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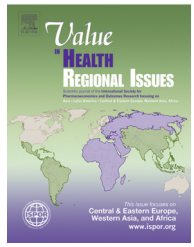

Performance Assessment of the Juaboso District Office of the National Health Insurance Authority

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ABSTRACT

Objectives: To assess the performance of the National Health Insurance Authority (NHIA) in Ghana. **Methods:** Using a thorough case study of the Juaboso District Office of the NHIA, this study assessed the community coverage rate, the annual expenditure and income, and the trend of claims payment for the period 2009 to 2012 as well as factors influencing the level of patronage of the National Health Insurance Scheme. A self-administered structured questionnaire was used to gather data from the management of the scheme. Secondary data were also gathered from the scheme's audited financial statements. Informal discussions were held with the premium collectors and clients to throw more light on revenue generation challenges. **Results:** The study found an increasing trend in the coverage rate on a yearly basis. Over the study period, the rate moved from 30.6 to 60.1, representing an increase of 96.7%. This shows that in terms of coverage rate, the Juaboso District Office of the NHIA is performing very well. The study also found that revenue has increased but the percentage rate of increase has decreased, compared with the coverage percentage rate. Expenditure has been on the rise, increasing by as much as 20.7% in 2011. Again, the study revealed a consistent year-on-year increase in the claims payment, consistent with the national trend. **Conclusions:** Constant clinical auditing of claims payments is required to ensure accountability. This would lead to transparency with regard to performance assessment of the claims. The findings have important implications for the effective management of the NHIA.

Keywords: balance scorecard, claims settlements, financial performance, Ghana National Health Insurance Scheme, nonfinancial performance, performance, performance appraisal.

Introduction

Although the right to social security and health is well established in international law, access to effective and affordable health services is a rarity in most developing countries. According to the International Labour Organization [1], the problem is not only due to the poor health care services but also due to the inadequate quality of care and the high cost of obtaining these services. Since independence in 1957, health care financing in Ghana has gone through a number of significant changes over the years. Following the country's independence, Ghanaians had access to free health care. This policy was, however, not sustainable in light of the needs of other sectors of the economy, and the government had to find alternatives to this financing mechanism. The introduction of the "cash and carry" system decreased access to health care, particularly among the poor. The government, in an attempt to cushion the burden of out-of-pocket payment for health care, introduced an exemptions policy. The policy exempted children younger than 5 years, prenatal care for pregnant women, and health care services for the indigent, the elderly (those older than 70 years), and for disease-specific services. Nevertheless, implementation problems at the district level meant that a significant number of clients who qualified for exemptions continued to face barriers in accessing basic health care. In an attempt to increase access and improve the quality of basic health care services, the government of Ghana passed the National Health Insurance Act 650 in August 2003, establishing Ghana's National Health Insurance Scheme (NHIS). The NHIS was fueled partly by the relative success of the numerous mutual health organizations, which existed with very diverse management structures and benefit packages [2,3]. The objective of this scheme was to provide sustainable health financing to ensure accessible, affordable, and good-quality health care, especially for vulnerable and poor people [4] (Government of Ghana, 2004). To mobilize financial resources for the fund, the government of Ghana established the National Health Insurance Levy (NHIL) of

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2.5% on specific goods and services. In addition, 2.5% of the 17.5% social security contributions paid by formal sector employees is automatically transferred to support the NHIS, and formal sector employees and their dependents (younger than 18 years) will automatically be enrolled. The issue of concern that necessitated the present study is how the scheme is performing in terms of its coverage rate, financial prudence, and sustainability. These are issues that are relevant considering the present struggles the scheme has had with claims payments. The focus of this study was therefore to assess the performance of the scheme using the Juaboso District Office of the National Health Insurance Authority (NHIA) as a case study.

Literature Review

The World Health Organization [5] defines *health financing* as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (WHO 2000).

In recent years, the consensus has grown that prepayment health care financing, whereby people contribute regularly to the cost of health care through tax payments and/or health insurance contributions, provides greater financial protection to households than, and is, therefore, preferable to, out-of-pocket health care financing [6]. A study by Grosskopf et al. [7], however, found a weak positive correlation between performance and the relative reliance on public funding of the health care sector. Thus, even though the developed world usually shows signs of having better health, it does not necessarily imply that this is a result of reliance on a larger share of publicly funded health care.

In Ghana, the major sources of financing health care are government funds through taxation, health insurance, and out-of-pockets payments. Government funds are generally derived from taxes, including direct taxes, levied on personal and company income, and indirect taxes, such as value-added tax and customs duties. Government funds may also accrue from deficit financing, whereby domestic or international loans are secured to fund government activities in addition to those funded from general tax revenue alone [8]. Mandatory health insurance is an insurance system that the law requires certain population groups or the entire population to adhere to, in contrast to voluntary health insurance, which carries no such legal requirement [9]. A national health insurance is also a form of mandatory health insurance and covers the entire population [10]. These schemes may include social and/or community-based schemes. There is also voluntary insurance, sometimes referred to as private health insurance schemes, and these may include employer-based schemes and individually underwritten risks [11], and membership may be open to anyone who chooses to contribute [12]. Out-of-pocket payments are direct payments made by a patient to a health care provider; that is, funds are not channeled via any financing intermediary [6]. Out-of-pocket payments are also made to private providers by individuals not covered by any form of health insurance.

Assessing Financing Mechanisms

According to McIntyre [10], health care financing mechanisms are frequently judged on the basis of the extent to which they are feasible, equitable, efficient, and sustainable. These are also used to identify financing mechanisms that exemplify best practice. In assessing financing mechanisms, the element of feasibility raises critical questions: Are stakeholders likely to support or to oppose a given financing mechanism? Is there adequate administrative capacity (e.g., actuarial expertise and information systems) to ensure its successful implementation? There is a general agreement that individuals should contribute to health care funding according to their ability to pay and should benefit from health services according to their need for care [13]. A good health care financing system would help to reduce inequalities by enabling individuals to contribute according to their ability to pay. An efficient financing mechanism is one that generates a relatively large amount of funding and thus forestalls the need for multiple funding mechanisms, with each generating only a limited amount of funds. An important point is the extent to which a health care financing mechanism fosters both allocative efficiency (doing the right thing) and technical efficiency (doing it the right way) in the use of resources [14]. Sustainability is linked to the ability of a financing mechanism both to maintain its level of funding in the long-term and to expand its level of funding over time as the need for health care grows [13]. Sustainability implies ongoing long-term, purposeful planning for gradual increases in domestic funding for health services.

The framework reveals a relationship between revenue and expenditure and performance. Figure 1 displays the conceptual framework for the study adopted from prior study [15]. If revenue exceeds expenditure it will impact positively on performance. Again, the framework reveals a relationship between rate of claims settlement and renewal rate. Together, they impact on the total performance of the scheme and the health of the populace. If renewal rate is high, the health of the population generally improves. Because it is generally affordable, more people will be willing to patronize the service.

Methods

Study Design

A case study design was chosen to investigate the community coverage rate, identify factors influencing the level of patronage, assess the trend of its annual expenditure, and assess the trend of claims payment within the Juaboso District Office of the NHIA for the period 2009 to 2012, using a descriptive design. A descriptive design was used because it presents an opportunity to fuse both quantitative and qualitative data as a means to reconstruct the "what is" of a topic. We used a structured questionnaire (see Appendix 1 in Supplemental Materials found at http://dx.doi.org/10.1016/j.vhri.2016.06.002) to collect revenue and expenditure data from the District Manager, the Accountant, and the sampled district population. The instrument used was pretested at the Ejisu District Office of the NHIA. The questionnaire was administered, which, in turn, offered an opportunity to probe for detailed information through follow-up questions. Informal discussions were also held with the premium collectors and clients to throw more light on revenue generation challenges. The data on the claims payment and coverage rate were obtained from the scheme's register, audited financial statements, and the monthly reports submitted to the NHIA. Convenience sampling technique was used to sample the members within the scheme, whereas the District Manager and the Accountant were selected using purposive sampling technique. A letter of introduction explaining the purpose and importance of the study was sent to the head of the Juaboso District Office of the NHIA to seek approval to carry out the research. After an assessment of the risks and benefits of the study to the district, permission was granted to undertake the study. Statistical Package for Social Sciences (SPSS, Chicago, USA) and Microsoft Excel were the tools used for data analyses.