NATIONAL HEALTH INSURANCE AUTHORITY

2016 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 basic health care for all residents in Ghana, and to delight our subscribers and stakeholders with an enthusiastic, motivated, and empathetic professional staff who share the values of accountability in partnership with all stakeholders.

Core values
- Integrity
- Accountability
- Empathy
- Responsiveness
- Innovation

Board Members

1	Mr. E. Ernest Kwesie	Chairman
2	Hon. Dr. Victor Bampoe	Member
3	Mr. Nathaniel Otoo	Chief Executive
4	Dr. Ebenezer Kofi Appiah-Denkyira	Member
5	Mr. Anthony Selorm Dzadzra	Member
6	Mrs. Czarina Baeta-Ribeiro	Member
7	Ms. Lydia Lariba Bawa	Member
8	Dr. Darius Kofi Osei	Member
9	Dr. Dennis Bortelabi Bortey	Member
10	Mr. Arnold Okai	Member
11	Mrs. Anna Pearl Akiwumi Siriboe	Member
12	Dr. Sodzi Sodzi -Tetteh	Member
13	Mr. William Affum Ani-Agyei	Member
14	Ms. Rejoice Sasu	Member
15	Mr. Seth Ofori-Ohene	Member
16	Mr. Eric Kwesi Armo-Himbson	Member
17	Rev. Richard Kwasi Yeboah	Member
18	Ms. Diana O. Ahene	Board Secretary

BOARD SECRETARY	**:**	**MS DIANA O. AHENE**
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**

MANAGEMENT TEAM

Nathaniel Otoo	Ag. Chief Executive
Edward Amissah Nunoo	Deputy Chief Executive, Admin & HR
Alex Odoi Nartey	Deputy Chief Executive, Finance & Investment
Dr. Gustav Cruickshank	Chief Audit Executive
Dr. Lydia Dsane-Selby	Director, Claims
Ben Kusi	Director, Membership & Regional Operations
Anthony Gingong	Director, Provider Payments
Perry Nelson	Director, Management Information Systems
Dr. Nii Anang Adjetey	Director, Corporate Affairs
Ben Yankah	Chief Actuary
Diana O. Ahene	Board Secretary/Director,Private Health Insurance Schemes
Emmanuel Fianko	Director, Procurement & Projects
Dr. Memuna Abass Tanko	Director, Quality Assurance
Ahmed Imoro	Director, Budget and Management Accounting
Ralphael Segkpeb	Director, Admin & HR
Francis-Xavier Andoh-Adjei	Director, Research, Policy, Monitoring & Evaluation
Rudolf Zimmermann	Director, Financial Accounting
Theresa Talata Kunlie	Director, Legal
Dr. Francis Asenso-Boadi	Deputy Director, Research & Policy
Adelaide Bunatal	Deputy Director, Corporate Affairs
Vitus G. Kaleo-Bioh	Deputy Director, Business Systems
Dr. Nii Anang Adjetey	Director, Corporate Affairs
Collins Danso Akuamoah	Deputy Director, Membership & Regional Operations
Angela D. Auch	Deputy Director, Training & Development
William Omane Adjekum	Deputy Director, Claims Processing Centre, Cape Coast
Nicholas Osei Afram	Deputy Director, Claims Vetting Operations
Stephen Bewong	Deputy Director, Business Systems
Vivian Addo-Cobbiah	Deputy Director, Compliance
Isaac Gideon Akonde	Deputy Director, Claims Processing Centre, Kumasi
Zankawah Baba Sadique K	Deputy Director, Claims Processing Centre, Tamale
George Omaboe	Deputy Chief Internal Auditor, Assurance
Prince Appiah Debrah	Deputy Chief Internal Auditor, Advisory & Risk Management
Thomas Adoboe	Deputy Director, ICT Business Infrastructure
Constance Addo-Quaye	Deputy Director, Credentialing
Hudu Issah	Deputy Director, Private Health Insurance Scheme
Emmanuel Reinfred Okyere	Deputy Director, M&E/Special Projects
Seidu Abudu Sampson	Regional Director, Eastern Region
Francis Asante-Mensah	Regional Director, Western Region
Francis Oti Frempong	Regional Director, Central Region
Lawrence Amartey	Regional Director , Greater Accra

Hudu Iddrisu	Regional Director, Northern Region
Titus Sorey	Regional Director, Upper West Region
Elliot Nestor Akototse	Regional Director, Volta Region
Amos Akurugu Akparibo	Regional Director, Upper East Region
Daniel A. Frempong	Regional Director, Ashanti Region
Sebastian Alagpulinsa	Ag. Regional Director, Brong Ahafo Region

PROFILE OF EXECUTIVE MANAGEMENT

CHIEF EXECUTIVE: NATHANIEL OTOO

Nathaniel Otoo, the Chief Executive of the National Health Insurance Authority, until his appointment in June 2015, was the Deputy Chief Executive responsible for Operations. He had earlier served as the organization's Director of Administration & General Counsel. For the past decade, he has pursued and developed expertise in risk protection, social security, Universal Health Coverage (UHC) and public sector reforms. At the NHIA, he was instrumental in the review of the NHIS enabling law which now addresses the administrative and legal challenges of the previous statute, including the transformation of the District Mutual Health Insurance Schemes to a National Health Insurance Scheme. He has also played key roles in positioning the NHIA as a promising public sector institution in Ghana

Before entering the health financing sphere, Mr. Otoo had about 20 years of work experience which spanned the social security, manufacturing, and trade promotion sectors. He holds a Masters' Degree in International Relations from the International University of Japan, a Bachelor of Laws Degree from the University of Ghana and a professional qualification in law from the Ghana School of Law.

In addition to his work at the NHIA, he participated in the review of the policy framework and the legislative instrument for the Health Facilities Regulatory Agency (HFRA) of Ghana, where he is currently a board member. He is also a board member of the National Identification Authority.

In June 2013, he was selected as the global convener of the Joint Learning Network (JLN), an international knowledge-sharing forum for 22 countries to co-develop tools and ideas that tackle the practical challenges of health systems reform to achieve Universal Health Coverage. Mr. Otoo has also undergone extensive training in management and health financing. He has co-authored and reviewed publications on Universal Health Coverage (UHC) and is a regular speaker and resource person at several UHC forums across the globe

EDWARD AMISSAH-NUNOO: DEPUTY CHIEF EXECUTIVE, ADMIN & HR

Mr. Edward AMissah-Nunoo, a Lawyer by profession, a security professional by training and a crisis management expert, is the Deputy Chief Executive in charge of Administration and Human Resource. A seasoned Administrator with exposure to emerging trends in Administration and International best practices, Edward joins the Executive Management of the NHIA with a wide array of expertise, having pursued a career in a broad spectrum of activities spanning security, public service, academia, and the private sector for the past 29 years.

He was in senior management position in the Ghana Customs, Excise and Preventive Service, a Law Lecturer at the Ghana Institute of Management and Public Administration (GIMPA) and a visiting lecturer at the Ghana Police College.

Prior to his present appointment, Edward was a Private Legal Practitioner and a National Security Consultant at the National Security Secretariat. He trained variously both locally and internationally including the US Department for Homeland Security.

Edward holds a Master's Degree from the Legon Centre for International Affairs (LECIA), University of Ghana, where he also obtained his first degree.

ALEX NARTEY: DEPUTY CHIEF EXECUTIVE, FINANCE & INVESTMENT

Mr. Alex Odoi Nartey, a former Chief Accountant of the Ministry of Health in Ghana and former Director of Finance for the Ghana Health Service (GHS, is the substantive Deputy Chief Executive in charge of Finance and Investment at the NHIA. A Chartered Accountant and Project Management Expert with over 27 years of relevant and considerable work experience in other parts of Africa, Alex joined the NHIA management in 2013 bringing on board a wide range of expertise to strengthen the finance and investment division of the the NHIA. .

As an Associate Consultant to PwC and later Ernst & Young, Mr. Nartey served as Senior International Financial Controller in Liberia's Ministry of Health & Social Welfare and later as the Financial Advisor to the same Ministry. He has been a lead Technical Designer and Implementer of Financial Systems with capacity building and financial decentralization in Ghana, Liberia and Sierra Leone. He has been involved in many reforms in financial management for the Government of Ghana (GoG) and has managed grants from various donors.

EXECUTIVE SUMMARY

The National Health Insurance Authority (NHIA) was 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 the persons covered by the Scheme. This report highlights key events, achievements, and challenges in 2016.

Active membership of the Scheme showed a reduction from 11.3 million in 2015 to 10.69 million in 2016. This reduction in active membership could be attributed to occasional shortage of materials (consumables) for printing membership cards and other administrative challenges. Children under 18 years (4.4 million) and employees in the informal sector (3.0 million) were the most registered groups, representing 41.3% and 28.2% of the total member population respectively. The security services (18,238) and SSNIT pensioners (15,989) were the least registered groups, representing 0.2% and 0.1% of the total member population respectively.

In 2016, all the regions recorded an increase in the number of credentialed health care providers except Upper East, which had a reduction from 109 to 91. The number of credentialed healthcare providers across the regions also reflect geographical distribution of member population of the scheme. This proportional distribution of healthcare providers would address geographical access to healthcare services particularly in the remote areas.

Claims cost increased by 0.5% between 2015 and 2016 compared to an increase of 0.7% between 2014 and 2015. About 53% of the total claims cost in 2016 constitutes service cost. For the year ended 31 December 2016, the Authority earned a total revenue of **GH¢1,388.31 million** and incurred a total expenditure of **GH¢1,379.67 million** resulting a net operating surplus of **GH¢8.64 million**. Claims cost for the period was **GH¢895.47 million,** representing 64.9% of the total expenditure.

The year under review recorded introduction of several innovations that were aimed at enhancing stakeholder confidence and interests in the scheme. Key among them were the improvement of Biometric Registration System performance to 8 minutes for new registrations and 4 minutes for renewals, the development of CLAIM-IT claims submission application to be used for claims management, the development of Electronic Premium Banking and e-receipting, the Development of Mobile Claims Check Code technical requirements and the development of technical requirements for credentialing software.

1.0 Introduction

The National Health Insurance Authority (NHIA) is mandated by law to secure the implementation of the National Health Insurance Scheme. 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 and devising mechanisms to ensure that indigents are adequately catered for under the NHIS.

1.1 Governance

The NHIA is governed by a 17-member Board drawn from various stakeholder organisations and is headed by a chairperson appointed by the President of Ghana. The Chief Executive of the NHIA and a Board Secretary co-opted from the NHIA are members of the Board. The Board is constituted by the President of the Republic of Ghana and is responsible for the proper and effective performance of the functions of the Authority.

1.2 Management

The Executive Management of the Scheme is headed by a 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 coverage for all persons, 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

Implementation of the NHIS is guided by a medium-term strategic plan to enable management focus on its core mandate. 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
7. To strengthen ***accountability and control systems for improved efficiency in the use of scarce resources***
8. To strengthen ***support systems to further enhance efficiency*** in the operations of the Scheme and promote the use of ***empirical evidence*** for ***informed decision-making***

2.0 Membership and enrolment

2.1 Membership

Figure 1 shows the membership trend of the scheme over the last five years. There was a consistent increase in membership from 8.89 million to 11.34 million members, representing 38% and 41% of the population in 2012 and 2015, respectively (Table 1). The year 2016, however, recorded a reduction of 2.7%, from 11.3 million to 11.03 million members. This drop in membership may be attributed to administrative challenges such as occasional shortage of materials (consumables) for printing membership cards and operational challenges. The total number of active members (11.03 million) in 2016 represents 39% of the population. This fell short of the anticipated target of 42% for the year as stipulated in the 2015-2018 Medium Term Strategic Plan.

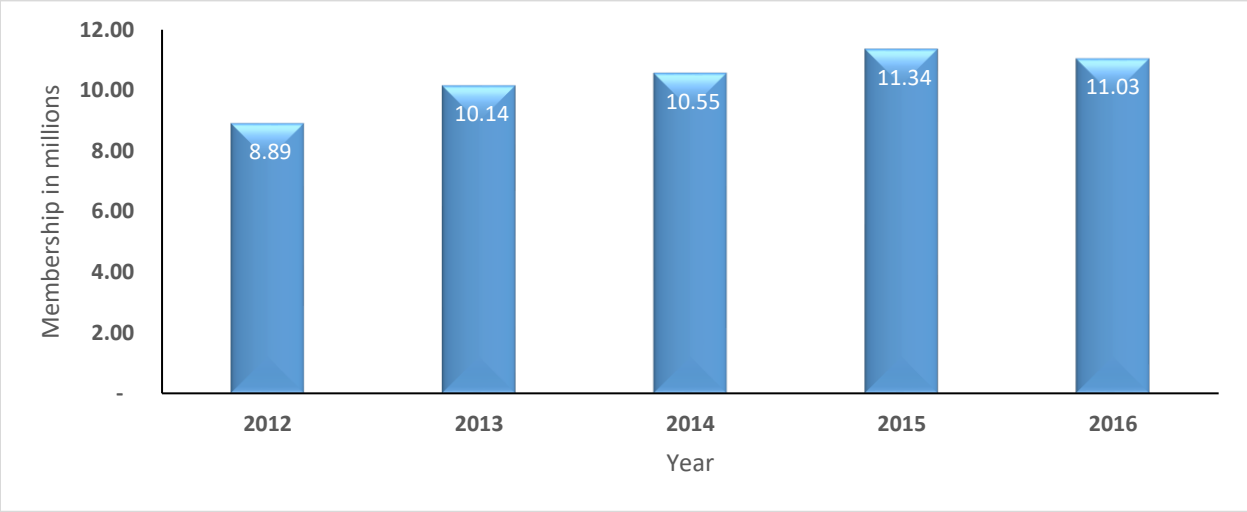

Figure 1:Membership enrolment trend, 2012-2016

2.2 Enrolment

Table 1 shows the trend of new enrolment and renewals over the 2013-2016 period. It is evident that more individuals are renewing their membership than enrolling as new members. The trend over the last four years (2013-2016) also reveals that new enrolment grew by 1% between 2013 and 2014 and 33% between 2014 and 2015. However, there was a reduction in new enrolment by 28% between 2015 and 2016. Renewal of membership, however, showed a contrasting pattern; it grew by 5% from 6.7 million in 2013 to 7.1 million in 2014, and declined by same percentage between 2014 and 2015. The year 2016, however, saw 15% growth from 6.7 million in 2015 to 7.5 million in 2016.

Table 1:Active membership, 2016

Year	New registrations	%Growth	Renewals	%Growth	Total	% of national population
2013	3,444,570	-	6,700,626	-	10,145,196	38
2014	3,487,007	1.2	7,058,421	5.3	10,545,428	39
2015	4,627,986	32.7	6,713,035	-4.9	11,341,021	41
2016	3,325,210	-28	7,704,129	15	11,029,339	39

2.3 Membership enrolment category of active members

Membership of the scheme is categorized into informal sector employees, formal sector employees (SSNIT Contributors), SSNIT pensioners, children under 18 years of age, 70 years and above, indigents (or core poor), pregnant women, and employees in the security services (police, fire service, prison service). In the year under review, active membership by category shows that children under 18 years (4.4 million) and employees in the informal sector (3.0 million) were the most registered groups, representing 41.3% and 28.2% of the total member population, respectively (Figure 2). The security services (18,238) and SSNIT pensioners (15,989) were the least registered groups, representing 0.2% and 0.1% of the total member population, respectively.

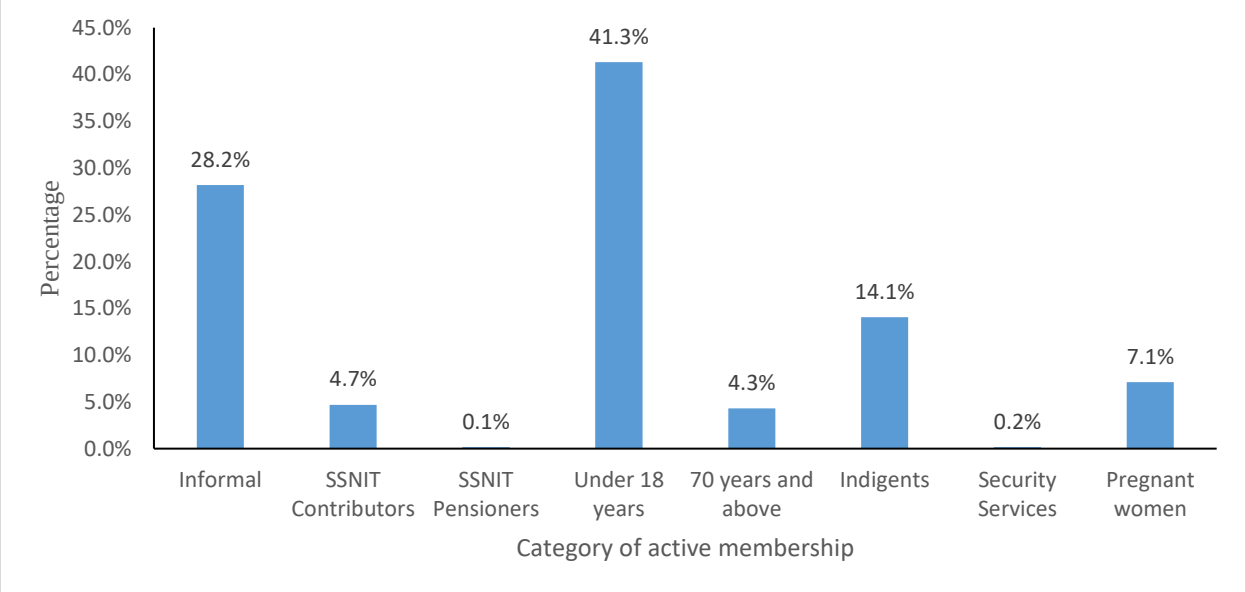

Figure 2:Active membership by category, 2016

2.4 Protection of the poor and vulnerable against financial risk

Since its implementations in 2004, the NHIS has strived to cover as many as possible, the poor and vulnerable in society. These groups are children under the age of 18 years, SSNIT pensioners, and elderly aged 70 years or above. Others are pregnant women and indigents (or core poor). In all, the exempt group constitutes 67% of the total member population in 2016 as shown in Figure 2 above. This is in line with the scheme's aim of providing financial access to healthcare services for the poor and vulnerable.

3.0 Healthcare providers

Over the last five years (2012-2015), there have been a remarkable increase in the number of credentialed healthcare providers across all the 10 regions (Figure 3). There were consistent increase in Ashanti, Brong-Ahafo, Greater Accra and Northern regions over the last five years. In 2016, all the regions also recorded an increase in the number of credentialed care providers except Upper East, which had a reduction from 109 to 91 (16.5%). The number of credentialed healthcare providers across the regions also reflect geographical distribution of member population of the scheme. This proportional distribution of healthcare providers would address geographical access to healthcare services particularly in the remote areas.

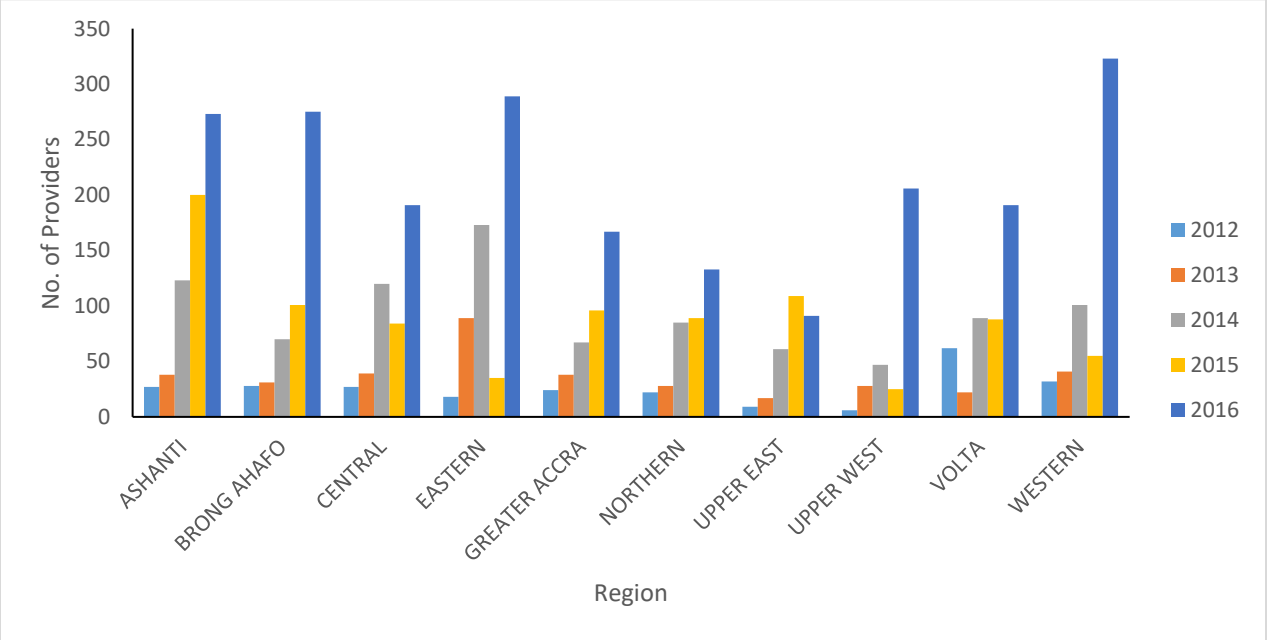

Figure 3:Credentialed healthcare providers by region, 2012-2016

Credentialed healthcare providers by grade shows that majority of the care providers obtained grade B and C, followed by A (Figure 4). Trends over the 5-year period show a consistent increase

in the number of healthcare providers in each grade category, an indication that more healthcare providers are being credentialed to increase geographical access to healthcare for the insured.

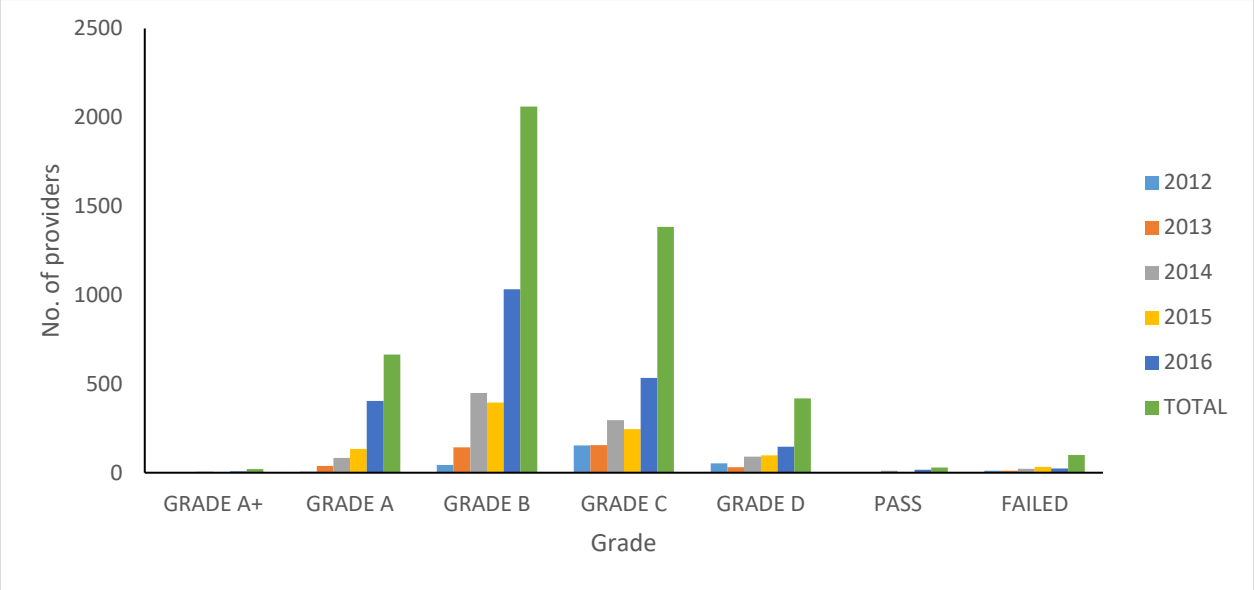

Figure 4:Credentialed providers by grade, 2012-2017

3.1 Health service utilization

Outpatient utilization over the last five years also depicts similar pattern observed under the membership coverage (Figure 5). There was a consistent increase from 23.88 to 30.37 million visits (27.2%) between 2012 and 2014, and reduction of 4.8% from 27.93 to 26.59 million visits over the last two years. Table 2 shows outpatient utilization per active member, which also increased from 2.69 visits in 2012 to 2.88 visits in 2014 and declined to 2.46 visits in 2015. The year 2016, also, saw a decrease to 2.41 visits.

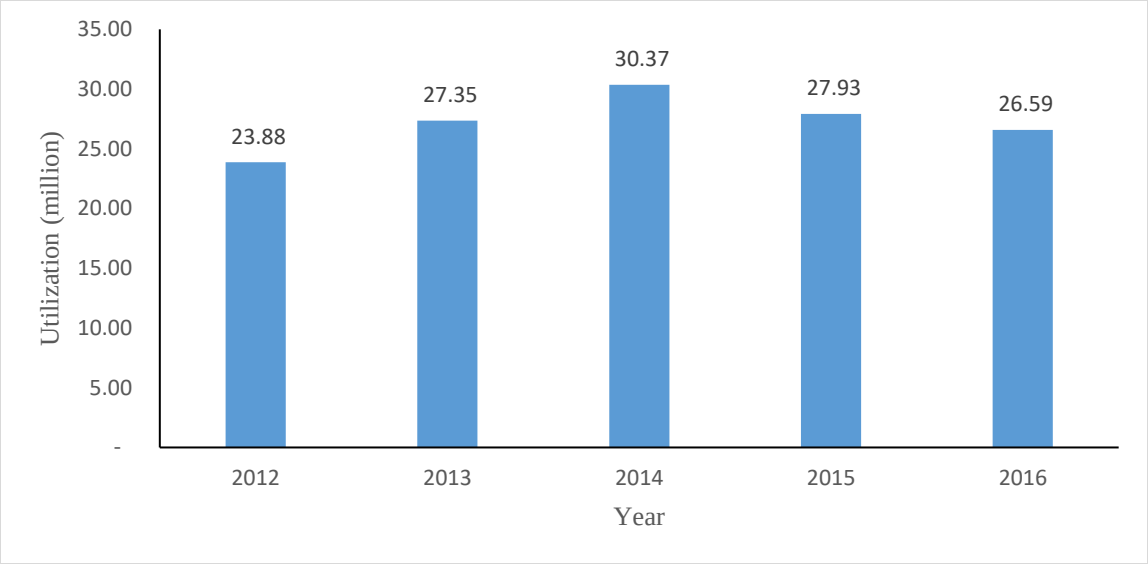

Figure 5:Trend of OPD utilization, 2012-2016

Trend in inpatient utilization also showed an increase of 22.4% from 1.43 million visits in 2012 to 1.75 million visits in 2015 (Figure 6). However, the year under review recorded a slight decline of 3.4% from 1.75 million visits in 2015 to 1.58 million visits in 2016. Inpatient utilization per active member, however, declined from 0.16 visits to 0.14 visits between 2012 and 2016 (Table 2).

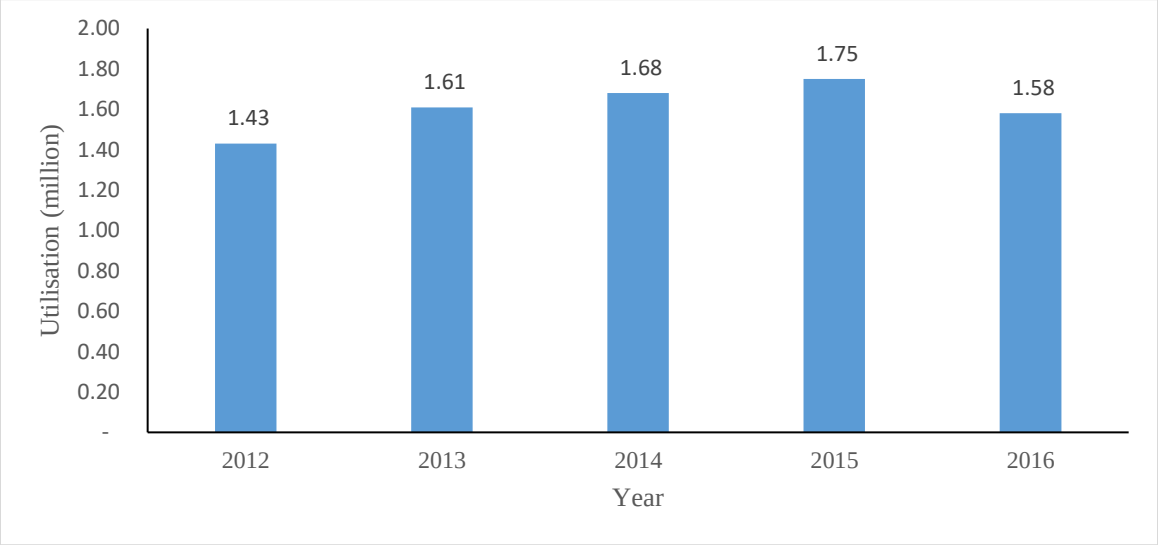

Figure 6:Trend in IPD utilization, 2012-2016

Table 2:Utilization per active member, 2012-2016

Year	Out-patient	In-patient
2012	2.69	0.16
2013	2.69	0.16
2014	2.88	0.16
2015	2.46	0.15
2016	2.41	0.14

4.0 Claims management

Unlike trends in membership coverage and utilization, there was a consistent increase in claims cost over the 5-year period. It increased by 45.3% from GHS616.47million to GHS895.47million between 2012 and 2016 (Figure 5). In the year under review, claims cost increased by 0.5% between 2015 and 2016 compared to an increase of 0.7% between 2014 and 2015. About 53% of the total claims cost in 2016 constitutes service cost.

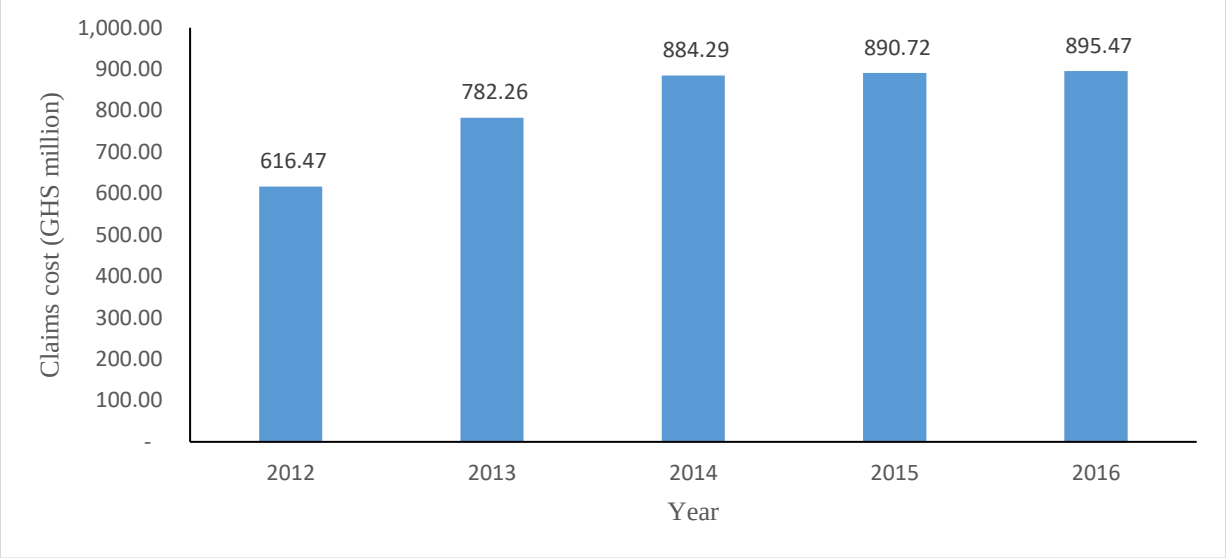

Figure 7: Trend in claims cost, 2012-2016

5.0 Summary of feedback, concerns and challenges from stakeholders

The NHIA through its Corporate Affairs Directorate continued to interact with its stakeholders to improve their experiences with the Scheme. During such interactions feedback received included:

- Perennial delays in claims reimbursement resulting in huge indebtedness to health care facilities which affect delivery of health care services across the country.
- Complaints of huge claims deductions effected by the Claims Processing Centres (CPCs) often without vetting reports.

- Irregular and late review of NHIS medicine prices against general rapid depreciation of the Ghanaian currency.
- Failure of authentication devices to generate Claims Check Code (CCC) in some instances in spite of several attempts. This is extremely frustrating for sick members, especially for persons who are over 60 years and under 10 years who appear to be the worst affected.
- Automatic locking of the authentication device when in use.
- Lack of clear directive on how to handle genuine finger print mismatch (false rejections).
- Frequent changes in date and time on the devices.
- Difficulties encountered by Patients who had to move from one clinic to the other to get themselves verified before they receive health care services are very frustrating.
- Frequent breakdown/malfunctioning of authentication devices.

6.0 Projects and programmes

The NHIA, as a dynamic institution continues to innovate into its operations to enhance stakeholder confidence and interests. These innovations culminated in achievements that attracted commendations from both local and international organizations. The year under review saw the following innovations and achievements:

Technological Innovations

- Introduction of NAVIS member authentication application:
- Development of CLAIM-it claims submission application to improve claims management process:
- Development of Electronic Premium Banking and e-receipting
- Initiation of project to integrate NHIS data sources
- Improvement of Biometric Registration system performance to 8 minutes for new registrations and 4 minutes for renewals
- Development of Mobile Claims Check Code technical requirements
- Development of technical requirements for credentialing software

Process Improvements

- Introduction of Multi-Year Registration for NHIS members
- Introduction of Paperless Registration at District Offices
- Electronic identification of the poor and vulnerable persons for enrolment onto NHIS
- Introduction of Provider Unique Identification
- 40% expansion of Clinical Audit capacity

Stakeholder and Donor Engagement

- Improved relations with providers
- Improved media engagement
- Secured extensions of USAID and Korea Foundation for International Health funding

7.0 Financial Report

The National Health Insurance Authority (NHIA) was first 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 the persons covered by the Scheme.

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 finance to subsidize the cost of provision of healthcare services to members of National Health Insurance Scheme.

For the purpose of implementing the object of the Fund, section 40 (2) of Act 852 stipulates that the monies from the Fund shall be expended as follows:

- to pay for the healthcare costs of members of the National Health Insurance Scheme;
- to pay for approved administrative expenses in relation to the running of the National Health Insurance Scheme;
- to facilitate the provision of or access to healthcare services; and
- to invest in any other facilitating programmes to promote access to health services as may be determined by the Minister in consultation with the Board.

The sources of money to the NHIF are provided under section 41 of the Act as follows:

- the National Health Insurance Levy (NHIL);
- 2.5 percentage points of each person's 18.5% contribution to SSNIT pension fund;
- such money that may be allocated to the Fund by Parliament;
- grants, donation, gifts and any other voluntary contributions made to the fund,
- money that accrues to the Fund from investments made by the Authority
- Fees charged by the Authority in the performance of its functions;
- Contributions made by members of the Scheme; and
- Moneys accrued under section 198 of the Insurance Act, 2006 (Act 724).

For the year ended 31 December 2016, the Authority earned a total revenue of **GH¢1,388.31 million** and incurred a total expenditure of **GH¢1,379.67 million** resulting in a net operating surplus of **GH¢8.64 million**. Claims cost for the period was **GH¢895.47 million,** representing 64.9% of the total expenditure. NHIL/SSNIT due from Government/Ministry of Finance at the end of the year 2016 was **GH¢544.98 million**. The Fund's investment portfolio (principal amount) stood at **GH¢78.28 million** as at 31 December 2016.

8.0 Conclusion

Even though active membership of the scheme recorded a decline in 2016, management is optimistic that the innovations introduced in 2016 will boost membership drive in the coming year. Additionally, the Claim IT software will enhance claims management for both providers and NHIA and hence minimise fraud and abuse in the claims management process. In the coming year, management will continue to introduce far-reaching measures and innovations to propel Ghana's NHIS towards achieving its vision of becoming a model of a sustainable, progressive, and equitable social health insurance scheme in Africa and beyond.

APPENDIX

Appendix 1: Audited Financial Statement

NATIONAL HEALTH INSURANCE AUTHORITY
STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 31 DECEMBER 2016

REVENUE		**2016**	**2015**
	Notes	**GH¢**	**GH¢**
Levies income	**3**	**1,287,422,701**	1,206,717,854
Investment income	**4**	**32,804,606**	16,618,461
Premium & processing fees	**5**	**62,717,825**	48,555,454
Bilateral donors	**6**	**3,520,736**	4,516,804
Other income	**7**	**1,848,356**	996,652
		1,388,314,224	1,277,405,225
EXPENDITURE			
Claims of Service Providers	**8**	**895,469,202**	890,723,248
Support to partner institution	**9**	**138,665,908**	55,665,201
General and administration expenses	**11**	**219,108,747**	182,129,936
ID cards & biometric expenses	**12**	**126,429,367**	129,274,649
		1,379,673,224	1,257,793,034
Excess revenue/expenditure	**10**	**8,641,000**	19,612,191

ACCUMULATED FUND
FOR THE YEAR ENDED 31 DECEMBER, 2016

	2,016	**2,015**
	GH¢	**GH¢**
Balance at 1 January	**(53,551,837)**	(73,182,715)
Prior year		18,686

Excess revenue/expenditure	**8,641,000**	19,612,191
Balance at 31 December	**(44,910,837)**	(53,551,837)

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, 2016

	Notes	2016 GH¢	2015 GH¢
Current Assets			
Receivable and prepayment	**14**	**565,241,979**	367,930,427
Investments	**15**	**78,284,483**	57,286,508
Cash and cash equivalents	**16**	**21,516,012**	5,909,584
		665,042,474	431,126,519
Fixed Assets			
Property, plant and equipment	**13**	**86,396,147**	69,012,631
Total Assets		**751,438,621**	500,139,150
Accumulated Fund and Liabilities			
Current Liabilities			
Accounts payables	**17**	**796,349,458**	553,709,674
Accumulated fund	**18**	**(44,910,837)**	(53,570,524)
Total Fund and Liabilities		**751,438,621**	500,139,150

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 2016

	2016	2015
OPERATING ACTIVITIES	**GH¢**	**GH¢**
Receipts		
National health insurance levy	**1,102,185,914**	1,096,290,577
Investment income	**31,020,031**	20,165,788
Bilateral donor	**3,520,736**	4,516,804
Premium & processing fees	**62,717,825**	48,555,454
Other income	**1,825,777**	996,652
	1,201,270,283	1,170,525,275
Payment		
Claims paid to service providers	**705,542,749**	825,616,281
ID card & biometric expenses	**93,169,005**	100,846,372
General & administrative expenses	**192,704,109**	176,101,483
Support to Partner Institution	**133,246,254**	47,316,594
	1,124,662,117	1,149,880,730
Cash flow from operations	**76,608,166**	20,644,545
INVESTING ACTIVITIES		
Purchase of PPE	**(40,014,764)**	(28,515,113)
Proceeds from disposal of PPE	**11,000**	0
Purchase of investment	**(42,968,865)**	(27,149,682)
Proceeds from disinvestment	**21,970,891**	64,974,369
Net cash generated in investing activities	**(61,001,738)**	9,309,574
FINANCING ACTIVITIES		
Loan principal and interest repayment	0	(57,606,539)
Net cash flow from financing activities	0	(57,606,539)
Increase/(Decrease) in Cash and Cash Equivalents	**15,606,428**	(27,652,420)

Cash and cash equivalent at start	**5,909,584**	33,562,004
Cash and Cash Equivalent at End	**21,516,012**	5,909,584

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 DECEMBER, 2016

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. IPSAS 39 should be applied effective January 1, 2018, with early adoption permitted. 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 IPSAS standards adopted by the Authority have been applied for the first time in the annual financial reporting period commencing 1 January 2016.

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 the of 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 years

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 cedis 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 receivables 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.

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2016

2. LEVIES INCOME	**2016**	2015
	GH¢	GH¢
VAT levy	**949,449,569**	908,597,634
SSNIT levy	**337,633,594**	297,784,643
National insurance commission levy	**339,538**	335,577
	1,287,422,701	1,206,717,854

3. INVESTMENT INCOME

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

4. 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.

5. BILATERAL DONORS

These are funds received from our development partners.

6. OTHER INCOME

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

7. CLAIMS EXPENSE	**2017**	2016
	GH¢	GH¢
Claims – medicines	**278,452,233**	224,567,849
Claims – services	**393,431,710**	268,907,979
Claims – capitation	**38,248,988**	32,708,222
Claims - district providers	**185,336,271**	364,539,198
	895,469,202	890,723,248

8. SUPPORT TO PARTNER INSTITUTION	**2016**	2015
	GH¢	GH¢
Primary health & preventive care	**77,229,929**	4,800,000
District health projects	**17,515,500**	19,595,955
Health service investment	**41,178,479**	28,365,246
Parliamentary monitoring and evaluation	**2,742,000**	2,904,000
	138,665,908	55,665,201

9. EXCESS SURPLUS IS ARRIVED AT AFTER CHARGING THE FOLLOWING:

Audit fees	**265,781**	288,400
Depreciation	**22,534,492**	14,530,424
Board monthly allowance	**177,060**	168,450
Basic salary	**80,748,490**	73,470,606
SSNIT	**9,193,944**	2,536,118
Provident fund	**3,524,410**	1,035,841

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2016

10. GENERAL AND ADMINISTRATIVE EXPENSES	**2016**	**2015**
	GH¢	**GH¢**
Audit fees	265,781	288,400
Bank charges	472,388	245,226
Call centre expenses	-	2,070,035
Cleaning and sanitation	936,326	698,194
Council member allowance and expenses	799,341	941,815
Depreciation expense	22,534,492	14,530,424
Loan interest and management fees	-	3,175,666
Maintenance (PPE)	1,796,320	1,644,527
Monitoring and evaluation activities	1,562,477	1,334,480
Publicity and communication	6,654,556	3,271,994
Rent	2,017,140	3,321,806
Software and hardware maintenance	34,577,534	27,810,900
Staff cost	110,398,637	85,706,913
Staff welfare and transfer grant	2,326,324	1,138,367
Admin & logistical support to schemes	2,825,811	8,278,560
Training and consultancy	8,983,738	7,522,084
Travelling and transport	7,760,389	5,501,259
Utilities	2,720,458	1,476,473
Other expenses	688,828	2,258,519
Archival expenses	10,648,976	9,678,630
Professional fees & subscription	69,391	225,167
Security services	459,010	344,483
Donations & sponsorships	465,933	497,743
Exchange rate loss	144,897	-

Corporate social responsibility	-	168,271
	219,108,747	182,129,936

11. ID CARDS AND BIOMETRIC EXPENSES

This represents cost incurred in printing ID cards for members

12. PROPERTY, PLANT AND EQUIPMENT

Cost/Valuation	**Balance as at 1/1/2016**	**Addition**	**Disposal**	**Balance as at 31/12/2016**
	GH¢	**GH¢**	**GH¢**	**GH¢**
Head office buildings	38,521,446	158,465	-	38,679,917
Work in progress	426,566	112,580	-	539,146
Land & buildings regional	7,932,437	-	-	7,932,437
ICT project	45,179,294	25,214,399	-	70,393,692
Computers	12,208,175	849,749	(93,750)	12,964,174
Furniture & fittings	4,317,975	1,844,954	(597,417)	5,565,513
Motor vehicles	9,637,831	6,109,958	(121,148)	15,626,642
Office equipment	18,907,635	5,724,657	592,400	25,224,692
	137,131,359	40,014,764	(219,915)	176,926,213

Accumulated Depreciation

	Balance as at 1/1/2016	**Charge for the year**	**Disposal**	**Balance as at 31/12/2016**
Head office buildings	4,290,071	1,933,996	-	6,224,067
Land & buildings regional	1,164,689	396,622	-	1,561,311
ICT project	40,554,015	9,086,183	(2,710,359)	46,929,839
Computers	7,328,691	2,243,560		9,572,251

Furniture & fittings	3,116,816	842,649	(142,683)	3,816,782
Motor vehicles	4,499,853	2,766,762	(121,148)	7,145,467
Office equipment	7,164,593	5,264,720	2,851,035	15,280,349
	68,118,728	22,534,492	(123,155)	90,530,065

NBV at 2016	**86,396,147**
NBV at 2015	69,012,631

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2016

13. RECEIVABLES AND PREPAYMENTS	**2016**	2015
	GH¢	GH¢
Levies receivable	**544,976,790**	359,740,004
Investment income receivable	**7,541,756**	5,816,980
Staff loans and advances	**1,309,891**	2,251,027
Prepayments and other receivables	**11,413,542**	122,416
	565,241,979	367,930,427

15. INVESTMENTS

CDH securities	**4,954,305**	2,284,000
Universal merchant bank	**6,816,106**	5,198,741
National investment bank	**11,330,027**	6,150,937
CBG (Erstwhile Unibank Ghana limited)	**5,269,898**	4,191,767
GCB (Erstwhile Unique trust bank)	**2,251,825**	8,279,144
GCB (Erstwhile Capital bank)	**7,067,579**	8,137,928
All-time capital Ltd	**9,694,899**	7,643,951
Stanbic bank	**-**	1,985,058
First BanC financial services	**11,310,910**	8,080,022
First Atlantic Bank (Erstwhile Energy bank)	**4,041,717**	2,092,080
Access bank	**2,265,000**	-

CBG (Erstwhile Beige capital)	**5,000,000**	-
Bank of Africa	**10,734**	515,523
Bank of Ghana	**8,271,482**	2,727,357
	78,284,483	57,286,508

NATIONAL HEALTH INSURANCE AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER, 2016

16. CASH AND CASH EQUIVALENTS	**2016**	2015
	GH¢	GH¢
Cash at bank	**21,495,029**	5,816,375
Cash at hand	**20,983**	93,209
	21,516,012	5,909,584

17. ACCOUNT PAYABLES	**2016**	2015
	GH¢	GH¢
Support to partner institutions	**19,416,713**	13,997,060
Claims to service providers	**686,442,102**	496,515,649
Accrued expenses and Other payables	**90,490,643**	43,196,965
	796,349,458	553,709,674

18. ACCUMULATED FUND

Balance at 1 January	**(53,551,837)**	(73,182,715)
Prior year adjustment	-	18,686
Surplus for the year	**8,641,000**	19,612,192

Balance at 31 December	**(44,910,837)**	(53,551,837)

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 (2016: Nil).