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The Funding Systems of National Health Insurance Schemes

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I. INTRODUCTION

The National Health Insurance Schemes are semi-autonomous and as such their operations are not restricted under the controller and accountant Generals' Department which handles all financial matters concerning government activities and operations through the government treasury (NHIS Act 650). After the introduction of health insurance schemes in the country, cases of mal-administration of the funds and delays in payment of the medical bills have been reported (Daily Graphic, July 2014). Ghana in its search for a framework to regulate its procurement system enacted the public procurement Act 663 in 2003. The act came to meet the basic principles of professionalism, competition, transparency, effectiveness, efficiency and value for money in public institutions (Zomboko, 2012) such as the NHIA. Many public procurement activities suffer from neglect, lack of direction, poor coordination, lack of open competition and transparency, deferring levels of corruption and most importantly not having a cadre of trained and qualified personnel who are competent to conduct and manage such procurements in a professional, timely and cost effective manner (Kiama, 2004). To help address such issues Ghana's Public Procurement Authority mandates all Public Institutions to comply with Act 663. The above, notwithstanding, (Ameyaw, *et al*. 2012) identified non-compliance with provisions of the law, deliberate controlling of competition, inadequate skills of procurement practitioners as draw backs to the realisation of the procurement law. This research explores the National Health Insurance Scheme to find out if such challenges are prevailing and are contributing factors for the authority's inability to pay claims on time.

According to NHIA mid-year report in 2013, the NHIA has lost about 20% of its clients due to poor services provided by the service providers as a result of failure to implement public procurement procedure and ensure that the clients get value for money through quality service and care and this has not been effective as expected. According to Thursday, July 3, 2014 (page 16)'s publication of Daily Graphic "The Christian Health Association of Ghana (CHAG) had started rejecting National Health Insurance (NHIS) Subscribers at its facilities. It explained that they had been forced to take that decision due to the inability of the National Health Insurance Authority (NHIA) to pay CHAG health facilities outstanding bills and economic tariffs for services rendered". The paper further reported that "the said decision was to avoid further deterioration in the quality of the services provided and the imminent collapse of CHAG health facilities". This therefore forms the basis of the study where it seeks to investigate into the factors militating against the successful implementation of the public Procurement Act 663 in Ashanti NHIA.

II. NATIONAL HEALTH INSURANCE

An effective and efficient system of financing healthcare unarguably still sparks arguments in the globe. Most underdeveloped as well as developing nations particularly, keep on finding various means of funding their health systems. This is mainly because of low funding available for championing health issues Hanson *et al.*, (2006). User fees were first brought so as to create income for the funding of their health systems. In other aspects, the becoming into being of user fees brought about the advancement of the quality of health care services Lagarde and Palmer, (2006). But, the awe-inspiring prove indicates that user fees form a formidable barrier to the utilization of health care services and avoiding adherence to continuous treatment among poor and vulnerable groups Palmer *et al*., (2004). These challenges led to yet another debate to look for other alternatives of health care funding. The global community is hence giving more consideration to Social Health Insurance (SHI) as an alternative way of insuring the populace against extreme cost of healthcare Hsiao and Shaw, (2007). It also makes it possible for people, especially the poor, to access health care services and help generate income for service practitioners Carrin, (2002). Nevertheless, the successful implementation of SHI schemes is handicapped with regards to operation expenditure, inadequate business strategies, difficulties in managing cost and ensuring broader coverage Lagarde and Palmer, (2006). Notwithstanding the above challenges, there are still some examples of SHI programmes operating at large scale in most developing countries WHO, (2005).

III. NATIONAL HEALTH INSURANCE SCHEME IN GHANA

Ghana is one of the few African countries that enacted a National Health Insurance (NHI) law. In year 2003, Ghana government initiated a National Health Insurance Act: dubbed Act 650. Before then, the country had been offering free health care services for her citizens after 1957's independence. This became possible due to the small population size (about 8 million) at the time and a promising economy Assensoh and Wahab, (2003). On the contrary, the economic situation in the 1970s and early 1980s adversely affected the sustainability of free health care services. This means that money which was available for the health sector was woefully inadequate and that led to acute shortages of essential medicines, supplies and equipment which invariably was detrimental to the quality of care in public health institutions Agyepong and Adjei, (2008).

To correct those menaces, cost recovery or user fees (popularly called "cash and carry") was introduced in the late 1980s in all government health facilities. Ghanaians, mostly the poor, were undertaking self-medication and reporting cases late to health providers for treatment Arhinful, (2003); Arhin-Tenkorang, (2001). The above situation called for ways of health care financing, which led to the introduction of some Community-based Health Insurance Schemes (CBHIS) in the early 1990s. As at 2003, such CBHIS covered only about 1% of the country's population of 19 million, leaving many Ghanaians unable to pay for high cost of health care services Sulzbach and Owusu-Banahene, (2005).
In Ghana's effort to promoting universal coverage and equity of health care services, the government of Ghana (2003) designed, set up, and adopted the National Health Insurance Scheme (NHIS) which was fully implemented in 2005. The overriding goal of the NHIS is the provision of universal health insurance coverage for all Ghanaians, despite of their socio-economic standing. As of June, 2009, approximately 67% of the Ghanaians had registered with Ghana's NHIS Asenso-Boadi, (2009).

The major funding of Ghana's NHIS is the revenue generated by a national health insurance levy of 2.5% on certain goods and services, 2.5% monthly payroll deduction being part of the contribution to the Social Security and National Insurance Trust (SSNIT) for formal sector workers, government budgetary allocation and donor funding. The informal sector members also pay premiums but some category of persons like the aged are exempted. About 95% of the disease conditions in Ghana are covered under the NHIS. But, some services classified to be unnecessary or very expensive are on the exclusion list. Some of them are; cosmetic surgery, drugs not listed on the NHIS drugs list (including antiretroviral drugs), assisted reproduction, organ transplantation, and non-commercial inpatient accommodation.
In the initial stage, a fee for service type of provider payment system was used for reimbursing health providers for services rendered. However, in April, 2008, it was replaced with the Ghana Diagnostic Related Groupings (GDRGs). The rationale behind the replacement was that the fee for service was found to be low and de-motivating, especially for the private providers to participate. Providers are encouraged to participate in the NHIS, so as to minimise congestions and delays for clients when seeking health care services Ankomah, (2009).

The comprehensive nature surrounded by a lot of paperwork made it uncomfortable for providers thereby refraining from it Ankomah, (2009). Therefore, the government introduced GDRGs to assist in the surrounding challenges. The tariff deals with a comprehensive cost component of the calculated primary consumables for primary patient care. The GDRGs takes around 80% of the overall cost component of the nation's hospitals, clinics, health centres, etc Ankomah, (2009). From the beginning of the NHIS operations, many studies have been conducted on the viability and acceptability of the NHIS, the qualifications of enrolment into the NHIS, and the health seeking characteristics of insured clients.

A. Funding of Ghana's Health System.

The funding of Ghana's health care started with a tax-funded module that gave free health care services of the public to all after independence. As the system slowly became economically unsustainable with financial stagnation in the 1970s, small user fees were charged for hospital services to deter subscribers from frivolous use. It was used locally to recompense some costs and create provider performance incentives. The increasing reduction in government's expenditure on health via the 1970s and 1980s led to reduction of medicines and supplies and deteriorating quality of care, Blanchat, et al, (2012). On September 05, 2003, following a number of pilots in chosen districts; the National Health Insurance Scheme came into being. Consequently, the National Health Insurance Act, 2003, (Act 650) was signed into law. In 2012, the Act was repealed and replaced by a new law (Act 852), NHIA Annual Report (2012).

The four types of health insurance broadly used to gather risk, foster advanced payment, boost incomes, and procure services: state-based systems funded by the government and managed through ministries of health or national health services, social health insurance, community-based health insurance, and voluntary health insurance, World Bank, (2006). In Ghana the law made three types of schemes available:

- *The District-Wide Mutual Health Insurance Scheme,*
- *The Private Mutual Health Insurance Scheme,*
- *The Private Commercial Health Insurance Scheme, Imurana, et al, (2014)*

In 2010 the NHIA was faced with concerns about unchecked cost escalation, apparent supplier-induced demand, and little evidence of improved quality or effectiveness of services. After careful consideration of the current challenges, the NHIA decided to pilot a capitation payment system for primary care (PHC) services in Ashanti region in 2011. Ashanti region has a population of over 3.8 million people and account for nearly over 25 percent of total NHIS claims. It is hoped that the pilot will help orient the NHIS toward making more effective use of provider payment mechanisms and begin to address more fundamental problems in the service delivery systems, such as lack of focus on prevention, poorly coordinated care, and inadequate management of chronic diseases, Shieber, et al (2012).

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