial risk protection especially for the poor. It is also widely acknowledged that despite the benefits of health insurance, the journey to implement it is challenging, long and risky.

Over the past hundred and fifty years, many high-income countries, as well as some middle-income ones, have achieved universal coverage by introducing a variety of financial risk pooling systems, most of which include tax-based financing and/ or social health insurance schemes. Despite the knowledge of and existence of these financing mechanism in low income countries, their population coverage (breath) and service coverage (depth) are usually limited. In earlier study, Wang and Pielemeier (2012) noted that unlike in high and some middle-income countries, the majority of people in low and middle income countries are self-employed, work in the informal sector, or are unemployed, making the formal economic sector simply too small for tax-based financing or SHI to cover the entire population.

Those attempts to encourage developing countries to adopt health insurance as a sustainable means of financing healthcare based their position on the successes of health insurance implementation in the developed countries. Countries like the United Kingdom, Germany, Denmark, Switzerland, Japan, South Korea and Singapore have shown that health insurance is effective means to achieve universal health coverage. South Korean has scaled up its social health insurance scheme beyond the formal sector employees to include those in the low income population.

2.2 Health Insurance

Health Insurance is a formal contractual arrangement between the insurer and the insured to the effect that the insurer provides cover for part or all healthcare cost of the insured as agreed between the two parties for a period of time. According to investopedia.com, health insurance "is a type of insurance coverage that pays for medical and surgical expenses that are incurred by the insured. Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly". Health insurance operation is based on principle of mutual solidarity, risk pooling and sharing with various mechanisms to pool resources (funds). Depending on mechanism for raising funds, ownership and the target beneficiaries, five (5) main types of health insurance can be distinguished.

2.2.1 Types of Health Insurance

Five (5) main types health insurance are distinguished here based on funding mechanism, ownership and target beneficiaries.

i. National Health Insurance Scheme (NHIS); is owned and managed by the government or delegated government agency with funding from tax or special

levies. It is usually compulsory for all residents and may limit service providers to public health facilities.

ii. Social Health Insurance Scheme or Compulsory Health Insurance (SHIS); is generally owned by the government, financed through social security contributions of employees most often from both public and private sector with employees as target beneficiaries.

iii. Community-based Health Insurance Scheme or Mutual Health Insurance Scheme (C/MHIS); is formed by voluntary affiliations by community members and mainly funded from their contributions and sometimes with funding support from central government. The scheme is collectively owned by the members, however some countries provide administrative, technical and financial supports from government for community schemes.

iv. Private Health Insurance Scheme - for profit (PHIS); this is a privately owned scheme with intention to make profit with funding from investor (s) and premium paid by members. Premium payment is based on ones risk profile and actuarial estimates and usually target the segment of the population in middle and high income group. The last mechanism of funding healthcare cost is through;

v. Free medical care for the population; a government policy to provide free healthcare to its citizens. This is mainly financed through tax and can take the form of universal free healthcare or targeted at some segment of the population.

2.3 Ghana's National Health Insurance Scheme

Following the successful design and implementation of Community-Based Health Insurance Schemes (CBHIS) in Ghana, the National Health Insurance Scheme was established in 2003 with passage of the National Health Insurance Act, 2003 (Act 650). This Act provided for three types of health insurance schemes to be establish and operated in Ghana; District Mutual Health Insurance Schemes (DMHIS), Private

Commercial Health Insurance Schemes (PCHIS), and Private Mutual Health Insurance Schemes (PMHIS).

The 258 CBHISs in existence prior to the passing of the law were integrated into 110 DMHISs largely facilitated by an enabling provision in Act 650; thus the Act required every District Assembly to "identify promoters to initiate action for the registration of the scheme as a company limited by guarantee under the Companies Code 1963 (Act 179) for the relevant district within sixty days of the coming into force of this Act or within such further period as the Council may direct". With this legal environment and a strong political will, structures were quickly put in place for the full takeoff of the district schemes.

There were technical and managerial training support for the districts based on manuals produced by the ministry of health, board members and key administrative staff were appointed (mainly through the local assemblies) and contractual arrangement with health service providers in the districts were all made. The then National Health Insurance Council (NHIC) - established by Act 650 - was responsible for the implementation of health insurance policy in Ghana. The council registered, licensed and regulated for all the district mutual health schemes. The council was also responsible for granting of accreditation to healthcare providers and monitoring of their performance as well as in consultation with various schemes determine premium to be paid by subscribers to the schemes.

One other important function of the Council was the management of monies accruing from the National Health Insurance Fund (NHIF) - a fund established by Act 650 "to provide finance to subsidize the cost of provision of healthcare services to members

of district mutual health insurance schemes licensed by the Council". Among others, the Council provides reinsurance, determines the extent of subsidies to support various district schemes and set aside monies for the healthcare cost of the indigents.

The implementation of health insurance in Ghana under Act 650 was not without challenges. The first challenge the Council faced was the huge task of providing regulatory and supervisory functions over 110 new individual companies - district mutual health insurance schemes. There were difficulties among the various schemes in managing members moving from one district to another; schemes had to signed individual contracts with healthcare providers and their sister schemes to attend to their clients. Healthcare providers also faced the challenge of preparing and submitting claims to various schemes. To address some of these challenges in managing the district mutual health insurance schemes under the Ghana National Health Insurance, the National Health Insurance Act, 2003 (Act 650) was revised in 2012 leading to the passage of National Health Insurance Act, 2012 (Act 852).

According to the National Health Insurance Authority (NHIA), the new law, (Act 852) has replaced Act 650 in October 2012 to consolidate the NHIS, remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the schemes". Act 852 replaced the NHIC with NHIA, consolidated all the existing DMHISs into "a nationwide health insurance scheme to be known as the National Health Insurance Scheme" and unlike Act 650, members of the Armed Forces of Ghana and the Ghana Police Services were not explicitly excluded from registering as members of the scheme.

2.3.1 Membership and coverage

Membership of the NHIS is by registration and mandatory for all residents of Ghana and employers are under legal obligation to ensure that their employees are registered with the NHIS. Act 852 (2012) exempted certain categories of persons from payment of contributions or premium to be registered as members of the schemes; those exempted include: a child (thus persons below 18 years); a person in need of ante-natal, delivery and post-natal healthcare services; a person with mental disorder; a person classified by the Minister responsible for Social Welfare as an indigent; categories of differently-abled persons determined by the Minister responsible for Social Welfare; pensioners of the Social Security and National Insurance Trust; contributors to the Social Security and National Insurance Trust; a person above seventy' years of age; and other categories prescribed by the Minister for Health.

Active membership of the NHIS has gradually increased over the years. It increased from 8.3 million active members in 2011 to 11.1 million in 2015, representing a national population coverage of 33% and 40% respectively. In assessing the health sector performance for 2014, Ministry of Health (2015) found that majority - two third - of active members of the scheme belong to the exempt categories and therefore do not pay premiums to the scheme. This position was affirmed by the NHIA to the effect that "these exempt categories account for close to 69% of registered members of the scheme, and as a consequence only an estimated 31% of members pay contributions, contributions which are also not fixed at actuarially determined rates".

Alfers (2012) found that, lack of detailed information on the NHIS, long waiting periods for NHIS members at healthcare facilities and out of pocket payments for medication were some of the reason for which people were not registering for the NHIS. For many of the workers interviewed, they felt that there was little point in joining the NHIS, because the drugs covered by the NHIS are often inadequate and they still have to pay extra for medication.

For the absence of appropriate 'means test' for the identification of the poor, targeting and enrolling the poor has been a challenge. The NHIA therefore has to use existing pro-poor and social interventions programmes as a proxy to identify the poor for free registration onto the scheme. Some of these programmes includes;

1. Beneficiaries of the Livelihood Empowerment Against Poverty (LEAP), 2. Children in orphanages across the country, 3. Children who are blind, deaf and dump in special schools and in the community, 4. Mentally retarded and mentally ill patients within mental homes and in the community who can be reached, 5. Persons currently receiving financial support from recognized institutions such as the District Assemblies and NGOs due to extreme poverty, 6. Mothers with twins and triplets within the communities and are begging to feed them, 7. People Living with HIV/AIDS who are poor and do not have any source of income, 8. Persons being treated for Tuberculosis on Directly Observed Therapy (DOTs) strategy and do not have any source of income, 9. Prisoners who are reported poor by the Prison Officers, 10. Children who are receiving free school uniforms and 11. Children benefiting from the School Feeding Programme as reported in NHIA (2013) annual report.

2.3.2 Funding Sources

Act 852 (2012) provided for how the NHIF can be spent and this includes, payment of healthcare costs of members, approved administrative expenses relating to the

running of the scheme and to facilitate provision or access to healthcare services. It further limits expenditure to not more than 10% annual funding amount on activities other than payment for healthcare cost and approved administrative expenses. The sources of money to the NHIF provided for under section 41 of the Act are:

- National Health Insurance Levy (NHIL) - 2.5% Value Added Tax;
- 2.5% percentage points of each person's 18.5% contribution to SSNIT pension fund;
- Such moneys that may be allocated to the Fund by Parliament;
- Grants, donation, gifts and any other voluntary contributions made to the fund,
- Money that accrues to the Fund from investments made by the Authority
- Fees charged by the Authority in the performance of its functions;
- Contributions made by members of the Scheme; and
- Moneys accrued under section 198 of the Insurance Act, 2006 (Act 724).

Over the years, monies accruing from the NHIL have been the main source of funding to the scheme averaging about 70% of total annual funding amount for the NHIF. SSNIT contributions and premium income (contributions from members) constituted on average 18.5% and 4% respectively. While both the NHIL and SSNIT contributions showed increase in their proportional contribution to the fund, premium income has decline from 4.5% in 2011 to 3.4% in 2014 (Otoo, 2016).

Some stakeholders have expressed concerns about who pays for persons exempted from membership contributions. Over 60% active members of the NHIS falls within this category and that deprived the NHIS a lot of revenue in membership contribution.

On achieving universal healthcare coverage, oxfam (2013) maintained that countries must raise sufficient public funds to cover the healthcare costs of those who cannot afford to contribute especially in developing countries, even in European countries with well-established health insurance systems, governments inject general revenues into the system to ensure coverage for those who are too poor to pay. There are examples where central governments set aside additional funds to pay on behalf of non contributing members, for example Thomson et al (2010) found the following;

***Czech Republic**; the Czech government pays about €300 per year per person on behalf of non-contributing beneficiaries (about 5 million people).*

***Germany,** Since 2008 the central government in Germany has made transfers to the national health insurance fund. These amounted to €2.5 billion in 2008 and €4 billion in 2009. From 2010 the government contribution is to increase by €1.5 billion per year until it reaches €14 billion in 2012. The increase in government revenue flowing into the health fund is intended to lead to a reduction in the health insurance contribution rate and lower non-wage labour costs. Although the transfers are nominally linked to financing coverage of children, there is no legal basis for this and no specific formula in place.*

***Hungary**, the government has made contributions on behalf of non contributing beneficiaries, including pensioners and children, since 2006, but the calculation of the amount is not as transparent as in the Czech Republic or Slovakia. In response to the current economic crisis, there will be a reduction in the payroll tax rate in 2010 (three percentage points from the employers' share) and an increase in government transfers to make up for the gap.*

Slovakia, the government pays on behalf of non-active people (about 3 million people). For 2010 the amount is 4.78% of the average wage in 2008, equal to €35 per person per month.

2.4.3 Expenditure by the NHIS

Utilization of health services has steadily increased since 2005 and the OPD per capita has more than doubled at 1.15 by 2014. About 90% of total out patients attendants are beneficiaries of the NHIS relative to about 38% population coverage of the scheme. This could be interpreted to mean that about 90% of health service utilization in Ghana occurs among NHIS members and a reflection of moral hazards, adverse selection and higher risk selection attributes of the scheme (MOH, 2015). Health service utilization by members of the scheme increased in absolute terms from about 600,000 in 2005 to 29.6 million out-patient visits in 2014 and from about 29,000 to over 1.6 million hospital admissions during the same period.

Expenditure on claims has grown rapidly, reflecting relative growth in utilization and increasing cost of service delivery. A total of GH¢ 7.60 million that was paid in claims to healthcare providers in 2005 has increased substantially to GH¢1,077 million in 2014 thereby exposing the scheme to financially stressful situations (NHIA, 2015). Though, most (about 75.6%) of the scheme's revenue are spent on payment of claims to healthcare providers, a sizeable amount goes into its operations; production of identification cards, support to the MOH and other administrative expenses (MOH, 2015).

Drug cost and prescribing practices also constitute substantial portion of the scheme's expenditure on claims and it is estimated that drugs and pharmaceuticals takes up to 40% of total claims reimbursements. The NHIS itself has identified the need to contain escalating cost of drugs and improving rational use of drugs as one of the efficiency measures (NHIA, 2015).

2.4 Financial Sustainability of Health Insurance Schemes

Ensuring universal access to good quality healthcare remains a major concern for most governments and health systems globally. According to Thomson et al, 2009 on addressing financial sustainability in health systems, they observed that the concept of financial sustainability has many facets, however, the concept is primarily a question of ability to pay more for health. They explained that "if governments can generate additional resources to finance health, and if the welfare gains derived from higher spending on health outweigh the opportunity costs of not spending those resources on other things, then societies may well choose to devote more resources to health in order to sustain these greater welfare gains". They recommended that attempts to enhance value by doing more with the resources being devoted to health care ought to be the first choice for government towards financial sustainability.

In related work on responding to financial sustainability of Estonia's health system, Thomson et al (2010), recommended four major policy options; broaden the public revenue base, improve financial protection by curbing out-of-pocket, continue to improve health system performance through better resource allocation and purchasing and maintain strong governance of the health system. Without a better understanding of what is meant by financial sustainability and importantly, without

explicitly linking the issue to questions such as willingness to pay for healthcare, the value of the benefits gained from health spending and how to improve the performance of the health system, policy responses to sustainability concerns may be misdirected and yield unintended consequences.

Dr. Odame (2013) on sustainability of recurrent expenditure on public social welfare programs: expenditure analysis of the Free Maternal Care Programme of the Ghana NHIS found that 62% of all claim the free maternal care programme was for antenatal care with 60% of claims was from regional specialist hospital. He further found that in 2009, FMCP expenditure was 23% of the total NHIS claims expenditure at a time when the NHIA expenditure exceeded income in 2009, resulting in a deficit.

CHAPTER 3

3.0 METHODOLOGY

3.1 Research Methods and Design

The study was a qualitative study using key informant interviews and a desk review of existing relevant literature and official documentation from the NHIA.

3.2 Data Collection Technique and Tool

A total of 15 key informants were interviewed for the study using an interview guide developed for the purpose of this study. All interview sections were taped and transcribed. The number of key informant interviewed was stopped after the 15th respondents since interview sections were no more yielding news responses, thus when a point of saturation was reached.

3.3 Study Population

The study population included persons with insights into the operations of the NHIS. Key informants interviewed included officials of the Ministry of Health, staff of the NHIA, healthcare providers including nurses, and pharmacists, members of the scheme and managers of health facilities.

3.4 Study Variables

The variables of the studied were;

1. legal and policy weaknesses exposing the scheme to high spending
2. Reasons for non enrollment
3. Extent of fraud
4. Mitigation measures to be adopted

3.5 Pre-testing

The interview guide for the key informant interviews were pre-tested among 2 key informants from the NHIA and the Ministry of Health. The findings were used to refine the interview guide before the main data collection was carried out.

3.6 Data Handling

All data collected were checked for consistency and relevance to the study variables.

All the audio tapes were transcribed into Microsoft word document.

3.7 Data Analysis

Data analysis codes were generated based on major themes from the study variables.

The transcribed documents were fed into MAXQDA version 12.0 for analysis.

3.8 Ethical Considerations

This study did not pose any serious threat to the key informants, however ethical clearance was granted for this study by the Ensign College's Ethics Committee prior to the data collection. Again, measures were put in place to ensure privacy and confidentiality of data collected especially personal identifiers of the key informants.

3.9 Assumptions

Assumptions were that key informants would not open up and honestly respond to questions asked them because they may not want to be recorded on tape. This was avoided. The rational of the study was explained to the key informants, they pre-informed of the need to record the interview section and their written consent were obtained. Efforts were made to ensure that key informants' names or any identifiers mentioned on tape.

CHAPTER 4

4.0 RESULTS

4.1 Background Information of Key Informants

In all, 15 key informants aged from 29 years to 57 years (average age of 45.5 years) were interviewed. Together, they had 87 years of experience in dealing with Ghana's health insurances. Nine of the key informants were around at the time the NHIS was established and had played various roles leading to its establishment. The educational qualifications of the key informants ranged from 1st degree to doctorial degree in various professional disciplines; Nursing, Pharmacy, Biostatistics, Legal, Public Health, Health Economics and Health Policy and Planning.

Most of the key informants were involved with the NHIS at various segments of the healthcare system; 1 International Development Expert, 2 Health Insurance Administrators, 1 Regional Director of Health Services, 2 District Director of Health Services, 2 Medical Superintendents, 1 Senior Pharmacist, 1 Nurse in-charge, 2 Health Economics, 2 Principal Physician Assistants, 1 Principal Health Planner and 1 Student.

One out of the 15 key informants was a female and 7 of them were active card holders of the NHIS at the time of the interview.

4.2 Operational information

This section examined the operational data of the NHIS to explore the trends of membership enrollment, funding sources, healthcare utilization and expenditure.

4.2.1 Membership Coverage of NHIS

The proportion of population who hold NHIS active membership card in 2015 was 40%. Total active membership increased from 10,545,428 in 2014 to 11,058,783 in 2015 representing an increase of 4.9%. Over the years, proportion of persons exempted from premium payment accounted for over 60% active card holders of the NHIS. Out of the total 513,355 members enrolled in 2015, 476,458 (92.8%) were in the exempt category and therefore did not paid premium. A detailed review of the NHIS membership data showed 65.7% of all active members in the exempt category in 2015 were children below 18 years. Table 4-1 below shows the trend in the proportion of population covered and proportion of NHIS members exempted from premium payment.

Table 4-1. Trend of population coverage and proportion of active members in the exempt categories

Year ⟹	**2011**	**2012**	**2013**	**2014**	**2015**
Total Population (million)	25.3	25.9	26.6	27.3	27.6
No. of Active members (million)	8.3	8.6	9.8	10.3	11.1
No. Exempt members (million)	5.3	5.5	6.1	6.7	7.4
Proportion of population Insured	*33%*	*34%*	*37%*	*38%*	*40%*
Proportion of Insured Exempted	*63%*	*63%*	*63%*	*66%*	*67%*

Source: MOH, Preliminary Holistic Assessment Report, 2016

4.2.2 NHIS funding sources

Over the years, the National Health Insurance Levy (NHIL) has been the main source of funding to the NHIS with average annual contribution of about 73% to the NHIF. The share of revenue generated from premium has been consistently marginal at 4.5% in 2011 declining to 3.2% in 2014. The share of premium out of the total funding to the scheme has increased from 3.2% in 2014 to 3.8% in 2015 following upward premium review in 2015. Table 4-2, below shows the contribution of various funding sources to the NHIS.

Table 4-2, Sources of funding (million cedi) to the National Health Insurance Fund, 2011 to 2015

Year	NHIL	SSNIT	Premiums	Interest	Other	TOTAL	*% Premium*
2011	449.96	107.61	27.54	30.92	0.78	616.81	*4.5%*
2012	573.36	141.76	28.56	29.07	11.72	784.47	*3.6%*
2013	650.2	180.49	30.58	42.25	12.7	916.22	*3.3%*
2014	756.73	223.57	33.61	22.58	8.3	1044.79	*3.2%*
2015	908.6	283.27	48.07	16.13	4.83	1260.9	3.8%

Source: MOH, Preliminary Holistic Assessment Report, 2016

4.2.3 NHIS Expenditure

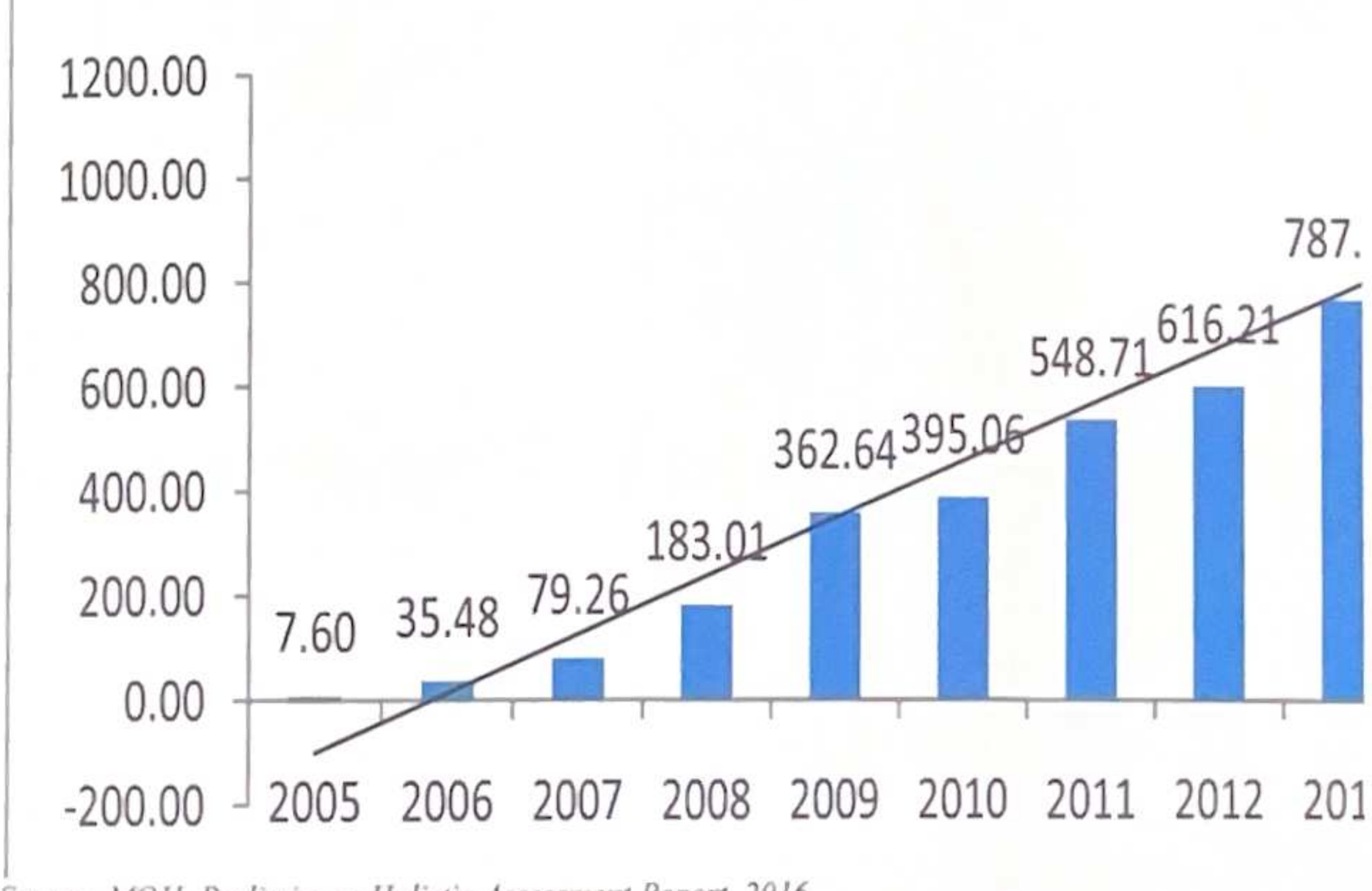
Expenditure on claims reimbursement increased from GH₵1,202.61 million in 2014 to GH₵1,277.32 million in 2015 representing an increase of 6.3%. Claims payment accounted for 76.1% of total expenditure in 2015 while about 24% was spent on administrative and operational activities as detailed in Table 4-3 below and Figure 4-1, shows the trend in claims payment from 2005 to 2014.

Table 4-3, Trend *NHIS Expenditure (in million cedi) , 2011 to 2015*

Year ⟹	2011	2012	2013	2014	2015
Claims	548.71	616.21	782.26	1,077.00	971.73
Admin. and log support	17.2	28.83	5.04	5.72	7.71
Support to MOH	147.33	74.67	31.11	15.65	33.21
Operation	36.75	61.85	150.91	150.25	169.08
NHIS ID card expenses	9.62	20.05	27.69	69.69	41.16
IDA project (WB)	3.29	9.07	0	0	0
Loan payment	0	0	0	73.61	54.43
TOTAL	762.9	810.68	997.01	1,202.61	1,277.32
% expenditure on claims	71.9	76	78.5	69.5	76.1

Source: MOH, Preliminary Holistic Assessment Report, 2016

Figure 4-1, Trend of Claims Payment, 2005 to 2014 i
Million Cedi



Source: MOH, Preliminary Holistic Assessment Report, 2016

4.2.4 Trend in health service utilization

Health service utilization by the insured members continuously increased from 600,000 Out-Patient Department (OPD) visits in 2005 to 29.64 million visits in 2014. Figure 4-2, below shows the trend in OPD visits from 2005 to 2014.

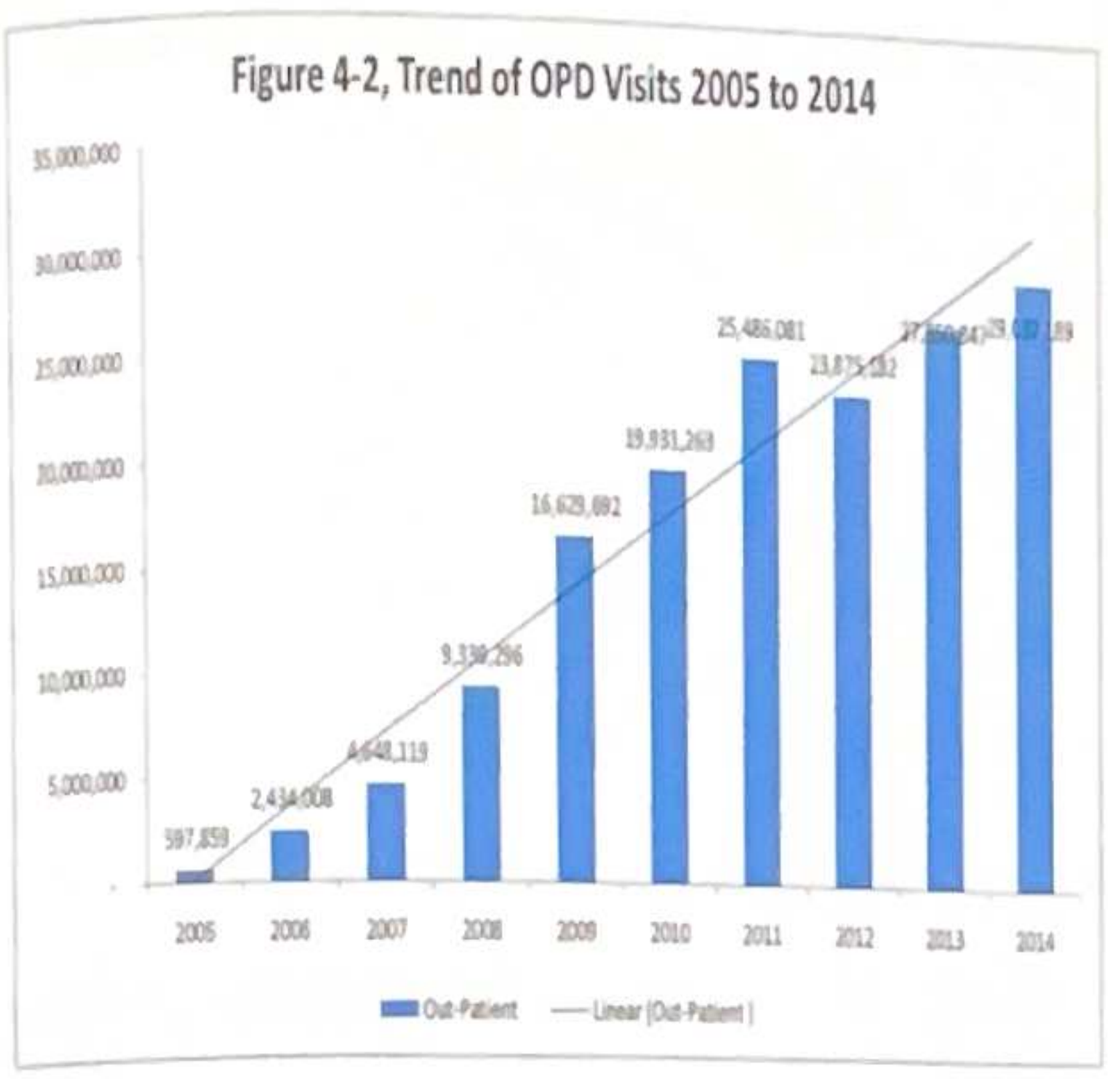


Figure 4-1, Trend of Health Service Utilization by NHIS Members, 2005 to 2014

4.4 Results of Key Informants Interviews

The findings have been grouped under 4 major themes namely; i) weaknesses relating NHIS law and operational policies, ii) why NHIS is not able to attract potential members to generate more revenue, iii) issues impacting negatively on expenditure and iv) possible mitigation measures.

4.4.1 Legal provisions and policy decisions

The key informant interviews, that some provisions in the NHIS law and subsequent policies have exposed the scheme to excessive financial burden. Section 29 of Act 852 which provides for persons exempted from premium payment was perceived to have burned the scheme. As a result, some questioned the rationale or objectives for establishing the scheme. Again, some policy decisions relating to the kind of diseases, conditions or services to be included in the benefit packages were also seen to be exposing the scheme to excessive financial risk. Table 4-4, shows some key informants' perceptions on what is not been done right with the NHIS.

Table 4-4, what is not been done right with the NHIS?

Revisit the objective of the scheme	Review Exempt Category	Fund management and expenses	Review Benefit package
- The main issue is to determine exactly what we want as a country? - "I think having one scheme that covers both public and private facilities is wrong" - Why are we exempting all these categories of people?	- "The exemption is too large. It's too huge. It will collapse the scheme." - It is too much. It's a huge challenge for the NHIS, so they should reduce the exemption categories - It's impossible to have all these categories of people exempted in one scheme - "We actually have the mindset that people are poor but it is not true."	- I think that the management of the funds is also a factor - "The problem with the NHIS is mismanagement of the funds. That is really what is crippling and crushing the NHIS" - "I think they are not spending properly on the core duty"	- If we add Malaria to a benefit package, exactly what do we want? - "improve on the benefit package and ask them to pay more" - "It should not only be seen as a cheap thing"

4.4.2 Membership and revenue mobilization

The NHIS can only pool resources better if it can improve on its membership coverage, especially those in the non-exempt category. Key informants sighted lack of confidence or trust in the NHIS, lack of education, delays and inconvenient registration processes coupled with misconceptions and negative experiences at the health facilities as some of the reasons why the NHIS is not able to attract more premium paying people. Table 4-5, below shows key informants opinions on why the NHIS is not able to attract premium paying members.

Table 4-5, why the scheme fails to attract the working class and non -exempt people?

No confidence or trust in the scheme	- probably they don't have trust in terms of the delivery of the scheme - It has to do with some of the misconceptions about insurance
Benefit does not meet expectations	- because it doesn't satisfy their requirements; if I have to register for the scheme only to be treating malaria etc, it's not what I am interested in
Delays and registration process	- it's not about the premium. It's about the cumbersome process to getting registered - the inconvenience of the registration process - even for SSNIT contributors, membership is not automatic. You have to go to the registration stations
Extra payments at point of service/ copayment	- Sometimes you go to the facility and even for some of the drugs, you'll have to pay - they go to the hospital they still have to pay for their drugs - As it stands now it will continue to happen (*illegal copayment charges by providers*) - because t people are registered and when they go to the facilities, they still have to pay for certain things
Lack of public awareness/ education	- The only challenge is about education and sensitization of the population - It boils down to people being adequately sensitized to know that the scheme is running properly - The NHIS should engage the public and let subscribers know their entitlements - first the people should know the advantages of Health Insurance and second, the benefit package

Perceived low quality services and negative experience at health facility	- People don't see any better service from facilities registered under health insurance - People think when we say NHIS pays for generic drugs; it means that they are paying for inferior drugs - because of some negative experiences they might have had at some health facilities they don't renew their membership

There have been concerns about coverage for the poor and its financial implication for the scheme. In response to who should pay for the poor, the key informants maintained that Ghana as a county does not have a clear definition for the poor and lack the ability to target them appropriately. Additional funding by government to pay the premium for the poor and support from relatives were suggested as sources of funding to support the poor. Table 4-6, shows key informants' comments on who should pay for the poor.

Table 4-6, Who should pay for the poor?

Definition of who is poor and how to identify the poor	- It is not true that you can't even know who is poor. Do it at community level - the poor have to be really well defined - The difficulty we have is determining who is poor? Who determines who is poor? - what is our definition of poverty or poor?
Let them pay in kind or relatives	- There are still local initiatives where people do things which will marvel you - But we know very well, how people can begin to help, in the local system - When a family member is sick everybody contributes, why can't they contribute to insured themselves?
Government through Social Welfare	- I feel government should handle that aspect. That is why you have social protection policies like the Livelihood Empowerment Against Poverty (LEAP) - Do the free registration for them but not the scheme registering them freely, so government should step in and take it up - A separate institution should register them other than the health insurance.
Pay from NHIF	- if it comes out clearly that these peoples are poor, fine, then the scheme should be able to absorb these people - if the insurance is based on the VAT, the poor can benefit

4.4.3 Leakages, fraud and Abuses

There was a widely held belief among the key informants about the pervasiveness of fraud and abuses against the scheme by all three major stakeholders of the scheme. Although, this is not exclusive to Ghana's health insurance scheme, the key informants were concerned about lack of efforts to deal with it. Table 4-7, below shows key informants' comments in response to whether there are leakages, fraud and abuses that impact on the finances of the scheme.

Table 4-7, Are there leakages, fraud and abuses against the scheme?

Fraud and abuse by scheme members	- Clients? Oh! Plenty. They can move from one facility to another - Within a week, someone can go to about three places to collect more drugs - because it is free, you know, people are really are abusing it
Fraud and abuse by scheme staff	- Some of the NHIS officers are in connivance with facility managers because they also get their cut - "the leakages are too many, if you look at the membership coverage that we have, I personally don't think we should be paying that much for claims"
Fraud and abuse by service providers	- Certainly, on daily basis in the workplace, it happens - Sometimes people are billed for medicines they are not supposed to pay - the providers, you know this fellow is not sick, yet you have fired a whole battery of medicines because you want more revenue - Even health professionals .....they sometimes use other client's medical records to get medications
General fraud	- Provider cheats, the scheme cheats and the client cheats. Everybody is cheating - As for the abuses, it's occurring throughout; from the administration to the providers - As for fraud and abuses, there's more than enough evidence - There is fraud everywhere, from the top to the bottom

4.4.4 Mitigation measures

In this section, key informants were asked if they think the introduction of mitigation measures in Table 4-7 below would make an impact on the finances of the NHIS.

Table 4-8, what mitigation measures can be adopted to improve finances?

Capitation	- if the rate realistic. if you give somebody so small that he has to squeeze within, then certainly you are sure quality will be compromised - So the two payment methods running parallel to each other is not the best - I think basically capitation will do a lot to help improve the system because, a lot of people are abusing the system
Copayment	- I will encourage copayment at a certain level and that level will be just beyond - primary care - Already co-payment is taking place but that is not preventing the abuse - there should rather be a ceiling after which for which patients will now put their healthcare cost on the insurance; e.g. NHIS will only come in if your bill is above GHC50.00 - without copayment the insurance will .. every insurance will collapse, because especially in developing countries, the premium is low
Enforce Gate keeper	- that is the policy so they have to enforce it - maybe 10 out of 1,000 patients should filter to the teaching hospital - resource the rural facilities, attention must be given to the facilities so that most of the people will be seen at the smaller primary care facilities
Limit benefit to primary level	- when we define what primary health care service is - that is quite something that I think if the insurance should really take a look at as it's saving cost to them. It also building the system because just with the example of the Malaria, it's the same treatment that will be given - the secondary and tertiary level, should move away from primary care services. That is why the second tier is very important
Two tier subscription	- you need people of all class on the scheme, so a 2nd tier scheme will let people register - The scheme should be able to create different levels to attract everybody - there should be opportunity for people to subscribe to secondary insurance packages - additional tier - NHIA should be seen to be encouraging that - this tier, the benefit package should be limited to catastrophic conditions because that is the interest of the middle-class.

CHAPTER 5

5.0 DISCUSSION

5.1 Legal and Policy Issues

Unlike the national health insurance act, 2003 (Act 650), the national health insurance act, 2012 (Act 852) appeared to have exposed the health insurance to much financial burden relative to the category of persons exempted from premium payment. Nine categories of persons have been exempted from premium payment and these include;

a. *a child (thus persons below 18 years);*
b. *a person in need of ante-natal, delivery and post-natal healthcare services;*
c. *a person with mental disorder;*
d. *a person classified by the Minister responsible for Social Welfare as an indigent;*
e. *categories of differently-abled persons determined by the Minister responsible for Social Welfare;*
f. *pensioners of the Social Security and National Insurance Trust;*
g. *contributors to the Social Security and National Insurance Trust;*
h. *a person above seventy' years of age;*
i. *and other categories prescribed by the Minister for Health*

Provision for exemption in Act 650, was contained in section 34 subsection 3 which stated that "Notwithstanding subsection (1), Regulations shall prescribe for exemptions of certain categories of persons from the payment of contributions". Subsection 4 and 5 further specifically exempted only contributors to and pensioners under SSNIT respectively. Section 38 made provision for determination, identification and registration of indigents and mandated the Minister of finance in

consultation with the NHIC to "determine at least six months in advance the Budget for the support of indigents".

The exemption policy as in the old insurance law was more flexible and could be expanded in a gradual manner depending on the financial strength of the scheme. Unlike the current system where the NHIS takes on the full burden of processing, registration and provision of benefits for the exempt categories, the previous act ensured that the Minister of finance made specific budget allocation to support the indigents.

Following the passage of Act 852, in 2012, the scheme's focus has shifted to registering more persons in the exempt categories especially, the indigents. Proportion of active members who were indigents increased from 1.4% (2011 and 2012) to 11.2% and 14.5% in 2014 while proportion active members who were non-exempt declined from around 33% in 2013 to 29% in 2014.

Many people who are sympathetic to the NHIS's financial situation felt the current exemption policy of the scheme ought to be reviewed to reduce the burden on the scheme. Two of such feelings were expressed by a senior official of the Ministry of Health and a Regional Director of Health Services who have both had in-depth experiences with health insurance implementation in Ghana respectively:

"The exemption is too large. It's too huge. It will collapse the scheme. You are exempting children under eighteen years, you are exempting older people, then there is nobody left".

"Now if we talk about pregnant women, fine, because we want them to come and have services so that we can reduce maternal mortality. So people who are above seventy (70) or so, what is the reason why we are exempting them? Less than eighteen (18), why are we exempting all those people? So I think it's too wide. If you want to exempt children, why not bring it down to five (5) years?"

Some would further argue that the exemptions should be targeted at the vulnerable rather than the current general exemptions for the various categories. It cannot be the case that all children under 18 years are from such economic background such that they cannot afford premium. Similarly, a significant proportion of various categories should be able to pay their own premium which would go further to strengthen the finances of the scheme.

Policy decisions that are exerting a financial burden on the scheme include issues relating to the benefit package, non enforcement of some key provisions and branding of the scheme to earn the trust and confidence of the scheme. Stakeholders believed that policy decisions should seek to achieve the goal for which the health insurance was established; some have questioned the decision not to increase premium until recently, NHIF support to the Ministry of Health budget and the increasing exemptions. There ought to be case by case assessment for need for every item included in the benefit package and each item should either pass cost effectiveness test or specifically targeted at public or social intervention. Below was how a Regional Director of Health Services put it;

" if I have GHC100,000.00, where do I put it? Do I use it to treat children with malaria or use it for 10 managing directors who have hypertension? But if a disease pass nothing, and it's included just for emotion sake, you will have a problem"

In a country where laws and regulations are not enforced or are difficult to enforce, it would be practically impossible to expect people to respect policy directives especially on gate keeping when there are no incentives to do so. Although, the current reimbursement policy seeks to discourage secondary, tertiary and teaching hospitals from attending to primary care services, they rather shift the burden to the beneficiaries of the scheme by demanding out-of-pocket payments for services already covered. Some hospital have gone further to establish in-house retail pharmacies to sell medicines not stocked in the hospital pharmacy. All these contribute to lack of confidence and trust in the NHIS.

5.2 Membership and Revenue Mobilization

Revenue from premium payment would be the surest means for the NHIS to improve its finances. The NHIL and SSNIT contributions would not change significantly anytime soon and prospects of generating enough from these sources are linked to the growth of the economy. Ghana has had experience with tax based health financing and how it could not last following decline in the economic performance of the country immediately after independence.

Currently, it appears the NHIS under estimated how premium revenue could significantly influence its finances. There have been more efforts aimed at registering those in the exempt categories than registering the premium paying members. Again, for some reasons, the NHIS has not been able to attract premium paying members. Some of these reasons include lack of confidence or trust in the scheme, poor public misconceptions about the scheme, delays and difficulty with registration processes, negative experiences with healthcare providers and general lack of public education.

There are lots of information circulating about the state and management of the NHIS including it been on the verge collapse mainly fueled by political commentators and persistent threats in the media by the service providers to the effect that if NHIS failed to pay them on time, they would withdraw services. There are also issues relating to the quality of services covered by the NHIS which are largely considered to be inferior especially the notion that the NHIS only covers inferior medicines - misconception is largely caused by healthcare providers who in attempts to make more money misinform the patients. There are serious issues that have to be addressed through proper public education and engagement.

Registered members of the NHIS are poorly informed and lack knowledge about what is covered or not covered in the benefit package and are therefore at the mercy of healthcare providers to inform them at the point of healthcare access. Some providers are believed to be charging double for their services; they would inform the patient that a service or medicine is not covered. They would request out-of-pocket payment from the patient and also bill the NHIS. Act 852, section 30 subsection 2 sought address this challenge and empower NHIS members, but its implementation has not fully started yet. It required of the NHIA to provide all relevant information at the point of registration, thus;

> *"The Authority shall provide information at the point of member registration, about the benefits package, rights and responsibilities of members and complaints and dispute resolution mechanisms under the Scheme".*

All these affect people's confidence in the scheme and their decision to subscribe as members of the scheme. The concerns about the coverage for the poor and its financial implication for the scheme is real especially in the Ghanaian context with

limited data to properly target the poor. Definition of who qualified to be classified as poor and lack of appropriate means of assessment further worsen the situation. It is highly possible for the poor to be overestimated in these context and hence the need to properly define the poor taking into consideration Ghanaian family support systems and local initiatives. One reason why one can easily assume that many people are poor is the fact that there is limited data on individual or household expenditure. Many individuals assumed to be poor makes huge expenses on non-essentials.

It could be possible to safely provide insurance coverage for the poor if the poor is properly defined, in order to reach the actual poor in society. Some also argue that existing social protection policies and agencies should be able to make provisions for the payment of premium for the poor to free some funds for the NHIS. The Livelihood Empowerment Against Poverty (LEAP) and Social Welfare Department, both under the Ministry of Gender, Children and Social protection should be able to take on this responsibility, rather than merely identifying them for the NHIS to process, register and provide benefits for them.

Government on the other hand could allocate and earmark a budget to support premium payment for the poor as envisaged by the previous NHIS law and this would not be unusual as is done in other countries. According to Thomson et al, 2010. Germany, Czech Republic, Hungary and Slovakia all set aside funds to pay on behalf of non-contributing beneficiaries.

5.3 Leakages, Frauds and Abuses

Expenditure on claims reimbursement accounts for over 75% of NHIS annual expenses. Although, active membership coverage of the NHIS is around 40% of the Ghanaian population, over 90% of OPD visits are occasioned by NHIS members. This has raised concerns among stakeholders about existence of fraud and abuses. Children below the age of 18 account for over 40% of the NHIS membership and it is expected that those beyond age 5 r would scarcely use health services which further go to support the fact that the NHIS is paying too much in claims reimbursement probably due to fraud and abuses.

All key informants agreed that there are fraud and abuses perpetuated on the scheme resulting in high expenditure. Below is how a Regional Director of Health Services summed up this opinion:

> *"Provider cheats, the scheme cheats and the client cheats. Everybody is cheating!"*

The healthcare providers were thought to be the main perpetuators of these negative practices at times in active connivance of NHIS' staff to make claims on the scheme. NHIS members on the other hand were accused of shopping for services, frivolous and use of services to obtain medicines for non registered sick relatives.

There are very little incentives for people to do the right thing. Currently, the NHIS seems to be interested in punishing healthcare providers for their mistakes. Health service providers who make conscious efforts to ensure efficiency and satisfy their clientele should be identified and recognized by the NHIS as summarized in the following recommendation by a senior health economist.

"There should be reward for efficiency gains for providers of healthcare. Even though, you have a contract with them, if you are seen to be making a certain level of efficiency gain, you should be rewarded rather than only looking at punishment for abusers".

NHIS was accused of unilaterally deducting money from service providers for genuine clerical errors on the part of the service providers and refusing to give them opportunity to correct the errors and resubmit. In attempt to recover these charges, providers make up for the lost in subsequent claims. Again, delays in claims reimbursement has provided the basis for healthcare providers to introduce unapproved out-of-pocket payments and in the process double charging the scheme and its members for the same service. Some providers were also of the view that NHIS tariffs are unrealistic with less frequent opportunity to review them resulting in providers under recovering for most of their services.

As a result, providers are tempted to do up coding for some services, ask the patients to make up for the difference or double charge the scheme and patients. A Medical Superintendent who also doubles as a District Director of Health Services provided the basis for some of these actions;

"Obviously, we have all been pushed to the wall to do that because if I go to supplier A, I credit items, for three months I do not pay, obviously s/he cannot give it to me again so I then move to supplier B and then try to also credit for the next three months. So if I keep on crediting for nine good months and I'm still not paid, obviously I must find a way of sustaining the hospital"

5.4 Mitigation measures

The finances of the NHIS would not improve dramatically in the next few years without a major decision to review the funding sources and hence the need to adopt some measures to mitigate the current financially stressful situation the scheme find itself. A mixed basket of mitigation measured were recommended by the key informants as likely to impact on the finances of the scheme during the medium term. These measures include adopting payment methods, review of benefit package and enforcement of existing polices.

Firstly, the need to enforce the gate keeping policy has been identified on the grounds that significant proportion (estimated at between 45% to 49%) of healthcare services are provided at the secondary level and beyond with higher overhead cost. The Ministry of Health ought to ensure that the referral policy is enforced. Consistent with ensuring that the gate keeping policy works, it should be possible for the NHIS to limit some of the benefit package to the primary healthcare facilities.

There were mixed reactions to scaling up capitation payment since Ghana has passed the stage at which to introduce capitation method. Those against, argued that using capitation alongside Diagnosis-Related Group (DRG) and Fee-for-Service (FFS) would only provide fertile grounds for provide to abuse the scheme. The prospects of making higher income when providers up-code or move patients into in-patient care to access DRG and FFS would be too tempting to resist.

Those in favour of capitation payment method argued that it would help providers have seed money and minimize complaints about delayed payments, reduced

workload for both provider and the scheme, link clients to specific providers and improved client - provider relationships. It would be important to review the current status of capitation payment method ongoing in the Ashanti Region before further scale-up to other regions; decisions to scale capitation payment to other regions should be backed by demonstrated superior benefits to all three major stakeholders; the scheme, the clients and the providers.

Most of the key informants generally believed introduction of co-payment would lessen the financial burden of the scheme especially if it is targeted at certain services and levels of healthcare facilities. They is evidence to support the fact that copayment is currently ongoing in the healthcare facilities, although illegal and unregulated. Introduction and regulation of copayment would be to the advantage of all stakeholders, unlike what exists now where providers decide what to charge and for which services.

Patients should be able to afford part of their medical bills once they can be assured of quality healthcare. With the health seeking behaviour of most Ghanaians, where the first attempt is to purchase medicine in a pharmacy, most patients end up spending more on out of hospital treatment than they would have paid for copayment. Again, with the notion that medicines covered by the NHIS are inferior, some patients are willing to pay a little more to secure "quality" medicines as captured in the comments of a senior medical officer and medical superintendent of a municipal hospital.

"...when you talk to the insurance clients when they come to the hospitals they say doctor, if this medicine is good for me and it's not in the insurance, write it for me I'll go and buy".

Copayment would also ensure that healthcare facilities have regular funds to support their operations, unlike what pertains now where most facilities runs out of suppliers especially essential medicines due to delayed reimbursement from the NHIS. It would further ensure that the NHIS would not be burdened by the entire healthcare cost of its members. Copayment would also ensure that NHIS members take keen interest in the cost of their medical bills since they would be paying for a proportion of their entire bill, they would ensure providers claim for only services the clients actually used. It would further reduce abuses from the clients; healthcare facility shopping and unnecessary service utilization would be cut to minimum.

The NHIS ought to be seen encouraging all class of persons to the scheme with various packages to meet various classes of healthcare needs. There are certain classes of income earners who do not see the current benefit package meeting their healthcare need and therefore are not motivated to subscribe to the scheme. They are also not able to purchase healthcare packages from the private for-profit health insurance schemes probably because the profit driven and risk-based pricing nature of such schemes makes it difficult for them to fit in there as well.

One of the mitigation measures alluded to was introduction of additional tier with enhanced benefit package for those who are willing to pay relatively high premiums to take advantage of and join the scheme. It is believed that persons interested in this kind of enhanced benefit package for extra premium would want to insure themselves against rare medical conditions that could push them to catastrophic healthcare expenditure. In this case, their use of health services would be less often compared to those who subscribed to the general benefit package. This would afford the scheme an opportunity to save money from one tier to support the other.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusions

The NHIS has reached a stage in its implementation requiring critical review and bold decisions to ensure its viability and financial sustainability. There is no point burdening the scheme to the extent that is cannot sustain its core mandate. In the light of the evidence presented, the study concludes as follows:

The new NHIS law, Act 852 has exposed the NHIS to more burden than the scheme can effectively sustain. The burden of sustaining all these categories of persons exempted from premium payment solely on the NHIF is extreme. Again, institutions responsible for social protection have somehow shifted their responsibilities to the scheme and in efforts to be seen as performing their duties end up pushing more people onto the NHIS.

It can be deduced that efforts to increase membership coverage were mainly focused on enrolling those in the exempt category because they appeared easy to reache than the premium paying members, which required more efforts. Again, the NHIS seemed unconvinced that they could generate significant revenue from the informal sector or the non-exempt category, hence relatively less effort to reach this group.

The NHIS by its actions and inactions has provided an enabling environment for stakeholders to perpetuate fraud and abuses against the scheme. Delayed payments and low tariffs only encourage healthcare providers to device means to achieve more

revenue to recover cost. The inability of the providers to stock their facilities with essential supplies and subsequent substandard services to patients provided the basis for some patients to shop for such services from one facility to another.

The NHIS would not be able to function at optimum if the whole health system is not organized to function as such. There some policy issues that needed to be implemented to support the operations of the scheme and they are clearly beyond the mandate of the NHIS. The ministry of health should be seen to be playing such leadership roles like enforcement of gate keeping or referral policy, ensuring proper utilization of Internally Generated Fund (IGF) by the public health facilities and introduction of unapproved charges and fees in health facilities.

6.2 Recommendations

The study recommend the following directed at managers of the NHIS, the Ministry of health and the government of Ghana as follows.

6.2.1 The Managers of the NHIS;

1. There is a need to engage all relevant stakeholders to review section 29 of Act 852 to properly target the exemption categories
2. Engage the government through the ministry of finance and ministry of gender, children and social protection to consider making budgetary allocation to support those exempted from premium payment
3. Review their position on extent to which income from premiums payment could impact the financial strengths of the NHIS.

4. Ensure adequate measures are put in place to detect and deal with fraud and abuses while also ensuring that the scheme honors its responsibilities to both the healthcare providers and members.
5. Prepare and employ adequate mechanisms to introduce targeted copayment and additional tier subscription with enhanced benefit package in its operations

6.2.2 The Ministry of Health

1. The ministry of health should provide an enabling policy environment for the NHIS to functional properly, including implementation and enforcement of relevant policies
2. Ensure that public health facilities effectively use their IGF to improve the facilities and their services, stop charging unapproved fees and ensure availability of essential supplies.

6.2.3 The Government of Ghana

1. Ensure effective and efficient revenue collections systems to continually increase revenue from the NHIL
2. Make additional budgetary allocation to support persons exempted from premium payment

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APPENDICES

APPENDIX A, PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Part 1: Participant Information

Introduction

My names are *Nicholas Nyagblornu*, a final year Master of Public Health student of Ensign College of Public Health, Kpong. I am conducting a study to assess the operations of the National Health Insurance Scheme (NHIS) to determine what can be done to make it financially sustainable. This participant information sheet explains the study to you. Please take all the time you need to read it carefully. You may ask me questions about anything you do not understand at any time. Your participation is voluntary and you may quit at any time.

Why you are being asked to participate

You are being asked to take part in this study because you or your institution is considered a very important player in the operations and sustainability of the NHIS.

Procedures

If you agree to grant me the interview, the interview will take 7 - 10 minutes. I will be recording or taping the session because I don't want to miss any of your comments. Although, I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that I do not miss your comments. The interview will only begin after you have agreed to be interviewed and have signed the consent form.

Risk and Benefits

We anticipate minimal or no risk to you. There is no direct benefit to you for being interviewed; however, study outcomes may lead to improvements in operations and finances of the NHIS.

Confidentiality

All your responses will be kept confidential. This means that your interview responses will only be shared with my supervisor (when necessary) and I will ensure that any information I include in my report does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may prompt me to make comments off tape or end the interview at any time.

Voluntariness and Withdrawal

Your participation in the study is completely voluntary and you reserve the right not to participate. This is your right and the decision you take will not be disclosed to anyone. If you join the study, you can change your mind later. There will be no negative consequences if you choose not to participate in the study. Please note however, that some of the information that may have been obtained from you without identifiers, before you chose to withdraw, may be used in analysis reports and publications.

Cost/Compensation

Your participation in this study will not lead to you incurring any monetary cost during or after the study.

Who to contact

This study has been approved by the College's Ethics Committee. If you have any concern about the conduct of this study, your welfare or your rights as a research participant or if you wish to ask questions, or need further explanations later, you may contact my supervisor, Dr. Juliana Yartey Enos (0504229909) of the Ensign College of Public Health. **Are there any questions about the forgoing?**

Part II. Consent Declaration

"I have read the information given above, or the information above has been read to me. I have been given a chance to ask questions concerning this study; questions have been answered to my satisfaction. I now voluntarily agree to participate in this study knowing that I have the right to withdraw at any time without any consequences"

Name of **participant** _____

Signature of **Participant** _____

Date __/__/20__

Left thumbprint of participant

Name of **witness** _____

Signature of **witness** _____

Date __/__/20__

Name of **investigator** _____

Signature of **investigator** _____

Date __/__/20__

APPENDIX B, KEY INFORMANT INTERVIEW GUIDE

Interview Questions and Closing remarks	
Questions: 1. *What is not being done right?* 2. *Why the scheme fails to attract potential members?* 3. *Support for the poor and exempt* 4. *Leakages, fraud and abuses* 5. *Cost-saving measures to adopted*	1. The NHIS seem to be in financial difficulties! Is there something you think is not being done right? i. Members registration ii. Revenue mobilization iii. Expenditure iv. Cost containment 2. Why do you think both formal and informal sector potential members are not interested in registering with the scheme? 3. Who should pay for the poor to be enroll? i. What is your opinion about the current exempt categories? 4. Are there leakages, fraud and abuses? i. Are there frauds by providers? ii. Are there abuses or frivolous use by members? iii. What do you think of the benefit package? 5. Without additional funding for the next 5 years, what measures will you recommend the NHIS adopt to reduce its expenditure? i. How do you think the adoption of the following will impact on NHIS' expenditure? *a. Copayment* *b. Strict referral or gatekeeper system* *c. Restriction of members to primary and secondary health facilities* *d. Implementation of capitation method of payment* e. *Two tier scheme*
Closing 1. *Additional Comments* 2. *Next Steps* 3. *Thank you*	Is there anything more you would like to add? I will be analyzing the information you and others gave me and submitting a draft report to the college in one month. I'll be happy to send you a copy to review at that time, if you are interested. I may be contacting you by phone or email, if I need further clarification on your comments. Thank you for your time

Format: adopted from Boyce and Neale, 2006