KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HUMANITIES AND SOCIAL SCIENCE

SCHOOL OF BUSINESS

DELAYS IN CLAIMS PAYMENT TO CREDENTIALED HEALTHCARE PROVIDERS; THE FINANCIAL IMPLICATION ON NATIONAL HEALTH INSURANCE SCHEME OF GHANA

By

Naomi Derkyi-Mante (PG 7258119)

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DECLARATION

I hereby declare that this submission is my own work towards the award of the MSc. Accounting and Finance and that, to the best of my knowledge, it contains no material previously by another person or any 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.

Candidate:		18/12/20
Naomi Derkyi-Mante	.....	….....
(PG 7258119)	Signature	Date

Certified by

Mrs. Akua Peprah-Yeboah	.....…….....	….....
(Supervisor)	Signature	Date

Certified by:

Dr. Daniel Domeher	…….	…… ……
(Head of Department)	Signature	Date

DEDICATION

This dissertation is dedicated to my adorable Husband, Acheampong Frempong and my beloved Sisters, Lydia Adoma Mante and Abigail Adwoa Mante for their immense support in the course of the study

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ABSTRACT

The issue of Delays in Claims payment to credentialed healthcare providers by the National Health Insurance Authority since inception has always been a major concern. Healthcare providers have time on ends claimed that the delays affect their financial schedules and often have threatened opting out. The larger scope that however precipitated this study was how this delays in payments is financially implicating on all the 3 major stakeholders; the regulator, the policyholder and the credentialed healthcare provider. Descriptive Research design was employed and both primary data in the form of questionnaires and secondary data from the NHIA featured. It was found that policyholders suffer financially through out of pocket payment at point of service, credentialed healthcare providers receives payment 'twice' for services rendered by charging members at their facilities and then submitting claims on these same members to NHIA for payment This implied that the provider shortchange the Regulator financially. There is the need to critically assess the recommendations outlined in the study to ameliorate the financial implication the study has underscored.

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

The National Health Insurance Scheme of Ghana (NHIS) was established by Act 650 in 2003 and amended by act 852 in 2012 (NHIA Annual Report-2014) with the clear objective to provide protection against financial risk for all people resident in the country for primary health care. It is a social health insurance policy aimed at the vulnerable and serves a pro-poor agenda. According to the NHIA the coverage level in terms of membership as December 2019 was at a little over 11 million indicating the huge number of people that enrolled unto the programme. Over 5000 heath care facilities are credentialed to take care of these members and that the NHIS purchases the services of these providers for their numerous members. According to the NHIA, claims on paid monthly bases are about 90 million Ghana Cedis (NHIA Annual Report-2015) .A huge portion of the Ministry of Health budgetary allocation.

The National Health Insurance Schemes is funded by 2.5 percentage points of the National Health Insurance Levy enacted in 2004 as Value Added Tax and 2.5 percentage points of Social Security and National Insurance Trust (SSNIT). Informal sector also contribute directly through payment of premium, which ranges from 7.8 Ghana Cedis to 48 Ghana Cedis depending on one's economic status. However there has been the raised issue of delay on the part of The NHIA in meeting their obligation of timely payment to providers. This has in most cases led to banter between the service providers and the NHIA. To an extent that providers have often times threatened to send NHIS members away or charge them at the point of service as existed in the cash and carry system.

The Health Insurance Providers Association (HISPA) as well as the Christian Health Providers Association of Ghana (CHAG) has been very loud about the delay in payment (Daily Graphic, June, 2019). The CHAG for instance claimed that since March 2019 up to February 2020 they had not been paid and that the NHIS owes them about 87million Ghana Cedis (Ghana Medical Association, 2019 Annual Review). The HISPA and other related bodies too have time past and recent made such demands. Again, the Ghana Medical Association of Ghana also in a statement released on the February 21, 2020 and signed by its president called on the NHIA to as a matter of urgency pay all the monies owed them or they will resort to cash and carry system.

The bases of all these is the underlying assumption that this trajectory of delays truncate financial capabilities of these credentialed health providers as it cripples their financial commitments and impoverish their ability to meet very pressing expenditures; monthly salary of staff, overhead cost, purchase of consumables and maintenance cost amongst others.

Moreover the real value of money depletes as the due date for payments prolongs and hence the contention is that they are deprived of the actual financial satisfaction from the delayed payments amidst inflation and unstable state of the legal tender.

This implies a worrisome trend due to the huge constituency of the members of the NHIS (over 11 million) and corresponding colossal expenditure they incur at these health facilities through utilization of health care. Such delays precipitate torrid financial deficiencies in the value chain of the operations of the health care facilities.

A typified alibi is highlighted by a World Health Organization report on Kenya (2005), stipulating that though their National Health Insurance covers only about 5% of the disease conditions, the delays in payment by the authority has affected greatly the financial standings of the health care providers as well as membership of the scheme whose household budgets are

considerably decapitated as a result of the out of pockets payments they are forced to make at the point of service (2008). Critical deduction from the WHO report on Kenya, hazards a conundrum where providers and members alike face dire financial consequences, even in this very diminutive 5% coverage of diseases cases where adjoining claims payment may sound insignificant, in terms of calibration of income which if not met is likely to prove fatal to the existence of an institution.

Such findings about Kenya and the likes, coupled with the consistent and incessant protest by the health care providers on delay of payment of claims by the NHIA and also the continuously defensive posturing of the NHIA has had the ultimate end product of intersection of disagreement between the two outstanding stakeholders in the National Health Insurance Scheme which covers about 95% of diseases in Ghana.

This therefore has necessitated an epoch of comprehensive study for retrospection and rumination on the financial implication, such delays have had and persistently consequent on all the major stakeholders of the NHIS.

1.2 PROBLEM STATEMENT

The financial standings of an institution is very paramount as it determines its value chain and ensure enactment of greater perspicacity in terms of the delivery of their kind of product. Again, it is very important that the source of purchase of that product that results in the Institution's financial replenishment is also protected and not short chained in such a financial transaction. Finally the beneficially of such a purchase should not be made to exert extra pressure on his source of financing as a results of the inaction of one of the pillars in such a triploid relationship's transaction. This is reflective of the performance of the three pillars of the NHIS.

The National Health Insurance Authority is obliged by law to reimburse its credentialed health care providers for the services it purchases for the members of the scheme. This financial obligation is tailored by law (Act 560) as amended (Act 852) for execution on tri - monthly bases post submission by the service provider. However the providers have time on end complained that the NHIA always delay in reimbursing them for the services provided. This affect their financial standings and weakens their capacity to meet very important monthly and recurrent expenditures which are central to their survival, since about 90% to 95% of their revenue, flows from the services they provide to the members of the NHIS. The ripples effects, affect members directly as providers because of such delays turn to demand money from members at the point of service. This invariably destabilizes and disturbs the financial equilibrium of such members who mostly are those within the poverty enclave. The NHIS as the insurer also faces repercussions from the delays in payment emerging from its end as the providers still submits bills to the Authority for reimbursement for same members in spite of demanding money at point of service. It therefore amounts to double billing affecting the finances of the NHIS and the members.

However, there is no any know study in this direction that establishes knowledge about the subject matter which comprehensively bring to fore the dynamics that entangles the three major stakeholders of the National Health Insurance scheme.

The study therefore underscored it, explicitly needful and implicitly interrogative to gauge the financial insinuation, such delays in payment of claims by the NHIS has on the Accredited Health Care Providers, the member who has subscribed and therefore to assess care without any further financial commitment as well as the NHIS that provides the payment. This Study

extensively sought to bring into focus the real financial relations, correlations and undertones that are incidental and more so factual to the problem of delays in claims payment.

The findings of this study is invaluably significant in reviewing the frequency of flow of payments in the value chain of the National Health Insurance Scheme of Ghana

1.3 RESEARCH OBJECTIVES

1.3.1 General objective;

The main objective, was to find out the financial implication of the delay in payments of claims to health care providers have, on the National Health Insurance Scheme of Ghana.

1.3.2. Specific Objectives

The specific objectives was:

1. To interrogate the implications of delayed claims payments for hospital patients on NHIS
2. To assess the challenges faced by NHIS accredited healthcare providers due to delayed claims payments
3. To interrogate the adverse effects of delayed payment on the National Health Insurance as a pro-poor scheme.

1.4 RESEARCH QUESTIONS

Based on the research objectives, the study seeks to find out outcomes of the following questions:

1. What are the implication of delayed claims payment on NHIS members
2. What are the challenges face by NHIS accredited healthcare provider as a result of delayed claims payment

3. What are the adverse effect of delayed claims payment on National Health Insurance as a pro-poor scheme

1.5 SIGNIFICANCE OF THE STUDY

There are a lot of controversies arising out of the inability of the NHIA to pay claims in line with the dictates of the law, which prescribes a 60-day for processing and payment of claims. This epitomizes a deviation from a lawful responsibility culminating in service providers complaining of insufficient funds to shove up their operation and other cost.

There was also the issue that health care providers, as a result of the delay in payment demand money from insured members of the scheme at point of service and again bill the NHIS same for reimbursement. This presumes double billing and has negative effect financially on both the scheme and the member. However there had not been any known study in this direction to establish the veracity of the myriad of issue raised and this study sought to fill that vacuum.

Moreover, findings from the study have engendered enough grounds for policy direction. This may include stringent primitive measures as well as prudent financial engineering to provide an efficient finance regime for the National Health Insurance Scheme.

1.6 SCOPE OF THE STUDY

The study was carried on in the Manhyia Sub-Metropolitan area and Claims Processing Centre of the National Health Insurance Scheme within the Kumasi Metropolis.

1.7 ORGANISATION OF THE STUDY

The study was organised in five (5) Chapters; Chapter one introduced the study whiles chapter two (2) took care of the literature review. Chapter three (3) is on the Research Methodology whilst Chapter (4) presented the results and discussion section of the study. Chapter five (5) finally summarised the findings and concluded the study with recommendation

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focus on review of relevant literature that correlates to the objectives of the study. It is thematically on the perspective of the three major stakeholders who form the epic of the study. It thoroughly individualized the literature on each on each stakeholder in relation the inquest that the study sought and concluded with what that critique implied to the study.

2.2 HEALTH CARE FINANCING STRATEGY (ILO 2006- 2010)

The rudiments of the HCF are incumbent on Social Health Insurance policy implementers to focus on the following:

- Ensure stable level of revenue over medium to long term,
- Financial sustainability of priority programmes of health,
- Removal of financial barriers to seeking health,
- Reduction in out or pocket funding for health and,
- Efficiency and effectiveness in resource allocation and use of health service of an acceptable quality.

These rudiments are very significant in terms of financial engineering amongst the stakeholders of a Social Health Insurance;

The need for the policy holder to be absolved from out of pocket payments at point of service, also per the rudiments health care providers are to be assured stable levels of revenue and finally, the policy maker need to have financial resources efficiently and effectively administered.

The roll out of any social health insurance scheme need to imbibe these concepts of the HCF so that in terms of finances, none of the stakeholders are put at a disadvantage that might derail the entire health programme.

2.3 GOVERNMENTS AND POLICY MAKERS' PERSPECTIVE - FINANCIAL INGESTION

According to the World Bank (2005), Social Health Insurers Schemes are challenged by growing health expenditure. These Social Health Insurance Schemes have higher expenditures in higher income countries. Per the World Bank report, in Hungary since the inception of the Health Insurance Fund, Social Health Insurance expenditure has exceeded both the expected and actual revenue. The resulting deficit as at 2003 amounted to 1.6 of Gross Domestic Product - GDP (World Bank 2005). Such repeated occurrence of high expenditure delays reimbursement and directly or indirectly affect the triploid variables in the social insurance setup.

The World Bank reports makes a case where governments need to step in, to Tax finance the deficit to enable the value chain flow of the required financial equation of such nature. Such unexpected truncation of the normal trends of the finance ingestion that then enables the characters function to the fullest, leads to the phenomenon of delays in release of monies to finance such packages.

This Hungarian situation as the World Bank grosses over, depicts the manifest problem of financial insufficiency but renege on the latent yet critical outcomes, these delays in acquisition

of funds and subsequent delays in payments to health care providers entails. Governments, policy makers and researchers mostly focus on rising cost of health insurance financing and fails to appreciate the fact that there may be innate cost that hides and aggravate ever increasing cost of financing the social health insurance scheme.

To corroborate globally, the much interest policy makers repose in making up for revenue short falls, when trying to fill funding gaps created by excruciating incremental cost is exemplified in the study on the Global Financing Facility by the World Bank Group (2005). It looked at how social health insurance manages administer funds that accrue to the insurance scheme either through contributions from beneficiaries or the government through tax financing and other financial ingestion interventions.

The World Bank establishes very interesting findings which is pivotal on conscious efforts government and policy makers make to finance any gap that impede financial flow in the financial value chain in the Social Health Insurance. It establishes that in several OECD countries government finances a large portion of the social insurance revenue; this includes Japan, China, Belgium and Finland. The research again brings into focus that in Eastern Europe employees and employers contribution are the main source of insurance revenue.

OECD (2017) report further widens up on this horizon with critical emphasis on levies that are imposed on and derived through payroll taxes paid by employers and employees alike and also that on the self-employed.

The underpinning principle is to make sure that the scheme remains financially sound and viable. The reports rehash deliberations on how governments seek to reduce financial burden on the policy holders by engineering to absorb some percentage points of the policy holder's contribution.

Per the OECD 2017 report, some countries have eased pressure on labour cost by reducing payroll tax and increasing government funding to social health insurance. It cites `Germany as having reduced social insurance payroll tax from 15.4% to 14.9%. These systems of ensuring financial viability of a public health insurance scheme are prevalent in the National Health Scheme of Ghana. Though in the Ghanaian context the government does so trough the National Health Insurance levy established by Act 650 and as amended by 852 (NHIA).

According to the National Health Insurance Authority (NHIA, 2006), the individual's direct contribution in terms of payments of premium is less than 1% compendium of payments made annually in respect of health providers claims, however this is made up for, by the 2.5 percentage points levy on the Value Added Tax with the corresponding 2.5 percentage points on Social Security and National Insurance Trust (SSNIT). This reminiscent or resonates, though on unequal bases amongst all social health insurance worldwide.

The OECD (2007) report indicates weak systems to manage cost as incentive to aggravate the ever-willing policy makers' zeal to finance escalating cost of health care, which mostly shrouds in leveraging the maintenance of funds for Social Health Insurance Programmes.

In the classical case of Peru and Vietnam, which the reports relates extensively, are the clear modules of the high expenditures government makes through their agents for the health sector. Peru for instance, experience escalating expenditures in engaging open ended fee for service system of payments, to providers of social health insurance system. This per the OECD report (2007) leads to cost escalations as there is no cap to control government expenditure.

Vietnam, according to the report also has issues with providers though they have fee for service system of payment with a cap of not spending beyond a certain point. The Health Insurance purchaser in Vietnam; Vietnam Social Security reimburse Hospital or providers through capped fee for service that underscore the global budget. Yet there are incentives by these

facilities to spend beyond the cap since the policy maker is ever prepared to finance 60% of the budget overruns of the providers. Interestingly, with this system, overspending results in higher caps and anticipate and implement much more generous budgets (OECD 2007).

These situations imply and connect to the effect of policy makers bent on ensuring the sustenance of social insurance systems. But paying not so much attention to the extreme ends of the value chain of financing flow of such public health insurance system.

The persistent payments of overrun in the Vietnam case means that there is a slow pace in reimbursing the services purchased from providers by the Vietnam Social security.

Financing the overruns in both the Peru and Vietnam case exemplifies a certain value shift that inure to sustainability of such pro poor policies but virtually truncates the realism of financial short-changing that are innate but embedded in such transactions.

Very interesting and thorny figures are churned out in this report, (OECD 2007) on Vietnam and Peru, which portends to incremental cost that accrue to implementation of social health insurance policies.

In trying to meet the millennium development Goals of universal health coverage for all, very aggressive policies that require extensive financial ingestion become inevitable to policy makers. Monitoring the ripples of such expenditures seem not to be paramount and becomes deeply relegated to the background. There is been concerted effort by countries to increase revenue for health financing in most lower and middle income countries (Cichon et al, 2004).

In 2012, per the OECD2007 report, Peru allocated just about 9% of the country's budget on health care financing, having recorded 4.8 GDP on total health expenditure in 2011.

In the case of Vietnam, the reports indicates that the country's share of health financing or budget commitment was raised from 6.3 percent in total government budget in 2002 to 9.4 in 2011 and 2.7 percent of Gross Domestic Product.

It is very interesting to note, as stipulated in the findings that Vietnam's health budgets grows faster than the national economic growth. It simply entrenches on the expenditure ratios in terms of government commitments to financing health care This in most cases is potent within public expenditure on national or social health insurance policies.

Germany, which is much touted for major breakthrough as an epic of exemplar or paradigm shift in achieving very sustainable social health insurance has it share of this astronomical budgetary allocation to sustaining the policy. The German experience of Public Health Insurance and its achievements which is analysed therein projects a certain magnified commitment to ensuring that people have access to unimpeded healthcare and thence universal health coverage.

According to (Busse 2014)) the German Social Health Insurance is financed through shared contribution by the policyholders and the government in which the policy is more concerned with the contributory rate rather than SHI as percentage to GDP. Moreover it does not concentrate solely on the total high expenditure, financing Social Heath Insurance accrues to the state. It attaches very important attention on the contribution, policyholders make towards the substance of the SHI.

These figures as churned out by (Busse, 2014) makes very important observation; the German system is financed through the sickness fund which is financed through contribution from policy holders. The reports indicates that contribution through income levels was as high with an upper threshold of €3750 per month in 2010, which was reduced in 2011 to €3712.50 as a result of the financial crisis. However in 2014, the threshold was again raised to €4050

(Bundesministerium für Gesundheit, 2014).

These figures as monthly contribution from policyholders means a lot in terms of payments from income as ascribed by the law establishing the SHI and it is mandatory and obligatory.

And per the report OCED 2007 these figures vary on monthly bases, based on fluctuation in income levels. It becomes therefore very impertinent to review social health insurance taking into considerations nuances of all possible leakages within the value chain of financial commitments specific or central to all key actors.

According to (Busse et al, 2014) between 2001 and 2003 the sickness fund which is the contributory portion by the policyholders encountered a deficit of approximation of €3 billion per year. The policyholders were therefore forced to raise additional funds since the law prohibits sickness fund to incur long-term debt. Such funds affect contributor's income and earnings and therefore it is very inconsistent and incoherent with the principle of prudent financial management that allows no room for short change on any of the variables within the equation.

Retrospection reflects a German situation, where a combination of government's financial ingestion and individual and or group of policyholders contribution smacks a very prudent and viable financially sustainable health insurance scheme.

However introspection wise, there is not inadequate study on whether these financial ingestions from the contributory duo amongst the triploid stakeholders - the insurer and the policyholder - are properly financially engineered. As credit base scheme, there is no evidence adduced to the effect, delay in claims payment may have on the actual value chain of the financial channel within.

According to Busse et al (2013) health expenditures have been rising with Germany having very substantial amount of its wealth spent on heath expenditure with whooping €300.4 billion spent in 2012.

Busse et al (2012) indicates again that Netherlands and France have higher health expenditure per GDP with 12% and 16% respectively.

Moldova expenditure to GDP is 11.4% as at 2012 and that of Denmark 11.2%.

Busse etal puts the average heath expenditure to GDP in the first established EU 15 States to 10.3% and the New EU member states to 6.9%. This paint a picture of how levels of health expenditure to GDP across European countries is escalating making health delivery a very expensive venture for the states and the other stakeholders.

Germany as an advanced country and countries like The Netherlands and France, which form part of the European Union, may not be sandwiched between the difficulties of generation of revenue to augment whatever financial deficiencies might exist in terms of individual contribution toward a contributory system of health insurance policy.

However it is meritorious for studies to be done in global space to ascertain the effect such delays in claims payment have on the financial perspicuity of the variables involved.

2.4 POLICY HOLDERS OR MEMBERS PERSPECTIVES -FINANCIAL CHALLENGES

A study of low and middle income countries (LMIC) by Armab et al (2013) on catastrophic expenditure as a result of out of pocket payments at the point of health care delivery is very

relevant in determining how financial commitment other than prescribed by law and fully satisfied by the policy holder may affect them (policy holder) .

According to Armab etal a study of 59 LMICs countries finds out that lack of health insurance is amongst the main factors that engender health expenditure levels that raises the issue of catastrophic expenditure to such households.

Xu (2003) was of the view that nearly 40% of all household expenditure of LMIC goes into health and therefore makes it catastrophic in nature and thereby recommended a form of health insurance to cushion them. This shows that any expenditure that is made apart from the one established by law, which may have some mitigation effect as in the National health insurance scheme of Ghana, is catastrophic in nature. This is detrimental to policyholder who is forced to make such payments at point of service.

Garg (2009) studies on India as LIMCs country came with the findings that 3.5% poverty rate of India is attributable to high level of health expenditure relative to expenditure on household or individual families.

Robert Townsend in 1994 made a very important injection with a study in India that is relevant in terms of how health crisis affects finance of households and families. According to Townsend (1994) his seminal empirical work showed that health crisis induced total and non-health consumption, hence derailing “consumption smooth” in the house holds.

This report substantiate that health crisis induce expenditure on health care and may also induce declines in households incomes.

It presents a situation where out of pockets payments by members of a pro poor programme which is situate within the National Health Insurance Scheme of Ghana can be destabilized from the financial equilibrium state.

It is imperative to draw the links between delays in payments of claims by the NHIA to its credentialed providers as a form of health crisis that has the potentials of affecting individual and the households who are members of the scheme.

Health crisis situation causing problem with distortions in "consumption smooth" situation have been exemplified in findings by Gertler (2002), Deaton (1997) and Cohen (2003) where it is found amongst all these reports that developing countries that are classified amongst LMIC have not escaped these situation.

Cohen (2003) furthers states that "Even a minor health shock can cause a major impact on poor persons' ability to work and curtail their earning capacity and given the strong link between health and income at low income levels, a health shock usually affects poor the most".

This is very important as it epitomizes the damming effect health crisis may have on the vulnerable who are mostly the target in designing social insurance health policies. For a scheme like NHIS in Ghana delay in payments sparks banters amongst providers and the insurer, which distorts the free flow of health care delivery under the scheme.

However paradoxically, the tincture to this banter is for the policyholder to fund again his already funded cost of health care at the point of service. It defeats the essence of risk pooling as it deviates from the principles of financial health risk protection into an arena of cash and carry.

This can best be described as the dilemma of the policyholder left with no solution than to commit extra funds from the already exhausted meager budget.

2.5 HEALTHCARE PROVIDERS PERSPECTIVE - FINANCIAL CHALLENGES

The health care provider who completes the three pillars of any social insurance policy also faces the syndrome of the disturbing canker of not having "consumption smooth" as the delay in claims becomes incumbent on them to distort their financial arrangements. This is a big challenge as the health care providers turn to agitate to receive the legitimate payments due them for the cost they incur as a result of services purchased by the insurer for the insured.

It is very pertinent to note that in most cases of government or policyholders trying to contain cost or realigning the existing financial arrangements, the healthcare provider suffers and this is further aggravated through delays in payments.

According to Tanner (2008) the French healthcare system which is much acclaimed as one of high quality has inherent challenges that affects the key stakeholders of the National health insurance.

To Tanner (2008), the challenges with the system become burdensome on the health provider, whiles the policyholder continues to enjoy the services. This clearly manifests in the situation where policyholders decides to go shopping by not observing the gatekeeper system.

The French system per Tanner (2005) permits providers to charge more than their reimbursement system. However when the cost of health care goes up as a result of provider shopping "nomadisme medical"- then government's response was to attempt to limit physicians (providers) reimbursement.

This is detrimental in finance terms, as the revenue that is made available is shortchange to the disadvantage of the health care provider. Yet there is not known study on the inherent cost that accrue as result of providers varying their reimbursements schedules and also what innate or intrinsic cost accrue to providers when the "nomadisme medical" is prevalent, warranting

government to limiting reimbursement.

The outcome of these limiting of reimbursement resonates directly with the consequential underscores of the National health insurance of Ghana due to a similar measures but on a diffident tangent.

Tanner (2008) emphases on physicians or providers in the well drilled French system resorting to strikes and protest as result of limiting of claims which affects their finances.

The Ghanaian context, have providers turning away policyholders or treating them as uninsured patients due to delays in reimbursements which detriments them financially, due to future value of money systems in financial administration.

In the Italian health insurance system (Tanner 2008) makes a case for the provider who suffers in the government's decision, to reduce reimbursement rate as result of trying to control and contain increasing cost. The challenges the French health system encounters is almost similar here as the financial constraints on the budget for health sector of Italy require cost containment and the option available is to reduce reimbursement rate to the detriment of health care providers.

The accompanying difficulties instigate an extreme reaction from health care providers in the Italian health insurance system who then resort to strikes and other protest mechanism. These rising cost of health care reminiscent in the Italian and the French set up are not facade by governments to avoid or reduce payments of what is due providers but the budget constraint makes room for it.

Per Tanner (2008), though Italian health expenditure to GDP is low, there is consistent and rapid rising cost in health expenditures which consistently exceeded government forecast. This has required the government to take some measures. According to Tanner between 1995 and

2003 there was excruciating rise in health care expenditure by 68% and the measure taken to try and arrest the situation leads to the health care provider losing some substantial amount of revenue through the government policy of reduction in reimbursement.

The bottom line is that the health care provider in this circumstances is made to bite the hard financial nut by been eluded the right to have sustained financial ingestion for the product purchased by the insurer.

Introspectively, there is the need to assess further, what happens in terms of cost to the healthcare provider as the reimbursement is reduced.

Such is the challenge the health provider faces in the performance of its responsibility as the third leg of a social health insurance (SHI)

2.6 SUMMING THE PERSPECTIVES – CHALLENGES

The situation in Ghana is more situated in delay in reimbursement and hence vary in terms of expression, but the connotation and principles are not different as there is a cost incidental to the performance of the duties in both jurisdiction should there be a negative shift in reimbursement and or a delay in payments respectively.

In the Kenya's experience (World Bank, 2005) the percentage covered by social health insurance is almost negligible and yet the accredited health care providers significantly feel the effect of delays in reimbursement. This raises the very probing tendencies that should engulf all the major stakeholder in the scheme.

There is important correlation that resonates through public health insurance policies word wide in terms of some forms of defects in financial engineering, which affects all levels of

stakeholders.

However what the OCED (2007) coupled with the World Bank (2005) reports and other literature reviewed fails to explore is the feature of untimely or delay payments of claims; as most social insurance policies are credit based in nature.

As a credit based system there is always anticipated phenomenon where there would be some form of indebtedness of some kind by the purchaser and in the Ghanaian contest the National Health Insurance Authority.

It implies that there will always be one of the stakeholders very expectant of when to be paid. This expectancy is not qualitative but quantitative since it borders explicitly on the disbursement of funds to compensate for services purchased. The provider of the health services to the insured member needs to get the reimbursement in time to stay in business.

Delay in this venture is financially disingenuous and reduces the propensity of the provider to harness fully any required financial commitments.

Such trend is worrying in financial managements as it reduces the fiscal space available to the health provider as was revealed by Tanner (2008) that limits in reimbursements causes financial loss or shortages and creates agitation within the heath sector.

The OCED (2007) reports links very correlational to that of the World Banks (2005) in measures policy makers undertake to ameliorate challenges policy holders goes through in terms of financial contriving.

However it leaves a vacuum as to what financial impression is visited on the stakeholders in the insurance scheme due to untimely payments of claims.

On the global scope, the world is fascinated by a success of the implementation of social health insurance policies as the conduit to mitigate the effect of poverty and other financial risks as a

result of inequality and uneven distribution of resources. The exigencies of these have either voluntarily or legislatively sway policy makers from estimating comprehensively, the entire cost of implementation of such policies.

When any peripheral of the three components of the policy suffers financially other than what the law stipulates there is the need to establish the ensuing repercussion on the other stakeholders on the financial value chain specific to the industry.

2.7 CONCEPTUAL FRAMEWORK – ITEMISED INDIVIDUALLY THE THREE STAKEHOLDERS (FINANCIAL IMPLICATION)

The National Health Insurance Scheme of Ghana since its inception in 2004 has had varied trend in claims payments with underlying feature of delays in payments of claims to health care providers. There has been backlash where the health care providers have time on ends threatened to opt out of the scheme. The remedial antidote predictable as it is has always premised government quickly releasing funds for payments to stem the tide.

This phenomenon of delay in payments of claims to provider's presents a surface case of the health care providers been denied the real value of service purchased by the National Health Insurance Authority and the member been made to most time employ the out of pocket payment at point of service, a concept that prevailed under then cash and carry system.

The National Health insurance Authority's report of monthly claim payments of approximately 90 million Ghana Cedis (Annual Report 2014) raise an adoption of a conceptual framework that inquest into a study to find out what financial outcomes these delays inhibit on the 3 major stakeholders of the NHIS.

This concept harnessed the financial obsession visited on the;

Healthcare provider as they wait for the released of the delayed payments which at times spanks over a year (Graphic online 22 November 2013).

The policy holders or members of the NHIS who as a result of the delay are denied the services legitimately bequeath to them by Act 650 (2004) and as amended 852 (2012).

The government or the policy maker who implements the policy and reimburses for the service provided.

This concept of looking beyond the veil of delay in payments and its subsequent remedy of payments is espoused to establish real financial implication either regression or appreciation the delays create.

From the various reports and research accessed and reviewed, there is not any, that directly employs the conceptual framework specific to this study in shaping policy makers direction towards this rather hiding but inherent cost that is contained in the policy (NHIS).

Almost all the literature reviewed concentrated on financial ingestion to sustain public health insurance policies without recourse to the focus of this study.

In a study by Andoh et al (2018) on provider payments mechanism in the NHIS, it looked at the then pilot of Capitation in the Asante region of Ghana, trying to prevent provider shopping which has the tendency to increase cost because a patient can access as many health post at a particular time.

In this payment system, the concepts of cost containments are skewed to protect the scheme from suffering financial manipulation but fail to explore other cost that are incidental to the policy.

The conceptual framework adopted by this study therefore took into consideration and highlighted most of the measures available to prevent financial manipulation in the interest of sustenance of the NHIS.

The study then itemized the three major stakeholders on individual pillars, and assessed the financial implication, delays in payments to health care providers have on each pillar.

Extrapolations from findings by the three pillars (major citadels) posited the outcome drawn by the study.

2.8 CONCLUSION

The various literatures reviewed, focus on the financial engineering needed to sustain Social Health Insurance worldwide yet there is no known research on the direction of this study hence very scanty, low or no literature that deals with the dictates of the study.

Thoroughly, there is correlation between the actual (classified and hiding, inclusive) costs and the costs (classified) known to the major stakeholders in any National Health Insurance Worldwide.

This study on the chosen perimeters, laying critical emphasis on the components conceptualised and referred to as the three major citadels is very significant.

Any financial variation that alters their normal conduct in financial terms is worthy of study and this study intensively satisfies and put a lot on the table for decision making in terms of prudent finance management of the National Health Insurance Scheme of Ghana and the world stage.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The methodology was premised on the requirement of the study to establish the financial implication on the stakeholders of the national health insurance scheme as a result of delay in payments of claims by the National health insurance Authority to credentialed health care providers.

There was therefore the need for the study to apply descriptive data design without intervening or manipulating the data. The study observed the variables in the process of analysis which gave the study the necessary research space to have thorough analysis of the data received.

The study applied quantitative data analytical tool by leveraging through with primary data collected and also the sourced secondary data in the analyses.

This processes and the various analytical tools that comprehend the entire methodology is further expatiated therein.

3.2 RESEARCH DESIGN

The study applied descriptive research design, quantitative as well as survey method analysis to obtain effective data. Since not much was known about the study, the choice of the design was appropriate to enable the study gather all fundamental and critical data that the study required. Moreover the tools therein are very feasible and capable to generalize the study results and draw conclusions.

According to Aina (2004), the survey methods is the commonest forms of research method used by Information experts and Liberians. It includes opinion gathering of respondent of a population or particular specific issue. He continued that the consent of opinion of respondents on a specific issue will make available solution to it.

Questionnaires were administered randomly amongst policyholders of the National Health Insurance Scheme and staff of National health Insurance Authority – Claims Processing Centre (CPC). It then purposively targeted specific healthcare providers in administering the rest to obtain the exact gen for the study. The secondary data was derived from the Regulator's outfit. Data from the NHIS as secondary source was subjected to critical trend analyses to comprehend the sequential payments made to providers, the period lapse between payments with extrapolations of trends of payments to verify the effects it has. Also the Health Care providers were all credentialed and therefore their contribution was highly invaluably to the study.

3.3 POPULATION

The study was conducted in the Manhyia sub-Metropolitan area of Kumasi with a population of 36 NHIS accredited healthcare facilities and NHIS active membership of 156,585 (NHIS Manhyia)

3.4 SAMPLE SIZE AND SAMPLING PROCEDURE

The study used a Sample size of 90 respondents made up of fifty (50) members of the National Health Insurance Scheme, Twenty-two (22) respondents of credentialed healthcare providers and eighteen (18) Staff of the National Health Insurance Scheme. The sampling technic used encompassed a mix; random sampling and purposive sampling. The policyholders and staff

of NHIA were randomly selected for the questionnaire, whiles purposive sampling was then employed for the other respondents.

3.5 DATA COLLECTION

Data was sourced through both primary and secondary source. The secondary data was sourced through the Claims processing Centre of the National health insurance Authority.

Primary data was collected through questionnaire administered randomly but strictly to policyholders of the National Health Insurance Scheme and staff of the Claims Processing Centre (CPC) of the National Health Insurance Authority.

The study then targeted some selected healthcare facilities on purpose of getting information specific to the study.

The secondary data was solely derived from the NHIA and this was in the form of payments made over a period of time as the study required.

The mode of data collection encompassed closed ended questionnaire administered to fifty (50) members of the NHIS who were randomly selected alongside eighteen (18) staff of the Claims processing Centre of the National Health Insurance Authority.

This gave the study the required space to encounter the policy holders from all angles within the Manhyia sub metro of the Kumasi Metropolitan Area. It therefore provided a factual representation of the views of a mix of members of the scheme on the objectives of the study.

The eighteen (18) selected staff which was randomly done was to a focus on the views of the staff who directly deals with the credentialed health care providers and again serves the complaints centre on issues that involves any financial consideration demanded from policyholders that is outside the premium they legally pay as per the law

The remaining twenty-two (22) were purposively selected health care providers from a pool of credentialed healthcare facilities of the national health scheme. This enabled the study to get apt inquest into the objectives as set by the study.

3.6 DATA ANALYSIS

The primary data was analysed using the Statistical Package for Social Sciences (SPSS) as a tool to derive the various outcomes from the data collected. Data generated by the package was analysed and inferences drawn based on the interpretation of the findings as provided by the tool.

The study found age and educational backgrounds of respondents (policy holders) very key in getting the results as the objectives sought to establish. It served an important component in analysing the primary data.

In the analysis of the data the key point was to establish the financial implication, that delays in payments of claims to healthcare providers have on the stakeholders of the scheme and the study did not lose focus on that. The secondary data as derived from the NHIA was subjected to trend analyses and establishing the depth of delay merited that the study access the trends of inflation as analytical tool in arriving at the key findings.

The inflation trends in financial analyses is very key and fundamental in making assessment base on nominal figures. This was highly justified as the objectives was to bring to fore either hidden or manifest implication that the objective of the study sought to establish. And that Inflation trends was applied amongst other indicators to validate or otherwise that there is a shortchange financially.

3.7 RELIABILITY AND VALIDITY OF DATA

The primary data was directly derived from inquest on the policyholders of the NHIS and thereby from very authentic source making it very credible and reliable as caution taken to randomly select active members of the scheme that is to say those who actually utilize the services of the national health insurance scheme. Also the respondents from the scheme were people who manage the claims from the credentialed providers and therefore the right source for the necessary information the study needed to establish its findings.

The credentialed healthcare providers are the very entities whose payments are delayed and therefore their answers served highly invaluable for the study.

Finally the secondary data was derived from the NHIA which does the payments to the providers and therefore the records of payments were very authentic and authoritative source.

3.8 ETHICAL CONSIDERATION

Fundamentally the privacy of the respondents to the questionnaire was protected and there was no identification tag included in the questionnaire. Also, the study was conducted without any premeditated predisposition thereby making the findings reliable and not biased.

Again, the three stakeholders in the study were fully represented and engaged though in different forms, their contribution very prominently factored in the entire study making the study very comprehensive and systematic.

CHAPTER FOUR

DATA PRESENTATION AND DISCUSSION

4.1 INTRODUCTION

This chapter highlights and analyzes the findings of the study. The chapter incorporated the outcomes derived through administered questionnaire based on the objectives of the study which sought to establish the financial implication on the three major stakeholders within the triploid fold of the National Health Insurance scheme of Ghana. This chapter also analyzed the remotest of the objectives employing the much-accepted financial model in calculating the future value of money, which is the determinant in accessing if delays in payments financially affect the financial wellbeing of an entity substantially

The chapter further subjected the derived outcome from the inquest made from the three stakeholders and discussed the outcome comprehensively as detailed therein.

4.2 PRELIMINARY TEST

The study first studied the trend in which the Healthcare providers were laying claims to the fact that the delays in payment of claims are becoming their bane financially. Analyzing those complains through the secondary available data on the frequency of claims submission and subsequent payments, the study found it prudently significant to derive data from the 3 key stakeholders through administered questionnaire to have a thorough and primary base data which was very fundamental. The preliminary test paved way for the comprehensive analyses therein.

4.3 DESCRIPTIVE STATISTICS

Secondary data was derived from the NHIA on the claims submission and payments schedule. The primary data collected through the administered questionnaire was purely subjected through descriptive Analyses.

. The quantitative research method was very helpful in the analysis as it made correlation and extrapolation very efficient in assessing the financial implication the study sought to establish.

4.4. BACKGROUND OF RESPONDENT

4.4.1 Gender

Table 4.4.1

Gender of Respondent

GENDER	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
Male	38	42		
Female	52	58	45	9.90
TOTAL	90	100		

Source: Researcher, 2020

The gender was evenly distributed as the male respondents were 42% and the female's counterparts also 58%. Such representation was very significant for the study as the study then had varying response based on the fact each group had its unique health conditions apart from the general health conditions. This was very instructive for the study as each group represented variedly the depth of financial implication.

4.4.2 Age

Table 4.4.2

Percentages of the age of respondents

AGE GROUP	FREQUENCY	PERENT (%)	MEAN	STDEV
15-35	30	33.33		
36-56	25	27.78		
57-77	20	22.22	22.5	6.45
76 and above	15	16.67		
TOTAL	90	100		

Source: Researcher, 2020

The age of the respondents in percentage terms showed that all the category of ages under the National Health Insurance Scheme were captured making the age levels very representative of the required variables. Ages 15- 35 had a representation of 33.33% of the total respondents and this is very significant since most of them form the dependent group that depends on other people for their financial activities notably health care, academic and social life and therefore their contribution in the study very important.

27.78% were of the ages of 36-56 purely falling the working class who definitively makes expenditure based on the availability of financial resources and that such category of people substantially feel the effect of financial constraints of availability. Their response was very instrumental in that they stabilize household financial by their income and this apportion goes into the premium that is paid as required by law under the NHIA Act 650 as amended Act 852.

The category of 57 -77 and 78 years and above were represented by 22.22% and 16.67%. These categories of people form the terminal stage in the relationship of dependency. However, though they form an important component, per Act 852 such people are normally treated as indigents. It therefore was very significant that the study quizzed such group on their take on the research objective. Such people encounter chronic health situation and their medication spans for a lifetime so the financial implication on them was very essential to the study.

The representation therefore in terms of age of respondents as presented by table 4.4.2 indicates that they were very crucial to the study

4.4.3 Educational level of Respondents

Table 4.4.3

Level of education of respondent

LEVEL	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
None	11	12.22		
J. High	27	30.00		
S. High	13	14.44		
Diploma	14	15.56	15	5.97
Graduate	13	14.44		
Post Graduate	12	13.33		
Total	90	100		

Source: Researcher, 2020

Most of the respondents had some form of education, though varied in nature, 13.33% of the respondents were postgraduates while first degree holders were made up of 14.44%.

15.56% of the respondents were Diploma holders while Senior High School graduates constituted 14.44% of the respondents. 30% of respondent were Junior High graduates and 12.22% of respondents who had no formal education. This indicates that respondents to the study were aptly represented in terms of varied educational background.

The level of education was very significant in the study as it is a critical and added enhancement of ones ability to appreciate fully and digest issues independently though not absolutely a sacrosanct factor in all issues, the levels of education in the study enabled respondents had a thorough appreciation of the questionnaire and responded in way that had no influence from the design.

The quality of the respondents terms of their ability to digest the questionnaire in appropriate terms gave much credence and incentive to the total outcome of the study.

4 .5 EFFECT ON POLICY HOLDERS

4.5.1: Policyholders often make out of pocket payment at the point of service

Table 4.5.1

Members often make out of pocket payment when assessing healthcare

Response	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	23	46		
Agree	22	44		
Disagree	5	10	12.5	11.73
Strongly Disagree	0	0		
TOTAL	50	100		

Source: Researcher 2020

4.5.2 Policyholders have their domestic budget derailed as a result of out of pocket Payment at point of service

Table 4.5.2

Domestic Budget derailed as a result of out of pocket payment

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	19	38		
Agree	26	52		
Disagree	3	6	12.5	11.90
strongly Disagree	2	4		
TOTAL	50	100		

Source: Researcher, 2020

4.5.3: Policyholders face financial challenge as a result of out of pocket payment

Table 4.5.3

Members face financial challenges as a result of out of pocket payment

RESPONSE	FREQUENCY.	PERCENT (%)	MEAN	STDEV.S
strongly agree	21	42		
Agree	23	46		
Disagree	6	12	12.5	11.27
strongly Disagree	0	0		
TOTAL	50	100		

Source: Researcher, 2020

Table 4.5.1 depicts that 46% of respondents indicated that they often makes out of pocket payment at the point of service whiles 44% agreed same.

Table 4.5.2 indicates that 38% and 52% strongly agree and agree respectively that their budgets are derailed as a result of out of pocket payment at the point of service

Table 4.5.3 indicates that respondents enrolled as policyholders face financial challenges by 42% indicating that they strongly agree with 46 % indicating that they agree.

These outcomes makes a strong case that Policy holders are financially adversely affected by out of pockets payments at credentialed healthcare facilities as a result of the delays in payment of claims which engender the providers to take these monies from them at the point of service

4.6 EF FECT ON CREDENTIALED HEALTHCARE PROVIDERS

4.6.1 NHIA delays in claims payment to credentialed healthcare providers

Table 4.6.1

NHIA delays in claims payment

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	8	36.36		
Agree	14	63.64		
Disagree	0	0	5.50	6.81
strongly Disagree	0	0		
TOTAL	22	100		

Source: Researcher, 2020

Table 4.6.1 shows that 36.36% of respondents strongly agreed that NHIA delays in reimbursement of claims, which was supported by 63.64% of respondents who agreed. This is indicative that the NHIA delays in claims payment to credentialed healthcare providers

4.6.2 Delays in claims payment to facilities affect the running of the entity

Table 4.6.2

Delays in claims payment affect the running of the facilities

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	7	31.82		
Agree	15	68.18		
Disagree	0	0.00	5.50	7.14
strongly Disagree	0	0.00		
TOTAL	22	100		

Source: Researcher 2020

Table 4.6.2. Indicates that 68.18% and 31.82% of respondents agreed and strongly agreed respectively that delays in payments of claims affected the running of their facilities. This indicates that delays in claims of payments by NHIA affect the running of the healthcare facilities.

Table 4.6.1 and 4.6.2 as depicted above supports the claims put out by the health care providers that there is delay in claims payments and this affect their financial activities and reduces their ability to function devoid of financial distortion.

However Nominal figures as put up per Claims submission and payment schedule below sway to support the findings in Table 4.6.2 as in the case of Tafo Government Hospital, claims of 152,502.22 submitted on 31/02/2019 was paid on 14/01/2020. Again Claims of 154,453.40 submitted by this same facility on February 18/03/19 was reimbursed on 14/01/2020.

Claims submission and payment schedule clearly in nominal terms indicates that at last claims submitted are reimbursed in about 12 calendar months from the day of submission This data reflects the situation the providers proffer to exist.

However per the Act (852) the Authority has a period of 60 days within which to process the claims and reimburse the provider from the day of submission.

From this provision above, it becomes imperative to note that claims that is paid in a period of 12 calendar months per the day of submission practically exempts the first 60 days when analyzing the period of delay.

4.6.2.1 Claims submission and payment schedule

SUBMISSION	MONTH	VOLUME	PAYMENT	DATE OF PAYMENT
TAFO COVERNMENT HOSPITAL				
21/02/19	January	5684	152,502.22	14-01-20
18/03/19	February	5399	154,453.40	14-01-20
16/04/19	March	5790	163,343.48	14-01-20
24/05/19	April	5856	198,734.17	10-02-20
18/06/19	May	6521	207,847.49	16-06-20
16/07/19	June	6220	207,847.49	16-06-20
SIAW LARBI HOSPITAL				
07/02/19	January	428	13,052.13	14-01-20
08/03/19	February	419	13,255.7	14-01-20
05/04/19	March	521	17,570.78	10-01-20
08/05/19	April	521	20,846.6	10-02-20
10/06/19	May	492	24,129.34	16-06-20
04/07/19	June	504	20,728.76	16-06-20
S D A HOSPITAL – BREMANG				
22/02/19	January	2,118	71,801.35	14-01-20
27/03/19	February	1,714	61,115.65	14-01-20
29/04/19	March	1,889	63,908.48	10-01-20
25/05/19	April	1,919	69,100.45	10-02-20
25/06/19	May	2,230	83,979.00	16-06-20
31/07/19	June	2,321	89,755.89	16-06-20

Source: NHIA 2020

4.6.3: Delay in claims payment to providers reduces the real value of payment they receive

Table 4.6.3

Delay in claims payment to providers

RESPONSE	FREQUECY	PERCENT (%)	MEAN	STDEV.S
strongly agree	9	40.91		
Agree	13	59.09		
Disagree	0	0.00	5.50	6.56
strongly Disagree	0	0.00		
TOTAL	22	100		

Source: Researcher, 2020

Table 4.6.3 indicates that 40.91% of respondents strongly agreed that delays in payment of claims reduces the real value of money they receive whiles 59.09% agreed same.

However the real or actual value of money is subject to rate of inflation in any particular period. In the period of 2019 financial year the inflation rate was 7.9% and 10. 50% ending the year 2020. The single digit inflation does not devalue in significant term. It therefore becomes inappropriate to suggest that the real value of money within that financial year reduces due to the marginal inflation rate.

This is further established in the Theory of Nominal or Quoted interest rate of cost of money. Inflation is a major determinant on interest rates. It erodes the purchasing power and lowers the real income. Investor's conscious of this invokes financial policies by building in an inflation premium equal to the average expected inflation rate over the life of the security. This Theory of Nominal or Quoted interest rate of cost of money supports this assertion.

Normal rate = $K = K^{*}+IP+DRP+LP+MRP$

Where K = Nominal or Quoted rate of interest on given security

K*= Real risk free rate of interest

IP= Inflation Premium

DRP= Default risk premium

LP= Liquidity or marketability premium

MRP= Maturity risk premium

This financial model indicates that the higher the inflation rate the lower the purchasing power Thus providers nominal value being paid in the year 2020 with an inflation rate of 7.9% in 2019 to 8.5% in January 2020 and 8.8 in June, 2020 shows that providers real value marginally reduces as the inflation rate does not substantially influence a high interest rate on their debt capital. This proffer that higher inflation rate of say 30% to 40% may affect very substantially the real value on any delay in nominal payments that is made to the providers

4.6 4: Providers receive full payments of claims notwithstanding delays in payments

Table 4.6.4

Providers receive full payments of claims

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	12	54.55		
Agree	7	31.82		
Disagree	3	13.64	5.50	5.20
strongly Disagree	0	0.00		
TOTAL	22	100		

Source: Researcher 2020

54.55% of respondents strongly agreed that providers receive full payment of claims submitted irrespective of the delays. 31.82% of respondents corroborated by agreeing.

4.6.5: Providers indirectly receive double payments in claims for actual claims submitted and the payment received out of pocket from policyholders

Table 4.6.5:

Providers indirectly receives double payments from the scheme

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	5	22.73		
Agree	11	50.00		
Disagree	4	18.18	5.50	3.87
strongly Disagree	2	9.09		
TOTAL	22	100		

Source: Researcher 2020

50% of respondents agreed that healthcare providers directly receives payment twice for services provided to members and this was supported by 22.73% who strongly agreed. 18.18% and 9.09% respectively however disagreed and strongly disagreed. The spread of 3.87 from the mean of 5.50 is highly indicative that the responses very representative and significant.

Tables 4.6.4 and 4.6.5 respectively has responses from purposive sampling of healthcare providers and therefore their responses comes from those in practice and the ultimate beneficiaries of this payments.

This indicates clearly that though the regulator delays in payment of claims to providers, the latter demand money at the point of service and again enter claims for these same members for reimbursement from the scheme managers.

This finding indicates that the providers shortchange the regulator by demanding money from members at point of service under pretext of delay in payments and again billing the NHIA same.

4.7 EFFECT ON THE REGULATOR (NHIA)

4.7.1 Delay in claims payment to providers allow providers to submit claims of policyholders they have already taken payments out of pockets

Table 4.7.1

Providers submit claims for members treated under 'cash and carry system'

RESPONSE	FREQUENCY	PERCENT (%)	MEAN	STDEV.S
strongly agree	3	16.67		
Agree	13	72.22		
Disagree	2	11.11	4.50	5.80
strongly Disagree	0	0.00		
TOTAL	18	100		

Source: Researcher 2020

16.67% of Respondents strongly agreed in table 4.7.1 that providers submit claims of members who have already paid at point of service. 72.22 % of respondents agreed to that with just about 11.11 % dissenting. The standard deviation of 5.80 from the mean of 4.50 is high indicative that there is much deviation from the mean making this finding very relevant.

This indicate that most of the respondents at the Regulator's outfit accentuated the point that providers still process claims and submit same for members they have already taken cash for treatment. Such findings indicates that the delay in claims payment affects the policy makers financially as they expend to health providers payment of 'illegitimate claims' This finding is very fundamental since the respondents in this enclave directly process the claims and also receives complains of members who may have challenges with providers in terms of out of pocket payments made at point of service.

4.8 DISCUSSION

The findings of the study implied highly that the reviewed literature has high significance as the two sync effectively though on diverse horizon in some instances

In the case of the regulator the literature was highly indicative that the regulator focuses very much on avenues to revamp the healthcare by ingestion of more funds and other means of financing the policy as was contained on the OECD 2007 report on Vietnam and other low income countries. It sought to clear any financial barriers that impede the operation through delays in payments. However the findings of the study indicates that other sources of funding being sought by the regulator needs to be efficiently utilized due to the fact that policy holders are charged at the point of service and so the increasing number of claims been submitted and which translates into cost needs to be critique very well to avoid a syndrome of paying twice for a service purchased. Moreover the study's findings that the National Health insurance scheme and for the matter the Regulator is shortchange, aptly franchise issues raised in the literature where countries under the enclave of social health policies need to make sure claims by providers are critically vetted before approval for payment.

The study's finding of "cash and carry" claims been submitted is very categorical and raises the need to review the level of financial ingestion by the regulator. The fact that respondents were of the view that they were made to pay at point of service and that these same members had their bills already paid submitted as claims, point to gaming on the scheme by health providers which the literature adequately professes and exemplified by Arab et al (2013) on their findings on LMIC.

The study's findings on the policyholders, that out of pocket payments disturb their finances substantially does give credence to the relevance of the literature as it's take on the

policyholders was the fact that out of pocket payments derails the financial schedules of policy holders. Being a social protection policy the poor are mostly the targets and therefore the out of pocket payments as a result of delay on payments of claims is fetal to the finances of the individual and household. This finding further underlines a very fundamental challenge that Arab et al (2013) raised on catastrophic expenditure as a result of out of pocket payments on study of low and middle income countries (LMIC). Though the issue of health insurance as a policy deflates the out of pocket payments principle, the findings establishes it exits and that there are serious ramification in relation to policyholders financial schedules. For the policyholder, membership protects the ramification of catastrophic financial challenges and that being a member, at least alleviate that portion of their financial commitment. Hence to make unbudgeted payments at the point of service at the provider site is a financial blight and a strain on an already pressured budget.

The findings as the provider's perspective was interrogated came up that though the NHIA delays in payments the overall effect does not support substantial financial loses to the healthcare provider, there was not substantial responses that proved otherwise. As many as over 85% of respondents of the study affirmed that, providers do not experience any substantive financial loss as a result of the delay. Rather, the findings indicated that the providers receives payment twice on a patient (member) at point of service and later through claims submitted to the regulator. Though this contrast Tanner (2008) findings that delays in claims affect the healthcare provider financially mainly exemplifying the French system. There was a proviso that a thoroughly study may reveal an inherently but a latent implication and this study have revealed same that the narration does not support a loss to providers substantially but they rather shortchange the regulator financially.

The study in synching with the objectives have originated findings that though not exhaustive gives a vivid analyses of what the three major stakeholders within the triangular enclave of the National Health Insurance Scheme of Ghana encounters in terms of financial implication. Much as the secondary data of submission and payments of claims as depicted in table 4.6.2.1 (Claims submission and payment schedule) presents a figure of some levels of delay in claims payments to healthcare providers, the study, through empirical analyses have established a very concrete though not conclusive, a state of how these delay do denote to the finances of the triploid.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a summary of findings by the study, conclusion drawn as a result of the analysis and recommendations made.

5.2 SUMMARY OF FINDINGS

It was found that policyholders are adversely affected financially as a result of delay in claims payment by making out of pocket payment at point of service to credentialed healthcare providers. This was established by the study to derail and substantially affects their budgets, as the expenditure already catered for a whole year reoccur as many times as the member visits the healthcare provider and as the delays spanks averagely over a six month period, this culminate in the frequency of such point of service payments.

It was found that credentialed healthcare providers shortchange the policy implementers by submitting claims of members whom they have taken money from at point of service for payment. This reflects a case of receiving payment twice on services provided and moreover the rate of inflation does not suggest the actual value of money substantially shift to affect healthcare providers through the delay in payment. The study therefore effectively, has established a very important point, where though services purchased from healthcare provider are not reimbursed in time as contained in the NHIS Act (650) as amended in (Act852). The providers are not substantially affected financially as the policyholder at point of service pays

for these same services. This is aptly conceptualized by the study as ‘intrinsically non delay in payment’ (payment already illicitly appropriated from members of the scheme).

The Regulators of the scheme reimburse healthcare providers based on ‘illegitimate’ claims submitted as a result of submission of claims by healthcare providers of members who have already paid for the service.

It was found that the perceived financial hardships specific to healthcare providers and which is attributed to delays in claims payment and which exerts excessive pressure on policy makers or the regulators on the need for prompt payment gives the healthcare providers an undue opportunity of impropriety to appropriate to themselves funds that Act (852) prohibits.

5.3 CONCLUSION

It was established that though there is financial adversity that engulf the 3 major stakeholders of the NHIS when there are delays in claims payment to healthcare providers, The regulator and the policyholder are highly affected whiles the provider leverages on the delay to accrue to itself illegitimate financial output, though in nominal terms the delay superficially affects the entity financially.

5.4 LIMITATION OF THE STUDY

Respondents (healthcare providers) were a bit reluctant responding to the questionnaire since it involves queries on their finances. The researcher has to impress upon the respondent that the study was solely for academic purpose and that the respondent confidentiality was assured. This erased the challenges that they had and accordingly contributed to the success of the study

5.5 RECOMMENDATIONS

Any credentialed healthcare providers who charge policyholders of the National Health Insurance Scheme out of pocket payments at point of service before delivering care and yet submit bills for payments should be suspended outright by the NHIA for a specific period (360 calendar days) punitive enough to deter others from doing same. Again all payments found to have been inappropriately received by healthcare providers of the NHIS should be refunded with interest at the current rate.

A more subtle approach of enactment by law that will requires revocation of the license of the offending provider by HEFRA to operate the facility for a 3 month period could be very deterrent.

There should be an established subsidiary legislation to Act 852 that will revoke credentialed status of health care providers of the NHIS and subsequently subject same to prosecution any healthcare provider found to have illicitly received payment ‘twice’ from the regulator and the policyholder.

The National health Insurance Authority as a matter of urgency should establish claims monitoring units in the various credentialed healthcare facilities to oversee and validate claims generated at provider site to ensure that only legitimate claims are submitted for reimbursement. This unit must also ensure that NHIS members are not subjected to any other payment regime at the point of service, provided services being accessed is covered by the National health insurance scheme.

Finally the policy makers should ensure early release of statutory funds meant for claims payment in time to meet the requirement of the law, Act 852 as amended which states that payment to NHIS service providers for services purchased should be done 60 days upon submission of claims. This will help alleviate the syndrome of delays in payment.

5.6 RECOMMENDATION FOR FURTHER STUDY

The study recommends further studies into the CAUSES OF DELAYS IN CLAIMS PAYMENT, which could be a precursor to finding antidote to the ramifications associated with the delays in payment. There is currently no known such research yet and a study there may be very useful.

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APPENDIX

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

DEPARTMENT OF ACCOUNTING AND FINANCE

QUESTIONNAIRES ON DELAYS IN CLAIMS PAYMENT TO CREDENTIALED HEALTH CARE PROVIDERS: THE FINANCIAL IMPLICATION ON THE NATIONAL HEALTH INSURANCE SCHEME OF GHANA

This questionnaire is purposely for academic work and therefore the obscurity of the respondent is assured whiles all information will be confidential.

GUIDE; please tick (√) the appropriate section that indicates your opinion in the table below.

SECTION A: RESPODENT BACKGROUND

1) Sex

(a) Male ( ) (b) Female ( )

2) Age

(a) 15-35 ( ) (b) 36- 56 ( ) (c) 57- 77 ( ) (d) 78 and above ( )

3) Level of education:

(a) Junior high ( ) (b) Senior High ( ) (c) HND ( ) (d) Graduate ( )

(e) Post Graduate disagree ( ) (f) None ( )

SECTION B:

A. NHIS MEMBERS

4) NHIS policyholders attend NHIS credentialed healthcare facility without incurring any other cost (a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

5) NHIS Policy holders make out of pocket payment at point of service

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree (

6) NHIS policyholders often make out of pocket payments at the point of service

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

7) NHIS policy holders faces financial challenges as a result of out of pocket payments

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

8) NHIS members have their domestic/ household budgets derailed as a result of out of pockets payment a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

9) NHIS Policy Holders faces financial constraint as a result of out of pocket payments at the credentialed facility a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

10) Delays in payments of NHIS claims to health provider's results in providers charging fees at point of service

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

11) Regular payments of claims to health care providers will reduce financial burdens on policy holders as out of pockets payments will reduce a) Strongly agree ( ) (b) Agree( ) (c) Disagree ( ) (d) Strongly disagree ( )

B. HEALTHCARE PROVIDERS

12) NHIA health care providers receives regular and prompt payments of claims

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

13) NHIA delays in claims payment to credentialed health care providers

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

14) Delays in claims payment to healthcare facilities affect the running of the facilities

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

15) Delays in claims payment pushes healthcare providers to charge policyholders at point of service a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

16) Healthcare providers receives full payments of claims notwithstanding Delays in payments

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

17) Healthcare providers submit claims of policyholders whom were made to pay for care at point of service because of delay in payment.

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

18) Delay in claims payment to providers reduces the real value of payment they receive

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

19) Health care providers indirectly receives double payments in claims for actual claims submitted and the payment received out of pocket from policy holders

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

C. POLICY IMPLEMENTERS (NHIA)

20) NHIA delays in payments of claims to credentialed health care providers

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

21) Delay in payment of claims contribute to financial difficulties by providers in running the administration of their facility

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

22) Delay in payment to healthcare providers constraints the budgets of the healthcare providers

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

23) Delay in claims payment to healthcare providers allows providers to submit claims from policyholders they have already taken payments out of pockets.

a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( ) (d) Strongly disagree ( )

24) Delay in payments to healthcare providers affect policyholders as they are

to pay for service rendered. a) Strongly agree ( ) (b) Agree ( ) (c) Disagree ( )

(d) Strongly disagree ( )