NATIONAL HEALTH INSURANCE AUTHORITY

2018 ANNUAL REPORT

Table of Contents

List of Figures

List of Tables

Vision, Mission and Core values

Vision

To be a model of a sustainable, progressive and equitable social health insurance Scheme in Africa and beyond.

Mission

To provide financial risk protection against the cost of quality health care for all residents in Ghana, and to delight our sub-scribers and other stakeholders with an enthusiastic, motivated, and empathetic professional staff who share the values of accountability in partnership with all.

Core values

- Integrity
- Accountability
- Empathy
- Responsiveness
- Innovation

Board Members

1	Prof. Yaw Adu-Gyamfi	Chairman
2	Dr. Samuel Yaw Annor	Chief Executive, NHIA
3	Hon. Kingsley Aboagye-Gyedu	Member/Dep Min of Health
4	Hon Abena Osei-Asare	Member/Dep. Min. of Finance
5	Dr. Dennis Addo	Member
6	Dr. Anthony Nsiah-Asare	Member
7	Mr.Justice Yaw Ofori	Member
8	Mr. Kwasi Ampadu-Kissi	Member
9	Dr Isaac Charles Noble Morrison	Member
10	Prof. Christian Agyare	Member
11	Mr. Kwesi Asante	Member
12	Mad. Anna Pearl Akiwumi-Siriboe	Member
13	Dr. Nicholas Ankomah Tweneboa	Member
14	Vahandi–Naa Dr Mohammed Nantogmah Mahama	Member
15	Rev. Richard Kwasi Yeboah	Member
16	Dr. Sylvester Yaw Oppong	Member
17	Mad. Joyce Konokie Zampare	Member
18	Mrs. Catherine Johnson	Secretary

BOARD SECRETARY	**:**	**MRS CATHERINE JOHNSON**
REGISTERED OFFICE	**:**	**NO. 36-6 AVENUE, OPPOSITE AU SUITE, RIDGE INDUSTRIAL AREA, ACCRA**
AUDITORS	**:**	**ERNST AND YOUNG, CHARTERED ACCOUNTANTS**
BANKERS	**:**	**GHANA COMMERCIAL BANK, ECOBANK GHANA LTD**

PROFILE OF EXECUTIVE MANAGEMENT

DR. SAMUEL YAW ANNOR: CHIEF EXECUTIVE

Dr. Samuel Yaw Annor is a Medical Doctor, Consultant Obstetrician Gynaecologist, an experienced Health Manager and a Businessman. He is a renowned physician with over 36 years of practice in local and international health management. He has an extensive work experience from South Africa and is acquainted with the healthcare delivery in other countries. Dr. Annor was the Senior Consultant Obstetrician Gynaecologist and Director at Lister Hospital and Fertility Centre. He is a successful businessman and the Executive Director at Annor & Associates. Between 2007 and 2008 he was the Board Chairman of Ghana Airports Company Limited.

Dr. Samuel Annor is a distinguished Fellow of the College of Obstetricians & Gynaecologists, South Africa from the King Edward VIII Hospital, University of Natal. He had his MBChB from the University of Ghana Medical School in 1982 and furthered his education at University of Natal, South Africa where he had a Diploma in Child Health. He was the former Eastern Regional Treasurer and Chairman of the New Patriotic Party between 2005 and 2014 and has held various positions in the party. He is married with four (4) children.

DR. LYDIA DSANE-SELBY: DEPUTY CHIEF EXECUTIVE, OPERATIONS

A Medical Doctor by profession with a specialty in ENT, Dr. Dsane-Selby worked as Medical Officer at Korle-Bu Teaching Hospital, Achimota Hospital and in the UK prior to taking the appointment at the NHIA. Lydia Dsane-Selby was the Director, Claims from May 2013 to March 2017. She was previously the Director, Clinical Audit for 4 years. She has 10 years' experience with the organization starting out as the Medical Advisor in the Research & Development Directorate.

As a former Director of Claims, she played an integral part in several key innovations including the development of the DRG payment mechanism, the development of the accreditation tools and processes, the introduction of clinical audits with the development of tools and a manual and the introduction of e-claims with business rules for cost containment within the NHIA.

MRS YAA POKUAA BAIDEN: DEPUTY CHIEF EXECUTIVE, ADMIN. & HR

Mrs. Yaa Pokuaa Baiden has a vast working experience in Management, Sales and Marketing, Procurement and Supply Chain systems within the pharmaceutical and health institutions in Ghana spanning both the public and private sectors. She has also held various leadership positions within the Pharmaceutical Society of Ghana, including her current role as the Chairperson for the Western Region. Prior to her appointment she was a senior pharmacist at Takoradi Hospital. She worked at Effia Nkwanta Regional Hospital and was in Senior Management position at DAAMASS Company and DANAFCO Limited where she developed business strategies to drive superior marketplace execution while maximising brand performance.

She is credited with redesigning business processes to increase organizational efficiency and profitability. Yaa Pokuaa holds a B. Pharm from the Kwame Nkrumah University of Science and Technology, Ghana; a Postgraduate Diploma in Management from the International Professional Managers Association, UK; an MBA in Project Management from the Ghana Institute of Management and Public Administration and an MBA from the Swiss Management Centre University. She is a Board member of the Chartered Institute of Administrators and Management Consultants, Ghana, and a Chartered Professional Administrator. She has published articles in Quality Assurance and Internal Audit Performance. Yaa Baiden is an astute Administrator who is practically oriented and ethically guided to manage business operations & management systems of an entity with scarce resources.

MR. FRANCIS OWUSU: DEPUTY CHIEF EXECUTIVE, FINANCE & INVESTMENT

Mr. Francis Owusu has over 25 years working experience in Corporate Finance, Banking, and Investment Analysis in Ghana and abroad. As a senior management member in most of the organizations he worked, he was involved in corporate strategy, policy development & direction and general management.

Mr. Francis Owusu served as a General Manager at Bedrock Venture Capital Finance Company, where his responsibility included due diligence, policy review and evaluation of prospective investee companies. He was also the Head of Credit at GN Bank at the critical time of the Bank's operations where he made significant contributions to the bank's growth. At GN Bank, he managed and monitored high end client portfolio and ensured compliance with agreed covenants

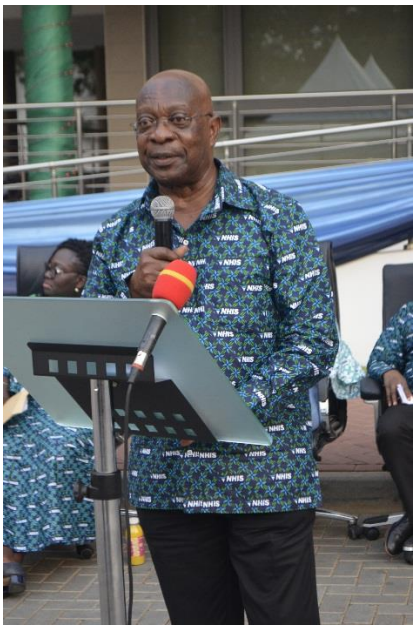
Prior to this, Mr. Francis Owusu worked with United Technologies Corp (Pratt and Whitney) in Connecticut in the United States. He was responsible for providing pricing for all large Engines Business products to ensure price competitiveness and meeting stringent company targets. He had a stint with AT&T Corp in New Jersey in the United States serving in various capacities as Market Analyst, Pricing Product Manager, Finance Manager and Strategy Manager.

Mr. Francis Owusu has a Master's in Business Administration (MBA) in Finance and International Business from Columbia University Graduate School of Business in New York and a Bachelor of Science (BSc.) degree in Accounting from Rutgers University in New Jersey. He also obtained a Master's Certificate of Project Management from Stevens Institute of Technology at Hoboken, New Jersey. The list of directors is shown below:

DIRECTORS

Ben Yankah	Chief Actuary
Ben Kusi	Director, Membership & Regional Operations
Dr. Gustav Cruickshank	Director, Financial Management
Ahmed Imoro	Director, Budget & Management Accounting
Perry Nelson	Director, Management Information Systems
Emmanuel Fianko	Director, Procurement & Projects
Francis-Xavier Andoh-Adjei	Director, Research, Policy, Monitoring & Evaluation
Raphael Segkpeb	Director, Administration & Human Resource
Dr. Francis Asenso-Boadi	Ag. Director, Provider Payment
Vivian Addo-Cobbiah	Ag. Director, Quality Assurance
Hudu Issah	Ag. Director, Private Health Insurance Scheme

CHAIRMAN'S ACKNOWLEDGEMENT



The NHIS, as was established 15 years ago, had an important objective of abolishing the financial crippling inequities of the cash and carry system through the provision of financial risk protection against the cost of basic quality healthcare for all residents in Ghana.

Over the past 2 years under my chairmanship, innovative financial and administrative measures required to make the Scheme sustainable using electronic solutions such as electronic claims payment, electronic-receipting and electronic-renewal of membership have been introduced. Huge financial savings are expected to accrue to the Scheme through these innovative approaches.

To this end, I pledge the Board's commitment to the use of these technologies to improve financial, administrative and operational efficiency to enhance transparency, accountability and cost effectiveness.

On behalf of the Board of Directors, I wish to thank our stakeholders for the firm confidence and support given to the NHIA over the years. I would also like to express my sincere gratitude to the loyal employees at all levels for their contributions to the growth and business performance for 2018.

We remain resolute and committed to the needs of our Members and cherished Providers in the coming years. I would therefore like to take this opportunity to request for the continued support and dedication of staff of the NHIA as well as our external stakeholders for the success of the Scheme.

Thank you.

Prof. Yaw Adu-Gyamfi
Board Chairman

CHIEF EXECUTIVE'S STATEMENT

The year 2018 has ended successfully amidst few challenges. During the year under review, the NHIA managed to put its finances on a solid foundation as the Government rescued the Scheme from debts accrued since 2014. Payment of claims improved in 2018 as Providers received reimbursements of outstanding claims from 2014 to the first quarter of 2018.

The NHIA is happy with the decoupling of the NHIL from VAT which is expected to increase the yearly inflow to the NHIA by about 60%.

The NHIA, in collaboration with the ILO, has developed a system where members can sit in the comfort of their homes and use their mobile phones to renew their NHIS membership. This innovation is expected to reduce the characteristic long queues usually found at most of our district offices.

Going forward into 2019, the NHIA will continue to:

- Strengthen internal controls to safeguard its funds by blocking all potential leakages
- Strengthen the internal policing mechanisms (Internal audit, Clinical audit and Legal) to effectively deal with fraud against the Scheme
- Improve on its electronic claims processing

The support received from the Board, Executive Management, staff and stakeholders cannot be over-emphasised. I appreciate the team spirit and cordial working relationship with a technically efficient management team who have always kept their "eyes on the ball".

I salute all Directors, Deputy Directors, Managers and Officers of the Authority and reiterate my appreciation of your collective talents, co-operation and friendship.

I wish to thank all NHIS stakeholders for their continued support and commitment to building a sustainable Health Insurance Scheme.

Thank you.

Dr. Samuel Yaw Annor

Chief Executive

EXECUTIVE SUMMARY

The National Health Insurance Authority (NHIA) is one of the agencies under the Ministry of Health, established by the National Health Insurance Act, 2003 (Act 650). In 2012, the Act was repealed and replaced by a new law (Act 852). The object of the Authority under Act 852 is to attain universal health insurance coverage in relation to persons residents in Ghana, and non-residents visiting Ghana, and to provide access to healthcare services to persons covered by the scheme. Thus, the NHIA is mandated by law to secure the implementation of the National Health Insurance Scheme (NHIS), by registering, licensing and regulating health insurance schemes in the country, both private and public.

The NHIA is also mandated by law to assess and credential healthcare providers, as well as monitor their performance for efficient and quality service delivery. The Authority is responsible for managing the National Health Insurance Fund (NHIF) and devising mechanisms to ensure that indigents are adequately catered for under the NHIS.

The NHIA is governed by a 17-member Board representing various stakeholder organisations appointed by the President of the Republic of Ghana. Executive Management team of the Authority comprises the Chief Executive and 3 Deputy Chief Executives.

During the year under review, active membership of the Scheme increased from 10.66 million in the previous year to 10.80 million. Registration of persons below the age of 18 years recorded the highest enrolment share of 47%. Credentialed health care facilities increased by 199 bringing the total number of credentialed facilities to 4,385. This increase represents 5% of the previous year's number of credentialed healthcare facilities. By ownership, 68% of the credentialed healthcare facilities are government or public healthcare facilities and 25% are private healthcare facilities. The remaining 7% constitutes Mission and Quasi-public facilities.

Utilization of both outpatient and inpatient health care services over the last two years (2017-2018) went upward. Outpatient visit increased from 25.25 million in 2017 to 27.55 million in 2018. Likewise, inpatient visits increased from 1.51 million to 1.65 million from 2017 to 2018. Average number of visits per active card-bearing member (per capita utilization) for the year under review

was 1.51 for outpatient services and 0.01 for inpatient services. A total of GHS1,008.45million was paid to healthcare providers as against GHS1165.61 paid in 2017. Claims incurred for the year represented 61.75% of the total expenditure of the NHIA for the year. The Authority earned a total revenue of GHS1,816.21 million and incurred total expenditure of GHS1,633.23 million, resulting in a net operating surplus of GHS182.98million.

Several stakeholder engagement activities and projects were also undertaken to create more awareness for the Scheme, increase enrolment and to improve efficiency. Key among the projects were the e-renewal of membership, on-site banking, e-receipting and roll out of Sage Accounting Software. The e-renewal allows members to conveniently renew their membership electronically by dialing *929#. This project has improved renewal rate considerably since its launch in December 2018. The NHIA is poised to improve and sustain the Scheme by securing a sustainable financial model for the Scheme; institutionalizing electronic claims processing; strengthening the internal policing (Clinical and Internal Audit) to detect fraud against the Scheme; and reviewing the NHIS law to make crime against the Scheme more punitive.

1.0 INTRODUCTION

The National Health Insurance Authority (NHIA) is mandated by law to secure the implementation of the National Health Insurance Scheme (NHIS). The Authority is responsible for the registration, licensing and regulation of health insurance schemes in the country. It also grants credentialing to healthcare providers and monitor their performance for efficient and quality service delivery. It is responsible for managing the National Health Insurance Fund (NHIF) and devising mechanisms to ensure that poor and vulnerable are adequately catered for under the NHIS.

1.1 Governance

The NHIA is governed by a 17-member Board drawn from various stakeholder organisations. The Chief Executive of the NHIA is a member of the Board. The Board which is responsible for the proper and effective performance of functions of the Authority is appointed by the President of the Republic of Ghana. The Board Members represent various stakeholder groups which include the Ministry of Health, Ghana Health Service, National Insurance Commission and the Ministry of Finance. Others are the Attorney General's Department, 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 of the National Health Insurance Scheme.

1.2 Management

The Executive Management of the Scheme is headed by Dr Samuel Yaw Annor, the Chief Executive and assisted by three Deputy Chief Executives in charge of operations, administration and human resource, and finance and investment. Other members include technical Directors and Deputy Directors of various Directorates and Departments. The regional offices of the NHIA are headed by Regional Directors while the district offices are managed by District Managers.

1.3 Corporate Goal

The goal of the National Health Insurance Authority is "to attain universal health insurance coverons resident in and or visiting Ghana in an equitable manner; and to provide them with access to quality health care services''.

1.4 Corporate objectives for 2015-2018 medium term

Implementation of the NHIS is guided by a medium-term strategic plan to enable management focus on its core mandate. Core among the corporate objectives for 2015-2018 are as follows:

1. To provide ***universal*** and ***equitable*** health insurance coverage for all residents in, and those visiting Ghana
2. To ensure ***efficiency*** in fund mobilization and the financial management of the Scheme
3. To purchase ***effective*** and ***quality*** health care services ***in a cost-efficient manner*** for members of the Scheme
4. To develop and maintain a ***robust institutional and managerial capacity*** for the efficient management of health insurance in Ghana
5. To secure a ***vibrant and progressive*** health insurance industry in Ghana
6. To promote a ***sustained public education*** on the NHIS

2.0 MEMBERSHIP ENROLMENT

2.1 Active membership and population coverage

Over the past five years, the NHIS active membership has seen a fluctuating trend as shown in Figure 2.1. The active membership increased by 8% from 10.55 million members in 2014 to 11.34 million members as at the end of 2015. Thereafter, there was a decline to 10.66 million members in 2017. However, it assumed an upward trend in 2018, posting an end of year record of 10.80 million members, representing an increase of 2%.

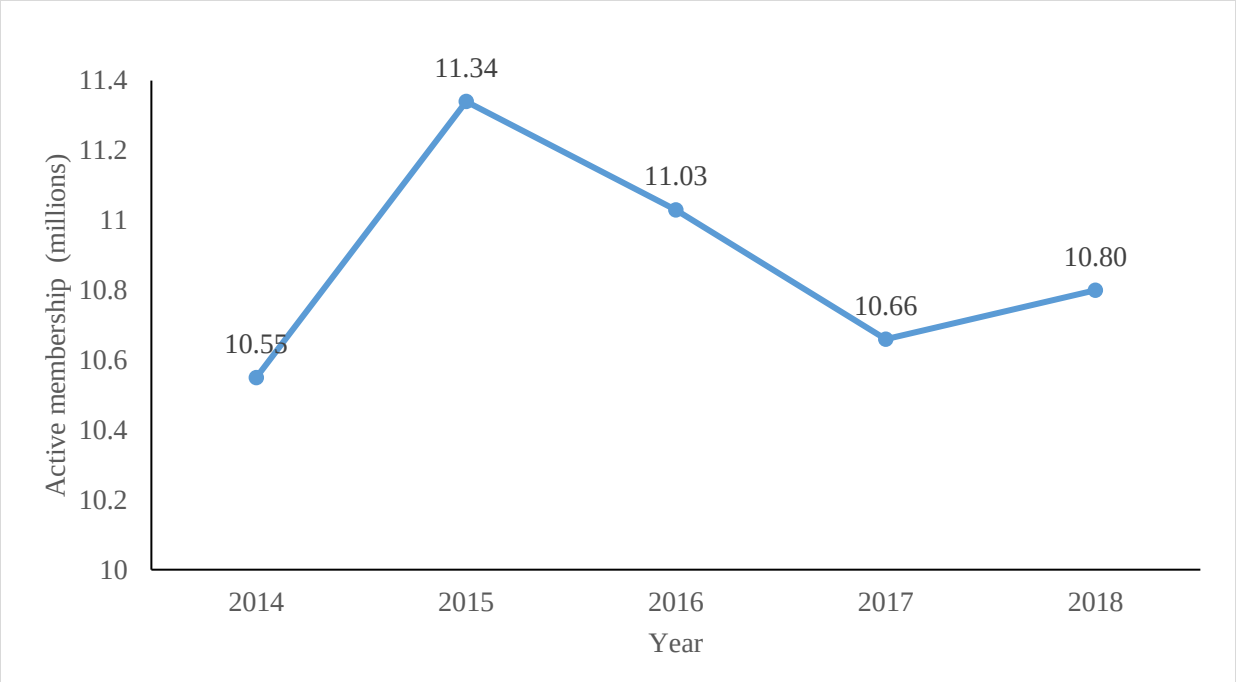


Figure 2.1 Active Membership in millions, 2014-2018

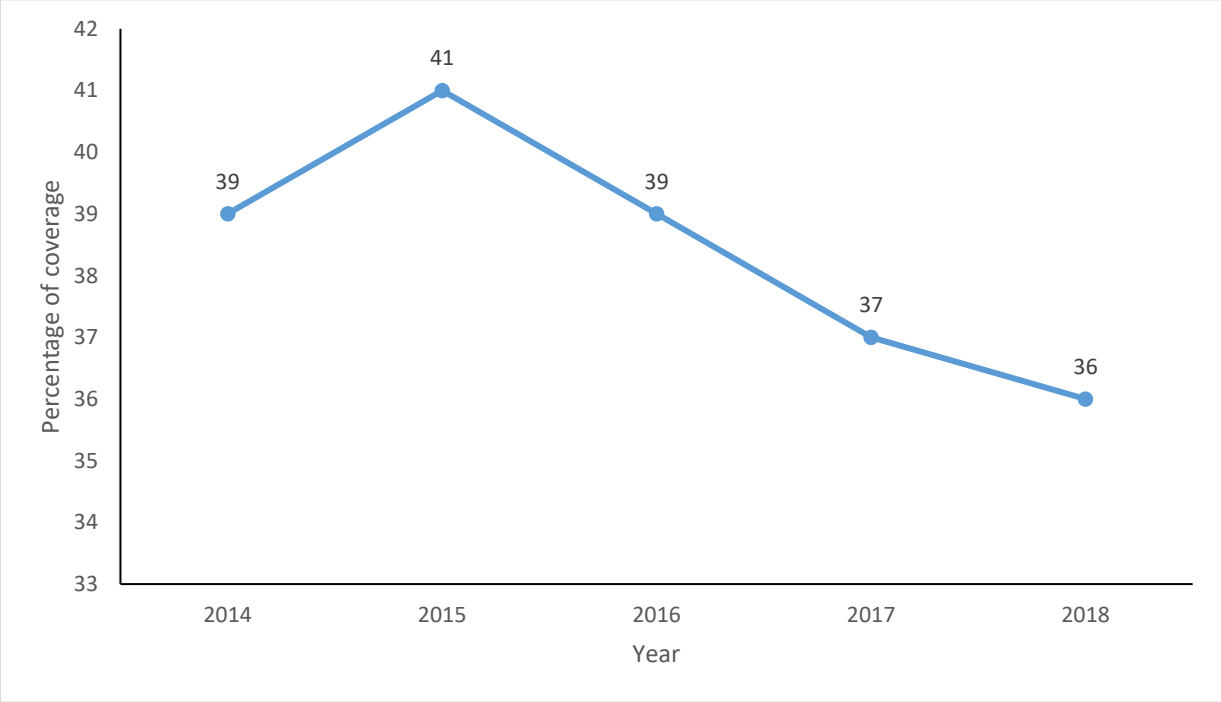


Figure 2.2 Population coverage, 2014-2018

In terms of regional population coverage, Figure 2.3 shows that Upper West Region recorded the highest population coverage of 55%, followed by Upper East and Brong-Ahafo with 54% and 49% respectively. The Greater Accra Region recorded the least coverage of approximately 30%.

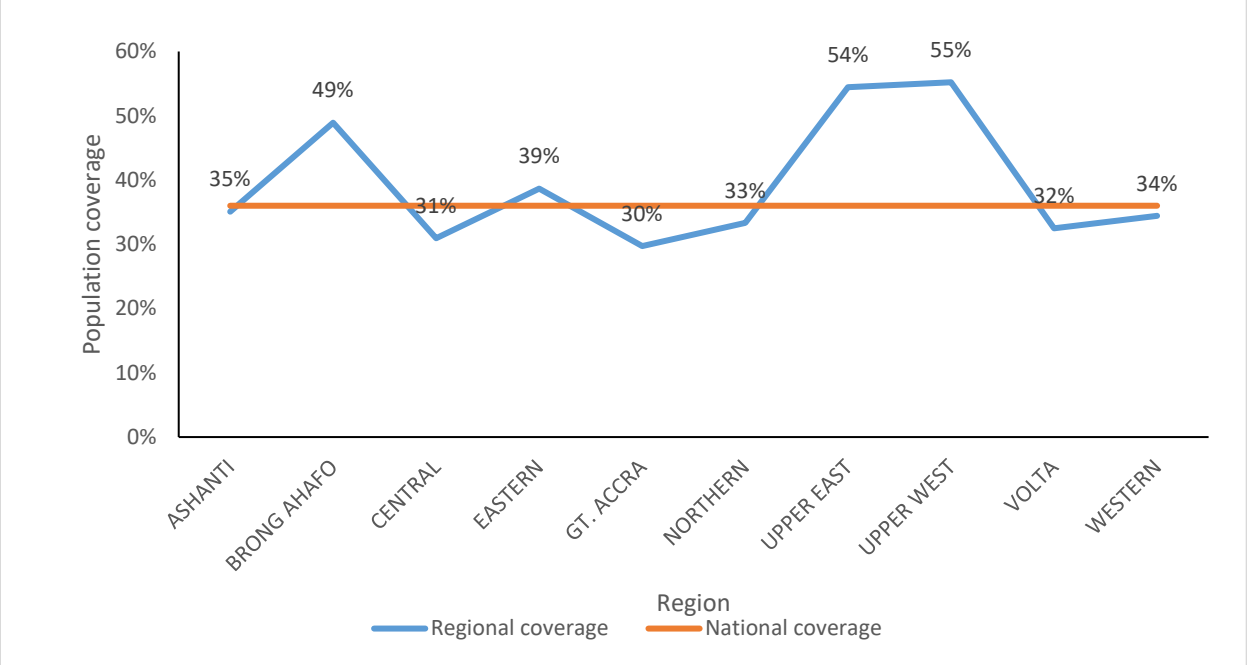


Figure 2.3 Population coverage by region, 2018

2.2 Enrolment of indigents

Enrollment of indigents showed a downward trend from 1.5 million in 2014 to 404,839 in 2018.. Figure 2.4 below shows the 5-year trend of indigent enrolment onto the NHIS.

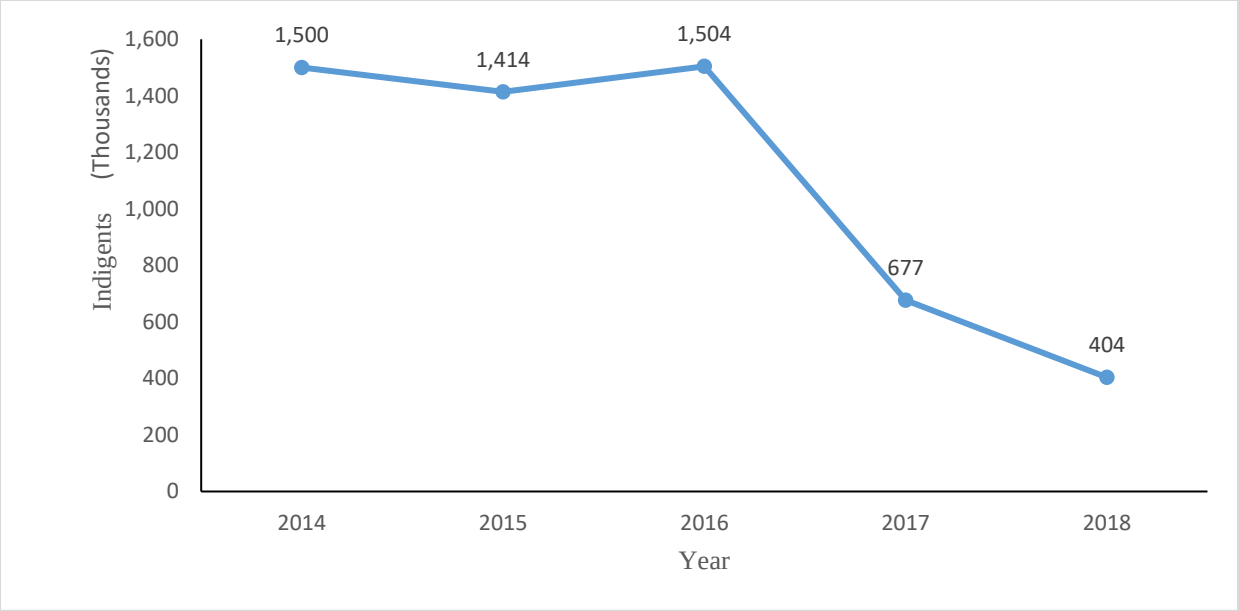


Figure 2.4: Trend of indigent enrolment, 2014 – 2018

2.3 Active membership by category

Active membership by category shows that persons under the age of 18 years recorded the highest share of membership (47%), followed by the informal sector (32%). Each of the other membership categories; however, recorded less than 10% of the total membership as shown in figure 2.5 below.

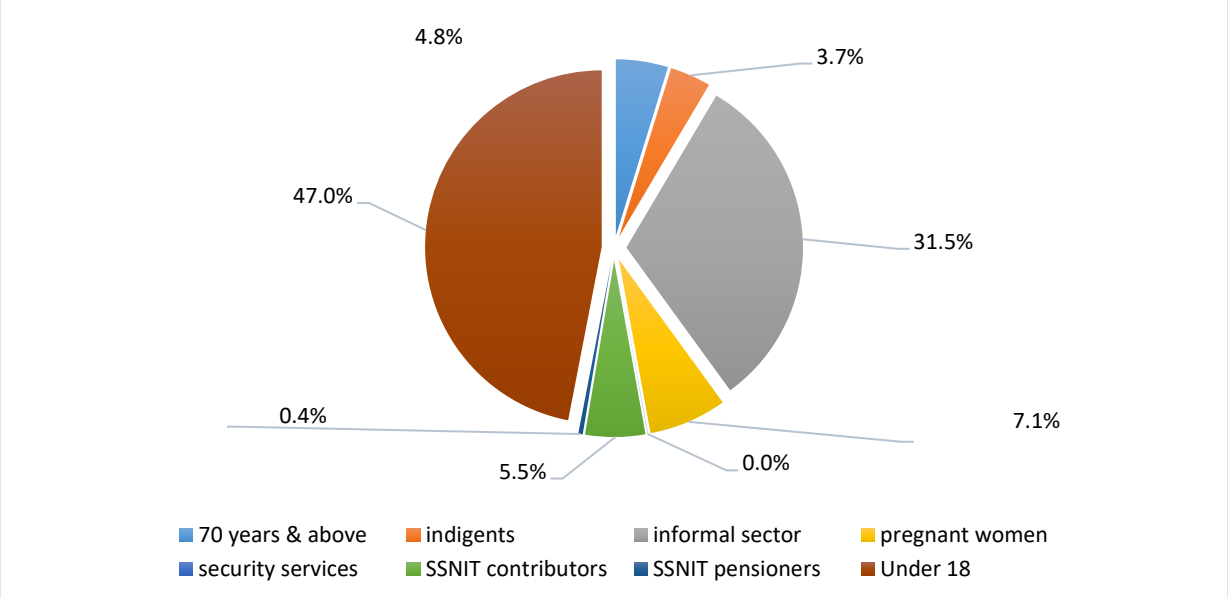


Figure 2.5: NHIS Active Membership by category, 2018

3.0 UTILIZATION AND CLAIMS EXPENDITURE

3.1 Out-patient Utilization

Out-patient utilization of healthcare services decreased by approximately 17% from 30.37 million visits in 2014 to 25.55 million visits in 2017. However, this downward trend changed between 2017 and 2018, where utilization increased from 25.25 million to 27.55million (9%) visits as shown in Figure 3.1 below.

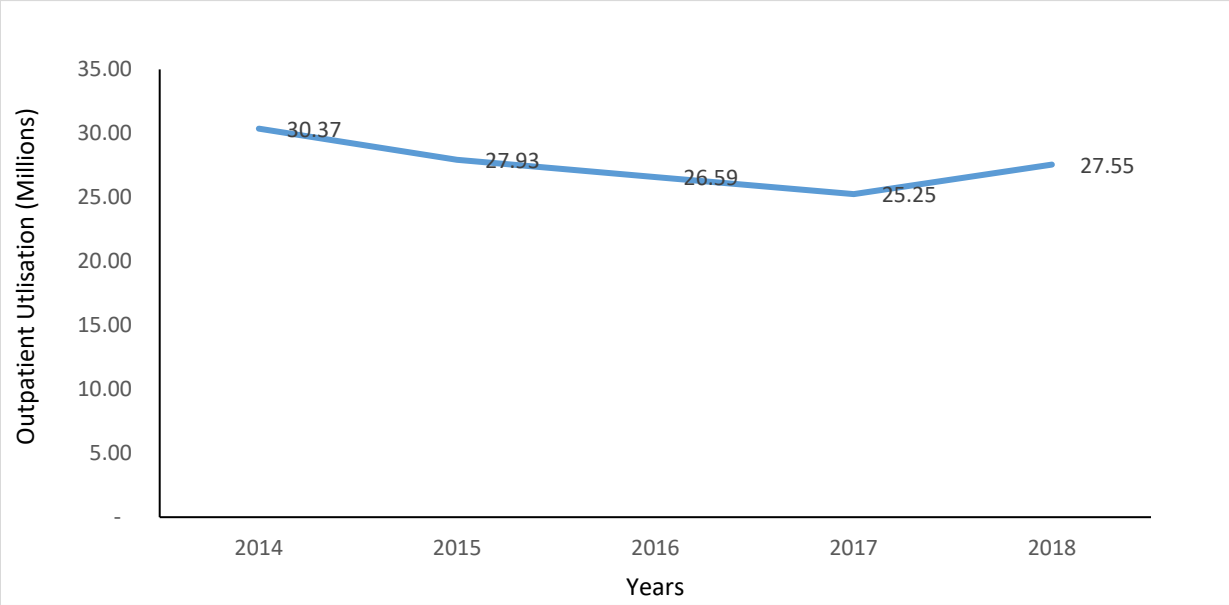


Figure 3.1: OPD utilization in millions, 2014-2018

3.2 In-patient utilization

In-Patient healthcare utilization (or admissions) increased from 1.68 million visits in 2014 to 1.75 million visits in 2015 after which it decreased sharply to 1.51 million visits in 2017. As seen under the out-patient utilization, the year under review recorded an upward trend in inpatient utilization. Figure 1.5 below illustrates the inpatient trend over the last five years.

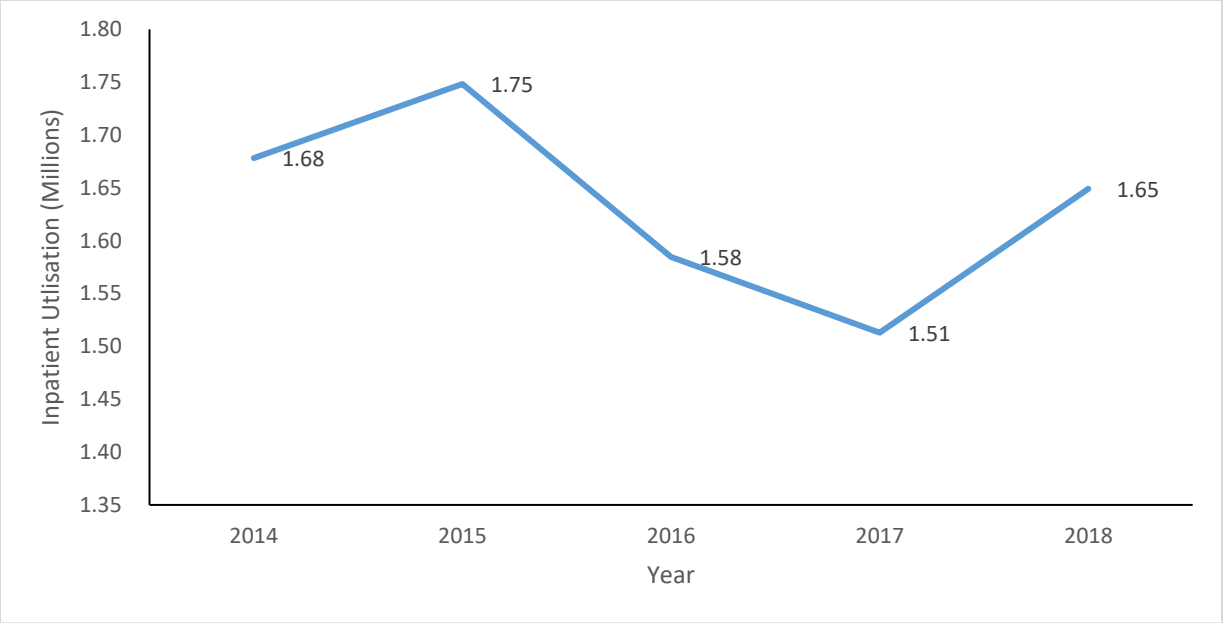


Figure 3.2: In-Patient utilization in millions, 2014-2018

3.3 Utilization per card-bearing member

Generally, utilization per member for both outpatient and inpatient services has seen a downward trend over the last five years, 2014-2018. This may be attributed to improved health status of members, thus changing their health care seeking behaviour. Furthermore, it could also be attributed to effective measures put in place by the NHIA to control provider shopping by members. As seen over the years, per capita utilisation for outpatient services was higher than that of inpatient services. Whilst the trend in per capita outpatient utilization decreased from 2.37 visits in 2017 to 2.54 visits in 2018, that for inpatient services increased marginally from 0.14 to 0.15 visits over the same period (Figure 3.3).

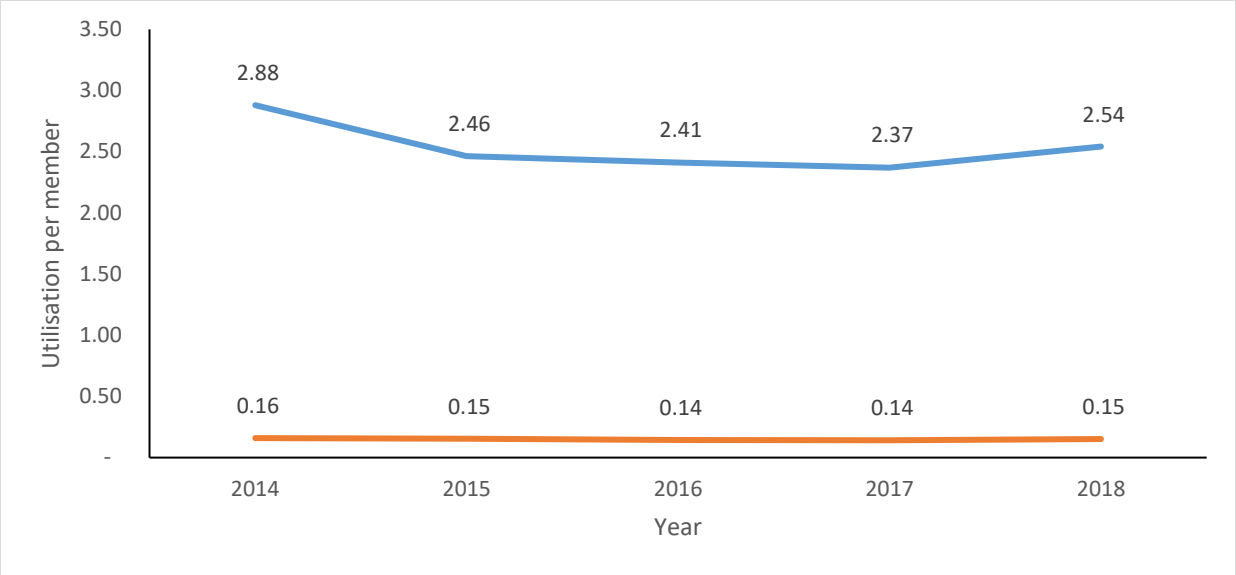


Figure 3.3: Utilization per card bearing member, 2014-2018

3.4 Claims Expenditure

Claims expenditure increased from GHS884.29 million in 2014 to GHS895.47 million in 2016, as shown in Figure 3.4. After this, claims expenditure to credentialed healthcare providers shot up by 30% to GHS1,165.61 million in 2017. There was however a decline from GHS1,165.61 to GHS1,008.45 million (13.5%) between 2017 and 2018.

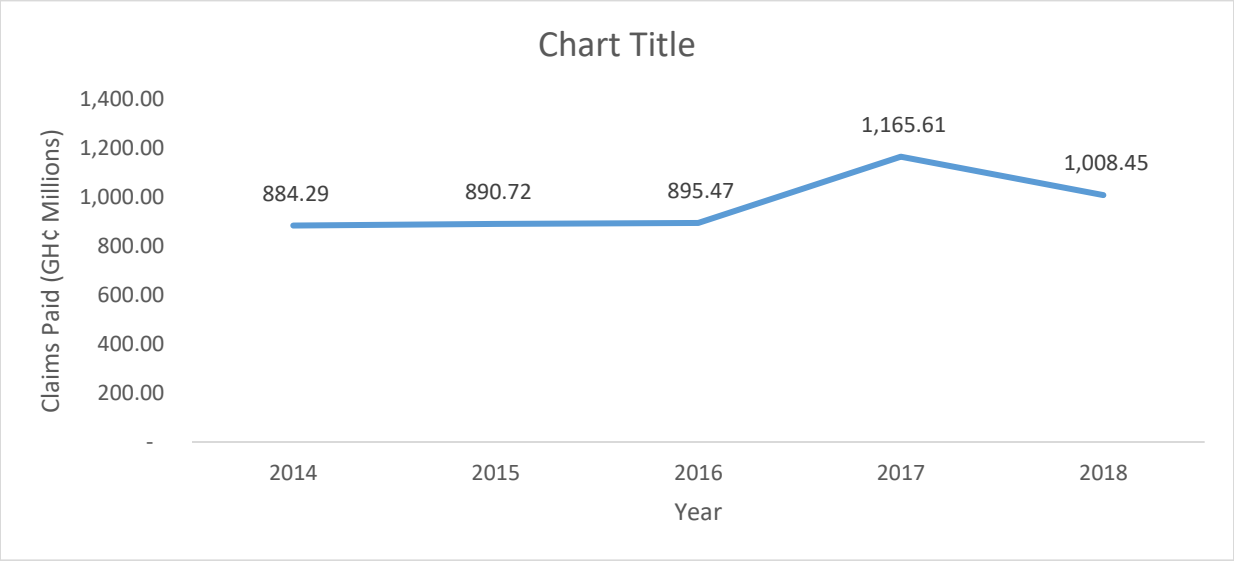


Figure 3.4: NHIS Claims Expenditure in millions, 2014-2018

4.0 CREDENTIALED HEALTHCARE PROVIDERS

The total number of credentialed health care facilities increased from 4,186 in 2017 to 4,385 in 2018 representing an addition of 5% (199) facilities. The Western region recorded the highest number of credentialed facilities of 598 followed by Ashanti and the Eastern regions with 589 and 566 credentialed facilities respectively. Upper West and Upper East regions had the least number of credentialed facilities. The wide network of credentialed facilities across the country is in line with the NHIS's aim of providing geographical access to healthcare services for the insured particularly in the remotest areas of the country. Figure 4.1 shows the credentialed facilities per region.

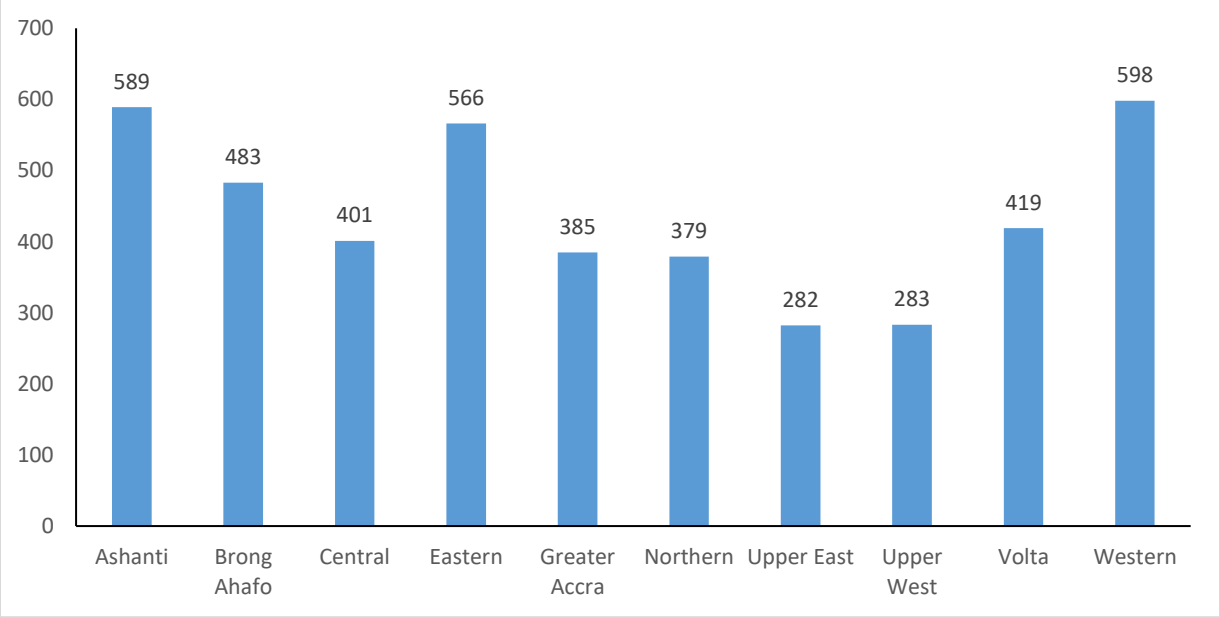


Figure 4.1: Number of healthcare facilities credentialed by region, 2018

The total number of credentialed facilities by ownership indicates that public facilities constitute the largest share of 68%, followed by private facilities with 25% ownership. Together, the Mission and Quasi-government facilities represent less than 10% of the total facilities credentialed in the year under review, as shown in Figure 4.2.

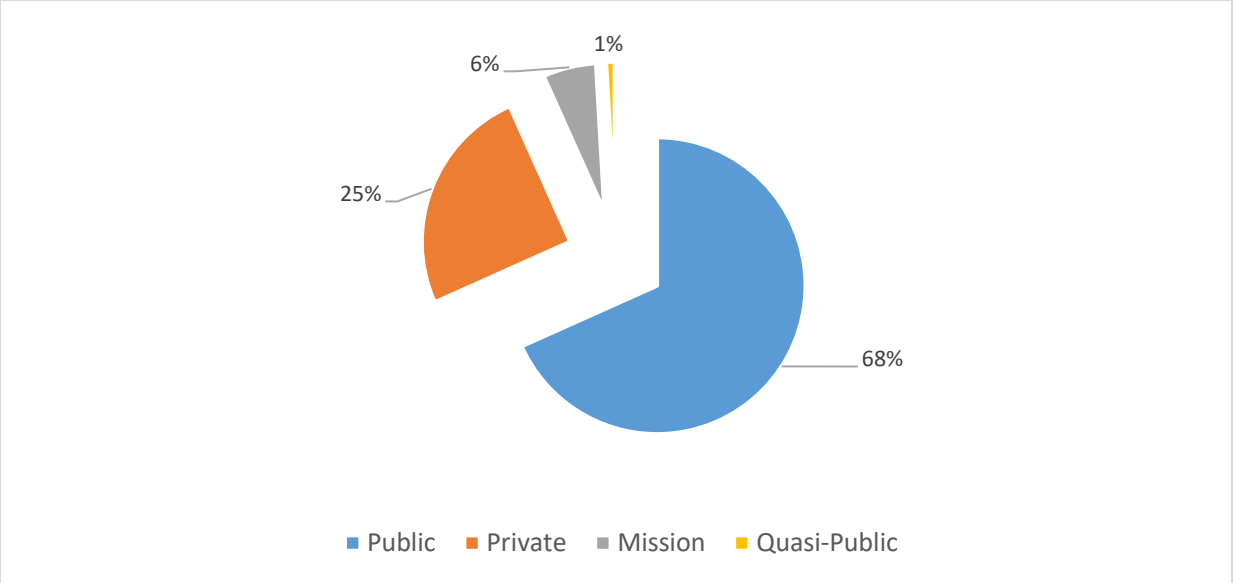


Figure 4.2: Percentages of credentialed facilities by ownership, 2018

Figure 4.3 shows that, majority of the credentialed healthcare facilities (2,341), were CHPS compounds, Health Centers (799) and the Primary Hospitals (366). These 3 types of credentialed facilities constitute about 80% of the total number.

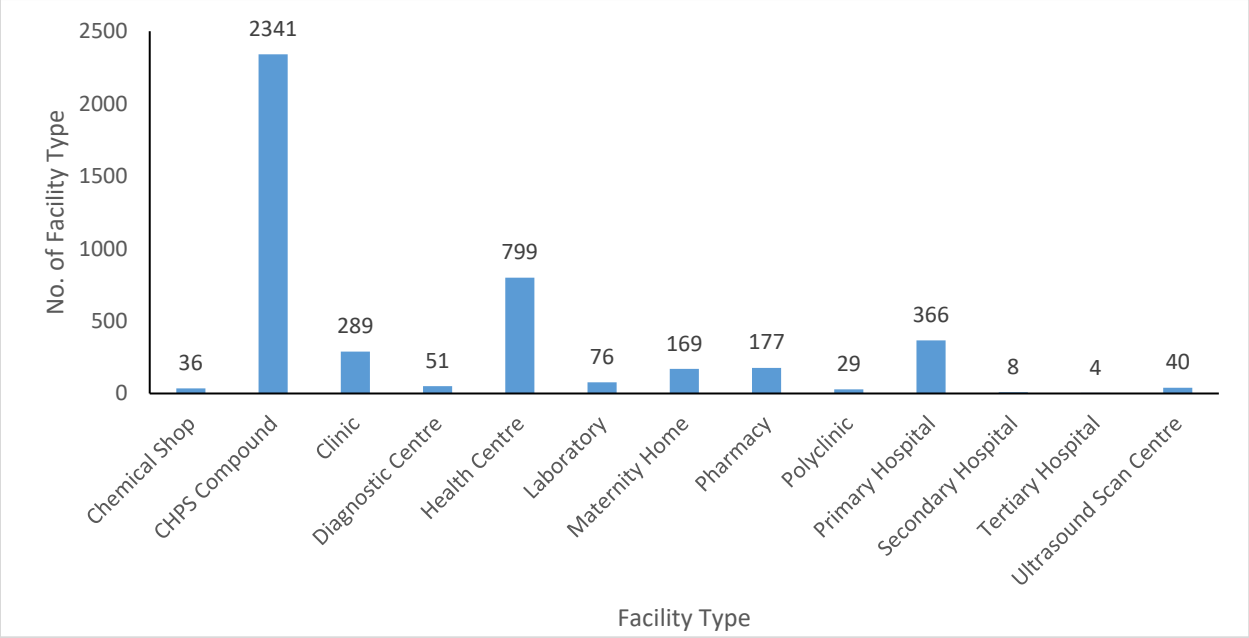


Figure 4.3: Number of Credential facilities by Type, 2018

In addition, majority of the credentialed healthcare facilities obtained Grade B, representing a score of 70-79%, followed by Grade C with assessment score of 60-69%. Together, healthcare facilities that obtained these two grades constitute approximately 75% of the total number of healthcare facilities credentialed in 2018 (Figure 4.4).

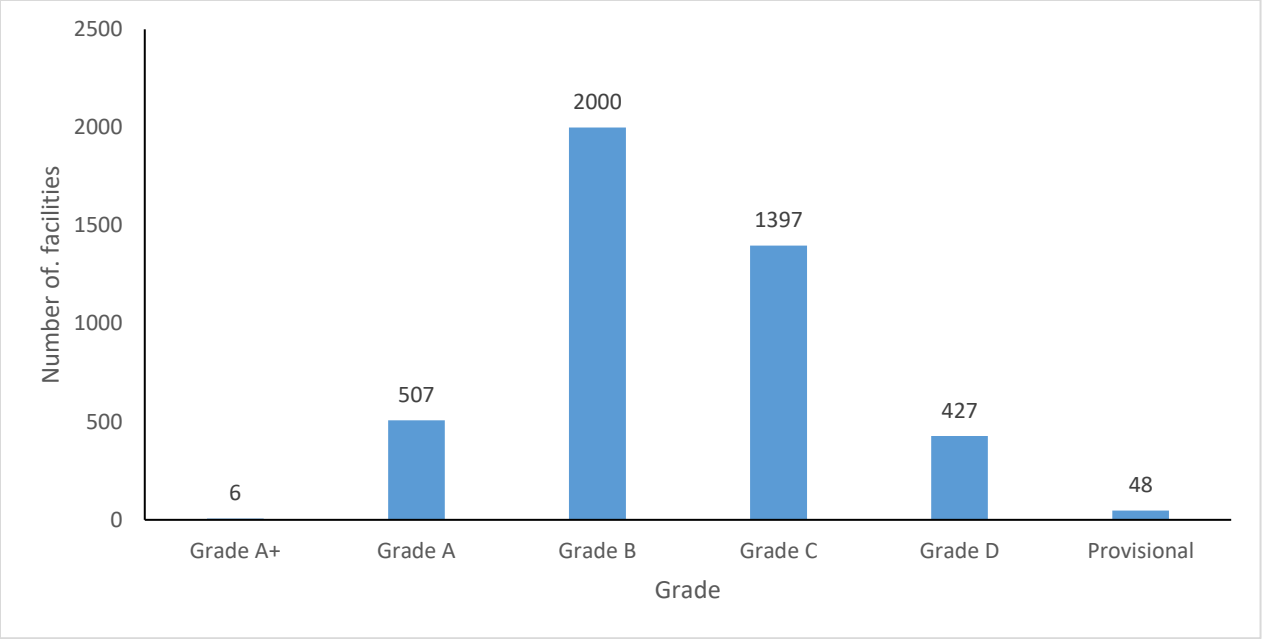


Figure 4.4: Number of facilities credentialed by standards

5.0 FINANCIAL MANAGEMENT

Section 39 of Act 852 established the National Health Insurance Fund (NHIF) and places responsibility of its management on the shoulders of the Board. The object of the Fund is to provide funds to subsidize the cost of provision of healthcare services to members of the NHIS. As of 31 December 2018, the Authority earned a total revenue of **GHS 1,816.21 million** and incurred total expenditure of **GHS 1,633.23 million,** resulting in a net operating surplus of **GHS 182.98 million**. Claims cost for the period was **GHS 1,008.45 million,** representing 61.75**%** of the total expenditure. The NHIL/SSNIT due from Government/Ministry of Finance at the end of the year 2018 was **GHS 1,169.68 million**. The Fund's investment portfolio (principal amount) stood at **GHS49.02 million** as at 31 December 2018. Detailed financial statement is attached as Appendix 1.

5.1 Financial sustainability

In the year under review, the Authority conducted actuarial evaluation based on best historical and current data assumptions. The results of the actuarial review showed that increase in membership coverage has a significant impact on utilization of healthcare services and consequently the cost to the Scheme. Even in the case of a modest increase in active membership by one percentage point per annum, with respect to the national population, the increase in utilization and hence cost, will be substantial. Tariff increases also have a significant effect on the expenditure of the Scheme. An aggressive increase in tariffs resulted in projected deficits appearing earlier. A moderate annual increase in tariffs resulted in a significant reduction in deficits. The NHIA has initiated a number of efficiency measures to address the dire financial situation confronting the Scheme. Considering the increasing demand for health services as evidenced in the increase in utilization over the years, the efficiency gains cannot replace the need for additional funding.

6.0 STAKEHOLDER ENGAGEMENT

As part of efforts to increase the involvement of stakeholders in the activities of the NHIA, series of engagements were held in the year to deliberate on specific issues relating to improvement in the operations of the Scheme. To this effect, several stakeholder engagements were conducted across the country, notable amongst them was the Chief Executive's nationwide tour to meet with organized labour groups and other stakeholders including regional and district staff of the Scheme.

6.1 Chief Executive's nation-wide tour

The Chief Executive and three Management members embarked on a nationwide visit from January 23 to February 13, 2018 to dialogue with staff at both regional and district offices, engage with regional and district representatives of organised labour and visit some provider facilities to acquaint himself with their operations. The main objective of the tour was to interact with regional office staff together with District Managers and organized labour groups to promote Management's 4 strategic pillars aimed at solving the major challenges confronting the Scheme.

The four strategic pillars centered on the following:

1. Exploring additional sources of funding

2. Implementing a fully electronic claims management system to improve efficiency and minimise fraud.
3. Improving compliance by enhancing Quality Assurance and Clinical Audit functions as a mechanism to mitigate fraud.
4. Amending the NHIS law to make crime against the Scheme more punitive and to serve as a deterrent to potential fraudsters.

The Chief Executive was accompanied by:

- Mr. Ben Kusi, Director, Membership & Regional Operations
- Mr. Oswald Essuah-Mensah, Deputy Director, Marketing
- Mr. Harold Boateng, Deputy Director, CEO's Secretariat

The team was later joined in by Dr. Lydia Dsane-Selby (Deputy Chief Executive, Operations) and some Board members notably Dr. Dennis Addo and Rev. Richard Kwasi Yeboah who made brief appearances at some of the events in the Ashanti and the Eastern Regions respectively. The nationwide tour offered the Chief Executive the opportunity to obtain information from the stakeholders which aided his planning. The tour culminated in decoupling of NHIL from VAT to generate more revenue for the Scheme; issuance of fiat (binding edict) by the Attorney General's Department to enable NHIA to prosecute its cases; and strengthening of collaboration with key stakeholders.

6.2 Public fora

The NHIA collaborated with other government agencies to develop and implement a Communication Strategy that aimed to create awareness of Management's proposals for new reforms and to gain stakeholder buy-in and support.

The Communication strategy resulted in the organization of public town hall meetings in 3 regions namely, Ashanti, Northern and Eastern. Management also visited district and regional offices of the Authority across the country and interacted with staff to better appreciate their working conditions and to provide motivation and support where needed. Courtesy calls were made to significant traditional leaders, health care facilities and the political heads including Regional Ministers in the regions. Media briefing and presentations were conducted for media practitioners

and other stakeholders to deepen their knowledge on the workings of the Scheme and to equip them with adequate information to enhance the public discourse on issues regarding the Scheme.

6.3 Media interactions

During the year 2018, over 300 interviews (radio & television) were granted to the media to discuss NHIS matters. Majority of the interviews were initiated by the NHIA to promote our policies and also to provide responses to issues affecting operations of the Scheme around the country. Social media engagements and interactions increased further with likes on Facebook hitting a record high of approximately 40,000 followers. Fifteen news stories were generated internally and circulated to media houses for publication and upload onto the corporate website and portals. Relevant stories were also culled from other media portals and shared on all NHIA news portals. On a daily basis, information affecting the general health industry including news on the NHIS were obtained and circulated as press cuttings for management attention and decision-making.

6.5 Study tour

The National Health Insurance Scheme, which is arguably Ghana's best social intervention program, has won the admiration of many countries the world over.

With the growth in membership of the NHIS and improvement in its service delivery, a number of countries and organisations from across the world visited the National Health Insurance Authority to understudy its operations including claims management and the credentialing assessment of potential providers.

In 2018, **s**ixty delegates from 14 countries embarked on study tours of the National Health Insurance Authority. The delegation comprised participants from the USA, Senegal, Tanzania, DFID-Uganda, Kenya, Democratic Republic of Congo, Malawi, Burkina Faso, Mali, Madagascar, Kenya, Niger, Cote d' Ivoire and Mauritania.

The visits created the platform for information and knowledge sharing between Ghana and the visiting countries. Various Directorates at the Authority took turns to share lessons with the visiting delegations on all occasions. Some participants of such study tours got the opportunity to experience hands-on operational dynamics at the head office, Claims Processing Centre in Accra and selected district offices.

6.4 Collaboration with Development Partners

The NHIA has benefited from the support of Development Partners (DPs) over the years. In the year under review, five DPs provided either financial or technical assistance to the NHIA. The DPs and their respective support or projects are indicated in the table below:

Table 1.3: Development Partners and their area of support

Development Partner	**Area of support/Project**
The United States Agency for International Development (USAID)	The USAID funded three projects namely; expansion of clinical audit activities, capitation rollout and capitation communication.
The British Department for International Development (DFID)	The United Kingdom through its agency, DFID provided financial support for the NHIA for the improvement of its financial management systems.
The Korean Foundation for International Health Care (KOFIH)	The NHIA and the KOFIH have been involved in a joint research study in the Volta Region since 2014 to improve membership enrolment in the NHIS. The first phase of the project ended in December 2018.The KOFIH partners also provided logistics, including one 4x4 Toyota vehicle (Fortuner), one 4x4 Toyota Pick Up (Hilux), and four motor bikes to support the project.
French Development Agency (AFD/ILO)	The International Labour Organisation (ILO), with financial and technical support from the French Development Agency (AFD), funded a 2-year collaborative project aimed at improving NHIS membership renewal process. The project was successfully completed in 2018.

Development Partner	Area of support/Project
United Nations International Children Emergency Fund (UNICEF)	UNICEF in collaboration with NHIA and other stakeholders from the MOH has developed "Every Mother Every New-born" (EMEN) Standards which have been incorporated into the existing NHIA credentialing tools. They have also donated 50 electronic tablets to NHIA for collecting data to support healthcare facility credentialing activities.
Marie Stopes International	In the year under review, Marie Stopes, together with Population Council supported the NHIA to pilot inclusion of family planning services in the NHIS benefits package in selected districts of four regions (Volta, Central, Ashanti, and Upper East). They also provided logistical support (computer tablets) to facilitate data collection.

6.6 General Staff Durbar

The NHIA held an end of year review meeting at the Head office on Friday, 21st December, 2018 for its head office and selected staff from the regional and district offices. The review meeting afforded Management and the Board the opportunity to interact with staff and to discuss progress made in relation to on-going policy reforms. For instance, a new human resource policy to rationalize conditions of service, and to incentivize staff to give off their best. Additionally, the day which is usually for refreshments and entertainment provided staff the congeniality to shed off stress in a relaxed environment. Long-serving staff who retired in the year under review were rewarded with refrigerators. Hardworking staff were also awarded accordingly.

7.0 PROJECTS AND PROGRAMMES

The NHIA has embarked on several Projects and Programmes over the years with the view to improving on its operations. These activities have yielded significant results to the benefit of the Scheme and its stakeholders. In the year under review, five new projects were rolled out: onsite banking and e-receipting, e-renewal of NHIS membership, facility mapping in the central region,

inclusion of family planning in the NHIS benefits package was piloted in selected districts across four regions; and implementation of Sage accounting software at the regional and district offices.

7.1: On-site Banking and E- receipting project

The NHIA has operated manual system of collecting its Premium & Processing fees since inception. An evaluation of this manual system of operation revealed a number of control weaknesses. In 2016, the Authority introduced the e-receipting system and On-site banking on pilot basis to inject efficiency into its financial operation. The objective was to ensure proper accountability of funds and to comply with regulation 15 of the Financial Administration Regulation 1802, LI 2014. To achieve compliance of the regulation, the Authority partnered with the National Investment Bank (NIB) to ensure that banking is done on the same day after the close of the day's business.

The electronic receipting system which uses automated platform to issue receipts for the collection of revenue is an in-house software developed by Management Information System (MIS) Directorate. In April 2016, the Controller and Accountant Generals Department (CAGD) granted the Authority approval to pilot the system in 34 selected District Offices across the regions. Following the successful implementation of the pilot, the CAGD granted the Authority approval to rollout the system nationwide. This was successfully done across the country in 2018

7.2: E-membership renewal project

In 2017, the NHIA and the International Labour Organisation (ILO), with support from the French Development Agency (AFD), started a 2-year collaborative project aimed at improving the NHIS membership renewal process. The objective of the project is to use digital technology to develop a user-friendly member renewal solution and a secure authentication system via strategic partnerships with third parties. This was to replace the manual renewal process that created long queues at the NHIA district offices across the country. The project is to digitize the renewal process to allow members the option of remotely renewing their NHIS membership through digital means, such as mobile phones. Following a period of rigorous investigation, successful prototype solutions for digital renewal and authentication processes were developed at East Mamprusi in the

Northern region and Asuogyaman in the Eastern Region and piloted. After a successful pilot of the system, it was rolled-out across the country in December 2018.

7.3: Implementation of Sage accounting software

Prior to the deployment of Sage 300 ERP, NHIA District Offices were operating different kinds of accounting systems. This posed a serious challenge to the Authority in the preparation of a consolidated financial statement over the years which is a legal requirement imposed by the coming into force of Act 852, 2012 which established the Authority.

To address these challenges, the Authority introduced a common Accounting Software called Sage 300 ERP to all the 165 District Offices and 10 Regional Offices, with support from DFID. The Authority started the deployment of the Sage 300 Accounting Software with Greater Accra Region. All the District Accounting staff were trained on the use of the system. The rollout was done in phases and has been extended to all the District Offices in the remaining regions. In 2018, a fresher training workshop was organized for Sixty (60) selected District Accounts Staff on all the modules in the Sage to upgrade their knowledge and skill on the Sage Software.

7.4. Implementation of health facility mapping

Since 2014, the National Health Insurance Authority (NHIA) and Ghana Health Service (GHS), in collaboration with the USAID's Health Finance and Governance (HFG) Project have been implementing a provider mapping exercise to provide information on the geographical location of providers and assess their capacity to provide basic primary health care package. To date, this exercise has been implemented in five regions: Upper East, Upper West, and Volta regions (2014); Ashanti region (2016); and Central region (2018).

To improve efficiency in the data collection exercise, the guidelines and tools used in the previous facility mapping study were revised in 2018 by NHIA and USAID-funded Health Finance & Governance Project (HFG The revised guidelines and tools include the collection of data using GPS digital devices and expanded to collect data on non-clinical facilities as well. It also made provision for continuous data collection to update the status of Health facilities in the region at any point**.**

The table below summarizes the findings from the provider mapping exercise conducted in Central region between May and August 2018, where **1,093 health facilities** (clinical and non-clinical) were mapped and surveyed.

Number of Facilities Surveyed

Health Facility Category	Count	Percentage
Clinical Facilities	415	38%
Non-Clinical Facilities	678	62%
Total	1093	100%

Key findings from Central region:

- CHPS made up the majority of clinical providers (63 percent) followed by health centres (15 percent) in Central Region.
- 77 percent of clinical facilities and 5 percent of non-clinical facilities are credentialed by the NHIA. Only 5 percent of clinical facilities are accredited by the Health Facilities Regulatory Agency (HeFRA).
- When Level 1 staffing capacity criteria (gold standard) are applied, 6 percent (23 of 415) of clinical providers meet the criteria and could serve as stand-alone PHC providers. No CHPS compounds meet these criteria.
- When Level 2 staffing capacity criteria (gold standard) are applied, 46 percent (192 of 415) of clinical providers meet the criteria and could serve as stand-alone PHC providers.
- 18 percent of clinical health facilities (75 out of 415) have the full set of equipment that is considered necessary to deliver primary health care services. The piece of equipment that is most often missing is suction machine.
- Findings from Central region are similar to those from Ashanti, Upper East, Upper West, and Volta regions.

Key policy implications:

- CHPS and health centres are critical part of the population's access to primary health care.
- There are large gaps in human resource capacity to deliver primary health care.

- Essential equipment needed for primary health care is lacking across regions in Ghana.

7.5. Piloting of Family Planning

The revised NHIS Act 852 (2012) specifies inclusion of 'any relevant FP package' in the NHIS benefit package. As part of preparation towards possible inclusion of FP onto NHIS benefit package, the NHIA in collaboration with the Marie Stopes, Population Council and the Ghana Health Service is piloting the inclusion of Family Planning (FP) services.

The pilot commenced on May 1, 2018 in 7 districts in the Northern Region (Bolgatanga, Bawku West and Nabdam Districts), Central Region (Mfantsiman and Ekumfi Districts), Ashanti Region (Obuasi Municipal) and Volta Region (Adaklu District). In addition, 3 districts (Upper Denkyira East, Upper Denkyira West and West Mamprusi) were selected as controls for evaluation purposes. All NHIS credentialed health facilities in the pilot districts are participating in the pilot. The pilot covers FP clinical methods (Vasectomy, BTL, implants, IUD, Three months and One Month Injectable). Family Planning commodities are procured by Government and donors and supplied free of charge to participating healthcare facilities through the Ghana Health Service Family Planning Division. In all, a total of 125 healthcare facilities from 7 districts are participating in the pilot which is expected to end in April 2020

7.6 NHIS @15 Celebration

September 2018 marked the 15th Anniversary of the enactment of the National Health Insurance Act, 2003 (Act 650) that gave birth to the NHIS. Over its relatively short existence, the Scheme has made significant strides thereby receiving global acclamation as a promising model of social protection and healthcare financing in Sub-Saharan Africa. On the occasion of its 15th year in existence, it was worthy for the Scheme and its stakeholders to pause, take stock of its successes, challenges and opportunities to inform future planning. Detailed Programme activities were

DATE	EVENT	VENUE
15/12/2018	Health Walk / Clean Up Exercise	All District Offices
18/12/2018	Kick-Off and Lecture	British Council, Accra

19/12/2018	Regional Floats	All Regional Capitals
19/12/2018	Launch of Innovations	Jubilee House, Accra

The main anniversary lecture was delivered by **Prof. Irene Agyepong** on the topic, "***NHIS@15: the Journey so far - success, challenges and the way forward".*** A panel discussions followed after the presentation.

Highlights of presentation

On the journey so far, Prof. Agyepong spoke on the history of the Scheme, the vision as at its inception and how that vision has been achieved. She gave the vision of the Scheme which was birthed through extensive stakeholder engagements as ***"to assure equitable universal access to quality basic package of health services to all residents of Ghana without being required to pay out of pocket at point of consumption of services".*** The presentation was in two parts – the journey so far, and successes, challenges and the way forward.

The Journey so far

Prof. Irene Agyepong gave brief history of how the Scheme was formed noting that there was wide stakeholder consultations. She gave the long-term, medium term and the short-term objectives for setting up the Scheme as follows:

Long term policy objective:

That every resident of Ghana shall belong to a health insurance Scheme that adequately covers him or her against the need to pay out -of -pocket at the point of service use and also obtain access to a defined package of acceptable quality needed health services.

Medium term policy objective:

Within 5 to 10 years in the life of the scheme, 50-60% of residents of Ghana will belong to a health insurance Scheme that adequately covers them against the need to pay out of pocket at the point of service use and obtain access to a defined package of adequate quality needed health services.

Short term policy objective:

Within the five years in the life of the scheme, the necessary bodies will be created, awareness raising and consensus building carried out, needed legislation passed and the enabling environment

created to ensure the realization of the medium and long term policy goals of Government. At the same time efforts will be made to achieve 30-40% nationwide insurance coverage. She mentioned that, the design of the proposed Health Insurance Scheme was to be guided by some principles and values of which EQUITY was of great concern. Equity was synonymous to fairness and justice.

The NHIA has however, not done well with the social equity it sought to offer. Other principles included risk equalization, cross-subsidization, and quality of care. The NHIA being a regulator and a purchaser of insurance poses as a major conflict of interest and in-balance of power in institutional arrangements. The regulator must be reasonably independent of the players, in this case, the NHIA as the purchaser, providers (public & private) and clients.

On the successes chalked by the scheme, Prof. Irene mentioned that there is increased OPD utilization and protection for the insured poor. Further, there is strong and genuine continuing high level government commitment to successful reform. She noted that the Scheme is resource constrained and said further that there are some administrative inefficiencies and barriers to enrolment that must be eliminated. In addressing some of the identified challenges facing the scheme, Prof. Agyepong suggested the following:

Universal Health Coverage (UHC)

Ghana should focus on covering essential health services and reducing the proportion of the country's population with catastrophic health expenditure.

Population Coverage

Encourage household registration using local government structures and deploying district Scheme office staff to focus on strategies to cover non-formal members. Negotiate with employers to deduct at source their premiums and deliver their cards to avoid long queues at the district offices.

Payment system

DRG as a payment system is not effective, and an alternative should be found. The NHIS should revisit the per capita payment and fix the glitches uncovered during the pilot in the Ashanti Region

Benefit Package

Given the NHIA context, the benefit package is comprehensive enough and any expansions should focus on health prevention and preventive services related to Ghana's burden of disease.

Credentialing

The NHIA should set a minimum and maximum number of providers who can be accredited to provide same service in a given geographical area in relation to population.

Prof. Irene Agyepong gave out strategies for reducing out-of-pocket (OOPs) and co-payments as follows:

- Timely and adequate payment of providers for the content of the package must accompany efforts to eliminate OOP fees and copayments
- If the NHIA cannot provide adequate reimbursement, then the NHIA should legalise a certain level of OOP to bring the problem out of the shadows and onto the table

7.7: Launch of innovations by H E Alhaji Dr. Mahamudu Bawumia, Vice President of Ghana

The NHIS@15 anniversary was climaxed with the launch of innovations of the NHIA by His Excellency, Alhaji Dr. Mahamudu Bawumia, the Vice President of the Republic of Ghana, on December 19, 2018 at the Jubilee House. The innovations were e-receipting and e-membership renewal. His Excellency, the Vice President, Alhaji Dr. Mahamudu Bawumia lauded the NHIA for the progress made in the Scheme noting that, the NHIS has become a beacon of health insurance models not only in Africa but in the world.

He commended the NHIA Management Team and the Ministry of Health for the sterling job done in the last two years having inherited a Scheme which was virtually on the verge of collapse. He recounted Ghana's resolve towards achieving Universal Health Coverage (UHC) hopefully before 2030 as well as the NHIS' unique position and legal mandate as the country's vehicle to attaining UHC. Ghana, he said, is still committed to the Abuja declaration of assigning not less than 15% of annual budgetary allocation to the health sector and steady progress is being made towards achieving that.

His Excellency, the Vice President noted that it was evident that Ghana's NHIS continues to provide at least 80% of internally generated funds (IGF) of most healthcare facilities in Ghana, and has improved the health seeking behaviour of the population.

He noted further that, the NHIS aside its enviable strides, is bridled with some challenges which are being effectively handled by the able Board and Management.

8.0 CONCLUSION

The year under review recorded an increase in the number of members enrolling in the Scheme compared to that of last year; however, it recorded a decline in coverage relative to the projected population. Both outpatient and inpatient utilization of health services also increased but there was slight decline in amount of claims paid, which is positive for sustainable growth of the Scheme. The number of healthcare providers joining the Scheme also grew compared to that of the previous year, with majority being CHPS compound, health centres, and primary hospitals.

The NHIA also embarked on a number of stakeholder engagement activities nationwide to create more awareness for the Scheme and also educate and sensitize the public on the need to enroll to seek financial risk protection. Besides, a number of projects were also undertaken to improve operations of the scheme. Key among them is the mobile membership renewal and authentication project with collaboration from the ILO. Since the launch of this project, the number of members renewing their membership has gone up considerably and it is anticipated that the negative trend in population coverage will be reversed in the coming years.

Going forward, the NHIA is poised to position the Scheme on a more sustainable level by pursing the following four foundational pillars:

1. Securing a sustainable financial model for the scheme
2. Institutionalising Electronic claims processing
3. Strengthening the Internal policing (Clinical and Internal Audit) to detect fraud against the Scheme.
4. Reviewing the NHIS law to make crime against the Scheme more punitive

APPENDIX : AUDITED FINANCIAL STATEMENT

NATIONAL HEALTH INSURANCE AUTHORITY
STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 31 DECEMBER, 2018

REVENUE		**2018**	**2017**
	Notes	**GH¢**	**GH¢**
Levies income	**3**	**1,676,794,966**	1,627,242,760
Investment income	**4**	**23,318,411**	24,952,735
Premium & processing fees	**5**	**103,250,675**	73,919,232
Bilateral donors	**6**	**11,177,169**	173,397
Other income	**7**	**1,666,633**	2,839,288
		1,816,207,854	1,729,127,412
EXPENDITURE			
Claims of Service Providers	**8**	**1,008,449,279**	1,165,612,644
Support to partner institution	**9**	**237,034,317**	89,922,343
General and administration expenses	**11**	**270,457,404**	219,635,881
ID Card & biometric expenses	**12**	**117,287,972**	59,093,211

	1,633,228,972	1,534,264,079
Excess revenue/expenditure	**182,978,881**	194,863,333

ACCUMULATED FUND

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018	**2017**
	GH¢	**GH¢**
Balance at 1 January	**149,952,495**	(44,910,838)
Prior year	**1,679,593**	-
Excess revenue/expenditure	**182,978,881**	194,863,333
Balance at 31 December	**334,610,969**	149,952,495

The notes on pages 12 to 22 form an integral part of these financial statements.

NATIONAL HEALTH INSURANCE AUTHORITY
STATEMENT OF FINANCIAL POSITION AS AT 31 DECEMBER, 2018

	Notes	**2018**	**2017**
		GH¢	**GH¢**
Non-Current Assets			
Property, plant and equipment	**13**	**75,991,268**	87,529,439

Current Assets			
Accounts receivable and prepayment	**14**	**1,208,867,166**	998,579,418
Investment	**15**	**49,023,120**	78,954,602
Cash and cash equivalents	**16**	**43,411,804**	82,752,650
Total Current Assets		**1,301,302,090**	1,160,286,670
Total Assets		**1,377,293,358**	1,247,816,109
Accumulated Fund and Liabilities			
Current liabilities			
Accounts payables	**17**	**1,042,682,389**	1,097,863,614
Accumulated Fund	**18**	**334,610,969**	149,952,495
Total Fund and Liabilities		**1,377,293,358**	1,247,816,109

The Financial Statements on pages 12 to 22 were approved by the Board of Directors on

…… and signed on its behalf by:

……. **…….**

DIRECTOR: **DIRECTOR:**

NATIONAL HEALTH INSURANCE AUTHORITY
STATEMENT OF CASH FLOW FOR THE YEAR ENDED 31 DECEMBER 2018

	2018	2017
OPERATING ACTIVITIES	**GH¢**	GH¢
Receipts		
National health insurance levy	**1,473,598,245**	1,205,740,038
Investment income	**16,278,711**	19,383,083
Bilateral donor	**11,177,169**	173,397
Premium & processing fees	**103,250,675**	73,919,232
Other income	**1,666,633**	2,839,288
	1,605,971,433	1,302,055,037
Payment		
Claims paid to Service Providers	**1,050,483,850**	880,806,447
ID card & biometric expenses	**101,726,972**	65,282,951
General & administrative expenses	**276,466,303**	169,118,290
Support to ministry of health	**228,897,338**	98,850,479
	1,657,574,463	1,214,058,167
Cash flow from operations	**(51,603,030)**	87,996,870
INVESTING ACTIVITIES		

Purchase of PPE	**(17,669,295)**	(26,138,461)
Proceeds from disposal of PPE	**-**	48,347
Purchase of investment	**-**	(57,215,434)
Proceeds from disinvestment	**29,931,479**	56,545,316
Net cash generated in investing activities	**12,262,184**	(26,760,232)
Net Increase/(decrease) in cash and cash equivalents	**(39,340,846)**	61,236,638
Cash and cash equivalent as at 1 January	**82,752,650**	21,516,012
Net Increase/(decrease) in cash and cash equivalents	**(39,340,846)**	**61,236,638**
Cash and cash equivalent as at 31 December	**43,411,804**	82,752,650

The notes on pages 12 to 22 form an integral part of these financial statements.

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2018.

1. REPORTING ENTITY

These financial statements are for a public sector entity (the National Health Insurance Authority) set up under the then National Health Insurance Act 2003, (Act 650) now replaced by National Health Insurance Act, 2012 (Act 852).

2. SIGNIFICANT ACCOUNTING POLICIES

a. Basis of Preparation:

The National Health Insurance Authority (NHIA) financial statements have been prepared in accordance with International Public Sector Accounting Standards (IPSAS) issued by the International Public Sector Accounting Standards Board. Where an IPSAS does not address a particular issue, the appropriate International Financial Reporting Standard (IFRS) issued by the International Accounting Standards Board (IASB) is applied.

The financial statements have been prepared on the historical cost basis unless otherwise stated in the accounting policies.

b. Accounting standards update

In July 2016, the International Public Sector Accounting Standards Board released IPSAS 39, Employee Benefits. IPSAS 39 will replace existing guidance in IPSAS 25, Employee Benefits, and is intended to bring the standard in line with its private-sector IFRS equivalent, IAS 19, Employee Benefits. On January 1, 2016, National Health Insurance Authority elected to early adopt the provisions of IPSAS 39 on a retrospective basis, which impacted the prior period financial statements.

c. Changes in accounting policies and disclosure

The preparation of financial statements in conformity with IPSAS requires the use of certain critical accounting estimates. It also requires the Board to exercise its judgement in the process of applying the Institute's accounting policies. All estimates and underlying assumptions are based on historical experience and various other factors that the Board believes are reasonable under the circumstances. The results of these estimates form the basis of judgements about the carrying value of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognized in the period in which the estimates are revised and any affected future periods. Areas involving a higher degree of judgment or complexity, or areas where assumptions and estimations are significant to the financial statements are:

- Useful life of Property and equipment,
- Net realizable value of inventories,
- Recoverability of receivables and
- Classification of financial assets

d. Revenue

The main sources of funding for the Authority are:

- The National health insurance levy
- 2.5% of the social security contribution
- Grants
- Investment income

- Levy from national insurance commission
- Premium income and processing fees

Other income principally comprises fees from credentialing of service providers, proceeds from sales of tender documents, NHIS authentication software and any other services provided. Where income had been received for a specific activity to be delivered in the following financial year, that income will be deferred.

Revenue is recognized to the extent that it is measured at the fair value of the consideration received or receivable.

e. Investments

Long term investments.

Long-term investments are valued at fair value at the closing date in accordance with IFRS 9. Any change in value is recorded under "change in fair value of investments" in the Statement of Financial Performance. The institution considers as long-term investments, if it has decided to keep for more than one year. This concerns the investments managed by financial institutions which have guaranteed capital at maturity date.

Short-term investments

Short-term investments are valued at fair value at the closing date. Any change in value is recorded under "change in fair value of investments" in the Statement of Financial Performance.

Surplus cash balance held by the Authority are invested in accordance with the Authority's Annual Investment Strategy and the National Health Insurance Act, 2012 (Act, 852).

The Investments are fixed deposits invested with various universal banks and financial institutions in Ghana.

f. Investment Income

Interests earned on investments are accrued and charged to Statement of Financial Performance.

g. Taxation

The Authority has received an exemption from the Ghana Revenue Authority (GRA) from income taxes under Income Tax Act, 2015 (Act 896). National Health Insurance Authority is required to make the appropriate tax payments on any income considered unrelated to its exempt purpose.

h. Employee Benefits Obligations

The Authority has defined benefit and contribution plan for its employees in respect of which the Authority pays contributions to publicly and privately administered pension schemes on a mandatorily and contractual basis.

The contributions are recognized as employee expenses (staff cost) when they are due. Under the plan the Authority pays fixed contributions to a separate entity and has no future legal or contractual obligation to pay further contributions if the fund does not hold sufficient assets to pay all employees their benefits relating to employee service in the current and future periods.

i. Property, Plant and Equipment

Property and equipment are carried at cost, and are depreciated or amortized on a straight-line basis over their expected useful lives. The useful lives, residual values, and depreciation methods are reviewed annually

The estimated useful lives of property and equipment are as follows:

• Buildings	-	20 years
• Nationwide ICT infrastructure	-	4 years
• Computers & accessories	-	4 years
• Office equipment	-	5 years
• Plant & machinery	-	5 years
• Furniture & fittings	-	4 years
• Motor vehicle	-	5 year

Gains and losses on disposals are determined by comparing proceeds with carrying amounts, and are included in the statement of financial performance. Repairs and maintenance are charged to the statement of financial performance during the period in which they are incurred.

j. Expenditure

Expenditure on support to schemes and partner institutions are recognized when the Authority has paid or has obligation to transfer funds to the District Offices and other beneficiary institutions. Other operating expenses are recognized when, and to the extent that, the goods and services have been received. Expenditure is shown inclusive of irrecoverable VAT. The irrecoverable VAT is charged to the most appropriate expenditure heading or capitalized if it relates to an asset.

k. Estimates and Assumptions

The preparation of financial statements in accordance with IPSAS requires the use of judgments, estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. The most significant estimates and assumptions relate to the allocation of revenues, expenses, assets, and liabilities for the purposes of segment reporting.

Although these estimates are based on management's best knowledge of current events and actions, actual results ultimately may significantly differ from those estimates.

l. Leases

Operating lease

(a) The Authority as the lessee: Leases in which a significant portion of the risks and rewards of ownership are retained by another party, the lessor, are classified as operating leases. Payments, including pre-payments, made under operating leases (net of any incentives received from the lessor) are charged to profit or loss on a straight-line basis over the

period of the lease. The total payments made under operating leases are charged to 'general administrative expenses' on a straight-line basis over the period of the lease. When an operating lease is terminated before the lease period has expired, any payment required to be made to the lessor by way of penalty is recognized as an expense in the period in which termination takes place.

(b) The Authority as the lessor: There were no lease arrangements at the reporting date in which the Authority was the lessor.

m. Impairment of non-financial assets.

The Authority assesses at each reporting date whether there is an indication that an asset may be impaired. If any such indication exists, or when annual impairment testing for an asset is required, the Authority makes an estimate of the asset's recoverable amount. The recoverable amount is the higher of the fair value less cost to sell and value in use and is determined for an individual asset, unless the asset does not generate cash inflows that are largely independent of those from other assets or groups of assets. Where the carrying amount of an asset exceeds its recoverable amount, the asset is considered impaired and is written down to its recoverable amount. In assessing value in use, the estimated future cash flows are discounted to their present value using a discount rate that reflects current market conditions of the time value of money and the risk specific to the asset.

An assessment is made at each reporting date as to whether there is any indication that previously recognized impairment losses may no longer exist or may have decreased. If such indication exists, the recoverable amount is estimated. Other than for goodwill, a previously recognized impairment loss is reversed if there has been a change in the estimate used to determine the asset's recoverable amount since the last impairment loss was recognized. If that is the case, the carrying amount of the asset is increased to its recoverable amount. The increased amount cannot exceed the carrying amount that would have been determined, net of depreciation, had no impairment loss been recognized for the asset in prior years. Such reversal is recognized in profit or loss. After such a reversal the depreciation charge is adjusted in future periods to allocate the asset's revised carrying amount, less any residual value, on a systematic basis over its remaining useful life.

n. Foreign Currency translation.

Transactions and balances.

Foreign currency transactions are translated into Ghana cedi's using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlements of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognized in profit or loss.

o. Financial Instruments

Financial instruments include cash and cash equivalents, accounts receivable, and accounts payable. Financial instruments are recognized in the statements of financial position at cost, which approximates fair value due to their short-term nature.

I. Cash and cash equivalents

Cash and cash equivalents are carried in the statement of financial position at cost. Cash and cash equivalents comprise cash on hand, balances with banks and other short-term highly liquid investments with original maturities of three months or less.

II. Accounts receivable

Accounts receivable are recognized initially at fair value. They are subsequently measured at amortized cost using the effective interest method, less provision for impairment. A provision for impairment of accounts receivable is established when there is objective evidence that the Authority will not be able to collect all amounts due according to the original terms of the receivables.

III. Accounts payable

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Accounts payable are classified as current liabilities if payment is due within one period or less (or in the normal operating cycle of the business if longer). If not,

they are presented as non-current liabilities. Trade payables are recognized initially at fair value and subsequently measured at amortized cost using the effective interest method.

3. LEVIES INCOME	**2018**	2017
	GH¢	GH¢
NHIL/SSNIT contributions	**1,676,414,750**	1,626,878,020
National insurance commission levy	**380,216**	364,740
	1,676,794,966	1,627,242,760

4. INVESTMENT INCOME

This income consists of interest earned on fixed deposit investments with banks and other financial institutions.

5. PREMIUM INCOME AND PROCESSING FEES

This relates to premium collected and 40% of processing fee collected by the District Offices and transferred to Head Office during the year under review.

6. BILATERAL DONORS

These are funds received from our development partners.

7. OTHER INCOME

This comprises proceeds from NAVIS Application (NHIS card authentication software), sales of tender documents and credentialing fees among others.

8. CLAIMS OF SERVICE PROVIDERS	2018	2017
	GH¢	GH¢
Claims – medicines	**349,281,275**	358,635,873
Claims – services	**659,168,004**	650,363,323
Claims – capitation	**-**	19,731,364
Claims - district providers	**-**	136,882,084
	1,008,449,279	1,165,612,644

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2018

9. SUPPORT TO PARTNER INSTITUTION	2018	2017
	GH¢	GH¢
Primary health & preventive care	**73,446,680**	49,642,880
District health projects	**22,025,000**	18,790,000
Health service investment	**13,724,237**	17,304,463
Parliamentary monitoring and evaluation	**5,480,000**	4,185,000
Nursing training allowance	**122,358,400**	0
	237,034,317	89,922,343

10. REVENUE SURPLUS IS ARRIVED AT AFTER CHARGING THE FOLLOWING:

Audit fee	**295,313**	**265,781**
Depreciation	**29,207,465**	**24,993,436**
Board monthly allowance	**180,594**	**124,365**
Basic salary	**109,907,924**	**79,628,507**
SSNIT	**14,261,327**	**10,347,010**
Provident fund	**5,473,824**	**3,945,805**

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2018

11. GENERAL AND ADMINISTRATIVE EXPENSES	**2018**	**2017**
	GH¢	**GH¢**
Audit fees	295,313	265,781
Bank charges	583,851	397,025
Call centre expenses	12,655	497,756
Cleaning and sanitation	1,376,893	1,704,352
Board allowance and expenses	1,187,760	729,551

Depreciation expense	29,207,465	24,993,436
Maintenance (PPE)	2,039,483	2,259,206
Monitoring and evaluation activities	843,171	428,401
Publicity and communication	1,947,146	2,019,033
Rent	1,464,227	2,822,016
Software and hardware maintenance	27,976,499	29,227,219
Staff cost	158,412,514	131,030,554
Admin & logistical support to schemes	15,099,282	2,200,147
Training and consultancy	1,293,888	456,421
Travelling and transport	7,688,608	3,327,572
Utilities	2,402,545	2,752,968
Other expenses	1,007,496	1,184,468
Archival expenses	15,390,995	9,332,829
Professional fees & subscription	291,201	2,334,880
Security services	534,126	597,750
Donations & sponsorships	53,086	32,225
Exchange rate loss	200,149	842,291
Corporate social responsibility	1,149,051	200,000
	270,457,404	219,635,881

12. ID CARDS AND BIOMETRIC EXPENSES

This represents cost incurred in printing ID cards for NHIS subscribers

13. PROPERTY, PLANT AND EQUIPMENT

Cost/Valuation	Balance as at 1/1/2018	Addition	Disposal	Balance as at 31/12/2018
	GH¢	GH¢	GH¢	GH¢
Head office buildings	38,679,917	-	-	38,679,917
Work in progress	820,989	364,310	-	1,185,298
Land & buildings regional	7,932,437	3,656,472	-	11,588,909
ICT project	95,617,096	10,330,765	-	105,947,861
Computers	12,964,174	1,079,014	-	14,043,188

Furniture & fittings	5,877,434	322,883	-	6,200,314
Motor vehicles	15,567,965	1,774,299	-	17,342,263
Office equipment	25,545,986	141,555	-	25,687,541
	203,005,998	17,669,298	-	220,675,291

Accumulated Depreciation

	Balance as at 1/1/2018	**Charge for the year**	**Disposal**	**Balance as at 31/12/2018**
Head office buildings	8,158,063	1,933,996	-	10,092,059
Land & buildings regional	1,957,933	409,445	-	2,367,378
ICT project	60,402,391	18,882,094	-	79,284,485
Computers	11,880,779	1,132,166	-	13,012,945
Furniture & fittings	4,625,268	701,296	-	5,326,564

Motor vehicles	9,767,836	2,827,950	-	12,595,785
Office equipment	18,684,289	3,320,518	-	22,004,807
	115,476,559	28,602,872	-	144,684,024
NBV at 2018				**75,991,268**
NBV at 2017				**87,529,439**

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2018

14. RECEIVABLES AND PREPAYMENTS	**2018**	2017
	GH¢	GH¢
Levies receivable	**1,169,676,235**	966,479,513
Clinical audit deductions	**4,149,954**	6,292,274
Investment income receivable	**18,875,274**	11,835,574
Staff loans and advances	**1,058,402**	3,157,695
Prepayments and other receivables	**15,107,301**	10,814,363
	1,208,867,166	998,579,418

15. INVESTMENTS

CDH securities	-	4,931,460
Universal merchant bank	-	5
First allied savings and loans	**10,000,000**	10,000,000
G N bank	-	8,067,891
GCB (Erstwhile Unique trust bank)	**2,316,835**	2,316,835
CBG (Erstwhile Premium bank)	**9,590,356**	9,590,356
OmniBank	-	9,520,107
Legacy financial services	-	2,701,915
All-Time capital Ltd	**14,271,520**	14,271,520
CBG (Erstwhile Beige capital)		6,400,000
Bank of Africa	**10,734**	10,734
Bank of Ghana	**12,833,677**	11,143,779
		78,954,602

	49,023,120	

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2018

16. CASH AND CASH EQUIVALENTS	**2018**	2017
	GH¢	GH¢
Cash at bank	**43,399,938**	82,752,150
Cash at hand	**11,866**	500
	43,411,804	82,752,650

17. ACCOUNT PAYABLES

Support to partner institutions	**734,470**	979,137
Claims to service providers	**925,135,043**	971,248,299
Accrued expenses and other payables	**116,812,875**	125,636,178
	1,042,682,389	1,097,863,614

18. ACCUMULATED FUND

Balance at 1 January	**149,952,495**	**(44,910,838)**
Prior year	**1,679,592**	**-**
Surplus for the year	**182,978,881**	**194,863,333**
Balance at 31 December	**334,610,969**	**149,952,495**

19. SUBSEQUENT EVENTS

Events subsequent to the financial position date are reflected in the financial statements only to the extent that they relate to the year under consideration and the effect is material. There were no subsequent events at the reporting date (2018: Nil).

Appendix 3: Gallery

Prof. Adu Gyamfi, Board Chairman of the NHIA exchanging pleasantries with the NHIA Choir at the End of year durbar.

CEO exchanging pleasantries with NHIS staff at the End of year durbar

NHIA Executives with a section of dignitaries at NHIS at @ 15 Public lecture

NHIA Board members and Management at the Launch of NHIS mobile renewal