Managerial Implications of Delayed Reimbursement of National Health Insurance Claims: The Case of two Hospitals in Northern Ghana

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Abstract
This study examines the managerial implications of the unpredictable payment pattern and the extent to which the phenomenon affect quality healthcare delivery using Bolgatanga Regional Hospital and the Bawku Presbyterian Hospital as multiple case study. Qualitative case study design was employed using multiple cases of two hospitals to allow for an in-depth exploration of delayed reimbursement of claims. A total of 12 management members of the two hospitals and 10 scheme managers were selected for interviews. Significant statements from transcribed data generated themes through coding and categorization. The purchaser-provider split model underpinned the study analysis and discussions. The results showed that managerial activities of the two hospitals are characterized by prize discrimination, weak purchasing power and impromptu prioritization. Stock level for drug and non-drug consumables often depleted, leading to the emergence of a certain unscripted form of 'co-payment'. Staff development, training and remuneration are halted, while basic diagnostic test could barely be carried out. The findings do not support the realization of technical and clinical quality. The paper recommends the creation of a separate account for NHIS funds and enforcement of sound financial management of the scheme's funds by the National Health Insurance Authority. A broader consultation is also recommended to explore the possibility of incorporating co-payment into the current system, to minimize cost of treatment burden as well as serve as a gate keeper.

Key Words: reimbursement, insurance, claims, managerial implications

Background

Healthcare accessibility and affordability are critical variables in many developing countries such as Ghana. Indeed, the comments by the Economic and Social Council of the United Nations states that "Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party" (UN, 2000; pp.3). Healthcare access is viewed as a non-negotiable necessity that cannot be compromised. Ensuring good quality and accessible healthcare does not happen by chance, it is planned.

Green (2012) posits that healthcare financing viability and sustainability are key ingredients to ensuring healthcare accessibility and affordability. Studies over the years suggest health insurance provides the prospects of better access and risk protection for the poor by pooling risks and resources against the cost of illness (Dror and Jacquier 1999; Preker *et al.* 2002; Ekman 2004; Carrin *et al.* 2005). In replacing user-fees known as *cash & carry,* the government of Ghana through an act of parliament (Act, 650) implemented a unique three-prong dimension of health insurance; district wide mutual insurance, private health insurance and private mutual health insurance. The district wide mutual health insurance which is the largest and most subscribed is financially supported by government and manned by a board of governors. This will later become national in nature with a central management and governance.

Send-Ghana (2010) and Osei-Akoto et al (2012) report that the implementation of Ghana's national health insurance scheme has significantly soared facility attendance resulting in increased workload. However, Seddo, Adjei, and Nazzar, (2011) note that there is a significant loss of revenue to providers due to claims payments delays among others. Sakyi *et al* (2012) observe that, delays can take up to 4 months. Dalinjong & Laar (2012) reveal that, the phenomenon can take as long as 6 months before the authority pays 'something' to service providers. It appears a widespread problem. Witter & Garshong (2009) and Blanchet, Fink & Osei-Akoto (2012) found out that over 70% of internally generated funds (IGF) of accredited facilities are accounted for by the national health insurance scheme's claims.

The dilemma is, can service providers function at optimum given that a major chunk of their IGF is held up by the National Health Insurance Authority (NHIA) often for 6 month or more? What does the future hold for accessibility and quality healthcare? How does the delay in reimbursement influence decision making and managerial tasks? Talks on the effect of unpredictable reimbursement of claims has been rhetoric and not grounded on empirics. Existing literature tend to comment on the general challenges of the scheme and not specific on the effects of delayed reimbursement hence, a gap. This paper consequently examines the impact of claims payment delays on managerial decision-making and task and the extent to which the phenomenon affect healthcare delivery.

Ghana's National Health Insurance Scheme

Health insurance simply put, is a way of pre-paying for service for consumers. Subscribers in principle agree to pay some amount which is spread over a specified time period within which any member can

benefit on need bases. When Ghana introduced the policy in 2005, the objective was that: "Within five years, every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services" (Government of Ghana, 2004 pp.4). The scheme is unique in that it is a combination of both Social Health Insurance and Mutual Health Insurance concepts.

At the centralized level, the NHIS is regulated by the National Health Insurance Authority who guides the management of the national health insurance fund (NHIF). The scheme is funded primarily from a combination of earmarked public revenues (2.5% VAT), contributions from civil servants to Social Security Funds, i.e. Social Security and National Insurance Trust (2.5% SSNIT) and income-adjusted premiums.

Revenues from the NHIF are used to provide a reinsurance mechanism for the District Mutual Health Insurance Schemes (DMHIS) and premiums for exempt groups such as children under the age of 18 years if both parents are registered, pregnant women, those above 70 years and the core poor under a legislative instrument (LI 1890, 2003). The minimum benefits package of the NHIS includes outpatient and inpatient care, maternal care, diagnostic tests, generic medicines, certain cancers such as cervical and breast cancers, emergency care, many dental and eye services as well as the cost of general ward and meals (Mensah et al., 2009, MOH, 20010). The NHIS contracts accredited providers (public, private and mission) to deliver services to its members and reimburses them after submission of claims for services. This system separates the purchasing and service provision functions across different stakeholders to increase transparency.

Provider Payment Mechanism

The Provider payment method is the mechanism used to transfer funds from the purchaser of health care services to the providers. A good provider payment method has to address and be implemented within strong support systems. Issues of importance in developing and implementing a successful provider payment strategy include: governance and accountability, fund management and stakeholder relationships between users, scheme managers and providers. Three main payment mechanisms define health insurance claims reimbursement: Fee for service (this is often itemized), diagnostic related groupings (DRG) and capitation. One method does not claim perfection over the other. In some instances, two or more methods can be used to counteract the disadvantage of using one. Amarteyfio and Yankah (2012) explain that a skillful mix of methods in the context of a country's economics and historical background perhaps is the best approach.

Ghana's NHIS uses itemized fee for service for medicines, diagnosis related groupings for services. In a typical case, when a client enters an accredited facility with active NHIS ID card, the client is issued an NHIS specified folder by the record department and he/she goes through the system of treatment. A cost sheet accompanies the folder upon which entries are made from one stage of the healthcare

delivery to another or software system captures the digital details of the client's service usage. The cost sheet is removed by the facility's billing officers after the treatment process and the folder sent back to the record unit for the next visit by client. Claims are then compiled using the individual cost sheet from each client's folder or using the software captured information about patient care and sent to NHIS after internal vetting. The scheme also vets (check for accuracy and genuineness) submitted claims. Successfully vetted claims that meets the terms of references is then approved by the Scheme managers for payment.

The Split Model

Healthcare thrived on efficiency and cost effectiveness in developed countries. Fischbacher and Francis (1998) thought that, a split in function for a provider and a purchaser will enhance efficiency and accountability. Essentially, the model involves actors in a tripartite relationship: the purchaser, the provider and the premium holder. The purchaser gets the mandate of the premium holder to negotiate and pay for healthcare services on his behalf. The system creates an atmosphere where providers are accountable to the public through the purchaser.

The split model is viewed in two dimensions: a total split and a partial split. A total split occurs when public providers are managed entirely by another public body while others may be totally privatized. On the other hand, a partial split denotes a situation where a public authority may retain management of some services of health provision (Zurn and Adams, 2004). An incentive to the split system is its capacity to empower purchasers to use their purchasing power to compel service providers to offer quality care. It also allows providers to focus on efficient delivery of quality healthcare as it stimulates competition among them (Zurn & Adams, 2004; World Bank, 2006).

Central to Ghana's NHIS is the purchaser-provider split model, where government performs a regulatory function for both the purchaser and the provider. This study is not a holistic review of the split model, rather, as the model underpins the study, delayed reimbursement is viewed as a negative function of the purchaser, thus, this paper explores its implications on the provider. The gap between the principles and practice of the model is discussed and lessons drawn for health policy makers. Figure 2: explains the relationship among the actors of the scheme.

Methodology

A qualitative philosophy reliant on the constructivist world view guided the approach of the study. This allowed managers of the study sites who run the hospitals to explain their experiences and the extent to which the issues affected the running of the health facilities. Two hospitals were chosen under the guide of inclusion criteria to enhance the explanatory power of the findings.

The criteria included: NHIS accredited hospital, a minimum of 3-years post-accreditation experience and evidences of delayed reimbursement for the last 2-3 years. Key informants within the pull of management in each hospital were purposively selected for a one on one in-depth interview. A total of 22 respondents comprising of 12 management members

of the two hospitals and 10 scheme managers were selected for interviews. The choice of participants was informed by the knowledge that in the Ghanaian context, management members are directly involved in the day to day activities of purchasing and payments in a hospital setting and can provide reliable and credible information to the study. This is consistent with Creswell's view on purposive sampling (Creswell, 2013). Same tools and strategy was used in collecting data from the two different points, thus, supporting the logic of replication as espoused by Yin (2009). The use of multiple data source also allowed for data triangulation. In all, 12 management members, 6 from each hospital, were interviewed one-on-one.

In-depth interviews

All participants granted face-to-face and tape recorded, except one, whose interview was via telephone. The time spanned a period of two months. On the average, an interview session lasted about 1hour 30 minutes, with time variance of over 15minutes. Respondents expressed themselves freely without interference, coercion or leading comments. Follow-up questions were asked as and when necessary and clarifications sought on issues that were not clear but relevant.

Analysis

Data analysis fundamentally, was inferential and assumed a thematic style. The multiple case nature of the study necessitated a thematic analysis across the cases, referred to as cross-case analysis (Creswell, 2007). The tape recorded interviews were transcribed verbatim, read over and over, extracting about 120 significant statements. These statements were coded to allow for proper categorization. Data that did not fit well into any of the categories developed were carefully examined to ensure that their exclusion will not negatively affect the results. Statements were then clustered using similarities and dissimilarities. Categorization of similar and common statement generated 4 themes under which findings are reported.

Results

Price discrimination

As a tactic to avoid losses, suppliers purportedly pegged their prices above the normal market prices of drug and non-drug consumables. Apparently, this allows suppliers to continue to meet the demand of providers, keeping them as customers and not running at a loss. These prices have been described as 'throat cutting'. An informant put it this way, *"We buy on credit and if you go for credit they will not give you at the normal market price. They will give you at a relatively more expensive price knowing that they will not get their money any time soon".*

Another informant agrees with his colleague, thus, *"Prices are high. If somebody agrees to supply, he will factor in the delays as compared to if they know the money will come next month.*

The fact that bankers may charge interest in addition to inflation was also highlighted as a possible causal factor to explain how the delay affects hospital managers vis a vis market prices. Interviewees suggested that suppliers go for loans with interest from the banks to work with, and rightly so, will consider interest rates and time when pricing their goods. A finance expert and a key management member of one of the hospitals had this to say;

"...By implications, all these (delays) are

factored into prices, work out bank interest and slap it on the cost of items. Probably, he took a loan from the bank and has to makes projections and adds it to the prices".

Moreover, due to prices discrimination, income generated from the scheme has little value and weak purchasing power. For example, the purchasing officer may be required to pay £100.00 for items which otherwise would have been £70.00, thus, there is a total reduction in quantity of goods and services with which insurance income could have obtained. A participant noted:

"…the hospital must run. Sometimes we have to plead…and sometimes, we have to look for alternative elsewhere, suppliers who do not know us much. They will go in and send us the items on a higher price which I think is very bad."

Higher prices for facilities and intermittent refusal by suppliers to supply essential items to providers necessitated unapproved survival strategies of rendering services. Informant reports of unapproved method of insurance/cash & carry style. This is where a client with valid insurance card access free consultation and services but pays cash for the drugs at the pharmacy or buys the drugs from private pharmacies for treatment. It appears an unscripted form of co-payment. He disclosed,

"We run some cash & carry alongside 'small small' to help the system… You know, when you prescribe a drug and it's not in stock, the client may have to buy it outside for use and if the pharmacy has it and says they need cash…what do you do?"

Weak purchasing power

"We don't have the purchasing power" a participant observed.

Interviewees noted with concern that hospitals ability to purchase equipment, drug and non-drug consumables has been rendered ineffective by the delays. Records from both facilities show that over 90% revenue generated by providers is from the National Health Insurance Scheme. Given that delays can take up to 6 months and when payment is eventually made, less than 50% of total claims due is reimbursed at a time, the purchasing power of hospital would somewhat be affected. A procurement officer of one case observed that the procurement department is at the mercy of the scheme.

"It affects procurement a lot because we buy many things with the money we receive from health insurance. We buy drugs, we buy non-drugs and even food staff…most of the times we pick these items on credit. When we pick and have no money to pay…suppliers threatens not to supply"

The hospitals in question have feeding programmes meant to reduce malnutrition in children and actually feed a section of admitted clients in the facilities. It is difficult to imagine what will happen to patients who cannot be fed because the facilities are not paid what is due them.

Suppliers actually carried out their threat quite often.

"Of course, just recently after our procurement evaluation we wrote to those who were supposed to supply and they told us that we owe them so much, so they cannot supply: they said they don't have money to go to the market to buy for us."

Another informant lamented that claims payment delays created a consequence of facilities paying so much for less items as compared to their counterparts who used cash & carry. He said:

"We normally have to strongly to negotiate. Some…know we are an institution and cannot run away. They will eventually give us but at a

higher price than what they would quote in the market for cash & carry. They take advantage of the situation and 'cut' against inflation to avoid losses."

In other instance, claims payment delays created a situation where facilities go to the extent of reducing the quantities of items they needed to persuade supplier to supply, It do not meet their quarterly requirements. The procurement officer lamented,
"The budget that we worked on recently, the quantities we were supposed to buy was huge, but because we don't have the money to finance the purchases we had to cut the quantities down, which I think will affect us because it will not be long and these items will finish and we will be running round looking for items."

A participant had an economic view of the above development. He thinks that inflation might catch up and affect the institutions purchasing power, should procurement be carried out in smaller quantities over time.
"Increased prices may not affect you much if you buy in large quantities"

Shortage of drug and non-drug consumables

Drugs are the single most important commodities with which hospitals operate. Science has yet to discover what could possibly deal decisively with microorganism in a hospital other than drugs. To that extent, it is probably outrageous to think that hospitals can function optimally without constant supply of drugs. Indeed, there was an account of crucial drugs that run out of stock and could not be procured due to lack of funds and accrued debt. A medical director bemoans:
"Sometimes there can be certain drugs that we do not have and have no money to go and buy. There was a time our insulin got finished and we had no money to purchase. The regional medical store couldn't help us to".

It is not a case of one incident or two. It regularly happens and more so when a facility gets unfavourable response from its major source of revenue. It appears to be a normal occurrence, however serious it might be.
"It has happened to us severally where they deny us drugs because we owe them"

The challenge does also take the form of managers changing suppliers, a situation which exposes procurement officers to buying substandard drugs or items. It appears to be a case of less money, less options. The surgical theatre of Bawku Presbyterian Hospital suffered directly from the situation.
"There was a time, the theatre run short of a particular suture which was very good. The sutures finished and we had not paid the supplier for long. We relied on another supplier and they supplied but the theater staff complained that it was not good."

One interviewee was straight forward with the effects of claims payment delays on health service delivery.
"Yes! Quality is compromised. You may not have a particular drug and cannot go back for it because you haven't paid. It may so happen that only that company can supply it."
Indeed, the phenomenon could potentially retard the gain made in achieving the United Nations' Millennium Develop[-ment Goal 5. Oxytocin is drug used by doctors and midwives during labour. One of the study hospitals had a shortage of this important drug and the supplier was

reluctant in supplying because the facility owed them for over 8 months.
"...Oxytocin was not in supply. We struggled to get it for the midwives..."

Private suppliers and companies are not the only ones affected. The precarious situation also poses a challenge to the regional medical store. One would expect that the regional medical stores will bail out facilities that are in dire need of drugs under such circumstances. The results suggest otherwise.
"At times you go to the regional medical stores and they complain of similar situation...they also need to pay their suppliers and if we own them for long, they cannot purchase for us"

Areas of non-drug consumables or equipment are equally affected if not more. Technical quality is potentially enhanced with the availability of required working tools. Appropriate working tools are incentive by themselves for quality healthcare delivery. However, the experience shared by interviewees, did not support a healthcare environment well equipped with working tools. Laboratory reagents were also in shortage causing the inability to run certain basic tests like hemoglobin, widal test and cultures.

A key informant lamented that clients were oftentimes referred to private laboratories for their investigations that are covered by the scheme and would have been carried out by the study site facilities but lack of funds due to the reimbursement delays. Essential equipment such as oxygen concentrators that facilities could have, were they paid regularly are not in adequate supply.
"We agreed to buy oxygen concentrators for all the wards. We even budgeted for it but no money"

Cotton wool, gauze and plasters have run out of the system according to participants. These are necessary for ward activities such as wound dressing, setting intravenous lines, putting Plaster of Paris (POP) and others.

Impromptu prioritization

Indeed, managers of the two hospitals seem to have braced themselves for ad-hoc measures whenever necessary. The payments of claims are unpredictable and unreliable and therefore allows minimal or no room for managers and Administrator to plan. If anything, managers' action in the current situation of claims payment is to survive. The findings suggest they have oftentimes changed certain policy arrangement to quickly accommodate a distress situation.
"Go to our ledgers, we have a lot of debtors...carry over front. You get this, and you patch some holes. You look at emerging areas and the age of the debt and then you manage... the most essentials like oxygen should be taking care of... So you do cash management".

In other instances, moneys meant for development and training would be diverted and reserved to cater for the salaries of casual workers or workers who have not been mechanized by the controller and accountant general's department. Projections which otherwise may not have happened appeared inevitable under the current payment style.
"Anytime we receive money from the health insurance, because it's their (unmechanised staff) monthly salary, we make provision for them for several months. That money is set aside to pay staff salaries."

Decision making appears to be adversely affected. Describing the development as

terrible, a key informant accounted how they are unable to implement managerial decision. The problem is made worse due to the high patronage of health insurance in the study areas. In the words of a top management member, the internally generated funds of the facilities are virtually reliant on the scheme claims payments, failure of which oftentimes throws the management and administrative processes into disarray.

"The hospital revenue is nearly 95% insurance…, we can't do anything. We cannot pay rural allowances. Basic administrative cost is affected. It has affected managerial decision. Even suppliers have threatened to withdraw. Some withdrew because we owe them so much."

The above statement is suggestive of a precarious situation of hospital managers and administrators brought about as a result of a failed system that promised to deliver.

Discussion

The results show that both hospitals practically depend on claims payment by the scheme for administrative and managerial activities. Over 90% of the total income of the Regional Hospital for example is from the insurance scheme. The breakdown of revenue between drug and services also shows a similar pattern. The dominance in percentages of insured revenue against out of pocket payment suggests the level of acceptance of the scheme by the people of the region. This is consistent with the findings of Asenso-Okyere *et al* (1997). This also support the findings of Blanchet, Fink and Osei-Akoto (2012) that the average individual enrolled in the insurance scheme is significantly more likely to obtain prescription, visit a clinic and seek formal healthcare when sick. The enhanced health seeking behaviours of both hospitals clients presuppose that, in the unpleasant event that the scheme becomes unattractive, facility users may resort to user fees, called 'cash & carry.

A major finding of the study is the weaknesses in the purchasing power of the hospitals marked due to late payments. Clearly, managers account of not being able to pay their suppliers on time work against them as their drug and non-drug consumables are limited. This supports Sodzi-Tetteh *et al* (2012) findings but inconsistent with Atinga *et al* (2012). Atinga and others report that hospitals under the national health insurance scheme are better-off in the area of cash flow and stock levels of drugs. The apparent inconsistencies of the findings with their work may be suggestive of the evolving changes of the scheme rather than a limitation of a scientific process of either study. In other words, the scheme probably paid well at the time Atinga and others conducted their study vis a vis the current situation as reported by this study.

Both facilities showed evidence of completely running out of essential drugs at some point in time. The study findings also showed that renovations works stalled and employee development and training suspended, all due to lack funds. Bakar *et al.* (2008) proposed a two-way approach to explain the dimensions of service quality in healthcare. They distinguished between clinical quality and service quality. The former refers to activities of the healthcare process such as surgical skill, sufficient drugs, logistics and other factors that translate into better outcome. Juxtaposing the results of insufficient drugs and logistics to Baker et al dimensions of

healthcare quality exposes clinical quality issues of the study hospitals. Hospital comfort and physical environment which are necessary variable to service quality according to Baker and his colleagues also remains a challenge in the hospitals.

The study also found that staff renumerations were outstanding. The most affected group are those paid on table. The picture is de-motivating, does not enhance job satisfaction and counteracts the prospect of quality healthcare. Stredwick (2000) suggests that the emergence of the concept of human resource management in the 1980's gave rise to the recognition that the workforce was one of the areas of competitive advantage and that a good and well-motivated staff will deliver the goods anytime in a day. Motivation creates in employees the 'will to work' while job satisfaction also positively correlate with employees' inclination to work effectively (Porter & Steers, 1973; Price, 1977; Mobley *et al.,* 1979). A competent worker who is unwilling to work may actually achieve nothing.

According to Engin and Com (2006), clinicians need motivation to accomplish their tasks and provide quality care. Factors such as workload, salaries, benefits, bonuses, leadership styles, reward systems, opportunities for growth and development, have been found to contribute to clinicians' levels of motivation (Barker, 2006). Heathfield also (2008) notes that the one key factor in employee motivation is the opportunity offered to them for continuous growth and development on the job. The perceived lack of control over factors like claims payment affect standard practices and can also lead to dissatisfaction, frustration and demoralization (Roseanne & Daniel, 2006).

The results also uncovered that prescriptions are issued by doctors for patients or their relatives to buy drugs and non-drug consumables such as cannulas and gloves for use by clinicians. It appears a new but very common practice that has been adopted by service providers to mitigate the consequences of claim payment delays. This is consistent with Agyepong and Nagai's (2011, pp.78) finding of "ridiculous modification" of insurance processes by providers to survive. The unscripted form of co-payment, however, could pose affordability challenges to the poor and destitute who are major beneficiaries of the social health insurance (NHIA report, 2010; Prinja et al., 2012). The development is a threat to the achievement of universal health coverage as trust between premium holders and service providers could potentially be damaged and eventually discourages individuals from renewing their membership.

Weaknesses of the split model

Siverbo (2003) writes that researchers recently begun to have doubt that the purchaser-provider split model is good for the public sector. He notes that the split-model does not support the creation and maintenance of market relationship. According to Elwood (1997), the purchaser pay limited attention to prizes and other market signals and that it was common for the purchasers to have a monopsony and providers to have a monopoly. Akerhurst & Ferguson (1993) reports that providers felt they were in the hands of purchasers and simply have to dance to their tune. Lapsley & Llewellyn (1997) and Flynn & Williams (1997) highlight the lack of clauses in contracts with regard to

penalties if contract was breached.

A stand out challenge in Ghana NHIS is a non-regular payment of claims (Witter & Garshong, 2009, Sakyi*et al.,* 2012; Sodzi-Tettey *et al,* 2012). Probably, the model does not suit the political terrain or there is some sort of a lop hole in the schemes legislative acts. The split model appears conflicting and problematic. Ghana's government regulates the health insurance scheme under the current arrangement and at the same time owns the public health sector thus, the state is the purchaser and to a large extent the provider. Scheme and hospital managers are merely employees of the state who can only make do with what is available to provide services. The state decides when to finance its healthcare services, through claims payment and should there be any delays, no sanctions are pronounced and civil society suffers. This probably explains why claims payment goes beyond the 4 weeks grace period as stipulated by law (Act 360) yet nobody is held responsible. It is an abuse of the purchaser-provider split model and may as well invite patients to the days user fees (Figure 1).

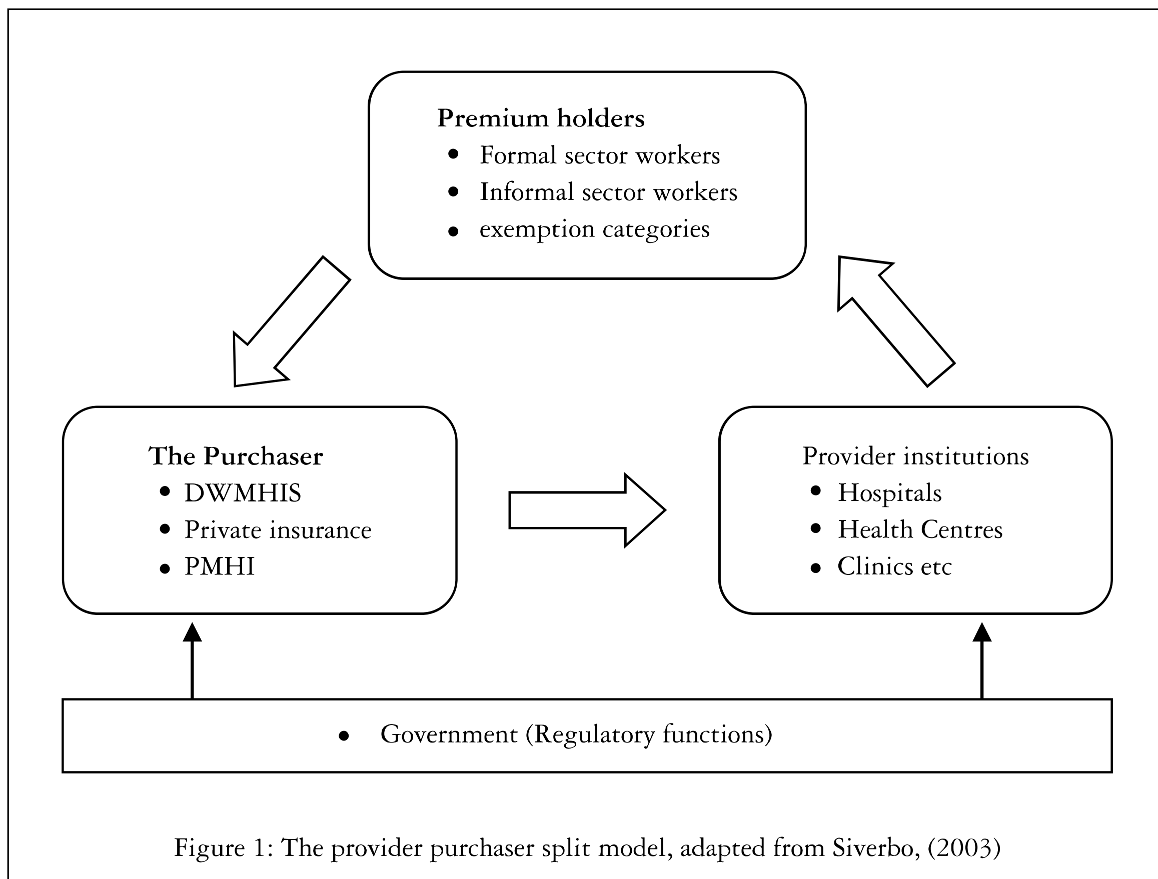

Figure 1: The provider purchaser split model, adapted from Siverbo, (2003)

Conversely, private health insurance in Ghana does better in terms of claims reimbursement. For example, SSNIT hospital accepts private insurance, but not national health insurance. The findings suggests Ghana's NHIS is at a cross road and this is congruent to earlier studies that reports that earlier health insurance scheme had collapsed in Ghana as a result of delayed reimbursement (Seddoh & Akor's, 2012). Figure 3, is the Author's impression of the country's healthcare financing chances in the long run should the current trends continue. The diagram show the phenomenon acts at both ends to dissatisfy the service provider and the consumer.

Conclusion

Managerial decisions of the two hospitals under the current rate of claims payment are generally ad-hoc and unplanned. Administrative activities such as procurement, staff remuneration, staff training and development have often been halted, thus, raising concerns over what Donabedian terms structure-process-outcome quality of care. Perhaps, technical quality is a challenge under the current situation. The apparent weakness of the purchaser-provider split model with regards to accountability of the purchaser may be traced to government as an owner and/or a regulator of both healthcare provision and purchasing. Conflict of interest issues arises.

The current structure further strengthens the grips of government on the scheme and support respondents' views that, the scheme funds are probably diverted to other government businesses. The phenomenon is a danger to healthcare financing viability, affordability and financial access. The happening puts pressure on providers, decreases the trust of premium holders and potentially prevent the full realization of the benefit of social health insurance thus, a threat to Ghana achieving universal health coverage. Perhaps, the guidelines should be reviewed to include regularized cost sharing system, so called co-payment, where some or all categories of subscribers are made to pay a certain percentage of the total cost of treatment to minimize pressure on the scheme.

Misapplication of the scheme's funds as suggested by the study participants is thought to also contribute to claims payment delays. There is, therefore, the need to take a critical look at the current system of lamping the scheme's funds into the consolidated fund, a general government coffers. Perhaps, it is time government created a separate account for the national health insurance scheme funds and also encourage the independence of the National Health Insurance Authority, where they are empowered to ensure that, sound financial management practices exist within the scheme to safe the current situation. This study also recommends large scale research quantitatively to measure the relationship between claims payment delays and healthcare quality.

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