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Value and Service Quality Assessment of the National Health Insurance Scheme in Ghana: Evidence from Ashiedu Keteke District

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ABSTRACT

Background: Ghana introduced the National Health Insurance Scheme (NHIS) in 2003 to provide financial access to health care for all residents. **Objectives:** This article analyzed claims reimbursement data of the NHIS to assess the value of the benefit package to the insured and responsiveness of the service to the financial needs of health services providers. **Methods:** Medical claims data reported between January 1, 2010, and December 31, 2014, were retrieved from the database of Ashiedu Keteke District Office of the National Health Insurance Authority. The incurred claims ratio, promptness of claims settlements, and claims adjustment rate were analyzed over the 5-year period. **Results:** In all, 644,663 medical claims with a cost of Ghana cedi (GHS) 11.8 million (US $3.1 million) were reported over the study period. The ratio of claims cost to contributions paid increased from 4.3 to 7.2 over the 2011-2013 period, and dropped to 5.0 in 2014. The proportion of claims settled beyond 90 days also increased from 26% to 100% between 2011 and 2014. Generally, the amount of claims adjusted was low; however, it increased consistently from 1% to about 4% over the 2011-2014 period. The reasons for claims adjustments included provision of services to ineligible members, overbilling of services, and misapplication of diagnosis related groups. **Conclusions:** There is increased value of the NHIS benefit package to subscribers; however, the scheme's responsiveness to the financial needs of health services providers is low. This calls for a review of the NHIS policy to improve financial viability and service quality.

Keywords: claims ratio, claims reimbursement, Ghana, National Health Insurance Scheme, service quality.

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Introduction

Many low- and middle-income countries are increasingly implementing social health insurance (SHI) programs as a preferred health financing system to ensure access to and equity in health care utilization [1]. African countries including Ghana, Nigeria, and Rwanda are at different phases of implementing SHI aimed at achieving universal health coverage. One distinct characteristic for SHI's attractiveness in developing countries is that it does not depend exclusively on public finance, but instead shares the responsibility of health financing among the population [2].

One of the major challenges of managing SHI schemes is that the services are provided by a third party (health services providers) and paid for by the SHI schemes, thereby introducing inherent problems such as fraud, high claims cost, excessive utilization, and poor service quality [3]. This situation has caused financial sustainability challenges for many SHI schemes in developing countries. A continuous monitoring of claims is seen as the surest measure to addressing the inherent problems mentioned above. Claims reimbursement analysis, therefore, is increasingly becoming an important exercise for payers of medical claims, particularly health insurance organizations at national and regional levels. Many health insurance institutions have incorporated claims monitoring applications in their operations to constantly monitor trends of important claims indicators for any emerging anomalies [3]. Others have also developed monitoring and evaluation frameworks and tools to track and address negative trends in health services utilization, claims cost, settlements periods, and rejection rates [3].

Ghana, a lower middle-income country in sub-Saharan Africa, started experimenting with SHI through the community-based health insurance scheme approach, spearheaded by non-governmental organizations. This was in response to challenges associated with the out-of-pocket payment system of health care financing in the 1990s popularly called "cash and carry." The out-of-pocket payment widened financial access to health care and

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caused ill health and avoidable deaths [4,5]. It was estimated that out of the 18% of the population who needed health care, only one-fifth could afford it [6,7]. The community-based health insurance schemes, however, covered about 1% of the population and offered limited benefit, mainly for catastrophic health care expenditures due to their inability to address key design issues and lack of financial support from the central government [8,9].

In 2003, the country introduced the National Health Insurance Scheme (NHIS) through an Act of Parliament, the National Health Insurance Act (Act 650) and Legislative Instrument (L.I. 1809) [6,8,10,11]. The policy was aimed at removing out-of-pocket payment by providing financial access to health care for all residents in Ghana. It was implemented in 2004 and currently operates in 160 districts across the country, with membership coverage of 10.5 million, representing 39% of the population [12,13]. A total of 4004 health care providers across the country are credentialed to render health services to card-bearing members [12]. In addition, the National Health Insurance Authority (NHIA) has a regional office in each of the 10 administrative regions in Ghana for direct supervision of the district offices. The NHIS is financed by 2.5% National Health Insurance Levy on selected goods and services, 2.5 percentage points of formal sector workers' social security contributions, and nonactuarially determined contributions from informal sector workers including the self-employed. Other sources of funding are interest on investments from the National Health Insurance Fund (NHIF), donor support from development partners, and earmarked funds by parliament [1,14].

Evidence shows that the NHIS has made important strides in population coverage, access to health care, mobilization of public and private resources to purchase health services, and contribution of revenue to health care providers [1,13,15,16]. However, a generous benefit package, coupled with increasing utilization levels and high claims cost, pose a threat to the long-term sustainability of the scheme. This article analyzes claims reimbursement data of the Ashiedu Keteke District Office of the NHIA to assess the value of the benefit package to the insured and responsiveness of the NHIS service to the financial needs of health services providers. The study was informed by a similar one that the authors conducted at the Ga District NHIA Office in 2009, where it was found that claims expenses were increasing and settlements going beyond the stipulated period of 28 days [7]. However, this article goes beyond the analysis of claims ratio and settlements period to include analysis of claims cost by service type, average cost per claim, and adjustment rate of the claims review system.

Methods

Study Design

This article is a review of retrospective medical claims data of the Ashiedu Keteke District Office of the NHIA. It covered the period January 1, 2010, to December 31, 2014, because of the availability and reliability of the claims reimbursement data. Data for the previous years were unreliable for this research because they were captured rudimentarily and cannot be properly attributed to particular periods.

Study Area

The area for this study is the Ashiedu Keteke District Office, one of the 14 district offices of the NHIA in the Greater Accra region. The district covers the Ashiedu Keteke submetropolitan area of Accra and is the smallest among the six submetropolitan districts with a population of about 117,525 [17]. In addition, about 200,000 people commute daily for public service work and trading in the district. Like most of the district NHIA offices, the Ashiedu Keteke District Office was fully established in 2005 and as of December 2014, the office had 18 staff, 346,218 insured members, and 12 accredited health services providers [18].

Conceptual Framework and Analytical Tools

The article adapted indicators for analyzing health insurance claims data from the Handbook for Microinsurance Practitioners titled "Performance Indicators for Microinsurance" [3]. The indicators that were selected for this study include incurred claims ratio, promptness of claims settlements, and claims adjustment rate (Fig. 1). Claims cost by type of service, that is, outpatient and inpatient, was also analyzed. According to Wipf and Garand [3], these indicators provide more insight about the value of the benefits and quality of service being offered to the insured and health services providers as explained in the conceptual framework below.

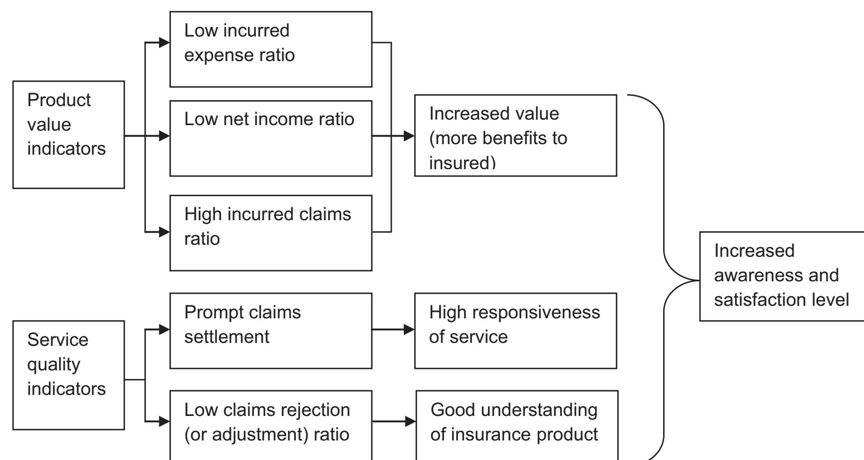

Fig. 1 – Conceptual framework for assessing health insurance value and service quality. Source: Adapted from Wipf and Garand [3].

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