

## REFORMS IN THE PROVIDER TARIFF FOR NATIONAL HEALTH INSURANCE SCHEME: KEY IMPLEMENTATION ISSUES

Martin Ankomah, (Administrator, HRD, GHS)

*This article focuses on the implementation of the NHIS new tariffs. It looks at the rationale behind the reforms, its benefits and the concomitant challenges.*

Improving financial access to basic healthcare services has long been considered an important goal in the health sector of many developing countries including Ghana. As a strategy to achieve this goal, the government has introduced National Health Insurance Scheme (NHIS) to finance affordable and quality healthcare to all residents of Ghana without ‘out of pocket’ payment requirement at the point of service.

The NHIS, which was established by the National Health Insurance Act 650 (NHI Act) in August 2003, is operated as a decentralized national health insurance system encompassing district mutual health schemes (DHMIS) in all the 145 districts of Ghana. The schemes provide cover for both the formal and informal sectors. Beneficiaries for the schemes receive care from accredited service providers including government health facilities, quasi-government, mission and private health facilities.

The NHIS has become critical to service delivery in terms of its contribution to the budget of the health sector. According to the health sector 2008 Programme of Work (POW), 31.30% of the sector’s total budget of GHc752.233 million for 2008 is from the NHIS, 35% from the government and 21% external aid while the rest is made up of user fees and HIPC fund (MOH, 2008). It is envisaged that NHIS will eventually become mandatory which implies that, there will be a complete elimination of ‘out-of-pocket’ payment for healthcare particularly in the public health facilities, and a greater increase in funding under the NHIS.

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. 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.

### **The Old Tariff Provider 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 following:

- 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, which 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.

### **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, house keeping, general administration and indirect labour (casual labour). The details of the components of the overhead costs are as follows:

- Building & equipment maintenance cost (minor repairs on official & residential buildings, drive ways, grounds, equipment/plant/machinery) ,
- Vehicle maintenance and running cost (fuel and lubricants and maintenance of official vehicles),
- Utilities (electricity, water and telephone),
- Housekeeping (cleaning materials, sanitation charges),
- General administrative and office expenses (printing and photocopying, purchase of publications, bank charges, refreshment, training and conferences, stationery and other office consumables, and
- 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.

### **Implementation of the New Tariff System: Key Challenging Issues**

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.

## **Conclusion**

Within the context of long-term sustainability of the NHIS, the current tariff is of no doubt, the best provider payment mechanism that the NHIA has adopted. What is required now is a clear understanding of the implementation process and the need to address the key challenging issues that have been pin-pointed in this paper. Finally, since no system is perfect, it is important that all the stakeholders actively get involved and collectively take critical steps to continually monitor, evaluate and improve upon the design and implementation of the system. It would be unfortunate if the lofty objectives behind the introduction of the new tariff system fail to materialize.

**References:**

- *Government of India, 2005: Framework for developing health insurance programmes, Ministry of Health & Family Welfare, New Delhi*
- *MOH, 2008: The Ghana Health Sector 2008 Programme of Work: Creating Wealth through Health, 'Year of Action'*
- *MOH, 2007: Health Sector 5 Year Programme of Work, 2002-2006; Independent Review of POW-2006*
- *NHIS, 2007: Provider Tariff Development Report, unpublished*
- *NHIS, 2007: Tariff and Benefit Package, Training Manual*
- *NHI Act, 2003 (Act 650) and L.I. 1809*

