

**SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA, LEGON**

**ASSESSING THE ROLE OF FRONTLINE PROVIDERS IN SHAPING THE  
IMPLEMENTATION OF CAPITATION PILOT AT KOMFO ANOKE**

**TEACHING HOSPITAL**

**BY**

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,  
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE**

**AWARD OF MASTER OF PUBLIC HEALTH DEGREE**

**JULY 2015**

## DECLARATION

I hereby declare that all information produced from this research is as a result of my own work and diligence in obtaining data. With the exception of articles and books, which have been cited and duly acknowledged in the references of this research, the entire work is mine. To the best of my knowledge, no part of this work has been obtained from a previous publication or accepted for the award of any degree in any University or institution of higher learning except where due acknowledgement is made in this text.

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## DEDICATION

This work is dedicated to my ever supportive husband and children.



## ACKNOWLEDGEMENT

This work has been accomplished through the contributions of various persons whose support, encouragement and commitment played a vital role in seeing me through the program successfully.

I am grateful to the most high God for his ever present strength and grace through out this research.

My academic supervisor, Prof. Irene Akua Agyepong who has been of immense help through her insightful suggestions, support and encouragement as well as guidance during the course of this research.

I am also grateful to Dr Reuben Esena and Dr. Genevieve Aryeetey for their various contributions.

I wish to express my gratitude to Mr. Dennis Amoah for his help as my research assistant. I also extend my gratitude to the head of department and staff of KATH polyclinic.

Finally, I wish to thank my parents and siblings for their encouragement and support.



## ABSTRACT

Over the years, health care financing in Ghana has evolved from free health care to cash and carry (out of pocket) at point of use. Due to the economic burden of cash and carry on citizens, the National Health Insurance Scheme was formed in 2003 through Act 650. This was to provide an alternative form of health care financing to ease the burden of rising cost of health care on citizens. The scheme commenced with itemized fee for service and subsequently Ghana Diagnostic Related Groups Provider Payment Methods. Challenges of cost escalations with these provider payment methods led to the pilot of capitation in NHIS accredited facilities in Ashanti Region. The pilot was introduced in January 2012.

The aim of the study was to assess the role of frontline providers in shaping the implementation of capitation pilot in Komfo Anokye Teaching Hospital (KATH), Ashanti Region. The study was an exploratory cross sectional study using qualitative data collection and analytical methods. Data was collected through key-informant in-depth interview, focus group discussions, observations and document review. Data collection tools were an interview and focus group discussion guide, notebooks and tape recorders. Study setting was the polyclinic directorate of KATH. Thirty (30) health workers were purposively selected using snowball technique. Two focus group discussions were done. Interviews and focus group discussions were recorded and transcribed into Microsoft word. Tools such as tables and matrices were used to present findings. Data sets were analyzed based on thematic content analysis.

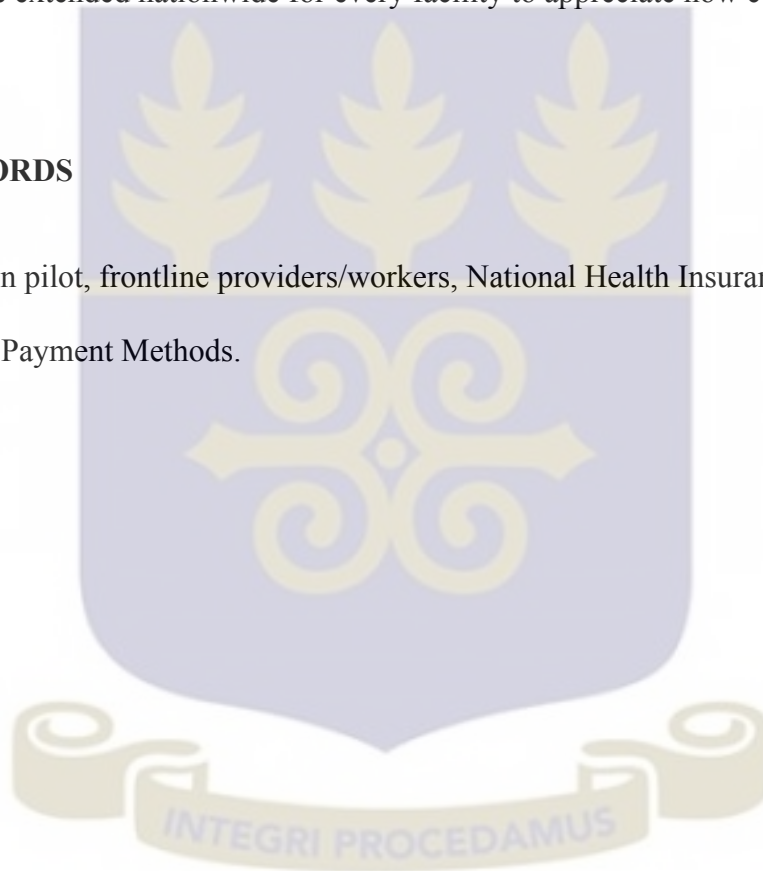
A key finding indicated, various categories of frontline providers had their own level of knowledge on the capitation pilot and its implementation design. They had some misconceptions on certain aspects of the policy. Factors such as, knowledge level and

availability of resources determined the extent to which the policy was implemented. In order to implement the policy health workers developed coping mechanisms such as copayment to keep the flow of health care delivery.

Generally, the frontline workers were of the perception capitation was good but it should be reviewed improve health care delivery. Policy makers should visit the facilities to review the successes and failures of the policy design. Finally, the policy should be extended nationwide for every facility to appreciate how constrained they were.

**KEYWORDS**

Capitation pilot, frontline providers/workers, National Health Insurance Scheme and Provider Payment Methods.



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## LIST OF ACRONYMS

1. CHAG-Christian Health Association of Ghana
2. CHI- Community Health Insurance
3. CHPS-Community based health planning and services
4. DANIDA- Danish International Development Agency
5. DFID- Department for International Development
6. DMHIS- District Mutual Health Insurance Scheme
7. FGDs- Focus group discussions
8. FFS-fee for service
9. G-DRG- Ghana Diagnostic Related Groups
10. IDI- in-depth interview
11. ILO- International labor organization
12. KATH- Komfo Anokye Teaching Hospital
13. LI- Legislative Instrument
14. MOH- Ministry of Health
15. NDPC-National Development Planning Commission
16. NHIA- National Health Insurance Authority
17. NGO- Non-Governmental Organization
18. NHIS- National Health Insurance Scheme
19. NHIL-National Health Insurance Levy
20. PMPM- Per member per month
21. PMPY-Per member per year
22. PPM-Provider Payment Mechanism
23. PPS- Provider Payment System
24. OPD- Out patient department

25. SHI- Social Health Insurance

26. SSNIT-Social Security and National Insurance Trust

27. VAT-Value Added Tax

28. WHO- World Health Organization



## **DEFNITION OF TERMS**

### **1. CAPITATION**

The system of provider payment in which the provider is paid in advance a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period of time.

### **2. PROVIDER PAYMENT METHOD**

The mechanism used to transfer funds from the purchaser of health care services to the providers.

### **2. ITEMIZED FEE FOR SERVICE**

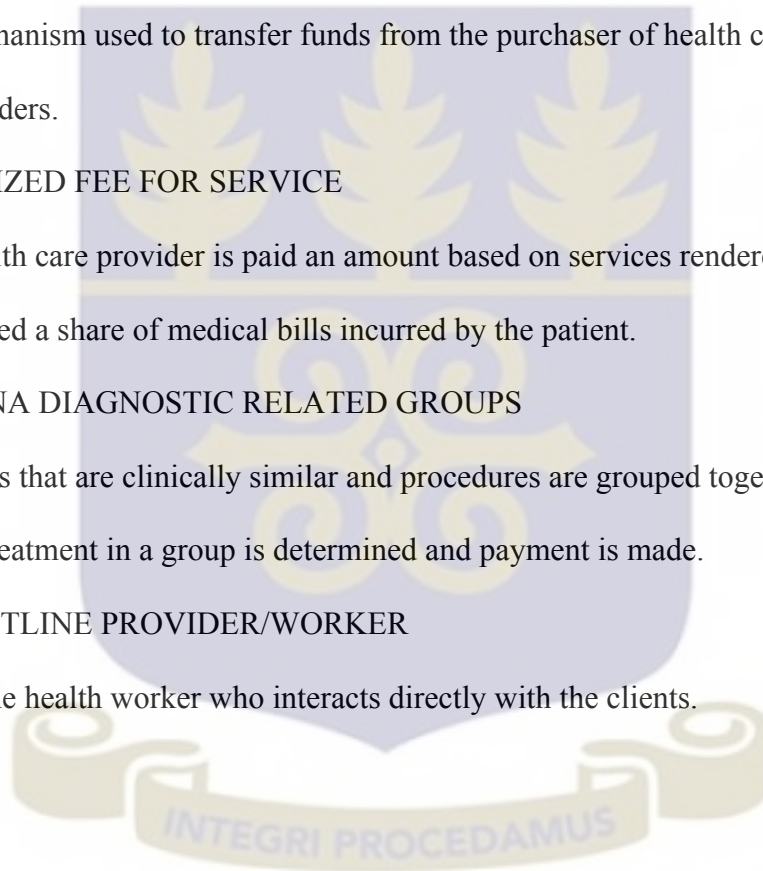
The health care provider is paid an amount based on services rendered. Providers are reimbursed a share of medical bills incurred by the patient.

### **3. GHANA DIAGNOSTIC RELATED GROUPS**

Diagnosis that are clinically similar and procedures are grouped together and average cost of treatment in a group is determined and payment is made.

### **4. FRONTLINE PROVIDER/WORKER**

This is the health worker who interacts directly with the clients.



## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 BACKGROUND

An optimum health care system is oiled by a good health financing mechanism (WHO, 2007). According to Goodman & Waddington (1994) financing an efficient and effective health care system is of a major concern to countries worldwide. This is even more critical in developing countries where there are several developmental challenges of which limited resources and poverty are dominant. Comparatively, Asian and African countries spend more on healthcare through out-of-pocket than from government general revenue or social health insurance (Jehu-appiah, Aryeetey, Agyepong, Spaan, & Baltussen, 2011).

On September 05, 2003, the Ministry of Health (MOH) Ghana, in consultation with its international health development partners (WHO, DANIDA, DFID, and ILO) and other relevant national agencies and NGOs, formed National Health Insurance Scheme (NHIS) (MOH, 2004a). The then President, John Agyekum Kufour launched the scheme with the intention of offering affordable medical care to all Ghanaians, especially the poor and vulnerable in the society. The scheme therefore supplanted the cost-recovery health delivery system (cash and carry) system in operation since 1985. Ghana's scheme has utilized three Provider Payment Method (PPM): fee-for-service (FFS), Ghana Diagnostic Related Groups and capitation.

In 2005, the scheme took off with FFS then later included G-DRG in 2008 (NHIA, 2013). However, down the years, contrary to expectations increased cost of care was observed under the FFS and G-DRG. This threatened the sustainability of NHIS.

As an antidote, the NHIA supported by the World Bank Health Insurance Project started planning and designing the implementation of the capitation system or the per capita pilot in Ashanti region. The capitation pilot was to improve cost containment, share financial risk between schemes, providers and subscribers and introduce some form of competition for providers and choice of patients. It was therefore introduced in 2012. The pilot scheme was started in the Ashanti Region due to its central location and heterogeneous infrastructure and culture. Additionally, Ashanti region was chosen because it had the highest NHIS accredited facilities in Ghana. The pilot was given a one year mandate ending in 2013 after which it was to be evaluated to inform roll out in other regions of Ghana (Ensor & Cooper, 2004; Loveman et al., 2011)

In capitation payment systems, the provider is paid in advance a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period of time. Per capita payment systems are output-based, and the unit of output is the coverage of all predefined services for an individual for a fixed period, usually one month or one year.

Characteristic of every insurance scheme is a client, payer and provider (NHIA, 2013). The client is the recipient of health care regardless of the state of health. The payer on the other hand, is an entity that finances or reimburses the cost of health services (medical dictionary, 2012). The Provider is an individual, institution or agency that provides health services to health care consumers. This study views the provider (individuals) as frontline workers. These are the workforce who usually interact directly with the clients. Policies are handed over to them for implementation. Resultantly, to a large extent they play a key role in the success or failure of policies.

Frequently, in policy formulation and implementation much effort is put into content

development and roadmaps for successful implementation whereas; little attention is paid to players involved in the practice of the policy. The case of capitation pilot is no exception. According to Walt & Gilson (1994): ‘The traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation’ this study considers the actors as frontline workers.

## **1.2 STATEMENT OF THE PROBLEM**

Capitation pilot was introduced to reduce the rising cost of care under the previously introduced FFS and G-DRG. Originally, it was to cover OPD primary cases, antenatal care, postnatal care, normal delivery and related laboratory test using rapid test if a laboratory is not present. Upon introduction of the pilot there were extensive provider agitations and protests such as strike actions by doctors and pharmacists.

Additionally, according to a KATH 2012 annual report, after the inception of the policy there was a decrease in OPD attendance at the polyclinic. Recorded attendance in 2011 was 382752 and 2012 was 340974. These values indicate a 26.14% decrease in attendance. Decline in attendance was attributed to capitation. Other challenges with the pilot were lack of understanding of the policy by frontline providers, unrealistic tariffs and delays in the payment of health insurance claims.

Consequently, the frontline workers who were to implement the policy agitated against it. Agitations were based on inadequacy of tariffs and unavailability of resources to deliver health care services stated in the policy framework. As a result they implemented the policy upon their discretion. Originally indicated health services have been watered down.

Ghana has plans of national scale up of this policy. Unfortunately little literature

exists on the role of frontline providers in shaping the implementation of capitation PPM. The study seeks to serve as a knowledge base to inform policy makers in their decision concerning capitation PPM.

### **1.3 CONCEPTUAL FRAMEWORK**

Lipsky (1980) researched into collective behavior of public service agencies. These agency workers interacted regularly with the public and have wide discretion over public policy implementation arrangements. The agencies he examined were public schools, welfare departments, lower courts and health services. He observed there were gaps in public policy implementation. He sought out therefore to find possible explanations for the persistent public policy implementation gaps. Out of his work, he developed street level bureaucracy theory of how and why some types of public service agencies perform contrary to their own rules.

Lipsky (1977) observed that, frontline workers interacted regularly with the public and had wide discretion over public policy implementation arrangements. The actions and inactions of these workers effectively become the face of public policy; they are also 'policy makers'. He referred to these frontline workers as "street level bureaucrats"; defining them as "Public service workers who interact directly with citizens in the course of their jobs, and have substantial discretion in the execution of their work".

He concluded that the policy making or shaping roles of street level bureaucrats were built upon the two interrelated factors of their relatively high degrees of discretion and relative autonomy from organizational authority. Additionally, the conditions of work of street level bureaucrats helped to influence their actions and inactions in shaping public policy. These conditions of work were chronic inadequacy of

resources relative to the tasks workers are asked to perform; demand for services tends to increase to meet the supply; expectations and goals for the agencies in which they work, are ambiguous, vague or conflicting and performance orientation towards goal achievement was sometimes difficult if not outright impossible to measure. Additionally, clients were typically non-voluntary; and partly as a result, for most part did not serve as the primary bureaucratic reference group for frontline health workers. In order to adapt to these work conditions frontline workers draw on their discretion and develop coping behaviours that may lead to results different from stated agency policy objectives. These coping behaviours include rationing services by imposing costs on clients that discourage them from seeking services, giving and withholding of information or differential allocation of services. They are able to effectively exercise control over their clients so that clients comply with inconvenient service arrangements. Simply because they have a superior relationship to clients as such control desired benefits, and have the potential ability to withhold these benefits or make their attainment more difficult or costly for clients. Lipsky (1980) carried out his work in the USA. However several studies carried out in low and middle-income countries including some in sub-Saharan Africa have demonstrated the relevance of this theory (Kaler & Watkin, 2001; Walker & Gilson, 2004; Kamuzora & Gilson, 2007, Agyepong & Nagai, 2011)

This study will explore to what extent Street Level Bureaucracy theory explains how frontline workers shaped the implementation of capitation pilot in Ashanti region. The premise is that frontline workers in the health sector in Ghana do indeed play the role of street level bureaucrats in policy implementation. They have a certain degree of discretion in their work and relative freedom from organizational autonomy. They also work under conditions of resource constraints and with conflicting objectives.

As part of coping behavior, they can shape and reshape the implementation arrangements of public policy in the health sector and thus the face of the policy as part of coping behavior; and this indeed was part of what happened in the implementation of the capitation pilot.

The study will therefore explore themes based on these assertions from the Lipsky theory to explain how and why the frontline workers at the polyclinic of KATH reacted to and shaped the implementation of the capitation pilot.

#### **1.4 PURPOSE OF THE STUDY**

The purpose of the study is to explore and understand why and how frontline providers shaped the implementation of the capitation pilot in the Ashanti region; the lessons for policy design and implementation in Ghana

#### **1.5 JUSTIFICATION OF STUDY**

Currently, according to NHIA a scale-up of capitation is underway in the Volta Region. All indications points to the fact that in the not too distant future policy makers would want to roll up capitation nationally. With obvious knowledge gaps on why and how frontline providers implemented the pilot, this study would help to bridge that gap. Policy framers would be better informed on appropriate PPM for NHIS. This study will immensely enrich literature.

#### **1.6 STUDY OBJECTIVES**

##### **1.6.1 GENERAL OBJECTIVE**

To explore how frontline providers shaped the face of the capitation pilot in its implementation at the Komfo Anokye Teaching Hospital (KATH) polyclinic.

### **1.6.2 SPECIFIC OBJECTIVES**

1. To describe what the stated policy objectives and implementation design of the capitation pilot were.
2. To describe how the capitation pilot was actually implemented by frontline providers at the KATH polyclinic.
3. To explore why any differences evolved in implementation between the stated implementation design of national level and the actual implementation design at the frontline in the KATH polyclinic
4. To explore whether the implementation approach used by frontline workers could inform the review of the current implementation design?

### **1.7 RESEARCH QUESTIONS**

1. What were the policy objectives and implementation design of the capitation pilot at national level as compared to what actually happened in implementation in the Ashanti region?
2. What could be the possible reasons for any differences between intended design and implemented design?
3. What lessons are there for improving policy design and implementation in Ghana?

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### INTRODUCTION

This review seeks to provide relevant existing literature on healthcare financing in Ghana, its National health insurance Scheme (NHIS), provider payment mechanisms, and the capitation pilot in Ashanti region. In addition, how frontline workers shape shaped the implementation of capitation pilot in KATH.

#### 2.1 EVOLUTION OF HEALTH CARE FINANCING IN GHANA

Healthcare financing in Ghana has been through a lot of changes. It took off on the pedestal of virtually free medical care through to the period of cash and carry to the current health insurance system. Health financing is concerned with how financial resources generated are allocated and used in a health system. It can also be defined as mobilization and allocation of funds to regions and population groups for specific types of health care. Again it can be described as mechanisms for paying health care (Hsaio & Liu, 2001).

Following the attainment of independence, the Government of Ghana made access to health services in the public sector free where as that of the private sector was paid for at the point of service. This free care was financed solely through taxes. Ghana's economic stagnation due to dwindling tax revenue affected the sustenance of free access to care policy. The rippling effect of economic challenges propelled the government of the day to take measures to remedy the situation.

In 1969, fees were introduced with the enactment of Hospital fees Decree 1969. This was amended to the Hospital Fees Regulation Act 1971. In that regard, in 1972 a low out-of-pocket fee (more or less a token) was introduced at point of service use in the

public sector to discourage frivolous use. By, 1980, user fees for government services had become an acceptable financing option for the health and social sectors in Ghana and many other developing countries (Sah, 2008). However, due to economic challenges, deteriorating health infrastructure, and massive emigration of health workers, the government could no longer sustain the system. It therefore implemented a cost recovery scheme (or *cash and-carry* system), as part of International Monetary Fund and World Bank-sponsored Structural Adjustment Programs in 1983. This system saw the withdrawal of government subsidies on health care delivery (Agyemang-Konadu, 2000).

Consequently, patients were made to pay fully for the cost of medicines and some medical consumables whenever they visited any public health institution. The State on the other hand was responsible for other cost including emoluments of doctors, nurses and other paramedic staff. The objective of cash and carry system was to enable health facilities expand, improve health care delivery services and to prevent patient abuse of the system. Contrarily, under utilization of basic health services was observed and the poor became marginalized, as they could not afford services (Johnson & Stoskopf, 2009).

The prevailing challenges propelled the Government of Ghana in July 1985, to enact the Hospital Fees Regulation, 1985 Act 387 (L.I.1313), as a cost-sharing measure for the use of MOH facilities. This led to nation wide fee for service system. Under this system tokens for services were increased to specific charges (Nyonator & Kutzin, 1999). Furthermore in 1990, Community-based mutual health insurance schemes were introduced. However out of pocket payment still existed in the country.

According to Bredenkamp et al., (2011) health expenditure through out-of-pocket contributes substantially to impoverishments of households. Consequently, increasing

incidence of poverty pushed households into deeper poverty. Studies carried out in these three countries Ghana, South Africa and Tanzania, showed there was a regression of out-of-pocket payments. This was due to the incomplete enforcement of exemptions and waiver policies. Additionally, partial or no insurance cover among poorer segments of the population and limited understanding of entitlements accounted for the regression in out-of-pocket (Macha et al., 2012). The out of pocket method of health financing came with its own challenges where clients had to pay money before care was provided to them. Alarming was the situations such that even in emergencies clients were expected to make payments before they were attended to. In 1992, the St. Theresa's Catholic Mission Hospital started a pilot community health insurance known the Nkoranza Health Insurance (Atim & Madjyuene, 2000).

Then in the mid 1990's, a unit was set up by MOH to establish a National health Insurance Scheme as an alternative to the nationwide cash and carry system. Consequently, in 1999, a pilot Social health Insurance (SHI) was formed for the formal sector and organized groups such as Cocoa farmers. The pilot was slated for Eastern region. However, this pilot never took off (Atim et al., 2001; Arhinful, 2003). After this failure the Social Security and National Health Insurance Trust commenced planning for another centralized insurance scheme to run by Ghana health care company. Again, this also did not see the light of day. Another pilot, a district wide Community Health Insurance was planned in Dangme West. This was for non-formal sector of the community and studies proved the community members were really interested in the program (Arhin, 1995). Scheme design and implementation was to be funded by MOH and monitoring and evaluation by European Union. However retirement of the Medical Director of Health services dwindled the interest of MOH. In spite of this challenge, the district assembly and development partners in October

2000, registered beneficiaries and delivery of benefits started (Agyepong & Adjei, 2012). The Ghana Health Service and MOH continued to finance the scheme.

After this, many Community Health Insurance schemes (CHI) sprung up (Baltussen, 2006). These CHIs were sponsored by development partners such as Danish International Development Assistance (DANIDA), Partnership for Health Reforms-plus, (PHR-plus) and faith based organizations such Christian Health Association of Ghana (CHAG). Though CHI existed in the communities, private health care in households was financed mainly through out-of-pocket. This accounted for 61% of total health expenditure. As a result, there was high out pocket expenditure on health and low utilization very low utilization of services (NHIA, 2013). Studies showed that exemptions were not often awarded despite existence of exemption policies (Agyepong & Nagai, 2011).

In August 2003, due to challenges of out-of-pocket fees at point of service use, the government through the passage of a Bill introduced National Health Insurance as a more equitable and pro-poor health financing policy (Agyepong & Adjei, 2008).

## **2.2 NATIONAL HEALTH INSURANCE SCHEME**

The NHIS was established under the National Health Insurance Act 650 in 2003. In 2004 it was implemented as a ‘pro-poor’ method of health financing (Dixon, Luginah & Tenkorang, 2013). Also it was set up by government to secure financial risk protection against the cost of health care services of all residents in Ghana (NHIA, 2013). The initial policy objective was “within the next five years, 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 in order to obtain access to a defined package of acceptable quality of health service” (MOH 2002, 2004). Funding of the scheme is perceived through three models: Beveridge Model:

National Health Insurance Levy (NHIL) - 2.5% Value Added Tax (VAT), Bismarck Model: 2.5 percentage points of Social Security contributions and Mutual Health Organizations Model: Graduated informal sector premium based on ability to pay. Earmarked funds (NHIL & SSNIT) constitute over 90% of total inflows. Benefit package covers 95% of disease conditions (NHIA, 2013).

Act 650 was revised in 2012 to NHIS Act 850. The objective of the revision was to remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and gaming of the system, and make for more effective governance of the schemes (NHIA, 2013).

### **2.3 PROVIDER PAYMENT MECHANISMS (PPM)**

Characteristic of every health insurance scheme is a provider payment system (PPS) that consists of a provider payment method (PPM). PPM is “the mechanism used to transfer funds from the purchaser of health care services to the providers”. A good PPM has to be implemented within strong support systems. Worldwide there are three methods used in paying providers under a health insurance scheme: fee for service, diagnosis related groups and capitation (Cashin, Langenbrunner & O’Dougherty, 2009). The mechanism used to transfer funds from the purchaser of health care services to the providers is known as a provider payment method (Cashin et al., 2009). There are various types of PPM.

#### **2.3.1 RETROSPECTIVE PROVIDER PAYMENT METHOD**

According to Jegers, Kesteloot, Graeve, & Gilles ( 2002), in retrospective PPM, provider costs are fully or partially reimbursed after services have been provided. Since reimbursement is based on real cost profit conscious providers are barely motivated to decrease costs. There is the incentive to increase costs with production as it gives a significant benefit. As there is no penalty for falsification these systems

do not stimulate technical efficiency. Examples are Fee-for-service, Per Diem payment (daily payment), and Diagnosis Related Groupings (DRG)

### **FEE FOR SERVICE (FFS)**

This is a type of method in which the provider is paid according to specific services provided (Janeba, 2008). Here the provider is reimbursed according to the number and type of different services provided to the patient. Price for services could be fixed or varied (Mukesh, Windak, Berman & Kulis, 1997; Lagenbrunner, 2002)

According to Barnum, Kutzin & Saxenian (2004), this PPM is used both in industrialized and developing countries. In Netherlands, a national tariff agency sets the rates after negotiations between representatives of physicians and insurers (Hurst, 1992). In Korea, associations of both fund holders and providers with government acting as mediators set the rates (Yang, 1991). In Zimbabwe, an association of private insurers negotiate a rate for specific services provided by the provider (Hecht et al., 1992). In United States, FFS is unregulated. However, insurers do not reimburse beyond a reasonable charge (Barnum et al., 2004).

In South Africa FFS is mostly used in the private health care sector and it is known to account for the rising cost of health (Langenbrunner, 2010).

This method can enable patient receive optimal level and quality of care but the bigger risk is, the physician may prescribe excessive treatment (Mukesh et al., 1997).

### **PER DIEM PAYMENT OR DAILY PAYMENT**

A provider is paid a set of amount per patient per daily care given (Janeba, 2008). Due to the likelihood of cost rising with the length of stay at the hospital, there is the incentive to prolong admission to increase cost of care.

Though countries such as Belgium, Croatia, Slovenia, Estonia and Slovakia practise this system (Langenbrunner & Wiley, 2002), Norway abandoned this PPM at the beginning of 1980. Over the years countries like Germany have replaced this method with DRG due to excessively high length of stay at the hospital (WHO, 2007). Since the inception of National health insurance Ghana has not yet adapted this method. (NHIA, 2012)

### **DIAGNOSIS RELATED GROUPS.**

Patients are classified into similar medical and economic groups. Providers are paid a fixed rate based on diagnosis, treatment type and discharges (WHO, 2007). This method expectantly is a good cost-containment device, as hospitals need to provide services within the overall constraint of the flat payment schedule (Carrin & Hanvoravongchai, 2003)

According Mukesh et al., 1997, this method is practiced in Brazil, Germany, Argentina and United States of America. This PPM was first introduced in 1983 for US Medicare. Australia piloted it in 1985 and Germany developed its system based on Australia pilot. Switzerland adapted the method based on Germany's system (WHO, 2007).

### **2.3.2 PROSPECTIVE PROVIDER METHOD**

Prospective provider payment rates or budgets are determined before services are provided. There is no link between individual costs and provision of service. Providers cost are financed with a given amount of money (Jegers et al., 2002). Examples are global budget and Capitation.

## **GLOBAL BUDGET**

A global budget is a payment fixed in advance to cover aggregate expenditures in a given period (Barnum, Kutzin & Saxenian, 2004). There are two major types of providers to which global budgets are applied, hospitals and physicians. Belgium is the only country that has set global budgets for drug expenditures (Wolfe & Moran, 1993). In Australia, Norway and Portugal, global budgets constitute the major form of payment for hospitals (Wolfe et al., 1993; Frossard, 1990; Hirdes et al., 1996). Mozambique uses global budget to reimburse providers (Langenbrunner & Liu, 2004). The budgets are formed from cost projections based on expected case mix and utilization of services (Wiley, 1992).

Global budgeting is expected to be a better tool for controlling hospital costs because there is a budget cap on spending (Langenbrunner & Liu, 2004)

## **CAPITATION GLOBALLY**

Capitation is one payment per person, for some bundle of services during a fixed period of time. This PPM transfers the economic risk from third-party payers to the health care provider (Barnum et al., 1995). Capitated budgets are usually awarded to primary care facilities that serve formally registered enrollees or residents in their geographical area (Gosden, Pedersen & Torgerson, 1999).

Countries such as United Kingdom, Netherlands, Denmark and Italy have implemented capitation. It has also been introduced in Costa Rica, Indonesia, and Thailand (Mills et al., 2000), as well as most of Eastern Europe and Latin America for primary care services (Dixon et al., 2002). Although capitation is one of the favored future health reforms for South Africa at the Primary Health Care level, it is not widely used presently (Gosden et al., 1999).

Capitation payment may be a flat fee for each provider or a risk-adjusted fee, based on the relative risk of the registered population (Barnum, Kutzin & Saxenian, 1995).

Its main benefit is, control of cost (Langenbrunner & Liu, 2004).

## **2.4 PROVIDER PAYMENT MECHANISMS UNDER GHANA'S NHIS**

### **2.4.1 FEE FOR SERVICE (FFS)**

The scheme took off with FFS high on its agenda in 2005. It covered outpatient, inpatient services and medicines (NHIA, 2013). The NHIA vets claims on behalf of government and makes payment (NHIA 2013).

Due to specialized knowledge of the health service provider which the client or patient often does not share; the service provider often chooses “items” for the client. Also, because providers are paid based on number of services provided there is a strong incentive of increasing services to attract more charges (WHO, 2007).

Down the years, challenges such as increase utilization with no lever to contain cost, ununiformed tariffs used by different schemes, elaborate labour intensive claims processes, delays and rejection of some claims payment emerged. Differences in reimbursements for different facilities for the same condition were observed (Amarteyfio & Yankah, 2012; Sodzi-Tettey, Aikins, Awoonor-Williams & Agyepong, 2012).

### **2.4.2 GHANA DIAGNOSTIC RELATED GROUPINGS (G-DRG)**

The consequent cost escalations saw the introduction of Ghana Diagnostic Related Groupings (G-DRG). This was introduced in 2007/08 as a measure to contain the rising cost with FFS. G-DRG covered outpatient and in-patient services. However, in 2012, specialist and emergency care was added to the services covered by GDRG. Medicines are funded by FFS through the claims process (NHIA 2012; Aikins,

Agyepong, Awoonor-Williams & Sodzi, 2012). Generally it is expected that cost escalations under a DRG is less than under a FFS. Contrarily, challenges of cost containment reared its head (Amarteyfio & Yankah, 2012). This threatened the sustainability of NHIS. Observably, between 2007 and 2009 the average out patient claims increased by nearly 50% from 6.93million to 10.11million Ghana cedis. Furthermore, in 2010, outpatient claims accounted for 70% of total NHIS claims and 30% of total cost. Evidently it can be seen that the G-DRG did not succeed in cost containment (Agyepong et al., 2013; NHIA, 2012).

### **2.4.3 CAPITATION PROVIDER PAYMENT METHOD**

As an antidote the NHIA supported by the World Bank health insurance project started planning and designing the implementation of the capitation system in Ashanti Region. This was to improve cost containment, share financial risk between schemes, providers and subscribers and introduce some form of competition for providers and choice of patients (Loveman et al., 2011; Ensor & Cooper, 2004).

Capitation is a PPM in which providers are typically given an advance monthly payment at a pre-determined fixed rate for a defined set of services. The NHIS Act, Act 650 gave room for the implementation of multiple payment methods under the scheme. The LI 1809 specifically mentions capitation as one of the payment methods. Capitation maybe a flat fee for each provider or a risk adjusted fee, based on the relative risk of the registered hospital (Barnum et al., 1995; Kutzin, 2009).

However, capitation can place a provider at risk because payment amount will be the same irrespective of resources needed to treat client for a predetermined period. This risk creates the incentives for the provision to control use of services in order to earn profit (Manton, Tolley, Vertrees, Care, & Mar, 2014). This type of PPM has been

implemented in Denmark, Italy, Netherlands, Costa Rica, Indonesia and Thailand (Liu & Mills, 2000). Additionally it is also used in Eastern Europe and Latin America (Lagenbrunner & Masiolis, 2002).

There are two models of capitation: global capitation and partial or blended capitation. Under Global capitation, network of hospitals and physicians come together to receive single fixed monthly payments for enrolled members. Partial or blended capitation model makes a single payment for a defined set of services. Other services involved in patient care are paid for on a FFS basis (Health Care Incentives, 2012). Ghana practices the partial or blended model.

#### **2.4.4 CAPITATION PILOT IN GHANA**

Capitation payments were introduced in January 2012 in consonance with the national health insurance Act, (Act 650). This Act was amended in 2013 to Act 852. Ashanti region was chosen for the pilot program. The region has since being using capitation payment for its primary care services (Adei, Osei & Diko, 2012). Capitation was introduced with the following objectives:

1. Improve cost containment and viability of NHIS
2. Share financial risk between schemes, providers and subscribers.
3. Introduce managed competition for providers and choice for patients (compatible with portability) to increase the responsiveness of the health system.
4. Improve efficiency and effectiveness of health services through more rational resource use.
5. Correct some imbalances created by the G-DRG e.g. OPD supplier-induced demand.
6. Simplify claims processing.

7. Address difficulties in forecasting and budgeting.
8. Ensure better provider-patient relationship (NHIS, 2012).

Under the proposed capitation system, the amount paid to providers will cater for selected OPD primary care cases. The package of services classified as the Primary care bundle include; Antenatal Care, Postnatal Care, Normal delivery including episiotomy, blood sugar (rapid test if no laboratory is present), Hemoglobin test (rapid test if no laboratory is present), urine for routine examination (dipstick if no laboratory is present). It also includes OPD consultation with a trained primary care prescriber and routine maintenance care for non insulin-dependent diabetes and hypertension (ambulatory care sensitive chronic conditions) once clients have been stabilized at a specialist review and related laboratory tests will be covered by DRG with referral from the PHC providing maintenance care (Dodoo, 2013). The rates per individual per type of facility are outlined in the table below.

**Table 1. Capitation rates by provider ownership.**

PMPM- Per member per month

PMPY- Per member per year

PROVIDER OWNERSHIP	CAPITATION RATES (GHC) SERVICES		CAPITATION RATES (GHC) DRUGS		TOTAL (GHC) SERVICE AND DRUGS	
	PMPM	PMPY	PMPM	PMPY	PMPM	PMPY
<b>PRIVATE</b>	1.11	13.32	0.64	7.73	1.75	21.05
<b>GOVERNMENT</b>	0.59	7.03	0.64	7.73	1.23	14.76
<b>MISSION</b>	0.79	9.52	0.64	7.73	1.43	17.25

## **2.5 PROVIDER EXPERIENCES UNDER CAPITATION**

In Ghana, Agyei-Baffour, Oppong & Boateng (2013), carried out a cross-sectional study on the perceptions of health workers on capitation. Findings indicated 52.4% of respondents had positive impressions about NHIS package, 18.5% had negative impression. Providers further asserted capitation was likely to simplify claims processing (22.2%) and improve efficiency and effectiveness of health services through more rational use of resources. It could also foster better provider-patient relationship (38.9%). Capitation improves primary health care delivery, enhances health care and wealth (29.6%). Furthermore, 94% of interviewees believed that some clients disliked capitation due to misconception that the pilot programs had political under tones. Additionally 34% of the clients were not given providers of their choice and 90% of providers also believed attendance had increased under capitation as compared with G-DRG.

## **2.6 HOW AND WHY DIFFERENCES EXIST BETWEEN INTENDED DESIGN AND IMPLEMENTED DESIGN**

Generally, lack of organizational and personal resources, poor working conditions and high demand of services makes decisions about allocation of services as who gets what difficult. This goes a long way as to how a policy is implemented, (Elmore, 1978; Hudson, 1989). Also gaps between objectives and outcomes explain why policies are recreated through the process of implementation, (Hill, 1997).

Schoen (1991), assessed capitation in dentistry, he observed some pertinent concerns with regards to capitation plans. The study asserts there were deviations from original concepts. Providers behaved as though they had no responsibility to the general population, but to only registered patients.

Providers often assume that lack of complaints means that a plan is performing well. Simultaneously, they are pleased that they have been able to buy a low-cost alternative, since a major concern today is escalating health care cost.

Whereas, in Nigeria, Mohammed, Soares, Bermejo, Sauerborn, & Dong (2014) stated conclusively, that during the transition period of National health Insurance implementation, measurements that would have evaluated the extent to which various aspects of the schemes met their key objectives are often neglected.

Though, front line workers can heavily influence policies during implementation, the policies are just handed down to them. There is usually a failure in alignment of frontline worker incentives and that of central policy makers. Again, development of conflicting and ambiguous agency goals can induce frontline worker coping behavior that modifies policy in implementation (Agyepong et al., 2014).

Aryee (2000) also stated that many policies are initiated and implemented over the protest and vehement opposition of some individuals and labor fronts. Imperatively, policy framers should consciously align interest of gatekeepers, policy goals and objectives. Some civil society groups took the opportunity to air their grievances concerning the policy (Adjei, 2013).

A key finding of a study by Dodoo (2013) in Ghana, suggests, though stakeholders were generally aware of the capitation policy and its pilot implementation, there were lots of misinterpretations of some parts of the policy especially at the pre-implementation phase which led to opposition from some primary stakeholders like the clients and staff of the District Mutual Health Insurance Scheme. However, as these stakeholders began to get a better understanding of the policy, their position changed. Generally, the providers were of the perception that capitation payment

system is a good idea (Doodoo, 2013). Again, Gajate-garrido & Owusu (2013) observed that operational challenges such as, inadequate staff and logistics, low monitoring of providers, untimely release of funds and reimbursement, inadequate funds, and noncompliance with the gatekeeper system and politicization of the scheme. These challenges resulted in lapses in the implementation of NHIS policies. Gatekeepers (healthcare professionals, primary care physicians who are in first contact with clients) usually do not comply with policy objectives (Gajate-garrido & Owusua, 2013)

## **2.7 EFFECTS OF CAPITATION**

Robyn et al., (2014) in their study observed that after a community-based health insurance was introduced in 2004 drop out rate increased. This was attributed to perceived poor quality of care by health worker dissatisfaction. However findings indicated infrequent schedule of capitation for reimbursing service fees led to work dissatisfaction and loss of work-related motivation (Robyn et al., 2014). Another study carried out by Bazzoli, Dynan, Burns & Lindrooth (2000), inferred that, capitation holds health providers responsible for services they deliver or arrange. This provides strong motivation for physician and hospital to integrate activities and reduce cost. Hill & Zuvekas (2004), postulate capitation by itself may increase access to consumer's usual sources of care improve primary preventive care but reduce coordination between client and provider. The study asserted that global capitation motivates tighter integration between physicians and hospitals in a number of respects.

A study conducted in Netherlands to assess changes in the remuneration system for general practitioners-effects on contact type and consultation length. It was observed that contact type and consultation length were hardly affected by the change in

remuneration system, though the proportion of home visits slightly decreased for privately insured patients compared with publicly insured patients. Declaration behavior regarding telephone consultations did change; general practitioners practiced more consistently declared telephone consultations after 2006. (Brake, Dijk, Dinny, Groenewegen, Verheij & Spreeuwenberg, 2007).

Mohammed et al., (2014); Bensing et al., (2010); Saxenian (2006); Barnum & Kutzin (2001), were of the perception that physicians are more likely to spend more time with non-capitated clients than with capitated clients. The frequency of a client getting access to a physician increased if they were on a non-capitated PPM than when on a capitated method is high.

Boachie (2013) agreed with the assertion that patients under capitation had poorer health outcomes than patients under DRG/FFS. Those who sought treatment from mission health providers had better health outcomes. Attitudes of mission and private hospital health providers were better than their counterparts under the capitation method. Visits and referrals were fewer for capitated clients than for their DRG/FFS counterparts.

Iversen & Luras (2000) in Norwegian study demonstrated that when remuneration changed from FFS to capitation- based payment, physicians increased the referral of patients to private clinics for services that could have been provided by the referring physician. However, Glazier, Klein-Geltink, Kopp & Sibley (2009) were of an opposing view. Comparing characteristics of capitation with FFS practice in Canada, they demonstrated that no difference existed in patient demographics, however, capitation was associated with more limited after-hours care, higher patient visits to the emergency department, and lower patient enrolment compared to the FFS cohort. A study by Capizzi, Hibbard, Greenlick & Kunkel (2001) demonstrated that

physicians with capitation-based remuneration were more motivated to ensure their patients are less reliant on medical organizations and promote patient self-care. Their results suggested that capitation-based remuneration may result in lower care continuity and reduced quantity of care.

Capitation payment is the most common PPM in Nigeria. Studies indicated that providers supported the capitation payment method more than fee-for-service (FFS) payment method. Another important finding was that, providers who received insurance funds regularly favored the capitation payment method. That observation provided further evidence that the capitation method likely encouraged providers' underproduction of healthcare services under health insurance. Moreover, distortion of government-set prices, which are lower than the real costs, gives lower incentives for providers that may result in under-utilization of health services by clients (Mohammed et al., 2014).

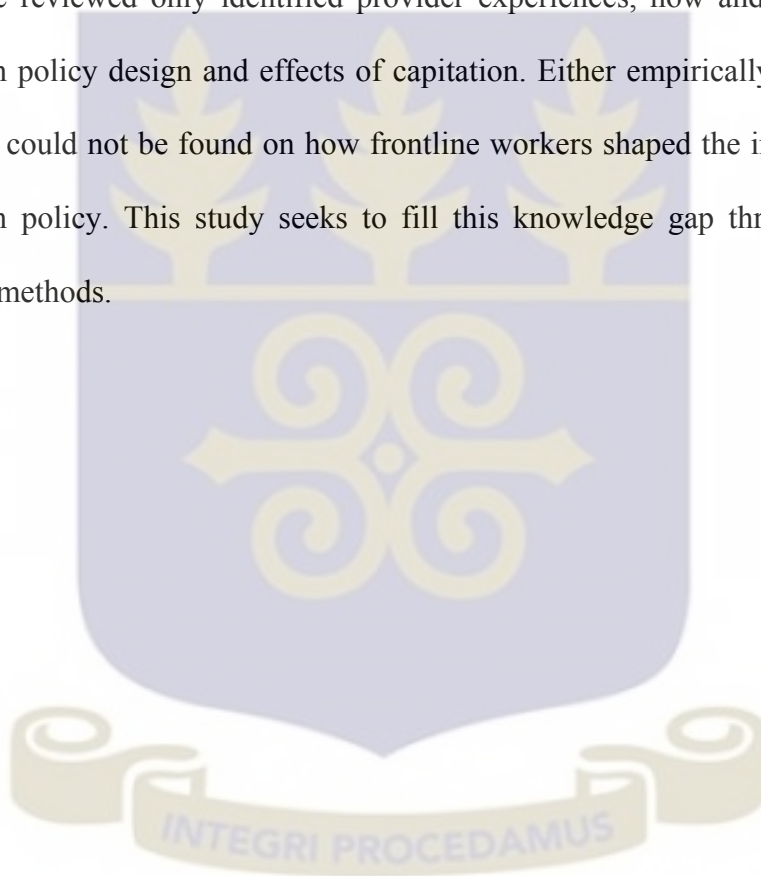
## **2.8 CONCLUSION**

Literature reviewed indicates, health care financing in Ghana has evolved over the years. The burden of increasing health care cost saw the birth of NHIS. NHIS took off with FFS, however, cost escalations led to the introduction of the G-DRG. Unfortunately this method did not salvage the problem of cost containment. This led to the introduction of capitation pilot in Ashanti Region. It is observed that in some situations, when capitation was being implemented policy objectives did not align with the objectives of implementers. As such implementation of intended policy design became a challenge.

Other frontline workers also felt they were only responsible to registered patients and not the general population. Review also revealed depending on prevailing working

conditions the workers implemented the policy to suit their environment. Consequently, though capitation in some situations fosters physician client relationship it did not contain cost. Rather cost escalations were observed. Some providers were of the view that some clients if given the choice may never enroll on the capitation payment scheme. Simply, because their “shopping” choices of hospitals have been reduced.

Literature reviewed only identified provider experiences, how and why differences existed in policy design and effects of capitation. Either empirically or theoretically, literature could not be found on how frontline workers shaped the implementation of capitation policy. This study seeks to fill this knowledge gap through appropriate research methods.



## CHAPTER THREE

### 3.0 METHODS

#### 3.1 STUDY DESIGN

The study is an exploratory cross sectional study, using qualitative data collection and analysis methods. This methodology was adopted to understand how and why frontline workers implemented the capitation pilot in Komfo Anokye Teaching Hospital.

#### 3.2 STUDY SETTING

The study was conducted at the polyclinic of Komfo Anokye Teaching Hospital (KATH) located in the Kumasi metropolis of the Ashanti region. The polyclinic is among the major NHIS accredited facilities in the Ashanti region where implementation of the capitation policy was undertaken on pilot basis.

Komfo Anokye Teaching Hospital was established in 1955 and became a teaching hospital for training medical students in collaboration with Kwame Nkrumah University of Science and Technology in 1975. It is the second largest hospital in Ghana. Its catchment population stretches beyond Ashanti region Brong Ahafo, Northern, Upper West, Upper East, some parts of Central and Western Regions. Catchment population is estimated at 10 million.

Presently, it is a 1000 bed capacity hospital having started with 500. It has eleven (11) clinical directorates and four (4) non-clinical directorates.

The polyclinic is one of the eleven clinical directorates. It consists of: family medicine and physiotherapy units. The directorate provides the following services: family medicine, physiotherapy, pharmacy accounting and administrative services.

The study was conducted at the family medicine unit, which offers general primary care, specialist family medicine, chronic care, staff clinic and medical examinations.

Human resource comprises of specialists in family medicine, medical doctors, nurses health care assistants, pharmacists, pharmacy technicians, administrative staff and accounting staff.

### **3.3 TARGET POPULATION**

The target population for the study was frontline service providers working at the polyclinic. This included nurses, doctors, pharmacists, records officer and NHIS personnel.

### **3.4 SAMPLING**

Study participants were purposively selected from the outpatient department (OPD) of the polyclinic. Thirty (30) health service providers were purposively selected on the basis of them playing a direct role in the implementation of the capitation. These are Sixteen (16) Nurses, ten (10) doctors, two (2) pharmacists, one (1) records personnel and one (1) NHIS personnel.

This approach was adopted to select frontline workers who played a direct role in the implementation of the policy. Snow balling technique was used to select study participants.

### **3.5 DATA COLLECTION**

#### **3.5.1 DATA COLLECTION TOOLS**

Field notebooks, tape recorder, Key Informant interview and FDG interview guides.

#### **3.5.2 DATA COLLECTION TECHNIQUES**

Data collection involved:

- Frontline health workers interviews using key informant (KI) in depth interviews and focus group discussions.
- Observation
- Documents review.

One research assistant was recruited for the study. He took additional notes during the FGDs to serve as a back up for recordings. Data was tape recorded and transcribed into Microsoft word for analysis.

### ***3.5.2.1 Key Informant Interviews***

Six (6) key informants were interviewed, comprising of 2 doctors, 1 nurse, 2 pharmacists and 1 records personnel. These participants were chosen because they are key informants on how capitation was implemented at the directorate. The doctors were a head clinician and the head of the polyclinic directorate. They were selected because they have in-depth knowledge on the capitation policy and were involved in the implementation process during its inception. Again they were also selected because they are prescribers. The nurse selected was the in-charge at the OPD, she is responsible for history taking of the patient and would know as per details given whether the condition is covered by capitation or not. Records officer was selected because he verifies the client registration in the hospital's database.

The pharmacists also check the pharmacy card for the stamp to ascertain client's status and the NHIS personnel ensured workers and clients were informed on policy objectives and design. All interviews were tape-recorded, transcribed verbatim into Microsoft word. Transcriptions were then coded into matrices and thematically analyzed. Findings were presented in tables and narratives.

### **3.5.2.2 Focus Group Discussions**

Two FGDs sessions were organized, each group comprising of participants from similar backgrounds and units. One group comprised of nurses working at the family medicine unit and the other group comprised of doctors in the consulting rooms. This method was used for nurses because they work at the family care unit, which administers care covered by capitation. The doctors were selected because they are prescribers, they are in the consulting rooms and they know conditions and drugs covered by capitation. Again they are direct implementers of the policy. Each group consisted of 8 to 12 people (Chaleuvong, 2009).

A discussion guide was used to moderate the discussions. Sessions lasted between 60-90 minutes. Facilitators (principal researcher and research assistants) took notes of respondent characteristics; influenced by other participants; context within which the comments were made; internal consistency - for example changes in opinion or influence by other participants; frequency and extensiveness; specificity of comments, such as personal experience or hypothetical situation; intensity of comments- like depth of feeling; relationship with other criteria. After discussions member checking was done to validate answers provided. All discussions were tape-recorded and transcribed verbatim into Microsoft word. Transcriptions were then coded in matrices and thematically analyzed. Findings were presented in tables and narratives.

### **3.5.2.3 Observations**

Observations were carried out at stations where health workers involved in the study were. The records officer was observed on how he verifies patient registration with the hospital. The pharmacists were observed on how they validate the pharmacy cards of the patients. The NHIS personnel on how they educate clients and workers on the policy. Additionally, the nurses were observed on how they give care to patients

under capitation. Finally, the doctors were observed on how they carried out their duties in the consulting rooms and family medicine unit in relation to capitation.

All observations made were noted in the field notebook.

#### ***3.5.2.4 Document review***

Review of relevant public documents (both published and unpublished) such as newspaper reports, hospital records, online articles and policy document were undertaken. Intended policy designs were also reviewed.

### **3.6 QUALITY CONTROL**

Data was collected from three main sources to allow for triangulation to improve upon data validity. Triangulation was done by checking the consistency of data findings generated through the different methods of data collection. Additionally, member checking (asking respondents to validate findings and analysis), reflexivity of principal investigator (reflected on my personal and intellectual biases that may influence the study and analysis) and clear description of data collection techniques were made to ensure quality of data. Research assistant was recruited and taken through rigorous training on how to use the data collection tools. Both the Principal Investigator and supervisor crosschecked data collected, to identify any inconsistencies. Data was captured through multiple means such as note taking by the principal investigator and research assistant, tape recording of interviews and FGD's. Transcripts were checked for accuracy in comparison to field notes taken and tape recordings by the principal investigator. All these techniques ensured data reliability and validity.

### **3.7 DATA PROCESSING AND ANALYSIS**

Data gathered from key informant interviews was recorded digitally on a recorder.

Information gathered was transcribed verbatim into Microsoft word. The interviews were ordered and given codes to ensure interviewee anonymity. Initial readings of the transcript helped to identify patterns, develop a coding framework and form themes based on study objectives. Elaborate narratives were also reduced and ordered based on study objectives.

Data was manually sorted according to relevant codes and themes using a matrix framework in Excel spread sheet. Appropriate quotes were subsequently used to highlight certain themes in the result section such as: knowledge on policy objectives, knowledge on actual implementation design and reasons for changes in implementation design. Various themes in the matrix were observed to identify existing relationships between them. Relationships between the themes were examined and this helped to give further explanations on how frontline workers shaped the implementation of the capitation pilot. Demographic data was presented in tabular form. Data gathered was analyzed manually.

Findings from the different data collection methods were compared and analyzed as part of triangulation to ensure rigor and improve validity of the results and conclusions (Pope & Mays, 2009).

### **3.8 ETHICAL CONSIDERATION/ ISSUES**

#### **Ghana Health Service Ethical Approval**

Before the commencement of data collection, ethical approval for the study was sought from the Ghana Health Service Ethical Review Committee of the Research and Development Division of Ghana Health Services.

### **3.8.1 APPROVAL FROM STUDY AREA**

Permission and approval was also sought from the research division and the head of polyclinic directorate at KATH.

### **3.8.2 POTENTIAL RISKS/BENEFITS**

Study population will have in-depth knowledge on the role they played in shaping implementation of capitation pilot and health policies. This will help them make informed decisions with regards to the performance of their duties. The research posed no potential risk to the study population or society.

### **3.8.3 PRIVACY/CONFIDENTIALITY**

Interviews were conducted in an enclosed place to ensure privacy. Data was also reported in aggregates to reduce possibility of tracing information gathered back to respondents. This was done to ensure confidentiality of information that was collected from participants.

### **3.8.4 COMPENSATION**

No compensation was given to caregivers for participating in this research. Their inputs were however recognized and appreciated.

### **3.8.5 DATA STORAGE AND USAGE**

Interview guides were coded and kept under lock and key in a cupboard. The principal investigator kept the key. Data collected were coded and entered within 24 hours of collection, and saved under a password known to only the principal investigator. Soft copy of data was stored on a CD-ROM and external hard drive. Data collected will be kept for 3-4 years to allow for publication of research. Questionnaires and other data collected will be destroyed through burning.

### **3.8.6 VOLUNTARY CONSENT**

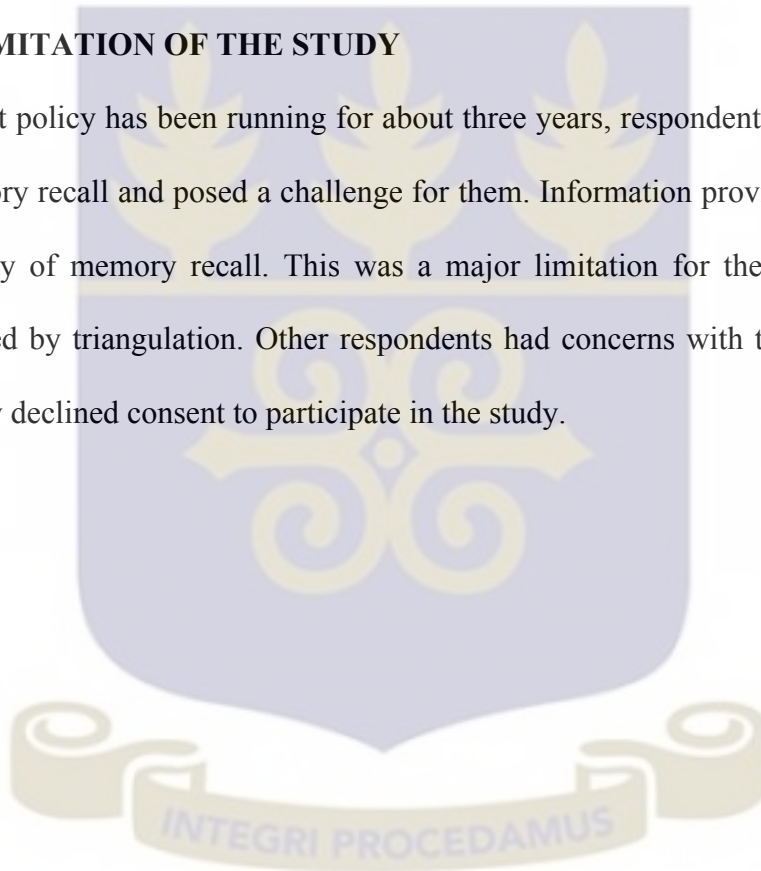
Written informed consent was sought from study participants before data was collected from them. Participation was absolutely voluntary. Respondents were made aware they were at liberty to opt out of the study anytime they wanted to.

### **3.8.7 CONFLICT OF INTEREST**

Apart from its academic and public health importance, I have no other personal interest in the study.

### **3.8.8 LIMITATION OF THE STUDY**

The pilot policy has been running for about three years, respondents therefore had to do memory recall and posed a challenge for them. Information provided depended on the ability of memory recall. This was a major limitation for the study. This was minimized by triangulation. Other respondents had concerns with tape recording, as such they declined consent to participate in the study.



## CHAPTER FOUR

### 4.0 RESULTS

#### 4.1 BACKGROUND CHARACTERISTICS OF RESPONDENTS

A total of 30 highly qualified and skilled health workers were involved in the study. Out of these respondents 54% were nurses of which some work at the triage area, consulting rooms and family medicine unit, 34% of the study participants were Doctors, these included the head of department, lead clinician and medical officers working in consulting rooms. The pharmacists constituted 7%, the records officer 3% and the NHIS personnel 3%.

#### 4.2 KNOWLEDGE ON POLICY OBJECTIVES AND DESIGN

Using study guide, it was observed respondents had limited knowledge on intended policy design and objectives. The various categories of frontline workers involved in the study had their varied perceptions on policy design and objectives. Inversely, some workers had no idea what the policy objectives were. Ninety-nine percent (99%) of respondents had some knowledge on the policy objectives whereas 1% had no knowledge on policy objectives. At the records department the perception was that, policy objective was for patients to choose their own facility and also ease pressure on patients and service providers.

*“Policy objective was for patients to choose facilities they want to when they are not well thereby easing pressure on patients and service providers” (Records officer, IDI).*

The nurses implied the objective was to regulate the number patients seen by the hospital.

*“ It helps the hospital to regulate the number of people who come to the hospital at a time” (Nurse, IDI).*

However, the Doctors were of the perception it was to reduce patient shopping between hospitals and provide health care at a cheaper rate.

*“To increase coverage at a cheaper rate, reduce patients shopping around on the same day and making people stick to one provider” (Doctors, FDG).*

The NHIS personnel asserted that it was to enable clients access facilities closer to them.

*“In fact to enable you access facility closer to you” (NHIS, IDI).*

Respondents at the pharmacy department viewed the policy as way of cutting down cost.

*“It was a way of cutting down cost” (Pharmacist, IDI).*

Whereas, the nurse at the triage unit felt it was a way of choosing a facility when one was sick.

*“All they are saying is you have to choose a clinic or hospital that you will go to when you are sick ” (Nurse, IDI).*

Another Doctor in the consulting room asserted the policy objective was to minimize the burden that came with claims processing and foster risk sharing between providers and government.

*“To reduce the burden of claims and share the risk between the service providers and government” (Doctor IDI).*

The final respondent had no knowledge on the intended policy design and objective.

*“I do not really know because I have not really read much on the capitation” (Pharmacist, IDI).*

### 4.3 IMPLEMENTATION DESIGN

Respondents asserted that, policy design on paper was to run the pilot for a period of six months to two years in Ashanti Region.

*“The policy was piloted in only Ashanti Region on March 2012” (Records personnel, IDI).*

Clients were to choose facilities, which could give them primary care,

*“People had to register and choose their primary care provider” (FDG Doctors);*

*“...health insurance cardholders were to choose facilities for primary care” (IDI Consulting room Doctor).*

Additionally, clients have three facilities to make choices from.

*“You know when they were filling their forms they were made to choose three hospitals and they will be definitely given one out of the three choices” (NHIS Personnel, IDI).*

Respondents also indicated according to intended design clients had to choose facilities in their vicinity. Clients could receive care from their primary care provider and after five visits in a month if improvements were not seen in condition client is to be transferred to a tertiary facility.

*“Your facility gives you primary care for a period of 5 times in a month but if there is any additional care needed then they will refer you to the tertiary facility” (Consulting room Doctor, IDI).*

Pregnant women and emergencies were exemptions whether the clients were registered with the facility or not. Overarching factor was client were to choose an NHIS accredited facility. Predetermined amount of 1.30 pesewas for services provided. This amount is paid by the NHIA at the beginning of the month. As per proposed design the amount was to cover consultation and some laboratory services.

*“Money per head per month was 1.30pesewas” (Doctors, FDG).*

Furthermore, as per implementation design a list containing covered disease conditions and its corresponding treatment was available as a guide. However this list of disease conditions and medicines was too restrictive and it limited the Doctors.

*“The list was not realistic it was like practicing medicine out of a booklet, you couldn’t move”(Doctor, FDG).*

Occurring scenarios due to the restrictive list where that, a condition maybe in the list but its treatment may not be there and vice versa.

*“The conditions in the list were restricted together with the list that came with it”  
(Doctors, FDG).*

#### **4.4 ACTUAL IMPLEMENTATION**

Data gathered indicated the following findings. On the ground, the policy was implemented by clients registering and choosing one preferred facility from which they were to receive primary health care. Liberty was given to clients to choose their preferred primary care giver.

*“People registered with their preferred primary care provider” (Doctor, FDG).*

When a client visits a facility, the client’s registration had to be checked before he was given health care. The names are checked online. Instances where the Internet was not available names were checked offline on a backup list. A person’s name had to be on the list before he could be attended to.

*“If you come here and you did not choose you would go back to the facility you chose” (Nurses, FDG).*

Pregnant women where exempted as well as emergencies depending on the staff that the emergency met at the point of call.

*“For pregnant women if they come we don’t even ask them about capitation” (NHIS Personnel, IDI).*

Contrarily, there were instances where some emergencies were made to pay for care given. Simply because the staff they met did not know whether the disease condition was covered by capitation or not. Other staff that were certain that the conditions were indeed emergencies intervened.

*“ It’s just that sometimes we do not understand it. For instance, when I was at the triage unit a child came with Asthma, the child was breathless, the workers insisted they should pay whereas they where not to pay. I was the one who called making enquiries to intervene that they should not pay even with that they made some payment” (Nurses, FDG).*

Clients using capitation where attended to in designated consulting rooms, they were given prescription forms with stamps which indicated they are covered by capitation.

*“What the hospital did is, you go to some consulting rooms and then they have a stamp and that any prescription that comes to us with that stamp means they have capitation” (Pharmacist, IDI).*

Without the stamp the client is expected to pay by cash. In cases where the prescribed medication was not available at the hospital’s pharmacy the clients were made to purchase the medicine from accredited pharmacies in town using a pharmacy card bearing a stamp.

*“If there are no medicines, we have what we call pharmacy card, that one is meant for insured patients who we could not get the needed service here, so the medications we couldn’t serve here we could write them, stamp it and they go to insurance accredited pharmacy for them to be served” (Pharmacist IDI).*

However, in some cases because of complaints of inadequacy of capitation fee, these pharmacies refused to serve the medications when patients presented the stamped pharmacy cards. The patients were expected to top up the amount or denied being served.

*“The patients have complained the pharmacists have said they do not have the drug unless the patients are ready to pay because the insurance money being paid is small, pharmacists in town are complaining the money is not enough.”(Nurses, FDG).*

These observations were made at the initial stages of the pilot program but currently the treatment list and laboratory services have been struck out and capitation covers only consultation.

*“They charge for some services, which are, suppose to be covered by insurance. Even though the spirit and letter of insurance says those services should be free of charge: including labs, consultation and drugs it is not so” (Consulting room Doctor, IDI).*

*“But now the treatment component is out. It covers only consultation now. But before it covered consultation and a whole list of medication” (Doctors, FDG).*

Presently, in the treatment of clients Doctors are not so conscious of whether the disease condition and its corresponding treatment are included in the list or not.

*“For now when you are a doctor in the consulting room you are not conscious of whether the condition is under capitation or not” (Doctors FDG).*

#### **4.5 HOW AND WHY DIFFERENCES EXISTED IN INTENDED DESIGN AND IMPLEMENTED DESIGN**

Differences between the actual policy design and implemented design were observed after the study. This was due to existing challenges on the ground. Each unit had its own unique challenge. The records section identified lack of constant supply of electricity and Internet access as their challenge. Client’s registration had to be

verified before care was given. This was done either by checking online or offline. Interruptions in Internet service hampered online verification.

*“If the system goes off its difficult to ascertain whether they are on your system. Once there is an outage, once the system goes off, its difficult to give off services” (Records personnel, IDI).*

The offline database is an excel spreadsheet which is updated monthly. There were occasions where client would have registered. Their names may not have been captured yet. As a result, their names may not yet be listed in the offline database and this brought so much confusion at the OPD.

*“So you may have chosen Komfo Anokye alright but if your name is not on this spread sheet you can not be seen” (Records personnel, IDI).*

Insufficient medicines in the facility’s pharmacy played a key role in how capitation was implemented.

*“The medicines are not enough” (Pharmacist, IDI).*

When medicines are unavailable, the pharmacist just issues a pharmacy card with a stamp for the patient to purchase the drug in town.

Another outstanding challenge, which shaped the implementation of capitation, was both health worker and client’s knowledge on the policy. It was realized some clients had no idea of what capitation was about. Embarrassing was the situation where clients had no knowledge of who their preferred primary care giver was and actually did not understand the whole capitation process. When asked, which facility did you choose? The answer was the facility was chosen for me so I do not know.

*“Facilities were chosen for them without their knowledge (Consulting room Doctor, IDI).*

*“The clients do not understand when they come here” (Nurses, FDG).*

This situation sometimes resulted in fights.

*“It was a nightmare at the facility” (Doctors, FDG).*

*“They always come here and fight” (Nurses, FDG).*

If upon verification it was realized their names were not in the database it meant they could not be attended to. This was really challenging for them as they might have travelled a long way for healthcare only to be turned away.

On the other hand, because some of the health workers did not know of exemptions and did not understand the capitation process, in situations where they encountered emergencies they faced challenges.

Other health workers had to intervene to save the situation.

*“Some emergencies we intervened like asthmatic attack sickle cell, (OPD Nurse, IDI), the health personnels ourselves we do not understand had it not been so we would not have sent the emergency away” (Nurses, FDG).*

Another factor, which shaped the implementation process, was the capitation rates. Concerns were that though the monies came on time the rates were inadequate as such services stipulated in the original design could not be implemented.

*“As for the capitation money it comes but it’s woefully inadequate” (Doctor, FDG).*

Finally, teamwork and good leadership also shaped the implementation of the policy.

*“In the first year it was quite difficult but we as a team decided to go all out. I remember we held several meetings to resolve whatever challenges that came up. We also drew protocols to serve as a guide to health workers” (Doctors, FDG).*

#### **4.6 EFFECTS OF CAPITATION**

Whereas the perception of one respondent was that client load had neither increased nor decreased, another felt client load had rather decreased but not substantially. This

decrease he attributed to clients being turned away upon reporting to the facility has come down.

*“No, I wouldn’t say attendance has increased or decreased its around the same range, if we were giving out 10,000 cards now we are doing around 9500 cards” (Records Personnel, IDI).*

*“Additionally, certain times patients were driven away. However, attendance it has not declined down so much” (Doctors, FDG).*

According to the Nurses capitation pilot had reduced workload.

*“It has reduced workload” (Nurses, FDG).*

Another perception was that, client load had increased but generally it has gone down.

*“Insurance itself has increased the number of attendance, but generally attendance has gone down” (Pharmacist, IDI).*

Another respondent felt capitation had resulted in disparities in health care delivery. Clients who lived near a facility with specialized primary care and had registered with that facility would receive optimum care compared to someone living near a Community based Health planning services (CHPS) facility.

*“ Idea was good but if you live near someone who specialized in primary care rate of services will be good than someone who live near a chips compound. This was the disparity” (Doctors, FDG).*

The study also agreed with literature indicating capitation reduced patient “shopping” facilities because they were registered with only one primary care giver.

*“They realized that because the patients could go anywhere they wanted, if they go to one hospital in the morning, when they are still not feeling fine they come to government hospital in the afternoon, and come for the same treatment” (Nurses, FDG).*

Another consequence of capitation identified during the interviews was that the policy determined the services the clients receive. Currently, the policy covers only consultation services. All other primary care services are rendered only when the client is ready to pay.

*“They charge for some services, which are, suppose to be covered by insurance. Even though the spirit and letter of insurance says those services should be free of charge:*

*including labs, consultation and medications it is not so” (Doctor, IDI).*



## CHAPTER FIVE

### 5.0 DISCUSSIONS

Provider payment methods can be powerful tools in achieving policy objectives and promoting development of health (Lagenbrunner & Cashin, 2009). After the study key findings were identified in relation to study objectives and conceptual framework. The frontline workers found themselves in a situation where they had to implement a policy, which they had not been informed let alone been consulted during its formulation. Mohammed *et al.*, (2014), though frontline workers can heavily influence policies during implementation, the policies are just handed down to them. Also perhaps due to misconceptions, prior to roll out of the policy, the polyclinic was not considered a primary care giver. Consequently, they were not included in the initial training programs for facilities that were to implement the pilot. Eventually when they were considered as primary care givers because of the polyclinic directorate, training programs were far advanced. So we can infer, right from the beginning information dissemination to the staff was challenging. As a facility they had to double up, as implementation date was due in no time. So with this already challenged situation, maybe staff were not adequately trained. This definitely in a way shaped how they implemented the policy. The rippling effect was that providers implemented the policy according to their understanding, which in some cases led to difficulties when they encountered emergencies. Consequently, these frontline line workers had varying levels of knowledge on the policy. So then we ask ourselves, how will the policy be effectively implemented in unison if the frontline workers themselves do not have the same level of knowledge.

With the respondents who had no idea about the policy, the question is what were they implementing.

This perhaps may explain why in some situations the respondents did not know what to do when they came across emergencies. These emergencies were at the mercy of those workers who were informed enough to know this is covered by capitation. In his literature, Lipsky (1977) posits that bureaucrats used their discretion in the performance of their duties and this finding goes to confirm this.

Again, Lipsky (1977); Elmore (1978); Hudson (1989), assert that conditions of work of street level bureaucrats helped to influence their actions and inactions in shaping public policy. Conditions of work such as chronic inadequacy of resources relative to the tasks workers are to perform plays a role in shaping policy implementation. So in order to adapt to these conditions bureaucrats adapted coping behaviours. Findings from this study confirmed this assertion.

Responses from participants indicated, capitation rates were insufficient and this to a large extent determined the sections of the policy they implemented. As per policy design, the policy was introduced to share financial risk between schemes, providers and subscribers (NHIA, 2012).

However, providers felt this objective was clearly being violated in view of the low rates. As a health institution the government expects them to implement the capitation to the letter, but how do we do this when the money given us is insufficient? This was one of the questions they were asking. They were of the opinion that if they did not come up with measures the system would not be able to sustain itself. As a coping behaviour, co-payments were introduced informally. Co-payments are implemented in forms of “top up.” For instance, clients were made to top up payment for treatment before they were served.

Another coping behaviour was in some instances referring cases back to themselves as tertiary providers. G-DRG PPM can then cover these referred cases. This is in a way aided in generating some extra money for the facility.

Another outstanding finding was insufficiency of the capitation rate, this greatly influenced health services that were given under the policy. But as an objective, the policy was to improve efficiency and effectiveness of health services through more rational use (NHIA, 2012).

To begin with, how can resources be rationally used when they are inadequate? End result therefore was services covered by capitation have therefore been reduced to just to only consultation cost. Whereas drafted policy stated all services in primary care where to be covered (NHIA, 2012).

Additionally, credence is given to the conceptual framework where Lipsky (1977), postulates clients were typically non-voluntary; and partly as a result, for most part did not serve as the primary bureaucratic reference group for frontline health workers. Also they (frontline providers) are able to effectively exercise control over their clients so that clients comply with inconvenient service arrangements because they have a superior relationship to clients. This is exactly the situation playing out in the study setting. Clients who report to KATH for primary care have no alternatives but to be on capitation. The frontline workers exercise their control on them by deciding what services they receive. Obviously, one cannot give what he does not have. Services are therefore given per what is in stock.

From the study it can be said frontline workers interpret and implement policies according to their level of knowledge and resources available.

## CHAPTER SIX

### 6.0 CONCLUSION

A policy is only as good as its implementation arrangements since these play a major role in determining whether the policy achieves its desired objectives or not. Frontline providers implemented the policy according to their level of knowledge and understanding. In view of the fact that they were, not involved in the policy formulation they did not have that sense of commitment towards the successful implementation of the policy.

Additionally how far the policy was implemented depended on the availability of resources. Challenges identified included, inadequate resources such as medicines, interrupted electricity and Internet supply, insufficient capitation rate and knowledge gaps on capitation with both the provider and clients. As a result, frontline workers developed coping behaviors such copayments and referrals to tertiary care. Findings also indicated exemptions were not applied appropriately.

Furthermore, though workers applauded the policy as being apt in containing cost. They wondered why the pilot which was to run for one year, has been running for the past three years.

Frontline workers were of the perception; political undertones were attached to the implementation of the capitation policy in Ashanti Region. They were of the opinion that as a region they were being treated unfairly the government.

Finally, currently, the frontline workers carry out their duties to the best of their abilities; not allowing the policy to restrict them.

## 6.1 RECOMMENDATIONS

Below are recommendations based on study findings:

1. The intended policy design should be reviewed. The scope of the review should be how frontline workers are implementing the policy. Policy makers should carry out review at the facility to identify challenges inhibiting the implementation of the intended policy design. Workers should be involved in the review process. This will encourage the attitude of commitment in them. In addition the review should be carried out to assess the successes and failures of the policy.
2. Periodic training programs should be organized for both frontline workers and clients to educate them on the capitation policy. Training programs should cover policy design, objectives and implementation design.



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## **APPENDICES**

### **Appendix 1:**

#### **INFORMED CONSENT FORM**

Please you are entreated to read this consent document carefully before you decide to participate in this study.

#### **GENERAL INTRODUCTION**

This is a study to assess the role of frontline workers in the implementation of capitation pilot in Komfo Anokye teaching hospital. This document is to seek your consent to be a participant in the study. As a provider you are a key player in the smooth running of capitation. Your inputs are therefore critical to this study. You are by way of this document being invited to participate in the study.

#### **RISK**

I do not envisage any risks to you in participating in this study.

#### **POSSIBLE BENEFITS**

Directly as a participant there will be no benefits. However indirectly, information gathered will inform policy framers when adapting capitation fully in future.

#### **RECORDING**

Interviews will be recorded. This will enable the researcher to clearly understand points discussed during sessions. Access to these recordings will be limited to only principal researcher and research assistants. It will be kept under lock and key for

academic purposes and destroyed three years after collection by burning. Transcriptions will be password protected on a computer. No form of identity will be required in any part of the study.

You are at liberty to withdraw from this study anytime you wish so.

#### CONFIDENTIALITY

Recordings will be kept privately. All collected related materials will be stored under lock and key.

#### COMPENSATION

Study participants who consent to be part of this study will not be given any monetary or non-monetary reward.

Taking part in this study is completely voluntary.

#### QUESTIONS

Please direct all questions to the:

Principal researcher: Sabina Ama Tannah- [sabaiden@yahoo.com](mailto:sabaiden@yahoo.com) or 0244957093.

Additionally for questions about your rights or any further clarifications, you can contact the, **Administrative Secretary, Ghana Health Service Ethical Review Committee:**

**Ms Hannah Frimpong, 0243235225 or 0507041223.**

**STATEMENT OF CONSENT**

I declare I have read all portions of this document and I have received satisfactory answers to all my questions. I consent to take part in this study.

.....

Date

Signature of participant.

.....

Date

Signature of Principal

Investigator

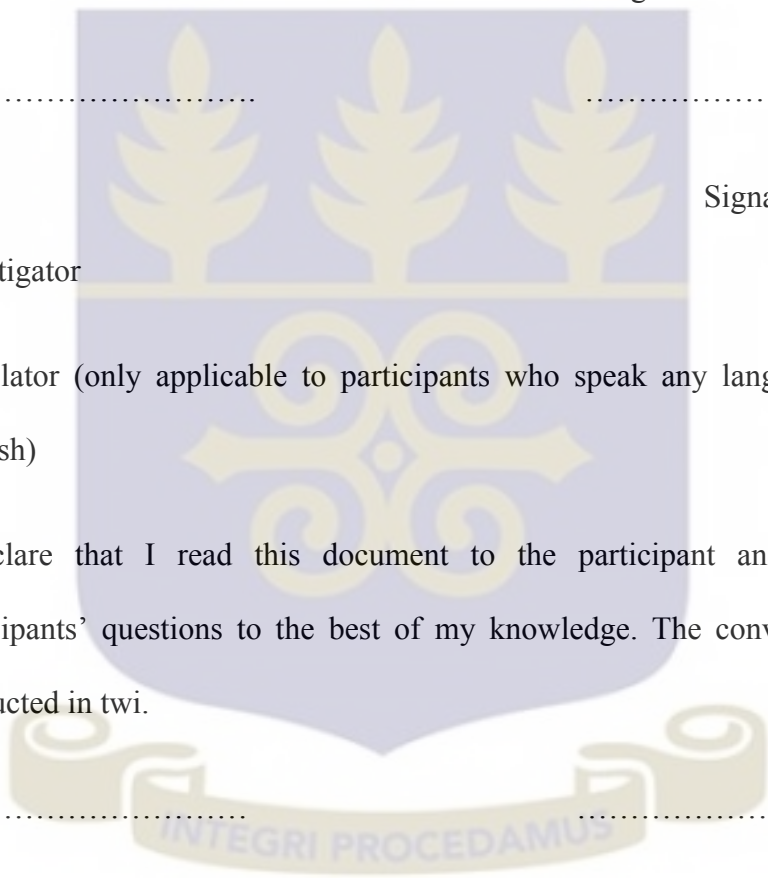
Translator (only applicable to participants who speak any language other than English)

I declare that I read this document to the participant and answered the participants' questions to the best of my knowledge. The conversation will be conducted in twi.

.....

Date

Signature of Research assistant



**Appendix 2:**

**FOCUS GROUP DISCUSSION AND INTERVIEW GUIDE**

TOPIC: ASSESSING THE ROLE OF FRONTLINE WORKERS IN SHAPING THE IMPLEMENTATION OF CAPITATION PILOT AT KOMFO ANOKYE TEACHING HOSPITAL.

OBJECTIVES OF STUDY

1. To describe what the stated policy objectives and implementation design of the capitation pilot were.
2. To describe how the capitation pilot was actually implemented by frontline providers at the KATH polyclinic
3. To explore how and why the differences evolved in implementation between the stated implementation design and the actual implementation by frontline in the KATH polyclinic
4. To explore whether the implementation approach used by frontline workers could inform the review of the current implementation design?

Participant code:

Age:

Sex:

Occupation:

Qualification:

Facility/department/unit:

Length of service in KATH

1. KNOWLEDGE OF THE POLICY OBJECTIVES: please can you tell me what you know about the policy objectives of the capitation provider payment method being implemented in your facility?
2. KNOWLEDGE ABOUT HOW POLICY IS TO BE IMPLEMENTED Please can you also tell me what you know about how you are supposed to implement this policy in your facility?
3. HOW IS THE POLICY ACTUALLY BEING IMPLEMENTED how are you actually implementing capitation?
4. PERCEPTIONS ON FEASIBILITY OF DESIGN AND IMPLEMENTATION DESIGNS: What are your perceptions (Frontline worker) about the feasibility of the design and implementation arrangements for capitation.
5. CHALLENGES WITH IMPLEMENTATION: Do you have any challenges with implementing capitation in this facility?
6. If yes, can you please describe the challenges you are facing
7. REASONS FOR CHALLENGES: Why do you think you are facing these challenges?
8. COPING BEHAVIOURS FOR CHALLENGES: As a frontline worker what are your coping behaviors to deal with these barriers
9. BARRIERS TO IMPLEMENTATION: Can you identify barriers to implementation of the policy as designed?
10. ENABLERS OF IMPLEMENTATION: Can you identify enablers of implementation of the policy as designed?
11. In terms of conditions of service
  - a. Are resources available for implementation of Capitation?

b. What is the nature of client load

12. PERFORMANCE OBJECTIVES: Have any performance objectives been set for the frontline workers as part of capitation?

13. If they have, what are these objectives?

14. CONFLICT AREAS: Are there any potential areas of conflict with the objectives of the capitation pilot?

15. ALTERNATIVE INSURANCE FOR CLIENTS: Do insured clients have an alternative if they choose not to use the services under capitation?

16. ADEQUATE INFORMATION FOR CLIENTS: Do insured clients have access to adequate information about capitation?

17. NATIONAL SCALEUP: What are your thoughts about a national scale up?

18. RECOMMENDATIONS: What do you recommend to be done presently and in future concerning challenges of capitation?

**Thank you for being part of this study.**

