CORRUPTION RISK ASSESSMENT OF CLAIMS MANAGEMENT PROCESS AND SUPERVISION FUNCTIONS

of the National Health Insurance Scheme (NHIS)

(A STUDY OF SIX DISTRICTS OF GHANA)

Ghana Integrity Initiative (GII)
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Assessment on Corruption Vulnerabilities and Loopholes in the Delivery of Healthcare, particularly to Women, Girls, and other Groups at Risk of Discrimination. (A Study of Six Districts of Ghana)

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TABLE OF CONTENTS

List of Acronyms 5

Executive summary 8

Introduction 12

background 15

Methodology 28

DESCRIPTION OF RESULTS 33

CORRUPTION RISK ASSESSMENT ....

CORRUPTION RISK ASSESSMENT 42

Major drivers of corruption in management and supervision 55

Impact of corruption on vulnerable groups 57

MITIGATION STRATEGIES 61

CONCLUSIONS 63

Recommendations 64

References 65

Annex 68

LIST OF ACRONYMS

Acronym	Meaning
CCC	Claims Check Codes
CHPS	Community-Based Health Planning Service
CIPFA	Chartered Institute of Public Finance and Accountancy
CRA	Corruption Risk Assessment
CSO	Civil Society Organisation
DMHIS	District Mutual Health Insurance Scheme
DP	Decision Point
DRC	Democratic Republic of Congo
FGD	Focus Group Discussion
GDP	Gross Domestic Product
G-DRGs	Ghana Diagnostic Related Groupings
GHS	Ghana Health Service
GII	Ghana Integrity Initiative
GTNI	Global Thematic Network Initiative
ISDA	Inclusive Service Delivery Africa
MoH	Ministry of Health
MMDA	Metropolitan, Municipal and Districts Assemblies
NACAP	National Anti-Corruption Action Plan
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
SDGs	Sustainable Development Goals
SSNIT	Social Security and National Insurance Trust
TI	Transparency International
TOR	Terms of Reference
UHC	Universal Health Coverage
UNCAC	United Nations Convention against Corruption
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime

EXECUTIVE SUMMARY

1. This report relates to an "*Assessment of Corruption Vulnerabilities and Loopholes in the Delivery of Healthcare, Particularly to Women, Girls, and Other Groups at Risk of Discrimination*" (Assessment), of the National Health Insurance Scheme (NHIS) in six (6) selected Metropolitan, Municipal and District Assemblies (MMDAs) – Ayawaso Central and Ada East in the Greater Accra Region, Cape Coast Metropolis and Upper Denkyira East in the Central Region and Kassena Nankana West and Kassena Nankana Municipal in the Upper East Region, as case study.[1]

2. The Assessment focused on claims management process and Management and Supervision functions of the National Health Insurance Scheme and it sought to collect views on corruption vulnerabilities and loopholes in the NHIS (the Scheme) and assess how those corruption risks would impact on access to health service delivery by women, girls and other vulnerable groups at risk of discrimination.

3. Data for the Assessment was gathered through 188 key informant interviews and six (6) focus group discussions carried out in the six (6) selected MMDAs, in addition to a review of relevant literature.

4. Key Findings.

   Claims Management:

   a. The claims management process is largely digitised/electronic. However, a few claims still go through the manual process.

[1] Ghana is divided into 16 Administrative regions, each with a number of local government structures known as Metropolitan, Municipal and District Assemblies (MMDAs). There are currently 261 MMDAs, which constitute ***the highest*** administrative, legislative, executive, planning and rating authorities of Ghana at the district level.

b. Health service providers submit their claims to the National Health Insurance Scheme monthly for reimbursement. The process of reimbursing the claims to the service providers goes through *fulfilment and reconciliation*, that is, confirmation of the volume and value of the claim, *vetting, data entry*, producing a *vetting report, approval and payment.*

c. Where queries on claims submitted for reimbursement come up during the processing, a team from the relevant district office of the NHIA is tasked to work with the provider concerned to address the queries. Thereafter, the claim is submitted to the Chief Executive Officer (CEO) and the Finance Directorate simultaneously for approval and then final payment.

d. Corruption risks exist in the claims management process. They include: *Bribery/kickbacks*, such as NHIA officials either demanding or receiving unofficial payments from providers to facilitate claims or other processes; *Conflict of interest or favouritism,* such as NHIA officials processing claims of Service Providers owned by either the NHIA official or his/her close relative; *Fraud,* such as NHIA officials deliberately including fake claims and approving same for reimbursement for personal benefit or NHIA officials colluding with Providers to cheat the Scheme; *Misappropriation,* such as NHIA officials diverting Scheme funds to other private investments.

e. The corruption risks are due, largely, to the following: the inability of the Scheme to raise funds to reimburse claims and on time; limited number of processing centres across the country to cope with the large volumes of claims submitted monthly; late submission of claims by providers; poor supervision of claims processing staff; lack of integrity of staff; negative attitude of some staff, and absence of a more robust system to enable the Scheme to validate whether a client has indeed obtained the services for which the provider is claiming payment from the Scheme.

f. The identified corruption risks have varying degrees of impact for women, girls and other groups at risk of discrimination in each of the sampled districts. The degree of risk of corruption, however, varies across the districts. It was considered high in Kassena Nankana East and Ayawaso Central Municipality and moderate in Navrongo Municipality, Cape Coast Municipality and Upper Denkyira East, whereas for Ada East it was low.

g. Kassena Nankana East and Ayawaso Central Municipality have poorest levels of access to health services among the sampled districts, meaning that, if there is a strain on resources caused by corruption in NHIS, it will likely affect the vulnerable populations in these districts more than the others.

h. The impact of the corruption risks on women, girls and other vulnerable groups who stand at a higher risk of discrimination include the following: financial burden; reduced access to and quality health services; exacerbates health inequity; resort to self-medication or herbalist care that may lead to serious illness or to death.

Management and Supervision:

a. Management and Supervision at the level of the District Mutual Health Insurance Scheme (DMHIS) rest with the District Directors or Managers, who are supported by other officers (such as the Public Relations Officer, Accountant and Management Information Services officer). These officers are responsible for monitoring credentialled providers either on routine basis or for purposes of addressing concerns that arise in relation to processing of claims.

b. The identified corruption risks in this area include: receiving kickbacks/bribes from Providers to avoid inspection of their facilities or for some other favours from the Scheme; bribery in assigning staff to certain schedules; receiving kick-backs from providers to speed up claims processing, and diversion of Scheme funds.

c. Corruption risks in management and supervision will have an impact on women, girls and other vulnerable groups who stand at a higher risk of discrimination, in the following ways: reduction of access to and quality of health services; it is a financial strain on them as they may resort to out-of-pocket payment, or if they do not pay self-medication or resort to herbalist care that may lead to serious illness or to death. Finally, the risks may exacerbate health inequities [i.e., unfairness, inequality].

d. The major drivers of corruption in both claims management and Management and Supervision include: poor remuneration, delays in claims payment, poor supervision of staff and non-enforcement of sanctions against providers, lack of integrity of staff, and limited number of claims processing centres (5) for the whole country.

5. The Assessment which was in furtherance of the Inclusive Service Delivery Africa (ISDA) Project, (the Project) being implemented by the Ghana Integrity Initiative (GII) seeks to improve access to healthcare services for women & girls, youth and other groups at risk of discrimination such as, persons living with disabilities, migrants and nomadic groups in Ghana. The Assessment has brought out a few risks in the processes of claim management and management and supervision functions of the NHIA under the National Health Insurance Scheme. These risks, if addressed, will assist to improve the quality of health services provided the vulnerable groups.

KEY POLICY RECOMMENDATIONS

1. The introduction of an electronic system of claims processing is one potent tool to prevent corruption as it reduces direct contact between personnel of the Scheme and service providers. However, the processing centres which apply the electronic system were said to be only 5 for the entire country, which are insufficient to cope with the large volumes of claims received monthly. The Scheme should consider increasing the number of Claims Processing Centres. Furthermore, efforts should be made to cover the few areas where manual processing of claims still exist.

2. The NHIA should introduce a system of transfer of staff who have served on specific schedules/ roles for a very long period to either other schedules (rotation) or to other offices of the NHIA.

3. To deal with the lack of integrity of Staff, the NHIA should build or enhance the capacity of its staff on the Code of Conduct for Public officers of Ghana (the Code) under Chapter 24 of the 1992 Constitution of Ghana. To enable the Staff of the NHIA to report corruption, the NHIA should also implement a system that encourages the staff to report misconduct without fear of victimisation as well as sanction staff who breach the Code.

4. The NHIA should conduct monitoring and supervision of its staff as well as accredited health facilities more frequently (for example, monthly).

5. The NHIA should strengthen collaboration with relevant stakeholders, such as the MMDAs, in its monitoring of the service providers.

INTRODUCTION

Corruption undermines the quality and quantity of public services. It fuels inequalities in accessing essential services, reduces the resources available to the public – particularly women, girls, and groups at risk of discrimination – and is a major obstacle in effectively and efficiently allocating public money for education and healthcare.

Inclusive Service Delivery for Africa (ISDA) project

The present research study was carried out as part of the Inclusive Service Delivery for Africa (ISDA) project. Transparency International (TI) is a global movement working in over 100 countries to end the injustice of corruption. TI is implementing a four-year regional project in five countries in Africa: Democratic Republic of Congo; Ghana; Madagascar; Rwanda; and Zimbabwe, aimed at improving access to education and healthcare services for women, girls and other groups at risk of discrimination. TI-S is managing the project in partnership with national chapters in the five countries, with technical expertise and stakeholder engagement support from TI's Global Health Programme and TI's national chapter in Canada. This work is supported by Global Affairs Canada (GAC).

The project responds to a core development challenge linked to the impact of corruption and impunity on access to education and healthcare services for groups at risk of discrimination, particularly women and girls in Africa. Corruption undermines the quality and quantity of public services, fuels inequalities in access to basic services and reduces the resources available for women and groups at risk of discrimination who are more reliant on public services, resulting in heightened poverty for those most marginalised.

To address corruption-related barriers to gender equality in education and healthcare, the project is focusing on three dimensions of change:

1. a performance change of public institutions that have the capacities to ensure that education and healthcare services are provided free of corruption (supply side of services);
2. a behavioural change among citizens, particularly women, girls and those at risk of discrimination, to speak out and report corruption and demand accountable and transparent services; and
3. a practice change among influential intermediaries and stakeholders who engage in coalitions and partnerships to mainstream anti-corruption issues within the education and healthcare agenda and create a supportive environment to reduce corruption-related barriers to gender equality in the education and health sector.

Ultimately, the desired impact is that more women, girls and individuals and groups at risk of discrimination are no longer being left behind because the attention and spotlight of the interwoven nature of corruption and discrimination and how they act as barriers to gender equality in education and health will become mainstreamed and top of mind among public institutions and influential stakeholders in the education and healthcare sector. Not only will they feel like they are no longer left behind, but they will exercise their rights and demand results and accountability from those entrusted to provide these services corruption free.

At the institutional and policy levels, governments that embed policies, procedures and mechanisms of accountability and transparency, will be able to more effectively detect and sanction those that abuse their power and hold to account those that prey on marginalized communities that already deal with other forms of discrimination.

This will ultimately help to close loopholes and reduce vulnerabilities that women, girls and groups at risk of discrimination face, giving them an equal opportunity to access vital basic services to protect and promote their human dignity and collectively, this will contribute to increased citizen trust and confidence in the institutions that deliver inclusive services as well as reinforce norms, behaviours and practices that strengthen a gender sensitive social fabric within communities and contribute towards countries' national development progress to reduce poverty and promote justice in line with the SDGs.

The corruption risk assessment (CRA) method used under the ISDA project, aims to assess existing policies in the health and education sectors for corruption vulnerabilities and loopholes and ascertain where specific gaps/loopholes are, that impact women, girls and groups at risk of discrimination. It aims to accomplish this by identifying where, how and why corruption occurs at specific decision points within operational processes, and to identify mitigation strategies to close these loopholes.

This Assessment focused on the National Health Insurance Scheme (NHIS) in six (6) selected districts of Ghana in terms of the following corruption risk areas: claims management processes and Provider payment, and Management and Supervision, with the view to making recommendations on how to mitigate the corruption risks identified.

The Report is organized in eight (8) section. Apart from the introduction in section 1 and Background in section 2, the Methodology used for the Assessment is presented in section 3. Description of the results of the study is presented in section 4, while the impact of corruption on vulnerable groups is captured under

section 5. The strategies to mitigate the corruption risks are set out in section 6. The conclusions of the study as well as recommendations are set out in sections 7 and 8 respectively. The tools employed in the study and bibliography are annexed to the report.

BACKGROUND

This section provides an overview of the health sector in Ghana including the National Health Insurance Scheme (from secondary data), how inclusive it is of women, girls and groups at risk of discrimination, and how it is affected by corruption.

Overview of the Health Sector

Most health sectors around the world are technically and inherently complex, composed of many actors often with competing interests and at times with unclear lines of accountability. There is often information asymmetry between stakeholders. In such a situation, information is not equally available to all actors, and this information asymmetry can allow one party to leverage information against another for their own benefit[2]. Thus, creating gaps in the oversight mechanisms.

Those factors, combined with large amounts of public funding and often a low risk of detection and punishment, as well as a lack of transparency and accountability in laws, regulations and processes, create opportunities for bribery, embezzlement and other corrupt activities.

Ghana's health sector is similarly complex. It is organized at three levels: national, regional and district levels, and has five levels of health providers: health posts, health centres, clinics, district hospitals, regional hospitals and tertiary hospitals.

The institutional structure of the health sector is made up of the Ministry of Health (MoH) as the main policymaker and regulator, the Ghana Health Service[3], the Teaching Hospitals and the Faith-based and Private-for-Profit practitioners as care providers (see Figure 1).[4] The National Health Insurance Authority (NHIA) is purchaser of health care services for its insured members.

[2] Ministry of Health. (2021). Health Sector Medium Term Development Plan 2022-2025. P. 11 https://www.moh.gov.gh/wp-content/uploads/2022/09/HSMTDP_2022-2025.docx14.pdf

[3] The Ghana Health Service was established in 1996 by act of Parliament with responsibility for service delivery and implementation of the health policies and programmes designed by the Ministry of Health. Among, other functions, it ensures access to health services at the community, sub-district, district and regional levels by providing health services, or contracting out service provision to other recognised health care providers;.

[4] Ministry of Health. (2021). Health Sector Medium Term Development Plan 2022-2025. P. 11 https://www.moh.gov.gh/wp-content/uploads/2022/09/HSMTDP_2022-2025.docx14.pdf

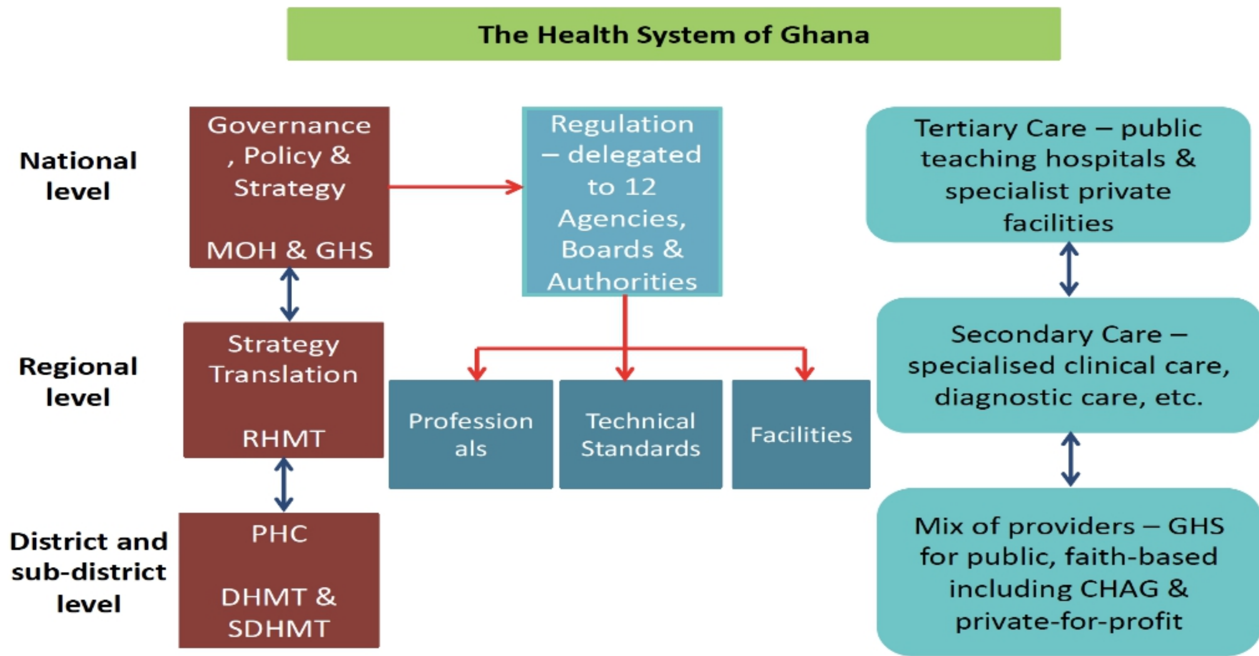

Figure 1: Structure of Ghana's Health System [source-MoH]

As of December 2020, Ghana had a total of 8,825 health facilities as follows: 7,137 public health facilities; 280 private for-non-profit; 1,331 Private self-financing, and 79 quasi-governmental facilities.

The health delivery system is decentralised and is organised on a three-tier level: primary, secondary, and tertiary, corresponding to district, regional and teaching hospital levels. The primary level is further organised on a three-tier level namely, the district hospital, the sub-district health centres, and the CHPS compound.

Health facilities providing the various levels of care are: Quaternary;[5]; five (5) Teaching hospitals; seven (7) Secondary Referral/Regional; 478 Primary Referral hospitals (Public and Private); 992 Polyclinics and Health centres; 5,876 community-based health planning service (CHPS compound), and 1,403 Maternity Homes and Clinics.[6]

Primary health care (PHC) which is the bedrock of the health system in Ghana and which is critical for the attainment of Universal Health Coverage (UHC), is provided at the district level and delivered through linkages between district hospitals, health centres, maternity homes, clinics and CHPS Compounds.[7]

[5]This level of care is an extension of tertiary care with advanced levels of medicine which are highly specialised and not widely accessed, and usually only offered in a very limited number of national or international centres. The University of Ghana Medical Centre is the only hospital providing such level of care in Ghana.

[6]Ministry of Health. (2021). Health Sector Medium Term Development Plan 2022-2025. P. 15 https://www.moh.gov.gh/wp-content/uploads/2022/09/HSMTDP_2022-2025.docx14.pdf

[7] MoH, 2021. Health Sector Medium Term Development Plan 2022-2025. P. 11 https://www.moh.gov.gh/wp-content/uploads/2022/09/HSMTDP_2022-2025.docx14.pdf

National Health Insurance Scheme

The implementation of the National Health Insurance Scheme (the Scheme) under the National Health Insurance Act, 2012 (Act 852) as amended is a key milestone in Ghana's efforts to achieve universal access to essential health care.

The National Health Insurance Authority (NHIA or Authority) was established with the objective to attain universal health insurance coverage in relation to all resident and visiting persons in the country and to provide access to healthcare services to the persons covered by the Scheme.

In order to achieve its object (to attain universal health insurance coverage), the NHIA has several functions, including the following:

- Implement, operate and manage the National Health Insurance Scheme;
- Register members of the National Health Insurance Scheme;
- Issue identity cards to members of the National Health Insurance Scheme;
- Ensure equity in health coverage; access by the poor to health care services; protection of the poor and vulnerable against financial risks, and grant credentials to health care providers and facilities that provide health care services to members of National Health Insurance Scheme;
- Receive, process and pay claims for services rendered by healthcare providers, and
- Ensure the efficiency and quality of services under the national and private health insurance schemes.

The NHIA has sixteen (16) Regional Offices in the sixteen (16) regions of the country which report to the Head Office through the Membership & Regional Operations Directorate and are headed by Deputy Directors. The Regional Offices supervise the operations of District Offices in the respective regions.

The Authority has a total of 166 district offices and five (5) registration centers[8] (as of the time of the research) that report to the Membership & Regional Operations Directorate through the Regional offices and are headed by Managers. Registration of members and renewal of membership of the Scheme are done at the district offices.[9]

The NHIA has a 17-member Board representing the Ministry of Health, Ghana Health Service, National Insurance Commission and the Ministry of Finance. Others are the Office of Attorney General and Ministry of Justice, Social Security & National Insurance Trust (SSNIT), Medical & Dental Council, Pharmacy Council, Organised Labour, Accountancy Profession, Legal Profession, two Health Professionals with expertise in health insurance and two members [subscribers] of the Scheme.

Management of the Authority is decentralised to the regional and district levels to ensure accountability and transparency. In other words, some of the functions of the NHIA in terms of managing the Scheme, are being

[8] One (1) each in Tamale, Kumasi, Cape Coast and 2 in Accra.

[9] https://www.nhis.gov.gh/districts

implemented not only at the NHIA headquarters but also at the regional and district offices of the Authority.

The Chief Executive, who is answerable to the Board, is responsible for the day-to-day administration of the affairs of the Authority. The regional offices are headed by Regional Directors while the district offices are managed by District Managers.[10]

The Finance and Investment Committee has oversight responsibility for the management of the National Health Insurance Fund (Fund) established for the purposes of paying for the healthcare costs of members of the Scheme, among others.

The National Health Insurance Oversight Committee advises the Board on systems for both the registration of members into the Scheme and for the identification and enrolment of disadvantaged groups into the Scheme[11]; benefit package for the Scheme; tariffs payable to healthcare providers; systems for credentialing health service providers, among others.

The Private Health Insurance Oversight Committee advises the Board on the registration and licensing of private health insurance schemes and compliance of private health insurance schemes, among others.

The sources of money for the Fund include the following: the National Health Insurance Levy (charged at the rate of two- and one-half percent calculated on [all] goods and services made or provided in Ghana); and two- and one-half percentage points of each person's mandatory contribution to the Basic National Social Security Scheme and moneys that are approved for the Fund by Parliament.

Other sources of money for the Fund are from investments made by the Authority; grants, donations, gifts and any other voluntary contributions made to the Fund; fees charged by the Authority in the performance of its functions. Another source of funding for the Scheme are moneys accruing under the Insurance Act, 2021 (Act 1061), which mandates the payment of a percentage of the emergency motor insurance premium paid by insurers to cover the cost of emergency treatment of road crash victims. From 2021-2024, the NHIA was allocated, on average, GH¢150,932,732, equivalent to about USD 12, 270,953.80 at an exchange rate of 12.3 cedis to the 1 US Dollar[12].

The Fund is used to pay for members' cost for health care, among others, based on the Ghana Diagnostic Related Groupings (G-DRGs), a reimbursement mechanism developed by the Authority, and the medicine tariff list.[13] The G-DRGs are standard groupings of diseases that are clinically similar, have comparable

[10] National Health Insurance Authority. (2018) Annual Report, 2018

[11] The Ministry of Gender, Children and Social Protection also provides guidance as to who constitute disadvantaged groups, particularly the poor.

[12] Extracted from the Budget Statements and Economic Policy of the Government of Ghana for the 2021-2024 financial years. The 2024 budget was presented in 2023.

[13] Huihui Wang, Nathaniel Otto, Lydia Dsane-Selby. (2017). Ghana Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review.

treatments or operations, and use similar healthcare resources.

Membership of the Scheme is open to all residents of Ghana upon subscription to the Scheme. However, some persons are exempted from paying the subscription and they include pregnant women, indigents, persons with mental disorders, contributors and pensioners under the Social Security and National Insurance Trust (SSNIT) and the elderly (persons above seventy years of age). The Ministers responsible for Health and Gender, Children and Social Welfare provide directions on the determination of the category of persons to be exempted.

Many are of the view that the exemption policy is a "blanket" one, and that, it is not target-specific enough so as to ensure that those who really need the services of the Scheme do get it. It also calls into question the issue of equity, which is a real challenge regionally-speaking between the North and the South, and rural and urban Ghana.[14] An example in point is that once a woman is pregnant - whether the woman is a wealthy person or not - is exempted in the same manner as a poor pregnant woman. Similarly, all children - be they children of the rich or the poor, are exempted.

The blanket exemption, it is argued, goes against the main objective of the Scheme which is to make healthcare affordable to all by removing out of pocket payment at the point of service, and to achieve equity of access based on need, rather than ability to pay.[15] Therefore, given the percentage (only 5.6% as of 2020), of active members of the Scheme considered as the extremely poor (Indigents), the Scheme which was intended to be a pro-poor initiative, is not the case in reality. The richest are more likely to be covered and are thus more likely to benefit from the Scheme "...*while the poor are less likely to be covered, exposing them to possible financial hardships associated with having to make out-of-pocket payments for healthcare."*[16] Based on this finding, a conclusion is drawn that ***"...****attaining UHC* [Universal Health Coverage] *in Ghana in its true sense will take nearly six decades to happen in 2076"*[17]

The Scheme offers a benefits package to its members covering both inpatient and outpatient services of all common illnesses in Ghana. The benefits package also include ancillary services such as physiotherapy and catering, healthcare specialised areas such as child health

[14]Adam Fuseini, (2016). The Politico-Economic Challenges of Ghana's National Health Insurance Scheme Implementation//International Journal of Health Policy and Management, 2016, 5(9), 543-552

[15] Adam Fuseini, 2016. The Politico-Economic Challenges of Ghana's National Health Insurance Scheme Implementation//International Journal of Health Policy and Management, 2016, 5(9), 543-552

[16] Fidelia A.A. Dake. (2018) Examining equity in health insurance coverage: an analysis of Ghana's National Health Insurance Scheme (*Abstract) IN: International Journal for Equity in Health (2018) 17:85* *https://doi.org/10.1186/s12939-018-0793-1*
Fidelia A.A. Dake. (2018) Examining equity in health insurance coverage: an analysis of Ghana's National Health Insurance Scheme (*Abstract) IN: International Journal for Equity in Health (2018) 17:85* *https://doi.org/10.1186/s12939-018-0793-1*, p. 9

[17] Ibid, p. 10

(Paediatrics), general adult surgery, paediatric surgery, Ear, Nose and Throat, orthopaedics, accidents and emergencies, general (Adult) medicine, maternal services, gynaecology and Eye Care. The others are surgical operations, medical diagnostic and therapeutic procedures, costs of equipment and consumables used to administer drugs such as syringes, syringe pump, infusion burettes, needles and cannula.

Services not covered under the Scheme include direct, indirect and overhead costs of pharmacy and patient transport services, such as ambulance transport from one facility to another on referral.

With regard to the number of persons on the Scheme, there are 16.75 million active members, amounting to approximately 54% of Ghana's population as at the end of 2021[18].

Of this number of active members, people working in the informal sector constitutes 34.1%. Members who are considered as the extremely poor (Indigents), as classified by the Minister for Gender, Children and Social Protection, represent 5.6%, active female members constitute 58.6% while males make up 41.4%.[19]

As already indicated, a key function of the NHIA is to receive, process and pay claims for services rendered by healthcare providers. Therefore, the NHIA enters into purchase agreements with health care service providers (providers) to provide services to its members for reimbursement through an accreditation system for both public and private health facilities. As of the time of this report, there were about 4,385 accredited or credentialed health care providers under the Scheme. Of this number, 68% are government or public healthcare facilities and 25% are private healthcare facilities and the remaining 7% are Mission and Quasi-public facilities.[20]

A claim by a provider credentialled under the Scheme for reimbursement, should ordinarily be filed at/through the District Office of the NHIA/Scheme within sixty (60) calendar days from the date of the discharge of the patient/client or the rendering of the service. The client, an NHIS member, should pay no out-of-pocket costs for the services or pharmaceuticals.

Providers are reimbursed only for the services they provide which they are credentialled to perform for their level of care. The claim by the provider has to be

[18] National Health Insurance Authority. (2022). NHIA clarifies issues raised by the Ranking Member on the Parliamentary Select Committee on Health: https://www.nhis.gov.gh/News/nhia-clarifies-issues-raised-by-the-ranking-member-on-the-parliamentary-select-committee-on-health-5391#:~:text=5%20billion%20to%20providers%20for,at%20the%20end%20of%202021.

[19] National Health Insurance Authority (2020). NHIS Active Membership Soars. https://www.nhis.gov.gh/News/nhis-active-membership-soars-5282

[20] National Health Insurance Authority (2018). 2018 Annual Report, Accra-Ghana.

documented on a prescribed claims form (a cost sheet of the DRG, the medication provided and all the diagnostics/ laboratory investigations done for the client), and the cost of the service is calculated based on tariffs approved by the NHIA.[21] The claim shall be paid by the Scheme within four (4) weeks after the receipt of the claim from the health care facility if there are no legal impediments preventing the payment of the claim. Where queries are raised on the claim, they are addressed by a joint committee comprising officials of both the Scheme and the provider[22].

In the resolution of queries of providers against the Scheme by the joint Committee of providers and the scheme, Observers are of the view that the participation of officials of the Scheme, is akin to being a judge in its own cause and that could lead as abuse of office and bribery.[23]

The claims management process at the Scheme begins from the point where a provider, after preparing its claim, submits it to the Scheme for reimbursement. The claim is submitted either electronically or via paper forms. On average, the NHIA processes 2.4 million claims each month.[24]

Informal sector workers receive the largest share of benefits relative to their share in total membership, while indigent individuals receive the smallest share, as they are more likely to seek health services at less expensive facilities. Indigent individuals also have the lowest cost per claim, while Social Security and National Insurance Trust (SSNIT) members have the highest as they often seek care at more expensive facilities.

A review of the literature indicates that, after receiving the claims (or bill) from a Provider for reimbursement by the Scheme, the claim is vetted against approved tariffs and adherence to approved standards and protocols. The Claims Manager may then recommend an approved claim [if the claim is manually processed] to the Scheme Manager of the district for payment, usually with a cheque.[25] The various steps in the process are i) Claims submitted by Provider, ii) Claims Received by Scheme and acknowledged, iii) fulfilment and reconciliation; iv) vetting; v) data entry; vi vetting report generation, vii) approval and payment request initiation.[26]

[21] S. Sodzi-Tettey1, M. Aikins, J. K. Awoonor-Williams, I. A. Agyepong. (2012). Challenges in Provider Payment under the Ghana National Health Insurance Scheme: A Case Study of Claims Management in Two Districts.

[22] S. Sodzi-Tettey, M. Aikins J. K. Awoonor-Williams, I. A. Agyepong. 2012. Challenges in Provider Payment under the Ghana National Health Insurance Scheme: A Case Study of Claims Management in Two Districts. *Volume 46, Number 4, Ghana Medical Journal.*

[23] This was the view of Stakeholders documented by the GII on the draft report.

[24] National Health Insurance Authority (2018). 2018 Annual Report, Accra-Ghana

[25] S. Sodzi-Tettey, M. Aikins, J. K. Awoonor-Williams, I. A. Agyepong. (2012). Challenges in Provider Payment under the Ghana National Health Insurance Scheme: A Case Study of Claims Management in Two Districts.

[26] Huihui Wang, Nathaniel Otto, Lydia Dsane-Selby, 2017. Ghana Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review, and S. Sodzi-Tettey et all (footnote 29)

The NHIA introduced an electronic claims processing system (e-claims) in 2017 and has so far opened five (5) claims processing centres for the entire country including two (2) centres in Accra where claims are submitted and processed electronically.[27] This system operates alongside the manual process.

Understanding Corruption

While there are many different understandings of corruption, it is unanimously recognised as a global problem that poses a threat to corruption to the stability and security of societies, and how it undermines institutions, democracy, ethical values and justice and jeopardises sustainable development and the rule of law[28].

For the purposes of this study, corruption is understood as the "abuse of entrusted office for private gain."[29] So defined, corruption takes several forms including bribery, embezzlement, misappropriation, extortion, sextortion, trading in influence, abuse of office/power, illicit enrichment, conflict of interest and nepotism.

No sector is immune from corruption, which is widespread and occurs in both the private and public spheres. In the public sector, there is a continual risk that public officials, by virtue of their positions as fiduciaries of the people, abuse the discretionary power entrusted to them for personal gain and at the expense of the State.[30]

Corruption in all its forms is costly. Corruption affects economic growth, the level of GDP per capita, investment activity and its efficiency especially in the health and education sectors. Corruption denies access to quality services for the poor and marginalized, weakens the effective distribution of wealth and income, and has the potential of magnifying child mortality in society.[31] Corruption impedes, among others, women's access to justice and adequate health services, including sexual and reproductive health services, as well as economic and social benefits. It exacerbates pre-existing gender inequalities and has a disparate *"…impact on women, children, migrants, and other equity-seeking groups such as persons with disability and other vulnerable groups.*[32]

A Public Expenditure Tracking Survey (PETS) conducted in 2000 indicated that there were large-scale leakages of 80% funds in the health care sector alone in Ghana.[33] A similar study by Send Foundation Ghana on the National Health Insurance Scheme (NHIS) covering the period 2004-2008, revealed "…*widespread*

[27] Huihui Wang, Nathaniel Otto, Lydia Dsane-Selby, 2017. Ghana Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review

[28] United Nations. (2003). General Assembly resolution 58/4 of 31 October 2003

[29] Transparency International. (2019). What Is Corruption? https://www.transparency.org/what-is-corruption.

[30] Republic of Ghana. (2011). National Anti-Corruption Action Plan (NACAP)-2015-2024, p. 20

[31] Corruption Watch Ghana (2021), NGO Launches Initiative to Fight Corruption in the Health Sector. https://corruptionwatchghana.org/2021/02/08/ngo-launches-initiative-to-fight-corruption-in-health-sector/#:~:text=Corruption%20denies%20access%20to%20quality,magnifying%20child%20mortality%20in%20society.

[32] Republic of Ghana. (2011). National Anti-Corruption Action Plan (NACAP)-2015-2024

[33] Ministry of Finance and Economic Planning. (2007). Public Expenditure Survey in Health and Education

abuses including cheating, over-invoicing by some service providers, fraud, irrational prescriptions by health professionals, and outright impersonation".[34] Studies of this nature have not been repeated in the past 15 years, meaning there is a research gap in terms of the level and risk of corruption in the health sector in Ghana.

Corruption in the Health Sector [from the literature]

As already indicated, the health sector in Ghana, just as in many other countries, is broad, complex and fragmented. In addition, there is information asymmetry within the sector, which make it also altogether vulnerable to corruption.[35]

The following forms of corruption are among those most relevant in the health sector globally from the literature reviewed: bribery (such as informal payments for receiving treatments); embezzlement (that is, diverting hospital funds under the person's control to private accounts); misappropriation (diverting funds meant for health care services for private profit); conflict of interest (where a medical officer refers patients to other health care providers in which she/he has a personal or financial interest); trading in influence (a person receives a favour to use his/her influence over health sector officials).[36]

Other forms are petty thievery (stealing of monies and office supplies) and diversion of supplies by public officers, generally referred to as quiet corruption,[37] 'ghost workers[38]' or padding of salaries; nepotism and favouritism; fraud; and the production and distribution of counterfeit drugs.[39]

The healthcare sector in Ghana is affected by corruption. In a recently released report on corruption in Ghana, 25.9 per cent of 14,842 survey respondents who had at least, one contact with a public official in the previous 12 months, paid at least one bribe, or were asked to pay a bribe, in the same period. Police officers constituted 53.2 per cent of these cases; in comparison to *doctors, nurses and midwives* which constituted 7.9 per cent, whilst the other health workers in public hospitals constituted 3.3. per cent. In terms of health care professionals in private healthcare institutions, the bribery prevalence rate for other workers was 7.6 per cent, surpassing their colleagues in the public health care facilities.[40] The report also found that on average, these public health care officials were paid bribes between GHC 91.00 and GHC253.00 in

[34] This study is cited in "Republic of Ghana. (2011). National Anti-Corruption Action Plan (NACAP)-2015-2024" at p.19, but the reference is not included therein.

[35] Tilman Hoppe, 2018. Checklists on Corruption Risks in the Healthcare Sector

[36] Ibid

[37] The World Bank (2010) Africa Development Indicators: Silent and Lethal, How Quiet Corruption Undermines Africa's Development Efforts. There has not been any other studies of this nature since.

[38] A "Ghost worker" is someone who has been recorded on the payroll system but who does not actually work for the institution or organisation. The act is also sometimes referred to as "padding of salaries"

[39] Obinna Onwujekwe, Prince Agwu, et al. (2018). Corruption in the health sector in Anglophone West Africa: Common forms of corruption and mitigation strategies. P. 11

[40] United Nations Office on Drugs and Crime. (2022). Corruption in Ghana: Peoples' Experiences and Views, 2022

2021.[41] Of these amounts, about 50.9 % constituted bribes that were directly requested by the health officials. Earlier studies reveal that there were large-scale leakages of up to 80% of funds in the health care sector in Ghana in 2000.[42]

In terms of health insurance schemes, the evidence indicates the sector is vulnerable to a number of corrupt practices. The overly complex benefit systems of health insurance may introduce vulnerabilities to fraud and corruption such as users being charged for services that are in fact covered by health insurance. For example, in Ghana, treatment for HIV/AIDS is not covered by the insurance scheme, but AIDS-related infection treatments are covered; orthopaedic treatments are not covered, unless resulting from a road traffic accident; and it is unclear which hospital services are covered for new-borns.[43]

The "occurrence of *"upcoding", (*a practice whereby providers bill for more expensive services than those actually performed, billing for services that are performed but unnecessary, the occurrence of kickbacks from patients to health personnel), have been highlighted in the literature as some of the corrupt practices.[44] Furthermore, "*duplicate billing (billing twice for the same procedure), unbundling (billing for separate services, although an inclusive code*[45] *is available) and billing for procedures that are not medically necessary,"*[46] are other examples of corruption.

Fraud has been identified as a basic [or fundamental] problem, notably, pharmacists making fraudulent claims for payment of products covered by the scheme, or members of the public attempting to procure free health services that they are not qualified to receive.[47]

In terms of Ghana's National Health Insurance Scheme, the following are some of the identified corrupt and related practices in the literature: illegal charges for services rendered in relation to accessing health facilities with the Scheme,[48] over-invoicing by some service providers, fraud, outright impersonation,[49] and the use of short cuts driven by corruption.[50]

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[41] Ibid

[42] Ministry of Finance and Economic Planning (2007). Public Expenditure Survey in Health and Education, Accra-Ghana

[43] Braimah K.B, Mensah J, 2013. Ghana's National Health Insurance Scheme: Insights from Members, Administrators and Health Care Providers In: Journal of Health Care for the Poor and Underserved, Vol. 24, Number 3, August 2013

[44] World Health Organisation (2020). Potential Risks in Health Financing Arrangements-Report of a Rapid Review of the Literature, p. 20

[45] "Inclusive coding" refers to a practice of combining two or more related services or procedures into a single code. This is done when one service is considered a component or integral part of another and is done to avoid double billing for overlapping services that are typically performed together.

[46] World Health Organisation (2020). Potential Risks in Health Financing Arrangements-Report of a Rapid Review of the Literature, p. 20

[47] Braimah K.B, Mensah J, 2013. Ghana's National Health Insurance Scheme: Insights from Members, Administrators and Health Care Providers In: Journal of Health Care for the Poor and Underserved, Vol. 24, Number 3, August 2013

[48] GII Consortium, 2018. Cost and Impact of Corruption on Education and Health Sectors in Ghana

[49] Daniel Dramani Kipo-Sunyehzi, 2021. Quality healthcare services under National Health Insurance Scheme in Ghana: perspectives from health policy implementers and beneficiaries

[50] Adam Fuseini, 2016. The Politico-Economic Challenges of Ghana's National Health Insurance Scheme Implementation//International Journal of Health Policy and Management, 2016, 5(9), 543-552

According to the literature, corruption in the health sector [in general] is driven by a number of factors including health patients' belief that one cannot secure quality healthcare unless he/she is known to service providers,[51] the lack of work incentives for frontline service providers and their managers, such as timely payment of salaries, in-service trainings and opportunities for promotion.[52] In addition, lack of transparency and accountability in health facilities operations, shortages of essential drugs, which then is rationalised to extort money from patients who are in dire need of such medication[53] are some of the drivers.

Corruption also limits the ability of countries to implement universal health coverage.[54] According to TI, the annual amount of healthcare funds globally which is stolen each year is more than enough to achieve Universal Health Coverage for all, a key commitment of the UN's Sustainable Development Goals, which seeks to provide affordable, accessible and quality healthcare for everyone and that of the US$7.5 trillion spent globally on health each year, US$500 billion is lost to corruption.[55]

Vulnerable Groups: Corruption in the health sector is a significant threat to public health delivery. It amplifies resource and performance challenges for public health facilities that can increase health care costs while decreasing their effectiveness, quality and volume. It can also create barriers to health care services and products, above all, for poor and marginalized populations.[56]

Studies illuminate how corruption impacts the most vulnerable patients regardless of country. Evidence indicates that individuals who are in poor health (that is, those patients who are very sick, e.g., suffering chronic illness)[57] are more likely to make informal payments or bribes, than those in better health. Data from sub-Saharan Africa suggests that individuals who reported paying bribes for health-related services were 4 to 9 times more likely to also report difficulty accessing health care.[58]

Other studies suggest that most victims of corruption in the health sector are poor uneducated patients in rural areas who are compelled to make informal payments so that they can access healthcare.[59] Besides the poor and uneducated patients, other patients provide bribes in return for certain 'favours' such as jumping

[51] Ibid.

[52] Onwujekwe et al., 2010. Willingness to pay for community-based health insurance in Nigeria: do economic status and place of residence matter?

[53] Obinna Onwujekwe, Prince Agwu, et al. 2018. Corruption in the health sector in Anglophone West Africa: Common forms of corruption and mitigation strategies.

[54] World Health Organisation. (2020). Potential corruption risks in health financing arrangements: Report of a rapid review of the literature.

[55] World Health Organisation. (2020). Potential corruption risks in health financing arrangements: Report of a rapid review of the literature.

[56] Transparency International. No date. Health and Corruption. https://www.transparency.org/en/our-priorities/health-and-corruption

[57] Emily H. Glynn, 2022. Corruption in the health sector: A problem in need of a systems-thinking approach. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9449116/, see also Habibov N, Cheung A. Revisiting informal payments in 29 transitional countries: the scale and socio-economic correlates. *Soc Sci Med*. (2017) 178:28–37. 10.1016/j.socscimed.2017.02.003 (see 2.3.4.-Heatlh Status)

[58] Emily H. Glynn, 2022. Corruption in the health sector: A problem in need of a systems-thinking approach. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9449116/

[59] Agbenorku (2012), Corruption in Ghanaian Healthcare System: The Consequences

queues and obtaining medication that is ordinarily free, quickly.[60]

The informal payments demanded of the poor for health care can reduce their access to those services when they cannot afford such fees, and can undermine the delivery of care and exacerbate health inequities.[61] These payments also increase health care costs while decreasing their effectiveness, quality and volume.[62]

As already indicated elsewhere in this report, the membership of the Scheme, though is open to all residents of Ghana upon paying a subscription fee, the vulnerable (pregnant women, women or girls, indigents, persons with mental disorder, the elderly (persons above seventy years of age) and persons working in the informal sector, together, constitute the largest membership of the Scheme. And therefore, rely on the Scheme to access health services covering about 95% of all common illnesses in Ghana, including Malaria, acute respiratory tract infection, diarrheal disease, skin disease and ulcers, hypertension, hernia repairs surgical operations, and medication on the Scheme drug list.

[60] Obinna Onwujekwe, Prince Agwu, et al. 2018. Corruption in the health sector in Anglophone West Africa: Common forms of corruption and mitigation strategies.

[61] Dovlo, D. (1998). Health sector reform and deployment, training and motivation of human resources towards equity in health care: Issues and concerns in Ghana. Human Resources for Health Development Journal, 2(1), 34-47

[62] Transparency International. No date. Health and Corruption. https://www.transparency.org/en/our-priorities/health-and-corruption

What is a Corruption Risk Assessment

A corruption risk assessment (CRA) can broadly be defined as the analysis and study of the likelihood and impact of specific corrupt acts for the purpose of mitigating them. It focuses on the potential for – rather than the perception, existence or extent of corruption.[63]

The CRA, a diagnostic tool, involves identifying the potential opportunities for corruption within a system, and evaluating how likely it is to occur as well as the impact it would have. By that, the organisation or sector undertaking the CRA is then able to put preventative measures in place and implement anti-corruption strategies.[64]

A corruption risk, therefore, is the potential for an offence of corruption to occur and requires proactive measures to address the risks, unlike corruption which refers to an offence that has already occurred and requires reactive measures to address it[65].

Corruption may or may not exist in the NHIS or the health sector, but the risk of it occurring always exists. This risk can grow and its devastating effects on the vulnerable population become even more evident in

[63] UNDP, 2018. Conceptual Framework Corruption Risk Assessment at Sectoral Level, UNDP. June 2018, New York, NY, 10017 USA. P.10.

[64] Corruption Risk Assessment, https://www.cipfa.org/services/cipfa-solutions/fraud-and-corruption/preventing-corruption-a-compendium-of-global-case-studies/corruption-risk-assessment#:~:text=This%20involves%20identifying%20the%20potential,and%20implement%20anti%2Dcorruption%20strategies.

[65] United Nations Office on Drugs and Crime. (2020). State of Integrity- A Guide on Conducting Corruption Risk Assessments in Public Organizations. United Nations, Vienna.

times of health crises[66] such as the COVID-19 pandemic.

It is therefore important to address and manage corruption risks in the health sector for a good number of reasons, i) to support Ghana efforts to attain Sustainable Development Goal (SDGs) goal 3-*"Ensure healthy lives and promote well-being*", such as Universal Health Coverage (UHC), and SDG goal 16 to "*promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels*", particularly with regard to its focus on reducing bribery and corruption, and developing effective, accountable and transparent institutions at all levels. Addressing and managing corruption risks also has the potential to increase transparency and efficiency in the health sector[67].

[66] United Nations Office on Drugs and Crime (2021). Speak Up for Health! - Guidelines to enable Whistle-Blower Protection in the Health Care Sector. UNODC, Vienna, 2021

[67] Ibid

METHODOLOGY

This section describes the methodology used to gather the evidence required to conduct the corruption risk assessment.

Research Design

The corruption risk assessment methodology implemented by the ISDA project is informed by a conceptual framework document titled *"Conceptual Framework-Managing Risks to Corruption at Sectoral Level" -2018 (Draft) by (UNDP)*. As of the time of writing, this document is still under development and is not yet published. UNDP has given permission to the ISDA project team to use the document.

That approach, in sum, comprises the following:

i. *Establishment of context:* defining the scope of the risk management process; setting criteria against which risks will be assessed; consideration of the overall objectives that can be affected by risks);
ii. *Risk assessment:* (identification of risks; analysis the "likelihood" of the risk occurring and "impact"; evaluation of results through convening the respective outcomes in a risk heat mapping exercise to visualize results and better prioritize further actions);
iii. *Risk treatments*: (focuses on concrete measures for mitigating the assessed risks into a mitigation plan for implementation);
iv. *Monitoring and review* (monitoring of the success of the mitigation measures), and
v. *Communication and consultation:* (sharing results with stakeholder arena to ensure transparency and support and general feedback)

We reviewed available relevant literature on the subject, including the legislative framework of the NHIS/NHIA, such as the National Health Insurance Act, 2012 (Act 852) as amended, and the National Health Insurance Regulations, 2004 (L.I, 1809), the main legal framework regulating the operations of the NHIS and the NHIA, among others. This was used to obtain a preliminary mapping of identified decision points and the potential actors.

Semi-structured interview questionnaires were used for key informants, whilst interview guides (open-ended questions) were used for focus group discussions. The interview questionnaires and guides were structured so as to enable a review of the preliminarily mapping, seek explanation and experiences of the respondents on the decision points in the operations of NHIA regarding claims management and provider payment, and management and supervision.

Sampling & Size

A total of forty-five (45) respondents were purposively selected in each of the six (6)

districts of the three (3) regions of Ghana, namely, Greater Accra, Central and Upper East, reflecting urban, peri-urban and rural mix, making a total target of 270. The districts were selected from a sample frame of ISDA project districts in Ghana, and are the following:

- Ayawaso Municipal and Ada East in the Greater Accra Region;
- Cape Coast Municipal and Upper Denkyira East in the Central Region, and
- Kassena Nankana West and Kassena Nankana Municipal in the Upper East Region.

The purposive sampling procedure allowed the research team to select respondents who are more appropriate for the Assessment as well as the members of the Scheme and persons directly involved in the implementation of NHIS. It was also considered most suitable in light of the project timeframe.

The respondents included medical officers, nurses, finance officers or claims officer of a hospital/Clinic, medical personnel of Community Health Planning and Services (CHPS Compounds), Medical Laboratory personnel, Pharmacist/Chemical Shop operators, District Superintendents/Directors, claims officers of the Ghana Health Service (GHS).

Public officials have experiences in or reports of corrupt and other related conduct in the operations of the DMHIS in provider payments, claims management and how the DMHIS conduct monitoring activities to ensure subscribers have good quality health services and the impact of the challenges on access to health services for vulnerable groups. They equally have experience on how to address challenges and improve provider payments and claims management challenges encountered in the process. As such, the rest of the respondents were public officers selected from the Ghana Education Service, the Commission on Human Rights and Administrative justice, Audit Service, Metropolitan, Municipal and District Assemblies.

Civil Society Organisations (CSOs), especially those working in the health sector, Teacher Unions, Vulnerable Groups, Students, the Association of Persons with Disabilities and opinion leaders, were also selected as respondents.

At the end of the data collection period, 188 key informant respondents and six (6) focus group discussions consisting of 10 respondents per each group were recorded. The key informants include NHIS personnel (19.4%), staff of Service Providers (70.6%), and Public Officers/CSOs /Vulnerable groups/ opinion leaders (82.6%) from the six districts covered in this study. Thus, representing an overall response rate of 69.6% in terms of the target sample. (see Table 1).

Table 1: Respondent Groups

Category of Respondents	Targeted	Achieved	%
District Mutual Health Officials-NHIA	36	7	19.4
Health Services Providers	102	72	70.6
Public Officers/ Civil Society Organisations/ Vulnerable Groups/ Opinion Leaders	132	109	82.6
Total	**270**	**188**	**69.6**

Data Collection

As already indicated, semi-structured interview questionnaires were used for key informants whilst interview guides (open-ended questions) were used for focus group discussions. Six (6) university graduates with considerable public service experience and in conducting qualitative interviews were recruited and trained for data collection for a day on the purpose and objectives of the study, pre-test of the data collection tools as well as the responsibilities of data collectors in the study.

Tools for focus group discussions (FGDs) and key informants (KIs) were administered through Google Forms.

All recorded interviews with KIIs and FGDs were transcribed verbatim for the analysis. The thematic approach was employed in the analysis where themes and sub-themes were developed around patterns of responses that enabled organizing, describing, and explaining the data for easy interpretation and discussion. For confidentiality and anonymity, the personal details of the interviewees such as names and contact details, were omitted.

The data collection begun on 11th September 2023 and ended on 31st October 2023. The research team had attempted to obtain an introductory/consent letter from the NHIA Head Quarters to enable officers of the District Mutual Health Insurance Scheme (DMHIS) to participate in the key informant interviews. Despite several requests, meetings and calls to the CEO of the NHIA, this letter was not obtained from the NHIA and in January 2024, the GII advised to end data collection and proceed with the next phase of data analysis.

Validation of Findings

The GII and TI Teams reviewed the draft report and their input was considered in preparing the final draft report for validation and stakeholder meetings. Subsequently, the GII organised a validation meeting in Accra for participants of the survey. The input of the participants was then taken into consideration in preparing the final report.

Data Analysis and Reporting.

The literature review enabled the research team to establish the context and map the corruption risks as well as identify preliminary decision points and the actors to obtain new information and seek explanation and experiences of the respondents on the decision points. The results were then analysed applying the corruption risk assessment methodology put forward in a UNDP conceptual framework document titled,

"Conceptual Framework-Managing Risks to Corruption at Sectoral Level" -2018 (Draft) by (UNDP).

This methodology involves the following steps:

1. Identify areas of focus (decision areas) within the NHIA, which is a key area of service delivery to be assessed.
2. Identify key operational processes within this area of focus (decision areas) and generate the decision points (DPs) within decision areas (i.e., the exact points/junctures within each sphere of responsibility where respective actors have to make choices) at which a "deviated decision" resulting from a corrupt act, can occur as well the potential actors in relation to each decision point.
3. Based on the decision points mapped out, identify the corruption risks likely to occur under each of the DPs. These corruption risks involve the forms of corruption that may occur as a result or consequence of a deviation (risk) under a DP.
4. Considering the various corruption risks identified for the decision point, a risk score is calculated for each decision point. The risk score is calculated as a combination of two scores: the likelihood and impact of the corruption risk(s) occurring. These scores are calculated on a 1-5 scale (where 1 represents very low and 5 represents very high).

   The likelihood score is calculated based on the available evidence that indicates how frequently corruption risks manifest at the decision point. The impact score is calculated based on a mixture of available evidence and hypothesising as to what would be the severity of the impact on the access to health (especially for women, girls and groups at risk of discrimination), were corruption risks to manifest at this decision point. These scores represent the opinions of the research team but are based on evidence collected from during the study.
5. The results are then evaluated through convening the respective outcomes in a risk heat mapping exercise to visualize results and determine areas that require a priority action to mitigate or treat the risk.

6. A mitigation strategy is designed to eliminate or reduce the corruption risks identified for the DPs as well as their impact. This is conveyed into a mitigation plan for implementation with indicators, responsible persons and timeframe, where possible. The mitigation plan with measurable indicators allows for monitoring of the success of implementation of the mitigation measures on a continuous basis.

Limitations

The assessment encountered a significant setback as the authorities of the NHIA at its Headquarters could not provide clearance for the participation of their officers in the assessment, and in light of the need to proceed with the study, the GII advised that the Assessment report be prepared using the available data.

Furthermore, while some respondents failed to respond to the questionnaires despite having initially agreed to participate, other respondents did not know the operations of the NHIA and thus, could not confirm the internal processes at the NHIA or mention the forms of corruption that may occur. Another group of respondents were hesitant in providing information on the nature and the likelihood of corruption in the NHIA processes.

To mitigate the impact of the non-cooperation and the hesitancy of some of the respondents, we relied on data provided by the focus group discussions which targeted key players in the sector as well as additional anonymous engagements with some officials of the DMHIS, among others, which enabled us to have a more balanced appreciation of the matters under investigation.

DESCRIPTION OF RESULTS

This section describes some of the main findings of the **primary research undertaken for this study.**

District Profiles

Ayawaso Central Municipality: Ayawaso Central Municipal District is one of the twenty-nine districts in the Greater Accra Region. It was carved from the Accra Metropolitan Assembly in February 2019 with Kokomlemle as its capital town. One of the key challenges in the Municipality is inadequate health infrastructure.[68] The Municipality has five (5) private hospitals, four clinics and one (1) public polyclinic, which serve the people and the surrounding areas in the Municipality. The Ministry of Finance, in the Composite Budget For 2024-2027 (Programme Based Budget Estimates For 2021 Ayawaso Central Municipal Assembly, identifies the only Polyclinic in the municipality as under resourced.[69] The Scheme has no office in the Municipality. Therefore, subscribers or members of the Scheme in the Municipality use NHIA/DMHIS offices of other districts.

Ada East District: Ada East District is one of the twenty-nine districts in Greater Accra Region, Ghana, formerly part of the then-larger Dangme East District. The district assembly is located in the eastern part of Greater Accra Region and has Ada Foah as its capital town. The district has one Hospital, a Clinic, 1 Health Centre and 1 Health Post as well as eight (8) functional CHPS Compounds[70]and a DMHIS office.

The Draft Medium Term Development Plan of Ada East District specified the health sector in the district as needing improvement. [71]

Cape Coast Metropolis: Cape Coast is the only Metropolis out of the Twenty (23) districts in the Central Region. It was established initially as a municipal Assembly in 1987 and later elevated to Metropolitan

[68] Ministry of Finance. (2024) Composite Budget For 2024-2027 (Programme Based Budget Estimates For 2021 Ayawaso Central Municipal) https://mofep.gov.gh/sites/default/files/composite-budget/2024/GR/Ayawaso_Central.pdf

[69] Ministry of Finance. (2021) Composite Budget For 2021-2024 (Programme Based Budget Estimates For 2021)

[70]Ada East District Assembly, 2018 – 2021 Draft Medium Term Development Plan: https://ndpc.gov.gh/media/GR_Ada_East_MTDP_2018-2021.pdf

[71] Ibid

status in 2007. It has a DMHIS/NHIA office, over 31 health facilities including University Hospital, Cape Coast metropolitan Hospital and a number of CHPS compounds. The Metropolis is predominantly urban with three-quarters of its population living in urban areas.

About 2.5 percent of the population of the Cape Coast have one form of disability or the other. About two out of five (42.4%) of all persons with disabilities (PWDs) 15 years and older in the Metropolis are employed whilst slightly more than half (53.1%) are economically not active.[72]

Upper Denkyira East: The Upper Denkyira East Municipal Assembly is one of the twenty-three (23) Districts of the Central Region. It was carved out of the then Upper Denkyira District. Its capital town is Dunkwa-on-Offin. The Municipality has 33 health facilities including a public hospital, two (2) private hospitals, three (3) Health Centres, two (2) clinics, and 24 CHPS Compound.

About 95.1% of the population are employed, 95.8% being males and 94.4 percent being females. About 3 percent of the males and 2.5 percent of the females are disabled, the most common form of disability being visual impairment.[73]

Kassena-Nankana West District is one of the fifteen districts in the Upper East Region, which was carved from the then Kassena-Nankana District.[74] The district has Paga as its capital town. A number of public institutions function in the district including the Ghana Health Service and the Ghana Education Service as well as public and private health facilities. It has no district health hospital, neither does it have a NHIA / DMHIS office. There are more people in rural than urban localities. 6.3 percent of the total population of the district live with disabilities, the commonest type being sight/visual disability.[75]

Kassena-Nankana Municipal Assembly also known as Navrongo Municipal, was originally called the Kassena-Nankana East District and later elevated to municipal assembly status 2012 to become Kassena-Nankana Municipal District. The district has quite a number of health facilities: the War Memorial Hospital, which serves as the Municipal Hospital and a referral centre to the other health facilities; two (2) Health Centres, 17 functional CHPs compounds, a Health Research Centre, a Private Clinic and a Health Post operated by the Catholic Mission. The municipality, which has a Municipal Mutual Health Insurance Scheme office, is mostly rural and has a youthful population. Most of the people of 65 years and over are widowed.[76]

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[72] Ghana Statistical Service, (2014). 2010 Population and Hosing Census District Analytical report-Cape Coast Municipality. https://www2.statsghana.gov.gh/docfiles/2010_District_Report/Central/Cape%20Coast.pdf

[73] Ghana Statistical Service, (2014). 2010 Population and Hosing Census District Analytical report-Upper Denkyira East Municipality https://www2.statsghana.gov.gh/docfiles/2010_District_Report/Central/UPPER%20DENKYIRA%20EAST.pdf

[74] https://en.wikipedia.org/wiki/Ada_East_District#cite_note-1

[75] Ghana Statistical Service, (2014). 2010 Population and Hosing Census District Analytical report-Kassena Nankana West District, p. 70: https://www2.statsghana.gov.gh/docfiles/2010_District_Report/Upper%20East/Kasena%20Nankana%20West.pdf

[76] Ghana Statistical Service, (2014). 2010 Population and Hosing Census District Analytical report-Kassena Nankana East: https://www2.statsghana.gov.gh/docfiles/2010_District_Report/Upper%20East/KASENA%20NANKANA%20EAST.pdf

CLAIMS MANAGEMENT PROCESS

Process Mapping

The NHIA which operates the Scheme, reimburses health service providers for expenses incurred by patients (clients) who are members or subscribers of the Scheme. The process employed by the NHIA to reimburse the expenses incurred by the client begins at the NHIA from the time a service provider submits a claim to the Scheme. The client, having received health services from the provider without paying from his/her pocket, is not involved in the preparation and submission of the claim for the services the client has received from the provider. Reimbursements take place between the NHIA and the service provider.

The Scheme is to reimburse the provider within sixty (60) calendar days from the date of the discharge of the client from the provider facility or the rendering of the service to the client by the provider.

The provider has to prepare its claim on a prescribed form to the NHIA for reimbursement. When the NHIA receives the claim from the provider either electronically or manually, the claim goes through the necessary processes, namely, **acknowledgment of receipt of the claim from the provider**, **fulfilment and reconciliation** to confirm the volume (quantity or number of the claims in the particular month) and the value (cost of the total number of claims). The NHIA then **vets the claims and produces a report**. Thereafter, **approval for payment** is sought from the Chief Executive Officer[77] of the NHIA before **final payment** is made to the provider based on the Ghana Diagnostic Related Groupings (G-DRGs)[78] and the drug tariff list. The entire claims management process, as described, is the same for all the sampled districts. (see Table 2)

Table 2: Claims Management Process

DP	Process
DP 1	Submission of Claim
DP 2	Receipt and Acknowledgment of Claim
DP 3	Fulfilment and Reconciliation
DP 4	Vetting and Report Generation
DP 5	Approval and Initiation of Payment Request
DP 6	Payment of Claim

Source: Field Data Collection, 2023

DP 1: Submission of Claim: The majority (71.2%) of Key informants in the sampled districts for the CRA indicated that providers submit all their claims electronically through a software called "CLAIM-it." One respondent stated:

> " Currently all facilities after compiling their claims for the month submit them electronically through a software called "Claim- it.
>
> ***(One Respondent)***

Three (3.0%) percent of the respondents said it was done manually, while 25.8% said some Providers employ both the electronic and manual modes of the submission of claims.

DP 2: Receipt and Acknowledgment of Receipt of Claim: After the claim has been submitted online, a copy of the claim is printed

[77] The Chief Executive approves all claims for payment.

[78] Ghana Diagnostic Related Groupings is a Ghana system used to categorise patients with similar clinical diagnosis in order to better control hospital costs and determine provider reimbursement rates.

and signed by both the provider and the District Office for reconciliation purposes. The printout also serves as an acknowledgement of receipt of the claim from the Provider. According to one respondent:

> *After the online submission a copy is printed and signed by both the facility and the district office for reconciliation purpose… This makes it very unlikely for changes to reduce or increase amount submitted [online] without being noticed.*

DP 3: Fulfilment and Reconciliation: According to the respondents, with the introduction of the software called Claim-it, the processes of fulfilment and reconciliation, vetting, data entry, producing a vetting report, approval and payment, are all done electronically. The respondents did not provide any further information on how the software, CLAIM-it, works beyond the view that it represents the electronic claims processing system used at the 5 claim processing centres (CPC) for the whole country. However, a cursory look at how the system operates,[79] would reveal its elaborate nature and sophistication which requires that persons operating it should have good IT skills.

The introduction of the software also means that the role of the district office of the NHIA in the processing of claims has been limited to those submitted in paper form (manually), in addition to undertaking activities to address concerns raised during the processing of the claims.

The process of fulfilment and reconciliation entails confirmation of the volume [total number] of the claims and value [total cost] of the claim submitted by the service provider.

Key informants were of the view that the electronic platform [Claim-it] makes it easy for both NHIS and service providers to confirm the volume and value of the claims. For example, one respondent said:

> *The electronic system makes it easy for both NHIS and service providers to confirm the volume and value of claims," but fell short of explicitly explaining reasons for this.*

DP 4: Vetting and Report Generation: Respondents expressed the view that when a claim is submitted to the Scheme, a report is generated at the Claims Processing Centres electronically in the form of a claims vetting report, which may contain queries discovered in the process, such as, double entries, expired/wrong claims check codes,[80] over prescription/invoicing and unsupported receipts.

> *The claims submitted are also electronically vetted and report generated. After the report generated by that claims processing unit known as the CPC to the CEO and the directorate, payment is then made….*

Where during the processing of the claims, queries arise, a team from the District Office

[79] National Health Insurance Authority. NHIS Standardized e-claims interface for health providers' Hospital Information Systems (HIS), XML Methodology (ver. 8.6).

[80] Claims Check Code is a five-digit number that authenticates the validity of a client's card.

follows up and addresses those queries. This team comprises the District Director, Public Relations Officer (PRO) and the Accountant. Where the team is unable to resolve any queries, it refers or as the respondents put it, *"escalates"* them [meaning refers them to higher authority] for resolution.

DP 5: Approval and Initiation of Payment Request: At this stage of the process, the Claims processing officer at the CPC submits the claim electronically to the CEO (without whose approval no payment can be made to any service provider) and the Finance Directorate simultaneously for approval and payment.

DP 6: Payment of Claim: Payment of claims by the Scheme should ordinarily take no more than four (4) weeks after the receipt of the claim from the service provider. However, according to the Respondents, it is not uncommon for the Scheme to pay providers their claims after the 4-week period even where no queries exist in the claims submitted. That, instead of the 4 weeks period, it takes about 12 weeks. Respondents also stated that while service providers began receiving payments for their claims every month in the period prior to the interviews, these payments are for those claims that have been in arrears. One respondent stated that:

> *Payments are not prompt and on time. Although of late providers receive payments every month, the payments are of arrears owed them a while ago*.

According to the respondents, three (3) main modes of payment were being used: bank transfer; open and closed cheques, and cash. It has to be noted that using cash as a mode of payment can potentially facilitate embezzlement and other corrupt practices.

Respondents expressed concerns about the delays in payment, attributing the cause partly to the limited number of CPCs, which they say overburden the claims processing staff as well lack of funds, late submission of claims by providers, poor supervision, lack of capacity of relevant staff to process claims, and lack of IT equipment.

Considering the volumes of claims received monthly (2.4 million claims), the officers at the CPC[81] who undertake the vetting of claims are likely to be overwhelmed with work, which may serve as a breeding ground for corruption since the possibility for some people to influence the officers to get their claims vetted faster than expected, is high.

MANAGEMENT AND SUPERVISION

Process Mapping

Management of the NHIA is largely decentralised to the regional and district levels to ensure accountability and transparency. The Chief Executive, who is answerable to the Board of Directors of the NHIA, is responsible for the day-to-day administration of the affairs of the NHIA. The regional offices of the NHIA are headed by Regional Directors while the district offices of the NHIA are managed by District Directors.

The district offices are responsible for registration and renewal of members onto the Scheme, issuing members with NHIS cards and maintaining membership records. The districts also receive and process claims, resolve claim-

[81] From anonymous sources, officers at the CPCs are, on average, 60 per CPC. However, not all this number actually undertake claims processing.

related concerns, and conduct monitoring and evaluation (M&E) activities to assess the quality of care by providers within their districts and address claims concerns and reporting their findings to the NHIA Headquarters.

The conduct of staff of the Scheme, as members of the public services of Ghana, are subject to the Code of Conduct for public officers of Ghana, under Chapter 24 of the 1992 Constitution of Ghana,[82] which includes prohibition against conflict of interest, abuse of office and power and illegal acquisition of wealth.

DP	Process
DP 1	Assigning Staff/Team for M&E Activities
DP 2	Conducting routine M&E Activities
DP 3	Resolution of Claims-related concerns
DP 4	Preparation of reports of supervision/monitoring with Recommendations
DP 5	Implementing sanctions

DP 1: Assigning Staff/Team for Monitoring and Evaluation: Some of the respondents opined that NHIS staff are assigned to the various health service providers for monitoring and evaluation. That management may be influenced in assigning staff to those and other schedules. Whilst some key informants indicated that the districts office have the right number and caliber of staff to monitor services provided to clients of the Scheme, others said they were not so sure about that but considering that the districts have a lot of workers who always attended to them, they believe the NHIA has the staff and is capable of ensuring that the services provided to members are good.

The respondents identified two types of M&E, namely routine M&E for assessing quality health care of providers among others and M&E to address challenges bordering on claims processing as and when the need arises.

DP 2: Conducting Routine M&E Activities: A Team comprising the District Director, Public Relations Officer (PRO), Accountant and Management Information Services officer at the district are responsible for the monthly monitoring and evaluation activities at provider facilities.

The respondents maintained that the NHIA conducts its monitoring activities once every quarter (46.9 %) and in some cases, once a month (18.8%), while 21.9% of the respondents indicated that it was being done once every two (2) years. The rest (9.4%) said that monitoring was done once every six months.

Though monitoring activities are being carried out, in the majority of cases, once a every quarter, the respondents were of the view that supervision of claims management staff is ineffective. The respondents expressed various views about this:

> *Some facilities may know people within the NHIS who can visit their facilities to monitor ... while other facilities have received zero monitoring, supervision since it started. They do not visit all health facilities regularly*. [one view]

[82] The Constitution of the Republic of Ghana 1992: https://lawsghana.com/constitution/Republic/Ghana/1

In other words, it is the claim that some provider facilities have not been monitored at all, and that those that have been monitored were done selectively based on “who you know” at the NHIA.

> *Most of the monitoring is done at the Regional or district offices instead of going right down to the health care facilities*. [another view]

> *...with inadequate technology devices and training, the staff may not be able to monitor services provided to NHIS members*. [third view]

The respondents suggested that the Scheme should do diligent monitoring and supervision of all accredited health facilities frequently and provide feedback to the providers to inform and for improved their services to clients, check over invoicing and ensure adherence to laid down procedures. The NHIA should also strengthen collaboration with relevant stakeholders such as the Assemblies to do effective supervision of the service providers.

DP 3: Resolution of Claims Related Concerns: According to the respondents, the NHIA has a management team at the district level that monitors and addresses all challenges concerning the payment of claims at the district level and to “escalate” those the team is unable to address for resolution [refer to higher authority e.g. the Regional Director]. A respondent stated:

> *The district has a team made up of District Director, PRO, and Accountant. This committee [team] is to address any issues on claims payment at the providers site by the members of the scheme. Issues not resolved are also escalated for resolution*.

But in terms of the staff responsible for claims processing, the respondents were of the view that the Scheme does not have an adequate number of staff to vet and process the huge volumes of claims submitted by service providers monthly which may result in various concerns or disputes around claims processing, that should be resolved, but the respondents fell short of mentioning a specific number of staff and number of claims they consider “huge.”

DP 4: Preparing reports of supervision/monitoring with recommendations: After the M&E activities, which in DP 2 above, were being undertaken once every quarter, and in some cases, once a month or once every six months and once every two (2) years, the teams prepare reports of the monitoring with recommendations for implementation or further action. The respondents, in the absence of NHIA staff who would have been in a better position to shed more light on this, believed that some reports are being compiled since some facilities [providers] do receive reports/feedback from the Scheme after monitoring activities have been carried out.

DP 5: Implementing sanctions: This is the least examined DP, because of the non-participation of the NHIA staff in the assessment, as already mentioned. Nevertheless, the respondents mentioned that

the NHIA has an-inhouse code of conduct, which provides for sanctions such as suspension, queries and termination of appointment. However, according to the respondents, though there is a code of conduct, they believe that the enforcement regime within the Scheme is weak.

The respondents further claim that there are instances where the NHIA fails to enforce sanctions against staff and service providers who infringe the rules and procedures of the Scheme.

The rules of the Scheme provide for sanctions[fine or a term of imprisonment or both the fine and imprisonment] to be imposed on providers who defraud or attempt to defraud the Scheme by presenting to the Authority for payment a claim for: (a) a service which the healthcare provider has not provided; (b) a service which the client/contributor, in respect of whom the tariff claim is made, does not need but which the healthcare provider purports to have provided; or (c) medicine prescriptions which the client/contributor, in respect of whom the tariff claim is made, does not require or which is far in excess of what the contributor requires.

Similar sanctions apply in respect of staff of the Scheme for falsifying or aiding another person or abetting the falsification of tariffs payable to a healthcare provider; or failure to keep proper records in respect of claims for healthcare services.

It may be inferred from the views of respondents on this issue that the monitoring team, in undertaking the monitoring activities, may discover infringements of the law or policies regulating the operations of the Scheme. Therefore, in preparing a report, the Team may recommend sanctions against defaulting providers but which, according to the respondents, are not usually enforced, perhaps in recent times, because reports show that a few sanctions have been applied in the past on some staff and providers for various infringements of the Scheme policies and regulations following monitoring exercises. The following are a few reported examples:

- In January 2013, the NHIA terminated the appointment of a regional accountant, and three other scheme officials including a Claims Officer, due to negligent attitudes demonstrated in the discharge of their duties which manifested in inflated claims paid out to a provider;[83]
- Again, a provider facility was directed by the Authority to refund to it an overpaid sum of money to the NHIA within six weeks.[84]
- Three other providers were suspended in August 2014 for three months from providing service to NHIS subscribers for illegally taking monies from subscribers for services already covered under the NHIS, and operating under poor standards and/ or inflating claims.[85]

[83] https://www.nhis.gov.gh/News/nhia-dismisses-four-officials-3.
[84] https://www.nhis.gov.gh/News/nhia-dismisses-four-officials-3.
[85] https://www.graphic.com.gh/news/general-news/3-health-insurance-providers-suspended.html

CORRUPTION RISK ASSESSMENT

This section identifies and analyses the corruption risks associated with Claims Management Process and Management & Supervision as well as the impact thereof.

Claims Management Process

Identification of DPs and Key Actors:

The following actors are responsible for the Claims Management Process at the NHIA:

a) Health Service Provider;
b) District Director;
c) Claims Processing Officer;
d) Fulfillment Officer;
e) Vetting Officer;
f) Finance Officer;
g) Director, CPC;
h) Internal auditor; and
i) Chief Executive Officer.

Whilst the process of reimbursing the provider for expenses made in relation to a client starts from the time of submission of a claim by the provider to the NHIA, the focus of the study at this point is to ascertain corruption risks involved in the claims management process at the NHIA. Therefore, the CRA is limited to the commencement of claims management process at the NHIA, that is, receipt and acknowledgement of claim.

Table 3 presents the respective DPs in the claims management process. Five (5) DPs were identified for processing claims for reimbursement to providers for services rendered to clients at the district level.

Table 3: Identification of corruption risks – Claims Management Process

Decision Point (DP)	Key Actor(s) from NHIA	Corruption risks/deviated decisions	How the decision point and corruption risks were identified
DP 1 - Receipt and Acknowledgment of the Claim	• Claims Processing officer at a Claims Processing Centre (CPC) • District Director	• Bias in releasing feedback to service providers	
DP 2 - Fulfilment and Reconciliation	• Fulfilment Officer at CPC • District Director	• Bribe from providers to induce the officers.	
DP 3 - Vetting and Report	• Vetting Officer at Claims	• Officials demanding for	

Generation	processing centre • Director at CPC • Vetting Supervisor, CPC	unofficial payments from providers or receiving payments to facilitate claims or other processes. • Processing claims of Service Provider owned by the official, his/her close relative, or friends. • Some mistakes made can be overlooked due to influence from some providers. • Schedule officer intentionally inflating figures on vouchers or cheques on claims for service providers, which are then later paid to the Officer. • Schedule Officer deliberately including fake claims not presented by Service Providers and approving same for payments for personal benefit.	The responses to the questionnaire indicated that these corruption risks exist at these decision points across the process of claims management.
DP 4-Approval of Claim and Initiation of Payment Request	• Director, CPC • Chief Executive Officer • Finance Office/Directorate	• Processing claims without verification. • Processing claims from non-credentialled providers. • Refusing to process claims of certain providers for no reason/without justification. • Favouring some providers and processing their claims out of turn. • Unjustified influence from "above" on claims officer to fast-track processing and payment in favour of certain service providers.	
DP 5-Payment of Claim	• Director, CPC • Chief Executive Officer • Finance Office/Directorate	• Officials of the NHIA diverting money meant for payment of service providers to private accounts or unknown account. • Officials of the NHIA demanding for unofficial payments from providers or receiving payments from providers to facilitate claims	

The following corruption risks were identified within the Claims Management Process by the Respondents:

- Abuse of function/office, such as**:** processing claims without verification; processing claims from non-credentialled providers, refusing to process claims of certain providers for no reason/without justification;
- Bribery/kickbacks: officials of the NHIA demanding for unofficial payments from providers or receiving payments from providers to facilitate claims or other processes;
- Conflict of interest**:** Processing claims of Service Providers owned by the official, his/her close relative, or friends;
- Fraud: Providers deliberately including fake claims for reimbursement:

> *In some cases, because you have accessed their service before, they will put your NHIS number in the system for the following month claims though you were not there within that month.*

- Collusion between Service Providers and Officers of NHIA to cheat the NHIA; "*This rest on the claims manager, the internal Auditor of the NHIS and the claims officer of the service provider. These three can condone and connive to inflate figures at the expense of the scheme*".
- Favouring some providers and processing their claims out of turn.

Likelihood and Risk Score

Table 4 presents the likelihood of the occurrence of corruption the Claims Management Process and the associated risk scores. The likelihood score is calculated based on the available evidence that indicates how frequently corruption risks manifest at the decision point and on a 1-5 scale (where 1 represents very low and 5 represents very high) as follows:

1 - Very low.
2 – Low
3 - Moderate
4 – High
5 - Very High

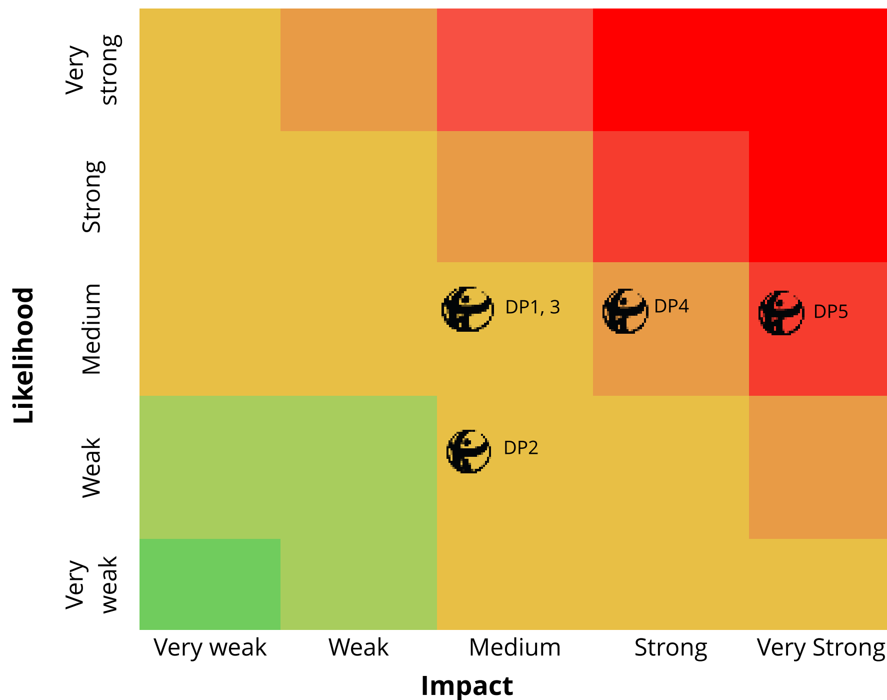
The Risk Likelihood Scores, which represent averages, were assigned by Key Informants and validated during the FGDs to sufficiently reflect the views of all the respondents.

Table 4: Risk scoring - Claims Management Process

Decision Point	Likelihood	Justification	Impact	Justification	Risk Score
DP 1 - Receipt and Acknowledgment of the Claim	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption	3	There is discriminatory effect at this DP that may cause delays in the	3

Decision Point	Likelihood	Justification	Impact	Justification	Risk Score
		occurring at this decision point		processing of claims, there is a moderate impact	
DP 2 - Fulfilment and Reconciliation	2	Based on survey data and key informant interviews, there is a low likelihood of corruption occurring at this decision point	3	The significant deviation at this DP causes discriminatory effect in the processing of claims, there is a moderate impact.	2.5
DP 3 - Vetting and Report Generation	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	3	The survey evidence suggests deviations at this DP may cause financial constraint to providers which may have ripple effect on the vulnerable	3
DP 4-Approval of Claim and Initiation of Payment Request	3	The survey evidence and key informant interviews indicates that bribery and favouritism may be common at this decision point	4	Unjustified and delays in approval of claims may cause a lot of health care providers to resort to cash and carry system which will affect the vulnerable mostly	3.5
DP 5-Payment of Claim	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	5	The impact of corruption at this decision point is hardest on marginalised groups as service providers may reject the NHIS card causing financial burden on this group	4

Figure 2: Risk impact score for Claims Management Process



Likelihood of Corruption and impact at the District Level

Table 5 presents the analysis of the likelihood of occurrence of corruption at the five (5) identified decision points at the district level.

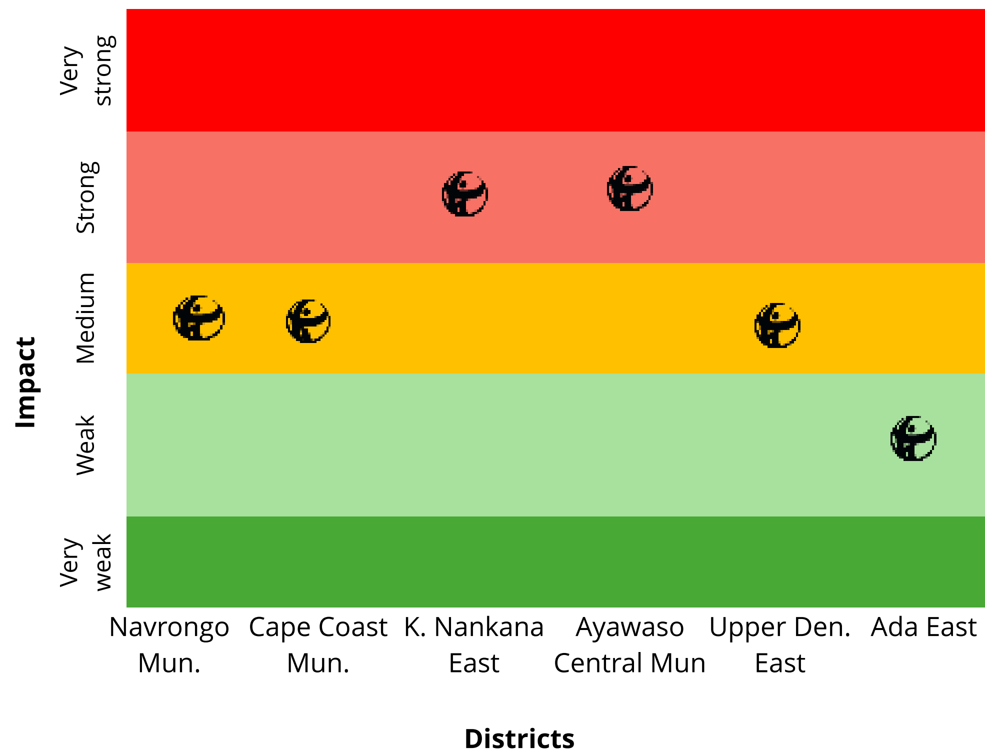
Table 5: DP Analysis of Corruption Risks in Claims Management

Districts	DP 1	DP 2	DP 3	DP 4	DP 5
Ayawaso Central (AC)	4	3	2.3	4	2
Ada East (AE)	2	2	2	3	2
Cape Coast (CC)	3	3	3	3	3
Upper Denkyira East (UDE)	2	2	2	3	3
Kassena-Nankana West (KNW)	2	2	2	3	3
Kassena-Nankana Municipal (KNM)	2	2	2	3	3

As the scores show, the likelihood of occurrence of corruption at DP 1 (Receipt and Acknowledgment of the Claim) was high at Ayawaso Central but moderate in Cape Coast Municipality and low for the rest of the sampled districts. In terms of DP 2 (Fulfilment and Reconciliation), the likelihood of occurrence of corruption is moderate at Ayawaso Central and low for the rest of the sampled districts. Furthermore, the likelihood of corruption occurring during the vetting and report generation process

(DP 3- Vetting and Report Generation), is low for all the sampled districts except Kassena Nankana Municipality, which score was very low. At DP 4 (Approval of Claim and Initiation of Payment Request), the likelihood of occurrence of corruption was high in Ayawaso Central and moderate in Ada East and Cape Coast. The rest of the sampled districts scored low in DP 4. The likelihood of corruption at DP 5 (Payment of Claim) is moderate for Cape Coast and Kassena Nankana Municipality, and low for the rest of the sampled districts except Ada East where the likelihood score in very low.

Figure 3: Risk impact score for claims management process



From Figure 3, it seems obvious that corruption risks in claims management in the Scheme have some level of impact on the quality of health service delivery on girls, women and other vulnerable groups at risk of discrimination. The degree of risk of corruption, however, varies across the districts. It was considered high in Kassena Nankana East and Ayawaso Central Municipality and moderate in Navrongo Municipality, Cape Coast Municipality and Upper Denkyira East, whereas for Ada East it was low.

As already noted, the two districts have poor levels of access to health, meaning that if there is a strain on resources caused by corruption in NHIS, it will likely affect the vulnerable populations in these districts more than the others. Therefore, the high scores for the Kassena Nankana East and Ayawaso Central Municipality are understandable.

Major drivers of corruption in claims management

The drivers of corruption in processing and payment of claims as indicated by the respondents included the following:

- **Poor remuneration [salary] for Staff of the Scheme**, which can hardly sustain them, coupled with the harsh economic environment, can constitute major drivers of corruption. As a result of the poor remuneration, some of the staff demand or receive bribes from service providers in order that the processing of their claims can be fast tracked.

  There were varying views on the effect of low income on corruption among NHIS staff. Some of the participants were of the view that corruption is inherent and irrespective of the level of salaries, the greedy nature of individuals coupled with harsh economic conditions may breed corruption. As one representative, supported by others, argued:

> *The harsh economic environment coupled with the greedy nature of individuals would always breed corruption irrespective of the quantum of salaries…Some of the workers [staff of NHIA] want to get more money than they earn and so resort to accepting bribery.*

- **Delays in payment of claims**: Instead of reimbursing claims within 4 weeks, it takes the NHIA up to 3 months or more to pay. Some of the participants also expressed that this state of affairs serves as a catalyst to some providers to corrupt staff of the NHIA in order that their claims are given priority attention. A respondent said:

> *Although payments often delay, some facilities are likely to receive payments faster than others because someone knows someone, or they are able to pay some money for their payment to be hastened.*

- Lack of capacity of relevant staff of the NHIA and lack of IT equipment;
- Favoritism, which respondents described as being "common", was said to be one of the drivers of corruption in the processing of claims and that:

> *Once you know someone inside there, they will fast track your claims…some facilities with people they know within the NHIS or facilities that can afford bribe are able to work their way out for their claims to be processed fast for payments. These facilities are likely to receive feedback on issues with their claims for correction while other facilities do not receive any feedback even after unjustified reducing their amount to be claimed.*

- Limited number of processing centres (only 5 for the whole country) were among the other drivers mentioned:

> *Vetting is done only at the Claims processing center…[*Tamale, Kumasi, Cape Coast, and Accra]. *The possibility of the claims officers being influenced to vet some claims faster than the rest is high. Also, some mistakes made can be overlooked due to influence from some providers.*

- Late submission of claims by some providers.

Management and Supervision

Identification of DPs and Key Actors

The following actors are responsible for Management and Supervision at the sampled districts of the Scheme:

- District Director;
- Public Relations Officer (PRO);
- Accountant;
- MIS Directorate, and
- Management of Information System (MIS) Officer.

Table 6 presents the respective DPs in the management and supervision process and five (5) DPs identified at the district level.

Table 6: Identification of corruption risks – Management and Supervision

Decision Point (DP)	Key Actor(s) from NHIA	Corruption risks/deviated decisions	How the decision point and corruption risks were identified
DP 1 - Assigning Staff/Team for M&E Activities	• District Director	• Bribery in assigning staff to certain schedules	
DP 2 - Conducting routine M&E Activities	• District Director • PRO • Accountant	• Receiving kickbacks/bribes from Providers to avoid inspection of their facilities or for some other favours	

	• MIS Directorate	from the Scheme.	The responses to the questionnaire indicated that these corruption risks exist at these decision points across the management and supervision.
DP 3 - Resolution of Claims related concerns	• District Director • PRO • Accountant • MIS Directorate	• Receiving kickbacks/bribes from Providers • Favouritism	
DP 4- Preparation of reports of supervision/ monitoring with recommendations	• District Director • PRO • Accountant • MIS Directorate	• Receiving kickbacks/bribes from Providers • Favouritism	
DP 5- Implementing Sanctions	• Regional Director • District Director	• Receiving kickbacks/bribes from perpetrators to avoid sanctions. • Favouritism.	

The forms of corruption and related conduct that may occur at the level of management and supervision that respondents identified include:

- Conflict of interest i.e. credentialling providers owned by Scheme Staff, their family members or close relatives or friends;
- Receiving kickbacks/bribes from Providers to avoid inspection of their facilities or for some other favours from the Scheme;
- Bribery in assigning staff to certain schedules;
- Receiving kickbacks from providers to speed up claims processing; and
- Diversion of Scheme funds. One respondent said management could divert the monies into investments for personal profit, which affects the finances of the scheme. The respondent said:

> *Actually, I don't have evidence but there is perception that monies meant for the service providers are being invested into other businesses by the authorities. They will invest the money into treasury bills and reap off the interest.*

- Favouritism: as a respondent revealed,

When the monitoring is done, some facilities have claims that were not done [may not have been done] correctly. The Likelihood of supervisors being influenced to cover up such mistakes is high especially if the said person [supervisor] has a relationship with the provider.

Likelihood and Risk Score

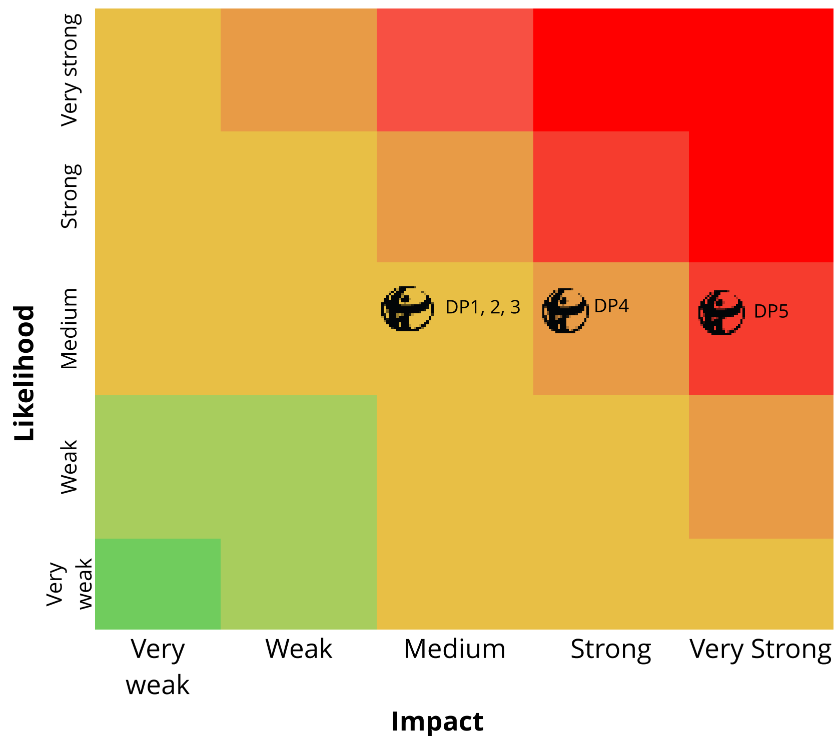
Table 7 presents the likelihood of the occurrence of corruption in management and supervision process and the associated risk scores. The Risk Likelihood Scores, which represent averages, were assigned by Key Informants and validated during the focus group discussions to sufficiently reflect the views of all the respondents.

Table 7: Risk scoring - Management and Supervision

Decision Point	Likelihood	Justification	Impact	Justification	Risk Score
DP 1 - Assigning Staff/Team for M&E Activities	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	3	There is discriminatory effect at this DP that may corrupt the system in service delivery, there is a moderate impact	3
DP 2 - Conducting routine M&E Activities	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	3	The significant deviation at this decision will affect service delivery under scheme. Thus, marginal groups who are major beneficiaries will be affected	3
DP 3 - Resolution of Claims related concerns	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	3	The survey evidence suggests deviations at this DP may cause financial constraint to providers which may have ripple effect on the vulnerable	3
DP 4- Preparation of reports of	3	The survey evidence and key informant interviews indicates	4	The marginalised groups are mostly affected	3.5

Decision Point	Likelihood	Justification	Impact	Justification	Risk Score
supervision/ monitoring with recommendations		that bribery and favouritism may influence implementation of recommendations		when concerns with the scheme are not addressed	
DP 5- Implementing Sanctions	3	Based on survey data and key informant interviews, there is a moderate likelihood of corruption occurring at this decision point	4	The sustainability of the scheme is crucial to the health care of the citizenry, most especially, the vulnerable.	3.5

Figure 4: Risk impact score for management and supervision



Likelihood of Corruption and impact at the District Level-Management and Supervision

Table 8 presents the analysis of the likelihood of occurrence of corruption at the five (5) identified decision points at the district level.

Table 8: DP Analysis of likelihood of occurrence of Corruption in Management and Supervision

Districts	DP 1	DP 2	DP 3	DP 4	DP 5
Ayawaso Central (AC)	3.2	2.7	3.4	2.7	3.2
Ada East (AE)	3.1	2.8	3	2.8	3.2
Cape Coast (CC)	2.3	3.3	3	3.3	3.3
Upper Denkyira East (UDE)	2.9	3.1	4	3.1	3.3
Kassena-Nankana West (KNW)	2.7	2.4	4	2.4	2.7
Kassena-Nankana Municipal (KNM)	2.6	3.6	3	3.6	3.4

The likelihood of occurrence of corruption at DP 1 (Assigning Staff/Team for M&E Activities) was low in four (4) districts (Cape Coast, Upper Denkyira East, Kassena-Nankana West, and Kassena-Nankana Municipal) and moderate in Ayawaso Central and Ada East where the respondents indicated that authorities could be influenced in assigning staff/team for M&E.

The low likelihood of corruption that the respondents put on DP 1 for Kassena-Nankana West, is presumably because of the absence of an NHIA office at that district. Same cannot be said of the low score for Ayawaso Central which also has no NHIA office yet the likelihood of corruption occurring at DP 1 is surprisingly moderate.

On DP 2 (Conducting routine M&E Activities), the views of the respondents differed. While some respondents said that M&E was being carried out once every 6 months, or once in 2 years, others said once in three months, among others. The respondents also said that supervision was selective and ineffective. These views of respondents culminated in the respondents assigning different likelihood scores for DP 2 in the sampled districts. Whereas the respondents' likelihood score is (3.3., 3.1., and 3.6), indicating a moderate likelihood of corruption occurring at Cape Coast, Upper Denkyira East and Kassena Nankana Municipal respectively, the likelihood of corruption score for the rest of the sampled districts is (between 2.4 and 2.8) which indicates a low likelihood of corruption.

The likelihood of the occurrence of corruption at DP 3 (Resolution of Claims related concerns), according to the respondents, is between 3.0. and 3.4 for Ayawaso Central, Cape Coast Metro, Ada East and Kassena Nankana Municipal, respectively, which is moderate but high (4.0.) in Upper Denkyira East and Kassena Nankana West, which indicate a high possibility of corruption at DP 3. This may mean that concerns relating to claims either remain unresolved or were resolved for corrupt purposes, as the respondents were of the view that the Scheme lacks the adequate number of staff to vet and process huge volumes of claims monthly.

Related to DP 4 is DP 2. Therefore, just like DP 2, the likelihood scores of 3.3. for Cape Coast, 3.1. for Upper Denkyira East and 3.6 for Kassena Nankana Municipal, all being moderate, under this DP 4 (Preparation of reports of supervision/ monitoring with recommendations), is consistent with the moderate scores for these districts in DP 2. Naturally, where the respondents found a moderate

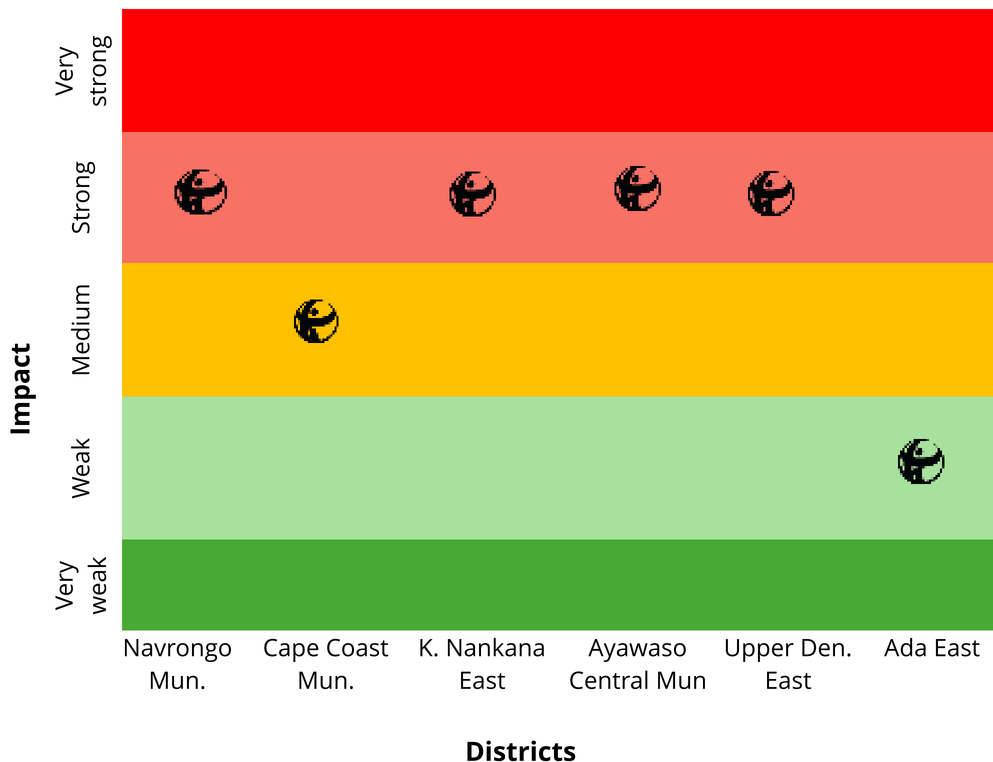
likelihood of corruption occurring at Conducting M&E Activities (DP2), a similar finding or score is likely to be made during the process of compiling reports of the M&E activities (DP4). On a similar premise, where there was low likelihood of corruption under DP 2, the respondents scored same low in DP4 for the rest the districts.

In terms of DP 5 (Implementing Sanctions), except Kassena Nankana West where the score is low, the respondents in all the other sampled districts provided a moderate score. The low score for KNW then, may be due to the fact that KNW has no NHIA office of its own and relies on the NHIA office at the sister district, Kassena Nankana Municipal. Consistently, the respondents put the likelihood of corruption in the other DPs low for KNW, presumably because of the absence of an NHIA office at that district.

However, in terms of preparing reports with recommendations (DP 3), the likelihood of corruption respondents assigned is high. As earlier indicated, the respondents had said that the fact that some providers receive feedback, is a testimony that the Staff of the NHIA prepare reports. Therefore, irrespective of the unavailability of NHIA office in a district, it is still possible to receive reports once the facility is accredited.

All in all, the risk likelihood scores, as presented above, represent averages assigned by key informants and validated during the FGDs to sufficiently reflect the views of all the respondents. It is worth noting that there has not been a very high possibility of corruption at this level from the point of view of the respondents.

Figure 5: Risk impact score for management and supervision.



With regard to impact, the score is calculated based on a mixture of available evidence and hypothesising as to what would be the severity of the impact on the access to health (especially for women, girls and groups at risk of discrimination), were corruption risks to manifest at this decision point. These scores represent the opinions of the research team but informed by the evidence collected from respondents during the study.

Corruption risks in management and supervision at the District Mutual Health Insurance Scheme would have an impact on the quality of health service delivery on girls, women and other vulnerable groups at risk of discrimination. The degree of risk of corruption, however, varies across the districts. It was considered high in Navrongo Municipality, Kassena Nankana East, Ayawaso Central Municipality and Upper Denkyira East, whereas in Cape Coast Municipality, it is moderate. The impact is also low in Ada East. (*see Table 8*).

The nature of the impact of corruption on women, girls and other groups at risk of discrimination, as identified during the study in relation to Management and Supervision, are similar to those already presented (above) on claims management. This is because corruption in management and supervision can mean that corruption in claims processing goes undetected and unsanctioned; in this way, it removes an important potential deterrent against corruption in claims processing and the impacts it has on vulnerable groups as outlined in the previous section.

Respondents, nevertheless provided additional forms of impact of corruption in management and supervision on the vulnerable to include *"delays/high time spent in accessing health services, increased chances of payment of bribes,* and *"refusal of providers to offer health services* to this group: "*… everyone especially the vulnerable groups of people will no longer be able to use their NHIS card to receive health care especially medication…NHIS is a pro-poor project. However, corruption and other factors will run it down to the point that the vulnerable groups can no longer access health care thus a wide gap been the vulnerable and well-established people."*

MAJOR DRIVERS OF CORRUPTION IN MANAGEMENT AND SUPERVISION

Many of the drivers of corruption identified in relation to Claims Management, such as poor remuneration, delays in claims payment, poor supervision of staff and non-enforcement of sanctions against providers, were also identified in management and supervision. The additional drivers the respondents identified include:

- **Delays and cuts in payment of claims:** Respondents claimed that some providers witness cuts in their claims at the vetting stage and in order "…*to avoid cuts in the amounts requested in claims during vetting*", and expedite the payment of their claims as well as maintain their accreditation status with the Scheme, some service providers corrupt staff of the NHIS responsible for claims management and management and supervision.

- **Poor supervision, poor enforcement of sanctions, and compromising systems** were also cited by some participants to be **contributory factors** to corruption among staff of the NHIA. Describing how poor supervision is, a respondent said:

> *Some facilities may know people within the NHIS who can visit their facilities to monitor and provide feedback to better their work while other facilities have received zero monitoring, supervision or feedback since it started*.

IMPACT OF CORRUPTION ON VULNERABLE GROUPS

This section presents the potential impact of corruption risks in the NHIS system relative to women, girls and other groups at risk of discrimination, as identified by the respondents.

Financial Burden: Corruption may pose a financial burden on the health facilities and patients are likely to pay for every service rendered.

> *If claims are not handled well, monies will not be paid to the health facilities which means that we will go back to the cash and carry system, as providers are likely to reject the NHIS card, which often occurs.*

Furthermore, some providers may refuse to accept NHIS cards, which can impose some financial burden on the vulnerable.

> *The health facilities will no longer like to accept the NHIS card which means that only people with money can afford health services while the vulnerable people will not be able to assess health care.... this will result in people paying for every bit of health care required. Our vulnerable people do not have that money to pay for medicines and other health care services... Vulnerable people like us are not able to work enough to earn a lot of money and if the corruption leads to cash and carry, we will not be able to visit the hospital for health care when we are sick.*

When NHIS funds are embezzled, it means the NHIS will not have money to pay providers. This also means that providers will not have enough money to maintain its facilities, procure drugs, and other medical consumables (such as gauge pads, gloves, syringes) to provide services to members of the Scheme. Members will have to access health services, therefore, at their own cost, (i.e., cash and carry) something which the vulnerable are less likely to be able to do. That also means that after consulting a doctor and being given prescription for medication, the member will have to purchase the medication from his/her own pocket, elsewhere.

> *If the monies that the government will use in improving health care is stolen through corruption, we can't have access to health care. Drugs at the hospitals will be in short supply and patients would be asked to buy the rest themselves. As at now, whenever we go to the hospital, we buy all drugs prescribed and sometimes those that must not be sold like the drugs for our mentally impaired friends, are not available [out of stock] which poses a lot of risk to us all.*

Put differently, the respondent says that if there are insufficient funds, then people have to buy their own medicine. However, there are some medicines that cannot be sold e.g. *drugs for our mentally impaired friends.* This in effect means they cannot buy it (even if they wanted to).
On this issue, one respondent also said:

> ...everyone especially the vulnerable *groups of people will no longer be able to use their NHIS card to receive health care especially medication. ... of late, health facilities do not have any medicines under the NHIS and so people buy from private chemical shops. The vulnerable groups are often not able to buy.*

Reduced Access to and quality health services: The majority of vulnerable groups depend on the Scheme for basic healthcare. Therefore, if the Scheme funds are lost due to corruption, there would be less or no money available to the Scheme to reimburse providers for services rendered to the vulnerable. In turn, if the providers do not recover their costs from the Scheme, it may result in shortage of medicines, equipment, and even qualified staff, especially, in rural areas. Thus, for the vulnerable, as a group that depend on the Scheme, it means going without treatment or having to pay out of pocket, [cash and carry] which they may not be able to afford. A respondent said:

> *Vulnerable people like us are not able to work enough to earn a lot of money and if the corruption leads to cash and carry, we will not be able to visit the hospital for health care when we are sick.*

> *After consultation at the hospital, we now have to buy all the medicines from outside so these groups of people don't get good health care because they cannot afford*.
>
> [Another Respondent]

> *People who have no financial resources would likely have their services delayed which may even lead to death. In cases they may be forced to compromise by paying bribe to access quality health care.*
>
> [One other respondent]

> *When we resort to cash and carry system, the less healthcare services would be for the less privileged. They are most likely unable to afford some medications and are also not able to bribe their way to have proper healthcare.*

[Another respondent]

Corruption which may cause delays in paying claims will affect the quality of healthcare delivery. This will in turn affect the vulnerable populations the most. Thus, leading to reduction in -

> *...the quality of care they receive from health facilities because most facilities complain of non-payments, so medicines and other service are not readily available.*

According to a respondent, already, the quality of care being given under the NHIS to members is not the best, "yet, *these vulnerable people are the highest users of the NHIS and this means that they do not receive the right kind of health care because they do not have enough money to afford top-ups or even pay if need be".*

Exacerbates health inequity: Another major consequence of corruption is unequal access to healthcare. There will be limited access for the vulnerable or as respondents put it, "the less privileged", in terms of access to healthcare. Only the rich will benefit, thereby further widening the inequality gap.

> *These people especially pregnant women who are poor will not be able to get proper care because they will not be able to afford paying for all the services...NHIS is a pro-poor project. However, corruption and other factors will run it down to the point that the vulnerable groups can no longer access health care thus a wide gap been the vulnerable and well-established people.*

> *NHIS is a pro-poor project. However, corruption and other factors will run it down to the point that the vulnerable groups can no longer access health care thus a wide gap been the vulnerable and well- established people*.

Resort to Self-medication or herbalist treatment: When providers turn away members of the Scheme for non-payment of their claims due to corruption in the Scheme, healthcare can become expensive for the vulnerable population as they have to pay for the services by themselves, out of pocket payments. As such, some of vulnerable groups are likely to resort to self-medication or other traditional medications or unregulated treatments. One respondent said:

> *If claims are not handled well, monies will not be paid the health facilities which means that we will go back to the cash and carry system. A lot of people especially the vulnerable will not be able to afford so they will end up self-medication and even worse, use herbal medicines.*

Another respondent expressed the inequities in the Scheme succinctly:

> *When we go to the hospital, they tell us to go and buy all the medicines and we mostly do not have enough money to buy all, so we end up going home to try treating ourselves. It is even worse as a*

Fulani person[86]; we are not able to work properly to get money to get proper health care now.

Leads to serious illness or death: corruption in the Scheme can mean that subscribers' ailments go untreated. This will lead to several poor health conditions which in turn, may lead to high mortality rates for the vulnerable, as:

> *They cannot access quality healthcare which may cause a deterioration to their condition or may cause death.*

[86] Migrant ethnic group of farmers known for cattle-keeping.

MITIGATION STRATEGIES

This section identifies mitigation strategies to tackle the corruption risks identified at the decision points identified for each of the priority areas.

Risk	Mitigation Strategy	Indicator	Responsibility
Deliberately including fake claims not presented by Service Providers for processing	Conduct monthly surprise monitoring visits on the Fulfilment Officer and other relevant officers of NHIA.	Number of surprise Monitoring visits on the Fulfilment Officer and other relevant officers of NHIA conducted; Reports of surprise monitoring visits.	Regional Director; NHIA Management
	Implement a system where NHIA staff who have served in specific roles for a very long period, are either assigned to other roles and/ or are transferred to other locations.	A system where a number of staff who have served on specific roles for a very long period, are either assigned other roles and or are transferred to other locations, implemented.	NHIA Management
	Implement a robust system that enables the Scheme to validate from Clients [at random] if they accessed the service from the providers as claimed.	A robust system that enables the Scheme to validate from clients [at random] if they accessed the service from the providers as claimed, implemented.	NHIA Management
Processing claims without proper vetting or verification.	Build capacity of relevant staff in claims processing	Capacity of staff in claims processing built; reports of capacity building programmes in claims processing.	NHIA Management
Favouring some service providers and processing their claims out of turn	Build capacity of staff on the Code of Conduct for Public Officers.	Capacity of staff on the Code of Conduct for Public Officers built; reports of capacity building activities on Code of Conduct for Public Officers.	NHIA Management
Officials demanding or receiving unofficial	Build capacity of staff on the Code of Conduct for Public	Capacity of staff on the Code of Conduct for Public Officers, built;	Regional Director; Management of NHIA

payments from service providers to facilitate claims processes.	Officers	reports of capacity building activities on Code of Conduct for Public Officers.	
	Apply sanctions on staff found liable for misconduct to serve as deterrent to others	Sanctions on staff found liable for misconduct applied; reports of application of sanctions on staff.	District Manager; Regional Director; NHIA Management
Schedule officers intentionally inflating figures on vouchers or cheques on claims for service providers, which are then later paid/refunded to the schedule Officer.	Implement a robust system that enables the Scheme to validate from Clients if they accessed the service from the providers as claimed.	A robust system that enables the Scheme to validate from Clients if they accessed the service from the providers as claimed, implemented.	NHIA Management
Bribery in assigning staff to certain schedules	Build capacity of staff of the NHIA on the Code of Conduct for Public Officers; Sensitise staff on impact of corruption and right to health; sensitise staff of the NHIA to report corruption to relevant institutions.	Capacity of staff on the Code of Conduct for Public Officers built; staff sensitised on impact of corruption and right to health; staff sensitised to report corruption to relevant institutions.	NHIA Management Regional Director; Ministry of Health
Receiving kickbacks/bribes from Providers in order to not inspect facilities			

CONCLUSIONS

This section provides the **Conclusion** on the Corruption Risk Assessment.

The NHIA, as purchaser of health care services for its insured members, has improved the processing of claims for service providers with the majority of claims being processed electronically through five Claims Processing Centres across the country. The introduction of the electronic system has helped to reduce the risk of corruption in the Scheme as the processes have minimised direct contact between officials of service providers and Scheme staff.

Despite this improvement, as the Assessment shows, there still exist some risks of corruption in the electronic processing of claims as well as the few claims that are submitted manually.

The main forms of corruption that threaten the Scheme include: bribery; conflict of interest; fraud; outright impersonation; diversion of Scheme funds; illegal charges for services rendered in relation to accessing health facilities with the Scheme, and over-invoicing by some service providers.

The risks drivers include the following:

- Inability of the NHIA to raise funds to reimburse claims of providers;
- Late submission of claims by providers;
- Limited claim processing centres to cope with huge volumes of claims;
- Poor supervision of both staff and health facilities;
- Lack of capacity of claim processing staff, and
- Lack of integrity and greed of some staff of the NHIA,

The corruption risks identified have the potential to impact negatively on access to health services by women, girls and groups at risk of discrimination, such as persons living with disabilities, migrants and nomadic groups in the country. The aspects of the impacts include reduced access to and quality of health services, financial strain leading to out-of-pocket payment, self-medication, or other unregulated health services, and ultimately may lead to serious illness or even death as a result inability to access health.

RECOMMENDATIONS

The leadership of the NHIA should undertake urgent measures to address the corruption risks. Such measures may include the following:

- Eliminate manual processing of claims entirely and increase the number of processing centres to cope with the huge volumes of claims submitted monthly ;
- Develop a system that will allow the Scheme to validate whether a client has indeed obtained the services for which the provider is claiming payment from the Scheme.
- Implement a system of rotation of staff involved in processing claims;
- Sensitise staff on the code of conduct for public officers and the impact of corruption on access to health service;
- Conduct surprise visits on staff monthly.

The Assessment was in furtherance of the Inclusive Service Delivery Africa (ISDA) Project, being implemented by the Ghana Integrity Initiative (GII). The project is a four-year regional project in five countries in Africa (Democratic Republic of Congo, Ghana, Madagascar, Rwanda, and Zimbabwe) that seeks to improve access to healthcare services for women & girls, youth and other groups at risk of discrimination such as persons living with disabilities, migrants and nomadic groups in Ghana. The Assessment will assist the NHIA to take steps to improve the quality of service to these vulnerable groups. It is the hope that the NHIA will give the findings of this Assessment the required attention.

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ANNEX

RESEARCH TOOLS

Questionnaire for Interviews with Key Informants

Introduction of Interviewer:

Good day. My Name is ……………. and I am collecting views on corruption vulnerabilities and loopholes in the NHIS/NHIA and their potential impact on the healthcare delivery, particularly for women, girls, and other vulnerable groups at risk of discrimination. I am doing this on behalf of the Ghana Integrity Initiative (GII). The main objective of the study is to identify risks of corruption and assess how those corruption risks would impact on access to health service delivery by women, girls and other vulnerable groups at risk of discrimination.

Information obtained from this interview will assist in achieving the objective of the study, in particular, improving access to good quality healthcare services for women, girls, and other groups at risk of discrimination. ***The exercise is not to find out who is corrupt or who is not? The exercise is about weaknesses in the NHIS system that may present opportunities for corruption to occur in the future.***

The information you will provide will be analysed together with the responses of other respondents. Your individual responses will not be identified. Therefore, we encourage you express your views freely. If you feel uncomfortable, you may decline to answer any question, or you may end the interview at any time with no negative consequences. It will only take you 20 to 30 minutes to answer all the questions. We sincerely appreciate your participation in this study. Thank you.

Section 1: Personal Information of Respondents.

1. **Sex**: Male [ ] Female [ ]
2. **Occupation**: Management Personnel of NHIS [ ] Service Provider [ ] Public Officer [ ] Farmer [ ] Business Person [ ] Pupil/Student [ ] Other [ ] Please specify………..
3. **Marital Status**: Single [ ] Married [] Divorced [ ]
4. **Educational Background**:
    - [ ] No formal education
    - [ ] Junior High School/Middle School
    - [ ] Senior High School/Secondary School/A level

[ ] Tertiary
[ ] Postgraduate

5. District of the Respondent:

Kasena Nankana West [ ]
Navrongo Municipal [ ]
Cape Coast Municipal [ ]
Upper Denkyira East [ ]
Ayawaso Central [ ]
Ada East [ ]

6. NHIS Member: Yes [ ] No [ ]

Section 2: Claims Management Processes

1. Kindly indicate how most claims from Service Providers under the NHIS are received by the DMHIS/NHIA?.

Manual [ ]
Electronic platform [ ]
Both Manual and electronic [ ]
Phone calls [ ]
Other [ ] Specify…………….

2. Kindly describe the processes that claims submitted by Service Providers for reimbursement go through at the DMHIS/NHIA.

3. How would you rate on a scale of 1-5 the likelihood of corruption taking place during the processing of claims at the DMHIS/ NHIA/.

4. Please, indicate your level of agreement with these statements on the forms/types of corruption likely to occur in claims processing. Use a scale of 1-5 where 1=Strongly Disagree; 2=Disagree; 3= partially Agree; 4= Agree and 5=Strongly Agree: 00=No Opinion

S/No.	Description	1	2	3	4	5	
		Strongly Disagree	**Disagree**	**partially Agree**	**Agree**	**Strongly Agree**	**No Opinion**
a	Abuse of function/office, such as: processing claims without verification; processing claims from non-						

	credentialled providers, or refusing to process claims of certain providers for no reason/without justification.						
b	Bribery/kickbacks: officials demanding for unofficial payments from providers or receiving payments to facilitate claims or other processes.						
c	Conflict of interest: Processing claims of Service Provider owned by the official, his/her close relative, or friends.						
d	Fraud: Deliberately including fake claims not presented by Service Providers and approving same for payments for personal benefit.						
e	Diversion of funds (embezzlement, misappropriation)						
f.	Collusion with Service Providers and Officers of						

	NHIA to cheat the NHIA						
g.	Favouring some providers and processing their claims out of turn.						

5. Do you agree that corruption in the NHIS/NHIA has a relatively high impact on quality of health service delivery to women, girls and other vulnerable groups at risk of discrimination? Strongly Disagree (1) [ ] Disagree (2) [ ] Partially Agree (3) [ ] Agree (4) [ ] Strongly Agree (5) [ ] No Opinion [ ]

6. Please, rate the level of impact/consequences of corruption in the claims management process on women, girls and other vulnerable groups at risk of discrimination, using very low (1) to very high (5):

Item	**Description**	**Score**					
		1	**2**	**3**	**4**	**5**	**No Opinion**
a.	Financial (cash & carry, i.e. out-of-pocket payments)						
b.	Reduces access to and quality of health services						
c.	Refusal to offer health services						
d.	Delays/high time spent in accessing health services						
e.	Self-medication, or herbalist care						
f	Increases school drop-out of sick pupils/students who cannot access private health facilities due to high cost						
g	Increased chances of payment of bribes						
h	Exacerbates[worsens] health inequities [i.e., unfairness, inequality]						
i	Death as a result inability to access health						

7. Describe the systems (such as complaint box, Telephone Hotline, confidential online reporting system) that DMHIS/NHIA has in place (if any) to detect corrupt practices in claims management process.

8. Has the DMHIS/NHIA ever detected that it had made claims payment to an underserving service provider? Yes [ ] No [ ] Cannot Tell [ ] If so, please describe

9. Describe any mechanism that the DMHIS/NHIA has in place to ensure that reimbursement of claims are not misappropriated and embezzled at the NHIA/NHIS for private benefit.

10. Do women, girls and other groups at risk of discrimination face any challenges in accessing health care under the NHIS as a result of non-payment or delayed payment of claims to service providers?

11. Is there anything else relating to today's topics that you would like to address which has not been raised so far?

Section 3: Provider Payment

1. Kindly indicate how most Service Providers submit claims to the DMHIS/NHIA for reimbursement.

   Manual [ ]
   Electronic platform [ ]
   Both Manual and electronic [ ]
   Phone calls [ ]
   Other [ ], specify………

2. Kindly state whether service providers submit claims to the DMHIS/NHIA within the stipulated period. Yes [ ] No [ ] cannot tell [ ]

3. Describe the feedback (if any) that Service Providers receive from the DMHIS/NHIA prior to payments on vetted claims…………………………………………

4. Please, how are concerns arising from the feedback to Service Providers addressed? ………………………………………………………………………………

5. What is the mode of payment to Service Providers for reimbursement of claims submitted? Cash [ ]; Open cheque [ ]; Closed cheque in name of Service provider [ ]; Bank transfer[ ] Other [ ]please, specify):______

6. Do service providers receive payments from the DMHIS/NHIA for their claims within the stipulated timeframe after submission of their claims to the DMHIS/NHIA? Yes [ ] No [ ] Cannot tell [ ].

7. If Service Providers do not receive payments for their claims from the DMHIS/NHIA within the stipulated timeframe after submission of their claims, kindly provide reasons why:

S/No	Reasons	Answer (Tick)
1.	Lack of funds	
2.	Lack of capacity of relevant staff to process claims	

3.	Lack of IT equipment	
4.	Late submission of claims by Providers, thereby causing delays	
5.	Refusal to process claims without justification	
6.	Poor supervision	
7.	Other Reason, Please Specify	

8. Please tick/select the answer that best describes your opinion about the statements below, on a scale of 1-5), Strongly Disagree (1) [ ] disagree (2) [ ]Partially Agree (3) [ ] Agree (4) [ ] Strongly Agree (5)[ ]: No Opinion [ ]

Statement	**1**	**2**	**3**	**4**	**5**	
	Strongly Disagree	**disagree**	**Partially Agree**	**Agree**	**Agree**	**No Opinion**
There is high level of corruption in provider payments at the NHIA						
Corruption in provider payments impact the quality of health service delivery on girls, women and other vulnerable groups under the NHIS						

9. Please, rate the prevalence of corrupt acts likely to occur in provider payment on the scale, low (1) to (5) very high:

Item	**Description**	**1**	**2**	**3**	**4**	**5**	**No Opinion**
a.	Billing the Scheme for services not provided Scheme member or for services that are performed but unnecessary						
b.	Illegal cash exchanges for prescriptions						
c.	Unbundling-billing for separate services, although an inclusive code is available						
d.	Double billing/submission of duplicate claims by providers						
e.	Over-invoicing						
f.	Diverting money meant for						

	payment of service provider to private account or unknown account (diversion)						
g.	Unjustified influence from “above” on claims officer to fast-track processing and payment in favour of certain service providers. [Political interference; Abuse of function/office]						
h.	Collusion between schedule officers to vet, pass and pay claims for unprovided services.						
i	Padding of claims/over-invoicing/abuse of power: Schedule officer intentionally inflating figures on vouchers or cheques on claims for service providers, which are then later paid to the Officer.						
j	Other, Please Specify and rate						

10. Do women, girls and other groups at risk of discrimination face any challenges in accessing health care under the NHIS as a result of non-payment or delayed payment of claims to service providers?

11. Is there anything else relating to this issue that you would like to address which has not been raised so far?

Section 4: Management And Supervision[Mismanagement and Poor Supervision]

1. Describe whether the DMHIS has the right number and calibre of staff to monitor services provided to members of the NHIS?..

2. How often does this DMHIS conduct inspections of Service providers?:
   1. Once every Quarter [ ]
   2. Once in a Month [ ]
   3. Once every six months [ ]
   4. Once in two years [ ]
   5. Not at all [ ]
   6. Other [ ] Specify

3. Do you think corruption can occur at the level of management and supervision at the District/Municipal Mutual Health Insurance Scheme? Yes [ ] No [ ] No Opinion [ ]

4. Rate the corruption and related conducts that may occur at the level of management and supervision on the scale of 1(very low) to - 5 (very high):

Item	Description	1	2	3	4	5	No Opinion
a	Credentialling providers owned by Scheme Staff, their family members or close relatives or friends						
b	Receiving kickbacks/bribes from Providers to avoid inspection of their facilities or for some other favours from the Scheme						
c.	Bribery in assigning staff to certain schedules						
d	Receiving Kick-backs from Providers to speed up claims processing						

5. Please, select from the statements below which best describe how mismanagement and poor supervision under the NHIS/DMHIS could impact on women, girls and other groups at the risk of discrimination:

1) Financial (cash & carry i.e. out pocket payment) [ ]
2) Reduces access to and quality of health services [ ]
3) Refusal to offer health services [ ]
4) Delays/high time spent in accessing health services [ ]
5) Self-medication, or herbalist care [ ]
6) Increases school drop-out of sick pupils/students [ ]
7) who cannot access private health facilities due to high cost [ ]
8) Increased chances of payment of bribes [ ]
9) Exacerbates[worsens] health inequities [i.e., unfairness, inequality] [ ]
10) Death as a result inability to access health [ ]
11) Other, Please Specify [ ]

6. Please, describe the nature of the impact of corruption on the quality of health care service delivery on women, girls and other vulnerable groups at risk of discrimination.

7. Kindly describe the disciplinary processes and procedures in place at the District/Municipal Mutual Health Insurance Scheme to address misconduct of Staff ……………………………………………………………………………………………

8. Does the District/Municipal Mutual Health Insurance Scheme have an In-house Code of Conduct for its Staff? Yes [ ] No [ ] I can't tell [ ]

9. Are staff at the District/Municipal Mutual Health Insurance Scheme aware of the Code of Conduct for Public Officers of Ghana? Yes [ ] No [ ] I can't tell [ ]

10. Is there anything else relating to this issue that you would like to address which has not been raised so far.

End

Questions Guide for FGDs

Introduction of Interviewer

Good day. My Name is ……………. and I am collecting views on corruption vulnerabilities and loopholes in the NHIS/NHIA and their potential impact on the healthcare delivery, particularly for women, girls, and other vulnerable groups at risk of discrimination. I am doing this on behalf of the Ghana Integrity Initiative (GII). The main objective of the study is to identify risks of corruption and assess how those corruption risks would impact on access to health service delivery by women, girls and other vulnerable groups at risk of discrimination.

Information obtained from this interview will assist in achieving the objective of the study, in particular, improving access to quality healthcare services for women, girls, and other groups at risk of discrimination. ***The exercise is not to find out who is corrupt or who is not? The exercise is about weaknesses in the NHIS system that may present opportunities for corruption to occur in the future.***

The information you will provide will be analysed together with the responses of other respondents/colleagues gathered here. Your individual responses in the group will not be identified. Therefore, I encourage you to express your views freely without fear of any negative consequences as a result of your participation in this FDGs, which would take about 30 to 40 minutes.

I would like to hear from the group/stakeholders about the loopholes/gaps that exist at the NHIA/NHIS at the District/Municipal Mutual Health Insurance Schemes that can lead to corruption and discrimination, and the consequences of those risks in terms of access by girls, women, and other vulnerable groups to good quality health services in the country.

Questions to Guide Discussions

1. Kindly comment on each of the processes relating to claims management, provider payment and management and supervision at the DMHIS as shown in the diagram in Annex 1(copies to be provided to each participant in the group)

2. What do you consider as the main challenges confronting the DMHIS and for that matter the NHIS in processing and payment of claims submitted by Service Providers? Does corruption, especially bribery, pose a challenge to these areas of service? If yes, what do think are the drivers of this corruption.

3. From your experience, is it easy for groups at risk of discrimination (such as persons with disability, herders, elderly women and uneducated poor) to access health services under the NHIS?

4. What would be your rate, on a scale of 1-5, the likelihood of corruption occurring at the DMHIS and in which area or areas of operations of the DMHIS is this likely to occur? Provider Payment, claims management or Management and Supervision?

5. What forms/types of corruption are likely to occur in the areas of operation of the DMHIS?

6. From your experience, are women, girls and other groups at risk of discrimination (such as persons with disability, herders, elderly women and uneducated), more likely to experience corruption when accessing health care under the NHIS?

7. What would you say is the potential impact of corruption on the NHIS system relative to quality healthcare delivery for women, girls and other groups at risk of discrimination (such as persons with disability, herders, elderly women and uneducated poor), who use the NHIS cards for health services?

8. What are some of the counter measures which can specifically help women, girls and other groups at risk of discrimination (persons with disability, herders, elderly women and uneducated poor), to mitigate the negative impact of corruption of the NHIS system on quality healthcare delivery to these groups?

9. What do you think are the opportunities and motivation (drivers/causes) of corruption at the DMHIS and what counter measures would you recommend to the DMHIS.

10. Has any of you ever been requested by the DMHIS to confirm if you have visited a provider and to authenticate a bill for services you received from the provider?

11. Is there anything else relating to today’s topics that you would like to address which has not been raised so far?

End, Thank You

Annex 1: Diagram: Decision Points-DMHIS/NHIA

DECISION AREA	Claims Management	Provider Payment	Admin, HR Management [Supervision]
DECISION POINTS	• Receipt of Claims from Provider • Fulfilment: [Confirmation of volume and value of claim received] • Vetting • Entry of Data: [collating and documenting adjustments from vetting and fulfilment] • Vetting Report: [to Scheme & Provider] • Issuing payment request: [to CEO & Finance Department]	• Submission of Vetting report to Provider • Receiving Feed-back on Vetting Report • Addressing concerns from providers on vetting report • Payment	• Monitoring/Supervising service providers • Producing reports of supervision/monitoring • Recommending sanctions for providers in breach of Protocols and standards • Implementing sanctions

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