Introduction to Health Care Financing

Overview

- Importance and rationale for the focus on health financing
- Definitions for health care financing
- Different mechanisms of financing
- Community based financing

Focus on health financing

- Late 1970s Voluntary community based health insurance attracted considerable attention
- 1980's financing of health care moved high on the agenda of the discussions on health policy
- Recurring theme in
  - Executive Board Meeting of the WHO in 1986,
  - World Health Assembly and the Commonwealth Health Ministers Conference in 1986
- User charges dominating the policy debates of 1970s and 1990s.
- Attention back on community based health insurance
- In developed countries the problem is containing the cost of health care
- In some developing countries the problem presents itself as how to maintain health spending and how to achieve "health for all" initiative

Definition of health care financing

Definition of health care financing

- **mobilization of funds for health care**
- **allocation of funds to the regions and population groups and for specific types of health care**
- **mechanisms for paying health care (Hsaio, W and Liu, Y, 2001)**

Health service financing source

- Health services financed broadly through private expenditure or public expenditure or external aid
- Public expenditure includes all expenditure on health services by
  - central and local government funds spent by state owned and parastatal enterprises as well as government and social insurance contributions
  - where services are paid for by taxes, or compulsory health insurance contributions either by employers or insured persons or both count as public expenditure.
- Voluntary payments by individuals or employers are private expenditure.
- External sources refer to the external aid which comes through bilateral aid programme or international non governmental organizations
- The ownership of the facilities used whether government, social insurance agencies, non profit organizations private companies or individuals is not relevant

Mechanisms of Health Financing

- general revenue or earmarked taxes
- social insurance contributions
- private insurance premiums
- community financing
- direct out of pocket payments

Each method

- distributes the financial burdens and benefits differently
- affects who will have access to health care
- determines the level of financial protection

General revenue or earmarked taxes

- the most traditional way of financing health care
- finance a major portion of the health care (especially in low income countries)

Social insurance

- It is compulsory. Everyone in the eligible group must enroll and pay a specific premium contribution in exchange for a set of benefits.
- Social insurance premiums and benefits are described in social compacts established through legislation. Premiums or benefits can be altered only through a formal political process.

Private insurance

- private contract offered by an insurer to exchange a set of benefits for payment of a specified premium.
- marketed either by nonprofit or for profit insurance companies
- consumers voluntarily choose to purchase an insurance package that best matches their preference.
- offered on individual and group basis. Under individual insurance the premium is based on that individuals risk characteristics.
- major concern in private insurance is buyer's adverse selection
- Under group insurance, the premium is calculated on a group basis. Risk is pooled across age, gender and health status.

Community based financing

The financing schemes are based on three principles: community cooperation, local self reliance and pre payment

Factors for success of community financing

- **Technical strength and institutional capacity of the local group**
- **Financial control as part of the broader strategy in local management and control of health care services**
- **Support received from outside organizations and individuals**
- **Links with other local organizations**
- **Diversity of funding**
- **Responding to other (non health) development needs of the community**
- **Ability to adapt to a changing environment**

Direct out of pocket

- It refers to payment made by patients to healthcare providers at the time a service is rendered
- In some jurisdictions, it refers to user - fees the patients have to pay to public hospitals, clinics, and health posts
- The proponents of user fees believe that the fee can increase revenue to improve the quality of public health services and expand coverage
- major objection raised against user fees had been on equity grounds

Community financing

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Changing government role in health care

- **Health is considered a public good**
- **Government needs to actively participate to avoid market failures**

Key points

- The role of health finance should be recognized
- Health financing cannot be dealt separately as it has got to do with good governance, economic growth, education
- There is the need for social inclusion and financial protection

Health care financing in Ghana - Historical perspective

Lecture 2

Introduction

- Healthcare financing in Ghana has travelled a long winding road, right from the period when;

➢ Medical care was virtually free

➢ The ‘Cash and Carry’ system

➢ Current health insurance system

HF before and during colonization

- Before the advent of colonialism, the natives used medicine prepared from herbal concoctions which were prepared by herbalists and other people who were well vexed in the spirit world.
- However, with colonization the British introduced orthodox medicine and hospitals as a **very improved curative method.**
- At this point, health care delivery became pluralistic: there were private medical practitioners, mission hospitals/clinics,
- Herbalists, and fetish priests, among many others.

HF before and during colonization

- The private practitioners, who were in business to make money and are concentrated in urban areas.
- The missions also initially located at underserved areas and exempted the poor from their fees.
- Herbalists, and fetish priests had various forms of payment mechanisms, but mostly articles, food stuff, birds and animals.

The colonial period

- Health care facilities initially built by the colonial masters were to cater for the health care needs of the colonial master for free for fee bases
- Their Ghanaian wives, interpreters, and close business allies equally enjoyed these service
- This practice gradually expanded and remained up to independence Ghana

Post colonization

- Ghana at independence provided free medical care for its citizens. Health facility attendance was free and did not require patients to pay any fees at points of health care delivery.
- This form of financing was solely tax-based.
- This however could not be maintained for long as tax revenue dwindled due to the economic stagnation during the early 1970s.
- The government of Ghana switched to tax-based financing and made all public sector health services free.

Post colonization – fees for service

- Fees for services was justified to enable government reduce its fiscal spending as well as make provisions for coverage for exempt citizens with particular severe diseases.
- The user-fee regime required joint management of resources generated by health facilities.
- Soon after, the Hospital Fees Act 387, quite similar to the user fees was passed.
- This means that patients had to pay for the full cost of medication and service at the point of service delivery.

Introduction of fees for services

- This system was built on the quest for full cost recovery to enable health facilities to expand and upgrade their services to citizens.
- In 1983, the PNDC government adopted an IMF and World Bank sponsored economic recovery programme (Structural Adjustment Program)
- Owing to this economic recovery programme, the costs of health care services in most public health institutions were significantly raised and this was commonly known as ‘cash and carry’.

Introduction of fees for services

- In July 1985, the government of Ghana enacted the Hospital Fees 1985 (L. I. 1313) to replace Hospital Fees Regulation, 1963 (Legislative Instrument) L. I. 1277 cost to be shared in this regulation were charges for consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examinations and hospital accommodation.
- This regulation paved the way for a nation-wide fee-for-service system.
- Within this period, fees were raised from token levels to specific charges for services.
- LI 1313 also provide some exemption, thought there later reintroduced.

Introduction of fees for services

- This means that patients had to pay for the full cost of medication and service at the point of service delivery.
- Secondly, the full cost recovery was targeted at reducing abuse of service through frequency of visits.
- In reality, none of these assumptions materialized.
- In turn, the implementation of the „cash and carry‟ system excluded mainly the poor from accessing health care service, thereby creating vast inequalities in health care delivery system.
- For this, the „cash and carry‟ system led to under-utilization of basic health services

Effect of LI 1313

The he fourth round of the Ghana Living Standards Survey (GLSS) covering the period April 1998 to March 1999 shows that;

- older people and young children are most vulnerable to illness or injury.
- The overall under-5 mortality rate was 155 deaths per 1,000 live births.
- The infant mortality rate was 77 deaths per 1,000 live births,
- The child mortality rate was 84 deaths per 1,000 children surviving to age 12 months.

Effect of LI 1313

- Only 39 percent of children aged five years and under had received, for example, post-natal care, though this phenomenon is not unique to Ghana .
- At least 16 percent of pregnant mothers had never visited an antenatal clinic or had been there only once.
- A strict adherence to a cost-recovery regime would further prevent many more people from accessing health care and worsen the unacceptably high health indicators.

History of NHIS

- The widespread unpopularity of the ‘cash and carry’ system, especially its negative consequences on the poor, led the Government to commission various studies into alternatives, principally insurance-based ones.

History of NHIS

- In August 1995, the MOH received a finding entitled “A Feasibility study for the establishment of a National Health Insurance Scheme in Ghana”.
- The report stated, centralized National Health Insurance Company should be set up to provide a compulsory “Mainstream Social Insurance Scheme” for
- all contributors to the Social Security and National Insurance Trust (SSNIT) and all registered cocoa farmers
- It also recommended pilot “rural-based community-financed schemes” for the non-formal sector but gave no further details or indication as to how the MOH was to do this.

History of NHIS

- The major emphasis of the report was on the NHIS. The key design features proposed were:
- (i) Inclusion of non-profit and for profit health facilities in the scheme
- (ii) Reimbursement by capitation
- (iii) Contribution rates equivalent to 5% of salary for formal sector employees or a fixed levy per tonne of cocoa produced (equal to 7.19% of the producer price)
- (iv) Enrollees to register with a single preferred provider

History of NHIS

- In 1997, the NHIS pilot project was formally launched in the Eastern Region, intended to cover four districts – New Juaben, Suhum/Kraboa/Coaltar, South Birim and South Kwahu.
- At the same time, the NHIS secretariat began preparation for the nationwide extension of the pilot scheme by producing public educational materials including relevant brochures and pamphlets.

History of NHIS

- Then is the implementation of various community based Health Insurance Schemes around the same time.
- First was the Catholic Diocese of Sunyani initiated in 1989, in response to **reduced financial access to health** care services by the general population following the introduction of user fees in Ghana in 1984.

Nkoranza Mutual Health Insurance scheme

- Memissa, a Christian Charity Non-Governmental Organization based in the Netherlands, pledged financial support to the scheme during its first 3 years of operation.
- The main objectives of the scheme were to:
- • Encourage the people of the Nkoranza district to pool their financial resources together to cater for their hospitalization bills.
- To improve the district population's economic accessibility to curative care, by making health care delivery more accessible and affordable.

Organizational & Functional Structure (CDS)

- The Catholic Bishop of Sunyani was highest authority of this scheme,
- The Diocesan Health Committee directly oversees the operations of the scheme, through the Diocesan and Primary Health Care Coordinator
- All the Diocesan Health Committee were answerable to the Bishop
- There was also a management team comprising all members of the Hospital Management team, the District Director of Health Services, the manager of the scheme, the Coordinator and Assistant Coordinator of the scheme and the Chairman of the Insurance Advisory Board.

Membership

- There were also field workers contracted to carry out social mobilization and public education for the scheme. They were also responsible for registration of members on a commission basis.
- Registration was on family basis. This means that, once a key person in the family decides to join, then all members of that family must register.
- A family card is issued to a family that has registered, with personal data of each member of the household at the cost of ₵ 12.00 per year, provided on the form, as well as a photograph of each member.

Benefit Packages

- The scheme offers 100% coverage for all costs associated with hospitalization, including Medical Consultations, Drugs, Laboratory services, Surgery, X-ray services, admission fees and Complicated Delivery.
- Out Patient costs for snakebites are also covered.
- Members who are referred from the St. Theresa's Hospital to another hospital outside Nkoranza are paid a sum equivalent to the average inpatient cost for that particular month that the referral took place, less expenses already incurred at the St. Theresa's Hospital.
- Conditions not covered; alcoholism and complications arising from criminal abortions.

Reimbursement

- Bills for services consumed were compiled at the end of each month,
- Calculation was on a Fee-for-Service basis. The hospital keeps records of bills of members admitted to the hospital.
- At the end of the month, the hospital prepares the bill and forwards it to the scheme for settlement.
- Until 2000, there was no system in place for the scheme to routinely cross check bills submitted to it for settlement.
- When a member of the scheme is hospitalized in a different hospital, then a sum equivalent to the average inpatient bill for that month is paid to the patient, less costs already incurred at St. Theresa’s hospital

Achievement

- Thought there were initially difficulties especially the first three years, By the sixth year, the scheme was basically covering most of its costs, besides the salaries of hospital staff seconded to the scheme and transportation provided by the hospital.
- It has also made access and quality health care available to a high percentage of vulnerable households in the district.
- By its mere survival, it has in no uncertain terms demonstrated the feasibility of a community based approach to risk sharing and resource pooling.

Problems

- Major problems include the failure of people to understand the concept of risk sharing, thus tending to withdraw from the scheme after a few years of not benefiting from the package.
- Some moral hazards still bewilder the scheme, arousing serious concerns.

The Tiyumtaaba Welfare Association

- The Tiyumtaaba Welfare Association, is a community managed MHO in the Sagnerigu health sub district of the Tamale district of Northern Ghana.
- The MHO, which comprises 8 different communities, that sprang up almost spontaneously in response to problems faced by community members in accessing health services.
- With the assistance of a staff of the Ministry of Health, these communities formed self-help pools into which members contributed
- from these contribution, they could borrow to meet their health care needs whenever the need arose.

The Tiyumtaaba Welfare Association

- Management of this scheme is decentralized to the community level.
- Each community management comprised of five-member committees, elected during a community meeting.
- Village health workers were automatic members of the committee.
- Every community decides on it’s design, dues, contributions and the type of services to be offered.

Premium

- Weekly contributions of ₵100/person for all adult members of the community-2 communities
- Monthly contributions of ₵5000/compound - 1 community
- Monthly contributions of ₵1000/per adult - 4 communities
- Monthly contributions of ₵2000/man and ₵1000/woman.- 1 community.

Benefit Packages

- Inpatient bills
- Drugs
- Ambulance/transport
- Delivery
- Laboratory

Reimbursement

- Three payment methods were practiced with the first one being the most practiced.
- Cash payment by the Association directly to the health facility in case of admissions.
- Cash disbursement to family of an admitted member presenting prescriptions from an approved health facility.
- Cash advance to members in case of labor, snakebite, transport and other life threatening conditions.

Challenges

- Most communities feel that the weekly/monthly contributions cannot adequately meet their needs in times of multiple health crisis.
- 2. The cost of hiring a means of transport in times of emergency is very high and is a major drain on their resources in the fund.
- 3. The lack of a nearby health facility to give first line treatment to members before transferring to hospital only when necessary is also a major concern and challenge.
- 4. The insecurity (in case of fire or theft) surrounding the money kept by the treasurer
- 5. The falling value of the Cedi and the dollarization of the economy is a threat to the survival and growth of the fund

THE DODOWA (DANGME WEST) COMMUNITY HEALTH INSURANCE SCHEME

- The Dodowa (Dangme West) Health Insurance Scheme began in 2000 with a lot of expectations and considerable (mainly donor) financial investment.

Premium

- ¢12,000 for people aged 6 – 69 years
- (non exemptible)
- - ¢6,000 for Children (0-5 years) & the elderly 70+ years
- -¢24,000 for non-group family members

Benefit Packages

- It was seen as alternative to out-of-pocket expenditure.
- It main aim was improve financial access to curative & preventive care Improve quality of care.
- - Free OPD care
- - Transport provided for acute emergencies
- - Basic lab tests
- - Antenatal care
- - Delivery & postnatal care
- - Family Planning
- - Child Welfare & immunization
- - Referral

Introduction of NHIS

- From the experience of all these MHO, an Act of parliament was passed in 2003, (Act 650) establishing a Nationwide Health Insurance Scheme, under the National Health Insurance Authority (NHIA).
- This was perceived as a mechanism for eradicating financial barrier to access to health care (GPRSII)

legal framework

An Act of Parliament , Act 650 (2003) and

Legislative Instrument LI 1809 (2004)

These are the main legal frameworks guiding the implementation of health insurance in Ghana.

Governance

- A 15-member National Health Insurance Council (NHIC) was established to manage the National Health Insurance Fund,
- They are among other things to

1. facilitate the establishment of three types of insurance schemes
2. regulate the insurance market, and
3. license and monitor service providers

LI 1809 (2004)

- Under Legislative Instrument LI 1809 (2004), there are three implementing agencies;

1. The National Health insurance Authority/council
2. The National Health Insurance Schemes and
3. The service providers

Functions of NHIA

- Policy making, planning, monitoring and evaluation
- Registrations and regulations of schemes
- Credentialing of service providers
- Management of funds and
- Drug tariff setting

Health Financing Options

Lecture 4

Health care financing

- Financing is the most critical of all determinants of a health system
- WHO – *"function of a health system concerned with the **mobilization, accumulation** and **allocation of money** to cover the **health needs** of the people, **individually** and **collectively,** in the health system"*
- The aim is to ensure that all individuals have access to effective public health and personal health care

Principles of a health financing system

Revenue collection

- Have to be collected equitably and efficiently

Pooling

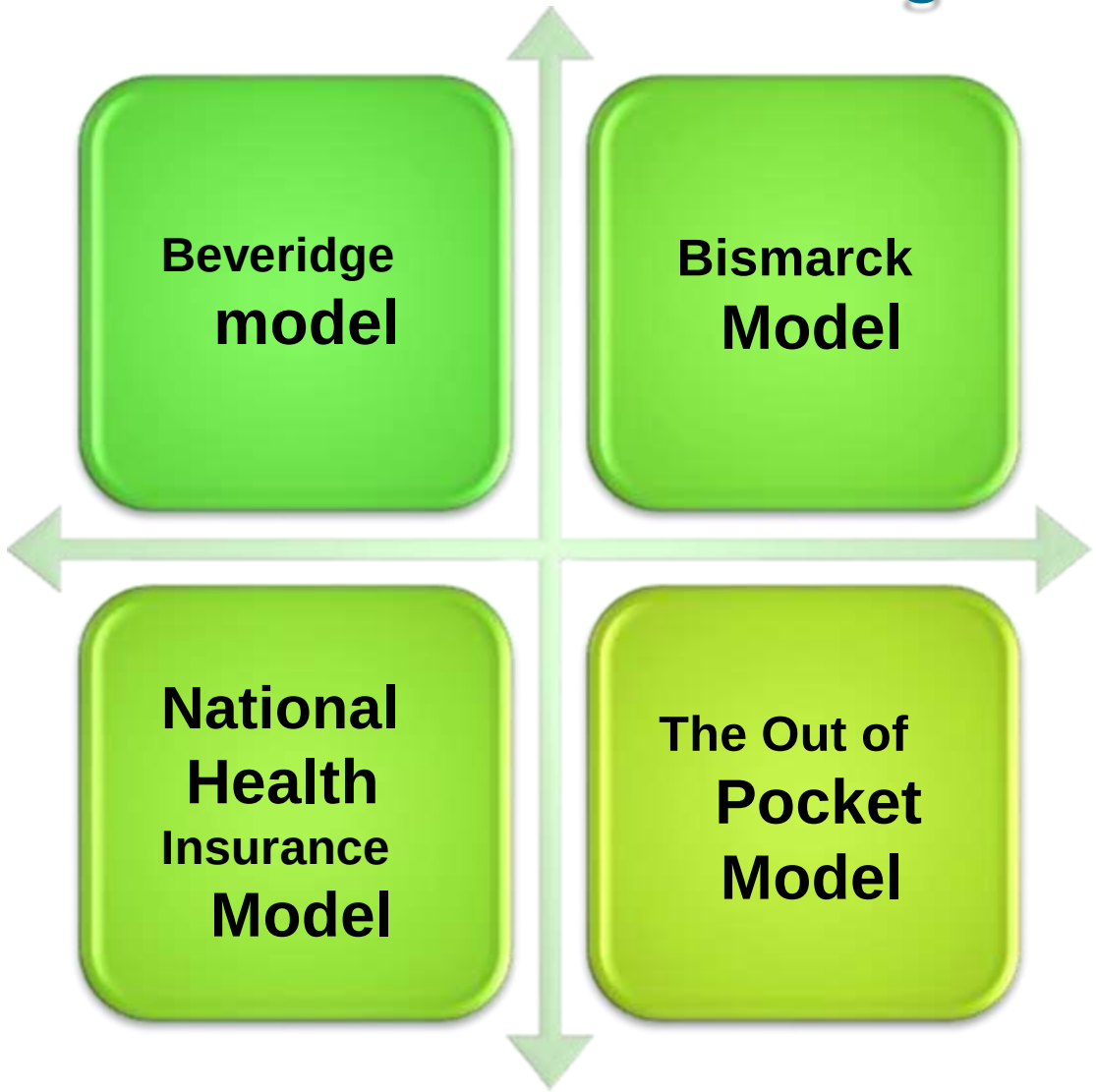
- costs of health care are shared by all and not borne by individuals

Purchasing

- Used to buy or provide health interventions that are allocatively and technically efficient

Source: Health systems financing-The path to universal coverage - WHO

Models of healthcare financing



Source: Health Systems financing. Report - World Bank.

Sources of health care financing

The tax-based public sector
Out of Pocket Expenditure
Insurance- social, community- based, private
External financing

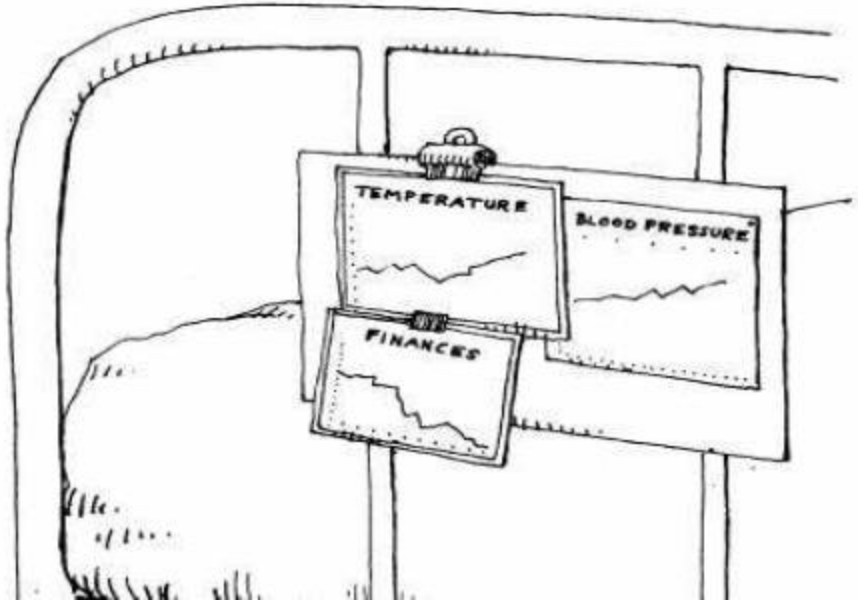
Out of Pocket Expenditure

- Simplest form

- ***Main financer*** of health services in developing countries and it is done ***individual and household levels***

- Consequences:

  - Lower the access to health care
  - Impoverishes the household



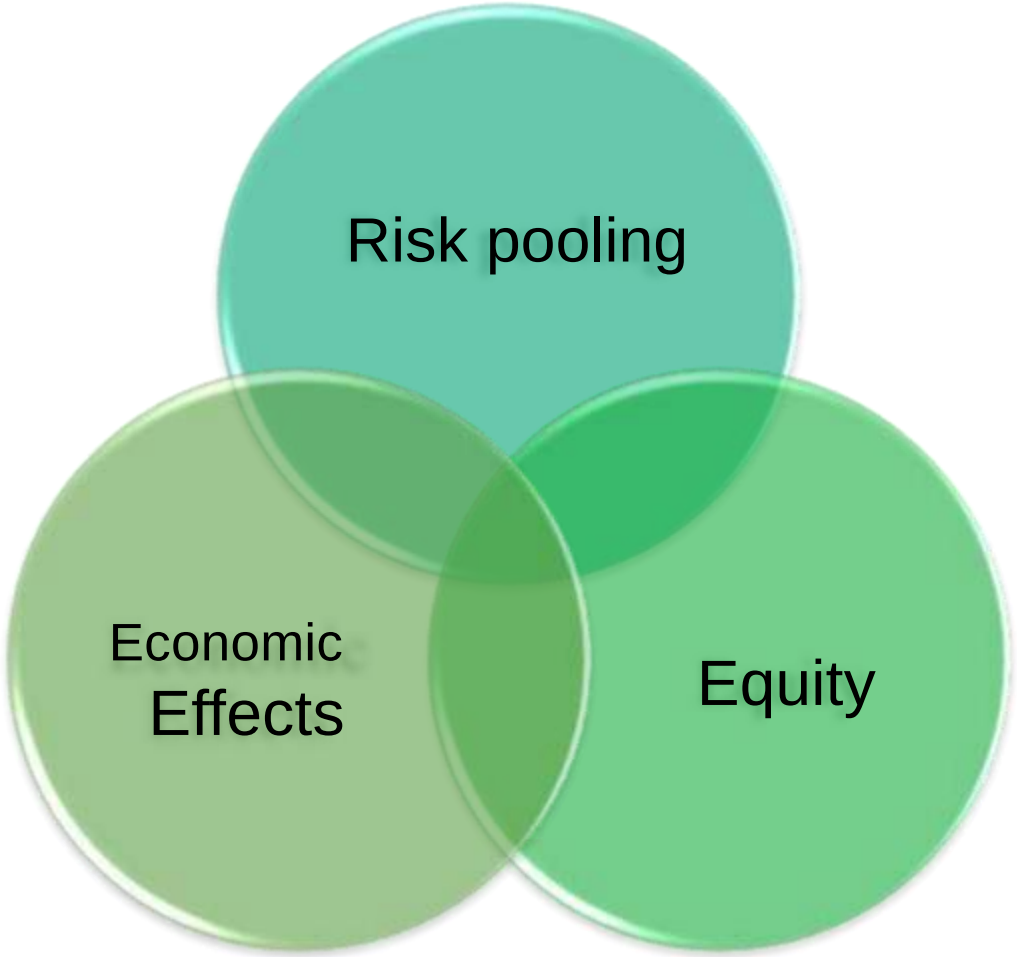
Insurance

- Most complex mechanism of financing health care

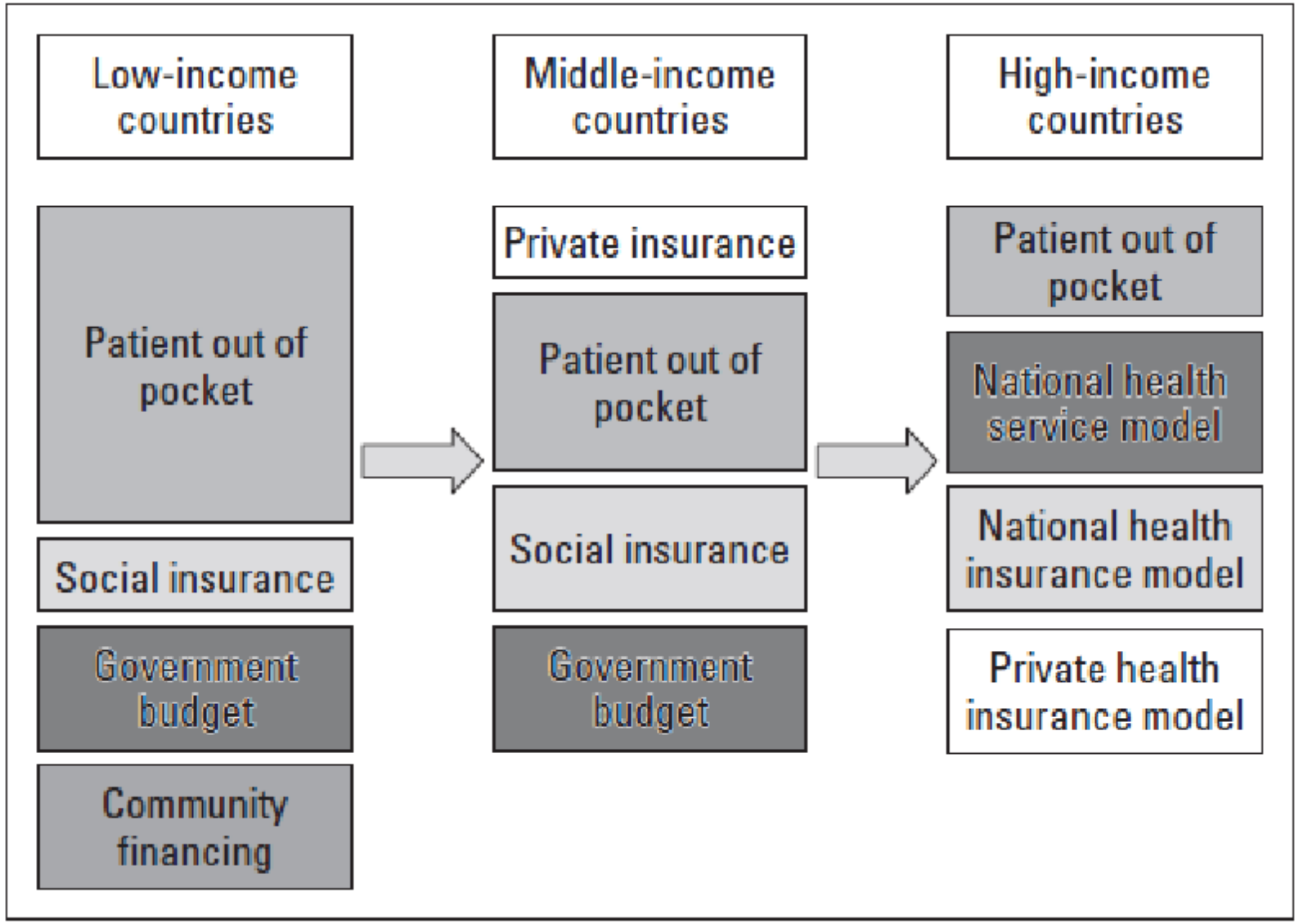
- Objective - manage the revenues equitably and efficiently allowing for subsidies from healthy to unhealthy, rich to poor and productive workers to dependents

Social Health Insurance (SHI)	• Employees State Insurance Scheme (ESIS) and the Central Government Health Services (CGHS)
Private Health Insurance	• Generally preferable to out of pocket expenditure • Increase financial protection and access
Community Health Insurance	• Not-for-profit prepayment plans

Criteria for choosing the financing system



Health system financing trends:



OOP 80% 40% 20%

Need for Health care financing

- Health sector - high maternal and child mortality, dual burden of communicable & non-communicable diseases
- Hospitalization for major illness is a cause of indebtedness for all income groups
- Inability of the poor to access good health care

Avenues of Health care financing

Private	**Public**	**Others**
Debt financing	Annual govt budget for rural health	Foreign donations
Foreign direct investment	Annual govt budget for urban health	PPP project funding
External commercial borrowing	Govt. funding for community programmes	
Individual investors	Govt. sponsored schemes	

Factors influencing health care financing

- Demographic dynamics
- Economic Recession
- Expectations from health care
- Drive for Equity
- Changing disease pattern

Health financing issues

- Low level of public health expenditure
  - % of population with no access to OPD services*
  - % of population to sell their assets or borrow to pay the bill*
- A mismatch between policy and practice
- Weak absorption capacity in the government
- Budgeting - not functional

Financial indicators in health care

Indicators (2014)	Value (US$)
Total Health Expenditure (THE) - % (GDP)	5
General Government Health Expenditure (GGHE) as % of Total Health Expenditure	30
Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)	70

Health expenditure series. Global health expenditure database. WHO

Financial indicators in health care

Indicators (2014)	Value (US$)
Out of Pocket Expenditure (OOP) as % of Total Health Expenditure (THE)	
General Government Health Expenditure (GGHE) as % of GDP	
Total expenditure on health	
General government expenditure on health	

Source: Health expenditure series. Global health expenditure database. WHO

Six dimensions healthcare financing are considered:

- Financing sources
- Financing agents
- Providers
- Functions
- Cost of Factors of Production
- Beneficiaries

Conclusion

- Countries have to move forward faster to develop equitable and efficient institutional structures, revenue-raising mechanisms and spending prioritizations
- To become more efficient and equitable in the use of resources
- Need for constant re-evaluation and adjustment

Sources Of Information on Health Financing Systems

Lecture 3

Background

- The national government's total budget and the part allocated to health are both usually public information and can be used to evaluate the government commitment to health in total amount as well as proportional to other priorities.
- A planned budget however, while an important indicator of commitment can **differ significantly from the funds that are eventually released to departments and the subsequent expenditures.**

Key Sources Information

- Information on government health expenditures channeled through the Ministry of Health is usually available through the Ministry of Finance (MoF), or regional authorities in decentralized systems.
- Government expenditures for health that are channeled through non-health ministries, such as military or police health services are sometimes more difficult to attain.
- While budget information is available in "real time", there is often a delay of a year or so in the production of consolidated expenditure accounts.
- Public expenditure reviews, if they are available, are often an excellent source of information

Public expenditure reviews

- They collate information from various sources to ask questions about
  - whether government expenditures followed budget plans and
  - stated strategic objectives.
- They seek to examine the efficiency of resource use, though in very broad terms
- They examine ability of the financial management and accounting systems and institutions to track expenditures

Existing financing records

- Information on commitments to official development assistance for health made by donor countries, international organizations and some foundations have been collated by the OECD for many years
- Key issues

-Firstly, part of the reported disbursements – a large part in some cases – does not reach the recipient countries and should not be included in estimates of country health expenditure

-Secondly, there has been an increasing move towards general budget support to countries, which is difficult to allocate to the different sectors.

-Thirdly, some emerging donors such as China and India, and some private philanthropists, are not included.

- It is better to track expenditure from external sources at the country level, but this is often difficult especially where this funding is channelled through non-governmental organizations (NGOs)
- National-level expenditures as a result of third-party payments (e.g., from insurance and/or social security) may be available from fund managers. If third-party payers are primarily small community based organizations, such as community-based health insurance funds, compiling expenditure information is much more difficult.
- Information on household out of pocket (OOP) expenditures is only available from household surveys. The World Bank has sponsored Living Standards Measurement Surveys (LSMS) since 1980 from which information on household health expenditures

- The World Health Surveys sponsored by WHO in 2000-2001 also contained a household expenditure module
- National Health Accounts (NHA): Despite these qualifications, the best source of health expenditure data is from national health accounts which combines expenditure data from all sources and through all types of financial agents

Vouchers and conditional cash transfer in Health Financing

Lecture 5

Vouchers and conditional cash transfers

Introduction

- Two common interventions, vouchers and conditional cash transfers (CCTs), make payments directly to individuals or households to empower them to use services.

These interventions typically target

- vulnerable,
- poor, and
- underserved populations.

Vouchers

- Vouchers are paper or electronic tickets that entitle clients to receive a specific health service from a specified group of accredited providers (which may include private sector providers),
- Typically at no cost but sometimes at a subsidized cost
- For several decades, vouchers have been used to increase access to a wide range of services and commodities, including

- Bed nets
- HIV testing
- Antenatal and delivery care
- Family planning

Voucher programs are a **pathway to improved strategic purchasing of health services** and can be an intermediary step to **establishing contractual arrangements with private providers.**

Conditional cash transfers

- CCTs are interventions that enable individuals or families to receive a payment after they have fulfilled certain conditions, such as participating in a health promotion class or using specific health services
- Such transfers are now commonplace in developing countries and have been used for a wide range of health services and for education (e.g., school attendance).
- These programs tend to operate at scale and for long periods of time, as opposed to vouchers and other interventions that tend to be piloted for short periods of time.
- The overall costs of CCTs are high, making them potentially more feasible to implement in upper-middle income countries compared with low- or lower-middle income countries.

Conditions required for implementation of vouchers and conditional cash transfers

- Designers of voucher and CCT programs must take care to ensure informed choice and to promote the quality of services, not just the quantity
- They require significant investment in systems to register and monitor providers,
- Definition of benefits and reimbursement rates,
- Identification of targets and reaching targeted populations,
- Validation of use of services
- Timely payments

Global dimensions

- Voucher programs in particular are mostly donor-funded, raising concerns about their sustainability.
- Over a quarter were initiated by a donor.
- In Africa and Latin America, most programs were initiated by social franchising organizations, nongovernmental organizations, or research institutes with donor support.

Case Study

- How Do Vouchers and CCTs Affect Use of Family Planning?

Introduction to health insurance

Learning objectives

- By the end of the session, students should be able to

1. Understand the relationship between the uninsured and insured
2. Explain the difference between insurance and health insurance
3. State the principle and objectives of health insurance
4. State the types of health schemes in Ghana
5. Benefit packages in the various insurances Schemes

Who are the uninsured? (Examples from the US)

- Mostly adults, not children – half are childless adults.
- The number of uninsured children increased from 8 million (10.9 percent) in 2005 to 8.7 million (11.7 percent) in 2006
- Poor and near-poor – 60% have incomes above federal poverty level
- Workers and family members – 80% in families with at least 1 worker
- Unskilled laborers, service workers
  - 3 of 5 of the uninsured who work, work in firms with <100 workers

Uninsured: Why are they uninsured

- Three primary reasons that workers don't have insurance:
  - The employer does not offer a health plan.
  - Employer offers health plan, but employee is not eligible for the plan because of part-time status or some other rule.
  - Employee doesn't buy plan because plan too expensive or does not perceive need for plan

Uninsured: Why are they uninsured

- Uninsured, more likely to:
  - Change jobs
  - Work part-time
  - Work for small firms
    - Small-firms pay much higher premiums because their risk is perceived to be large.
- Why don't they buy private health insurance
  - There is no risk pooling with private health insurance and it is expensive
    - Average annual cost of family policy in the private market (3,330)
    - Average annual cost an employee pays out of pocket towards group insurance (2,700)

Uninsured: Impact on health outcomes

- Empirical research gives mixed results
  - Empirically difficult to measure
    - *Selection bias:* Those who choose not to buy health insurance do so because they are healthier
    - *Endogeneity:* does lack of insurance cause poor health, or does poor health decrease the probability of being insured. (can't determine direction of causality)
- Despite inconclusive empirical evidence, the argument that those without insurance experience poor health is powerful.
- As the number of uninsured grow, policy makers will have an increasingly difficult time ignoring health consequences of the uninsured.

Concept Of Insurance

- Insurance is a way of pulling resources into a pool to support another in times of need.
- Kwegyir- Aggrey (1998) – insurance is a system of handling risk by combining many loss exposures, with the cost of losses being shared by all participant.
- It is a way of protecting oneself against the future financial shocks.
- In terms of health insurance it provides the individual with financial accessibility to healthcare

What Is Health Insurance

- Health insurance is a way an individual, community or a state decide to pay for health care.
- According to Joseph Kutzin (1995), it is a means of financial protection against the risk of unexpected and expensive illness.
- Britannica Concise encyclopedia defined Health Insurance as ‘it is for advance financing of medical expense through contributions or taxes paid into a common fund to pay for all or part of health specified in an insurance policy or law.

What Is Health Insurance

- Hilary Goodman and Catriona Waddington (1993), health insurance is a prepayment scheme that operates to provide health care only for people who are members of the scheme. In order to join, it is necessary to make regular payment of a determined sum whether the healthy or the sick

Components of a Health Insurance Policy

- **Health insurance premium** is the fee that you pay in order to have coverage of the medical conditions and/or treatments described in the policy.
- Premiums are established through an underwriting process whereby potential purchasers of health insurance are categorized into specific risk categories based upon such factors as age, gender, and medical history.
- The level of premium is intended to reflect the likelihood that members of the insured group will incur medical costs equal to the projected loss ratio or less.

Components- Premium

- Underwriting is necessary to avoid “adverse selection” – ideally, premiums are set high enough so as to deter participation by those most likely to use the insurance, and low enough to encourage participation by those least likely to use it.
- Underwriting ensures that the people who purchase health insurance are a true cross-selection of risks, and don’t only represent those who purchase health insurance because they are ill or expect to need it.

Deductibles

- In some circumstances, Health insurance usually requires that the covered policyholder bear a portion of the risk by paying initial medical costs up to an agreed-upon level before the health insurance is liable for payment.
- As the deductible amount increases, the premium decreases. e.g an annual deductible of $3,000 (₵12000.00) would require the policyholder to pay the first $3,000 (₵12000.00) in medical bills out-of-pocket before the insurance company will pay or reimburse any claim.

- Deductibles can be applied to individuals or to family groups. For example, the policy might have a $3,000 (₵12000.00) individual deductible and a $5,000 (₵20,000.00) family deductible.
- In this case, the insurance company would pay the individual's medical claims when the accumulated expenses for that individual or family exceed the total family expense exceeds

Co-payments

- In addition to the deductible, policyholders are usually required to pay a portion of the cost of each medical treatment covered to reduce frivolous use of medical services.
- While higher co-pays reduce the insurance company's total exposure, the amount of the co-pay per incident is rarely high enough to result in substantial premium reduction for the policy.

Exclusions

- Health insurance policies do not normally cover all medical expenses.
- The non-covered expense may be defined by

1. medical condition,
2. type of treatment, or
3. medical provider.

For example, most health insurers do not cover elective cosmetic surgery, such as face lifts, tummy tucks, or bariatric (obesity) surgery, except in certain rare occasions.

Policyholders remain 100% liable for any excluded treatment or expense, and these expenses do not apply to the deductible amount defined in the policy.

Provider Panels

- One of the biggest ancillary benefits to health insurance policyholders is the schedule of discounted fee payments negotiated between the insurer and medical suppliers and providers.
- In some cases, the amount actually paid for the treatment will be 30% to 40% of the provider's "usual and customary" fees.
- Each insurer negotiates a discount with providers based upon the number of the insurer's policyholders and the projected utilization of the provider's services.
- Based upon the rates to be charged, physicians, hospitals and other medical providers will be included into a defined network:

Preauthorization

- This is the process by which a health insurance policyholder gets prior approval of a medical procedure, or approval to see a specialist to ensure that the service or visit is covered.
- Policyholders should note that preauthorization is not a guarantee that the service will be covered, but rather that it is the intent of the insurer to cover the service pending review of the claim and the determination that the service was necessary.
- Many non-critical treatments require preauthorizations, and it is usually the policyholder's responsibility to know if preauthorization is required.
- Failure to get preauthorization can result in the payment of a claim being denied.

Principle

- Other principle is that no individual carries the risk of paying for future health care cost
- Another principle is that the health insurance redistribute the financial resources for members according to their needs and at the time of need.

Objective

The main objective of health insurance is to cover future risk of ill health

Types of Health Insurance

- There are various types of health insurance.
- Medical health insurance may be attained for you and your family through a

1. private insurer,
2. an employer, or
3. through the Government, also known as public health insurance

Types of Health Insurance

- Other types of health insurance may cover more than just medical services, and you may need to purchase additional insurance plans to cover all of your needs.
- Those may include:

1. Prescription drugs
2. Vision
3. Dental
4. Travel
5. Life
6. Disability

National health insurance

BACKGROUND The National Health Insurance Authority (NHIA) is mandated by National Health Insurance Act, 2012 (Act 852) to register, license and regulate Private Health Insurance Schemes (PHIS) in Ghana.

In performing its regulatory functions, the Authority registers, licenses, and supervises the operations of PHIS in Ghana.

Private Health Insurance under NHIA

The law established two (2) types of private health insurance schemes:

1. Private Mutual Health Insurance Scheme (PMHIS)
2. Private Commercial Health Insurance Scheme (PCHIS)

PRIVATE MUTUAL HEALTH INSURANCE SCHEMES

- A PMHIS refers to a health insurance scheme operated exclusively for the benefit of its members.
- A PMHIS is required to have a minimum capital requirement of One Million Ghana Cedis (GH¢1,000,000.00). The capital requirement refers to paid-up initial subscription.

National health insurance

- The National Health Insurance scheme was established under the National Health Insurance Act 650 of 2003 and operated under the National Health Insurance regulation (legislature Instrument 1809)2004.
- The Objective of the NHIS is to **provide financial access** to all residents in Ghana, especially, the **poor and the vulnerable** with **quality basic health care services.**

Right of members

- Membership with the NHIS makes one a stakeholder of the scheme
- You have the right to possess an NHIS
- Access to health care with your card (except exempt group, new subscriber serves a waiting period of I month).
- access to information at your district office
- Right to be given prescription where it is not available at the facility

Responsibility Of Members

- Yearly renewal of your card
- Not to access health care on behalf of another person
- Not to engage in provider shopping
- Observe gate keeping system

Benefit Package

- About 90% of disease conditions that afflict residents in Ghana are covered by the NHIS.
- The package is categorized into the following
- Out-patient services
- Inpatient services
- Oral health services
- Eye care services
- Maternal health services and
- Emergency services

Out-patient Services

- The out-patient services which refer to services render to patients outside the hospital's wards and may be carried out in a day, are classified into general and specialist consultations.
- In each of these services, the cost of patient folder, investigations and consultations are covered.
- **On investigations**, the following and covered;

1. Laboratory test
2. X-ray
3. Ultrasound scanning

Out-patient Services

- **On medications,** drugs on the approved NHIS list that are prescribed
- Traditional medicines approved by the Food and Drugs Board and are prescribed by accredited medical and traditional medicine practitioner are covered
- Treatment for opportunistic infections **(HIV/AIDS)**

Out-patient Services

- OPD/ Day surgical operations including hernia repair, incision and drainage, suturing etc.
- OPD physiotherapy

Inpatient Services

- The inpatients services which refer to services render to patients who are admitted into the hospital's wards and may be carried out in more than a day, could also be general or specialist care.
- **Request for investigations**, the following and covered;

1. Laboratory test
2. X-ray
3. Ultrasound scanning for in-patient care.

Inpatient Services

- **On medications,** drugs on the approved NHIS list that are prescribed
- Traditional medicines approved by the Food and Drugs Board and are prescribed by accredited medical and traditional medicine practitioner, blood and blood products are covered
- Cervical and breast cancer treatment
- Surgical operations,
- In-patient physiotherapy
- Accommodation in general wards and
- Feeding (where available)

Oral Health Services

- Service under oral services covered by NHIS include
- General consultation,
- Procedures such as pain relief which includes incision, drainage, tooth extraction and temporary relief
- Another procedure is Dental Restoration; this include simple amalgam filling and temporary dressing.

Eye Care Services

- Eye care services covered under the NHIS are;
- Refraction,
- Visual field
- A-scan
- Keratometry
- Cataract removal and
- Eye lid services

Maternal Health Services

- Antenatal care
- Spontaneous virginal delivery (normal/assisted) with or without episiotomy
- Caesarean Section
- Postnatal care etc.

Emergency services

- All emergencies are covered. These are crisis health situations that demand urgent intervention. These are

1. medical and surgical emergencies
2. Paediatric emergencies
3. Obstetric and gynaecological emergencies
4. Road traffic accidents
5. Industrial and work place accidents

Exclusion

- The following are excluded under the HNIS

1. Rehabilitation other than physiotherapy
2. Appliance and prosthesis including optical aids, hearing aid, orthopedic aids and denture
3. Cosmetic surgeries and aesthetic treatment (excluding reconstructive surgery)
4. HIV antiretroviral medicine
5. Assisted reproduction – artificial insemination

Health Insurance and Documentation

Claims Generation

Leaning Objectives

- By the end of the session, students should be able to;

1. Explain the meaning of health insurance claim
2. State the various process involve in claims generation
3. Identify the features of a claims form
4. Authenticate eligibility of card holders
5. Conduct registration of card holders
6. Carry out the filing of claims forms
7. Carry out compilation of claims

Health Insurance Claim

- There are many definitions of what health insurance claims is

1. It a demand for payment in accordance with an insurance policy or other formal arrangement or the sum of money demanded
2. It the request for payment of service rendered.
3. It a notification to an insurance company requesting for payment of an amount due under the terms of the policy

Claims Generation

- Claims generation is the processes of collecting and computing the services provided in a health facility, in accordance with the terms of engagement between the insurance company and the facility.
- This is for the purpose of claiming for reimbursement.
- Claims generation involve the following.

- Authentication of eligibility
- Registration
- Service provision
- Filling of the claims form and
- Compilation of claims records and submission.

Authentication of Eligibility

- This involve the process of ascertaining whether the individual coming to access the services at the facility is eligible.
- There are two methods of verification.
- First is manual verification. This a method where by the service provider examines the card to find out whether
- 1. **the card is valid or has expired.**

- One of the responsibilities of the card holder is to keep his or her membership active to be able to access health care services always. Once the card is expired and has not yet been renew, there is no contract between the subscriber and the insurer.
-

- **The bearer is the true owner of the card**
  Non- subscribers can use the card of subscriber to access service if verification is not done. It is the responsibility of the service provider to provide this gate keeping exercise.
- **Verify whether the service demanded falls**
- Insurance company usually have different benefit packages depending on the premium paid.
- It is important to verify which benefit package is the subscriber entitle to.
- Some are indicated on the card or listed in a form of different cards.

- The second method is an electronic means called **NAVIS**
- It is a web-based application designed to allow organizations and institutions to verify the identity of individuals registered with the Scheme.
- It aim is to solve the cumbersome and time consuming verification procedures.

- It also addresses the issue of fraudulent NHIS ID cards
- Shows card status. (Active, Inactive, Expired, Invalid)
- Tracks transaction history
- Generates comprehensive reports

Registration

- This involves documentation after the authentication.
- The subscriber is registered if that is the first time of visit.
- Taking the bio- information (name, age, sex,etc)
- Subscriber is given the necessary document that will enable the subscriber to access services (hospital folder and I.D card)
- For an old subscriber, it involves retrieval of old records

- This very important because it is the beginning of claim processing at the facility
- If all the vital information while the subscriber’s insurance I.D card is available, vital information may be missed and will affect filling of the claim forms.

Service Provision

- This involves giving medical care to subscribers based on the benefit package.
- **Revisited the benefit packages with students**
- However, service provision begins after the subscriber is found to be eligible.
- The most important element of service provision in as far as claims administration is concern is **proper documentation**.

- Documentation have two major components
- 1. proper records keeping (folders & accessory content) in the facility
- Keeping folders in the facility will ensure confidentiality, continuity as well as quality of care.
- 2. recording the services provided in the folders properly.
- This require eligible hand writing, Proper recording of services (procedures, diagnosis & medications)

- Diagnosis services must be clearly indicated, procedures must be full indicated including what was done, report on the procedure.
- All diagnostic services must be recorded including the result.
- Full prescription of medicine served must be indicated
- For in-patient, all medicines served must be charted.
- Prescriber must all sign in the folder to indicate that the treatment completed.

Patient Information

Health Facility No./Code	Registration No. / Folder No. 11011/16
Facility Name S T. G . C . H	Date of First Attendance 18/09/16
[redacted]	
Date of Birth 12/05/2003	Place of Birth
Age 013	Sex:- Male ☐ Female ☑
Marital Status	Single ☑ Married ☐ Divorced ☐ Widowed ☐
Race / Nationality GEL.	Other Information
Address: Postal Address	Home Address (House No.) FETTEH KAKRABA
Locality GOMOA	Telephone
Occupation PUPIL	Religion CHRISTIAN
Name of nearest Relative (FATHER MOSES AKOTO	Contact Address 0572234929
Name of Scheme	
Insurance No.	Scheme Identification No.
Unique No.	Client Identification No.

Patient Information

Health Facility No./Code	Registration No. / Folder No.: 11323/15
Facility Name: ST. G. C.H	Date of First Attendance: 16-10-15
Surname / Last Name:	
11-01-2014	Place of Birth: Age: 0 01 — Sex:- Male ☐ Female ☑
Marital Status	Single ☑ Married ☐ Divorced ☐ Widowed ☐
Race / Nationality: GHANAIAN	Other Information
Address: Postal Address	Home Address (House No.): Z-1 CAMP
Locality: CAMP.	Telephone
Occupation: PUPIL	Religion: CHRISTIAN
Name of nearest Relative: MOTHER BLESS MOSAKA	Contact Address: 0543585316
Name of Scheme	
Insurance No.: 4645835	Scheme Identification No.: GRWB0001D7112
Unique No.	Client Identification No.

FOR O.P.D USE

NAME:.....

AGE:.....

DATE	HISTORY - EXAMINATION FINDINGS	INVESTIGATIONS - TREATMENT
18/09/16 7:20pm	Temp – 38.7°c wt – 10kg	PLAN – Susp. Panadol 250mg tds x 24hs Tepid Spge PRN
	Pt.c. Feverish, Vomiting 2x, Teething 1x.	– Tab. AL 20/120mg bd x 3/7
	O&O: Cough+, vomiting+, Feverish, headache, Nausea, Loss of appetite+	– Syrup Piriton 1/2 tsp tds x 5/7 – Susp. Cefuroxime 125mg bd x 5/7
	Dtlx: Administering Inj at home.	– Syr Multisite 2.5mg tds x 5/7
	O/E: CNS – Conscious, alert. – Skin warm & Tout	
	IMP – Malaria – ? Sepsis	

FOR O.P.D USE

NAME:

AGE:

DATE	HISTORY - EXAMINATION FINDINGS	INVESTIGATIONS - TREATMENT
22/8/15 10:55am	Temp – 37.1°C Wt – 2.5kg	
11:10am	PC – Referred case from KPC on Retro-positive mother. c/o no complaints [illegible] after [illegible] state [illegible] c/o signs of dehydration not lethargic or unconscious	pt to Report on Monday to MCH clinic.

Filling Of Claims Form

- This is done after the service provision. It begins from authentication.
- Once authentication is completed and subscriber found to be eligible, claims forms are generated during the registration and services
- services are captured as the subscriber moves through the service points.
- In some cases claims forms are filled after the service provision.
- This often depends on the type of re – imbursement package applicable. For example, for Capitation, providers do not need to capture details of the services rendered as they have standard or fixed re – imbursement package.

- For itemized fee for service, all items must be captured at all service points. This is because every item used in providing services should be billed for.
- For Diagnostic Related Grouping, capturing services at service points may be useful for administrative reasons.
- Claims forms are better filled at the end of the service to enable providers make diagnosis to determine what tariff should be applied for the service rendered.

- This requires proper record keeping which is very key to claims administration.
- Claim forms are invoices and therefore must be properly filled with all the relevant details.
- All claims forms must also have the name of the facility or stamp, name and signature of the officers who fill the forms on them.

NATIONAL HEALTH INSURANCE SCHEME
GOMOAMAN DMHIS
Claim Form

Printed: 03/05/2013
Time: 17:12
Page #: 1

Name of Facility: ST. GREGORY'S HOSPITAL, BUDUBURAM
Scheme Code*: GOM
H. I. Code: 0000000000
Month of Claim*: 05/2013

Client Information

Patient Name*
Member Number*: 88501744
Card Serial No*: CRGOM88501744
Hospital No.: 0815/13
Age: 36
Gender: FEMALE
Date of Birth: 05/04/1977

Services Provided

Type of Services
[X] Out-Patient [ ] In-Patient [X] Pharmacy
[ ] Diagnostic
[X] All Inclusive [ ] Unbundled

Outcome
[X] Discharged [ ] Died [ ] Transferred Out
[ ] Absconded/Discharged against medical advice

Dates of Service Provision (DD/MM/YYYY)
1st Visit / Admission: 01/05/2013
2nd Visit / Discharge:
3rd Visit:
4th Visit:
Duration of Spell (days): 0

Type of Attendance
[ ] Chronic Follow-up [X] Emergency/Acute episode
Specialty Code: OPDC
Specialty Description: OPD CONSULTATION

Name Of Physician/Clinician: GIFTY OCHEREWAH YEBOAH
Physician/Clinician ID: 000005

Procedure(s)

	Description	Date	G-DRG
0.			

Diagnosis(es)

	Description	Review	ICD-10	G-DRG
1.	MUSCULOSKELETAL PAIN	No		OPDC06A
2.	UPPER RESPIRATORY TRACT INFECTION	No	J06.9	OPDC06A

Investigations

	Description	Date	G-DRG
0.			

Medicines

Description	U. Price	Qty	Total Cost	Date	Code	Dosage
1. tab Amoxicillin + Clavulanic Acid 500 mg + 125 mg	0.800	14	11.20	01/05/13	COAMOXTA1	1 BD X 7 DAYS
2. supp DICLOFENAC, 100mg	0.430	10	4.30	01/05/13	DICLOFRE2	1 DLY X 10 DAYS

Client Claim Summary

Type of Service	Prefix Mod.	G-DRG/Code	Tariff Amount
A. In-Patient			0.00
B. Out-Patient	00	OPDC06A	9.89
C. Investigations			0.00
D. Pharmacy			15.50
TOTAL:			¢ 25.39

Signature

Name
KWAMENA ARTHUR HUGHES
(Health Facility Insurance Officer)

Scheme Use Only

Date Received | Action 1 | Date | Signed

Compilation Of Claims Records

- This involves putting all claims together by the provider in readiness for submission to the insurer.
- All the claim forms are put together, summaries of the claims put together stating the amount involved.
- A covering letter is then written by the head of the facility or an officer designated by the head to that effect.

- It is important to segregate the claims according to specialties if specialty services were provided.
- This helps to determine the incomes generated by the various specialties so that resources can be adequately allocated.
- It also ensures easy vetting of claims as claims officers will not be moving in between specialty tariffs during vetting.

ST GREGORY CATHOLIC HOSPITAL

CLAIMS SUMMARY PER SPECIALITY-SEPTEMBER 2016

NO	SPECIALITY	GDRG CODE	ATTENDANCE	AMOUNT OF CLAIMS IN (¢)		
				SERVICE	MEDICINE	TOTAL
1	OPD(ADULT)	OPDC06A				
2	OPD(CHILD)	OPDC06C				
3	OPD(ANTENATAL)	OPDC02				
4	OPTHAMOLOGY	OPTH				
5	ORTHOPAEDICS	ORTH				
6	DETENTION	ZOOM				
	TOTAL IN GH¢					
	INPATIENTS					
1	PAEDIATRICS	PAED				
2	MEDICAL	MEDI				
3	OBS&GYNAECOLOGY	OBGY				
	TOTAL IN GH¢					
	GRAND TOTAL					
	GRAND TOTAL IN GH¢					

- The covering letter must be on the company's letter head and should indicate the period for which the claims is being submitted.
- It must indicate the amount for services, that of the medicines and the overall total amount. The letter must be duly signed by the head of the facility and stamped with official stamp.

Health Insurance and Documentation

Claims submission

CLAIMS SUBMISSION

- This involves the carriage of the claim forms from the provider side to the insurer.
- There are several ways this can be done. It may be done

electronically or

manually.

- Manual submission can either be direct submission or by courier or mail.
- The claims have to be submitted with following documents.

1.the claims forms

2.The cover letter

3.The summary sheets

4. Claims register

The Claims Forms

- They are the value documents (invoices) on which demand for payment for services rendered or medicines supplied by health care providers are made.
- Claims are generated at service points as a subscriber goes through these service points.(mention the service points)
- To enable the health care provider be able to capture all the necessary information on the claims form and to get the required re – imbursement, there should be proper documentation.

Important Claims Forms

1. They are the acceptable documents through which health care providers request for payment for services rendered to subscribers from the insurer.

Insurer shall not honor payments when demand for payments is not made on their claim forms.

2. It also helps health care providers to know how much they have to be re-imbursed by the insurer.

The Cover Letter

- This is the official letter from the health care providers which usually accompanies the claims forms.
- This letter should be

➢ written and **signed** by the head of the facility.

➢ bear the **official stamp** of the facility.

➢ indicate the **total amount** of the claims and

➢ the **period** for which the claims are being submitted.

The Importance Of The Covering Letter

1. It authenticates the demand for payment as it indicates that the claims are coming from the health care provider.
2. It also serves as reminder to the provider that claims have been prepared.
3. It enables heads of facilities to be aware of claims amounts to the insurer.

In most cases, top management of facilities are not involved in the filling of claims forms and are therefore not aware of claims amounts.

They usually get to know when they are signing the covering letters.

4. It also serves as a reminder to the insurer that claims have been received.

The Summary Sheet

- Summary sheets are documents that give details of individual claims forms in a particular batch.

Parts of summary sheet

summary sheet contain the following

- name of the facility
- month and batch of claim
- names of subscribers,
- insurance number,
- date that service was rendered,
- type of service (revise benefit packages and list types of service diagnosis, service cost, medicine cost.
- total amount for each individual claims.
- name and signature of the claims officer in charge.

- The main importance of the summary sheet is to provide information to heads of facilities on how much to be expected from the insurer.
- It also provides useful planning information in terms of resource allocation and distribution.

ST GREGORY CATHOLIC HOSPITAL

CLAIMS SUMMARY PER SPECIALITY-SEPTEMBER 2016

NO	SPECIALITY	GDRG CODE	ATTENDANCE	AMOUNT OF CLAIMS IN (¢)		
				SERVICE	MEDICINE	TOTAL
1	OPD(ADULT)	OPDC06A				
2	OPD(CHILD)	OPDC06C				
3	OPD(ANTENATAL)	OPDC02				
4	OPTHAMOLOGY	OPTH				
5	ORTHOPAEDICS	ORTH				
6	DETENTION	ZOOM				
	TOTAL IN GH¢					
	INPATIENTS					
1	PAEDIATRICS	PAED				
2	MEDICAL	MEDI				
3	OBS&GYNAECOLOGY	OBGY				
	TOTAL IN GH¢					
	GRAND TOTAL					
	GRAND TOTAL IN GH¢					

The Claims Register

- This is a document in which the provider submitting the claims to the insurer enters the details of the claims been submitted.

The register should have

- the facility name,
- total number of claims,
- date of submission ,
- month of claim,
- claim amount
- names and signatures of submitting and
- receiving officers.

- Its provides evidence to the provider that the insurer has received the claims.
- It also provides useful information as to when the insurer received the claims and for which periods the claims cover

Claims Reception

- This is where the claims are received by the insurer from the health care provider.
- This goes through a process call fulfillment.
- Fulfillment involves the following;

1. Assessing provider eligibility
2. Checking for the necessary documentations on the claims. E.g. Covering letters, summary sheets and register
3. Cross checking the number of claims and the amount involve.
4. Entering claims information in the insurer's register
5. The submitting and receiving officers signing each of the claims register (i.e. The provider and insurer registers).

Assessing provider eligibility

- The insurer verifies whether the provider has the right to provide services to the subscribers. The right is given to providers through contractual agreement.
- Other aspect of this deals with right to provide particular services under the contract i. e. Providers are contracted to provide specific services under the contract they have with the insurer.
- If a provider provides services outside the contract arrangement the insurer is obliged not to honor those claims.

- The importance of assessing provider eligibility is to ensure that the insurer deals with only contracted providers.
- It ensure that the insurer pays only for services it has contracted the provider to render.

Checking For Proper Documentation

- This involves the verification of all documents accompanying the claims.
- The documents that usually accompany claims forms are covering letters and summary sheets.
- The information on these documents i.e. amounts, the services and periods of claims must tally.
- If there are differences, the claims should not be received, the provider should be asked to rectify all anomalies and re – submit.

- A major importance of documentation verification is to prevent insurer and provider conflicts as different figures can result in conflict.
- It also ensure that claims documentations are complete

Filling Of Claims Register

- Insurers and providers alike should have their own claims register into which details of all claims received are entered into.
- The providers' register should have the following details entered,

➢ date of submission,

➢ month of claim,

➢ claim amount,

➢ names and signatures of submitting and receiving officers.

- The importance of claims register to the insurer is to provide evidence to the insurer that the provider has submitted claims
- It also provides useful information as to when the insurer received the claims for which periods the claims cover.

Signing Of Claims Register

- When claims information is entered in the claims register, both the submitting and the receiving officers must sign.
- When the register is not signed, it makes the information recorded in it not authentic.
- The importance of signing of the register is to make the information in the register authentic.

Terminologies And Calculations Of Claims

- Tab Paracetamol 500mg TDS X 3/7 (3times daily for 3day)
- Syr simple linctus 200mls BD X 3/7 (3times daily for 3days
- Tab Paracetamol 1mg TDS X 3/7 (3times daily for 3day)
- Syr simple linctus 200mls BD X 3/7 (3times daily for 3days)
- Tab b Paracetamol 1g TDS X 3/7 (2, 3times daily)
- Tab benfroflumethiazide mg daily X 1/12 (30days or 1month)
- Ivf sodium chloride 500ml QID X 24HRS (4times a day)

The end