UNIVERSITY FOR DEVELOPMENT STUDIES

CHALLENGES ACCREDITED HEALTH SERVICE PROVIDERS FACE IN HEALTH INSURANCE CLAIMS MANAGEMENT IN THE BRONG-AHAFO REGION

FRED EFFAH-YEBOAH

THESIS SUBMITTED TO THE DEPARTMENT OF AFRICAN AND GENERAL STUDIES, FACULTY OF INTEGRATED DEVELOPMENT STUDIES, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN DEVELOPMENT STUDIES

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BY

FRED EFFAH-YEBOAH (B. SC. ADMINISTRATION)
(UDS/MDS/0101/09)

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SEPTEMBER, 2018

DECLARATION

Student

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere:

Candidate's Signature……..Date……

Name**: FRED EFFAH-YEBOAH**

Supervisor

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

Supervisor's Signature……..Date……

Name**: PROF. SYLVESTER ZACKARIA GALAA**

ABSTRACT

This study was conducted to find out the nature and causes of claims management challenges in the Brong-Ahafo Region of Ghana, and to find out what was being done to address those challenges. The study covered three (3) accredited hospitals and 112 respondents. Data for this study comprised both primary and secondary data sources Primary data was collected using questionnaires. Secondary data was derived from annual reports of the service providers and National Health Insurance Scheme claims reports. The research was descriptive and cross-sectional in nature. Findings from the study showed that the sheer volume of claims work handled by the facilities has been a major source of challenge to them. Moreover, delayed submission of claims was also identified as a key challenge. Though claim rejection was also identified as a type of challenge, the proportion of claims rejected has gone down significantly. The study results showed that causes of claims management challenges related mainly to increase utilization of provider services as a result of the introduction of the National Health Insurance Scheme, lack of a valid accreditation and contract with the National Health Insurance Authority (NHIA), failure of providers to comply with National Health Insurance Authority documentations and arrangements, and generally weak claims management unit in the provider facilities. The study strongly recommends improvements in claims management activities of health insurance accredited facilities, as well as periodic accreditation and contracting with the NHIA. In addition, the study recommends the strengthening and resourcing of existing facility based claims management units. It is also the recommendation of this study that a course in claims management be introduced in Ghana to train a cadre of health insurance claims professionals as it pertains in other countries.

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DEDICATION

This work is dedicated to my Wife Vida, and my children, Josephine Winner, Precious Ann, Fred Paul, and Blessing Owusunana.

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LIST OF ABBREVIATIONS AND ACRONYMS

AHIMA	American Health Information Management Association
AHSPs	Accredited Health Service Providers
AMA	American Medical Association
ARV	Antiretroviral
BFT	Business and Financial Times
CBHIS	Community Based Health Insurance Scheme
CCD	Clinical Care Division
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
CMCIP	Claims Management Capacity Improvement Programme
DCE	District Chief Executive
DCPP	Disease Control Priorities Project
DHS	District Health System
DMHIS	District-wide Mutual Health Insurance Scheme
DSL	Digital Subscriber Line
FFS	Fee-For-Service
FTP	File Transfer Protocol
G-DRG	Ghana-Diagnosis Related Group
GHK	Government Hospital, Kintampo
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HICM	Health Insurance Claims Management

HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
IGF	Internally Generated Funds
ISD	Information Services Department
LI	Legislative Instrument
MHW	Methodist Hospital, Wenchi
MHIS	Mutual Health Insurance Scheme
MoH	Ministry of Health
NCBI	National Centre Biotechnology Information
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Law
NHIS	National Health Insurance Scheme
NLCD	National Liberation Council Decree
OOP	Out of Pocket Payment
OPD	Out-Patient Department
PFH	Public Funded Hospital
PHA	Pentecost Hospital, Accra
PHD	Presbyterian Hospital, Dormaa-Ahenkro
PNDC	Provisional National Defence Council

SPSS	Statistical Package for the Social Sciences (Also known as Statistical Products and Service Solutions)
SSNIT	Social Security and National Insurance Trust
TPP	Third Party Payer
UDS	University for Development Studies
UNDP	United Nations Development Programme
VAT	Value Added Tax
VRHD	Volta Regional Health Directorate
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The National Health Insurance Scheme (NHIS) of Ghana was established through the promulgation of the National Health Insurance Act, 2003 (Act 650) and the National Health Insurance Regulations, 2004 (L.I. 1809). The NHIS was introduced with the view to improving financial access of Ghanaians, especially the poor and the vulnerable, to quality basic health care services and to limit out-of-pocket payments at the point of service delivery (Mensah et al, 2009; Goba and Liang, 2011). The NHIS became fully operational in 2005 (Sodzi-Tettey, 2009; Health Systems 20/20, 2009; Auditor General's Department, 2011).

Following the introduction of the NHIS as the main health financing strategy for health services in Ghana, there has been a major shift from direct out-of-pocket (OOP) payment, commonly referred to as "cash and carry" by the client (Goba and Liang, 2011). With the shift from direct OOP, there has emerged a claims management relationship between Accredited Health Insurance Providers (AHIPs) of the scheme and the National Health Insurance Authority (NHIA), which is the Central Government agency responsible for overseeing the implementation of the NHIS.

Over the period of its implementation, stakeholders generally agree that there are serious challenges confronting the NHIS (NHIA, 2010; VRHD, 2010). One important area of concern for stakeholders is claims management (NDPC, 2009). The NDPC, for instance, associated delays by the NHIA to pay providers for claims submitted to delay in submission of the claims

by the providers. A monitoring report of the VRHD (2010) on 19 facilities from the Volta Region highlighted the submission of claims with so many errors as a common phenomenon in all the facilities. Meanwhile as a guiding principle, the NHIA is bound to reject claims filled with errors. That notwithstanding, the preparing of claims with errors is not limited to only the Volta Region but cuts across all the Regions of Ghana, and it is pervasive (NHIA, 2010).

Unfortunately much of what is known about the challenges facing health providers in claims management in Ghana has come to the fore through media reports and discussions, and not through authoritative academic or scientific research. As a result, the nature and causes of challenges faced by accredited health service providers in health Insurance claims management are not well documented. Researchers, writers and policy analysts with interest in the operations of the NHIS have focused their work primarily on of the NHIS policy, and have been concerned more with how it opens access to health services and its utilization, as well as its prospects and general challenges (Mensah et al, 2009; Jehu-Appiah et al, 2011; Gobah, 2011; Kuffour, 2011; Schieber et al, 2012; Aniah, 2016). The lack of many scientific studies into claims management under the NHIS of Ghana has been pointed out by Sodzi-Tettey (2009) who concedes that while the NHIS has been running since 2005, there is no formal documentation found that focuses on the claims aspect of the scheme. The view taken by Sodzi-Tettey is supported by Yakubu (2009) who has also indicated that there has not been much scientific assessment of claims reimbursed and an estimation of the nature of claims reimbursement and related causes of non-payment of health insurance claims.

1.2 Problem Statement

Since its introduction in 2005, the success of the NHIS of Ghana has been highlighted from different angles (Health Systems 20/20 Project, 2009; Gobah, 2010; NHIA, 2010; Seddoh et al, 2011). For instance Apoya and Marriot (2011) have said the Ghana NHIS has been lauded as an early success for health insurance in developing countries by many international players in the health community, most notably the World Bank. In support of the position taken by Apoya and Marriot, Ghana's NHIA Chief Executive believes that the NHIS was set to become a global model (NHIA, 2010).

Despite the praise heaped on the NHIS of Ghana as being on the path to becoming a global model, there is what has been described as serious challenge associated with health provider claims management (NDPC, 2009; NHIA, 2010; VRHD, 2010).

In the implementation of the NHIS, it is a necessary requirement that after rendering healthcare services to insured patients, an accredited health provider submits claims to the scheme for re-imbursement to be made by the NHIA (AGD, 2012). The claims management relations between AHIP and the NHIA has been imposed by Section 37(7) and Section 38 (1) of the National Health Insurance Regulations, 2004 (L.I1809). The law provides that a claim for payment of health care services rendered under a scheme licensed under the National Health Insurance Act, 2003 (Act 650) must be filed within sixty calendar days from the date of the discharge of the patient or rendering of the service payment of health care service rendered which is submitted to the scheme must, unless there is any legal impediment, be paid by the scheme within four weeks after receipt of the claim from the health care facility.

Despite the legal obligation of claims management imposed on both AHIP and the NHIA, the 2008 Citizens' Assessment of the NHIS pointed to the processing and administration of claims as an area which strongly threatened the sustainability of the scheme (NDPC, 2009). In the view of the NDPC, reimbursement to providers was delayed, and availability of resources crucial for the effective functioning of accredited health service providers was significantly affected. The delays in processing, submission and vetting of claims appear to be very problematic not only to the NDPC (2009) but same has been highlighted by other studies and other writers such as Witter and Garshong (2009), Dalinjong (2012), and Aniah (2016). Consequently, it was recommended that the NHIA should continue the search for an effective way to address the issue relating to provider claims management (NDPC, 2009).The NHIA also alludes to the fact that service providers are faced with certain challenges in claims management and this is captured in the annual report of the Authority (NHIA, 2010).

It is pertinent to note that chaotic claims management over the period of the implementation of the NHIS has produced and perpetuated two types of delays. Firstly, there is a claim submission delay caused by the provider and secondly, claims payment delay caused by NHIA (Sodzi Tettey, 2009). In each of these delays, however, AHSPs are the most affected as it hampers smooth revenue inflow to support quality and effective health delivery (Seddoh et. al., 2011). Currently the NHIS contributes not less than 85% percent of the revenue generated by accredited health providers (NHIA, 2013). The effect of delay in claims submission and reimbursement on availability of resources and its subsequent impact on quality of health services delivery cannot be overemphasized. To the extent that effective health service delivery

is hampered by what is known to be claims management challenges make, and to the extent that the nature and causes of the challenges in claims management in Ghana have not been properly documented ignited the interest for this kind of study. The focus of this study was therefore to assess the nature and causes of claims management challenges AHIPs face in the Brong-Ahafo Region.

1.3 Research Questions

The main research question of the study is "what is the nature and causes of the Health Insurance Claims Management challenges AHIPs face in the Brong-Ahafo Region"? The specific research questions of the study are indicated below.

1. What is the nature of claims management challenges in accredited health provider institutions in the Brong-Ahafo Region?
2. What are the causes of claims management challenges in accredited health provider institutions in the Brong-Ahafo Region?
3. What is being done to solve claims management challenges in accredited health provider institutions in the Brong-Ahafo Region?

1.4 Research Objectives

1.4.1 General Objective

The main objective of this study was to assess the nature and causes of the challenges accredited service providers face in Health Insurance Claims Management in the Brong-Ahafo Region.

1.4.2 Specific Objectives

The specific objectives for this study were:

1. To examine out the nature of claims management challenges in accredited health provider institutions in the Brong-Ahafo Region.
2. To examine the causes of claims management challenges in accredited health provider institutions in the Brong-Ahafo Region.
3. To assess what is being done to solve claims management challenges in accredited health service provider institutions in the Brong-Ahafo Region.

1.5 Justification for the study

Establishing the nature and causes of claims management challenges and how the challenges are being addressed would serve as a guide for all service providers and in the end promote quality, efficient and timely health insurance claims management that ensures that health care providers recover full cost and obtain prompt reimbursement for services provided to NHIS subscribers.

Again, this study is an attempt by the researcher to contribute to building literature on claims management in the implementation of Ghana's NHIS. This study documents scientifically

grounded findings relating to challenges in the claims management process, particularly within the operations of the District Health System (DHS) of the Brong-Ahafo Region, which may serve as a reference material for interested stakeholders in the implementation of the NHIS.

Moreover, a thorough understanding of claims management is expected to promote cooperation at the health facility level to engender an "all hands on deck" attitude to promote efficiency in claims management, maximize revenue from NHIS, and reduce the lag time in claims submission by providers.

In addition, this study raises critical contemporary issues in the literature review, and in the findings and recommendations, which may serve as the basis for further independent academic or operational research studies for the advancement of knowledge and for the improvement of health service delivery.

Finally, the findings of this study are expected to inform policy about claims management at the various levels of health service delivery and for that matter the implementation of the NHIS.

1.6 Scope of the study

This study is about Accredited Health Service Providers and the challenges they face in Health Insurance Claims management in the Brong-Ahafo Region. The study was basically to explore the nature of claims management challenges that confront accredited health service providers in the Brong-Ahafo Region, the causes of those challenges and how the challenges were being addressed.

Claims management in Ghana has two sides. There is the health provider side that yields claims submission. There is also the NHIA side that yields claims payment. This study was limited to the challenges in the health provider side of claims management.

Accredited health services providers are categorized by the NHIA as Community-Based Health Planning and Service (CHPS), maternity home, health center, clinic, polyclinic, primary care (district) hospital, secondary care (regional) hospital, and tertiary care (teaching) hospital. There is also the licensed chemical shop as well as the pharmacy that also form part of service providers of the NHIS. For the avoidance of doubt, this study was limited to primary care (district) hospitals, and was carried out in district hospitals located in the Kintampo, Wenchi, and Dormaa municipalities.

1.7 Limitations of the study

This was a cross sectional study and the advantages for such a study include the fact that it is relatively less expensive and the time taken to gather data is also relatively short. Nonetheless, because of the cross sectional nature of the study, the data gathered was taken at a point in time. Findings are therefore only a snapshot: the study may provide differing results if another time-frame had been chosen.

Secondly, due to time and resource constraints, the study covered only 3 accredited service providers out of over 225 in the Brong-Ahafo Region as at the time of the study. In spite of the reliability and validity measures taken by the researcher to improve the results of the study, finding may not be representative of the entire population.

The study method and the strong passion that the NHIS evokes among the populace might have created room for bias on the part of both researcher and respondents. That notwithstanding, the researcher is aware and was guided by the assertion of the US National Center for Biotechnology Information (2016) that while some study designs are more prone to bias, its presence is universal and it is difficult or even impossible to completely eliminate bias.

While challenges in NHIS claims management is a national phenomenon, the nature of the challenges in the Brong-Ahafo Region as the findings of this study portrays may not be the same in other regions due to factors which may include differences in resource availability and institutional capacity for claims management.

1.8 Definition/Explanation of key concepts

i. Health Insurance Claims Management:

Health insurance claims management is the organization, billing, filing, updating and processing of medical claims related to patient diagnoses, treatments and medications. Without effective health insurance claims management, the NHIA would not be able to determine what they owe the service provider and the service provider on the other hand would not receive the funds due for patient services.

ii. Challenges in Health Insurance Claims Management:

The terminology "challenge" is the key concept of interest to this study, but it is not out of place because all business operations are faced with one form of challenge or another at a certain stage of their operations. A challenge arises in business or in any form of formal operations when the organization is in a situation or faced with something that needs great mental or physical effort in order for the core business of the organization to be done successfully.

iii. The Nature of Claims Management Challenges:

Studying into the nature of a phenomenon is not new in research. "Nature" as used in this study means type(s). A study into the "nature" of something calls for identification and description, especially of the essential characteristics of the phenomenon under consideration. The nature of claims management challenges is explained in this study to mean the type(s) of challenges associated with claims management in the implementation of the NHIS.

iv. Causes of claims management challenges:

The "cause" of something is what makes that thing happen. Therefore the "cause" of a phenomenon is the reason for its occurrence. Causes of claims management challenges are therefore the reasons why there are challenges in claims management.

1.9 Organization of the study

The study is organized into five (5) logically arranged chapters. Chapter one is the background to the study and covers the introduction, the problem statement, the research questions and objectives of the study. Chapter one also covers justification, scope and limitations of the study.

Chapter two presents a review of literature relevant to the study and concludes with a theoretical framework that puts the study in a proper perspective. The literature is reviewed along the main objectives of the study. Some of the themes include health financing in Ghana, health insurance claims management in Ghana as well as challenges of associated with claims management in the country.

Chapter three is devoted to the research methodology. It discusses the research design, the target population, sampling technique and sample size. The chapter also touches on the sources of data and the data collection methods, among others. Similarly, the approaches adopted for the discussion of findings is also discussed in that chapter. In the same chapter, brief profiles of the three hospitals selected for the study are presented.

Chapter four presents the results and discussions of the study. In chapter four, the research result is first presented and literature is subsequently employed to do the discussions. Chapter five, which is the concluding chapter presents the summary, findings, and conclusions of the study and ends with some recommendations to guide both policy and action.

CHAPTER TWO

LITERATURE REVIEW ON HEALTH INSURANCE AND CLAIMS MANAGEMENT

2.1 Introduction

As discussed in chapter one, the objectives of this study was to find out the nature of challenges in claims management in the operations of the NHIS, to critically assess the causes of the challenges in claims management and also to critically assess what was being done to solve claims management challenges under the implementation of the NHIS. For any meaningful analysis to be done to arrive at acceptable results, the study needed to be anchored in existing literature relating to the study. This chapter reviews relevant literature in Health Insurance and claims management, and briefly sheds light on then HIS of Ghana. The chapter also introduces some related concepts in health insurance that under-pin claims management such as Health Service Provider Accreditation, the Health Insurance contract, ethical and moral conduct in Health Insurance claims management among others. Reviewing literature means that the researcher had taken notice of the accumulated knowledge from books and articles on the topic under consideration.

2.2 Health Financing in Ghana

Health financing in Ghana has a long history. Ghana has since independence gone through various regimes of health care financing such as free health care, and varying degree of user fee systems (Tinorgah, 1999). Immediately after attainment of independence, the Nkrumah Administration introduced free health care, abolishing user charges. However, it became clear soon afterwards that this was not sustainable and that government alone could not provide adequate financing for social services including health delivery. Several laws were therefore

passed by some of the post-Nkrumah era Governments to legitimize the introduction of some kind of user fees, examples of which were the Hospitals Fees Decree, 1969 (NLCD 360) and later amended in the Hospital Fees Act, 1970 (ibid). As it turned out however, the fees imposed were too minimal, and that it did not yield much revenue due to the poverty considerations on the part of the populace (who were the target of the legislations). Moreover, laxity in the enforcement of the hospital fees legislations and regulations by hospital authorities, and corruption on the part of some health staff rendered hospital fees policies ineffective.

By the late 1970s and the early 1980s health financing had declined in real terms to about 20% of former levels (ibid). A user fee system aimed at substantial cost recovery for drugs and non-drug consumables was therefore introduced in 1985 through the passage of LI 1313. This was necessitated by the general economic decline in the early 1980s that significantly reduced government spending to all sectors of the economy (Tinorgah, 1999).

The hospital fees introduced under LI 1313, which became known as **'cash and carry'** system had good intentions: to resuscitate the ailing health delivery system. The main problem was the inhumane manner in which it was implemented. It attracted public outcry right from its inception, and its unpopularity with the majority of Ghanaians was too glaring as the policy made it difficult for the poor and low-income earners to access health care services.

This prompted policy makers to look for a more practical, innovative, and sustainable way of financing health care for the country. A Health Insurance Scheme was seen as the best option opened to the country. This fact was acknowledged by the erstwhile Provisional National

Defense Council (PNDC) government even as far back as 1988 when it expressed the hope that when health insurance scheme is introduced, the health needs of the country would see a general and continuous improvement that would relieve the masses of the people of the pain involved in the past (Information Services Department, 1988). Also, Tinorgah (1999) acknowledged that health care financing in Ghana has been a problem not only for government, but also for the private health sector and that consideration of a National Health Insurance arose out of the difficulties to finance health care both at the national and household levels. For almost two decades however policy makers were caught up in a debate as to the character and details of such a health insurance scheme.

In 2003, after years of debate, feasibility studies, and piloting, Parliament of the Republic of Ghana enacted the Six Hundred and Fiftieth Act of the Republic of Ghana which is known as the *National Health Insurance Act, 2003 (Act 650)*. The Act was enacted to secure the provision of basic healthcare services to persons resident in Ghana through mutual and private health insurance schemes; to put in place a body to register, license, and regulate health insurance schemes and to accredit and monitor healthcare providers operating under health insurance schemes; to establish a National Health Insurance Fund that will provide subsidy to licensed district mutual health insurance schemes; to impose a health insurance levy and to provide for related matters.

In exercise of the powers conferred on the Minister for Health under section 103 of the Act, and on the advice of the National Health Insurance Council established under the same Act, the National Health Insurance Regulations, 2004 (LI 1809)was introduced in September 2004.

The NHIS subsequently and formally became operational in 2005 resulting in a major policy shift from a health care system based on substantial fees charged to users, to a system based on universal health insurance that is financed mainly through payment of annual premiums by individuals, a health tax on commercial transactions, and the transfer of a small percentage of formal sector workers' contributions towards retirement benefits (Brugiavini and Pace, 2010).

2.3 The National Health Insurance Scheme of Ghana

The National Health Insurance Scheme of Ghana was established under the National Health Insurance Act 2003 (Act 650), and operates under the National Insurance Regulation (Legislative Instrument-L.1.1809) of 2004. The objective of the National Health Insurance Scheme is to provide financial access to all residents in Ghana, especially the poor and the vulnerable, with quality basic healthcare services (Apoya and Marriot, 2011; BFT, 2015).

Ghana's Health Insurance Scheme has attracted a lot of attention from researchers, and assessments and analyses of its design and impact are increasing in number (Alfers, 2009). Consequently a number of scientifically based evaluation reports on the NHIS have been published since the policy was initiated in the later part 2004 (Brugiavini and Pace, 2010; Nguyen et al., 2011; Apoya and Marriott. 2011; Gobah, 2011; Jehu-Appiah et. al 2011; Mensah et al., 2009). Most of these research studies have focused on the Health Insurance policy itself, especially its impact on health services utilization or protection of the poor from catastrophic health expenditure as in the case of studies conducted on the NHIS by Agyepong and Adjei (2008), and Salisu et al (2009).

By its design, Ghana's National Health Insurance Scheme (NHIS) is a social intervention programme intended to provide financial risk protection against out of pocket health care expenditure for all residents (National Health Insurance Authority (NHIA), 2010). Undoubtedly, the NHIS is an innovative attempt to extend social protection to informal workers (Alfers, 2009). Alfers notes further that Ghana's NHIS holds important policy lessons for other countries where the informal economy is large and growing and where informal workers are excluded from existing social protection mechanisms.

The National Health Insurance Act (650, 2003) established a National Health Insurance Authority (NHIA), governed by a Council, to regulate the health care system, including the accreditation of providers, agreeing on contribution rates with the schemes, managing the National Health Insurance Fund and approving cards for membership. Act 650 also stated that three types of health insurance schemes may be established and operated in the country:

a) District Mutual Health Insurance Scheme (DMHIS, one for each district, with a minimum of 2,000 members);
b) Private commercial health insurance schemes; and
c) Private mutual health insurance schemes (not eligible for subsidies from the NHIA)

The Council, which includes representatives of main stakeholder groups, establishes formulae for the allocation of funds to pay for subsidies to schemes, the cost of enrolling the indigent and supporting access to health care. The funding sources come mainly from the National Health Insurance Levy (2.5% of Valued Added Tax). Secondary sources are payroll deductions (2.5% of income) for formal sector employees and premiums for informal sector members. Other funds come from donations or loans.

In terms of membership of the NHIS, the Act establishes that it is mandatory, unless alternative private health insurance can be demonstrated. However, in practice, membership is optional for non-formal sector workers, who represent the bulk of the population. For formal sector workers, a payroll deduction of 2.5% is transferred to the NHI fund as part of their contribution to the Social Security and National Insurance Trust (SSNIT) fund. Informal sector workers are charged premiums that should be income related. Contributions by those outside the formal sector are supposed to be defined according to income. There is a six-month gap between joining and being eligible for benefits.

2.4 Benefits Package under the National Health Insurance Scheme of Ghana

The benefit package of the NHIS consists of basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation. It also includes maternity care (normal and caesarean delivery), eye care, dental care, and emergency care. About 95% of the diseases in Ghana are covered under the NHIS (NHIA, 2013). However, some services classified to be unnecessary or very expensive are on the exclusion list. Among these are; cosmetic surgery, drugs not listed on the NHIS Medicines List (including antiretroviral drugs), assisted reproduction, organ transplantation, and private inpatient accommodation.

A prescribed medicines list is also delineated. Expensive, highly specialized care such as dialysis for chronic renal failure, and organ transplants are not covered by the NHIS. Neither

are Anti-Retroviral drugs for the treatment of HIV/AIDS is covered as these drugs are supplied by a separate government programme (Asante and Aikins, 2008).

There is a notable emphasis on female reproductive health in the benefits package. Benefits include antenatal care, caesarean sections, and postnatal care for up to six months after birth. Treatment for breast and cervical cancer are included in the package, although treatment for other cancers is not.

The five main categories under the NHIS include outpatient services, impatient services, oral health, maternity care and emergencies. The services covered under the outpatient include: general and specialist consultation reviews; general and specialist diagnostic testing including laboratory investigation as well as X-rays, ultrasound, scanning; medicines on the NHIS medicines list; surgical operations such as a hernia repair and physiotherapy. On the other hand inpatient services include: general and specialist inpatient care; diagnostic tests; medication – prescribed medicines on the NHIS medicines list, blood and blood products; surgical operations; inpatient physiotherapy; accommodation in the general ward and feeding (where available). Oral health services under the NHIS include pain relief (tooth extraction, temporary incision and drainage) and dental restoration (simple amalgam filling, temporary dressing). With maternity services, it includes antenatal care; deliveries (normal and assisted); caesarean session and post-natal care. Finally, services covered under NHIS at times of emergency include: medical emergencies, surgical emergencies, paediatric emergencies, obstertric and gynaecological emergencies and road traffic accident. There is a tall list of exclusion list.

The exclusion list include: Appliance and prostheses including optical aids, heart aids, orthopaedic aids, dentures etc; Cosmetic surgeries and aesthetic treatment; HIV Retroviral

drugs; Assisted Reproduction (e.g. artificial insemination) and gynaecological hormone replacement therapy; Echocardiography; Photography and Angiography; Dialysis for chronic renal failure; Organ transplantation; All drugs not listed on the NHIS list; Heart and brain surgery other than those resulting from accidents; Cancer treatment other than breast and cervical; Mortuary Services; Diagnosis and treatment abroad; Medical examinations for purposes other than treatment in accredited health facilities (e.g. Visa application, Educational, Institutional, Driving license etc); and VIP ward (accommodation).

The National Health Insurance Fund

The National Health Insurance Act, 2003, Act 650, provides for the establishment of a National Health Insurance Fund (NHIF) which is administered by the NHIA.

The NHIF is financed from several different sources. These include: Donor funds; Funds allocated to the scheme by the Government of Ghana via Parliament; 2.5% of the 17.5% Social Security and National Insurance Trust (SSNIT) contribution made by formal sector employees; A 2.5% health insurance levy added to Valued Added Tax (VAT); The central exemptions fund, formerly used to provide exemptions from user fees for those classed as 'indigent'; Membership premiums; and Money that accrues to the fund from investments made by the NHIC

2.5 Enrollment and Health Service Utilization under Ghana's NHIS

Since its introduction, the NHIS has grown to become a major instrument for financing health care delivery in Ghana (NHIA, 2013). The Scheme is credited with improvements in the health-seeking behaviour of a significant portion of the population, with membership and utilization of

healthcare services growing significantly (Aniah, 2016). Currently, NHIS covers 8.8 million active subscribers. The Scheme has enrolled over 3,500 healthcare providers, both public and private, and accounts for more than 85% of service delivery income of public and quasi-public health care facilities. Just within a decade of its inception, the NHIS of Ghana has seen an increase in both outpatient and inpatient utilization, with an attendant growth in claims payment (NHIA, 2013).The NHIA says the total active membership of the scheme stood at 8,885,757 in 2012 representing 35% of the population (NHIA, 2013). As at December 2012, Ashanti Region had the highest number of active members totaling 1,536,557. Greater Accra Region was next to Ashanti Region with 1,200,747 members, and Brong-Ahafo Regions followed with 1,094,214 active members. Upper East and West regions had the least active members of 561,359 and 392,900 respectively. It must be noted that the number of active NHIS members in a particular region is influenced by population density and voluntary subscription to the scheme.

Available data indicates that the NHIS has been experiencing increasing claims and other costs over the years. According to the NHIA while this may be attributed to the increasing number of active members, moral hazards that are associated with Insurance Schemes and fraudulent acts of providers in claims management may not be ruled out.

Out-patient utilization of healthcare services among NHIS subscribers increased from 0.6 million in 2005 to 25.5 million in 2011. Between 2011 and 2012 however, outpatient utilization decreased to 23.9 million. Figure 2.1 represents outpatient utilization trend of the NHIS from 2005 to 2012 (NHIA, 2012)

According to the same NHIA (2012) annual report, in-patient utilization followed the same trend as outpatients, increasing from 28,906 in 2005 to 1,451,596 in 2011. However, in 2012, inpatient admissions decreased to 1,428,192. The NHIA concede that claims payment is the major cost driver of the NHIS. Claims payment increased from GH¢7.60 million in 2005 to GH¢616.47 million in 2012. It is evident from narrations above that there is a positive correlation between service utilization levels (OPD and In-patient) and claims paid or received. This sits in well with Beik (2009) which indicates that, all things being equal claims paid should equal claims received.

2.6 Health Insurance Claims Management

Healthcare firms are very unique in the manner in which they receive compensation for the services that they provide (Casto and Layman, 2006). The American Health Information Management Association (AHIMA) has pointed out that healthcare services are often provided before payment is made. As a result, physicians, clinics, hospitals, and other healthcare provider organizations request reimbursement for health services provided in addition to expenses incurred.

Tucker (2015) has said Health Insurance Claims Management is the organization, billing, filing, updating and processing of medical claims related to patient diagnoses, treatments and medications. According to Tucker, Health Insurance Claims Management which also involves maintaining patient records, interacting with health insurance agencies and issuing invoices for medical services are time consuming responsibilities, nonetheless, it is worth doing because

without effective medical claims management, patients wouldn't know what they owe and medical facilities wouldn't receive the funds due for patient services.

Casto and Layman (2006) shares the view that Claims Management typically occurs when, a physician, healthcare organization, or other practitioner prepares a bill for each service provided on a **claim (Sheet)** that lists the fees or charges for each service. The claim is sent to the Third Party Payer (TPP), which is health insurance company or health agency. It is recommended that health insurance claims are submitted as early as possible and close to the date of the provision of the service (United HealthCare Services, Inc., 2016). In the USA for instance, some Health Insurance Companies do not consider claims submitted after 90 days of provision of service as clean claims (JUSTIA, 2017). Accurate and timely submission of claims is therefore a critical component to a provider's compensation (New Mexico Health Connections, 2016)

Sending claim to the TPP is known as submitting a claim. Under the NHIS of Ghana claims submission is monthly. Within the stipulations of the health insurance policy (contract) or the governmental regulations, the TPP pays the claim or makes a reimbursement after receipt and vetting of claims.

Huffman (1994) defines ***Health Care Reimbursement*** broadly as charging and receiving payment for services after they are rendered. A keynote in Huffman's definition is the retrospective nature of reimbursement which is also raised by Jacobs (1996). Casto and Layman (2006) also view reimbursement as the healthcare term that refers to the compensation or repayment for healthcare services. In general, while a patient is responsible for paying some

of the cost of health care directly to the provider, an insurer, that is a third party acting for the patient pays the bulk of the costs directly to the provider in health care reimbursement.

Three characteristics describe various methods of healthcare reimbursement. These characteristics are the unit of payment, the time orientation, and the degree of financial risk for the parties (Beik, 2009). The unit of payment can range from a payment for each service, such as a payment for each laboratory test, to a block payment for an entire population for a period of time, such as a governmental budget transfer to the state health department. The time orientation is either retrospective or prospective. In a retrospective regime, the payer learns of the costs of the health services after the patient has already received the services. The provider also receives payment after the services have been provided. In a prospective payment method, the payments are preset before care is delivered. Financial risk refers back to the definition of health insurance. When the costs of health services are known after the care is provided, the third party payer (health insurance entity) is at risk. When providers must project the costs of treating patients into the future and contract to provide all care for those estimated costs, the provider is at risk. In a co-payment health insurance system, patients also assume some risk as they must pay higher and higher percentages of the costs as their share. The United Nations (2002) has emphasized the need for a reliable health insurance claims reimbursement as part of the prescriptions to enhancing the capacity of public administration to implement the United Nations Millennium Declaration.

This in no doubt points to the important place that claims management and reimbursement occupies in the effective running of public affairs. Atim et al. (2001) argue that reimbursement

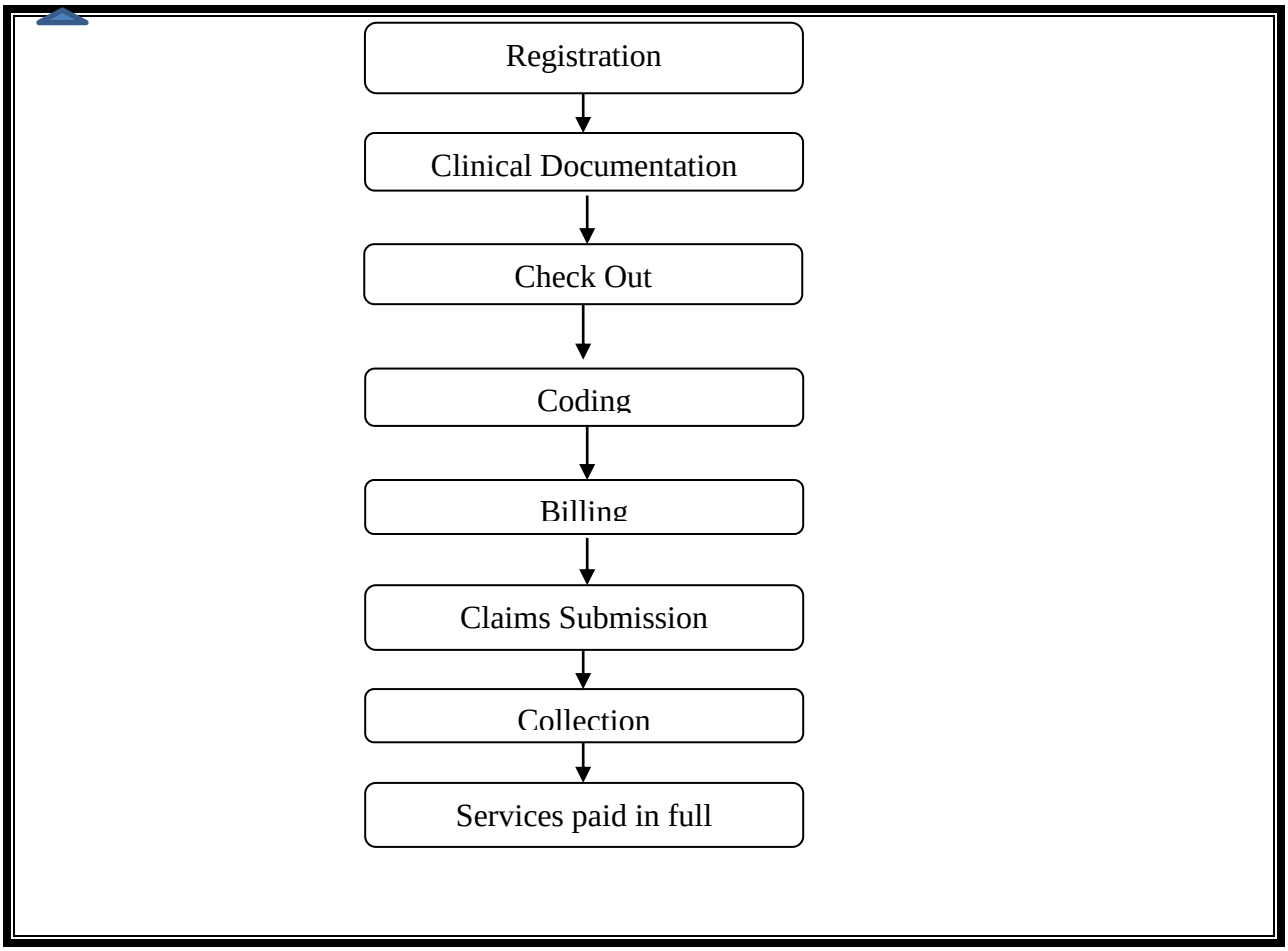
could be done either as fee-for-service or as case-based payment, but points out that fee-for-service is the most common *retrospective* payment method, both in developed and developing countries.

2.7 The Claims Management Process

Health Insurance Claims Management is seen as a process (Beik, 2009). To better appreciate the intricacies of claims management, it is important to appreciate what the process is and why claims management is a process. This is so because Beik is of the opinion that understanding how the (Health Insurance Claims) process works allows the health insurance officer or professional to file claims properly (on behalf of the health care provider) to ensure full and timely reimbursement.

Beik (2009) has noted that the claims process involves many steps, and each step must be performed thoroughly and accurately. A claims management process must essentially enable the AHSP to achieve timely submission of claims and also contribute unavoidably to the maximization of revenue and minimization of loses to the organization. The Claims Management Process is the internal workflow for preparing, submitting, and collecting claims (American Medical Association, 2011). The emphasis here is on internal workflow, meaning the AHSP is responsible for establishing, maintaining and evaluating the claim process to make it relevant to the needs of the organization. Figure 2.4 details out the steps in the claims management process based on a model developed by the American Medical Association.

Figure 2.1: The Claims Management Process



Source: American Medical Association (2011)

The first stage in the claims management process is registration of insurance card bearers, which involves collection of the patient's demographic and health insurance information and accurately entering it into the health provider's Health Management Information System (HMIS) database by the registration staff. It further entails confirmation of the patient's benefits, applicable deductibles, and or co-payments by verifying with the NHIS through online verification or any applicable means. It is suggested for the registration staff to make a copy of the patient's health insurance card to obtain the necessary health information. Returning or established patients must go through verification to establish any changes to their health

insurance status. Where applicable, the registration staff should also give the patient a copy of the health provider's payment policies during check-in.

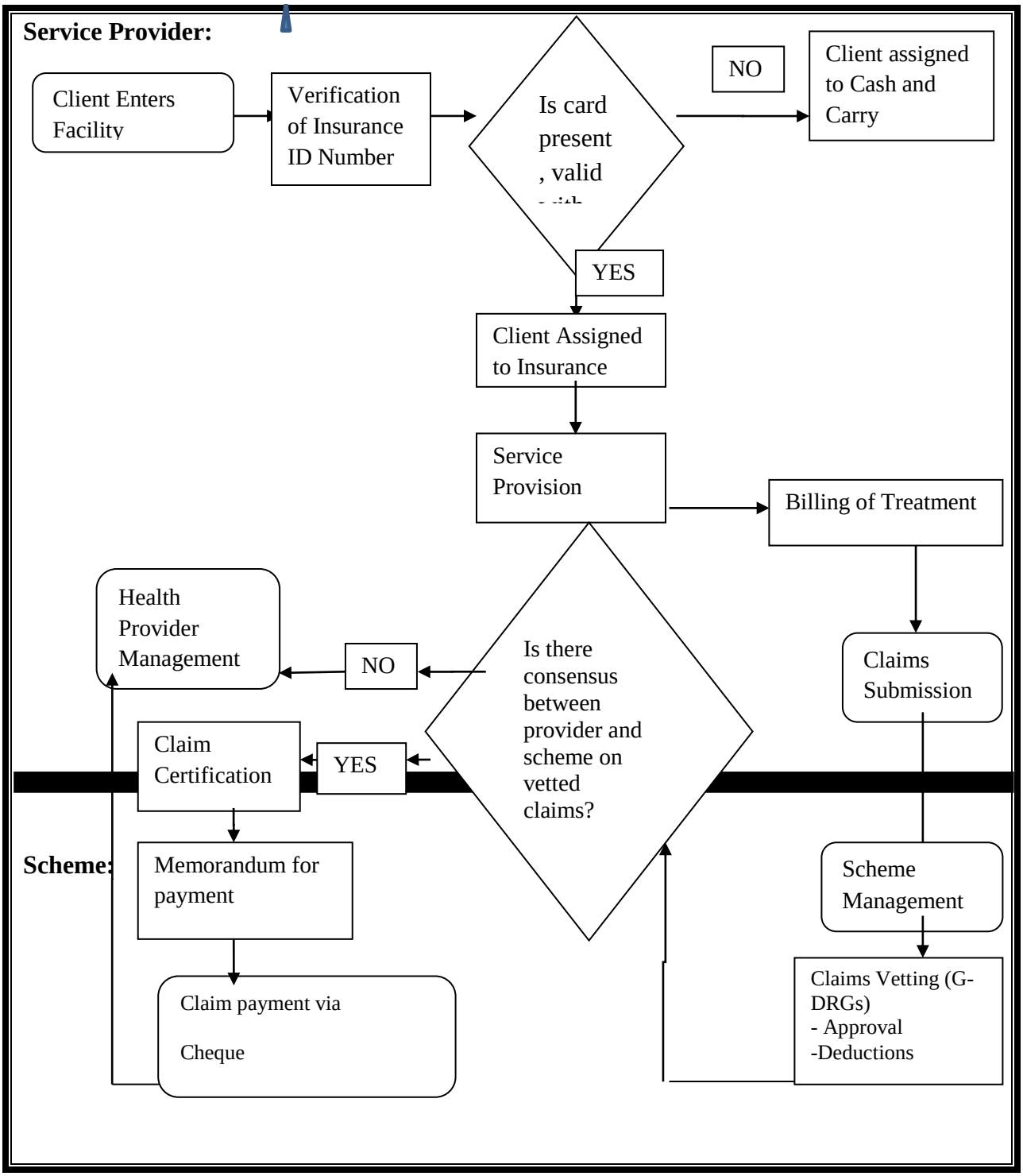
Clinical Documentation is the second stage of the claim process. The American Medical Association (2011), explains clinical documentation to mean the capturing of the patient's history, symptoms, diagnosis and treatment plan, including appropriate tests that may be ordered, in the medical record by the treating physician or clinical team. Clinical documentation also involves the treating physician or clinical staff assigning the appropriate codes and documenting these codes in the medical records as applicable. This is necessary for the final billing. The importance of the clinical documentation is that it is the basis for any claim and therefore must be recorded painstakingly in an accurate, comprehensive and legible manner. Beik (2009) is empathetic that substantiating claims with health records documentation is a precondition for receiving maximum payment.

The third stage of the claim process, according to the American Medical Association, is Check-out. This requires the registration staff to collect the patient's balance (e.g. deductibles and co-payments) and scheduling the next appointment.

Coding constitute the fourth stage of the claims process. At this stage, two things are important: firstly, code verification and review and secondly pre-authorization, pre-certification or predetermination of the patient's benefit coverage prior to a procedure or service. Billing is the next stage of the claims process and requires the billing staff to enter the codes and fees accurately as they appear on the patient encounter form (medical documentation), and then generating a paper or electronic claim. Claim review is also essential at this stage and require

billing staff to review each claim for completeness and accuracy before submitting it to the health insurer. When this has been done, payment follows after the claim has been cleared as clean by the third party payer. This also points to the fact that the claims management process is of two segments. Sodzi-Tettey (2009) identifies the two components of the claims process as the provider component and the scheme component. Similar to the American Medical Association version of the claims process, Sodzi-Tettey suggests that the claims process starts with the entrance of the client into the health facility, and ends with the reimbursement or rejection of the claims submitted by the provider for the services rendered. The process is enhanced by Sodzi-Tettey who pictures it in a flow chart. What looks like a gap and which Sodzi-Tettey did not substantiate vividly in his version of the claims management process is the option of claims appeal by the service provider in the event of claims rejection. Figure 2.5 represents the claims management process from the perspective of Sodzi-Tettey (2009).

Figure 2.2: Flow chart of NHIS Claims



Source: Sodzi-Tettey, 2009

Newby (2010) has also defined ten (10) steps in health insurance claims management which she has named "the Medical Billing Cycle". The steps described by Newby are essentially in agreement with the AMA (2011) and Sodzi-Tettey (2009). The Newby Medical Billing Cycle is described below.

Step 1: Preregister Patients

The first step in the medical billing cycle is to gather information to preregister patients before their office visits. This information includes the following. The first to be done is the patient's name. Second, is the patient's contact information; at the minimum, address and phone number. The third thing is the patient's reason for the visit, such as a medical complaint or a need for an immunization. (The visit reason is used to calculate an estimated visit length for scheduling appointments, often done at this time as well). Finally, whether the patient is new or returning to the practice (different information is gathered in these two situations).

Step 2: Establish Financial Responsibility for Visit

The second step is very important, and it is to determine financial responsibility for the visit. For insured patients, these questions must be answered or considered: What services are covered under the plan?; what medical conditions establish medical necessity for these services?; what services are not covered?; what are the billing rules of the plan?; and finally what is the patient responsible for paying? Knowing the answers to these questions is essential to correctly billing payers for patients' covered services. This knowledge also helps medical assistants ensure that patients will pay their bills when benefits do not apply. To determine financial responsibility, these procedures are followed: verify patients' eligibility for their health insurance; check the health insurance coverage; determine the first payer if more than

one health insurance covers the patient. The first payer is the payer to whom the first claim will be sent; and meet payers' conditions for payment, such as preauthorization, ensuring that the correct procedures are followed to meet them.

The provider's financial policy (when bills have to be paid) is explained so that patients also understand the medical billing cycle. Patients must be told that there is medical billing cycle process that results in timely payment for medical services.

Step 3: Check In Patients

The third step is to check in individuals as patients of the admit patient and assign the appropriate payment method as applicable. When new patients arrive for their appointments, detailed and complete demographic and medical information is collected at the front desk or the patient information office. Returning patients are asked to review the information that is on file for them, making sure that demographics and medical data are accurate and up to-date. Their financial records are also checked to see if balances are due from previous visits.

Both the front and back of insurance cards and other identification cards such as driver's licenses are scanned or photocopied and stored in the patient's record. If the health plan requires a copayment, the correct amount is noted for the patient. Copayments should always be collected at the time of service. Some practices collect copayments before the patient's encounter with the physician; others collect them after the visit.

Also, during the office visit, a physician evaluates, treats, and documents a patient's condition. The notes taken at this time include the procedures performed and treatments provided, as well as the physician's determination of the patient's complaint or condition.

Step 4: Review Coding Compliance

Office visit physician notes contain two very important pieces of information—the diagnosis, which is the physician's opinion of the nature of the patient's illness or injury, and the procedures, which are the services and treatments performed. When diagnoses and procedures are reported to health plans, code numbers are used in place of descriptions. Coding is the process of translating a description of a diagnosis or procedure into a standardized code. Standardization allows information to be shared among physicians, office personnel, health plans, and so on, without losing the precise meaning.

Step 5: Review Billing Compliance

Medical practices bill numerous health plans and government payers. The provider's fees for services are listed on the medical practice's fee schedule. A fee schedule is a listing of standard charges for procedures. Each charge, or fee, is related to a specific procedure code. However, the fees listed on the master fee schedule are not necessarily the amount the provider will be paid. Instead, each of the health plans and government payers reimburses the practice according to its own negotiated or government-mandated fee schedule. Many providers enter into contracts with health plans that require a discount from standard fees. In addition, although there is a separate fee associated with each code, each code is not necessarily billable. Whether

it can be billed depends on the payer's particular rules. Following these rules when preparing claims results in billing compliance.

Step 6: Check Out Patients

Checkout is the last step that occurs while the patient is still in the office. The medical codes have been assigned and checked, and the amounts to be billed have also been verified according to payers' rules. The charges for the visit are calculated, and payment for these types of charges is usually collected at time of service. The key things that are cross-checked include: previous balances, copayments, coinsurance, non-covered or over-limit fees, charges of nonparticipating providers, charges for self-pay patients, deductibles for patients with certain types of health plans and billing for supplies. A receipt is prepared for the payments made by the patients, and follow-up work is scheduled as ordered by the physician.

Step 7: Prepare and Transmit Claims

A major step in the medical billing cycle is the preparation of accurate, timely health care claims. Most practices prepare claims for their patients and send them electronically; these are electronic claims or e-claims. A claim communicates information about the diagnosis, procedures, and charges to a payer. The practice has a schedule for transmitting claims, such as daily or every other day, which is followed. When a patient is covered by more than one health plan, the second and any other plans must be sent claims after the primary payer sends a payment on the account.

Step 8: Monitor Payer Adjudication

When the payer receives the claim, it goes through a series of steps designed to determine whether the claim should be paid, a process called adjudication. Claims may be paid in full, partially paid, or denied. Payments from insurance companies are listed on a remittance advice, which is sent to the provider along with the payment. The remittance advice lists the transactions included on the claims, states the amount billed and the amount paid, and provides an explanation of why certain charges were not paid in full or were denied entirely. The remittance advice provides details about each patient transaction, such as: date of service, services provided, patient name and control number, provider identifier number, amount allowed by contract, amount paid to provider and amount owed by patient.

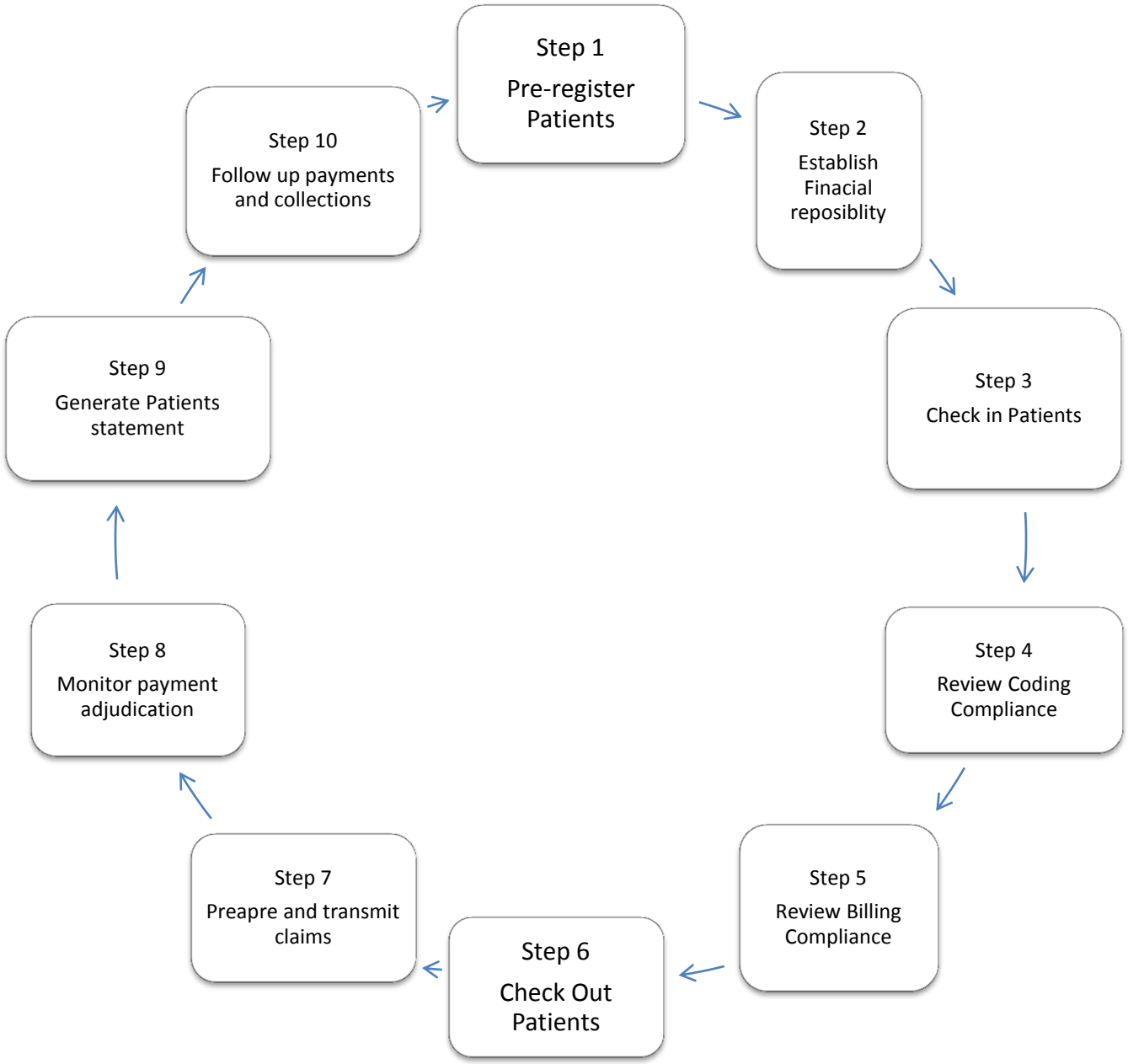
Step 9: Generate Patient Statements

Payers' payments are applied to the appropriate patients' accounts and patient statements are generated. In most cases, payer payments do not fully pay the bills, and patients will be billed for the rest. The amount paid by all payers (the primary insurance and any other insurance) plus the amount to be billed to the patient should equal the expected fee. Bills that are mailed to patients list the dates and services provided, any payments made by the patient and the payer, and the balances now due.

Step 10: Follow Up Patient Payments and Collections

Practice management programs (PMPs) are used to track accounts receivable (AR) and to produce financial reports that are used to manage the revenue cycle by following up on late or reduced payments.

Figure 2.3: The Medical Billing Cycle



2.8 Challenges with Claims Management and why claims payments are denied

Hospital and health system managers are facing several problems following the introduction of Ghana's National Health Insurance policy (Sakyi et al., 2012).In the view of Sakyi et al., among the challenges are cash flow delays from the NHIA. The delay in cash flow from the

NHIA is as a result of delays in claims processing, especially at the provider side due to inadequate administrative capacity, technical issues, human resource factors and working environment challenges (Sodzi-Tettey et al., 2012) These challenges invariably become bottlenecks against achieving the primary goals of health insurance claims management which are, to complete and submit insurance claims and conduct billing and related procedures that ensure that it generates as much money for the provider as legally and ethically possible that the medical records available would support (Beik, 2009).

There are several bases on which claims could be rejected by the NHIA (Seddoh et al., 2011).The NHIA may deny or reduce the payment of tariff claimed by a health care facility where the management of the scheme is satisfied that the claim contains a number of irregularities. The ability of staff to fill the NHIA forms as required is therefore a necessity to ensure that they maximize their revenue and avoid unnecessary rejections of claims (Yakubu, 2009). Other irregularities common with health insurance claims that may result in reduced claims are billing for services, procedures, and supplies that were not provided to the patient, billing for a more expensive service or procedure than what was provide, unbundling charges or code fragmentation – billing services separately that usually are included in a single service fee, and falsifying diagnosis to obtain insurance payment on something that is not covered (Beik, 2009).

The NHIA considers most of the irregularities uncovered in the claims of AHSPs as financial malfeasance and corruption, and believes such irregularities had become associated with the

NHIS country-wide (NHIA 2011). In NHIA's own words, "nowhere was corruption more pervasive than in claims administration".

As to which health professional group may be responsible for the poor claims, experts admit that most health care providers are caring, honest, and ethical professionals however, just about anyone can commit health care fraud – physicians, hospitals, medical suppliers, pharmacies, to name a few Beik (2009).

2.9 Successful Claims processing

Today, claims processing is a source of escalating costs and increased risk for property and casualty insurance companies around the world. System-wide inefficiencies can lead to inaccurate claims assessments, delayed settlements, losses due to fraud, litigation, regulatory non-compliance prosecutions and a shrinking customer base

Beik (2009) who worked in various medical facilities in the USA and gained experience and expertise in all facets of "Front Office Work", including the preparation and submission of insurance claims says there are six keys to successful claims processing which she identified as collecting and verifying patient information, obtaining the necessary preauthorization, documentation, following payer guidelines, proofreading to avoid errors, and submitting a clean claim.

2.10 Health Provider Accreditation

The South Africa Department of Health (2011) defined health services provider accreditation as the process through which an entity undertakes to certify healthcare and health services

providers according to appropriate and specific criteria in order for them to be contracted and reimbursed for rendering services to a defined population. According to Rooney and van Ostenberg (2001) accreditation is a formal process by which a recognized body, usually a non-governmental organization, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years.

Even though Rooney and van Ostenberg (2001) think that accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation, in Ghana, the latter is the case for health providers under the NHIS. Section 70 (1) of the National health Insurance Act, 2003 (Act 650) provides that:

"A scheme shall not use the services of a healthcare provider or a health facility in the operation of the scheme unless the healthcare provider or the health facility has been approved and accredited to the scheme by the Authority".

As per the above provision, it is a legal necessity for a health service provider to be duly accredited by the NHIA before it qualifies to participate in providing the approved level of care to NHIS subscribers. **Section 104 of Act 650 says, "accreditation"** means a process by which

the qualification and capability of a healthcare provider is verified for the purpose of enabling that person to provide healthcare services (under the scheme).

The NHIA requires a health care facility whose previous accreditation had lapsed, a health care facility which changes ownership, and a health care facility that upgrades or downgrades its facilities to offer itself for accreditation for the purposes of issuance of certificate of accreditation to enable it provide service to members registered under the National Health Insurance Act (650, 2003). The NHIA has emphasized that a Health Insurance Claim submitted by a healthcare facility for services rendered before the issuance of a Certificate of Accreditation to that provider shall be invalid.

Regulation 23 of the National Health Insurance Regulation, 2004 (L.I. 1809) sets out the requirements of a healthcare facility before accreditation. Among the requirements are the following. The facility must have the human resources, equipment, physical structures and other requirements that meet the standards of the Council. Also, the facility must accept the quality assurance standards and utilization review of the Council and the payment mechanism approved by the Council. In addition, the facility must adopt the referral protocols, practice guidelines and health resource sharing arrangements of the schemes as approved by the Council. The facility must have its own formal quality assurance programme. The facility must accept to comply with the information system requirements and regular transfer of information, including any reporting mechanism established by the Council and the schemes to which it is accredited. Finally, the facility must maintain accurate records of its patients or customers, services rendered and results from the services.

2.11 The Health Insurance Contract

The first legal item in the business of handling health insurance is the insurance contract, which is also known as a policy (Fordney, 2008). A contract is an agreement between two or more competent parties, based on mutual promises, to do or to refrain from doing some particular thing that is neither illegal nor impossible (Brown and Sukys, 2001). Flight (2004) has said that a contract comes into being when an offer is made by one party, accepted by another party, and consideration passes between them. The agreement between the parties results in an obligation or a duty that can be enforced in a court of law and in the opinion of Flight, the economic system is built on the expectation that contracts between parties will be honoured.

The American Medical Association (2011) says Health Insurance contracts are essentially contracts in which one party, the health insurer, pledges to pay for the services of another party, i.e. the health service provider, The American Medical Association believes that carefully evaluating a health insurer contract is extremely important, and that before a health service provider signs a contract and or the staff prepare claims to submit to the insurer, they should have a solid understanding of how the contract will affect their revenue and expenses.

A policy paper prepared by the Department of Health of the Republic of South Africa in 2011 on National Health Insurance explained contracting of health service providers to mean the process through which an entity enters into formal and legally binding arrangements with appropriately licensed and accredited healthcare and health services providers for rendering services to a defined population. The contractual arrangements may stipulate the rates for

reimbursement of providers, the penalties and sanctions that may be imposed if specific provisions of the contract(s) are violated.

Jones and Mills Jr. (2006) have indicated that negotiating a contract with a health insurer is often time-consuming and labor intensive, and it usually leaves health providers feeling frustrated and uninformed. Jones and Mills Jr. stress that this should come as no surprise since the contracting process is structured to put the health provider at a distinct disadvantage. The upper hand which the health insurer typically enjoys over the health provider is attributed to the luxury of a dedicated legal department, advanced software systems, and a staff of financial and network analysts paid to gather and organize relevant information regarding benefit plan costs, reimbursement levels and advantageous contract provisions that will guarantee the health insurers success in each contract negotiation. Jones and Mills Jr. (2006) suggest that health providers and their staff must be willing to invest significant time and effort in trying to ensure a successful negotiation and to secure a mutually favorable contract.

2.12 Tariffs under the National Health Insurance Scheme of Ghana

Ankomah (2015 has observed that the sustainability of the NHIS, however, depends to a large extent on a well designed provider payment mechanism which allows providers to achieve reasonable income, provide quality services and avoid wastage and unnecessary service provision. The laws that established the NHIS of Ghana also empowered the NHIA that was subsequently established to introduce tariffs to resource service providers. Ankomah (2015) suggests that with a view to supporting the scheme's long-term sustainability, the National

Health Insurance Authority (NHIA) has taken critical steps to pursue reforms in the provider tariff payment.

2.12.1 The Old Health Insurance Tariff

One of the most important linkages in health insurance is the payment system link between the insurance schemes and service providers. Service providers, like most organizations, are interested in maximizing their income. They would like to provide as many tests and treatment as possible, asking patients to come back several times even when it is not necessary, needlessly using expensive equipment they have purchased in order to recover cost. It has often been suggested that without a well designed provider payment system to curtail these supply-induced demands, any insurance scheme, however well conceived, might break down.

There are many different methods for paying providers; each one has different effect on quality of health care services, cost containment and administration. The commonly used provider payment methods include the fee for services or itemized per case costing, daily (per diem) payment, capitation and case payment (e.g. Diagnosis Related Group). At the inception of the NHIS, a provider tariff system, this was based on 'itemized per case costing' was adopted for implementation. Under this system, providers were paid a fee for each service, procedure or act provided to patient-consultation fees, accommodation, non-drug consumables, x-ray, laboratory, feeding and so on. The administration of this tariff system, however, faced a lot of challenges.

One of the challenges was the fact that the volume of information required to be provided by the providers brought about prolong vetting of claims and delay in the reimbursements. Another was the issue of proliferation of tariffs among the schemes resulting in great variability of the cost of treatment for the same condition in related facilities. The delay in the reimbursement and the fact that diverse prices were charged for similar procedures and investigations provided in similar facilities in the same or in different regions obviously threatened the sustainability of the NHIS.

Another dimension of the problem was that some providers particularly private ones did not find the NHI tariff attractive and therefore those who otherwise would have applied for NHI accreditation did not do so. Acceptable rates were important for increasing provider participation, thus reducing congestion at current NHI accredited facilities.

2.12.2 The New Provider Tariff System

The new tariff system is based on Diagnosis Related Group (DRG) concept. The DRGs are standard groupings of diseases that are clinically similar, have comparable treatments or operations and use similar healthcare resources. Under this tariff system, service providers are paid an already decided all-inclusive flat payment for a patient's treatment according to his/her diagnostic group irrespective of the costs.

This payment system has tremendous administrative benefits, as the scheme does not have to scrutinize individual bills. Again, despite the fact that the system can compromise quality of

care, as providers may actually skimp on relevant treatment to make profits, the incentive for the providers to prescribe extra services is quite limited.

One other benefits of the new tariff is that it provides the service providers, opportunities to earn a reasonable income which, if well managed, will go a long way to bridge the current funding gap in the public health facilities. Unlike the previous one, the new tariff is made up of estimated direct and indirect/overhead costs of providing the various services to each patient depending on the patient's diagnostic related group and level of care. The direct cost includes direct consumable cost for investigations, anesthesia and direct patient care while the overhead cost consists of maintenance of buildings & equipment, vehicle running & maintenance cost, utilities, housekeeping, general administration and indirect labour (casual labour). The details of the components of the overhead costs are explained below. First is the building & equipment maintenance cost (minor repairs on official & residential buildings, drive ways, grounds, equipment/plant/machinery). The second item cost line is vehicle maintenance and running cost (fuel and lubricants and maintenance of official vehicles), Utilities (electricity, water and telephone). It is followed by housekeeping (cleaning materials, sanitation charges). Then, there are also general administrative and office expenses (printing and photocopying, purchase of publications, bank charges, refreshment, training and conferences, stationery and other office consumables. Finally, the last item of cost is indirect labour (casual labour).

It is important to point out that, the new tariff covers the full cost of the estimated direct consumables for direct patient care, anesthesia and investigations, and about 80% of the estimated overhead cost for the public health facilities. The implication is that the insurance

schemes, in addition to paying for the full cost of the direct consumables for the treatment of the insured patients, also pay a substantial amount for the estimated cost for overhead cost including building and equipment maintenance, housekeeping and utilities in the various public health facilities. In the case of the private and quasi-government facilities, the new tariff covers the full estimated cost of both the direct and overhead costs.

2.12.3 Implementation of the New Tariff System: Key Challenges

A major challenging issue confronting the implementation of the new tariff system is the accounting system being operated at the public health institutions. With the new tariff system, service providers particularly the public health facilities are expected to generate adequate revenue from the NHIS (provided the schemes pay promptly) to enable them cover a significant portion of their cost of operation which otherwise were very much dependent on government and donor funds, the flow of which has been low and erratic. The accomplishment of this, however, requires an accounting system with in-built checks and balances for the management of the revenue from the NHIS. Currently the way the accounting system for revenue is structured for the public health sector does not reflect the components of the direct and overhead costs as embodied in the new tariff.

This means that there is the need to review the accounting system to provide a classification of revenue according to the various cost components of the new tariff. This need has to be fulfilled in order to ensure that every Ghana cedi spent from the NHIS revenue can easily be identified with the purpose for which the money is allocated to achieve. If this is not done and everything is put together as one pool of revenue, it will be extremely difficult for the

management to keep track of the revenue for the purpose for which they are intended. In this way the whole exercise will be like a drop of water in the ocean and nothing much could come out of it.

The issue of service availability also requires attention. As aforementioned, with the new tariff, service providers are required to be paid an all-inclusive flat payment for a patient's treatment according to his/her diagnostic group. The principal thrust of this system is to make hospitals and health centres fully functional at their levels. This implies that hospitals and health centres should be able to provide all the required services including laboratory, ultrasound and x-ray investigations at their levels. It is important, however, to note that most of the facilities do not have the requisite infrastructure and human resources to provide the desired services. There is the need therefore for the NHIA to take the necessary steps to support the less resourced facilities by sufficiently upgrading the infrastructure and human resources in those facilities.

Another key issue is the attitude of the staff of both the scheme and service providers towards the implementation of the new tariff. It is important to point out that no matter how efficient the design of the new tariff system is, it is the officers of the scheme and service providers that operate and manage it. They can make the system work or not depending on their level of comprehensiveness of the process of implementation of the new tariff. Therefore maintaining the right attitude of the officers by way of involving all those who matter in the implementation of the new tariff in regular training to enable them appreciate the purpose and the process of the implementation of the new tariff should remain a critical consideration of the NHIA, the scheme managers as well as managers of service providers.

One more issue needing serious attention on the part of the scheme managers is the promptness of the payment of claims to service providers. Among the considerations for adopting the new tariff system was the need to reduce the indebtedness by the scheme to the service providers by cutting down the rigorous process of scrutinizing the individual bills, which resulted in the delay in reimbursement. It appears, however, that the issue of indebtedness to the service providers is still a problem and this has a tendency to a large extent to defeat the purpose for the reforms in the tariff system. In order for the service providers to keep confidence in the new tariff, it is imperative for the schemes to expedite action to refine their claims management procedures and fast track the payment of the claims to the service providers.

2.13 Revenue function for health care firms

Hospitals must generate revenue in order to provide their community with crucial health care services and the complex system of hospital financing includes a variety of revenue sources (Florida Hospital, 2013). Casto and Layman (2006) cite four reasons why the revenue function for healthcare firms is so different compared to other industries. Firstly, the vast majority of payment is not actually paid by the client (patient), but rather by a third party on behalf of the patient. Secondly, the level of payment for a set of identical services may vary dramatically based upon the actual third party payer. Thirdly, the actual determination of payment for a specific third party payer is often complex, based upon pre-established or negotiated rules of payment that are frequently related to the codes entered upon a patient's bill or claim. Fourthly, the government is often the largest single payer and does not negotiate payment but simply defines the rules for payment upon which it will render compensation for services provided to

its beneficiaries. Casto and Layman (2006) suggest that many healthcare firms can lose substantial sums of money because they are not coding their patients' claims in an accurate and complete manner.

Hospital operating revenue comes from two payment sources: public payers and private payers. Public payers are health insurance programs funded by the government. Private payers include employer-sponsored health coverage, self-payments and individually purchased private health insurance (Florida Hospital, 2013).

2.14 The Health Insurance Claims Form

Providers who are accredited by the NHIA to serve insured clients are mandated to complete a claims form for each client provided with care (Regulation 62 of NHIS Regulation 2004, LI 1809). This is a standard practice in all countries with National or other forms of insurance (Beik, 2009).

The NHIS form is the basis for claims management and if well completed, it captures the patient's personal data such as name, gender, date of birth, age, NHIS registration number, and hospital record number. The form also captures the details of type of services provided, the nature of visit, whether first, second, third or fourth (the maximum visits allowed within a specific time period is 4). Provision has also been made on the form to capture the duration of spell (days) and the outcome of care, whether patient was discharged, transferred out, died or absconded. The procedure performed on the patient, the date of the procedure and the associated Ghana Diagnosis Related Grouping (G-DRG)/code must also be indicated on the

form. Other important details that the claims form must capture are description of diagnosis made, investigations conducted, medicines dispensed: showing the type of medicine, the quantity dispensed, the cost, date and medicine code. There is also a portion of the claims form that summarizes the claim of the client in respect of out-patient care, in-patient services provided, investigations conducted and pharmacy services provided showing the cost of each and the G-DRG/code. The overall cost must be indicated after which the Health Facility Insurance Officer signs and forwards the forms to the NHIA Office.

2.15 Moral Hazards and Fraud in Health Insurance

Vetting of claims is an important activity in processing claims for payment (Ghana Audit Service, 2012). Regulation 39(1) of the NHIS Legislative Instrument (L. I. 1809) requires Health Insurance Officers to deny or reduce claims submitted by accredited providers where management of the Health Insurance Scheme detects fraud and or other anomalies.

Health insurance reduces price sensitivity because patients do not pay for medical care at the point of service (Buff & Terrell, 2014). This separation of consumption and payment makes people act as though they are receiving low-cost or even free services. In the view of Buff & Terrell, a patient may opt for a procedure that costs taxpayers or insurance policy-holders $1,000 even though the value to the patient is only $200. Litigation aggravates the problem as patients and their attorneys seek large numbers of radiology procedures and other tests in an effort to locate one result to bolster a case. Additionally, because insured patients lack price sensitivity, physicians have little incentive to consider the full cost of services provided. According to Fordney (2008), the tendency to over consume medical care as others bear the cost is an example of moral hazard. More generally, moral hazard is a term used by economists

to describe the tendency to take on more risk as the costs are shifted to others. Related to moral hazard in health insurance management is fraud.

Dsane-Selby (2013) defines Health insurance fraud is an intentional act of deceiving, concealing, or misrepresenting information that results in health care benefits being paid to an individual or group. The PA Insurance Fraud Prevention Authority in Pennsylvania agreed with Dsane-Selby when they said there is fraud when false or misleading information is provided to a health insurance company in an attempt to have them pay unauthorized benefits to the policy holder, another party, or the entity providing services.

Both Dsane-Selby and the PA Insurance Fraud Prevention Authority share the opinion that fraud can be committed by both a member of a health insurance scheme and an accredited health care provider. The offense can be committed by the insured individual or the provider of health services. The types of fraud and abuse committed include billing of services not rendered, up-coding of services, double billing/duplicate claims, misrepresentation of diagnosis, unbundling of services, unnecessary services, inappropriate referral for financial gain, insertion/substitution of medicines, unauthorized co-payments, impersonation (a non-member using a member's identity), ganging (all the family using one member's card), provider shopping, illegal cash exchange for prescription and frivolous use of services (drugs for sale) Dsane-Selby (2013).

2.16 Theoretical framework for Health Insurance Claims Management in Ghana

Layman (2006) defined a conceptual framework as a visual or written product, one that explains, either graphically or in narrative form, the main things to be studied—the key factors,

concepts, or variables—and the presumed relationships among them. It could be understood from the definition of Layman that the conceptual framework is primarily a conception or model of what is out there that the researcher plans to study, and of what is going on with these things and why.

The conceptual framework developed for this study was a tentative theory of the phenomenon that the researcher went to investigate. It is the authors own construct as depicted in Figure 2.6. There are five key elements in the framework which are inter-linked, namely; Health System (HS), Legal Commitment (LC), NHIS Approved Documents, Preparation of Claims and Submission of Claims.

The health system is composed of interacting, interrelated and interdependent components that form a complex and unified whole. The organization of a Health System and its institutions are primarily geared towards improving, maintaining and restoring the health of the population it serves (Christian Health Association of Ghana, 2014). The Christian Health Association og Ghana conceives the essential components of the HS as Leadership and Governance, Service Delivery, Health Human Resources, Health Technologies, Health Information, Partnerships, Community Participation and Research.

The effectiveness of a service provider to deliver on its mandate of securing the good health of its target population is directly related to the effectiveness of the health system. In other words, the nature of the Health System (HS) of a service provider is very important when it comes to implementation of the NHIS and for that matter, claims management. The NHIA determines

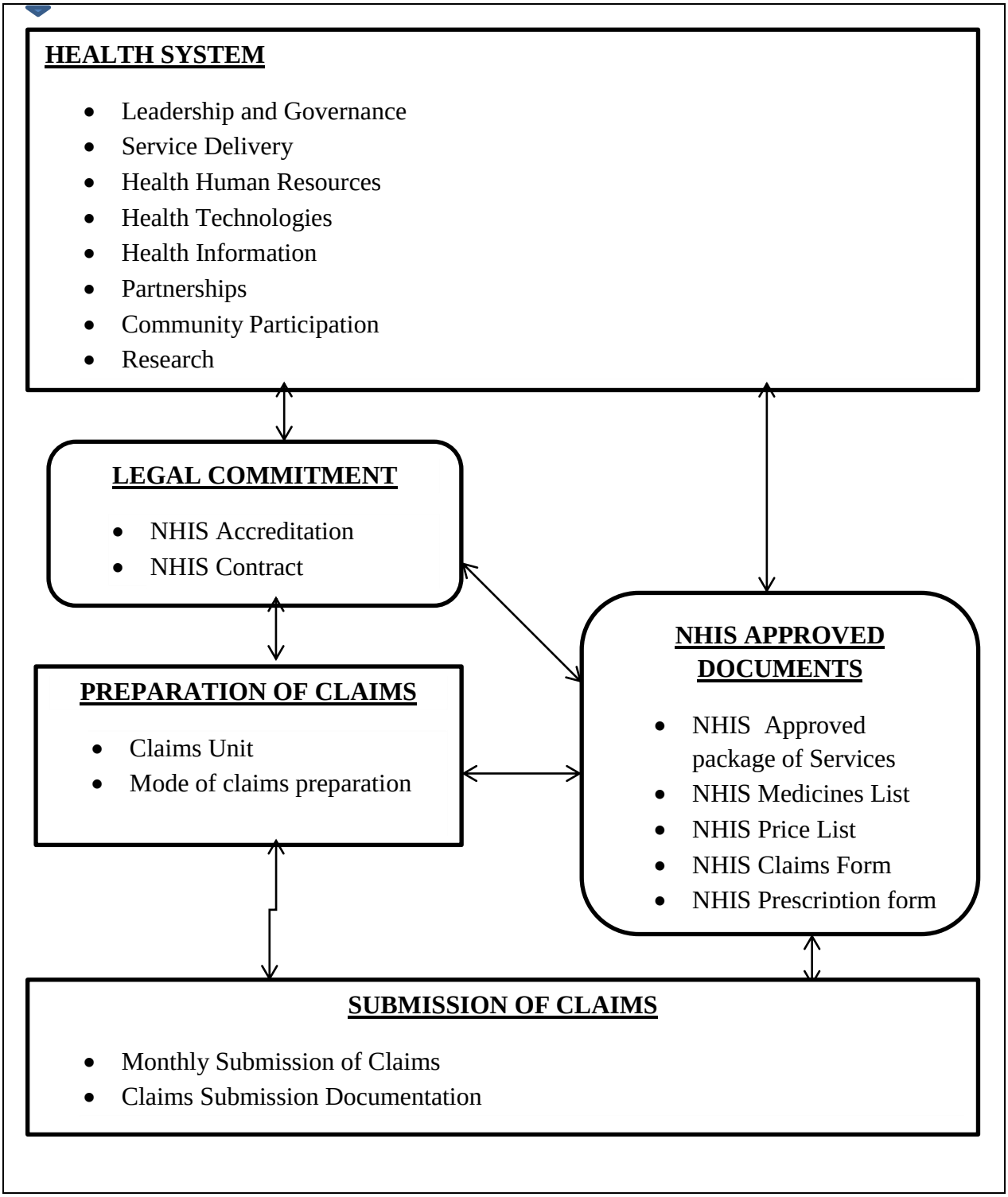
the capacity, the strength and the performance of the HS of a provider by applying the NHIS Accreditation Tools which the NHIA introduced for Health Facilities in 2009.

Where after the assessment of a provider's HS the NHIA finds it well prepared, and resilient enough, to support quality health care to card bearing NHIS members, the NHIA then makes legal commitment to the provider by granting accreditation and also entering into an insurance contract.

A provider that has a legal relationship with the NHIS through accreditation and a duly signed contract is required to apply NHIS approved documents in service delivery. The documents include approved Services with prices, Medicines List, Claims Form, and Prescription Form.

An accredited health service provider of the NHIA is obliged not to take money out of pocket from NHS card bearing members. Rather, accredited health service providers of the NHIA must prepare claims and submit on monthly basis to the NHIA for payment.

Figure 2.4: Framework for Claims Management



Source: Author's Construct, 2015

CHAPTER THREE

RESEARCH METHODOLOGY AND STUDY AREA

3.1 Introduction

This chapter presents the methodology for the study. As suggested by Opoku (2009), under this methodology chapter is the design of the research, sampling and the procedure used in the collection of data and how the data was analyzed. The Chapter concludes with a brief profile of the study area (the Brong-Ahafo Region) and the three district hospitals that were the source of data for the research.

3.2 Research Design

The research design refers to the overall strategy that a researcher chooses to integrate the different components of a study in a coherent and logical way, thereby, ensuring that the research problem is effectively addressed; it constitutes the blueprint for the collection, measurement, and analysis of data (De Vaus, 2001).

This study was descriptive in nature and according to Mustafa (2010) a descriptive research measure the state or condition at any particular time, and involves gathering data that describe events and then organizes, tabulates, depicts, and describes the data collection. It often uses visual aids such as graphs and charts to aid the reader in understanding the data distribution.

The researcher also adopted a survey research design which was also cross-sectional, that is, the data collected pertained to a particular point in time. The survey approach was used for this study because it aided the collection of a large amount of data from the population in an

economical way. The survey was undertaken through the administration of questionnaires in the three hospitals used for this study.

In terms of methods of data collection, primary data was gathered using structured questionnaire specifically designed for this study. Secondary data was obtained by reviewing the reports of the three facilities and earlier works done which related to the subject matter. Interviews were conducted with selected hospital management personnel and district officers of the NHIA to get additional information to compliment the data gathered through questionnaires.

The researcher opted for quantitative data analysis for this study. Quantitative analysis was the researcher's preferred tool of analysis because as noted by Abeyasekera and Lawson-MacDowall (2000), quantitative methods of data analysis is of great value to the researcher who is attempting to draw meaningful results from a large body of qualitative data. The main beneficial aspect is that it provides the means to separate out the large number of confounding factors that often obscure the main qualitative findings. The researcher also favored quantitative analytical approach for this study because it allowed the reporting of summary results in numerical terms that can give a specified degree of confidence.

3.3 Profile of Brong-Ahafo Region

Brong-Ahafo Region was selected out of the ten (10) regions of Ghana for this study. The selection of Brong-Ahafo Region for the study was based primarily on the interest of the researcher to understand the real issues and the challenges in claims management in the region

where he himself lived and worked at the time. The three districts where this study was carried out are shown on the map of Brong-Ahafo Region in appendix 4.

The Brong-Ahafo Region is one of the ten (10) Administrative Regions in Ghana. The Region was carved out of the former Ashanti Province in March 1959 when the Brong-Ahafo Bill was passed under a certificate of urgency by Parliament. The administrative capital of the Region is Sunyani. There are 27 Administrative Districts in the Region, each headed by a District Chief Executive (DCE) who, in turn, is under the political and administrative jurisdiction of the Regional Minister.

The Brong-Ahafo Region lies within longitude 0° 15'E to 3° W and latitude 8° 45''N to 7° 30'S. The Region shares common boundaries with five others. Northern Region is to the North, Ashanti and Western Regions to the South, the Volta Region to the East and the Eastern Region to the South East. It has an international boundary to the West which it shares with La Côte d'Ivoire. The region occupies a total land area of 39,554 sq. km, which makes it the second largest region of the country in terms of land size.

The population of the region grew from 1,815,408 in 2000 to 2,310,983 in 2010 (GSS, 2010). With a growth rate of 2.3% the population is estimated to increase to 4.6 million by 2040.The male population represents 49.6% of the total population of the region, whiles the females are 50.4%. The age structure of the region indicates that, the proportion of the population aged 0 - 14 (under 15 years) is 40.4%, and those aged 15 -64and 65+ are 55.1% and 4.5% respectively. It has a population density of 58.44 people per sq. km. The region is 44.5% urban with an

annual urban growth rate of 4.5%. It experiences more inflows of people from other parts of the country than people migrating out the region; this therefore gave the region a net migration value of 117,844 in 2010 (GSS, 2010).

The region recorded an Infant Mortality Rate (deaths of infants under age one) of sixty-six infant deaths per 1,000 live births in 2011 (RHD, 2012), this was among the highest rates in the country. Child Mortality Rate (deaths of children between ages one and four) was 41 deaths per 1,000 live births and Under Five Mortality (number of children who die by age five) was reported at 104 deaths per 1,000 live births, the third highest among the regions. Maternal Mortality Rate (relates the number of deaths due to pregnancy related causes to the number of women of child-bearing age,15 -49years) in the region, was 421 per 100,000 live births in 2010, this was lower than the national value of 485 per 100,000 live births (RHD, 2012).

The profiles of the hospitals that were used for this study are provided in the sub-sections below.

3.3.1 Profile of Kintampo Government Hospital

Kintampo Government Hospital (KGH) also referred to as Kintampo Municipal Hospital, is located at a place generally considered as the geographical center of Ghana from the north and the south of the country. The hospital is situated on the main trunk road that links southern Ghana to the north-eastern section of the country.

It began as a clinic in the 1940s by the West African Frontier Force. With the rapid expansion in the population of the area and the associated demand for improved care, the Hospital was upgraded to a District Hospital in 1994 to position it to effectively serve the needs of the people.

The Hospital has a bed complement of 125 and attended to an average of 210 patients a day in 2013, receiving referrals from and providing clinical support to 23 sub-district facilities. With 2 medical officers, 67 nurses and midwives, 2 pharmacists, and 5 physician assistants (Community Medicine) and a total staff population of 194, the Kintampo Government Hospital provides services in general out-patient care, general in-patient care, reproductive and child health care, emergency care, eye care, counseling, pharmaceutical and drug administration and cervical cancer screening. Kintampo Government Hospital participates in clinical trials through effective collaboration with the Kintampo Health Research Center. The Hospital is NHIS accredited grade B facility and has been involved in providing services to clients of the NHIS since its inception in 2004 (KGH, 2014).

3.3.2 Profile of Methodist Hospital – Wenchi

Wenchi Methodist Hospital (WMH) is located at Wenchi on the main Techiman-Wa trunk road. What is today the Methodist Hospital at Wenchi was the initiative of the chiefs and people of Wenchi and started as a dressing station in a small room in 1951. It was transferred to its present site, in the same year 1951, when a single block of the erstwhile local Methodist Middle School was released by the Methodist Church under the auspices of the then

Superintendent Minister, the Late Rev. Captain (Rtd.) John Dixon, who was instrumental in getting the people of Wenchi a Hospital.

From humble beginnings, the Hospital has now grown to become a 110 bed facility employing the services of 5 doctors , 79 nurses and midwives, 2 pharmacists, and three physician assistants (Community Medicine). The hospital has total staff strength of 231. It serves as a referral center for 19 health facilities within Wenchi Municipality, as well as the Tain and Banda Districts. Because of its strategic location (on the main trunk road that links southern Ghana and the north-western corridor of the country, it also receives referral cases from Bamboo and Tinga Health Centers in the Northern Region. The Hospital is recognized by the Ministry of Health as the Municipal Hospital for Wenchi and provides health care for an area with a population of 93,914 (WMH, 2014).

With the vision to become a Christian Medical Centre of excellence, the hospital, a duly accredited health service provider of the NHIS, has been involved in providing care to health insurance subscribers since the inception of the scheme in 2004.The Hospital is currently a specialist center for Urology and related care and a member of the Christian Health Association of Ghana (CHAG).

3.3.3 Profile of Presbyterian Hospital, Dormaa-Ahenkro

The Presbyterian Hospital, Dormaa-Ahenkro (DPH), is located about 80 kilometers west of Sunyani, the capital of the Brong-Ahafo Region. The hospital is situated very close to the La Cote d'Ivoire boarder.

The Presbyterian Hospital, Dormaa-Ahenkro though formally founded in 1955, traces its origin to 1928 when the wife of the Basel Missionary, Rev. Wilhelm Schäfer joined the husband (who arrived two years earlier) in Dormaa from Germany, and opened a small clinic to provide health care for the people of the area. After the Schäfer family had left Dormaa, the health activities stopped for some time until in 1951when a Basel Missionary at Dormaa, Rev. Richard Haller formulated an application to the Basel Mission Head Office in Switzerland on the request of the Dormaahene, the Late Nana Agyeman Badu I for the resumption of health services in the area. Construction of a health facility for the people of Dormaa through the collaboration of the Basel Mission and the Dormaa State started in 1951 and completed in 1954. The hospital was officially opened in 1955 (DPH, 1996)

The Presbyterian Hospital, Dormaa-Ahenkro currently serves as the Municipal Hospital for the Dormaa Central Municipal Assembly. It has 2 specialists (in Paediatrics and Obstetrics & Gynaecology), 3 Medical Officers, 67 Nurses and Midwives, 2 Biomedical Scientists and 1 Pharmacist (Dormaa Presbyterian Hospital, 2014). With total staff strength of 318, the hospital attends to a population of 250,000 people across three Administrative Districts (Dormaa Central, Dormaa East, and Dormaa West) and parts of La Côte d'Ivoire (Dormaa Municipal Health Directorate, 2010). Presbyterian Hospital, Dormaa-Ahenkro provides out-patient care, in-patient care, diagnostic services, and specialist services in Eye Care, Obstetrics & Gynaecology and Paediatrics. The hospital also provides reproductive health services, HIV/AIDS and TB specific counseling, dental and physiotherapy services. Today the Presbyterian Hospital, Dormaa-Ahenkro is the referral facility for over 25 other health facilities located in three political districts of the Brong-Ahafo Region and a registered member of CHAG (DPH, 2014).

3.4 The Survey Population

The population for this study was accredited health service providers in the Brong-Ahafo Region This meant that the researcher needed to identify all the accredited health service providers in the region. For accredited health providers in the Brong-Ahafo Region the researcher depended on a list 225 posted on www.ghanahospitals.org.which was not different from the list of providers registered in the books at the regional office of the NHIA.

3.5 Sampling Techniques and sample size

3.5.1 Sampling Technique

The study into health insurance claims management challenges in the Brong-Ahafo Region entailed sampling at two levels. Firstly there was the need to sample Accredited Health Service Providers in the region to select some of the institutions for this study. Secondly, there was sampling of health personnel in each of the selected institutions to get the required number of respondents for the study. This demanded that the researcher worked with two sample frames. The first being the full list of all accredited NHIS service providers in the Brong-Ahafo Region. As at the time of this study, www.ghanahospitals.org listed 225 accredited health service providers of the NHIS in the Brong-Ahafo Region. The second sample frame the researcher had to deal with was the list of all health professionals from the selected hospitals. The nature of this study and the nature of the population involved greatly influenced the selection of accredited service providers and also the respondents.

3.5.2 Selection of Accredited Service Providers

The researcher selected three (3) accredited health service providers from among 225 in the Brong-Ahafo Region for this study through non-probability sampling. This involved a purposive selection of one Government Hospital and two (2) Mission Hospitals (one belonging to Methodist Church of Ghana and one belonging to the Presbyterian Church of Ghana). The management of all government health care facilities is under the Ghana Health Service. This made them homogenous in terms of ownership. Mission health providers on the other hand differed in terms of ownership. It was to ensure some level of balance that two mission hospitals were selected. Moreover, mission hospitals are more dominant in the Brong-Ahafo Region. Hospitals were selected for this study as against health centers, clinics, maternity homes or pharmacy shops because hospitals deal with more health insurance claims than any of these other health providers. The three (3) Hospitals selected for the study are listed in Table 3.1

Table 3.1: Hospitals selected for the study

No	Health Facility	District/Municipal Health Directorate
1.	Presbyterian Hospital, Dormaa-Ahenkro	Dormaa Municipality
2.	Methodist Hospital, Wenchi	Wenchi Municipality
3.	Government Hospital, Kintampo	Kintampo Municipality

Source: Author, May 2015

Selection of Respondents

Due to limited resources and other practical challenges, the sample size of the study will be 120 respondents in total from the 3 hospitals for the study.. The researcher takes consolation from

the central limit theorem which states that any sample size greater or equal to 30 is enough for any statistical analysis. This argument is also supported by Hyndman and Kostenko (2007) when they said that any sample equal to or above hundred is robust for any statistical analysis. The selection of respondents for this study was done as follows:

i. Out of the 120 respondents, an equal number of 40 respondents were assigned to each of the three hospitals because the hospitals are of the same level by Ministry of Health and National Health Insurance Authority categorization.

ii. To get individual respondents, the health staff were classified according to their specific role in health delivery and how their work yields information for the completion of the NHIS claims forms as indicated in Table 3.2. The selection of the respondents from each category was proportionately assigned to project the various professional perspectives on the issues.

iii. A simple random sampling was used to select the respondents from each professional category.

Table 3. 2: Category of health professionals selected as respondents

Professional Group	Place of Work	Kintampo	Wenchi	Dormaa	Total
Records/Statistics Office	Registration	4	4	4	**12**
Nurses & Midwives	Care Giving	15	15	15	**45**
Laboratory/X-ray/Ultrasound	Investigations	4	4	4	**12**
Doctors/Physician Assistants/Other Prescribers	Diagnosing and Prescribing	3	3	3	**9**
Pharmacy personnel	Drugs services	5	5	5	**15**
Claims Office Staff	Collation of claims	5	5	5	**15**
Accounts and Management Personnel	Supervision	4	4	4	**12**
TOTAL		**40**	**40**	**40**	**120**

Source: Field Survey, 2015

3.6 Sources of Data

This study was based on two data sources: primary and secondary, both of which were relied on in the data analysis.

3.6.1 Primary Source of Data

The primary data for this study was obtained from responses received from the field when the researcher and his assistants administered questionnaire at the selected study sites, and interviewed specific persons who served as key informants. Refer to appendices for sample of the questionnaire used. The questionnaires were carefully designed based on the research questions, objectives of the study, and thorough review of literature (Kuffour, 2011).

3.6.2 Secondary Source of Data

Secondary source of data involves existing data, collected for the purposes of a prior study, in order to pursue a research interest which is distinct from that of the original work (Bohrnstdt and Knoke, 1988). In this study, the researcher did secondary analysis dwelling on institutional reports of the three accredited health facilities. This was complementary to the primary data analysis. Specifically, existing data on NHIS clients and service utilization levels, the levels of claims submitted and correspondence between the providers and the NHIA on NHIS claims were of great interest to this study. The study also utilized documented evidence on efforts made by individual facilities to improve claims management. Secondly, the researcher also reviewed available NHIS documents, namely accreditation tools, service package/ price list, Medicines List and annual publications. Reports of districts/municipal and regional health directorates that the researcher could lay hands on were also reviewed.

3.7 Data Collection

As asserted by Twumasi (2001), primary fact finding was one of the goals of this research. In this regard, a semi-structured questionnaire was administered on the field to collect primary data that made it possible for this study to assemble and utilize available facts in the interest of critical analysis.

3.8 Pilot Study

This study involved initial visits to the study sites to scout for information necessary for the main survey. This phase afforded the researcher the opportunity to test the questionnaire for the necessary adjustments to be made. It was at this stage that the researcher gathered information about the levels of involvement of various staff in health insurance claims management based on which a conclusion was drawn regarding the categories of health staff to be targeted for the study.

3.9 Administration of questionnaire

Face-to-face approach was used for the collection of data and it involved quality time with each respondent. Direct contact with the respondents was preferred to get the opportunity to clear all ambiguities and also observe the respondents' non-verbal expression, an advantage which a self-administered questionnaire does not offer to the researcher.

Nonetheless, a few of the respondents who opted to self-administer their questionnaire due to work pressure and their inability to sit with the researcher were allowed. Data collection was done by the researcher and six (6) trained research assistants.

3.10 Key Informants Interviews

The researcher was aware that interviews are an important part of most research projects as they provide the opportunity for the researcher to investigate further, to solve problems and to gather data which could not have been obtained in other ways (Cunningham, 1993, p.93). At the same time the researcher was also aware that though much of the health insurance claims activities are operational in nature, very important information regarding claims management could be concentrated at managerial levels. For this reason the researcher interviewed key officials for all the three hospitals visited namely, the Hospital Administrator, the Medical Superintendent and the Accountant. The interviewees were officials either involved in decision-making or policy implementation as regards claims management. The interviews were to enable the researcher understand the processes and procedures involved in claims management. A simple and suitable guide was developed for this process. To validate the data gleaned through the field survey and the purposive interviews in the health facilities, two staff each of the respective NHIA district offices at Kintampo, Wenchi, and Dormaa were also used as key informants to get the NHIA perspective of claims management in the districts and in the facilities under study.

3.11 Research Assistants

In view of the important nature of this study which aimed at providing health care providers and all other interested stakeholders in the operations of the NHIS with insight into the factors militating against effective claims management, the data collection process was very meticulous. Six research assistants were trained to work closely with the researcher. They were

made up of one (1) Health Services Administrator, two (2) technical assistants (biostatistics), two (Administrative Managers) and one person with finance background.

3.12 Ethics in Research

As much as possible the researcher ensured that this study conformed to accepted principles and procedures for conducting academic research. In particular, all the relevant guidelines approved by the University for Development Studies (UDS) for conducting academic research by both faculty members and students were duly observed. In this connection, the express approval of interviewees was sought by the signing of a consent form before their involvement was allowed in this study.

The express agreement of the research assistants was a requirement for their participation in the data gathering for this study. Due recognition has been given for their contribution to this project in the acknowledgement. All data sources for this study have been duly acknowledged. No secondary data was incorporated into the final report without the prior approval from the data owners.

3.13 Data Analysis

The study began with specific questions about health insurance claims management within the Brong-Ahafo Region (refer to section 1.4 of Chapter One), based on which clear objectives were set to guide the entire research process (refer to Section 1.5 of Chapter One). Based on clearly formulated research methodology described in Chapter 3, the researcher proceeded to the field and collected relevant data. Data for this study was collected based on the four main

elements described by Yeboah (2003) as being so crucial to research namely in mind; participation, observation, in-depth interview and review of documents (Secondary sources).

Following the field survey and examination of the various secondary data and after the researcher had become satisfied with the data obtained, the data was presented in appropriate tables and charts, where possible, using the Statistical Package for Social Science (SPSS) tools of analysis, dwelling mainly on tables and charts.

3.14 Reflections from the field and limitations of the study

Health staffs are by nature very busy people and so it took tact, diplomacy and much patience to get respondents to interact with the researcher and his assistants. Due to the media hype about the NHIS, some of the facility heads were skeptical about the intention of the study in spite of the assurances that it was only for academic purposes. Some officials of the NHIA were also unwilling to provide information critical to the study citing confidentiality and information security as reasons. The researcher overcame these challenges and in the end, obtained the necessary information, but not without difficulty. This has only gone to confirm the fact that getting access to information from public institutions remains a major challenge in Ghana.

3.15 Conclusion

The purpose of this chapter was to describe the research methodology of the study, explain the sample selection process, describe the procedure used in collecting the data, and provide an explanation of the methods used to analyze the data. The process adopted involved the selection of three health facilities out of 225 NHIS accredited service providers in the Brong-

Ahafo Region, administration of questionnaire to relevant health professionals as respondents, and interviewing of specific individuals on claims management, alongside the review of secondary data. The next chapter is about the presentation and analysis of the data collected.

CHAPTER FOUR

DATA ANALYSIS ANDPRESENTATION

4.1. Introduction

This chapter presents and analyses data collected from the field relevant to the objectives of this study. The chapter is an attempt to make meaning out of the data through systematic presentation and logical analysis. The chapter has been organized according to the following themes: background of respondents, nature of claims management challenges, causes of claims management challenges and addressing claims management challenges.

4.2. Background of respondents

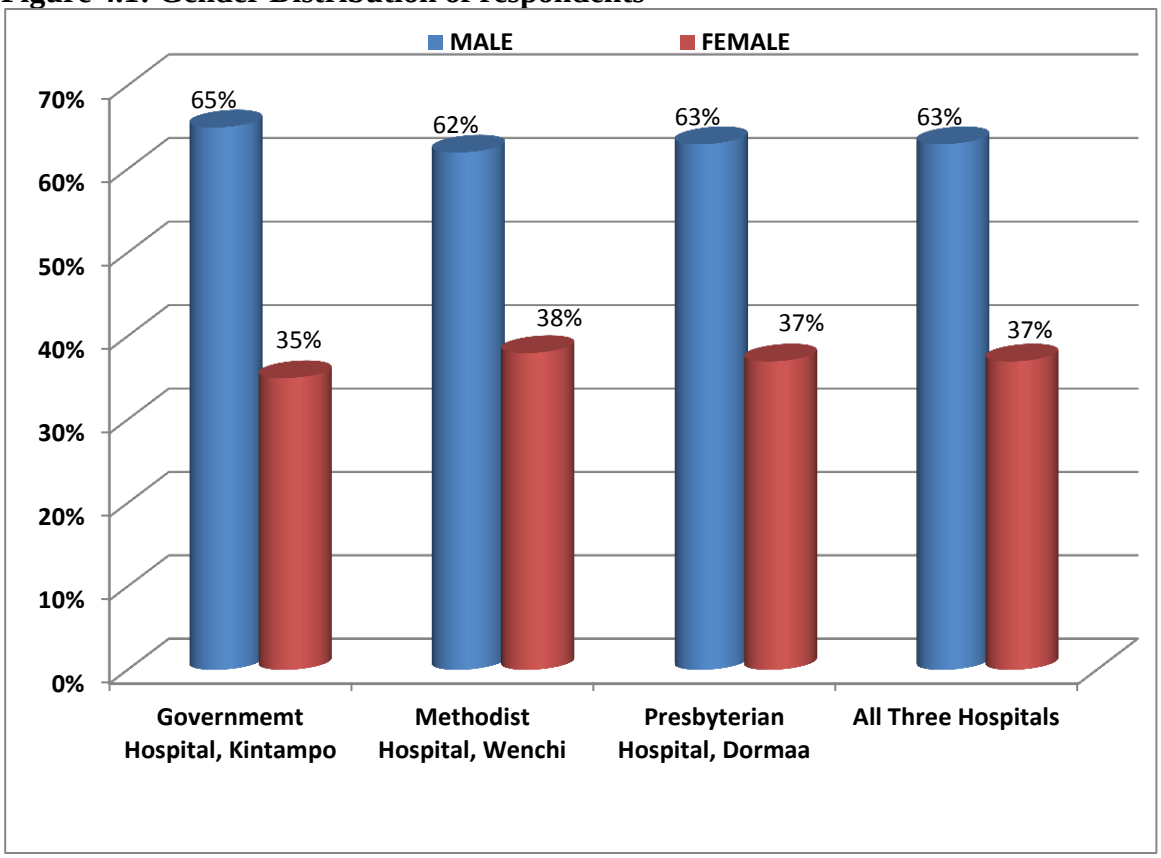
This study into claims management challenges in the Brong-Ahafo Region involved a sample of 120 health professionals selected from three hospitals. Out of the number, 112 participated in the study translating to 93.3% response rate. Even though all the 120 questionnaires could not be retrieved, the response rate is considered acceptable because in the view of Punch (2003) a response rate of 80-85% in a face to face survey is sufficient for analysis. The background characteristics of the respondents are presented in the next sub-section.

4.2.1. Gender Characteristics of Respondents

The gender distribution of respondents is important in any research because it makes it possible for the researcher to know the sex composition of his research participants. Figure 4.1 shows the gender distribution of the respondents in this research. Out of the 112 respondents drawn from the three hospitals, 71 of them representing 63% were males. The remaining 41 respondents constituting 37% were females.

Specific to the three hospitals, 26 out of the 40 respondents from the Government Hospital, Kintampo, representing 65% were males while 14 of them, making up 35% were females. Respondents from the Methodist Hospital Wenchi numbered 37 in all and comprised 23 males and 14 females constituting 62% and 38% respectively. In all, there were 35 respondents from the Presbyterian Hospital, Dormaa, composed of 22 males and 13 females representing 63% and 37% respectively.

Figure 4.1: Gender Distribution of respondents



Source: Field Survey, 2015

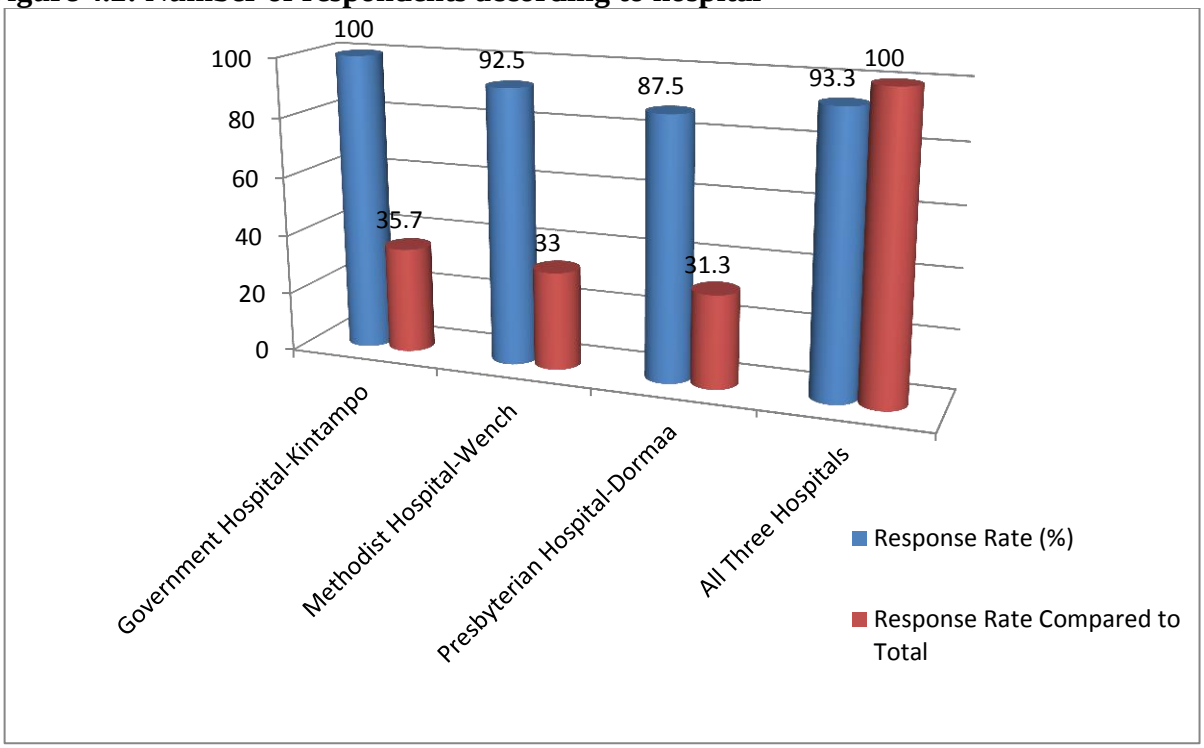
Figure 4.1shows that 30 more males participated in this study than females and that in each of the three hospitals, there were more male respondents than female respondents. The higher literacy rate among Ghanaian men compared to women, which also allows more men to be

employed in formal jobs than women may partly account for the seemingly wide gap between male and female respondents for this study (GSS, 2010). Nonetheless, it is instructive to note that it was not possible for gender characteristics per se to influence the outcome of this study because challenges in claims management are not necessarily gender sensitive.

4.2.2. Respondents According to Hospital

Three hospitals from the Brong-Ahafo Region were used for this study. They were, Government Hospital, Kintampo, Methodist Hospital, Wenchi and Presbyterian Hospital, Dormaa. Each hospital was assigned 40 respondents across board and the basis for this has been elaborated under the methodology. The responses from the respective hospitals are as depicted by Figure 4.2.

Figure 4.2: Number of respondents according to hospital



Source: Field Survey, 2015

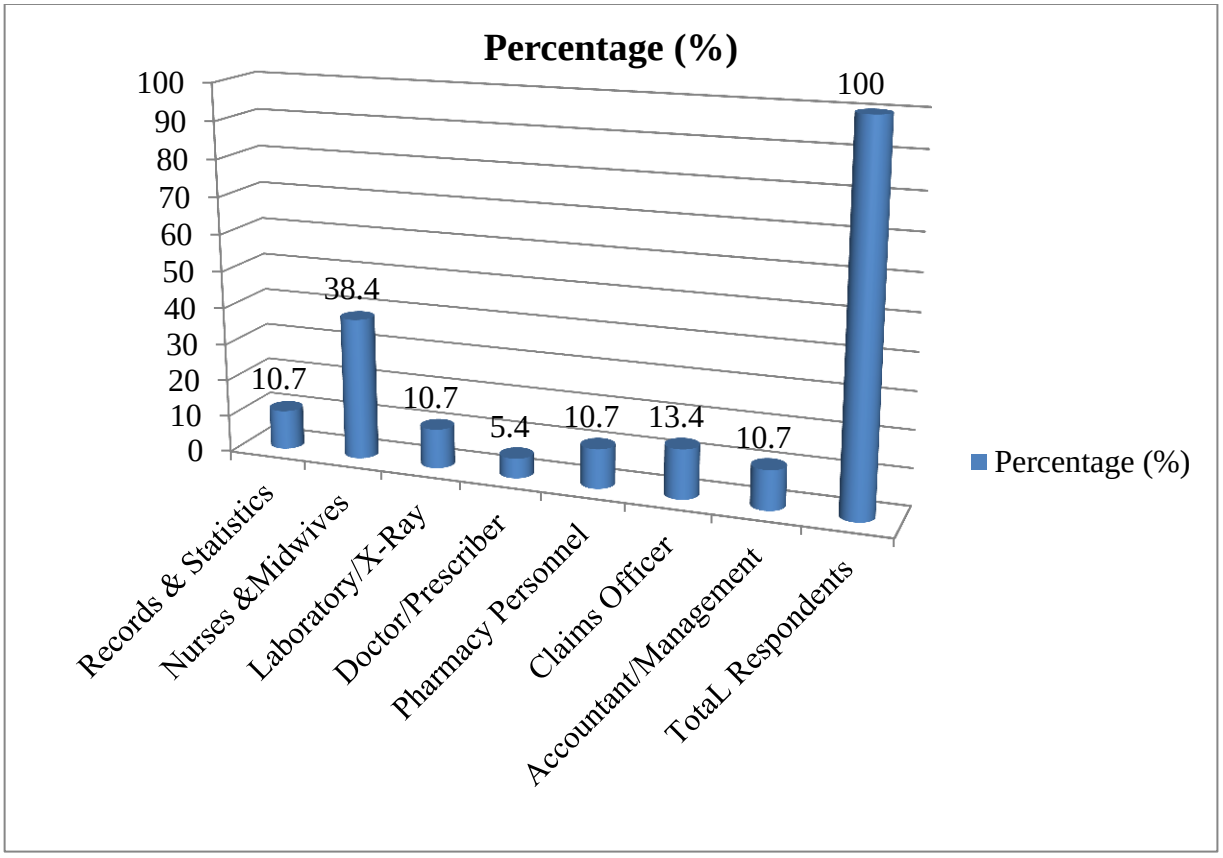
Figure 4.2 shows that out of the 40 respondents selected from each of the three hospitals, the Government Hospital, Kintampo recorded 100% response rate. The response rate from the Methodist Hospital, Wenchi was 92.5% while the Presbyterian Hospital, Dormaa recorded the least response rate of 87.5%. Overall, response rate for the study was 93.3%.

Response rates are generally considered to be the most widely compared statistic for judging the quality of surveys (Biemer and Lyberg, 2003). In view of this the researcher put in much effort to ensure a high rate of responses from each of the three hospitals and to a large extent, this was achieved. The 100% response rate achieved at the government hospital, Kintampo was as a result of the interest and the direct involvement of the hospital administrator of the facility. This goes to reinforce the fact that when there is commitment to a process from top management the success rate is high, Moorman et al (1993).

4.2.3. Professional Background of respondents

Health workers are many and diverse in terms of their professional background and functions. The categorization of health workers according to the role they play was allowed to reflect in this study. Categorizing health workers for this study was done based on the requirements of the NHIA Claims Form. Figure 4.3 shows the professional background of the respondents.

Figure 4.3: Professional background of respondents



Source: Field Survey, 2015

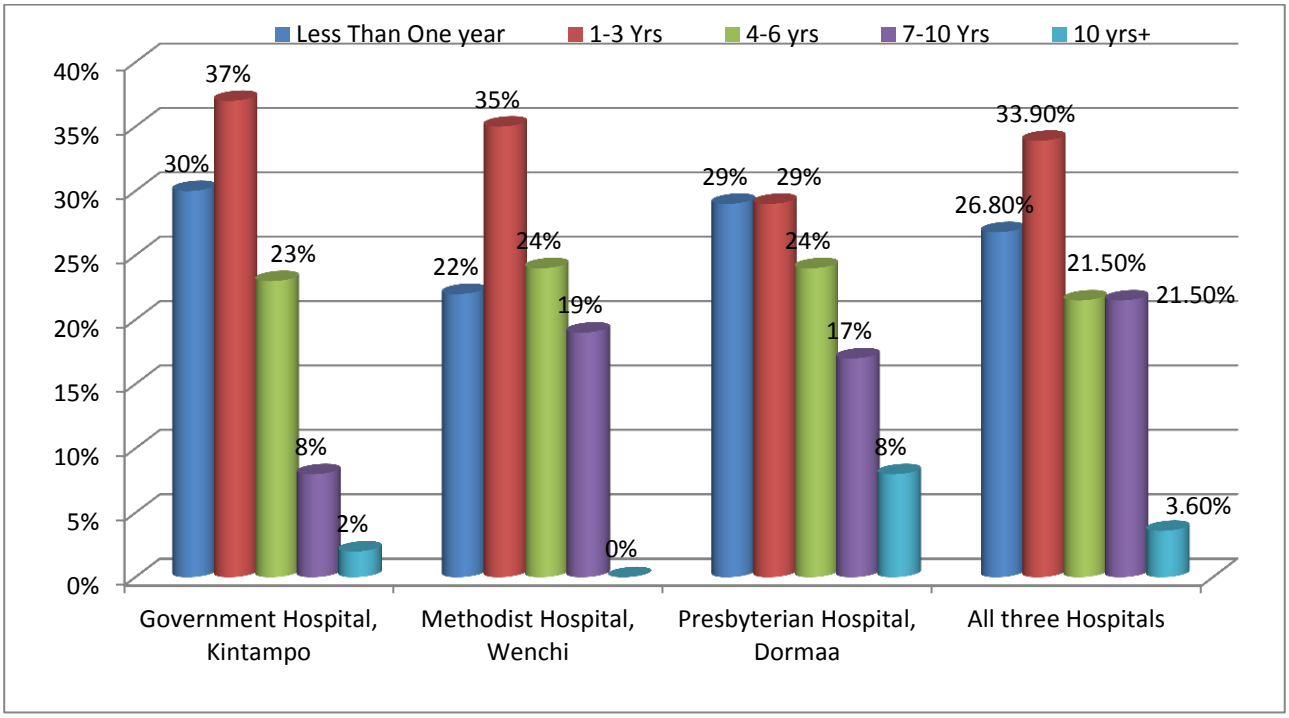
The researcher selected respondents in proportionate relationship to hospital staffing levels for the various categories as explained under selection of respondents in chapter three. The majority of respondents were nurses and midwives, who constituted 38.4%. Doctors and other prescribers such as physician assistants (community medicine) were the least among the respondents constituting 5.4%. There were fewer doctors and other prescribers because they are among the category of staff who are always in short supply in Ghanaian hospitals, and that was exactly the case in the three hospitals at the time of the study. Response rates among the rest of the professional groups were 13.4% for claims officers and 10.7% for records and statistics, laboratory and X-ray, Pharmacy, as well as Accountant & Management personnel.

The significance of Figure 4.3 is that data collected on the field on claims management challenges was largely proportionally representative of the key actors who play a major role in the claims management process.

4.2.4 Number of Years of Experience in Claims Management

The terminology ***experience*** as used in this study practical knowledge, skill, or practice derived from direct observation of or participation in events or in a particular activity. In other words in this study, experience relates to having been involved in claims management for a considerable period of time such that it renders health workers capable of playing their role in health insurance claims management effectively. Respondents were asked to indicate how long they had been involved in claims management in their respective hospitals. The responses received are captured in Figure 4.4.

Figure 4.4: Number of years of experience in claims management



Source: Field Survey, 2015

Figure 4.4 shows that 30 out of the total 112 respondents, representing 26.8% had been involved in claims management for less than one year. Another 38 of them representing 33.9% of all the respondents had been involved in claims management for a period ranging from 1 to 3 years only. The chart further shows that 24 respondents or 21.5% of them had been involved in claims management for a period between 4 to 6 years. There were 16 respondents representing 14.2% whose experience in claims management ranged between 7 to 10 years. Only 4 respondents, constituting 3% of total respondents said that they had experience in claims management for more than 10 years.

What is clear from Figure 4.4 is that, on aggregate, 68 of the respondents representing 60.7% had been involved in claims management for a period 3 years or less. On the other hand only

20 respondents constituting 17.8% had been involved in claims management for 7 years or more. If the number of years of exposure, participation and practice has anything to do with efficiency and effectiveness in claims management, then it is clear from Figure 4.4 that the percentage of respondents with more years of experience in claims management is far less compared to those with few years of experience in claims management.

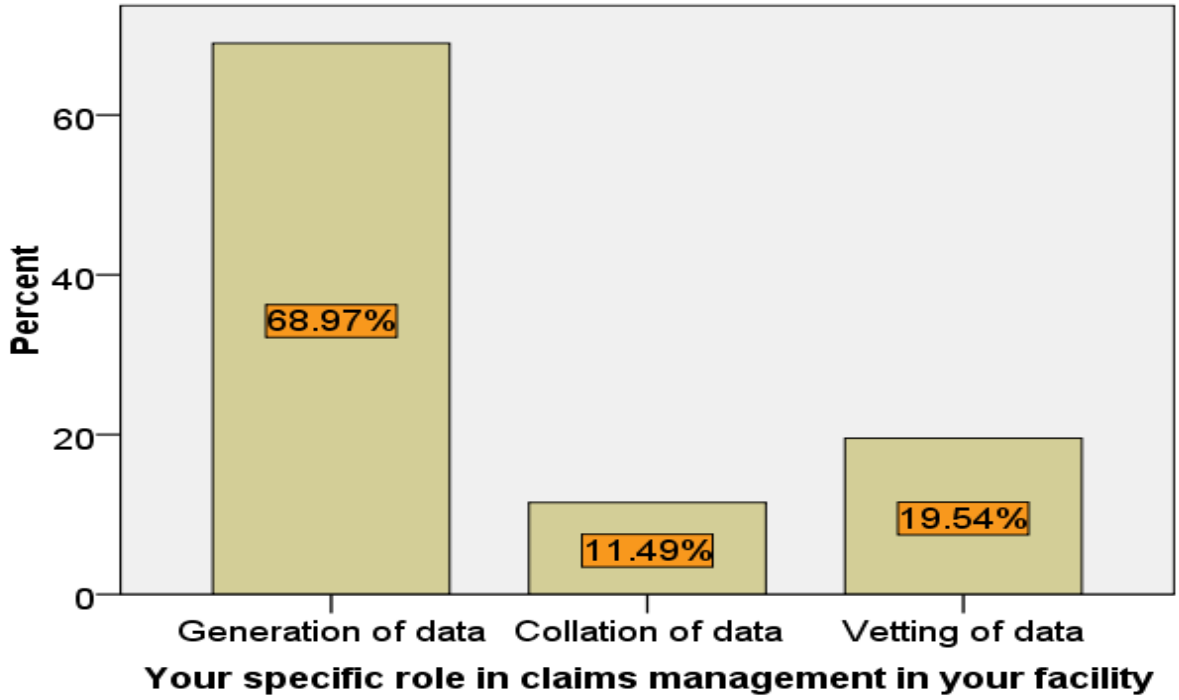
Comparing the three hospitals, respondents who had less than a year experience in claims management were 30%, 29% and 22% in Government Hospital, Kintampo, Presbyterian Hospital, Dormaa and Methodist Hospital, Wenchi, respectively. What this meant was that there were more respondents who were now getting used to the claims management process in the Government Hospital, Kintampo than in the other two Hospitals. Among the three hospitals, however, Methodist Hospital Wenchi had the least percentage of respondents who were still getting used to the claims process. The results of this study shows that many of the persons contributing to claims management in the three hospitals had not been involved in the process for long and may not have mastered the principles, the procedures and the practical aspects of claims management enough. This may have some implications for effective claims management in the three hospitals. As Beik (2009)has pointed out, that there are six keys to successful claims processing which she identified as collecting and verifying patient information, obtaining the necessary preauthorization, documentation, following payer guidelines, proofreading to avoid errors, and submitting a clean claim. However, with relatively high numbers of new staff, the ability of the hospitals to achieve what is prescribed by Beik may be low as far as claims management is concerned.

At the other extreme, percentage of respondents who had 7 years or more experience in claims management was highest in the Presbyterian Hospital, Dormaa with 25%, followed by the Methodist Hospital, Wenchi, with 19% and then the Government Hospital, Kintampo, with 10%. Despite these differences in the length of stay of staff in the three hospitals, the results indicated that this did not provide any of the hospitals a significant advantage in claims management over the others. However, the fact that staff who have stayed in the facilities for 7 years or more and might have mastered the claims management process were fewer in number compared to those who have stayed fewer years pointed to a problem of retention at the district and sub-district levels of health care.

4.2.5 Role Played by Health Professionals in Claims management

Health Insurance claims management involves team work of all health professionals (Yakubu, 2009). This reflects in the various roles played by the different workers in the health facilities. According to the American Medical Association (2011) the Claims Management process is the internal workflow for preparing, submitting, and collecting claims. This means that for any given personnel of a hospital contributing to claims management, the person could either be doing one or the combination of two or all of; generation of data; collation of data including data entry, and vetting of data.

Figure 4.5: Role of respondents in claims management



Source: Field Survey, 2015

Responses as depicted by Figure 4.5 indicate that 77 respondents representing 68.97% of the total respondents understood their role in health insurance claims management to be the generation of data, as in what appears on the face of the claims form. A total of 13 respondents or 11.49% said their role in claims management was about data collation which is interpreted to mean translating the client clinical information into a cost build up for claims. A total of 22 respondents representing 19.54% saw their role in claims management as vetting of data. The vetting of claims process involves ensuring appropriateness and accuracy to meet the standards of the NHIA.

Responses in Figure 4.5 show that a large chunk of claims management work involves generating the claims data which is done mainly by clinicians with 77 respondents representing

68.97%. This is contrary to the popularly held view that claims management is done mainly by non-clinical staff in the claims office or accounts department.

The fact that many of the respondents, especially the records, statistics and clinical staff who do not work directly in the claims office see claims see their role as part of claims management confirms that the Claims Management Process is the entire internal workflow for preparing, submitting, and collecting claims (American Medical Association, 2011). This internal work flow as indicated by Sodzi-Tettey (2009) begins with registration of clients and continues with the clinical treatment of the client which are all activities that generate data that feeds into the final claims.

4.3 Nature of Claims Management Challenges

In exploring the nature of challenges in claims management faced by AHSP institutions in the Brong-Ahafo Region, data was collected on the following indicators: the volumes of claims managed, timeliness of claims submission, and the rate of claims rejection.

4.3.1 Volumes of Claims Processed

The study sought to find out how voluminous the claims managed in the three hospitals posed a challenge to them. For the purpose of this study the volumes of claims managed was assessed using the revenue sources of the hospitals from NHIS and "cash-and-carry". In this regard, data on a three-year inflow of revenue from insured and non-insured clients of the three hospitals was assessed to find out the volumes of claims processed. The results are captured in Table 4.1.

Table 4. 1: Volumes of NHIS Claims compared to Cash and Carry - 2011 to 2013

		2011		2012		2013	
HOSPITAL		**Insured**	**Uninsured**	**Insured**	**Uninsured**	**Insured**	**Uninsured**
GHK	%	93.0	7.0	94.4	5.6	94.7	5.3
	Amount (Gh¢)	1,242,663	92,378	1,787,062	109,187	2,124,833	124,314
MHW	%	93.4	6.6	93.7	6.3	94.6	5.4
	Amount (Gh¢)	1,706,057	120,031	2,022,869	134,491	2,207,505	124,145
PHD	%	78.0	22.0	82	18.0	81.3	18.7
	Amount (Gh¢)	1,814,639	509,443	2,253,508	490,443	2,846,604	651,980

Source: Field Survey, 2015

The data showed that in 2011 out of a total Internally Generated Fund (IGF) of GH¢1,335,041 generated by the Government Hospital, Kintampo, an amount of GH¢1,242,662 constituting 93.0% was derived solely from insured clients. The results show that within the same period, out of a total IGF of GH¢1,826,088 generated at the Methodist Hospital, Wenchi, as much as GH¢1,706,057 constituting 93.4% was realized from health insurance clients alone. In the same year, 2011, the Presbyterian Hospital, Dormaa-Ahenkro generated IGF totaling GH¢2,324,082 out of which an amount of GH¢1,814,639.29 constituting 78.0% was received from insured clients only.

Similarly, the contribution of NHIS to IGF compared to cash-and-carry was high in 2012 as in 2011. From the data the contribution of NHIS to total IGF in 2012 was 94.4% for the Government Hospital, Kintampo, 93.7% for the Methodist Hospital, Wenchi, and 82% for the Presbyterian Hospital, Dormaa-Ahenkro. A closer look at the data showed that the situation was not different in 2013. Moreover, in 2013, the three hospitals namely, GHK, MHW and

PHD received 94.7% (2,124,833), 94.6% (2,207,505), and 81.3% (2,846,604) respectively of IGF from insured clients.

The very high level of IGF from NHIS agrees with available data which indicates that the NHIS has been experiencing increasing claims and other costs since its introduction (NHIA 2012). As has been noted, healthcare organizations today are therefore challenged to process high volumes of claims quickly and accurately (Yakubu, 2009) as has been seen in the case of the three hospitals. This often results in an error-prone, inefficient structure with dramatic variations in performance.

While the study finding shows that generally the volumes of IGF from cash-and-carry was abysmally low compared to NHIS, the PHD had the highest percentage of IGF from non-insured sources compared to the other two hospitals. This phenomenon was explained by the fact that PHD is located very close to the Ghana-La côte d'Ivoire boarder as already indicated in the profile of that hospital under chapter three. As a result, the hospital receives a high number of clients across the border from the neigbouring country who are not covered by the NHIS of Ghana. This is because the objective of the Scheme is to provide financial access to residents in Ghana (Apoya and Marriot, 2011; Business and Financial Times, 2015). It is pertinent to state that even though PHD had relatively more clients who were on cash-and-carry it still received the highest revenue from NHIS compared to GHK and MHW. The results from this study confirm the observation that, with the introduction of the NHISAHSPs are compelled to process high volumes of claims because practically all their IGF is derived from NHIS (Yakubu, 2009; Sodzi-Tettey, 2009).

From the study on sources of revenue, two interesting findings emerged. Firstly, the disproportionately higher revenue from NHIS compared to cash-and-carry. Secondly, there was an increasing trend in the percentage contribution of NHIS to revenue. These findings are highlighted below.

The proportionate contribution of NHIS to IGF was higher than the contribution from cash-and-carry in all the three hospitals for the three year period. This meant that there was more demand on the facilities to process claims before earning their revenue. Among the three hospitals, it was highest in the Methodist Hospital, Wenchi in 2011 and highest in Government Hospital, Kintampo in 2012 and 2013. The study further found out that though NHIS contribution to IGF was high in all the three hospitals, the levels of contribution of NHIS to IGF in the Presbyterian Hospital, Dormaa was lower than the NHIS contribution to IGF in the other two hospitals.

From the data presented above, it is clear from the study that all the three hospitals handled large claims compared to what they billed directly under out of pocket payment popularly called “cash-and-carry”. In his interaction with the hospital administrators and accountants of the three hospitals, the researcher found out that the sheer volume of the claims handled by the hospitals was a major source of delay and inadvertent errors. This was confirmed during the researcher’s interaction with scheme officers of the Kintampo, Wenchi and Dormaa Municipal offices of the NHIA.

4.3.2 Timeliness of claims submission

Prompt submission of claims is very important for service providers to receive timely payment for services provided under the NHIS. Over all, respondents constituting 73% said that as far as they were aware, health insurance claims in their facilities were ready for submission within two weeks from the end of the month. However, 4% of respondents said that claims for their facilities were submitted later than two weeks from the end of the month. There were 18% of respondents who had no idea exactly when claims for their facilities were submitted. Going by the responses, the study established that claims were ready for submission in all three hospitals within one month.

Despite these responses, interactions with key management members revealed that PHD and MHW were among a few district hospitals selected by the NHIA in September 2013 for a pilot programme in Electronic Claims Management System (E-Claims), which is purely a paperless claims system. The purpose was to ensure prompt claims submission directly to the NHIA claims processing center in Accra. It was explained that the E-claims system had rather rendered the claims process very slow contrary to expectation. For instance as at the end of June 2014, PHD had submitted claims up to the month of March, 2014, with claims for April, May and June, 2014 still outstanding. The situation was the same at MHW. A further investigation by the researcher through key informants' interview revealed that the slow nature of the E-Claims system in the two hospitals had to do more with the Internet-Service Provider and not necessarily with the E-Claim infrastructure.

The GHK was not on the E-claims platform and so was still submitting paper claims and had a relatively shorter claims submission time at the end of any particular month. The claims submission time for GHK averaged two weeks from the end of the month. Table 4.2 summarizes time taken by the three hospitals to submit their claims at the end of the month.

Table 4. 2: Time taken to submit claims at the end of the month

Facility	Recommended time for submission of claims	Average claims submission time	Narration	Remarks
Government Hospital, Kintampo	One Month	Two Weeks	Submission of claims is within recommended time	Submission of paper claims
Methodist Hospital, Wenchi	One Month	Three Months	Submission of claims is delayed two months beyond recommended time	Electronic Claims
Presbyterian Hospital, Dormaa-Ahenkro	One Month	Three Months	Submission of claims is delayed two months beyond recommended time	Electronic Claims

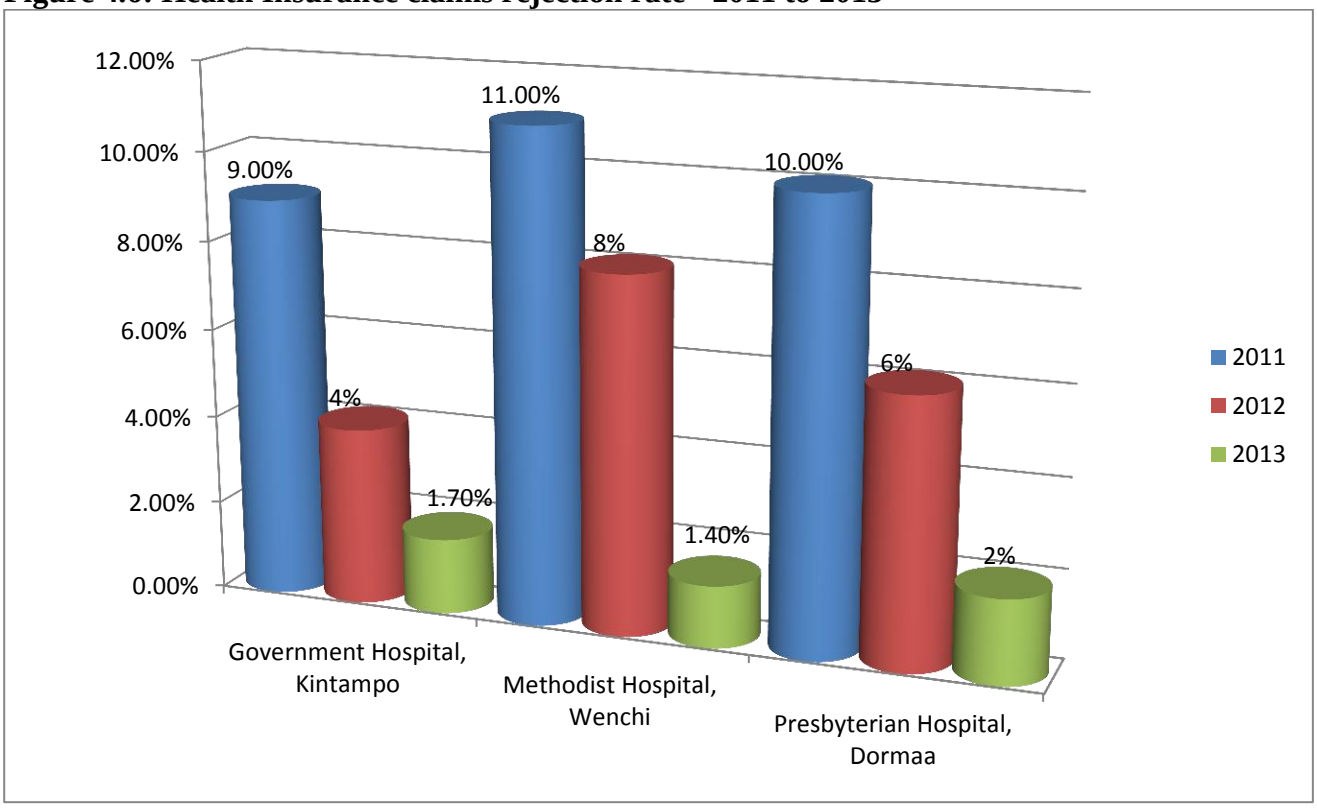
Source: Field Survey, 2015.

4.3.3 Claims Vetting and Rejection

The study therefore sought to find out whether the facilities experienced claims rejection in their role as NHIS service providers and if they experienced claims rejection, the rate of claims rejection they experienced. A total of 106 out of the 112 respondents, representing 94.6%, answered "Yes", meaning their facilities experience claims rejection. Only 2 respondents representing 1.8% answered "No". Those who were not sure whether their facilities experienced claims rejection numbered 4 and represented 3.6% of respondents. Following the

confirmation that all facilities experienced claims rejection, the researcher proceeded to establish the rate of rejection. The data is captured in Figure 4.6.

Figure 4.6: Health Insurance claims rejection rate - 2011 to 2013



Source: Field Survey, 2015

The study established a steady reduction in claims rejection rate from 9% in 2011 to an average of 2% in 2013 in all the three hospitals. The annual average claims rejection rate for 2011 to 2013 for the three hospitals is represented by Figure 4.6. From the chart, it can be seen that claims rejection rate for all three hospitals was relatively high in 2011 ranging between 9-11%. It is further observed from Figure 4.9 that among the three hospitals, annual average claims rejection rate was highest with the Methodist Hospital, Wenchi (11%), followed by the Presbyterian Hospital, Dormaa (10%). The Government Hospital, Kintampo experienced the least annual average claims rejection rate of 9% in 2011.The lower rejection rate in government hospital, Kintampo, could be explained by the fact that they had functioning pre-vetting

committee that validated their claims before submission while the pre-vetting committees were dormant in the other two institutions. This finding is consistent with the conclusions drawn by the Volta Regional Health Directorate (2010). They established that a dormant pre-vetting committee was due to poor time management as most hospitals claim to have pre-vetting committees in place but there is no evidence of its functioning. It may also be due to lack of resources or adequate motivation for the committee members.

The high rate of claims rejection in the three hospitals can be partly explained by low experience level of personal working in the health insurance claims units. As observed from the background of respondents, 60.7% of them had less than three years of experience on the job and also in claims management. Secondly, this could be explained by the lack of a focal person for the claims unit as recommended by the Volta Regional Health Directorate (2010).

Figure 4.9 also reveals a steady decline in the rejection rate in all the three hospitals between 2011 and 2013 and this was attributable to training services that was initiated by the NHIA and the facilities themselves. According to the officials of the hospitals and collaborated by officials of NHIA several training sessions were organized for officers involved in the processing of these claims.

As part of the researcher's assessment of the quantum and causes of claims rejection, the study found out from both providers and scheme officers that there existed some form of mistrust between health providers and officers of the NHIS. While NHIA assert that they have a fiduciary duty to prevent doubtful and fictitious claims, hospital officials think, claims rejection

is sometimes arbitrary and unjustifiable and is used as a cost cutting measure by the NHIA. Salisu and Prinz (2009) had earlier pointed to this mistrust between providers and scheme staff as one of the challenges facing the NHIS. The study found out that hospital providers found it difficult to accept rejection of claims as genuine, especially when the NHIA mentioned savings from denied claims as one of its achievements (NHIA, 2011). It was evident that service providers entertained fear of having their claims slashed by the NHIA even if there was no basis for such a rejection.

4.3.4 Mode of Claims Preparation

The study sought to establish the mode of claims preparation in each of the three hospitals. By this measure the researcher wanted to find out whether claims were prepared manually (Paper Claim), electronically or whether the procedure adopted involved the combination of both. The responses received are capture in Table 4.3.

Table 4. 3: The Mode of Claims Preparation

Mode of Claims Preparation	**All Three Hospitals**		**Government Hospital Kintampo**		**Methodist Hospital Wenchi**		**Presbyterian Hospital Dormaa**	
	Frequency	**(%)**	**Frequency**	**(%)**	**Frequency**	**(%)**	**Frequency**	**(%)**
Claims are Prepared manually	21	**19**	3	**8**	11	**30**	7	**20**
Claims are prepared Electronically	39	**35**	11	**27**	16	**43**	12	**34**
Claims preparation combines both manual and electronic systems	52	**46**	26	**65**	10	**27**	16	**46**
TOTAL	**112**	**100**	**40**	**100**	**37**	**100**	**35**	**100**

Source: Field Survey, 2015

The results from this study in relation to mode of claims preparation as represented by Table 6 shows that in total, 52% of respondents said claims management in their hospital combined both manual and the electronic systems of claims management. Another 39% of the respondents said their hospital claims were prepared electronically, while 21% of them said their facilities prepared claims manually. Respondents who said claims preparation adopted wholly electronic means scored the highest in the Methodist Hospital, Wenchi (43%) followed by the Presbyterian Hospital, Dormaa-Ahenkro (34%) and then the Government Hospital, Kintampo (27%).

A synthesis of the responses received and observation of the claims process of the three hospitals revealed that though some aspects of the claims management process was electronic, the process is largely manual or dominated by paper claim. A paper claim by definition is one that is submitted on paper, including optically scanned claims that are converted to electronic form (Fordney, 2008). It is the view of Fordney that paper claim may be handwritten, typed or generated via computer as against electronic claims that was submitted via dial-up modem (telephone line or computer modem), direct data entry, or over the internet by way of digital subscriber line (DSL) file transfer protocol (FTP).

The researcher found out that the Methodist Hospital, Wenchi and the Presbyterian Hospital, Dormaa-Ahenkro were part of 40 district hospitals selected by the NHIA for a World Bank sponsored pilot Electronic Claims Management (E-Claims) programme. Despite this intervention, the only aspect of the claims process which the researcher found out to be

electronic was client status verification at the point of registration and the point when claims summary is inputted into the claims database.

The study established that the fact that paper claims continued to dominate the claims system especially in the Government Hospital, Kintampo and the Presbyterian Hospital, Dormaa has been a potential cause for delays in submission of claims. Because the claims processing was manual, the claims form had to necessarily move round to each service unit one at a time. Other units could not work on the form while it was still with a particular unit. Further to this, the paper claim form which was left lose in the patient folder usually slip off and the information on it is lost in the process. This increased the work at the collation point as a new form would have to be completed, fishing for relevant information from the patient folder. The volume of documents that are physically carried to the NHIA office on monthly basis becomes overwhelming because of the manual or paper claims. In view of the enormous claims the NHIA office receives from all its providers, a service provider risks losing some of the claim sheets sent to the NHIA office with the subsequent risk of losing part of the claims. But such was the challenge faced by the Government Hospital, Kintampo which was still inundated with manual (paper claims).

At the Methodist Hospital Wenchi and the Presbyterian Hospital, Dormaa, while the E-Claims system was to ensure that the Claims form which is an E-Form was filled online at every service point as the patient received care, lack of total automation and networking had confined inputting into the electronic claims infrastructure to only the claims unit of the hospitals.

Secondly, it was found out that the internet bandwidth granted by the NHIA to the hospitals on the e-claims was too small such that it had rendered internet connectivity very slow at the Presbyterian Hospital and the Methodist Hospital. The Presbyterian Hospital, Dormaa, for instance had to remedy the problem by running both day and night shifts for the claims unit. In effect, while E-Claims was meant to ensure prompt submission of claims, the study found out that it had rather slowed claims submission and imposed undue delays of approximately three months on both the Presbyterian Hospital and the Methodist Hospital.

The researcher concluded that claims preparation in the three hospitals is largely manual. An attempt to introduce E-Claims to expedite claims processing has not yielded the desired result to the extent that while the manual claims system takes between two weeks to one month the e-claims system delays claims processing up to three months as observed in Wenchi and Dormaa Hospitals.

4.4 Causes of claims management challenges

Claims management challenges manifest in several forms and could vary in magnitude from one facility or service provider to another. Similarly, challenges arising in claims management could be caused by a number of factors. In trying to assess the causes of claims management challenges within the three hospitals, this study sought to find out:

i. The Nature and Status of Accreditation
ii. The Nature and status of contract
iii. The number of Out-patient registrants;
iv. The availability of a well resourced claims management unit;

v. The availability and the adequacy of supporting documentation for claims management (such as the claims form, service package/price list and medicines list); and,

4.4.1 Status of Accreditation and Health Insurance Provider Contract

Accreditation is an important concept in Health Insurance. It is a process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined criteria and standards to ensure that quality is maintained throughout all aspects of the organization (Accreditation Commission for Health Care, 2008). The study therefore sought to know from respondents what they knew about the nature and status of the accreditation of their respective Hospitals. The results show that 93% of the total respondents said their hospitals had full accreditation. On the other hand, 0.88% of respondents said their facilities had provisional accreditation while 5.26% were not sure about the nature of their hospital's accreditation.

On the status of accreditation, 86.49% said the accreditation of their hospitals was valid, 1.80% said the accreditation had expired, while 11.71% were not sure of the accreditation status of their hospitals.

During key informant's interview with the Administrators and Accountants of the three hospitals and upon physical examination, it was confirmed that all three hospitals were fully accredited in 2009 through a very rigorous process instituted by the NHIA. Again, from the key informant's interview it was not difficult to establish the reason for the high level of awareness among respondents regarding the nature of accreditation of their facilities when 93.86% of respondents said their facilities were fully accredited. According to the key informants, the accreditation process which was instituted by the NHIA in 2009 was rigorous and open. Also

when the accreditation process ended, staff were made aware of the outcome, hence the high awareness among the respondents regarding the nature of accreditation of their hospitals. This therefore means that the 0.88% who said their facility accredited was temporary and the 5.26% who were "Not Sure" of their accreditation status were respondents who were part of staff that joined the hospitals after the accreditation and did not have information about the accreditation of their hospitals.

On the other hand, concerning the status of accreditation, while 86.49% of the respondents said the accreditation of their hospitals were still valid, the key informants interviews in all the three hospitals and evidence from the accreditation certificate pointed to the fact that as at the time of the study, the accreditation of all the three hospitals had expired and were therefore no longer valid. This means that many of the respondents did not know that the accreditation of their hospitals had expired. This amounted to non-disclosure of vital information.

The expiry of the accreditation of the three hospitals as at the time of this study was dangerous because the South Africa Department of Health (2011) has said Health Services provider Accreditation is the process through which an entity undertakes to certify healthcare and health services providers according to appropriate and specific criteria in order for them to be contracted and reimbursed for rendering services to a defined population. Also accreditation requirements change from time to time and so where a provider fails to subject the facility to accreditation the current demands for claims processing, submission and reimbursement might have changed. This may result in discrepancies in what providers do and what the insurance authorities may expect. All the three hospitals were at risk when it came to being contracted

and being reimbursed for rendering services. While an expired accreditation in itself had implication for quality of care, the situation had actually put the health providers at the mercy of the NHIA.

The study concluded that the facilities were all accredited by the NHIA in 2009 and because the process involved all staff, awareness about the facility accreditation was very high. It was however clear from the study that unknown to most of the respondents, their facility accreditation was for a limited period of two years and was actually expired as at the time of this study without renewal. The study found out that the non-renewal of the expired accreditation was as a result of a lack of agreement between the NHIA and the service providers as to who was to initiate the process. Whatever the cause why the accreditation was not renewed on time, the hospitals were in breach of National Health Insurance Act of 2003 (Act 650) and the National Health Insurance Regulations LI 1809 of 2004. The delayed renewal of the accreditation by the service providers weakened their bargaining position as they were unaware of some of the changes in requirements of the NHIA as far as claims management was concerned, which may likely affect the claims they submit.

4.4.2 Status of Contract with the NHIA

The study sought to know from respondents whether their facilities had a contract with the NHIA and whether the contract was still valid or expired. In all 82.73% respondents said their facilities had a signed contract with the NHIA. Also 20% of respondents were not sure whether their hospitals had signed a contract with the NHIA but 1.82% of respondents said their hospitals had not signed any contract with the NHIA. The high level of awareness among

respondents that the relationship between their respective hospitals and the NHIA was based on a contract was seen by this study as a positive development.

Regarding the status of the contract, the study further revealed that 96.2% of all respondents said their hospitals had valid contract, while 1.8% said the insurance status or the contract of their hospitals were expired. Another 2.0% of respondents did not know the status of the contract between their hospitals and the NHIA. Similarly, in an interaction with hospital administrators of the three hospitals on the contract relationship between their hospitals and the NHIA and the physical inspection of the contract showed that the NHIA signed a contract with the hospitals in 2010 but as at the time of the study, the contract had expired and it had not been renewed, just as the accreditation.

At its most basic level, the NHIA-Health Provider contract is designed to secure the services of a provider for NHIS members and also to establish the basis for payment to the provider for services rendered to the NHIS Members. However, the NHIA is only obligated to pay claims which clearly set forth the services rendered so that the NHIA can determine whether the services, were indeed, covered under the terms of its agreements with members. All over the world, the relationship between health services providers and health payers, which converge in claims management and payment, is under-pined by a valid contract (Flight 2004; Jones and Mills Jr., 2006).

The study found it risky for the hospitals that they were providing services to registered members of the NHIA and all that effort was not covered by any binding agreement which is a

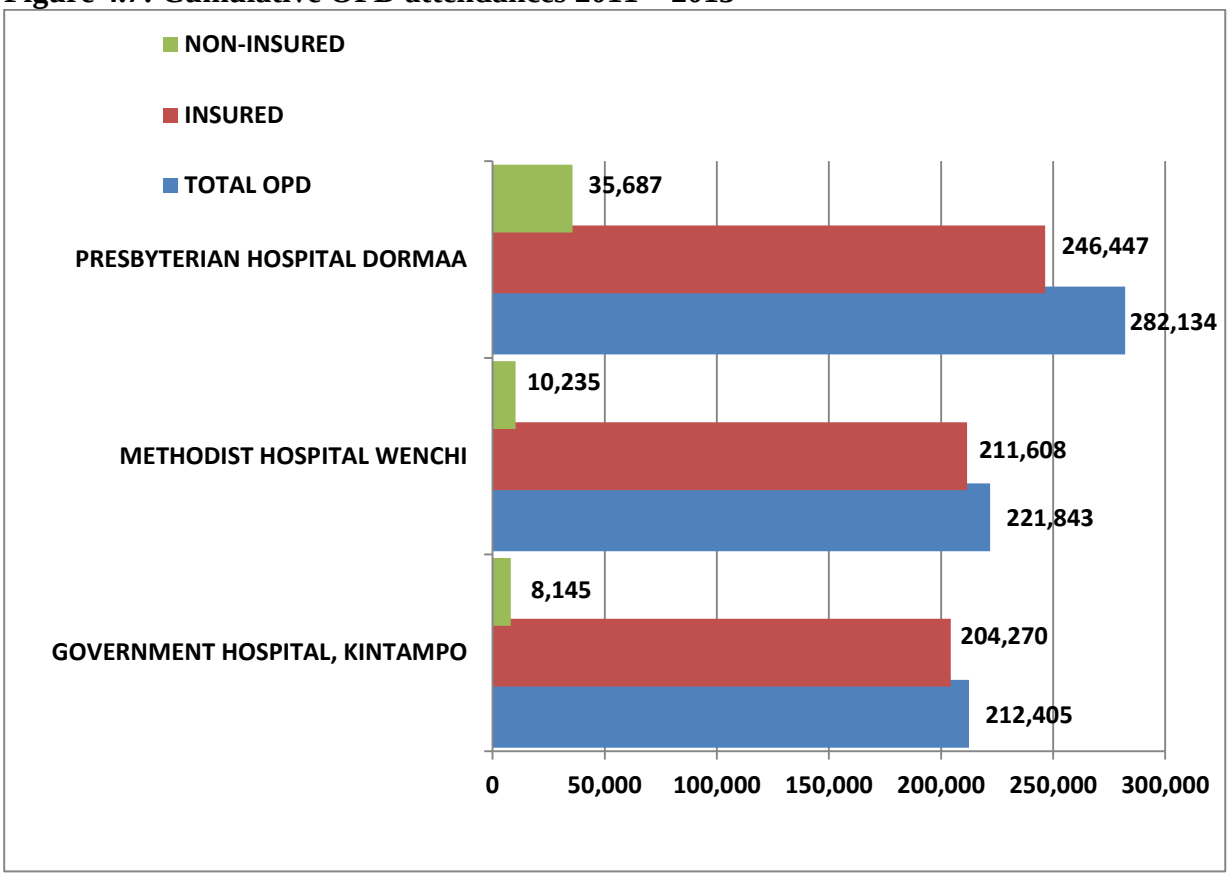
requirement in health insurance relationship (Flight 2004; Jones and Mills Jr., 2006). On the other extreme is the fact that the hospitals had not made the workers aware that its contract with the NHIA was no longer valid. All of these showed that the hospitals were not taking claims management serious because the NHIA could one day decide not to reimburse the hospitals and there would be no basis to compel them to do otherwise.

4.4.3 The Number of Insured Clients Accessing Health Care

Figure 4.10 presents the cumulative figures of insured and non-insured OPD attendances for the three hospitals for the period 2011 to 2013. Figure 4.7 on the other hand shows the proportion of insured and non-insured OPD attendances out of the cumulative OPD attendances for the same period, 2011 to 2013.

Data collected by the researcher from the three hospitals indicated that for the period 2011 to 2013, 204,270 (96%) of the cumulative OPD attendances recorded at Government Hospital, Kintampo were insured under the NHIS. Only 8,145 (4%) of OPD attendances at that same facility were not insured. Within the same period, 211,608 (95%) of cumulative OPD attendances recorded at the Methodist Hospital, Wenchi, were insured leaving 10,235 (5%) who were not insured. Data from the Presbyterian Hospital, Dormaa-Ahenkro indicated that 246, 447 (87%) and 35,687 (13%) of cumulative OPD attendances recorded from 2011 to 2013 were insured and non-insured clients respectively.

Figure 4.7: Cumulative OPD attendances 2011 – 2013



Source: Survey Data, 2015

The results confirmed the position taken by earlier reports that the NHIS has increased utilization of services (Dalinjong and Laar, 2012; NHIA, 2013; BFT, 2015). As Dalinjong and Laar put it, the increased utilization of health care services by the insured leading to increased workloads for providers has influenced provider behavior. The BFT (2015) has also noted that the increased utilization of health services under the NHIS has further increased the cost of providing health care for NHIS subscribers. A joint review of public expenditure in 2011 indicated that between 2006 and 2007, outpatient utilization increased by as much as 28 percent and as of 2009 NHIS was providing 41 percent of the total funding for curative care.

From Figures 4.7 it is incontestable that majority of persons who accessed health care in the three hospitals under study were insured with the NHIS and to the extent that the clients were in good standing with the NHIS, the responsibility for getting their services paid for by the NHIA was placed on the hospitals. Invariably, this translated into more work in claims management for the hospitals.

The study established that the more NHIS card bearers in good standing accessing health care in the three facilities the more claims the hospitals had to process. This obviously called for more qualified and experienced claim staff, more man hours and more logistics. Where these are not adequately put in place it impacts negatively on the timeliness and quality of claims. The study further established that the overall preparedness of the health facilities and their respective claims management units were not adequate to deal with the volumes of claims arising from increasing attendance of insured OPD clients.

4.4.4 Availability of a Health Insurance Claims Unit and challenges facing the unit

A health insurance claims management unit is the functional section of a hospital charged with the responsibility of overseeing, coordinating, pre-vetting and summarizing claims into the most appropriate form before the claims are forwarded to the NHIA. The researcher therefore introduced this particular indicator to enable the study assess the institutional preparedness, and for that matter, the level of seriousness attached to claims management by the three hospitals in the Brong-Ahafo Region.

All 112 respondents in this study or 100% of respondents said that there was a claims management unit in their respective hospitals. A physical inspection by the researcher confirmed this. It was also established by the study that the health insurance claims units were not autonomous units but were organized under the finance and accounts departments of the hospitals. The head of the claims unit in each of the three facilities therefore reported to the Head of Finance and Accounts of the hospital. The establishment of a claims management unit is an indication that the hospitals were aware of the need to attach more importance to claims management to maximize health insurance claims.

To assess the capacity of the claims units of the hospitals to deliver on their mandate, the researcher sought the views of respondents on the problems their claims units faced in their day-to-day work. Some of the problems stated by the respondents were inadequate claims space, lack of technically qualified persons to prepare the health insurance claims, unreliable powered supply, and unreliable e-claims set-up.

The study found out that because the claims units were put under the finance and accounts department in the hospitals, it subsumed their importance and so most of their issues were left unresolved, which invariably impacted negatively on claims management. This finding confirms the observation by the Volta Regional Health Directorate (2010) that the absence or redundancy of the claims unit was a major cause of claims rejection.

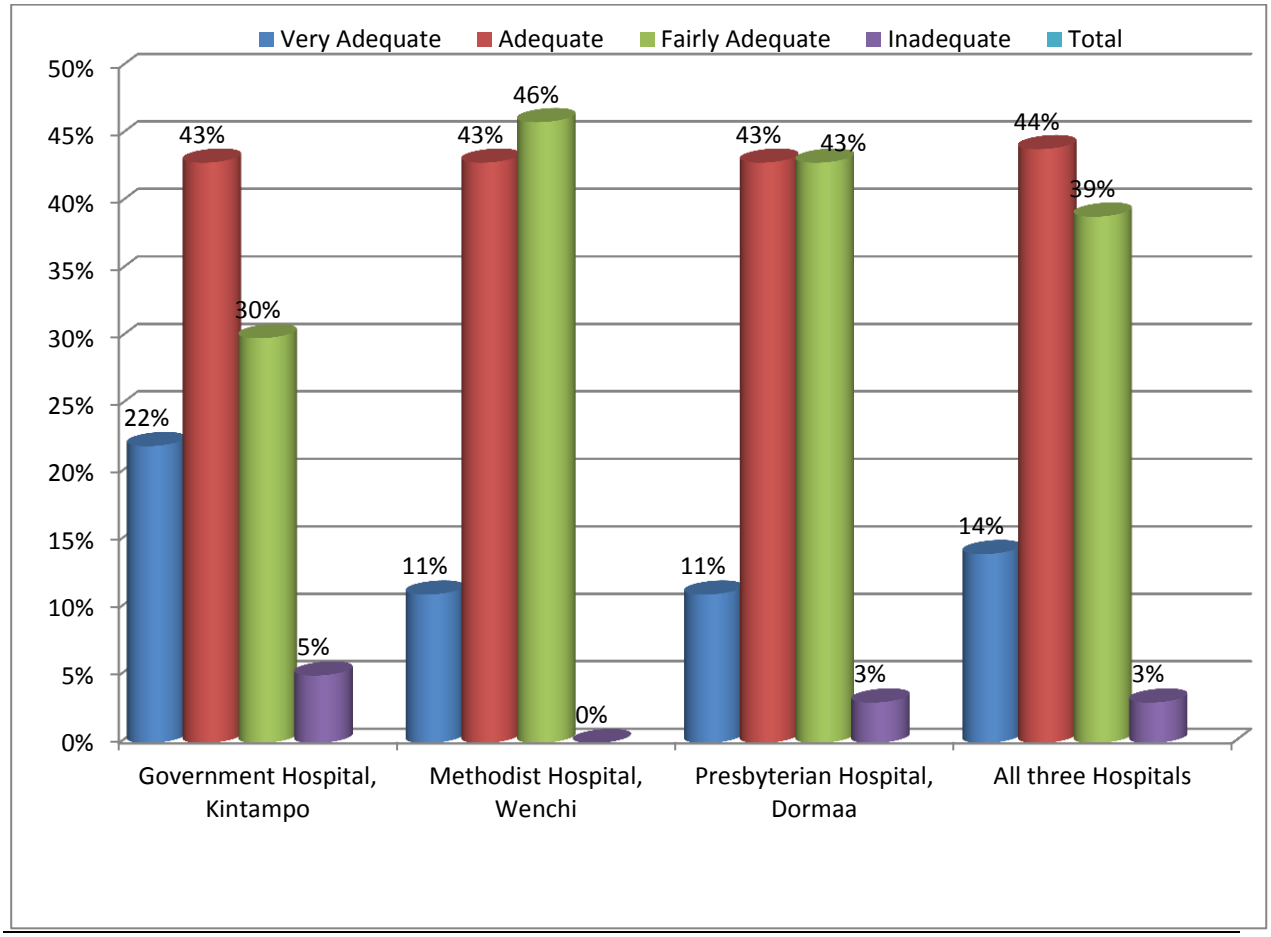
4.4.5 Adequacy of the NHIS Claims Form

The NHIS has a uniform Claims Form used by all accredited service providers to capture information of individual clients who are provided with care. Information on the Claims Form

provides a basis for health service providers to collate claims and for the NHIA to reimburse service providers. It was therefore important for the study to find out from respondents the adequacy or otherwise of the NHIS claims form for capturing claims data. Clients were to rate whether the claims form was "Very Adequate", "Adequate", "Fairly Adequate" or "Inadequate".

Overall, 14% of respondents rated the form very adequate, 44% rated it adequate, 39% rated it fairly adequate and 3% rated it as inadequate. The responses suggested that in its current state the NHIA Claims Form was adequately serving the needs of the providers. The responses are represented in Figure 4.8.

Figure 4.8: Responses to the adequacy of the claims forms



Source: Field Survey, 2015

Hospital specific responses showed that 22% rated the form as very adequate in the Government Hospital, Kintampo, compared to 11% in the Methodist Hospital, Wenchi and Presbyterian Hospital, Dormaa. Also, 43% of respondents from each of the three hospitals rated the form as adequate. It was further seen that 46% of respondents from the Methodist Hospital, Wenchi said the form was fairly adequate compared to 43% in the Presbyterian Hospital, Dormaa and 30% in the Government Hospital, Kintampo. On the contrary, 5% and 3% of respondents from the Government Hospital, Kintampo and the Presbyterian Hospital, Dormaa

respectively said the form was inadequate. No respondent from the Methodist Hospital, Wenchi saw the form as inadequate.

The NHIS form is the basis for claims management and if well completed, it captures the patient's personal data , type of services provided, and the outcome of care, whether patient was discharged, transferred out, died or absconded. The overall cost of care must be indicated after which the Health Facility Insurance Officer signs and forwards the forms to the NHIA Office. From the responses, the study concluded that the NHIS claims form was adequate for recording the necessary information to aid claims.

The study then sought to know from respondents whether the claims form was appropriately and comprehensively completed. The study found out that with respect to manual claims, the claims form was issued and inserted in the patient's folder right at registration because at every stage (i.e. at every department or unit) of care, documentation on the form is required. In the case of electronic claims, the claims form was available and completed electronically, but this required total automation of the patient care process before each department or unit of the hospital could access it online.

The study found out that in view of its comprehensiveness, there is the need for service providers to be meticulous in completing the forms as recommended by Beik (2009). That notwithstanding the study established that between 5-10% of claims forms reached the claims units of the hospitals wrongly or partially completed. Common among the problems with completed claims forms as listed by claims officers were lack of diagnoses, mismatch between

diagnoses and prescription, failure to indicate G-DRG/code or drug code and sometimes indecipherable handwriting. Claims staff also indicated that sometimes important sections on the claims form that needed to be filled were left blank.

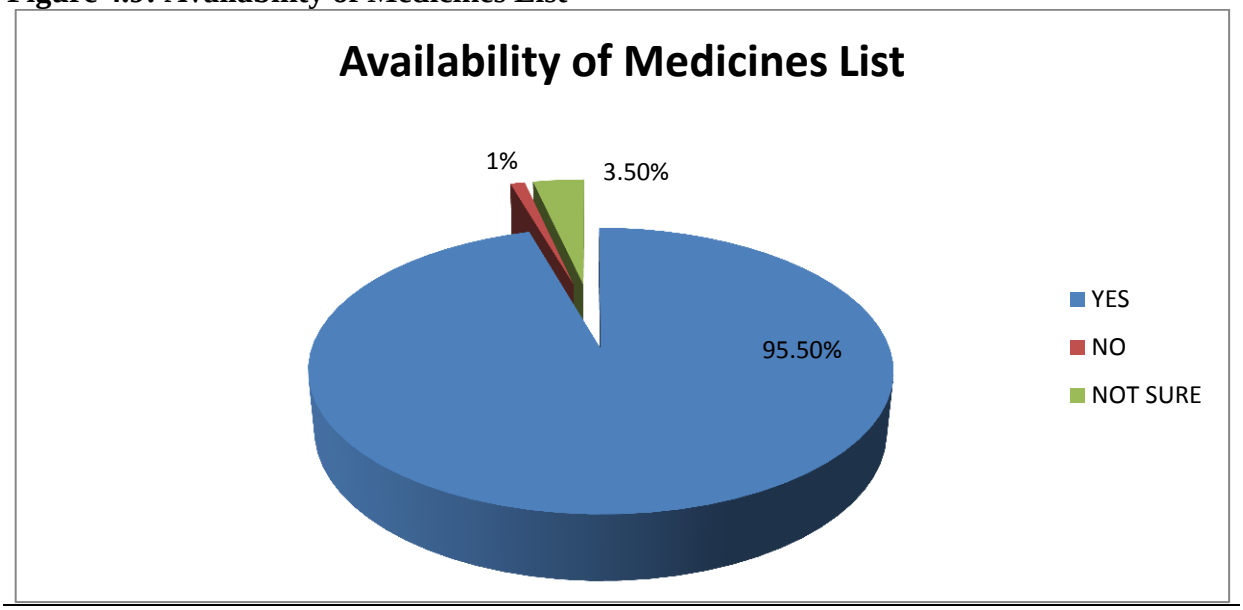
The finding of this study is that the problems the hospitals encountered in claims management was not because the claims forms was not comprehensive but it was due to the inappropriate and incomplete way the form was processed.

4.4.6 Availability of Medicines List

The NHIA has a Medicines List which was developed using a process that involved the evaluation of evidence for the management of health problems commonly seen at health facilities in Ghana (NHIA, 2011). The need for NHIS service providers to have the NHIA approved medicines list handy is to avoid a situation where NHIS clients would be served non-essential drugs to satisfy the profit motive of providers as against quality of care. Serving drugs outside the NHIS approved list was therefore a genuine basis for rejecting health insurance claims.

Over all 95.5% of all respondents knew that their facilities had the NHIA medicines list. Only 1% of total respondents said their facilities did not have the medicines list while 3.5% were not sure of the availability of the list in their facilities as shown in Figure 4.9. Responses indicating that the NHIA medicines list was available were highest in the Government Hospital, Kintampo (95%), followed by the Presbyterian Hospital, Dormaa-Ahenkro (92%), with the Methodist Hospital, Wenchi recording 90%.

Figure 4.9: Availability of Medicines List



Source: Field Survey, 2015

Despite the high awareness of the availability of the NHIA Medicines List, respondents indicated that prescribing outside the list was common in their respective hospitals. There was therefore non-compliance on the part of service providers with the requirements of the NHIA regarding the Medicines List.

The very high rate of awareness among respondents that their hospitals had the NHIA Medicines List was seen as a good development by the researcher because the NHIA demands of service providers to prescribe medicines on their approved list, by the names on the list and cautions prescribers to avoid the use of personal abbreviations. The medicines list also had a price column which indicated the amount that service providers could bill the NHIA for supplying a particular medicine to a subscriber of the scheme. Another feature of the medicines list was what is termed ***level of prescribing,*** which is the lowest level of health care delivery at which a specific medicine can be prescribed. According to the NHIA (2011), the overall goals

of enforcing the prescription levels for medicines on the NHIS medicines list were to improve quality of care, promote rational use of medicines and contain escalating costs of medicines to the scheme. Knowing that there is an NHIS medicines list was to some extent an assurance that service providers would apply it and thereby minimize the prescription of non-essential drugs, and also ensuring that prescriptions were in a manner acceptable to the NHIA.

The study found out that there was the NHIS Medicines list in the hospitals but there was non-compliance to the list in the form of prescribers prescribing outside their institutional categorization, not using the approved medicine name and over prescribing of medicines among others. This finding of the study agrees with the findings of a similar study conducted by Sodzi-Tettey et al. (2012) who pointed to infractions of the medicines list by prescribers.

4.4.7 Defined Range of Services

In the implementation of the NHIS, the NHIA has set provider service boundaries or ceilings for the various levels of care within the district health system. Under the NHIS, health service providers were required to provide services commensurate to their accredited levels of care which also determined drugs permissible to be prescribed at that level.

Over all the study found out that a sizable 91% of respondents were aware of a document specifying the range of services to be provided by their facilities under the NHIS. On the other hand 9% of respondents were not aware of such a document in their facilities. Awareness of the existence of a document specifying range of services among respondents was highest at the

Government Hospital, Kintampo (93%), followed by the Presbyterian Hospital, Dormaa (91%) and then the Methodist Hospital, Wenchi (90%).

The fact that a sizable 91% of respondents were aware of a document specifying the range of services to be provided by their facilities under the NHIS was indicative of the fact that an appreciable number of health staff were also conscious of what services could be provided by their facilities to members of the NHIA.

The study found out that the hospitals were aware of the restrictions imposed on them regarding the range of services they could provide, yet, in contravention to the NHIA range of services, the Methodist Hospital, Wenchi had Urologist and Gynaecologist providing specialist services on permanent basis, while Presbyterian Hospital, Dormaa-Ahenkro had a Paediatrician and Gynaecologist who were also providing services on permanent basis. These constituted breach of the range of services approved for those hospitals, as those specialist services were above their level.

In consonance with the policy on accredited range of services, the services of these specialists in the two hospitals were therefore reimbursed by the NHIA as if they were general practitioners. It was observed that the difference in the cost of service was billed directly to the patient by the two hospitals, which was seen as copayment by the NHIA, a practice which was illegal under the NHIS (National Health Insurance Act 2003, Act 650; National Health Insurance Regulation, 2004, LI 1809).

4.5 Solving Claims management challenges in health service provider institutions

4.5.1 Interventions to improve claims management

As part of this study, the question was put to respondents if their respective facilities had put in place interventions to improve claims management. A total of 102 out of the 112 respondents, representing 90.9% indicated that their facilities had put in place interventions to improve claims management. The remaining 10 respondents representing 9.1% were not sure if their hospitals had instituted any measures to deal with claims management challenges.

The study went further to ask respondents who answered in affirmative to indicate some of the important interventions introduced to solve claims management challenges in their respective hospitals. The responses were captured under five broad categories as depicted by Table 4.4

Table 4. 4: Interventions to deal with challenges in claims management

Indicator		**Total Respondents**	**Frequency**	**Percentage**
i.	Establishment of a claims management unit	112	101	**90**
ii.	Appointment of full time claims officers	112	90	**80**
iii.	Improving Health Information Management	112	83	**74**
iv.	Introduction of E-claims	112	77	**69**
v.	Periodic meetings with NHIS District Officers.	112	64	**57**

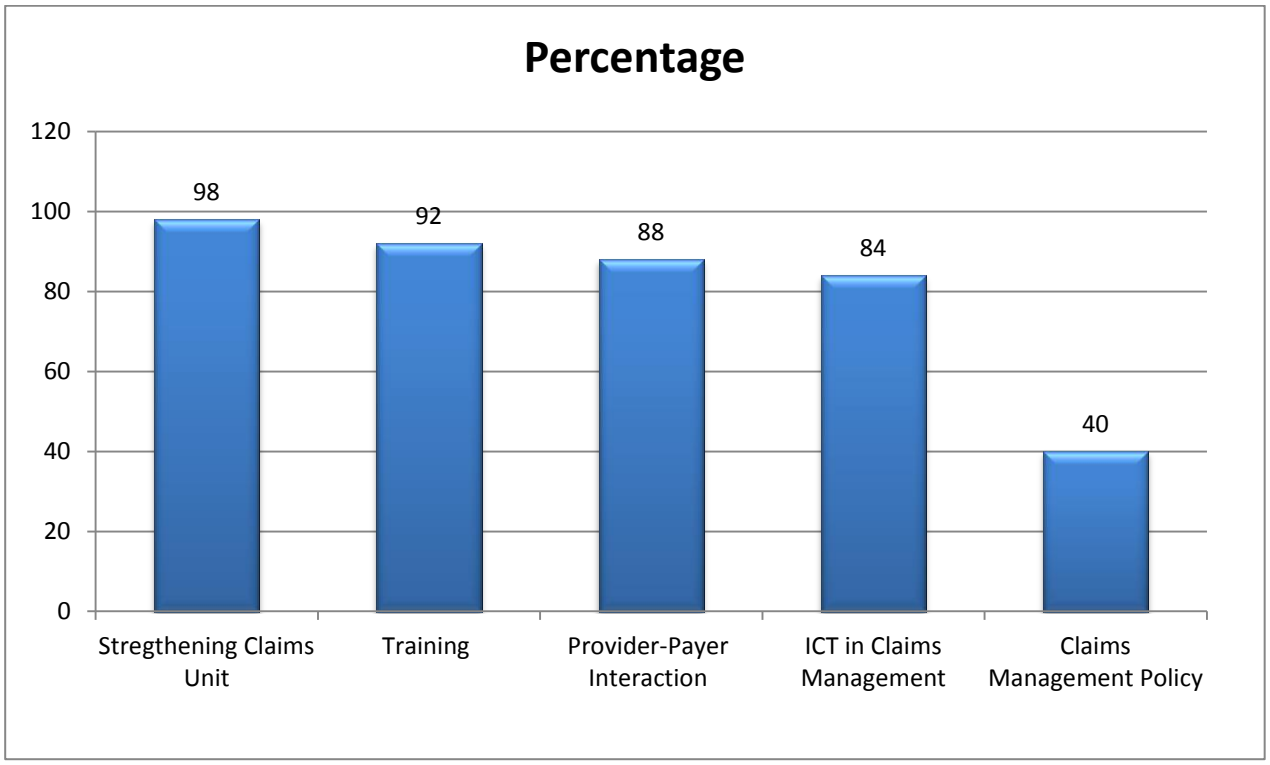
Source: Field Survey Data, 2015

From Table 4.4 the study established that at the district level the facilities were doing a number of things to enhance claims management. Among the interventions the top three that were important to respondents include establishment of a claims management unit, appointment of

full time claims officers and improving health information system. The researcher however observed that the level of implementation of these interventions and their development varied significantly among the three facilities with The Methodist Hospital, Wenchi, having the best organized claims management unit compared to others.

Aside some of the interventions mentioned by respondents as presented above, the researcher also gave respondents a list of five measures that stakeholders (Volta Regional Health Directorate, 2010; Apoya & Marriot, 2011; NHIA, 2010 & 2013) have always said could improve claims management. Respondents were asked to rank them according to what pertains in their institution. The ranking is as depicted in Figure 4.10

Figure 4.10: Measures to Improve claims management as ranked by respondents



Source: Survey Data, 2015

From the above rankings, the study established that within the hospitals they are strengthening claims management units, providing regular training to staff as well as enhancing communication between service provider and the NHIA. Largely the interventions been implemented by the hospitals are addressing the expectations of key stakeholders in the health insurance implementation (Volta Regional Health Directorate, 2010; Apoya & Marriot, 2011; NHIA, 2010 & 2013).

The study concluded that although there are many factors that ensure efficient claims management, having a functional claims management unit with requisite equipment, trained staff including efficient intranet and internet is key pre-requisite for successful claims processing and management. A well established claims unit will ensure collecting and verifying patient information, obtaining the necessary preauthorization, documentation, following payer guidelines, proofreading to avoid errors, and submitting a clean claim as Beik (2009) established in her study on Health Insurance Today.

This finding is also consistent with findings by American Medical Association (2011) in which they described the health insurance claims as internal process. In the research the authors maintained that a claims management process must essentially enable the health service provider to achieve timely submission of claims and also contribute unavoidably to the maximization of revenue and minimization of loses to the organization. In the study they explained that the Claims Management Process is the internal workflow for preparing, submitting and collecting claims. They placed emphasis on internal workflow, meaning the

AHSP is responsible for establishing, maintaining and evaluating the claim process to make it relevant to the needs of the organization.

Similarly interactions with scheme managers, accountants and unit mangers of the claims department indicated strongly that the NHIA has key role in claims management in provider institutions. The scheme officers said the NHIA at National and Regional levels had taken a number of steps to improve claims management not only for providers but for the scheme as well. Prominent among the initiatives by the NHIA to improve claims management in provider institutions was the introduction of clinical audit which assessed the level of compliance to service standards and claims requirements. Clinical Audit by the NHIA is in response to Regulation 39(1) of the NHIS Legislative Instrument (LI1809) which requires Health Insurance Officers to deny or reduce claims submitted by accredited providers where management of the Health Insurance Scheme detects fraud and or other anomalies such as over servicing of patients by providers, unnecessary diagnostic and therapeutic procedures, irrational medication and prescriptions and use of fake, adulterated or substandard pharmaceuticals. Clinical audit is also to expose gross and unjustified deviations from current accepted standards, inappropriate referral practices, and provision of service other than what the accreditation has granted. The study established that through the clinical audit activities of the NHIA, Presbyterian Hospital, Dormaa and Methodist Hospital, Wenchi lost revenue to the tune of thirty-four thousand Ghana Cedis and ninety thousand Ghana Cedis respectively, in 2013 alone.

The study further established that though the facilities lost money through the initial clinical audits conducted, it helped claims management by placing providers on the alert to pay attention to specific details in service delivery and patient billing. The study also established

that the tool for undertaking clinical audit was also accessible to health providers. They could therefore improve clinical practices and claims management by undertaking mock clinical audits and using the outcome to train staff and to correct identified weaknesses in the system.

Interaction with NHIA officers showed that the district level also has key role to play in claims management. According to them some steps that have been taken to enhance claims management in provider facilities included communicating mistakes detected in claims to affected providers, technical support and monthly reconciliation of claims submitted vetted and paid. Firstly, the NHIA writes to providers for them to know the mistakes identified during claims vetting, which are subsequently discussed at quarterly meetings with providers to respond to their concerns. Secondly, NHIA officers undertake technical support visits to provider facilities as well as facilitate regular in-service training for providers. Also monthly reconciliation meetings are organized with providers during which technical advice to health providers is offered on a number of issues that could enhance their claims processing.

The district officers of the NHIS recognized that when service providers achieve improvements in their claims management operations, it is to the advantage of the provider and the Health Insurance Scheme as well as the subscribers. This is because poor claims management results in financial loss to the health fund, and Oxfam (2011) indicates that efficiencies and appropriate investment could save an estimated 36% of health spending.

4.6 Conclusion

In this chapter the data collected was systematically presented, analyzed and discussed. Based on the analysis and the discussions, the researcher arrived at the conclusions and the recommendations in the next chapter.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

In the previous chapter, data collected from the field was presented with analysis. This final chapter provides a summary of the work, followed by the key findings of the study. Based on the key findings, some recommendations, which in the researcher's opinion would help improve health claims management in the three hospitals in the Brong-Ahafo Region and Ghana as a whole, have been proffered.

5.2. Summary

This study focused on the claims aspect of the implementation of the NHIS of Ghana. The study aimed to examine the extent to which NHIS accredited health service providers in the Brong-Ahafo Region have themselves contributed to the challenges in claims management. The specific study objectives were to find out; (1) the nature of challenges facing accredited service providers in claims management in the operations of the National Health Insurance Scheme in the Brong-Ahafo Region; (2) to assess the causes of those challenges; and (3) to find out what was being done to address claims management challenges facing accredited service providers in the Brong-Ahafo Region.

This study was descriptive in nature. To achieve its objectives, a cross-sectional survey was carried out in the three 3 selected district hospitals in the Brong-Ahafo Region, where in all, 112 health workers of different professional backgrounds served as respondents. The respondents were selected using the mixture of stratified and simple random sampling.

Secondary data from the study hospitals was collected to complement the primary data obtained from the survey, and both data were subjected to quantitative analysis, relying mostly on basic statistics.

5.3 Key Findings and conclusions

In relation to the first objective of the study, which was to find out the nature of claims management challenges in the Brong-Ahafo Region, the study established that claims management challenges were real in all three hospitals involved in the study, namely, Government Hospital, Kintampo, Methodist Hospital, Wenchi and Presbyterian Hospital, Dormaa. From the data analysis, four types of claims management challenges emerged: challenges relating to volume of work; challenges relating to delayed submission of claims; challenges of claims rejection and challenges relating to processing of claims manually.

The client mix of the service providers shows that on the average 95% of all the OPD attendances recorded were insured under the NHIS. The trend was the same for inpatient services where on the average 87% of all in-patients were insured under the NHIS. This had serious implication for claims work as the more insured clients the providers served, the more claims they had to prepare to get reimbursement. Revenue from patient care, also known as Internally Generated Fund (IGF), constituted the main source of income for all the facilities. On the average 90% of IGF came from insured patients. The increasing volume of claims keeps overwhelming the providers.

The study also found out that time taken to submit claims to the NHIA at the end of the month ranged from 10 working days to 60 days. The Government Hospital, Kintampo which prepared predominantly manual claims submitted claims within 10 days from the end of the month but the other two, Methodist Hospital, Wenchi and Presbyterian Hospital, Dormaa were actually challenged when it comes to timely submission of claims. It took on the average 60 days. This meant that it took about two months for the facilities to submit claims for services already rendered. The study found this state of affairs to be inimical to early reimbursement, because the study found the claims payment waiting time applied by the NHIA for a respite during claims vetting to be a minimum of 90 days (or three months).Thus effectively, reimbursement for services provided took about five months to be received. The study concluded that delay on the part of service providers to submit their claims, added to the long grace period for vetting, was indeed a source of great frustration to the providers. It must be indicated that both service providers and NHIS district officers could not provide a documentary proof or basis for the 90 days grace period. Nonetheless, it becomes the reference point when reimbursement to service providers is delayed.

Another key finding from this study in relation to objective one was that claims rejection in the facilities studied had dropped considerably from between a monthly average of 10-15% to an average of 1- 5% monthly. The study found the reduction in claims rejection rate to be a positive development which is highly commendable. Nevertheless, while the current levels of claims rejection may seem small, amount lost in revenue in real terms to the hospitals was significant when one considers the quantum of claims submitted annually.

Furthermore, it came up during the study that the claims management system of the facilities studied were pre-dominantly manual in nature. Patient folders were retrieved manually. Patient records were captured manually and the NHIS claims forms were completed manually. At the end of each day, the folder of each patient and its accompanying claims form were gathered and carried to the hospital claims office for processing. This usually led to a backlog of unprocessed claims. This also affected the swift retrieval of patient folder during follow-up visits. The experiences of the Methodist Hospital, Wenchi and Presbyterian Hospital, Dormaa-Ahenkro in a pilot electronic claims processing leaves much to be desired. While the E-Claims system was to ensure that the Claims form which is an E-Form was filled online at every service delivery point as the patient receives care, lack of total automation and networking had confined inputting into the electronic claims infrastructure to only the claims unit of the hospitals. Secondly, it was found out that the internet bandwidth granted by the NHIA to the hospitals on the e-claims was inadequate such that it had rendered internet connectivity very slow at the two facilities. The Presbyterian Hospital, Dormaa-Ahenkro for instance had to remedy the problem by running both day and night shifts for the claims unit staff.

Regarding objective two of the study which aimed to examine the causes of claims management challenges, the study found out that the main contributory factors that acted as setback to effective claims management included: Increased utilization of provider services, expired accreditation and expired contract for providing services to NHIS card bearers. Other causes of claims management challenges included non-compliance with NHIA range of services, Medicines List and Price List

Data from this study confirmed earlier studies that pointed to increase in service utilization as a sequel to the introduction of the NHIS. The study also found out that those clients who seek health care but are not covered by the NHIS has reduced to an average of between 5-10% and still dropping. It emerged that this is the major cause of high volume of health insurance claims prepared by service providers.

Another key finding under objective two of the study was that service providers were found to be in a state of non-compliance when it comes to approved range of services, the price list and the NHIA medicines list. Non-compliance with the range of approved service was traced to the fact that the providers had introduced certain services for which they had not been accredited. Also, the non-compliance with the NHIA price list stemmed from the fact that the NHIA delays in reviewing the price list to be in tune with prevailing market conditions. Unfortunately, the study found out that this was always a source of contention between the service providers and the NHIA. The study also found out that the service providers sometimes prescribed medicines outside the NHIA medicines list blaming it on the fact that some necessary medicines were not on the NHIA medicines list, but the study found out that the NHIA disputed this and frowns on prescribing outside their approved list.

Still on objective two, the study found out that the claims management system of the study hospitals were not robust enough to support the volumes of claims and the speed with which claims were expected to be processed to beat the deadlines for submission. The study found the processes of claims management in the hospitals to be unclear. Most of the workers whose

roles fed directly into claims management had not been trained and the claims management units were found to be rather poorly resourced.

Objective three of the study was to assess what had been done to address claims management challenges. The study looked at this from the provider perspective and from the perspective of the NHIA. From the health provider perspective the study found out that interventions introduced to deal with claims management challenges included creation of the claims management unit, appointment of claims officers, discussion of claims management challenges at meetings and attempts to introduce computers and networking into claims management. From the side of the NHIA, interventions to help service providers to improve claims management include quarterly stakeholders' discussions of claims issues, introduction of e-claims system and introduction of a periodic clinical audit.

5.4 Recommendations

The essence of a research study of this kind is to help bring improvement into society by proffering practical recommendations that when implemented, would address problems identified by the Study. In this section, the researcher makes a number of recommendations based on the findings from the study. In the opinion of the researcher, these recommendations are to help shape, lessen the burden, and fasten claims management in health provider facilities.

Firstly, service providers should introduce a carefully planned Claims Management Capacity Improvement Programme (CMCIP). This means finding adequate and attractive space for the claims management unit. The unit should be viewed from a business perspective, understanding

that its importance lies in the fact that it is now the action spot when it comes to health insurance provider revenue or internally generated fund.

Improving the institutions capacity for claims management may also require the re-orientation of staff to embrace claims management as everyone's business within the facility. This means that training in claims management should be regular and should not be limited to staff of the claims unit only but should be opened to all staff whose work serve as input for claims management.

It is recommended that providers must comply with the agreement or arrangements they have with the NHIA on claims Management.

It is further recommended that providers should maintain an up-to-date accreditation and contract relationship with the NHIA by initiating the process at least three months before the expiration of their accreditation or contract.

Lastly, the researcher recommends that policy makers should consider health insurance claims management as a technical area that needs specialized education and training to produce Health Insurance Claims professionals to take over claims management in health provider institutions as is currently the case in other countries. When this is done service providers must embrace change and recruit these persons whose background training is in claims management.

5.5 Areas for future research

Based on the findings of this study, and other interesting issues that emerged during the field work, the researcher recommends a future study into the sustainability of hospitals under the NHIS and also clients' perspective of quality of care in a Provider Facility under the NHIS.

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APPENDIX

APPENDIX 1 Questionnaire for hospital workers

QUESTIONNAIRE FOR HOSPITAL WORKERS

A. RESPONDENT'S PROFILE

1. Gender: Male ( ) Female ( )
2. What is your professional background?

   Medical Officer ( ) Physician Assistant ( ) Pharmacist ( ) Midwife ( ) Nurse ( )

   Health Information Officer ( ) Accountant ( ) Health Services Administrator ( )

   Other ( ) Specify……
3. How would you describe the extent of your involvement in health Insurance claims management in your facility?

   Not involve at all ( ) Minimal involvement ( ) Much involved ( ) Very Much involved ( )
4. How long have you been involved in health Insurance Claims management as a health worker? Less than 1 year ( ) 1 to 3 years ( ) 3 to 5 years ( ) 5 to 10 years ( )

   Above 10 years ( )
5. How long have you been involved in health Insurance Claims management in this facility? Less than 1 year ( ) 1 to 3 years ( ) 3 to 5 years ( ) 5 to 10 years ( )

   Above 10 years ( )
6. What is your specific role in health insurance claims management in this facility? Tick as many as applicable. Generation of data ( ) Collation of data ( ) Vetting of data ( )

7. Please indicate how many times you have participated in Health Insurance Claims Training. Never ( ) Once ( ) Twice ( ) Thrice ( ) More than thrice ( )

B. PROFILE OF INSTITUTION

8. Name of Institution……

9. Is your facility accredited by the NHIA to provide health services to NHIS card bearers?

   Yes ( ) No ( ) Not Sure ( )

10. What is the nature of your facility's accreditation?

    Full Accreditation ( ) Temporary Accreditation ( ) Not Sure ( )

11. What is the status of your current accreditation? (Evidence necessary) Valid ( )

    Expired ( ) Not Sure ( )

12. Has your facility signed a formal contract with the NHIA to be NHIS service provider

    Yes ( ) No ( ) Not Sure ( )

13. What is the status of your contract with the NHIA? (Evidence necessary) Valid ( )

    Expired ( ) Not Sure ( )

C. NATURE OF CLAIMS MANAGEMENT CHALLENGES (Section E is to be completed by Accountant or Administrator or Head of each facility)

14. Within what time frame does your facility submit claims at the end of each month?

    a. Within the first week of the ensuing month ( )

    b. Within the second week of the ensuing month ( )

c. Within the third week of the ensuing month ( )

d. Within the fourth week of the ensuing month ( )

e. After the fourth week of the ensuing month ( )

f. No idea ( )

15. Has the NHIA ever rejected your entire claims?

Yes ( ) No ( ) Not Sure ( )

16. If you answered "Yes" to question 31, how many times have your claims been rejected?

……

17. If you answered "Yes" to question 31, please state the reasons why the claims was rejected……

……

18. What do you do when your entire claims is rejected?

……

……

……

……

19. On the average what proportion of your monthly claims is denied payment by the NHIA?

Less than 1% ( )

Between 1 – 3 % ( )

Between 3 - 5 % ( )

Between 5 – 10 % ( )

More than 10 % ( )

No idea ( )

20. What proportion of your total Internally Generated Fund was from the National Health Insurance Scheme in 2012…….. and in 2013……..?

21. Do you think your facility could have generated more revenue from the NHIA in 2012 and 2013 if your claims management practices had been more rigorous?

No ( ) Probably ( ) Surely ( )

D. CAUSES OF CLAIMS MANAGEMENT CHALLENGES

22. Do you have a National Health Insurance Claims Department/Unit?

Yes ( ) No ( ) Not Sure ( )

If "No", please explain how you handle claims in this facility……

……...……

23. Do you have an approved document outlining the range of services for your facility under the NHIS? Yes ( ) No ( ) Not Sure ( )

If "No", how do you determine that your services are within the NHIA approved limit?

……

……

24. Do you have a well-documented Drug List from the NHIA? Yes ( ) No ( ) Not Sure ( )

25. Does the Drug List indicate the prescription level of your facility? Yes ( ) No ( ) Not Sure ( )

26. Do you have a Price List from the NHIA? Yes ( ) No ( ) Not Sure ( )
27. What do you do when the cost of drug or services provided to a client is higher than what the NHIA pays for that particular drug or services?
    - Billed under NHIS and institution loses ( )
    - Patient is made to pay out of pocket to prevent lost to institution ( )
    - There is co-payment share between NHIS and client ( )
    - Client is denied the services/referred under such situations ( )
28. How would you describe the NHIS Claims Form?

    Very User Friendly ( ) User friendly ( ) difficult to complete ( ) Very difficult to complete ( )

29. How does the NHIS Claims Form serve your need for capturing clients' service data?

    Very Adequate ( ) Fairly Adequate ( ) Adequate ( ) Inadequate ( )

30. Mention some of the problems you have with the completion of the NHIS Form

    ……

    ……

31. How do you prepare your claims?

    Manually ( ) electronically ( ) Combination of manual and electronic ( )

32. Do you have a Local Area Network (Internal Network) linking departments to support claims management?

    Not at all ( ) Limited Network available ( ) Well established network available ( )

33. Does your unit have a computer that facilitates inputting the claims system?

    Yes ( ) No ( )

34. Have your facility a health insurance claims management manual or policy?

    Yes ( ) No ( ) Not Sure ( )

    If "No", move to Question 29.

35. Who prepared the policy if you have one?

    The facility management ( ) Ministry of Health ( ) Ghana Health Service ( ) Christian Health Association of Ghana ( ) National Health Insurance Authority ( )

36. How do you find the health insurance claims manual if available?

    Too technical to understand ( ) Technical to understand ( ) Somehow easy to understand ( ) Very Easy to understand ( )

37. Ranking them in order of importance, list five of the following that you consider as a source of challenge to claims management in your facility.

    i. Incomplete records in patients' folder,
    ii. Matching diagnosis to prescription,
    iii. Identifying clients in good standing with the NHIA,
    iv. Reading prescribers' handwriting,
    v. Lack of cooperation among staff involved in claims management,
    vi. Basic services not listed by the NHIA
    vii. Cost of drugs/services higher than NHIS quotations making copayment necessary

E. WHAT HAS BEEN DONE/WHAT IS BEING DONE TO SOLVE CLAIM MANAGEMENT CHALLENGES (Section F is to be completed by Accountant or Administrator of Head of each facility)

38. Has your facility put in place any interventions to improve claims management?

Yes ( ) No ( ) Not Sure ( )

39. If "No" move to Question 41. If you answered "Yes" to the above, please mention some of these intervention(s)

i. ……

ii. ……

iii. ……

iv. ……

.

v. ……

.

40. Which of the interventions you mentioned above do you find most helpful in improving claims management in your facility?

……

41. Are you aware of any interventions by the NHIA to improve claims management in your facility?

Yes ( ) No ( ) Not Sure ( )

If "No", move to question 44.

42. If you answered yes to the above, please mention the intervention(s)

i. ……

ii. ……

iii. ……

iv. ……

v. ……

43. Please rank the following in order of importance as means of improving claims management.

Regular Interactions between providers and the NHIS

Strengthening the Claims Management Unit

Developing a Claims Management Policy

Adopting ICT in claims management

Regular Training in NHIS Claims Manual

Source: Author, 2015

APPENDIX 2 Questionnaire for the health insurance scheme officers

QUESTIONNAIRE FOR HEALTH INSURANCE SCHEME OFFICERS

1. Name of District……
2. What is your position/Grade/

   Scheme Manager ( ) Scheme Accountant ( ) Scheme PRO ( )

   Claims Manager ( ) ICT Officer ( ) Other

   (state)……
3. What are the key issues in claims management in recent times?

   ……

   ……
4. What is your opinion about how claims are managed by health institutions?

   ……

   ……

   Which aspect of claims management is fraught with difficulties?

   ……

   ……
5. State some of the challenges you face with service providers generally regarding claims management

   i. ……

   ii. ……

   iii. ……...

   iv. ……

v. ……

6. What specific challenges regarding claims management do you as a scheme face with this particular facility? …….

i. …….....

ii. ……..

iii. ……..

7. How is the Scheme helping service providers to improve claims Management?

i. …….

ii. …….

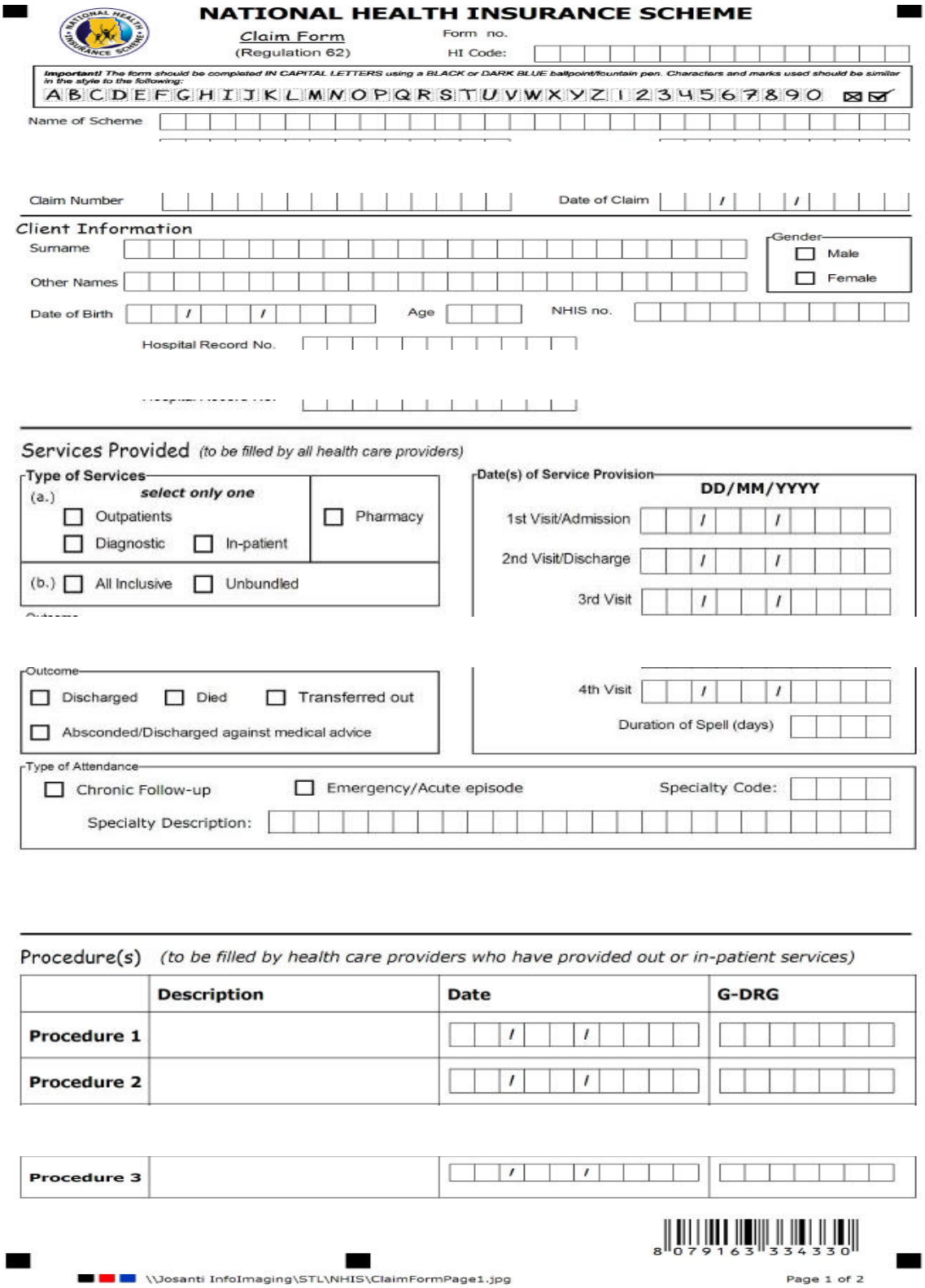
iii. …….

iv. …….

v. …….

Source: Author, 2015

APPENDIX 3 Claim Form



NATIONAL HEALTH INSURANCE SCHEME

Claim Form (Regulation 62)

Form no.

HI Code:

Important! The form should be completed IN CAPITAL LETTERS using a BLACK or DARK BLUE ballpoint/fountain pen. Characters and marks used should be similar in the style to the following:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0

Name of Scheme

Claim Number

Date of Claim

Client Information

Surname

Other Names

Gender: Male Female

Date of Birth

Age

NHIS no.

Hospital Record No.

Services Provided (to be filled by all health care providers)

Type of Services

(a.) select only one: Outpatients, Diagnostic, In-patient, Pharmacy

(b.) All Inclusive, Unbundled

Date(s) of Service Provision DD/MM/YYYY

1st Visit/Admission

2nd Visit/Discharge

3rd Visit

4th Visit

Duration of Spell (days)

Outcome: Discharged, Died, Transferred out, Absconded/Discharged against medical advice

Type of Attendance: Chronic Follow-up, Emergency/Acute episode, Specialty Code:

Specialty Description:

Procedure(s) (to be filled by health care providers who have provided out or in-patient services)

	Description	Date	G-DRG
Procedure 1			
Procedure 2			
Procedure 3			

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Page 1 of 2

Form no.

Diagnosis(es) *(to be filled by health care providers who have provided out or in-patient services)*

	Description	ICD-10	G-DRG
Diagnosis 1			
Diagnosis 2			
Diagnosis 3			
Diagnosis4			

Investigations *(to be filled by health care providers providing diagnostics services only)*

	Description	Date	G-DRG
Investigation 1		/ /	
Investigation 2		/ /	
Investigation 3		/ /	
Investigation 4		/ /	
Investigation 5		/ /	

Medicines *(to be filled by health care providers who have dispensed medicines)*

	Description	Price	Qty	Total Cost	Date	Code
1		.		.		
2		.		.		
3		.		.		
4		.		.		
5		.		.		

Client Claim Summary

Signature

	Type of Service	G-DRG/Code	Tariff Amount
A	In-Patient		.
B	Out-Patient		.
C	Investigations		.
D	Pharmacy		.
	TOTAL		.

Signature

Name

(Health Facility Insurance Officer)

Scheme Use Only

Available choices
A & D or B & D or C & D or C or D

Date Received		Action 1		Date	Signed
Signed		Action 2		Date	Signed

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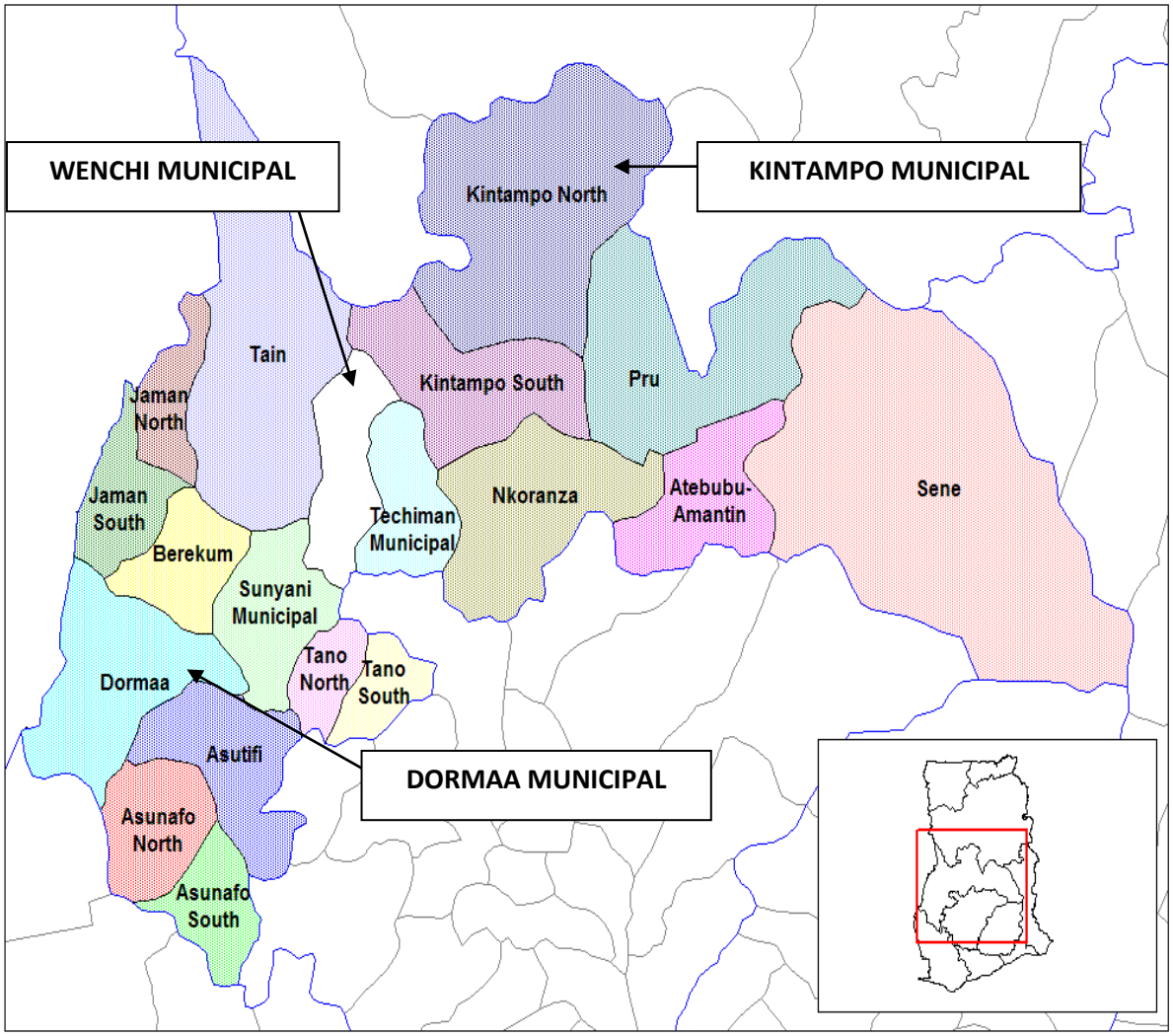
Page 2 of 2

Source: National Health Insurance Authority, 2015

APPENDIX 4 Map of Brong-Ahafo Region showing the study districts



Source: Ghana Districts.com, retrieved in February, 2017