

The Effects of Delays in Reimbursement of Claims by National Health Insurance Authority on Financial Management of Health Care Facilities in Brong Ahafo Region of Ghana

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Abstract

Financing health care system is of a major concern to countries all over the world. The Act of Parliament (Act 650) passed in 2003 health care financing and being implemented and supervised by the National Health Insurance Authority (NHIA). National Health Insurance Authority aimed to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential health care services without payment being required at the point of use. The efficiency and sustainability of the health care facilities depend on funding and timely disbursement of claims. It has been observed that, whilst health care facilities do comply with section 37 (7) of L.1 1809, the scheme has not been able to comply with section 38(1) of the L.1 1809. This leads to undue delays in reimbursement of funds to accredited institutions. This delays of reimbursement of claims by National Health Insurance Authority therefore has adverse effects on the financial management of health care facilities. It is therefore recommended that, Government should speed up on releasing funds to National Health Insurance Authority for payment of claims. Further research needs to be done to verify the findings among other groups of facilities, and explore comparative studies involving facilities from different industries. Future researchers should also develop measures of additional dimensions to find out if the premium charged on scheme members of NHIS is fair enough to pay claims and also suggest whether premium charged should be increased or maintained.

Keywords: National Health Insurance Authority, Reimbursement, Financial Management, Accredited Health Facilities

Background

Brong Ahafo is made up thirteen (13) administrative districts: Sunyani, Asutifi, Tano, Berekum, DormaaAsunafo, Techiman, Wenchi, Sene, Nkoranza, Atebubu, Kintampo and Jaman(Koya, 2010). According to Koya (2010), there are two foremost ethnic groups namely the Brongs and the Ahafos who are of the Akan stock. Koya claims that minority groups are the Nafana of Sampa, Koulongo of Seikwa and Badu, the Mo/Degha of Mo, Libya of Banda and also the Nchumuru of Atebubu and Sene. Akan is the lingua franca throughout the region (Koya, 2010).

According to Abdul-Korah (2006), there are forty-four Paramount chiefs and five Divisional Councils constituting the Brong Ahafo Regional House of Chiefs. He further explained that, the Region can boast of first class roads linking its major towns to the regional capital, Sunyani and other fragments of the country. Sunyani has an airport, which links the region by air to Kumasi, Accra and Takoradi. Air transport is however irregular and is therefore unreliable. Lake Brong Ahafo is made up of three inland lake ports on its boundaries of Volta Lake.

These are; New Buiepe, Yeji, and Yapei, which can all be linked from Akosombo using the Yapei Queen among others (Abdul-Korah, 2006). Abdul-Korah (2006) claims that there is an effective

communication system in place with over 6,800 direct telephone lines linking most district capitals; radio phones are used in other districts.

Mobile phones are also in use now. He further states that the thirteen (13) district capitals have access to electricity whose electrical energy amounts to the general one of 220 volts and of 3-pronged and 2-pronged outlets and about 30 health care facilities that are registered with the National Health Insurance Authority.

Financing health care system is of a major concern to countries all over the world (Van Lerberghe, 2008). In 2005, Ghana spent 6.2% of GDP on health care, or US\$30 per capita making healthcare financing challenging for the State, which culminated in the implementation of alternate health care financing in Ghana (Maharajh, 2015). Several healthcare financing models have been experimented; from the system of 'cash and carry' to the current National Health Insurance Scheme (NHIS) (Owusu-Sekyere & Bagah, 2014). The Act of Parliament (Act 650) passed in 2003, health care financing and being implemented and supervised by the National Health Insurance Authority (NHIA).

The NHIS is an alternative health care financing system which involves resource pooling and risk sharing among members (Owusu-Sekyere & Bagah, 2014). The NHIS has been adjudged by World Health Organization as better system of healthcare finance because the 'cash and carry' system or user fees policy introduced in 1985 is thought as constitute a strong barrier to the utilization of health care services, as well as preventing adherence to long term treatment among poor and vulnerable group (Dalinjong & Laar, 2012). Dalinjong and Laar, (2012), claim that, the ultimate goal of the NHIS was the provision of universal health insurance coverage for all Ghanaians, irrespective of their socio-economic background.

The National Health Insurance Authority (NHIA) since it was established in Ghana in 2003 has gone through some reforms (Witter & Garshong, 2009). In October 2012, a new law, Act 852 replaced Act 650 to consolidate the NHIS, remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the scheme (Blanchet, Fink, & Osei-Akoto, 2012). However, NHIS which is thought to provide better health care service for Ghanaians is fraught with numerous challenges including fraudulent practices among managers of the scheme and service providers leading to a high cost of providing health care with medicines accounting for 53% of claims cost and about 80% of medicines acquired from sources unknown by management of the insurance scheme (Seddoh, Adjei, & Nazzar, 2011).

According to Dalinjong and Laar (2012), the delay in claims payments has a trickling effect on subscribers to the scheme in the following ways. First of all, service providers are compelled to turn their attention to non-subscribers who are ready to pay cash for services. This causes non-subscribers to the scheme to spend less time in seeking health care as compared to scheme subscribers. Secondly, service providers are also compelled to issue prescription forms to subscribers to the scheme to buy drugs out of the facilities. The efficiency and sustainability of the health care facilities depend largely on funding.

Gobah and Zhang (2011), investigated the causes and effects of reimbursement delays of the National Health Insurance Authority (NHIA) to health facility. The study indicated that the effect of delay of reimbursement to health facilities is provision of health service.

Gobah and Zhang (2011) claim that, the responsibilities of the scheme and the service providers are spelt out succinctly in Section 37(7) of the National Health Insurance Regulations, 2004 (L.I 1809) as follows: "A claim for payment of health care services rendered under a scheme licensed under this Act shall be filed within sixty calendar days from the date of the discharge of the patient or rendering of the service .

On the other hand, section 38 (1) of the L.I 1809 states "A claim for payment of health care service rendered which is submitted to the scheme shall, unless there is any legal impediment, be paid by the scheme within four weeks after receipt of the claim from the health care facility". It has been observed that, whilst health care facilities do comply with section 37 (7) of L.I 1809, the scheme has not been able to comply with section 38(1) of the L.I 1809. This leads to undue delays in reimbursement of funds to accredited facilities and if not addressed can stifle the operations of the accredited health care facilities in the country (Gobah & Zhang, 2011). The delay in claim reimbursement has led much health facility to return to the 'cash and carry' system (Dalinjong & Laar, 2012).

According to Takyi (2017), the total debt owes to the service providers as at April (2017) was 1.2 billion Ghana cedis. This study therefore sought to examine the effect of delays in reimbursement of claims by national health insurance authority on financial management of health care facilities in Brong Ahafo Region.

This study sought to identify the main causes of the delays in reimbursement of claims to accredited health facilities and the effect of the delay in reimbursement on the operations of the health facilities

Methodology

Specifically, a case study analysis was used to assess two primary areas of interest

1. effects of the delays of reimbursement of claims by NHIS on the financial management of health care facilities in the Brong Ahafo Region of Ghana
2. The cause of the delays in reimbursement of claims by NHIA to service providers.

Descriptive method of research design was used in the study. The strategy used for this work was exploratory, with both qualitative and quantitative approach since the data collected was converted into numerical value for better interpretation. The target population was the management staff of accredited healthcare facilities in the Brong Ahafo region of Ghana. The sample was composed of 30 accredited hospital facilities in the Brong Ahafo Region. Both primary and secondary sources of data were used in this study. A survey questionnaire was used to obtain information from the target staff of the selected health facilities. The data gathered were analyzed quantitatively by using descriptive statistical tables and percentages where correlation and regression were considered. Statistical package for social sciences (SPSS) version 22 software was also used in the analysis. The study has managed to add to the existing body of knowledge in furthering our understanding to the effect of the delay in reimbursement of claims on health facilities in Brong Ahafo.

Findings

The findings of the study are presented, analyzed and interpreted below

Data presentation, analysis and interpretation

The table below shows the questionnaire administered and their results presented.

Table 1.1. Response to questionnaire

Questionnaire	Respondents	Percentage (%)
Questionnaire returned	90	97
Questionnaire not returned	2	2
Questionnaire incomplete	1	1
Total	93	100

Source. field data, 2019

From 1.1 above, it can be seen that most of the respondents were able to return their questionnaires. With the total of ninety three (93) questionnaire administered, ninety (90) respondents returned their completed questionnaire to the researcher representing 97%. Two (2) of the remaining were not returned and this represented 2%. The remaining one (1) spoiled representing 1%. The high rate of respondents returning their questionnaires explained the fact that, there was a favorable response to the questionnaires.

The researcher wanted to know the gender distribution of the respondents and from the findings, the total respondents were 90. The male respondents were 57 representing 63% of the total respondents. The female respondents were 33 representing 37% of the total population. This indicates that majority of the respondents were males

From the findings, the marital status of the respondents indicates that about 58 percent were married whilst 42 percent were single. This means that the majority of the respondents were married.

Again, from the findings, 50 of respondents representing 56% of the total respondents were between the ages of 18 and 40. 36 of the remaining respondents representing 40 percent were between the ages of 41 and 60. Only 4 of the remaining respondents were between the ages of 61years and above and this

represent 4% of the total respondents. This indicates that majority of the respondents were between the ages of 18 and 40.

The researcher wanted to know the educational level of the respondents and this is represented in table 1.2

Table 1.2. Educational level of respondents

		Frequency	Percent	Valid Percent
Valid	secondary school	3	3	3
	Diploma	13	14	14
	First degree	28	31	31
	Second degree	33	37	37
	Others	13	14	14
	Total	90	100	100

Source. field data, 2019

From Table 1.2 above, 3 of the respondents representing 3% of the total population were secondary school leavers. 13 of the remaining respondents were diploma holders and this represents 14% of the total respondents. Only 28 of the remaining respondents had first degree and this represent 31% of the total respondents. 33 of the respondents were second degree holders representing 37% respondents' responds rate. 13 of the remaining respondents were other degree holders representing 14% response rate.

This indicates that majority of the respondents were second degree holders.

The researcher wanted to know the occupation of the respondents and this is represented on table 1.3 below.

Table 1.3. The ranks of respondents

		Frequency	Percent	Valid Percent
Valid	Medical superintendent	35	39	39
	Administrator	29	32	32
	accountant	26	29	29
	Total	90	100	100

Source. field data, 2019

From the table 1.3 above, 39 percent of the respondents were medical superintendent, whilst 32 percent were administrators. The remaining 29 percent were accountants.

This indicates majority of the respondents were medical superintendents.

The researcher again wanted to know the number of years the respondent has worked with the facility and this is represented in table 1.4 below;

Table 1.4. Number of years' respondents worked with the facility

		Frequency	Percent	Valid Percent
Valid	one year	8	9	9
	two years	18	20	20
	five years	19	21	21
	ten years	32	36	36
	fifteen years	13	14	14
	Total	90	100	100

Source. field data, 2019

From table 1.4 above, 8 of the respondents worked with the facility for one year and this constitute 9% response rate. 18 respondents said they worked with the facility for two years representing 20%. 19 respondents worked with the facility for five years representing 21%. 32 respondents also worked with the facility for ten years representing 36% and 13 of the remaining respondents worked with the facility for fifteen years representing 14% response rate.

This therefore indicates that majority of the respondents worked with facility for ten years.

The researcher wanted to know the causes of delay in reimbursement of the facility by NHIS and this is represented in table 1.5 below

Table 1.5. Causes of delay in reimbursing the facility by NHIS

	N	Mean		Std. Deviation	Variance
	Statistic	Statistic	Std. Error	Statistic	Statistic
fraud	90	3.3444	13141	1.24667	1.554
bureaucracy	90	3.3556	11752	1.11488	1.243
Inaccuracy Information	90	2.7000	13357	1.26713	1.606
inadequate staff	90	2.8333	12666	1.20159	1.444
government delay in releasing funds	90	3.8444	11051	1.04839	1.099
Valid N (list wise)	90				

Source. field data, 2019

From table 1.5 above, standard deviation measures how concentrated the data are around the mean. The more concentrated, the smaller the standard deviation. The standard deviation is therefore affected by outliers (extremely low or high numbers in the data set). That's because the standard deviation is based on the distance from the mean. This therefore means that a small standard deviation stands for data set that are close to the mean of the data set, on average, and large standard deviation means that the values in the data set are farther away from the mean, on average.

From the findings in table 1.5 the respondents indicated fraud as a cause of delay in reimbursement by NHIS to health facilities. This is to a great extent as indicated by a mean of 3.34, standard deviation of 1.24447 and a variance of 1.554. Standard deviation of 1.2447 is close to the mean of 3.34 on average. This therefore indicate that fraud causes delay in reimbursement of claims by NHIA to health facilities.

The findings also revealed that, bureaucracy as a cause of the delay in reimbursement by NHIA to health facilities is of a major extent as indicated by a mean of 3.3556, standard deviation of 1.11488 and a variance of 1.243. Standard deviation of 1.11488 is close to the mean on average. This therefore indicates that bureaucracy is a cause of the delay in reimbursement by NHIA to health facilities.

Again, inaccuracy of information as a cause of delays in reimbursement by NHIS to health facilities is to a great extend as indicated by a mean of 2.7000, standard deviation of 1.26713 and a variance of 1.606. Standard deviation of 1.26713 is close to the mean on average. This therefore indicates that inaccuracy of information is a cause of delays in reimbursement of claims by NHIA to Health facilities.

The respondents also indicated inadequate staffs of NHIS to render service to health facilities. This to a great extend causes delay in reimbursement of NHIS to health facilities. This is indicated by a mean of 2.8333, standard deviation of 1.20159 and a variance of 1.444. Standard deviation of 1.20159 is close to the mean on average. This therefore indicates that inadequate staff of NHIA to render service to health facilities causes delay in the reimbursement of NHIA.

The results also revealed that Government delays in releasing funds to NHIS causes delay of reimbursement to health facilities. This is indicated by a mean of 3.8444, standard deviation of 1.04839 and a variance of 1.099. Standard deviation of 1.04839 is close to the mean on average. This therefore indicates that Government delays in releasing funds to NHIA causes delay of reimbursement to health facilities which goes a long way to affect the financial management of the health facilities.

The researcher also wanted to know the factors that affect NHIA and these are represented in the table 1.6 below

Table 1.6. Factors affecting NHIA in the claim processing (correlation analysis)

		inadequate professional	political reason	unmatched coding	prior authorization	funding gap
inadequate professionals	Pearson Correlation	1	926**	819**	-350**	941**
	Sig. (2-tailed)		000	000	001	000
	Sum of Squares and Cross-products	128.622	121.511	127.289	-40.578	142.956
	Covariance	1.445	1.365	1.430	-456	1.606
	N	90	90	90	90	90
political reason	Pearson Correlation	926**	1	862**	-285**	917**
	Sig. (2-tailed)	000		000	006	000
	Sum of Squares and Cross-products	121.511	133.956	136.844	-33.689	142.178
	Covariance	1.365	1.505	1.538	-379	1.598
	N	90	90	90	90	90
unmatched coding	Pearson Correlation	819**	862**	1	-199	897**
	Sig. (2-tailed)	000	000		060	000
	Sum of Squares and Cross-products	127.289	136.844	187.956	-27.911	164.622
	Covariance	1.430	1.538	2.112	-314	1.850
	N	90	90	90	90	90
prior authorization	Pearson Correlation	-350**	-285**	-199	1	-309**
	Sig. (2-tailed)	001	006	060		003
	Sum of Squares and Cross-products	-40.578	-33.689	-27.911	104.322	-42.244
	Covariance	-456	-379	-314	1.172	-475
	N	90	90	90	90	90
funding gap	Pearson Correlation	941**	917**	897**	-309**	1
	Sig. (2-tailed)	000	000	000	003	
	Sum of Squares and Cross-products	142.956	142.178	164.622	-42.244	179.289
	Covariance	1.606	1.598	1.850	-475	2.014
	N	90	90	90	90	90

**Correlation is significant at the 0.01 level (2-tailed).

Source. field data, 2019

From the findings in table 1.6 the respondents indicated inadequate professional as a factor affecting NHIS in reimbursement of claim to health facilities. From the table, Pearson’s “r” is 1 and any number close to 1 indicates a strong relationship. This means that change in the variable, ‘inadequate professional’ will affect reimbursement of claims to NHIA facilities. This is indicated by a strong relationship between inadequate performance and factors affecting NHIA in claims processing. This therefore means that inadequate professionals of NHIA staff is a factor that affect reimbursement of claims to health facilities.

The findings also revealed political influence as a factor affecting NHIA in reimbursement of claims to health facilities. This is evidence in the table as indicated by Pearson correlation R of .926**, significance level of .000 and a covariance of 1.365. Pearson Correlation ‘r’ of .926 indicate a strong positive relation between the variables, ‘political reason’ and ‘factors affecting NHIA claims reimbursement’. This means that when there is an increase in the influence of politics in NHIA activities, it has a strong effect on claims processing and hence causes delay in reimbursement of health facilities.

Again, the respondents claim unmatched coding as a factor affecting NHIA in reimbursement of claims to health facilities. This is to a great extend as indicated by Pearson Correlation r of .819**, significance level of .000 and a covariance of 1.430 in table 1.6 above. Pearson Correlation ‘r’ of .819 indicate a strong positive relationship between the variables unmatched coding and factors affecting NHIA Claims processing. This therefore means that when there is an increase in the practice of unmatched coding on the side of health facilities, it affects NHIA claims processing and this will contribute to delays in reimbursement of claims to Health facilities.

The respondents indicated prior authorization as a factor that does not affect NHIS in reimbursement of claim to health facilities. This is indicated by Pearson Correlation of -.350**, significance level of .001 and a covariance of -.456 in table 1.6 above. Pearson Correlation ‘r’ of -.350 indicate a weak negative relationship between the variables prior authorization and factors affecting NHIA Claims processing. This therefore means that when there is an increase or decrease in prior authorization activities on the side of NHIA, it has no effect on claims processing.

The respondents also claim that funding gap is another factor that affect NHIS in the reimbursement of claims to health facilities. This is to a major extent as indicated by a Pearson correlation ‘r’ of .941**, significance level of .000 and a covariance of 1.606 in table 1.6 above. This therefore means that when there is a change in funding gab by Government, it affects NHIA claims processing.

The researcher also wanted to know the effect of the delay in the reimbursement of claim on the financial management of the health facilities and this is represented in the table 1.7 below:

Table 1.7. Effect of the delay in the reimbursement of claim on the financial management of the health facilities (regression analysis)

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.123	743		5.551	000
	staff compensation	-154	138	-.126	-1.117	267
	stock of medicine and consumable	125	124	.126	1.007	317
	Motivation among health service providers in providing Services to NHIA members	-.264	173	-.208	-1.523	132
	High cost of procurements	-.213	120	-.236	-1.777	079
	Distortion in Programme of Work	.236	137	.202	1.722	089

a. Dependent variable: financial performance of health facilities

Source. field data, 2019

From table 1.7 above, the coefficient is taken in to consideration to know the slope and intercept from charging relationships. The unstandardized coefficients are the slope and intercept in the model unit. In trying to predict the level of effects of the delays of reimbursement of claims by NHIA on financial performance of health facilities, it gives an intercept of 4.123. This means that its gives each model 4 standard deviations above the mean. The regression equation can be written as this $4.123 - .154 * \text{staff compensation} + .125 * \text{stock of medicine and consumables} - .264 * \text{motivation among health service providers to NHIA members} - .213 * \text{high cost procurements} - .236 * \text{distortion of work}$.

Respondents indicated that delays in the reimbursement of claim have negative effect on the staff compensation of the health facilities. This is to a great extent as indicated by an unstandardized coefficient of $-.154$, standard deviation of $-.126$. Unstandardized coefficient of $-.154$, means the more the delays in the reimbursement of claims by NHIA, the lower the compensation of staff of health facilities. This therefore indicates that delays in reimbursement of claims by NHIA has effects on the staff compensation of health facilities.

The findings also revealed that delay in reimbursement of claims have positive effect on the stock of medicine and consumable of the health facilities. This is of a major extent as indicated by unstandardized coefficient of $.125$, standard coefficient of $.126$. Unstandardized coefficient of $.125$ means that the more the delay in the reimbursement of claims by NHIA, the higher the level of stock of essential drugs and consumables by health facilities.

Again, the delay in the reimbursement of claim had negative effect on the provision of health service to NHIA members by health facilities as indicated in table 1.6 by unstandardized coefficient of $-.264$ and standard coefficient of $-.208$. Unstandardized coefficient of $-.264$ means that the more the delay in the reimbursement of claims by NHIA, the lower the level of health service provision to members of NHIA by health facilities. This therefore indicates that delays in reimbursement of claims by NHIA has negative effect on the provision of health services to NHIA members by health facilities.

The respondents also indicated that delay in the reimbursement of claim to health facilities bring about high cost of procurement. This is indicated in table 1.7 by unstandardized coefficient of $-.213$ and standard coefficient of $-.236$. Unstandardized coefficient of $-.213$ means that the more the delay in the reimbursement of claims by NHIA, it brings about high cost of procurement to health facilities. This therefore indicates that the delays in reimbursement of claims by NHIA brings about high cost of procurement among health facilities.

The results also revealed that delay in the reimbursement of claim to health facilities by NHIS does not lead to distortion of Programme of work. This is indicated in table 1.7 by unstandardized coefficient of $.236$ and standard coefficient of $.202$. Unstandardized coefficient of $.236$ means that the more the delay in the reimbursement of claims by NHIA, the less the effect on distortion of program of work. This therefore indicates that the delay in reimbursement of claims by NHIA to health facilities does not have negative effect on distortion of program of work by health facilities.

The researcher also wanted to know the measures put in place by management of health facilities to manage the operation of the facility in the face of the delay in reimbursement of claims by NHIS. The results represented in table 1.8 below.

Table 1.8. Measures to minimize the effects of the delay in reimbursement

	N	Mean		Std. Deviation	Variance
	Statistic	Statistic	Std. Error	Statistic	Statistic
Return to cash and carry system	90	3.8000	10970	1.04074	1.083
Charge high for non-insured clients	90	3.6333	11224	1.06476	1.134
No insurance cover on expensive drugs	90	3.2000	12562	1.19173	1.420
stock only essential consumables	90	3.5889	12924	1.22607	1.503
regular review of internal control	90	3.67778	136688	1.296736	1.682
engage in non-insured business	90	3.7444	11988	1.13732	1.294
Valid N (list wise)	90				

Source. field data, 2019

From the findings in table 1.8 above, the respondents indicated a high response rate of returning to cash and carry system of health facilities as a measure put in place by the management of the health facilities in the face of the delays in the reimbursement of claims by NHIS. This therefore indicates a major extent by a mean of 3.8000, a standard deviation of 1.04074 and a variance of 1.083. standard deviation of 1.04074 is close to the mean of 3.800 on average as explained earlier in table 1.5. This therefore indicates that respondents have returned to cash and carry system as a measure put in place by management in the face of the delay of reimbursement by NHIA.

The findings also revealed a high response that health facilities charge high for non-insured patients as a measure put in place by the management of health facilities in the face of the delays in reimbursement of claims by NHIS. This is also to a major extent as indicated in table 1.8 by a mean of 3.6333, standard deviation of 1.06476 and a variance of 1.134. Standard deviation of 1.06476 is close to the mean of 3.6333 on average. This therefore indicates that health facilities charge high for non-insured patients in the face of the delay in the reimbursement by NHIA.

Again, the respondents also indicated a high response on no insurance cover on expensive drugs as a measure put in place by the management of Health facilities in the face of the delays in reimbursement of claims by NHIS. This is indicated in table 1.7 by a mean of 3.2000, standard deviation of 1.19173 and a variance of 1.420. Standard deviation of 1.19173 is therefore close to the mean of 3.2000 on average which indicates that respondents do not put insurance cover on expensive drugs in the face of the delays in reimbursement of health facilities by NHIA.

The respondents again indicated a high response on stocking only essential consumables as measures put in place by management of health facilities in the face of the delays in reimbursement of claim by NHIS. This is indicated in table 1.8 by a mean of 3.5889, standard deviation of 1.22607 and a variance of 1.503. Standard deviation of 1.22607 is closer to the mean of 3.5889 on average. This therefore indicates that respondents only stock essential consumables as a measure put in place by management of health facilities in the face of the delays in the reimbursement.

The results of the study also revealed a high response rate of respondents on regular review of internal controls as a measure put in place by management of health facilities in the face of the delays in the reimbursement of claim by NHIS. This indicated table 1.7 by a mean of 3.67778, standard deviation of 1.13732 and a variance of 1.294. Standard deviation of 1.13732 is therefore closer to the mean of 3.67778 on average. This indicates that health facilities do run regular review of internal controls as a measure put in place by management of health facilities in the face of the delays in the reimbursement of claim by NHIA.

The results of the study again revealed a high response rate of respondents on engaging in non-insured business as a measure put in place by management of health facilities in the face of the delays in the reimbursement of claim by NHIA. This is also indicated in table 1.7 by a mean of 3.7444, standard deviation of 1.13732 and a variance of 1.294. Standard deviation of 1.13732 is close to the mean of 3.7444 on average. This therefore indicates that respondents engage in non-insured business, as a measure put in place by management of health facilities in the face of the delays in the reimbursement of claim by NHIA.

Discussion

The findings to this study are discussed below:

To investigate the factors contributing to the delay of reimbursement of claims

Woolhandler, Campbell, and Himmelstein (2003) claimed that, Health Insurance Association of America (2003) mentions four common reasons for delay of reimbursement to health facilities. These factors include; unmatched code, prior authorization, medical necessity and pre-existing conditions. These factors from the side of health facilities contribute to the delay of claims reimbursement by NHIA. From the findings, the factors that contribute to the Delays of Reimbursement of the National Health Insurance claims to Accredited Health Facilities include fraud, bureaucracy, and inaccuracy of information, shortage of staff, Government delay in releasing funds to NHIS, unmatched coding by facilities, funding gap, political influence and inadequate professionals.

This is in conformity to the study above. These factors are in line with Woolhandler et al. (2003), and hence contribute immensely to the delays of reimbursement of claims by NHIA to health facilities.

To investigate the financial effect of the delays in the reimbursement of claims on the operation of the health care facilities in brong-ahafo region of Ghana.

According to Dalinjong and Laar (2012), the delay in claims payments has a trickling effect on subscribers to the scheme in the following ways. First of all, service providers are compelled to turn their attention to non-subscribers who are ready to pay cash for services. This causes non-subscribers to the scheme to spend less time in seeking health care as compared to scheme subscribers. Secondly, service providers are also compelled to issue prescription forms to subscribers to the scheme to buy drugs out of the facilities.

From the findings it can be concluded that, the effect of the delays in the reimbursement of claims on the operation of the health care facilities in Brong-Ahafo include; staff compensation is high, ability to meet health facility expenditure are high, high cost of procurement. The findings therefore confirms Dalinjong and Laar (2012) assertions and hence the delay in reimbursement of the claims by NHIA to accredited health facilities has great effects on the operations of health facilities in the Brong Ahafo region.

To examine the financial measures adopted by the accredited health facilities to manage their operations in the event of delay in re-imburement of claims.

Dalinjong and Laar (2012) claim that, service providers are compelled to turn their attention to non-subscribers who are ready to pay cash for services due to delays in reimbursement. The delays also cause non-subscribers to the scheme to spend less time in seeking health care as compared to scheme subscribers. Dalinjong and Laar, (2012), also claim that, service providers are also compelled to issue prescription forms to subscribers to the scheme to buy drugs out of the facilities. From the study, the financial measures adopted by the accredited health facilities to manage their operations in the event of delay in re-imburement of claims are; return to cash and carry system, charging high for non-insured clients, no insurance cover on expensive drugs, stocking only essential consumables, engaging in non-insured business and regular review of internal control. These measures are adopted by the accredited health facilities to manage their operations in the event of the delays in reimbursement of the claims by NHIA, confirms Dalinjong and Laar (2012) claims.

In general, the study has managed to add to the existing body of knowledge in furthering our understanding to the effect of the delay in reimbursement of claims on health facilities in Brong Ahafo.

Conclusions

To sum up, the study has revealed the following findings:

A lot of factors according to the literature discussed, contribute to the delay of reimbursement of claims by NHIA to the accredited health facilities but the most frequent factors from the findings include; fraud, bureaucracy, inaccuracy of information, shortage of staff, Government delay in releasing funds to NHIS, unmatched coding by facilities, funding gap, political influence and inadequate professionals. These factors contribute immensely to the delays of reimbursement of claims by NHIA to health facilities.

Again, from the findings, it can be concluded that delays in the reimbursement of claims by NHIA has serious effects on the operation of the health care facilities in Brong-Ahafo Region. These effects include; staff compensation is high, ability to meet health facility expenditure are high, high cost of procurement.

Finally, from the study, Accredited health facilities adopt some financial measures to manage their operations in the event of delay in re-imburement of claims. These financial measures from the study include: return to cash and carry system, charging high for non-insured clients, no insurance cover on expensive drugs, stocking only essential consumables, engaging in non-insured business and regular review of internal control.

Recommendations for practice and future research

From this study, the researcher recommends a few approaches that could be taken to improve effects of the delay in reimbursement of claims on financial management of health facilities in Brong Ahafo.

It has been shown empirically by this research that delay in reimbursement of claims on health facilities in Brong Ahafo Region is due to factors contributing to the delay. This factor includes: fraud, bureaucracy, and inaccuracy of information, shortage of staff, Government delay in releasing funds to NHIS, unmatched coding by health facilities, funding gap, political influence and inadequate professionals. It is therefore recommended that Government should speed up on releasing funds to NHIS for payment of claims. NHIS should not also be politicized but allow to operate independently. Fraud, bureaucracy, inaccuracy of information, shortage of staff should also be addressed with immediate effect. Health facilities should also focus on quality work by providing the required matched coding for processing of claims. Professionals should also be hired to occupy key positions that require delicate works.

The financial measures adopted by the accredited health facilities to manage their operations in the event of delay in re-imbursement of claims are; return to cash and carry system, charging high for non-insured clients, no insurance cover on expensive drugs, stocking only essential consumables, engaging in non-insured business and regular review of internal control. With respect to future research, it is recommended that further research needs to be done to verify the findings among other groups of facilities, and explore comparative studies involving facilities from different industries.

Future researchers should also develop measures of additional dimensions to find out if the premium charged on scheme members of NHIS is fair enough to pay claims and also suggest whether premium charged should be increased or maintained. This will allow for a deeper understanding of the delays in reimbursement and funding gaps by NHIS to health facilities.

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