Value and Service Quality Assessment of the National Health Insurance Scheme in Ghana: Evidence from Ashiedu Keteke District

Eric Nsiah-Boateng, MSc, MPH1,*, Moses Aikins, PhD2, Francis Asenso-Boadi, PhD1, Francis-Xavier Andoh-Adjei, MSc, MPH2,3

ABSTRACT

Background: Ghana introduced the National Health Insurance Scheme (NHIS) in 2003 to provide financial access to health care for all residents. Objectives: This article analyzed claims reimbursement data of the NHIS to assess the value of the benefit package to the insured and responsiveness of the service to the financial needs of health services providers. Methods: Medical claims data reported between January 1, 2010, and December 31, 2014, were retrieved from the database of Ashiedu Keteke District Office of the National Health Insurance Authority. The incurred claims ratio, promptness of claims settlements, and claims adjustment rate were analyzed over the 5-year period. Results: In all, 644,663 medical claims with a cost of Ghana cedi (GHS) 11.8 million (US $3.1 million) were reported over the study period. The ratio of claims cost to contributions paid increased from 4.3 to 7.2 over the 2011-2013 period, and dropped to 5.0 in 2014. The proportion of claims settled beyond 90 days also increased from 26% to 100% between 2011 and 2014. Generally, the amount of claims adjusted was low; however, it increased consistently from 1% to about 4% over the 2011-2014 period. The reasons for claims adjustments included provision of services to ineligible members, overbilling of services, and misapplication of diagnosis related groups. Conclusions: There is increased value of the NHIS benefit package to subscribers; however, the scheme’s responsiveness to the financial needs of health services providers is low. This calls for a review of the NHIS policy to improve financial viability and service quality. Keywords: claims ratio, claims reimbursement, Ghana, National Health Insurance Scheme, service quality.

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Introduction

Many low- and middle-income countries are increasingly implementing social health insurance (SHI) programs as a preferred health financing system to ensure access to and equity in health care utilization [1]. African countries including Ghana, Nigeria, and Rwanda are at different phases of implementing SHI aimed at achieving universal health coverage. One distinct characteristic of SHI’s attractiveness in developing countries is that it does not depend exclusively on public finance, but instead shares the responsibility of health financing among the population [2].

One of the major challenges of managing SHI schemes is that the services are provided by a third party (health services providers) and paid for by the SHI schemes, thereby introducing inherent problems such as fraud, high claims cost, excessive utilization, and poor service quality [3]. This situation has caused financial sustainability challenges for many SHI schemes in developing countries. A continuous monitoring of claims is seen as the surest measure to addressing the inherent problems mentioned above. Claims reimbursement analysis, therefore, is increasingly becoming an important exercise for payers of medical claims, particularly health insurance organizations at national and regional levels. Many health insurance institutions have incorporated claims monitoring applications in their operations to constantly monitor trends of important claims indicators for any emerging anomalies [3]. Others have also developed monitoring and evaluation frameworks and tools to track and address negative trends in health services utilization, claims cost, settlements periods, and rejection rates [3].

Ghana, a lower middle-income country in sub-Saharan Africa, started experimenting with SHI through the community-based health insurance scheme approach, spearheaded by non-governmental organizations. This was in response to challenges associated with the out-of-pocket payment system of health care

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financing in the 1990s popularly called "cash and carry." The out-of-pocket payment widened financial access to health care and caused ill health and avoidable deaths [4,5]. It was estimated that out of the 18% of the population who needed health care, only one-fifth could afford it [6,7]. The community-based health insurance schemes, however, covered only 1% of the population and offered limited benefits, mainly for catastrophic health care expenditures due to their inability to address key design issues and lack of financial support from the central government [8,9].

In 2003, the country introduced the National Health Insurance Scheme (NHIS) through an Act of Parliament, the National Health Insurance Act (Act 650) and Legislative Instrument (L.I. 1809) [6,8,10,11]. The policy was aimed at removing out-of-pocket payment by providing financial access to health care for all residents in Ghana. It was implemented in 2004 and currently operates in 160 districts across the country, with membership coverage of 10.5 million, representing 39% of the population [12,13]. A total of 4004 health care providers across the country are credentialed to render health services to card-bearing members [12]. In addition, the National Health Insurance Authority (NHIA) has a regional office in each of the 10 administrative regions in Ghana for direct supervision of the district offices. The NHIS is financed by 2.5% National Health Insurance Levy on selected goods and services, 2.5 percentage points of formal sector workers' social security contributions, and nonactuarially determined contributions from informal sector workers including the self-employed. Other sources of funding are interest on investments from the National Health Insurance Fund (NHIF), donor support from development partners, and earmarked funds by parliament [1,14].

Evidence shows that the NHIS has made important strides in population coverage, access to health care, mobilization of public and private resources to purchase health services, and contribution of revenue to health care providers [1,13,15,16]. However, a generous benefit package, coupled with increasing utilization levels and high claims cost, pose a threat to the long-term sustainability of the scheme. This article analyzes claims reimbursement data of the Ashiedu Keteke District Office of the NHIA to assess the value of the benefit package to the insured and responsiveness of the NHIS service to the financial needs of health services providers. The study was informed by a similar one that the authors conducted at the Ga District NHIA Office in 2009, where it was found that claims expenses were increasing and settlements going beyond the stipulated period of 28 days [7]. However, this article goes beyond the analysis of claims ratio and settlements period to include analysis of claims cost by service type, average cost per claim, and adjustment rate of the claims review system.

Methods

Study Design

This article is a review of retrospective medical claims data of the Ashiedu Keteke District Office of the NHIA. It covered the period January 1, 2010, to December 31, 2014, because of the availability and reliability of the claims reimbursement data. Data for the previous years were unreliable for this research because they were captured rudimentarily and cannot be properly attributed to particular periods.

Study Area

The area for this study is the Ashiedu Keteke District Office, one of the 14 district offices of the NHIA in the Greater Accra region. The district covers the Ashiedu Keteke submetropolitan area of Accra and is the smallest among the six submetropolitan districts with a population of about 117,525 [17]. In addition, about 200,000 people commute daily for public service work and trading in the district. Like most of the district NHIA offices, the Ashiedu Keteke District Office was fully established in 2005 and as of December 2014, the office had 18 staff, 346,218 insured members, and 12 accredited health services providers [18].

Conceptual Framework and Analytical Tools

The article adapted indicators for analyzing health insurance claims data from the Handbook for Microinsurance Practitioners titled “Performance Indicators for Microinsurance” [3]. The indicators that were selected for this study include incurred claims ratio, promptness of claims settlements, and claims adjustment rate (Fig. 1). Claims cost by type of service, that is, outpatient and inpatient, was also analyzed. According to Wipf and Garand [3], these indicators provide more insight about the value of the benefits and quality of service being offered to the insured and health services providers as explained in the conceptual framework below.

Fig. 1 – Conceptual framework for assessing health insurance value and service quality. Source: Adapted from Wipf and Garand [3].
Incurred claims ratio
The incurred claims ratio was analyzed as cost of claims in a fiscal year divided by earned contribution for the same period. This indicator measures the value of the benefit to the subscribers, that is, the average proportion of subscribers’ contribution that is returned to them in the form of benefits. It helps to address the question “how valuable is the health insurance to the insured?” [3]. A high incurred claims ratio shows that subscribers are aware of the benefits of the scheme and are using them. However, a higher than expected incurred claims ratio might be due to adverse selection, supply- and demand-side moral hazards, and accurate or inaccurate statistical fluctuations. Other potential contributing factors are fraud and epidemiological patterns in the population. Nevertheless, a consistently low incurred claims ratio shows that the benefits are not relevant to the insured or the insured find it difficult in accessing the full continuum of services in the benefit package [3].

Promptness of claims settlements
This indicator was analyzed as the proportion of submitted claims that have been paid within the following category of days (<30 days, 31–60 days, 61–90 days, >90 days). It is a service quality indicator that helps to address the question of “how responsive is the service to health service providers’ needs?”, “how well does benefit fits the insured’s needs?”, and “how well does the insured understand the benefits?” [3]. In most cases, the settlement period depends on the context and type of product being offered. In SHI schemes, the shorter the delay in claims settlements, the better it is for the health services providers and the insured. It helps health services providers to manage their finances and be able to provide adequate and continuous services to the insured. Significant delays in claims settlements may force health services providers to take actions that defeat the purpose of providing financial risk protection to the insured. Among the possible reasons for delays in claims settlements are excessive documentation requirements and government interference in the disbursement of health insurance funds, especially in tax-funded health insurance systems [3,19].

Claims adjustment rate
This was analyzed as the proportion of claims amount that has been adjusted (or deducted) for benefit payment because of reasons including fraud, membership ineligibility (expiration of coverage period), ineligible health service provider (expiration of contract), and breach of sublimit on certain expense category. Like the promptness of claims settlements indicator, the claims adjustment rate tells a lot about how well health services providers understand the health insurance system, particularly service delivery and claims preparation. This indicator also shows how well the insured understand the health insurance system, especially the expiration period and utilization of benefits. The indicator further provides information about the risk management and claims adjudication process of SHI schemes. It also helps to address the responsiveness issues raised under the “promptness of claims settlements” section.

According to literature, a high claims adjustment rate indicates that both insured and health services providers do not understand the benefits being offered [3]. It could also mean that health services providers submit spurious claims. Although a low claims adjustment ratio is desirable, this could also indicate inadequate claims management.

Data Collection Methods
Membership and medical claims data were retrieved from the database of the Ashiedu Keteke District NHIA Office. The article also used participant observation method to collect other relevant data for the study. This method was used on the basis of author’s extensive involvement in the implementation and management of the NHIS at the district level. Patton [20] argues that

Experiencing the program as an insider is what necessitates the participant part of participant observation. At the same time, however, there is clearly an observer side to this process. The challenge is to combine participation and observation so as to become capable of understanding the program as an insider while describing the program for outsiders.

Results and Discussion

Brief Description of Membership and Claims Reimbursement Data
A total of 644,663 claims with a cost of Ghana cedi (GHS) 11.8 million (US $3.1 million) were received from health services providers from 2010 to 2014. During the first 4 years of this period, the number of insured increased from 33,242 to 84,060 (Table 1). The number of claims and claims cost also increased from 97,001 to 151,755 (56%) and GHS1.7 million to GHS2.9 million (71%), respectively, over the same period. The year 2014, however, recorded a reduction in the number of insured, number of claims received, and claims cost by 12.1%, 17.0%, and 3.0%, respectively. In 2010, there were 18 health services providers delivering services to the insured patients; however, this number reduced to 12 in 2014. The current number of health services providers consists of two district hospitals, five clinics, and five community practice pharmacies.

Contributions and Claims Expenses
Over the period under study, a total contribution of GHS2.0 million (US $536,080) was collected and an amount of GHS11.5 million (US $3.0 million) was expended on claims (Table 2). The contributions collected increased remarkably by 90% between

<table>
<thead>
<tr>
<th>Data characteristic</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
</tr>
<tr>
<td>No. of insured</td>
<td>33,242</td>
</tr>
<tr>
<td>No. of claims received</td>
<td>97,001</td>
</tr>
<tr>
<td>Claims cost (GHS thousand)</td>
<td>1,678</td>
</tr>
<tr>
<td>No. of health services providers</td>
<td>18</td>
</tr>
</tbody>
</table>

Source. Ashiedu Keteke District NHIA Office data.
GHS, Ghana cedi; NHIA, National Health Insurance Authority.
increase claims cost. In addition, lack of cost-sharing measures over their 1-year subscription period, a practice that is likely to subscribers unlimited access to and utilization of health services the bene package has the potential to incentivize subscribers to overutilize the generous one-for-all bene

of GHS20.00 (US $5.30) per member per year relative ers. As shown in Table 3, this contribution rate is lower than the underlying causes of this situation might be due to the low flat contribution of GHS20.00 (US $5.30) per member per year relative to the generous one-for-all benefit package available to subscripti

The NHIS one-for-all broad benefit package for subscribers and the lack of cost-sharing measures to control utilization might also account for the high claims cost. The generous benefit package has the potential to incentivize subscribers to overutilize the benefits and cause claims expenses to increase. It offers subscribers unlimited access to and utilization of health services over their 1-year subscription period, a practice that is likely to increase claims cost. In addition, lack of cost-sharing measures such as co-payments, deductibles, or ceiling in the scheme’s design might contribute to the increasing claims cost observed over the first 3 years of the study period. Evidence shows that absence of such cost-sharing methods leads to both demand- and supply-side moral hazards, and eventually increases claims expenses to the insurer.

Also, the increasing trend of the incurred claims cost might be due to the weak claims review system at the district level. Presently, the district office lacks a robust claims management system for detecting fraudulent claims and controlling cost. A study in two district offices of the NHIA in the Upper East region also found the claims review system as weak in its ability to reject spurious claims and cut down cost. Although the NHIA is in the process of centralizing its claims review process, some of the district schemes including the one under study still review their claims manually, a practice that has the tendency to increase payment of fraudulent claims, and eventually increases claims cost to the scheme. Another potential factor for the high claims expense is the absence of medical screening methods in the NHIS membership registration process. This design limitation could lead to enrollment of sick people into the scheme and eventually increase health services utilization and claims cost, as evidenced in literature as adverse selection.

Nevertheless, the positive side of the upward trend in the claims ratio is that subscribers are aware of the benefits of the NHIS and are using those. This stems from the fact that enrollment onto the scheme is practically voluntary; hence, potential subscribers would weigh the cost of contribution against the benefits before enrolling onto the scheme. Therefore, the extremely high claims ratio shows that subscribers are getting more benefits from the contributions they pay, and to a larger extent are satisfied with the contribution-benefit combination. However, in the long-term, this situation could threaten the financial viability of the scheme and defeat the purpose of offering financial risk protection to the poor and vulnerable in society.

The remarkable decline in claims ratio in 2014 could be attributed to an increase in contributions and reduction in the number of claims and claims cost in that same year. This positive trend is encouraging considering the financial difficulties the

<table>
<thead>
<tr>
<th>Year</th>
<th>Contributions (GHS) (a)</th>
<th>Claims cost (GHS) (b)</th>
<th>Claims ratio (b/a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>237,281</td>
<td>1,678,836</td>
<td>7.1</td>
</tr>
<tr>
<td>2011</td>
<td>449,972</td>
<td>1,929,681</td>
<td>4.3</td>
</tr>
<tr>
<td>2012</td>
<td>422,336</td>
<td>2,433,534</td>
<td>5.8</td>
</tr>
<tr>
<td>2013</td>
<td>388,125</td>
<td>2,787,242</td>
<td>7.2</td>
</tr>
<tr>
<td>2014</td>
<td>539,391</td>
<td>2,678,259</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Source. Ashiedu Ketke District NHIA Office data. GHS, Ghana cedi; NHIA, National Health Insurance Authority.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of claims</th>
<th>Claims cost (GHS)</th>
<th>Average cost per claim (GHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient</td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>2010</td>
<td>95,061</td>
<td>1,940</td>
<td>1,553,437</td>
</tr>
<tr>
<td>2011</td>
<td>119,639</td>
<td>2,049</td>
<td>1,737,422</td>
</tr>
<tr>
<td>2012</td>
<td>145,822</td>
<td>2,309</td>
<td>2,196,568</td>
</tr>
<tr>
<td>2013</td>
<td>149,486</td>
<td>2,269</td>
<td>2,553,114</td>
</tr>
<tr>
<td>2014</td>
<td>122,703</td>
<td>3,385</td>
<td>2,335,826</td>
</tr>
</tbody>
</table>

GHS, Ghana cedi.
NHIS is facing currently. A continuous increase in contributions and decline in claims cost over a long-term period would reduce the financial burden of the NHIS. It would also improve the financial operations of the health services providers because delays in payment of their claims would be reduced.

**Number and Cost of Claims by Type of Health Care Services**

Although the number of claims for inpatient services increased consistently from 1,940 to 3,385 over the study period (74%), that for outpatient services increased by 57% from 95,061 to 149,486 between 2010 and 2013, and dropped by 18% in 2014. Claims cost for both services showed similar trends over the same period. The average cost per claim for inpatient services was higher than that of outpatient services in each year of the study period.

The number of claims and the amount of claims for outpatient services were higher than those for inpatient services during the period under study, and this could be attributed to the large number of outpatient facilities in the district. Only 1 of the 12 health services providers offers inpatient or admission services to the insured. The average cost per inpatient claim, however, was substantially higher than that of outpatient in each year of the study period, indicating that the insured patients used more extensive inpatient services. This situation could also be attributed to the relatively high Ghana Diagnosis Related Groupings (G-DRG) charges for inpatient services in the NHIS tariff.

In 2014, the average cost per claim was GHS22.08, a little higher than the flat contribution of GHS20.00, and this means that more revenues are needed to take care of increasing levels of health services utilization. Other cost-containing measures including change in payment method from the existing G-DRG to capitation for outpatient services at the primary level of care would also be necessary, especially as the NHIS strives to achieve the overarching goal of universal health coverage in the near future.

**Trends in Claims Cost by Medicine and Nonmedicine Services**

Over the period under study, amounts of GHS4.9 million (US $1.3 million) and GHS6.9 million (US $1.8 million) were reported to the insurance office for payment as medicine cost and service cost, respectively. There was a consistent increase in the proportion of service cost from 15% to 24% between 2010 and 2014 whereas that for medicine cost grew by 30% and 82% at an average rate of 7.5% and 21%, respectively from 2011 to 2014.

The service cost constitutes nonmedicine costs, which include the cost of consultations, laboratory tests, x-rays, scans, accommodation, and catering services. The high and increasing service cost might be attributed to the use of DRG payment method for both outpatient and inpatient services at all levels of the health system, that is, primary to tertiary. Other studies show that the use of DRG for primary health care services has the tendency to increase claims cost to insurance companies [1,21].

The DRG replaced the itemized fee-for-service payment method that was used to pay health services providers between 2005 and 2007. This payment method incentivized providers to oversupply services, which led to huge claims cost to the NHIS [5,21]. However, implementation of the DRG payment method to address the escalating cost of claims associated with the fee-for-service method has not yielded the expected result; rather, it is increasing claims cost and putting financial burden on the NHIS [21,22]. Thus, the continued use of the DRG payment system for outpatient services at the district, regional, and national hospitals could pose sustainability challenges to the NHIS. The relatively high proportion of medicine cost (GHS4.9 million) vis-à-vis the use of the DRG payment system for both outpatient and inpatient services also suggests an element of irrational prescribing and polypharmacy. Therefore, further investigations would be necessary to identify the underlying drivers of the high medicine cost.

**Promptness of Claims Settlement**

The promptness of claims settlement indicator could not be determined for the year 2010 because of lack of decomposed data on payment dates. In 2011, about 22% of all claims submitted by health care providers were settled between 31 and 60 days. The settlement period for the subsequent years worsened; less than 1% of the total claims received were settled between 31 and 60 days, and none of the claims was settled within the same period in 2013 (Fig. 3). The proportion of claims settled beyond 90 days increased consistently from 26% in 2011 to 100% in 2014. Similar findings were revealed in other studies by Nsiah-Boateng and Atkinis [7] and Dalinjong and Laar [23].

These lengthy delays are due to the inability of the NHIA to mobilize enough revenue especially from the informal sector to meet the increasing cost of medical claims. Government interference in the disbursement of the NHIF for the payment of medical claims is also a major contributory factor. The delay in the release of statutory funds from the consolidated account to the NHIF is a major challenge facing the NHIS as evidenced in a report [12].

The new National Health Insurance Act (Act 852) mandates payment of the National Health Insurance Levy into the NHIF 30 days after the collection of the levy [14]. However, strict
compliance to this law has not been adhered to, resulting in lengthy delays in settlements of claims [7,14]. Although Act 852 is silent on the number of days required to settle health service providers’ claims, the lengthy delays observed do not augur well for efficient management of health services providers’ finances.

It is found that health care providers depend heavily on the NHIS for their internally generated funds; about 81% of their revenue is generated through provision of services to NHIS subscribers [12,24]. Therefore, significant delays in claims settlement could distort the financial operations of the health services providers and affect the delivery of quality health care to the insured patients. In the long-term, this situation could have a negative effect on enrollment in and growth of the scheme. It could also deter other service providers from joining the pool of accredited providers to offer services to the increasing number of enrollees, thus affecting equity and geographical access to health care.

Claims Adjustment Rate

Out of an amount of GHS11.8 million reported by health care providers as claims, 317,062 (2.7%) was adjusted, with the highest rate of 4% occurring in 2010 (Table 4). The proportion of claims cost adjusted increased from 1% to about 4% over the 2011-2014 period. The 2.7% adjustment rate over the study period is quite low and the probable reason might be that health services providers have a good understanding of the NHIS system, particularly application of the G-DRG system in claims preparation. It is also possible that most, if not all, health services providers prescreen their claims for errors, omissions, and so forth before submitting to the insurance office for payment. This prescreening practice could limit the number of erroneous claims and the proportion of adjustments.

According to managers of the Ashiedu Keteke District Office, reasons for the adjustments were membership ineligibility, overbilling of medicines, and overbilling of services. Others were misapplication of DRG codes, treatment-diagnoses mismatch, and duplications. These reasons indicate that some of the subscribers are unaware of the yearly renewal of their membership, and health services providers either do not fully understand the application of the G-DRG system or they are deliberately misapplying it to claim a higher amount, as seen in some instances in which providers used complicated malaria DRG code to request payment for treatment of simple malaria [21].

Besides the reasons cited for the low rate of adjustments by managers of the district office, the manual system of claims review at the district offices of the NHIA might be another contributing factor. The claims review system has limited human resource capacity and weak electronic infrastructure. Most of the claims officers have inadequate technical capacity in the medical field and this limits their ability to detect spurious claims and cut down claims expenses. A study by Sodzi-Tettey et al. [22] in two district offices of the NHIA also identified the manual system and the low capacity of the claims reviewers as one of the challenges affecting claims review and payment.

Study Limitations

Data on the number of rejected claims for the period under study were not available; thus, the claims rejection ratio could not be estimated. However, adjusted amounts that were available were used to estimate adjustment rates over the study period. Although this indicator does not give a fair performance assessment of the claims review process, it provides an insight into the proportion of amount paid out of the total claims received from health services providers. Second, the database had inadequate information on claims cost drivers, and this made it cumbersome to identify and analyze major cost drivers such as diagnoses (disease conditions) and medicines. Inadequate information on age groups and enrollee subgroups in the claims database also made it difficult to identify groups with high claims cost. In addition, inadequate information on disease conditions in the claims database did not allow this article to compare the prevalence of disease conditions, for example, malaria, hypertension, and diabetes, among enrollees.

Conclusions

The study reveals higher than expected claims to contribution ratio, which reflects an increased value of the NHIS benefit package to subscribers. There is also low rate of claims adjustments, which shows that health services providers understand the NHIS system, especially claims preparation and request. Most of the claims reported to the insurance office for payment, however, were settled beyond the period of 3 months, indicating low responsiveness to the financial needs of health services providers. Although the NHIS is a propoor scheme, the study recommends limitation to the scope of the benefit package to contain the high and increasing claims cost. Other important considerations are upward review of the insurance levy, introduction of actuarially determined contributions, or cost-sharing methods such as co-payments. Further research would also be necessary to identify reasons for the downward trend in membership observed in the study, to improve growth.

Acknowledgments

We thank the management of Ashiedu Keteke District NHIA Office for the use of its membership and claims data for this study. We also thank the reviewers for their invaluable comments and suggestions.

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount of claims received (a)</th>
<th>Amount of claims adjusted (b)</th>
<th>Adjustment rate (b/a \times 100) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,749,366</td>
<td>70,529</td>
<td>4.0</td>
</tr>
<tr>
<td>2011</td>
<td>1,952,086</td>
<td>22,405</td>
<td>1.1</td>
</tr>
<tr>
<td>2012</td>
<td>2,471,257</td>
<td>37,723</td>
<td>1.5</td>
</tr>
<tr>
<td>2013</td>
<td>2,867,599</td>
<td>80,357</td>
<td>2.8</td>
</tr>
<tr>
<td>2014</td>
<td>2,784,307</td>
<td>106,048</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Source. Ashiedu Keteke District NHIA Office data.
NHIA, National Health Insurance Authority.
REFERENCES


