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## Performance Assessment of Ga District Mutual Health Insurance Scheme, Greater Accra Region, Ghana

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### ABSTRACT

**Objective:** This study assessed performance of the Ga District Mutual Health Insurance Scheme over the period 2007–2009. **Methods:** The desk review method was used to collect secondary data on membership coverage, revenue, expenditure, and claims settlement patterns of the scheme. A household survey was also conducted in the Madina Township by using a self-administered semi-structured questionnaire to determine community coverage of the scheme. **Results:** The study showed membership coverage of 21.8% and community coverage of 22.2%. The main reasons why respondents had not registered with the scheme are that contributions are high and it does not offer the services needed. Financially, the scheme depended largely on subsidies and reinsurance from the National Health Insurance Authority for 89.8% of its revenue. Approximately 92% of the total revenue was spent on medical claims, and 99% of provider claims were settled beyond the stipulated 4-week period. **Conclusions:** There is an increasing trend in medical claims expenditure and lengthy delay in

claims settlements, with most of them being paid beyond the mandatory 4-week period. Introduction of cost-containment measures including co-payment and capitation payment mechanism would be necessary to reduce the escalating cost of medical claims. Adherence to the 4-week stipulated period for payment of medical claims would be important to ensure that health care providers are financially resourced to deliver continuous health services to insured members. Furthermore, resourcing the scheme would be useful for speedy vetting of claims and also, community education on the National Health Insurance Scheme to improve membership coverage and revenue from the informal sector.

**Keywords:** claims settlements, Ghana, membership coverage, National Health Insurance Scheme.

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### Introduction

Many low- and middle-income countries are challenged with how to finance their health care systems to achieve universal coverage of health services. In 2005, the member states of the World Health Organization adopted a resolution encouraging countries to develop health financing systems aimed at providing universal coverage [1]. This was defined as securing access for all to appropriate promotive, preventive, curative, and rehabilitative services at an affordable cost.

In the 1990s, a number of mutual health organizations were established in Ghana, with funding and technical support from external partners. Most of these mutual health organizations, however, primarily focused on providing financial protection against the potentially catastrophic costs of a limited range of inpatient services for the disadvantaged people in society [2]. The National Health Insurance Scheme (NHIS) was introduced in 2004 to build on these organizations and provide comprehensive health services to all citizens in Ghana [3].

The National Health Insurance Act, Act 650, was passed into law in Ghana in 2003 through the Legislative Instrument (LI 1809),

though implementation in terms of access to benefits began in November 2005 [3–5]. Its policy objective is that “within the next five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at point of service use in order to obtain access to a defined package of acceptable quality health services” [6]. The NHIS was designed as a mandatory health insurance system, with risk pooling across district schemes, funded from members’ contributions and a levy on the value-added tax charged on selected goods and services [3–6].

As a key social sector initiative to support the Ghana Poverty Reduction Strategy II policy objective of ensuring sustainable financial arrangements that protect the poor, the NHIS’s performance and long-term sustainability are significant. The performance assessment of the scheme is also key to Ghana’s attainment of the Millennium Development Goals 1, 3, 4, and 5.

Since its full implementation in 2005, the NHIS has been facing major structural and administrative challenges, including significant delays in issuing membership cards; lack of a uniform contribution system across schemes, which has implications for portability and equity within the national scheme; and

Conflicts of interest: The authors have indicated that they have no conflicts of interest with regard to the content of this article.

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2212-1099/\$36.00 – see front matter Copyright © 2013, International Society for Pharmacoeconomics and Outcomes Research (ISPOR).

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<http://dx.doi.org/10.1016/j.vhri.2013.06.005>

considerable delays in provider claims reimbursement [3,7,8]. An independent health sector review report shows that at the end of 2008, the health facilities had outstanding claims worth GH¢49 million [7]. A number of initiatives and activities by researchers and development partners aimed at tackling performance challenges facing the District Mutual Health Insurance Schemes (DMHISs) have taken place. Most of these research and initiatives, however, focused on inventories of DMHISs and access, utilization, and quality of care and were largely uncoordinated. Moreover, key findings and associated recommendations were left unimplemented [9]. Therefore, little is known about performance elements of membership coverage, revenue mobilization, expenditure, and medical claims settlements of the DMHISs. The study aimed at filling this gap by providing performance assessment of Ga DMHIS.

According to the 2010 NHIS Annual Report, there are 145 DMHISs nationwide, with 10 in the Greater Accra region [10]. The Ga DMHIS is the biggest DMHIS in the Greater Accra region in terms of catchment area. The Ga district has a large number of suburban and rural communities, making it suitable for this study. Madina is the largest cosmopolitan settlement in the district, which also made it appropriate for the household survey. This article reports performance assessment of the scheme for the 2007-2009 period and recommendations for improving its operations.

### Conceptual Framework

The conceptual framework for the study was adopted from the World Health Organization proposed framework for health systems performance assessment and modified to reflect the International Labour Organization's core performance indicators for assessing social health insurance schemes [11,12]. According to the framework, high membership coverage, high revenue base, low expenditure, and prompt settlement of provider claims enhance performance ratios such as coverage rate, renewal rate, expense ratio, and claims ratio, which, in turn, results in high performance and an improved health status of the target population (Fig. 1).

## Methods

### Study Area

The study was conducted at Ga DMHIS and Madina Township, all in the Ga district of the Greater Accra region. The Ga DMHIS has a staff strength of nine and 74 contracted health care providers. The Ga district lies in the northern part of the Greater Accra region and is bounded in the north by Akuapim South district, in the east by Tema Municipal, and in the south by Accra Metropolitan. It has three subdistricts, namely, Ga South, Ga East, and Ga West, with 594 communities comprising mixed settlements: urban, periurban, and rural areas. The district has an estimated population of 891,609 and a growth rate of 4.4%. There are 58 health facilities in the district comprising public, private, and Christian Health Association of Ghana facilities. The main economic activities in the district are public service, trading, farming, and craftsmanship.

### Study Design

The study was a cross-sectional survey of households and a retrospective analysis of membership, revenue, and expenditure records of the Ga DMHIS for the period 2007-2009. The study population consisted of membership data of Ga DMHIS and selected heads of surveyed households in the Madina Township.

## Data Collection Method

### Desk review

Documents on membership, operational reports, audited reports, financial statements, and claims payment books of the scheme were reviewed. The registration files were reviewed in terms of the number of people registered, number of membership cards issued, and number of renewals for each year under review. The audited accounts for 2007-2008 and unaudited accounts for 2009 were examined for total contribution collected, subsidies received from the National Health Insurance Authority (NHIA), donor support, and other internally generated funds. Information on administrative expenditure and medical bills was also collected. The claims submission registers and claims payments for 2009 were reviewed to determine the number of days between submission of claims and reimbursement.

### Face-to-face interview

A community household survey was conducted in the Madina Township to determine the community coverage rate. A multi-stage sampling method was used to select the study subjects. In all, 376 household heads were sampled on the basis of an estimated prevalence rate of 43% membership coverage, a confidence level of 95%, and 5% margin of error. The questionnaire covered background characteristics and membership in the NHIS. The household membership section looked at knowledge on the NHIS, membership status, and reasons for not enrolling into the scheme.

### Data Analysis

The performance indicators for the study were analyzed as follows.

#### Coverage rate

Membership files for the period 2007-2009 were reviewed to determine the total number of valid card-bearing members in each year. The coverage rate was determined by dividing the total number of valid card-bearing members in each year by the estimated district population in the same year.

#### Community coverage rate

This was estimated by dividing the total number of participants with valid membership cards as of March 2010 by the total number of participants interviewed.

#### Annual revenue

This was estimated by adding the total amount of money collected from contributors, received from the NHIA and other donor agencies, and investment returns in each year of the period under review (2007-2009).

#### Annual expenditure

This was estimated by adding administrative expenses and medical claims expenses in each year of the period 2007-2009. The administrative expenses comprised salaries, membership cards' processing cost, and other operational costs, while the medical claims expenses constituted payment of outpatient, inpatient, specialized medical services and essential medicines in the NHIS minimum benefit package.

#### Expense ratio

This was estimated by dividing the total administrative expenses incurred in each year by the total amount of contributions collected in the same year for the period 2007-2009.

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