

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

**A STAKEHOLDER ANALYSIS OF THE CAPITATION PILOT UNDER
GHANA'S NATIONAL HEALTH INSURANCE SCHEME IN THE ASHANTI
REGION**



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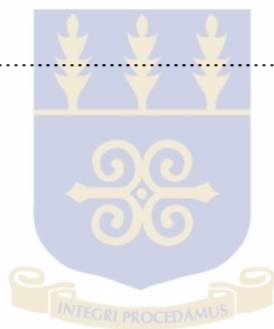
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PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF
MASTER OF PUBLIC HEALTH (MPH) DEGREE**

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DECLARATION

I, Joseph Dodoo, hereby declare that except for the other people's investigations which have been duly acknowledged, this dissertation is an original work produced by me under the supervision of Dr. Justice Nonvignon. Neither the whole nor any part of this work has been submitted or is intended to be submitted for the award of another degree in this or any other institution.

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JULY 2013

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JULY 2013

DEDICATION

This work is dedicated to my lovely wife and son Irene and Lordwin for their support and understanding.



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Furthermore, I am very grateful to my family and my love, Irene Dodoo, for enduring loneliness while I was studying and for offering me the moral and prayer support I needed for the success of this study.

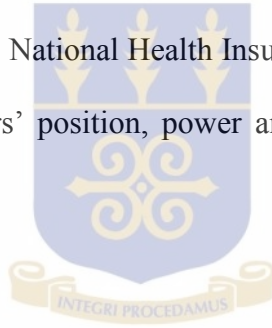
Mr Owusu Ansah and the Director of Policy Planning Monitoring and Evaluation of the Ministry of Health, have all contributed immensely to this study during the data collection.

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ABSTRACT

Ghana established the National Health Insurance Scheme (NHIS) through the enactment of Act 650 in 2003 which was to secure the provision of basic healthcare services to persons resident in the country. Since the implementation of NHIS in 2004, the Fee-For-Service (FFS) has been used for the payment of drugs and some other services until 2008 when the Ghana Diagnostic-Related Groups (G-DRGs) was introduced to pay providers on the basis of claims made by them to the District Mutual Health Insurance Scheme (DMHIS).

In January 2012, the NHIA initiated the pilot implementation of the capitation policy in the Ashanti Region. The aim of the study was to undertake a stakeholder analysis of the capitation pilot under Ghana's National Health Insurance Scheme pilot in Ashanti Region to investigate the stakeholders' position, power and interest during the piloting of the policy.



This is a single case study design using qualitative data collection and analysis methods. Data were collected using an interview guide for regional level actors and a Focus Group Discussion guide for clients. The study area was Kumasi Metropolitan Assembly, Ejisu Juabeng Municipal Assembly and Atwima Nwabiagya District Assembly all in the Ashanti Region. Twenty (20) stakeholders were purposively selected and interviewed. Two Focus Group Discussions were held. Data analysis was done manually using thematic analysis. Stakeholder tools like tables, matrices and force field analysis were used to present findings.

One of the key findings of this study was that 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.

The general position of stakeholders (both primary and secondary) is that capitation payment system is a good idea. However, a critical attention must be given to the contentious aspects of the policy in order to facilitate effective scaling-up implementation. Measures such as reviewing the capitation rate and implementing an alternative provider payment method for smaller facilities such as Health centres, CHPS compounds and maternity homes should be considered.

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LIST OF ABBREVIATIONS

DDHS:	District Director of Health Services
DHMT:	District Health Management Team
DMHIS:	District Mutual Health Insurance Scheme
DRG:	Diagnostics Related Groupings
ERC:	Ethical Review Committee
FFS:	Fee-For-Service
FGD:	Focus Group Discussion
GHS:	Ghana Health Service
LI:	Legislative Instrument
MOH:	Ministry of Health
NHIA:	National Health Insurance Authority
NHIL:	National Health Insurance Levy
NHIS:	National Health Insurance Scheme
NPP:	New Patriotic Party
ODA:	Oversees Development Agency
PPP:	Preferred Primary-Care Provider
PSCH:	Parliamentary Select Committee for Health
SA:	Stakeholder Analysis
WHO:	World Health Organization

DEFINITION OF TERMS

- Small Facilities:** Smaller facilities for this study are defined as health centres, CHPS compound, clinics and private maternity homes in private, CHAG and public health sectors.
- Bigger Facilities:** Bigger facilities for this study are defined as district hospitals, Regional hospitals and polyclinics in private, CHAG and public health sectors.
- Provider Shopping:** This means the act of clients moving from one facility to the other with the same episode.
- Facility Managers:** Facility Managers are the head/s of facilities who may or may not be a medic.
- Facility:** The term facility for this study is limited to hospitals (health centres, clinics, CHPS compounds, maternity homes and polyclinics in private, public and CHAG sectors.

CHAPTER ONE

1. 0 INTRODUCTION

1.1 Background

Ghana established the National Health Insurance Scheme (NHIS) through the enactment of Act 650 in 2003 which was to secure the provision of basic healthcare services to persons resident in the country through mutual and private health insurance schemes; to put in place a body to register, license, and regulate health insurance schemes and to accredit and monitor healthcare providers operating under health insurance schemes...” (National Health Insurance Act, 2003). The scheme which was implemented in 2004 is currently operational in 145 districts and five satellite offices across the country and has a total active membership of 8.2 million representing 33% of the population (Annual Report NHIA 2011). In order to ensure efficiency, improve quality and effectiveness in any health insurance system, the mechanisms for paying provider for services rendered must be highly prioritized. Payment for health care services rendered by a health care facility in Ghana under Legislative Instrument (LI) 1809 is to be made either by capitation, fee-for-service and any other payment system that the Council may determine. Since the implementation of NHIS in 2004, the Fee-For-Service (FFS) has been used for the payment of drugs and some other services until 2008 when the Ghana Diagnostic-Related Groups (G-DRGs) was introduced to pay providers on the basis of claims made by them to the District Mutual Health Insurance Scheme (DMHIS) (McIntyre *et al.*, 2008). The use of per capita payments for primary care under the National Health Insurance Scheme is being proposed to address some of the observed shortcomings of the

current provider payment system. The G-DRG payment system for instance has been cited for not being able to successfully contain cost especially for outpatient services with outpatient claims now accounting for 70% of total NHIS claims and 30% of total cost (HIP, 2000). As part of a process of improving provider payment systems under Ghana's National Health Insurance Scheme (NHIS), there has been a design and pilot implementation of a per capita (capitation) provider payment system in the Ashanti Region. Capitation is a payment mechanism in a written agreement by which a fixed rate of payment for a fixed period per person is negotiated with an accredited health care facility to deliver health care services to a person, family, household or a group of persons covered under the terms of the agreement for health insurance services (LI., 1809). It was among the implementation alternatives suggested to make the scheme sustainable. This, to a large extent, is due to its ability to check the abuse in the existing payment systems by service providers. There are perceived inefficiencies in the NHIS and the health delivery system which must be addressed in order to protect the scheme from becoming solvent (Schieber, G., Cashin, C., Saleh, K., & Lavado, R. 2012).

In January 2012, the NHIA initiated the pilot implementation of the capitation policy in the Ashanti Region. The pilot was aimed at testing the overall effectiveness of a capitation payment system in achieving stated objectives which include identifying key features of implementation that are essential for success and to make recommendations for scale-up of the capitation system after the pilot period has elapsed. According to the Health Insurance Project, HIP (2010), the per capita payment system has six main technical components which are the package of services paid through the per capita rate,

the base per capita, adjustment coefficients, enrolment/registration, financial management and reporting system and quality monitoring system. Under the capitation proposals being developed, each National Health Insurance subscriber is required to indicate their preferred primary-care provider (PPP). The introduction of the capitation payment system will have ramifications for the various stakeholders in the health system of the Ashanti Region.

1.2 Statement of the problem

In view of recent challenges facing the NHIS especially in the area of soaring outpatient claims, the NHIA planned and piloted a capitation payment system (per capita payment system) for Primary Health Care (PHC) services in the Ashanti Region in 2012 (HIP 2010).

Anecdotal evidence and media reports suggests that the pilot programme was confronted with fierce resistance from some key actors like the Medical Professionals, Ashanti Region Caucus in Parliament and the Asante Development Union (ADU). Such resistance may arise mainly due to the limited attention paid to communicating these changes to actors (Gilson *et al.*, 2003) among other factors. In addition to this, a recent stakeholder consultative meeting held in Kumasi to evaluate the pilot implementation of the policy and to build consensus on the way forward also revealed that there are still lingering issues amongst major stakeholders which may affect attempts to scale-up implementation nationwide.

All these notwithstanding, the NHIA is considering scaling-up implementation of the capitation policy across the country this year. There is, therefore, a need to investigate

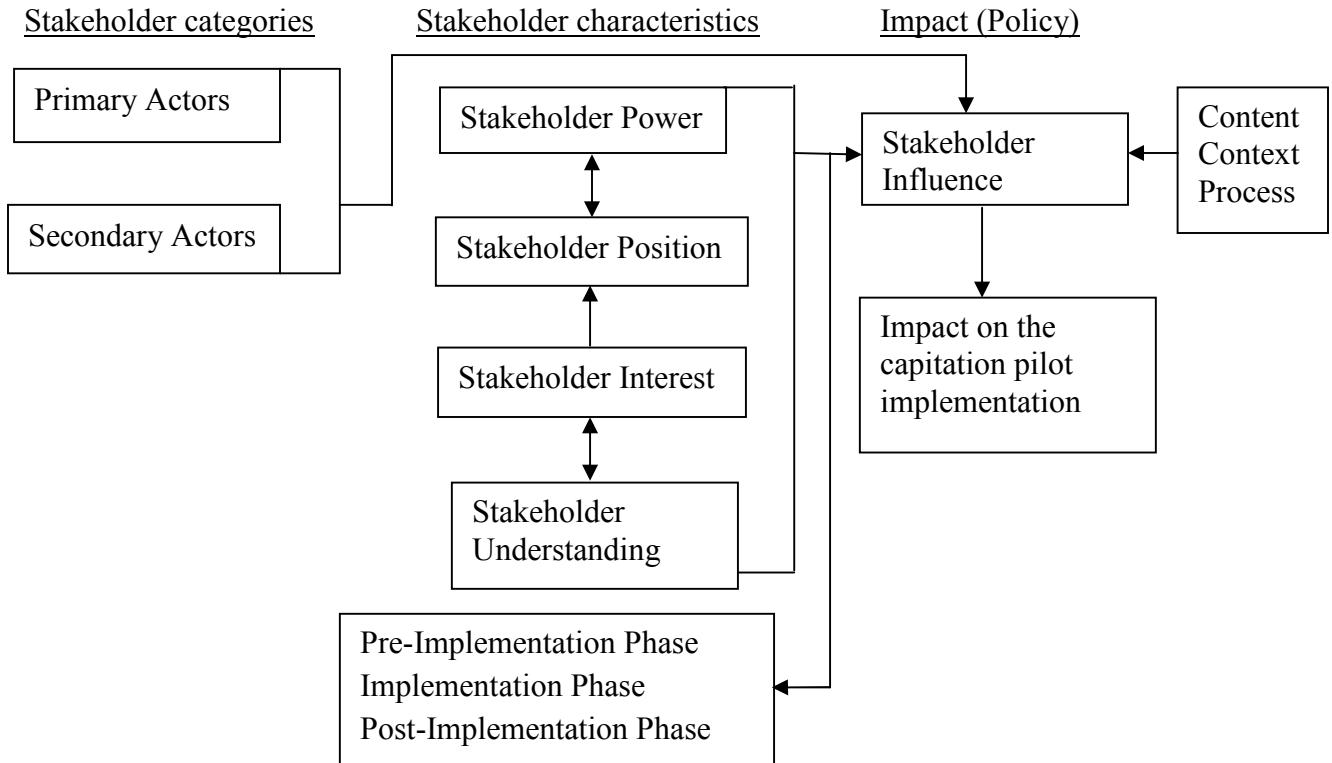
the position, interest and power of various stakeholders during the pilot implementation of this policy to contribute to assessing the feasibility of the nation-wide scale up. This is because stakeholder's decision to either support or oppose a policy depends on their appreciation of the tenets of the policy. This study was therefore designed to investigate the stakeholders' position, power and interest during the piloting of capitation in the Ashanti Region.

1.3 Conceptual framework

Stakeholder analysis is primarily used to analyze and plan around a complex issue and in some cases as part of a conflict management tool and negotiation procedures (Ramirez, 1999). The conceptual reasoning for this study is that the success of a policy implementation depends partly on the characteristics of stakeholders. Stakeholder characteristics range from their understanding of the policy to their influence on policy implementation. Stakeholder understanding of the issue will be determined by their level of interest while their interest in the policy can also influence their understanding of the policy. Their interest will determine their positions on the policy and based on their level of power, they will end up exerting influence on policy implementation (see Figure 1). The nature of influence (positive or negative) that stakeholders are likely to have on policy implementation will affect its feasibility. In relation to stakeholder categories, this study postulates that categorizing policy actors into primary and secondary actors depend on the importance of their influence on the policy process (ODA, 1995, Grimble and Wellard, 1996).

Finally, the study is premised on the conceptual thinking that stakeholder characteristics are dynamic. According to ODA (1995), stakeholders wear multiple “hats”; they are likely to change at every stage of the policy development process due to certain factors. The study seeks to identify stakeholder characteristics at three various phases of implementation (i.e. pre-implementation phase, implementation phase and the post implementation phase) in order to identify and understand the factors responsible for any observed differences at each of these stages in the implementation cycle. In doing this the study mainly focused on the analysis of the stakeholder characteristics and their potential influence on scaling-up implementation of the policy. This study was a stakeholder analysis with the emphasis on actor mobilization around the policy issue. Although the study examined actor dynamics in relation to the pilot implementation of the policy, it drew on issues about the policy content, the context and process of the policy as illustrated in the conceptual framework below.

Figure 1: Conceptual framework for the study



1.4 Justification

Government is planning a nation-wide scale up of the capitation policy in 2013. In order to ensure a successful scale-up, in-depth information on stakeholder's characteristics at the pre-implementation, implementation and post implementation phases influenced implementation in order to inform policy-makers. This information is required to manage the expectations of these groups, individuals and organizations that may be affected by the policy in order to ensure successful nationwide implementation of the policy. Daniel Maceira (1998) identified health care facilities (e.g., hospitals), health professionals (e.g., physicians and nurses), patients, and insurers/payers as actors who are affected by provider payment reforms. Each actor has its own set of goals that may or may not coincide with those of others.

Undertaking a stakeholder analysis at this stage of the policy process is therefore relevant as it will provide useful information to policy decision-makers on the various actor dynamics exhibited during the pilot implementation and how these dynamics influenced the pilot implementation of the policy in order to assist them device a formidable strategy on how to engage stakeholders in the nation-wide implementation. Stakeholder analysis can be used as a tool to enhance negotiations by making relationships more transparent (Ramirez, 1999). In planning for the scale-up implementation, there will be negotiations on various aspects of the policy and each stakeholder must be well informed about the existing communication channels amongst the various actors.

1.5 OBJECTIVES

1.5.1 General Objective

The general objective of the study was to undertake a stakeholder analysis of the pilot implementation of capitation policy in the Ashanti Region.

1.5.2 Specific Objectives

The specific objectives of the study were:

1. To identify the primary and secondary stakeholders involved in the pilot implementation of the policy.
2. To assess each stakeholders' understanding and awareness of the capitation policy and why and how it affect implementation
3. To describe the interest, positions and the power of each stakeholder at the pre-implementation, implementation and post-implementation phases and why they changed and how they influenced the process
4. To identify the prospects and challenges for the scale-up implementation of the capitation policy.

CHAPTER TWO

2.0 Literature Review

The literature review is aimed at providing a conceptual and empirical foundation for the study. It presents a review of theoretical literature on healthcare financing in Ghana, provider payment mechanisms, capitation, stakeholder analysis and characteristics, which are the approach used for this study and empirical literature on stakeholder analysis.

2.1 Health care financing in Ghana

Health care financing involves mobilizing and allocating funds to regions and population groups for specific types of health care (Esen 2011). Health care financing is one of the six building blocks of the World Health Organization's (WHO) health systems strengthening framework (WHO, 2010). From the pre-colonial era, successive governments have made strategic decisions concerning the future direction of health care financing as a strategy to remove financial barriers to healthcare. Prior to the advent of the National Health Insurance Scheme, Hospital fees were used as a means of financing health. Hospital fees were introduced following the enactment of the first Hospital and Dispensary Fee ordinance in 1898 (Nyonator and Kutzin 1999). Under the Convention People's Party (CPP) Government, healthcare was virtually free. With the overthrow of Ghana's first President, Healthcare financing in Ghana saw a complete 'U-Turn'. Under the National Liberation Council (NLC), Ghanaians were asked to pay for their healthcare through the Hospital Fees Decree, 1969 (NLCD 360). This later became what we now know as 'Cash and Carry system'. This system of healthcare financing survived until 2004 when the present health insurance system came into being. There is evidence that as

part of its healthcare financing reform in the 1970s, the Progress Party (PP) considered health insurance as a financing option. In the period leading to the introduction of National Health Insurance the implementation of user fees had become uneven with total disregard for equity mechanisms and provisions in the legislation (Coleman, 1997). Ghana initiated a process of replacing out-of-pocket payments at point of use to national health insurance in 2001 (Arhinful 2001; Agyepong & Adjei, 2008).

2.2 Ghana's National Health Insurance Scheme

Ghana's national health insurance was born out of an electioneering campaign promise made by the New Patriotic Party (NPP) in 2000 (Agyepong & Adjei, 2008). Prior to this, there had been similar attempts by previous governments to introduce health insurance as an alternative healthcare financing approach. There is evidence that as part of its health care financing reform in the 1970s, Dr. Kofi Busia's government established a committee to develop the National Health Insurance Scheme (Govt. of Ghana 2003b, Parliamentary Debates Report, August 19, 2003). Several years down the line in January 1986, E. G. Tanoh, the Secretary for Health also announced that a health insurance scheme was to be introduced "to ease the burden of payment of hospital fees by the average Ghanaian." (Daily Graphic, Jan. 16, 1986). Beyond the rhetoric, the National Health Insurance Scheme (NHIS) was finally established with a statutory enactment, the National Health Insurance (NHI) Act, Act 650 in 2003. The NHI Act, established three types of health insurance schemes in the country consisting of the District Mutual Health Insurance Schemes (DMHIS), Private Mutual Health Insurance Schemes (PMHIS), and Private Commercial Health Insurance Schemes (PMHIS) (NHIA, 2010).

Funding for healthcare under the NHIS as established by Act 650, comes from a Fund created by the Act, with income from two main sources, also created by the act (LI 1809). These are the National Health Insurance Levy (NHIL), a 2.5percentage top up of the Value Added Tax (VAT), and a 2.5percentage transfer from the existing Social Security and National Insurance Trust (LI 1809).

2.3 Provider payment mechanisms in health financing

There are various provider payments mechanisms (PPM) used in financing health service worldwide. A recent study revealed that developing countries have adopted the use of provider payment mechanisms such as fee-for service, salaries, capitation, co-financing and coverage ceiling as means of financing health services (Robyn *et al* 2012). Other studies have also shown that financial incentives for physicians to provide health services should be improved by using appropriate payment systems (Davis *et al* 1990; McGinnis *et al* 2002). In their work, Liu and Langenbrunner (2005) revealed that payment to healthcare providers under the resource allocation and purchasing (RAP) arrangements can be approached in three ways which are; direct payment to providers by the patient, direct payment to providers by the patient, but with later full or partial reimbursement and direct payment to the provider by the RAP mechanism, with only limited copayment or informal charge paid by the patient.

In Ghana, PPMs suggested in the NHI law includes capitation, fee-for-service and others as determined by the NHIA (LI 1809). There are a number of suggestions in the literature concerning the appropriate payment mechanism for providers for services rendered. Ghana started its NHIS with paying for all services by fee-for-service. Under this

payment method, after the provider had offered the service to the insurance client, they would send a bill listing everything that had been done for the client and how much was being charged for it and request payment reimbursement. All over the world fee-for-service is known to have a tendency to cause a rapid rise in costs and is therefore a significant threat to the sustainability of any health insurance scheme if it is applied alone as the payment method without any controls or balances by mixing other methods (Daniel Maceira, 1998). There was rapid cost inflation in the Ghana NHIS. The lack of standardization of the fees charged was also a source of confusion and controversy. In 2008, the NHIA introduced the Ghana Diagnostic Related Groupings (G-DRG) for services and standard itemized fees for medicines for NHIS clients. Thus the medicines remained under the fee for service system, but their prices were an agreed uniform standard across the country. Diagnostic Related groupings (DRG) means that payment rates to providers are fixed for a given group of diagnoses. The G-DRG payment method is used at all levels from the primary care right up to the tertiary (teaching) hospitals.

2.4 Capitation

The NHIS Act, Act 650 provided for the institution of multiple payment methods including capitation. The LI 1809 specifically mentions capitation as one of the provider payment methods to be considered for use under the NHIS. This is international best practice given there is no perfect provider payment method (Daniel Maceira, 1998). The proposed reform in Ghana does not do away with any of the already existing provider payment methods. Rather it introduces capitation for a specific level of care – the primary level of walk in outpatient care, which is the fundamental base of the health care system,

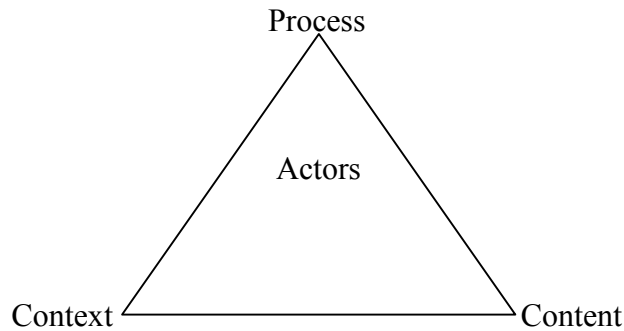
and reserves the DRG for services and Itemized Fee for medicines system to the higher levels of care.

Global budgets for instance have been used as a means of paying for public health services in many countries. Global budget is a one line-item budget for facilities, for some fixed period of time (typically a year) for a specified population or service use. A study conducted by Liu and Mills (2002) revealed that in China, the governments at different levels provide global budgets to disease control centres.

Under Ghana's National Health Insurance Regulations, 2004 (LI 1809), payment to providers can be made through a number of systems including capitation. Capitation is a prospective means of paying health care staff based on the number of people they provide for through a capitation fee (usually a negotiated payment made for an agreed period by an insurance scheme to a health care provider per person covered by the scheme Esena (2011). This type of payment system transfers the economic risk from third party payers to health care providers.

2.5 Pilot Implementation of Capitation in Ghana

The NHIA planned and piloted a capitation payment system (per capita payment system) for Primary Health Care (PHC) services in the Ashanti Region in 2012. Although the study examined actor dynamics in relation to the pilot implementation of the policy, it drew on issues about the policy content, the context and process of the capitation policy. This was illustrated in Walt and Gilson's policy triangle (see figure 2).

Figure 2 Walt and Gilson's Policy Triangle

2.5.1 Context: Context according to Walt and Gilson “refers to systemic factors-political, economic and social both national and international- which may have an effect on health policy”. The Ashanti Region is the most populous region in Ghana with all the various ethnic groups. It has all the characteristics of urban, suburban, rural and is the most central of Ghana. Nearly seventy per cent (69.0 per cent) of the households in the region have access (geographic) to a health facility. Access to health services is better in urban areas (81.6 per cent) than in rural (55.6 per cent) areas. Rural poor households record the lowest access rate of 48.4 per cent.

There are five hundred and thirty (530) health facilities in the region. The Ghana Health Service operates about 32% of all health facilities in the region. Most of the healthcare facilities in the Ashanti Region provide mainly OPD services. Health Facilities by Ownership are as follows; Government: 170 Mission: 71 Private: 281 Quasi Government: 08. There were massive administrative and staff time costs from claims preparation, submission, vetting and reimbursement under the current G-DRG and fee for services for medicines payment for first line OPD care. There were problems of delayed payment of claims – for the monies were paid in advance to providers. The NHIS had difficulties to

forecast and budget due to inconsistencies in claims that were reported by providers. Anecdotal and research evidence have reported fraud and inconsistencies in reported claims. All these problems resulted in cost escalation and the sustainability of the NHIA became an issue of concern.

The Region has thirty (30) administrative districts which are made up of one (1) Metropolitan Assembly, seven (7) Municipal Assemblies and twenty-two (22) District Assemblies. Apart from the fact that the pilot year was an election year, the Ashanti Region has been described as the strong hold of the New Patriotic Party. In the just ended 2012 elections, the NPP won 70.86% of the presidential elections as well as winning 43 parliamentary seats as against the National Democratic Congresses 28.35% and 4 representing presidential and parliamentary wins respectively (www.peacefmonline.com)

2.5.2 Content: The objectives of the per capita payment system include; improvement in cost containment, sharing financial risk between schemes, providers and subscribers as well as introducing managed competition for providers and choice for patients. Other objectives were to improve efficiency and effectiveness of health service through more rational resource use, correct some imbalances created by the G-DRG, simplify claims processing and address difficulties in forecasting and budgeting. The main components of the capitation policy were centred around the following; Package of Primary care services, Capitation Rate, Enrolment of Client to PPP, General and financial management and reporting system and quality monitoring systems.

Package of Primary Care Services: 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 PHC bundle include; Antenatal Care, Postnatal Care, Normal delivery including episiotomy, blood sugar (rapid test if no laboratory is present), Hb (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 giving maintenance care.

Enrolment of Client to PPP: Under the Ghana capitation model, clients are required to voluntarily choose their PPP. Clients are expected to be enrolled to accredited primary provider facilities within their district of residence on the basis of managed open enrolment that promotes healthy competition. Specialist clinics cannot be selected as PPP under the policy. New members of the scheme will have the opportunity of selecting their PPP at the time of enrolment. Clients have the option to change their PPP a maximum of two times a year. Each primary provider shall be allowed a predetermined maximum membership.

Referral: Under the per capita payment system, services beyond the primary care package will only be paid for if the client was referred by the primary care provider by filling a standard National Health Insurance referral form. Bills from accredited non-primary care providers will only be reimbursed if accompanied by the standard referral form as evidence that the client first passed through the PPP.

Table 1: Capitation Rates by Provider Ownership

Provider Ownership	Capitation Rates: Service GH ¢		Capitation Rate: Drugs GH ¢		Total: Services & Drugs GH ¢	
	PMPM	PMPY	PMPM	PMPY	PMPM	PMPY
Private	1.11	13.32	0.64	7.73	1.75	21.05
Government	0.59	7.03	0.64	7.73	1.23	14.76
CHAG	0.79	9.52	0.64	7.73	1.43	17.25

Source: (HIP, 2000)

2.5.3 Process: Process within Walt and Gilson's triangle considers amongst other things how policies are implemented. For the purposes of understanding the various actor dynamics this study has categorised the processes leading to the pilot implementation into three main phases namely: the pre-implementation phase, the implementation phase and the post implementation phase.

The pre-implementation phase: This was the period beginning July 2010 to December 2011. A National Capitation Technical Committee (TSC) was set up and chaired by Dr Irene Agyepong with representation from all major of health care providers; Ghana Health Service, Christian Health Association of Ghana (CHAG), Ghana Arm Forces Health Services, Private Medical Health Providers, the Pharmaceutical Association of Ghana, National Health Insurance Authority (NHIA) and health financing experts . In addition, some external consultant was contracted to provide support to the TSC (HIP 2010). A similar team as existed in the National level was replicated at both the Regional and District levels. Activities at this stage include; making final design decisions, conducting stakeholder consultations, developing methodology for calculating base rate,

upgrade public facilities, develop common management arrangements for NHIA, District Schemes and providers amongst others.

The implementation phase: This was the period beginning January 3rd 2012 to January 3rd 2013. From the literature, the pilot implementation of capitation was scheduled for a year. The main highlights of this phase were that PPP's begun providing services to subscribers under capitation as well as monitoring and analysis of pilot results (HIP 2010).

The post implementation period: This was the period between Jan 4th 2013 to July 15, 2013. The main activity under this period is an evaluation and a potential nationwide implementation of capitation policy.

2.6 Stakeholder analysis and dynamics

Stakeholders are actors in the policy arena (Varvasovszky & Brugha, 2000). These actors can be individuals, groups, organizations and institutions. Stakeholder analysis (SA) has been adopted as a means of examining the interests, positions, power, alliances and influence of various stakeholders on the policy process as well as assessing the importance of such influences on the realization of the policy's goals (Schmeer, 2000; Varvasovszky & Brugha, 2000). Different stakeholders view policies from their individual, organizational, group or institutional perspectives hence the need for undertaking a stakeholder analysis. It has also been used to "gain an understanding of a system by means of identifying the key actors or stakeholders in the system, and assessing their respective economic interests in that system" (Grimble & Chan, 1995). As a tool for conducting policy analysis, stakeholder analysis was adapted from the

organizational and management literature in the 1970s and 1980s (Brugha & Varvasovszky, 2000). One important aspect of stakeholder analysis as a tool is that it can be used at any point of the policy development process (Reich 1995). Stakeholder Analysis can either be done retrospectively to examine the roles played by actors in the development of a policy and prospectively to provide assistance for a policy change (Brugha & Varvasovszky 2000). Prospective stakeholder analysis has been described as being future oriented (Hyder *et al.* 2010). According to Reich (1996), health system reform has both technical and political dimensions. This affirms Carol S. Wissert and William G. Wissert (1996) assertion that health policy is politics at its fullest and richest. Many policies are initiated and implemented over the protest and vehement opposition of some individuals and group (Aryee, 2000). This makes it imperative for policy decision makers to manage the interest of actors in order to arrive at desired policy goals and objectives.

A study by Agyepong and Adjei (2008) and Rajkotia (2007) revealed differences in stakeholders' dynamics during the introduction of the National Health Insurance policy in Ghana. In that study, the Ministry of Health (MOH), the NPP and politically connected consultants were identified as very strong proponents of the policy process while the position of the private sector was between neutral and proponents and that of civil service and donors were between neutral and opponents. Strong opponents of the reform were the main opposition party (NDC), labour unions and community based mutual health insurance schemes (Rajkotia 2007). The opposition to the policy was mainly centred on either the policy process or aspects of the content (Agyepong & Adjei 2008).

As regards stakeholders' influence over the policy process, it has been documented that the MOH (political), the then incumbent political party (NPP) and the politically connected consultants had high influence over the process. The influence of labour unions was between medium and high, but that of the opposition political party, donors, MOH (civil servants) and the private sector was just medium, while the existing Community-Based Health Insurance Scheme (CBHIS) had low to medium influence (Rajkotia 2007).

2.7 Stakeholder characteristics

According to Ramirez (1999), stakeholder analysis seeks to differentiate stakeholders on the basis of their attributes. Stakeholder characteristics refers to stakeholders' understanding of or knowledge of a policy issue, their interest, positions, powers, actual or potential influence, the multiple "hats" they wear and the networks and coalitions to which they belong on the formulation and implementation of the policy (Gilson *et al.* 2003; Brugha & Varvasovszky 2000; Schmeer 2000; Freeman & Gilbert 1987; Freeman 1984). In most cases, the stakeholder's interest and positions on a policy issue is driven by how the stakeholder understands the policy. In some cases, stakeholders' level of understanding also influences their interest. The interest of a stakeholder relates to the perception of the stakeholder about the likely impact of a policy on it, which could either be positive or negative (Thomas & Gilson 2004). The various levels of interest that different stakeholders have in a particular policy can be placed on an ordinal scale of low, medium and high interest (Varvasovszky & Brugha 2000). The interest of a stakeholder can be clearly visible or hidden (ODA, 1995).

Another important stakeholder characteristic is the stakeholder's position on a policy issue. Driven by the interest they have in a policy, stakeholders will tend to either support, oppose or remain neutral or non-mobilised on a policy issue. The level of support or opposition of a stakeholder for a policy therefore defines its position on the policy (Thomas & Gilson, 2004). Stakeholder's position in a particular policy decision can either be described as strong opposition or strong support (Schmeer, 2000).

A stakeholder's power is usually expressed in the stakeholder's ability to either enhance or impede the policy development process (Thomas & Gilson, 2004). Most stakeholders use power as a tool to protect their interest (Erasmus & Gilson, 2008). Stakeholders' power can be categorised into: power as decision making; power as non-decision making and power as thought control (Lukes, 2005). A number of studies have given credence to stakeholder's understanding as a key ingredient in ensuring policy success.

In a prospective stakeholder analysis of the proposed one time premium payment policy in Ghana, different stakeholder characteristics were identified. The study revealed that although stakeholders were highly aware of the proposed policy, there was lots of confusion in their understanding of it (Abihiro & McIntyre, 2012).

In India, a stakeholder approach towards accreditation also revealed that there was a consensus amongst key stakeholders including (professional associations, government officials and consumer organizations) on the need for accreditation and indicated a willingness to participate while others did not. Despite their initial lack of interest, one financial company commented that a hospital rating system would make it easier for the company to determine whether or not to provide loans.

2.8 Conclusion

The literature review has revealed that the legislation marked a transformative change in healthcare financing adding social health insurance to existing healthcare financing mechanisms - including general tax revenue, employer-financed schemes and donor funding - and more significantly eliminating user fees, a major barrier to access to healthcare services. To contain cost and to remove the economic incentive of overprovision as experienced under the FFS, the NHIA has introduced the capitation payment system. Review of the literature also reveals that various developing countries and developed countries use either one or a combination of payment methods based on their country specific objectives and problems.

In order to determine the success or failure of the proposed capitation and the imminent nation-wide implementation, a retrospective stakeholder analysis is important to explore the interest, positions, power and influences of various stakeholders on the pilot implementation. However, such retrospective stakeholder analyses of health care financing reforms in Ghana are seldom done. This study will, therefore, contribute empirical information in filling this gap in knowledge of retrospective analysis of policy experiences in Ghana.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This is a single case study design using qualitative data collection and analysis methods to retrospectively investigate the perceptions and characteristics of various key stakeholders involved in the pilot implementation of the capitation policy in the Ashanti Region. The qualitative approach was adopted because it offers a better opportunity to investigate the opinions, concerns, expectations, possible and identifiable contradictory behaviours and power relations and influences of various stakeholders.

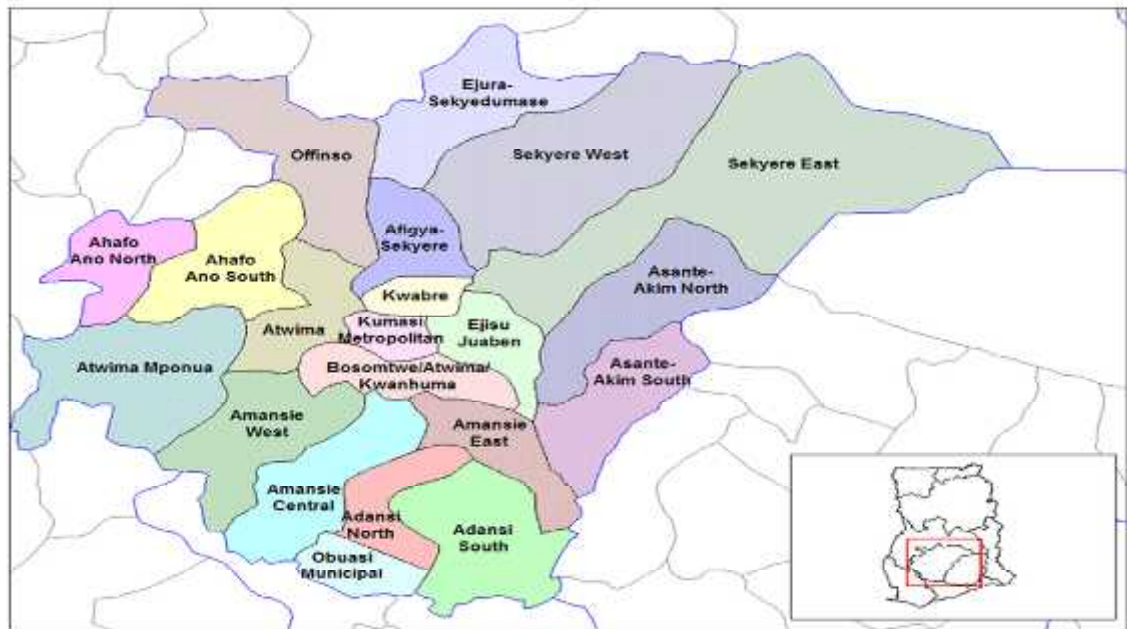
3.2 Study area

The research was conducted in the Ashanti Region. The focus of the study was to a large extent in the Ashanti Region due to its strategic position as the pilot region.

The Ashanti Region is centrally located in the middle belt of Ghana. It lies between longitudes 0.15W and 2.25W, and latitudes 5.50N and 7.46N. It occupies a total land area of 24,389 square kilometres and has a population density of 148.1 persons per square kilometre. Nearly seventy per cent (69.0 per cent) of the households in the region have access (geographic) to a health facility (GHS website). Access to health services is better in urban areas (81.6 per cent) than in rural (55.6 per cent) areas. Rural poor households record the lowest access rate of 48.4 per cent.

The Region has thirty (30) administrative districts which are made up of one (1) Metropolitan Assembly, seven (7) Municipal Assemblies and twenty-two (22) District Assemblies.

Figure 3 Political Map of the Ashanti Region (Adopted from Ghanadistricts.com)



3.3 Study Population

The target population was stakeholders who had an interest in the pilot implementation of the policy in the Ashanti Region. The study to a large extent looked at all actors within and outside the health sector of the Region.

3.4 Sampling

With the focus of the study being the Ashanti Region, study participants were sampled from the Region. Actors were selected purposively from the Region. Actors sampled included; Providers which includes Facility Managers (Public facility managers, Private facility managers and Christian Health Association of Ghana (CHAG) facility managers) and Facility level workers (Doctors, Pharmacist and Nurses), Staff of District Mutual Health Insurance Scheme (DMHIS) and clients/beneficiaries. The criterion for the

selection of these actors stems from the fact that they will be affected directly or indirectly by the implementation of the policy. Also selected were NHIA (National/Regional), Parliamentary Select Committee on health and the Media. These actors were selected because they had formal bureaucratic or political authority to make health policy decisions in the region and Ghana as a whole. In all twenty (20) stakeholders were recruited and interviewed.

3.4.1 Recruitment of Study Participants

Selecting regional level actors: In order to obtain an unlimited amount of views on stakeholders, samples of identified stakeholders were purposively selected at the regional level for inclusion based on specific characteristics. The criterion for the purposive sampling was all groups, individuals and organizations that were influenced by the implementation of the policy.

This approach of sampling is standard in qualitative research; it allows theories to be generated and developed from the data (Green & Thorogood 2004). A snowballing technique was adopted as a means of identifying other stakeholders who may have been left out.

Selection of districts in the Region: To provide a proper representation of the Region, Kumasi was selected together with one Municipal and District Assembly. Kumasi Metropolis was selected because it is the only Metropolitan Assembly. Ejisu Juabeng Municipal Assembly and Atwima Nwabiagya District Assemblies were randomly selected. A list of all the districts were typed in excel application and an index of that list

was created. The function `randbetween` was used to create a randomized list out of which the above districts were selected by a simple click through the list.

3.4.2 Data Collection techniques/methods & tools

Data was collected using three data collection techniques, which are: review of relevant public documents (both published and unpublished) such as newspaper reports, online articles and policy documents, in-depth interviews with stakeholders; and finally two FGDs were organized for two separate groups of beneficiaries. These data collection techniques were used in order to be able to appropriately capture a wide range of information from stakeholders and as a way of methodological triangulation to improve upon the study's credibility (Mack *et al.* 2005, Silverman 2006).

The size of each FGD was between 8-12 participants. Beneficiaries/clients upon entering the premise of the District Mutual Health Insurance Scheme office were contacted and recruited as participants for the FGD when they accept. Participants of the two FGD were a mix sex group made up of national service persons, civil servants, market women and security personnel. Issues discussed covered the research questions ranging from each stakeholder's understanding and awareness of the policy to assessing their interest, power and position during the pilot implementation of the capitation policy as well as identifying prospects and challenges for nation-wide implementation. FGDs lasted between 60-95 minutes whiles interviews lasted approximately 60 minutes. FGD's were tape recorded and later transcribed for analysis. Five research assistants were recruited for the study. They took notes during the FGDs to serve as a quality control measure and interviewed some stakeholders. All sampled stakeholders for the semi-structured

interviews were initially contacted through a telephone call to inform them about the study and to schedule a suitable time and day for the interviews. Personal visits were made to respondents in situations where telephone contact proved futile. Data collection tools used in this study was interview guides and focus group discussion guides.

3.4.3 Quality control

Data was collected from three main sources to allow for triangulation to improve upon data validity. To ensure quality of data collection tools, all tools were pre-tested. Research assistants were recruited and taken through rigorous training on how to use the data collection tools. Data collected were cross-checked by both the Principal Investigator and supervisor to identify any inconsistencies in the data. Data was captured through multiple means such as note-taking by different investigators and tape recording interviews and FGD's ensured data reliability and validity. Instruments that have already been formulated by Abihiro and McIntyre (2011) and used for stakeholder analysis were consulted in the design of the interviews and FGD guides for this study. To ensure validity in the data collected, stakeholder's perception on other stakeholder's characteristics during the pilot implementation of the policy were sought.

3.4.4 Data Processing and Analysis

All interviews and FGDs were tape recorded, transcribed and analyzed using thematic content analysis of stakeholder characteristics ranging from stakeholders awareness of the policy, their position, interest and power exhibited during the pilot implementation of the policy in the Ashanti Region. Thematic content analysis looks at the content of text around a particular main theme of interest. Appropriate quotes were selected from the

FGDs and interviews to support the thematic content analysis. Codes were developed for themes that were identified from the data. The results from the study were presented in verbal quotations, tables and diagrams. Specific stakeholder tools such as force-field analysis, stakeholder matrix and position maps were used for the analysis and presentation of stakeholder characteristics. With the force field analysis, potential forces (positive, negative or neutral) that could affect the implementation of the capitation policy were identified. An examination of these forces and their potential impact on the implementation of the policy were further carried out. Those forces that were in support of the change were listed in the left column, those in opposition were also listed in the right column and those that were neutral were listed in the centre. These were later presented visually in a diagram (force field diagram). An assessment of whether these forces would act either in support or opposition of the policy was then ascertained. Microsoft excel was used to develop the spreadsheets for the analysis of stakeholder characteristics. Data analysis was undertaken manually.

3.4.5 Ethical consideration

Ethical approval: Ethical approval was sought from the Ghana Health Service (GHS) Ethical Review Committee (ERC).

Approval from study area: Approval was sought from the Ashanti Regional Health Directorate in writing to the Regional Health Director of Health Services.

Potential risk/benefit of the study: There were minimal risks of participating in this study. The study does not anticipate any major cost for participants except the participant's time that was spent in the interviews and FGD's. In order to protect participants against

victimization by other stakeholders as a result of their opinions (negative), all information gathered from the interviews and FGDs were treated confidentially.

There were no direct material benefits from participating in this study except that the results of the study were made available to interested participants.

Informed Consent: Written informed consent forms for interviews and FGDs were given to participants to sign or thumb print. Two versions of the consent forms were used: one for interviews and the other for FGDs (see appendix for details). All consent forms for interviews will be in English. Participation in this study will be entirely voluntary and participants have the option not to participate or to discontinue their participation without any adverse consequence. Participants were given sufficient information about the study to enable them decide whether to take part or not.

Conflict of interest: The PI has no conflict of interest in the study.

Privacy/confidentiality: Information obtained was secured and access was limited to the PI and Supervisor. Findings have been presented in a way that individuals, groups and organizations will not be identified by names with their opinions unless these views have been made public. Participants are will be assured of high degree of confidentiality and anonymity. Interviews will be tape recorded when participants give permission.

Data storage/security and usage: Hard copy and electronic data was stored in locked file cabinets, and access was limited to the PI and the Supervisors of the study.

Compensation/payment: There was no compensation for participants in this study.

Proposal & funding information: This study was sponsored by the Ministry of Health (MOH) through a Rockefeller support and the PI.

3.4.6 Study Limitation

A major limitation of stakeholder analysis is the difficulty in establishing with certainty and surety the validity and reliability of stakeholder responses. For instance, stakeholder may express support for a policy while covertly opposing and obstructing it. Though they may become more evident as the process of data collection and analysis develops. This limitation was minimized by means of triangulation (Brugha & Varvasovszky 2000).

Again, because of the inherent dynamic nature of the policy making process, as the position of one major player changes, others' positions are also likely to change which may affect the reliability of the study beyond the period of this research. Actors may receive new information on the policy and this to a large extent can affect their interest, position and understanding.

CHAPTER FOUR

4.0 RESULTS

4.1 Stakeholders, sources of power, interest and influence

In identifying stakeholders, Moore (1995) postulates that for any policy issue, stakeholders can be identified by first and foremost examining who has formal bureaucratic and political authority to make relevant decisions and also who has interests in the outcome of a decision.

The categorization of stakeholders, their interest in the policy, sources of power and the way in which they exercise power (influence) has been summarised in the table below.

Table 2: Stakeholders power, their exercise of power (influence) and their interest

Stakeholder	Power	Influence	Interest
Primary Stakeholders			
PROVIDERS: Facility Managers			
Public Facility Managers -Big Facilities -Small Facilities	Provide healthcare services within their specific catchment areas	Facilitated the modification of the per capita rate	Generate IGF to provide quality healthcare service to patients.
Private Facility Managers -Big Facilities -Small Facilities	They are very strong on the ground. Leading service provider in the region with the highest number of facilities providing healthcare service to their respective communities	Facilitated the modification of the capitation rate which they felt was low and campaigned for the removal of maternal care services from the capitation basket	To maximize profit to effectively run their facilities. Concerned about the low capitation rates. Listing of drugs under capitation
CHAG Facility Managers -Big Facilities -Small Facilities	Their presence in very remote parts of the region	Facilitated the modification of the capitation rate which they felt was low and campaigned	Ensuring the sustainability of their facilities
Clients	Votes	Decision to vote either for or against any political party.	Access affordable and quality healthcare services at their preferred facility

NHIA National/Regional	Constitutional power to initiate and implement policy reform and control over resources	Facilitated the implementation through the provision of resources and technical expertise	To ensure cost containment
Staff of DMHIS: Scheme Managers	Control over policy implementation at the local level and have the ability to influence public opinion	Facilitated the process by educating subscribers on the policy issue and embarked on strike to protect their interest	Ensure that their jobs are secure
Claim Managers	Knowledge of local area and have direct contact with clients Technical expertise and knowledge of local area		Reduced workload
Secondary Stakeholders			
Media	Ability to influence public opinion Ability to rapidly convey messages to large numbers of people	Provided a platform for mass public education on the policy ensure	Protect the public interest
Facility level workers: Public Doctors	Ability to organize members, ability to influence public opinion through direct contact with clients. Have very rare skills and very limited in number		To ensure that the policy does not disrupt healthcare service delivery

Nurses	Their skills are rare and are limited in supply.	Facilitated the removal of medicines from the capitation basket	Patients receive quality healthcare
Pharmacist	Their skills are rare and are limited in supply. Organized under an umbrella body.		Inclusion of medicines in the capitation basket. Ensure enforcement of separation of services by prescriber and dispenser
Parliamentary Select Committee on health (PSCH) Minority & Majority	Constitutional and political legitimacy to approve policies and resources for policy implementation	Facilitated pilot implementation of the policy in the Ashanti Region	To ensure the sustainability of the NHIS Maintain as many parliamentary seats as possible in the region

The results as illustrated in table 2 show that seven (7) key interest groups were identified in the piloting of capitation payment system in the Ashanti Region. These are the NHIA, Providers, Staff of District Mutual Health Insurance Schemes (DMHIS), Parliamentary Select Committee on Health, the Media, Frontline Workers and Beneficiaries/Clients. The results further show that within these key stakeholder groups identified were other sub interest groups.

For instance, the study revealed that within the providers were the Facility (hospital) Managers sub group who were head/s of facilities and frontline workers sub group. Other key distinctive features of these providers were their status as Public, Private and CHAG Facilities and their size whether big or small. Even though the staffs of the DMHIS are employees of the NHIA they were identified as key stakeholders for this study. Within the Parliamentary Select Committee on Health were the majority and minority caucus. The NHIA, Staff of DHMIS, Providers, and Clients are those ultimately affected, either positively or negatively (for example, those involuntarily affected) by the implementation of the policy and thus constitute primary stakeholders. The Media, Frontline Workers and Parliamentary Select Committee on health were identified as the intermediaries in the delivery process who constitute secondary stakeholders

The study revealed that stakeholders' influence, power and interest varied among both primary and secondary stakeholders. Private facility managers (big or small) were identified as wielding high power because they own the highest number of facilities in the Ashanti Region. Out of 548 facilities in the Ashanti Region, the private sector owns 315 facilities representing 57.5% of total facilities. The remaining 42.5% are distributed

between CHAG, Government, Quasi Government and Islamic facilities (GHS Facts and Figures 2010). Their interest was that, as profit making organizations, they need to maximize profit in order to manage their facilities effectively. For them, the capitation rate was too low and needed to be reviewed upward. Although this was a general sentiment shared by facility managers across board, the private facility managers were more vociferous. This was due to the fact that their survival largely depends on how much they make as profits. Some private providers expressed the following views;

“...Private facilities are collapsing...” (Private Provider Manager, IDI)

“...Our facilities are suffering...” (Private Facility Manager, IDI)

Public facility managers’ influence was not visible because of their critical position as government-owned facilities.

“Where the government wants to implement a policy and a government worker tries to oppose, that person is seen as a threat and they can take you out” (Public Facility Manager, IDI)

“Government institution cannot say no so they started” (Medical Doctor, IDI)

Private facility managers on the other hand were able to influence the process more overtly through their association. They were able to achieve their objective of getting the capitation rate reviewed but still contend it is low.

“NHIA was bent on starting, they forced to start...Private facilities did not start” (Facility level worker. IDI)

“The private practitioners’ position was that they will not do it” (Facility level worker)

The main interest of clients was identified as the ability to assess quality healthcare at their preferred facility and not to be restricted. These were some of the sentiments expressed by some of the beneficiaries.

“When they started the health insurance without capitation, you could go to any hospital with the health insurance, but since they introduced the capitation, if you go to a hospital that you did not choose, they will not attend to you” (Trader, FDG)

“When you are sick and you go to the private hospital because you are near them, the doctors will reject you on the basis that you did not register with them but will attend to you if you have money” (National Service Person, FGD)

Since the implementing year coincided with the 2012 general election of the country, it was expected that beneficiaries would have voted massively against the ruling government especially when the region is a known stronghold for the major opposition party in the country. However, an analysis of the voting pattern in the region revealed that there was a slight reduction in votes for the New Patriotic Party for the 2012 general elections. In 2008, the New Patriotic Party pulled 72.53% of the total votes in the region while the National Democratic Congress Party pulled 26.01%, but in 2012, the New Patriotic Party pulled 70.86% of the total votes in the region while the National Democratic Congress Party pulled 28.35% (<http://www.ec.gov.gh/>).

4.2 Stakeholders characteristics- awareness and understanding of the per capita payment system

The results showed that, there is a high level of stakeholder awareness on the capitation policy and its pilot implementation in the Ashanti Region at the time of data collection. The level of awareness was similar among primary stakeholders and secondary stakeholders. Radio jingles, workshops campaigns, public statements by politicians and key staff of the NHIA, and radio discussions were reported as the main sources of information on the per capita payment system. Awareness did not vary from Metropolitan, Municipal or District assembly. It was, however, not clear whether awareness was high during both the pre-implementation and implementation phases. This is the summary of response from all stakeholders on their awareness of the piloting of the policy;

“Yes I am aware” (All stakeholders, IDI)

Table 3: Level of understanding across phases

Stakeholder	Understanding		
	Pre-Implementation	Implementation	Post-implementation
Primary Stakeholders			
Clients	Low	Low	Medium
NHIA	High	High	High
Staff of DMHIS(Scheme and claims managers)	Low	Medium	High
Facility Managers (Public, Private and CHAG facilities both big and small facilities)	Low	Medium	High
Secondary Stakeholders			
Media	Low	Medium	High
Facility level workers (Doctors, Nurses and	Low	Medium	High

Pharmacist)			
Parliamentary Select Committee on health	High	High	High

Regarding understanding, the study revealed that stakeholders' understanding of the policy varied across the various phases (see Table 2). Understanding in the post implementation era was between medium and high as compared to the pre-implementation and implementation eras where understanding of some stakeholders was low. However, understanding at the pre-implementation phase was between low and high among different stakeholders. For instance the NHIA and the Parliamentary Select Committee had a high understanding of the policy. This was because of their role as policy initiators. The facility managers, clients, the media and staff of DMHIS had low understanding of the policy.

However, at the time of data collection, stakeholders demonstrated a high level of understanding of the per capita payment system. This was ascertained from stakeholders (both primary and secondary) response to questions on their understanding at various phases of the pilot implementation. These were some of their responses;

“Formally I did not understand but I came to understand” (Client, IDI)

“People were not sensitized initially what capitation really meant it was later that they were saying it wasn't this so initially they didn't really know what capitation was. People where not well educated and even we were not educated well” (Medical Doctor, IDI)

“I think initially it was very confusing for most patients” (Medical Director, IDI)

“The media initially also didn’t understand so everybody sat on radio and spoke his mind or her mind about the capitation” (Regional Manager, NHIA, IDI)

“Now you see people have come embrace the whole concept of capitation and they are actually cooperating both the providers and the clients...” (Scheme Manager, IDI)

In addition to this, the result revealed that some stakeholders’ interpretations of the policy were different at the pre-implementation phase and this had a direct effect on their position, interest and influence on the capitation policy and its implementation. A range of understanding about the policy was revealed from the explanations stakeholders gave on what they anticipated it to achieve.

Provider Shopping: One of the main objectives of the introduction of capitation is to reduce the soaring cost of claims paid by the NHIA as a result of provider shopping. In order to ensure the sustainability of the NHIS, the authority initiated the capitation system as a means of reducing cost by sharing risk with facility managers and Clients. In demonstrating their understanding of the per capita payment system, the issue of cost containment was highlighted by stakeholders.

“The capitation is a good policy that capitates the people for you as a facility so that he may come to your facility alone and not facility B or facility C and

therefore the benefits of the capitation is that, it stops shopping, jumping from one facility to the other” (Public Facility Manager, IDI)

Improvement in quality of service: Under the Ghana capitation model, clients are being asked to voluntarily choose their PPP. This was aimed at ensuring continuity of care to clients that will result in improved quality of care to the patient. Stakeholders’ understanding of the capitation policy was to a large extent around this issue.

“I understand that their clients are doing very well because a client choosing the facility means that they will have accumulated history of the client and then with that they will be able to assess the client better, it means with that they will be able to adopt preventive measures” (Claims Manager, IDI)

Advanced Payment: The capitation payment policy aims at advancing funds to service providers at a pre-determined fixed rate over a determined period for agreed package of services. The study however revealed that, there are delays in payments to providers for services rendered. This was what a provider said;

“Right now my facility since December has not received the capitation as well as March capitation and am now chasing it” (Public Facility Manager, IDI)

“The money delays and handicaps health institutions and results in facilities running out consumer drugs hence retarding the services” (Private Facility Manager, IDI)

“The payment must be early... “(CHAG Facility Manager, IDI)

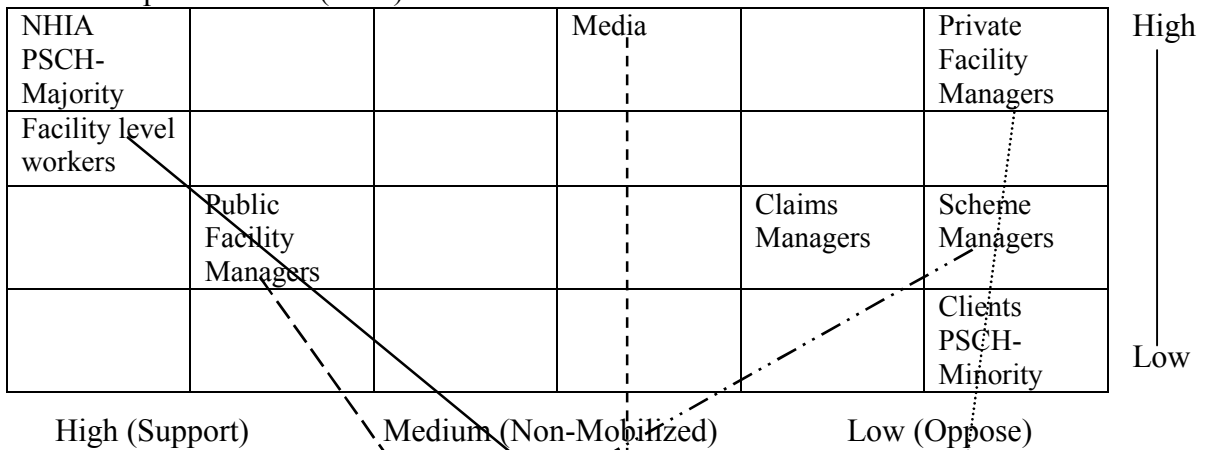
4.3 Stakeholders position and its evolution during the pilot of capitation

Stakeholders’ level of power and position during the pilot implementation of the capitation policy varied in relation to the particular phase of implementation and most importantly their understanding of the policy (see figure 4).

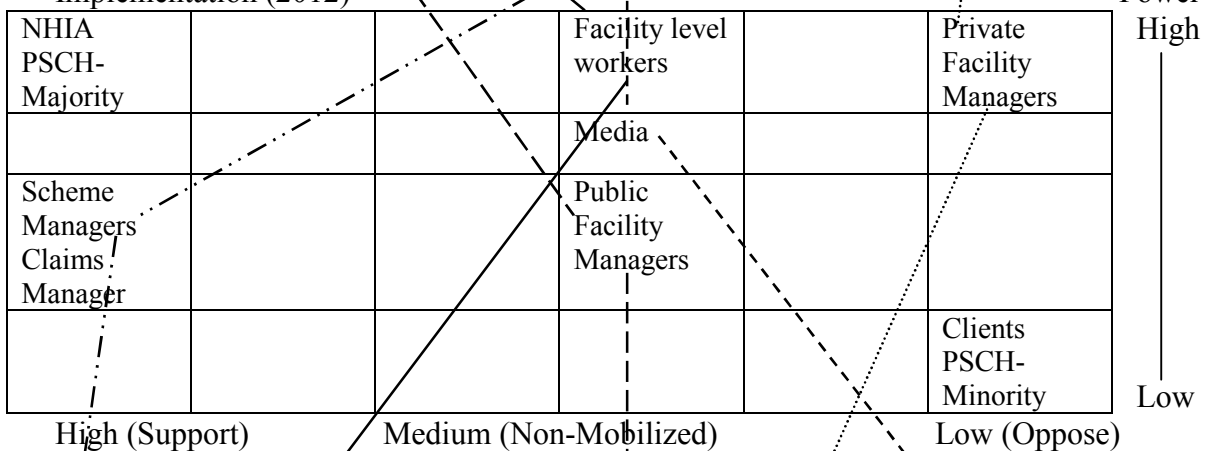
Figure 4: A force field analysis: The position and power of stakeholders across phases

Phases:

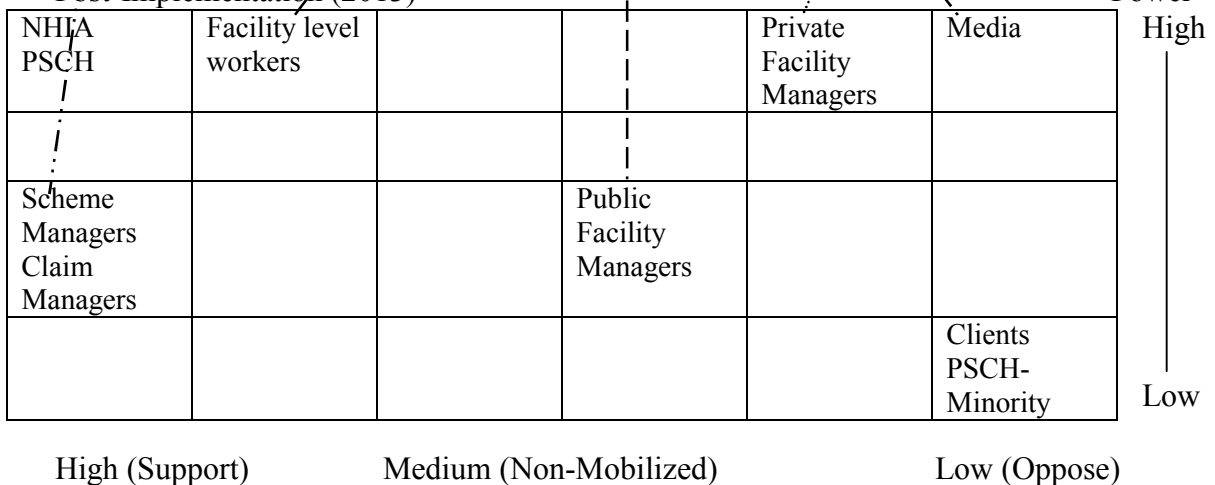
Pre-Implementation (2011)



Implementation (2012)



Post-Implementation (2013)



From the force-field analysis, the NHIA who is a primary stakeholder, is the main proponent of the capitation policy and possesses high power. There was no change in support throughout the various phases. They have constitutional legitimacy to initiate any reform aimed at ensuring the sustainability of the health insurance system. They have technical knowledge to design and enforce its implementation and resources to make design and implementation possible.

“The policy makers stand to achieve the objectives of the capitation which seems positive to them” (Media, IDI)

The other proponent of the capitation policy was the Parliamentary Select Committee on health (majority caucus) who also has political and constitutional legitimacy to approve policies and resources to make design and implementation possible. However, the study revealed that eight out of the twenty members on the committee who belong to the largest opposition party in parliament were opponents. Since parliamentary proceedings require majority, the members from the ruling party succeeded. Their support cuts across the various phases. Due to the fact that these stakeholders are not directly involved in service delivery, they will therefore have to directly involve facility managers who own (in the case of private facilities) and manage these facilities. Generally, facility managers were opponents of the policy issue at the pre-implementation phase. If the NHIA chooses not to consider their interest and decides to maintain the per capita rate as it stands, facility managers especially the private facility managers will continue to oppose the policy or may look for a way of surviving. The private facility managers possess high power. In relation to the survival and success of the policy since the private facility managers

constitute the largest number of facilities in the region. These were some of the reasons for their opposition;

“The provider opposed because there would be no demand for medicine and if demands cease it affects productivity” (Scheme Manager, IDI)

“...and also the amount paid for the policy is too small so they have to increase it for us all so that we the stakeholder can also provide good service to users” (CHAG Facility Manager, IDI)

Facility level workers may be a key source of education on the capitation policy to beneficiaries and may also encourage their patients to register with the scheme.

At the pre-implementation phase, staff of DMHIS (Scheme Managers and Claims Managers), felt that implementing the policy would affect their work which resulted in their opposition of it. Although they were not able to openly oppose it because they are civil servants, they secretly undermined its implementation. Their power is high because they could facilitate implementation by giving client education on the policy, preventing fraud and ensuring that clients and providers are fully satisfied with the services received from them. However, at the implementation and post-implementation phases, their positions changed due to a better understanding of the policy as shown in the force field analysis. The Media appeared to be divided on the policy issue. They possess high power on the basis that they can shape public opinion on the policy issue. Although they have the power to influence public opinion by feeding the public with either the wrong or right information, they are not mobilized and often not directly involved in the policy process.

Their interest was to protect what was in the public interest. At the pre-implementation stage, they were opposed to capitation as a result of public outcry. Their position changed with series of engagements they had with the NHIA officials.

Beneficiaries/clients' interest was to access quality healthcare service at their preferred healthcare facility. The reason for their opposition had to do with the misunderstanding around the issue of enrolment on to PPP's. It was found that clients were made to choose three PPP's at the initial stages of implementation. In the process, clients were asked to chose a first, second and third choice not because they could use all 3, but so that if for any reason they could not be tied to their first choice PPP, it would be clear which new PPP to tie them to. This was however reduced to two without proper communication to clients.

Facility level workers who have the power of discretion and have direct contact with clients generally supported the policy idea especially when it sought to ensure continuity of care. Their position at the implementation phase however was that of opposition because of aspects of the policy they felt could undermine quality health care delivery.

4.5 Stakeholder opinions on prospects and challenges for nation-wide scale-up

Table 3 summarises the opinions of stakeholders on the prospects and challenges for the nationwide implementation of the policy and the recommendations stakeholders made for consideration.

Table 4: The prospects and challenges for nationwide implementation of policy

<i>Issue</i>	<i>Prospects</i>	<i>Challenges</i>	<i>Recommendation</i>
<i>The policy idea</i>	<i>Generally, stakeholders perceive the policy as a good idea</i>	<p><i>The determination of the per capita rate</i></p> <p><i>The enrolment of Clients on PPP</i></p> <p><i>The delay in reimbursement</i></p>	<p><i>Engage stakeholders to build consensus on available options. Provide a fixed amount to smaller facilities in order to cushion them</i></p> <p><i>Proper education of stakeholders especially clients on enrolment must be undertaken</i></p> <p><i>The NHIA must ensure that funds are transferred to providers on time</i></p>

CHAPTER FIVE

5.0 DISCUSSION

There were important findings in relation to the study objectives and conceptual framework that provides information on the awareness, understanding, interest and positions of stakeholders to serve as a tool for engaging stakeholders to ensure a successful nationwide implementation of the capitation policy.

One of the key findings of this study is that certain stakeholders' characteristics changed across every stage of the implementation process (i.e. pre-implementation phase, implementation phase and post implementation phase) due to a number of factors. According to ODA (1995), stakeholders wear multiple "hats" and are likely to change at every stage of the policy development process due to certain factors. The study revealed that during the pre-implementation and implementation phases, stakeholders' understanding of the policy was between low and medium which affected their interest and position on the policy. This perhaps may be attributed to the fact that the policy issue was not very clear to some stakeholders at these stages. Although at the later part of the implementation phase and post-implementation phase, stakeholders' understanding of the policy had significantly improved, there were aspects of the policy which were contentions thereby serving as arenas of conflict. One of the arenas of conflict within the policy was the per capita rate. There was a strong disagreement between the NHIA and facility managers on the capitation rate and how the amount was arrived at. What this means is that, stakeholders will tend to protect their interest from being affected as a result of the introduction of a new policy and will therefore take positions to ensure this. The study also identified lack of stakeholder involvement in the decision making process

as one of the major causes of stakeholders' lack of understanding of the policy issue. This finding supports Rosenberg-Yunger, et al (2012) position regarding stakeholder involvement. According to them, stakeholder involvement in health policy should embrace diverse group of representatives including professional organizations, health authorities, academic groups, patient organizations, manufacturers, and other public representatives in actual decision-making and/or in the process of decision-making to ensure all groups are in agreement.

The way stakeholders understood the policy at each phase of the process to a large extent accounted for the change in their interest and position around this period. The NHIA (National and Regional) for instance remained proponents at every stage of the process because they are the initiators of the policy and had a high understanding of the policy. Scheme Managers on the other hand were opponents at the pre-implementation phase due to lack of understanding of the policy. What this means is that the opinions, positions and interest of stakeholders may change as fresh information on the policy issue is released to them as has been found in this study. (Abiuro & McIntyre, 2012) also explains how stakeholders' confusion around a policy issue affected their continuous shift in position on the issue. It is therefore possible to conclude on the feasibility and sustainability of the planned scale-up implementation of the policy since many of the stakeholders are certain about its impact and have taken clear positions on the policy issue. The NHIA and the policy-drivers need to consider the interest of key stakeholders (especially primary stakeholders) in order to build consensus on the way forward and to further ensure the reduction of stakeholders' resistance. The stakeholders' concerns captured in this study

need to be critically considered before proceeding with further attempts to scale-up implementation of the policy.

Another important finding of this study confirms the fact that within major stakeholder groups lie different other groups with different interests, positions regarding a policy issue. There were diverse positions, interest and power within major stakeholder groups. For instance, a facility manager's position was highly dependent on whether the facility was a CHAG, Private or Public facility. This finding supports (Grimble & Chan, 1995) who are of the opinion that different stakeholders view policies from their individual, organizational, group or institutional perspectives. The study revealed that all providers generally perceive the capitation payment system as detrimental considering their collective interest of providing healthcare services to their clients. However, the private provider's opposition can be more overt and consistent considering their individual interest of maximizing profit to run efficiently and effectively. On the other hand, public provider's position was covert and more erratic. According to Agyepong & Adjei (2008) and Rajkotia (2007), the introduction of the National Health Insurance policy in Ghana revealed differences in stakeholder dynamics. Beyond this categorization there were significant differences in stakeholders' position with regards to whether the facility was small or big. In practice, stakeholders tend to influence policy decision which they deem not favourable to them in various ways. This influence is to a large extent dependent on the level of power wielded by the stakeholder. Stakeholders who do not have the power tend to form alliances with other stakeholders to influence the policy process. The study revealed that, private facility managers were not part of the process at the initial stages of

implementation despite controlling the largest number of health facilities in the region. In a similar study conducted in India, even though there was a consensus amongst key stakeholders on the need for accreditation and had indicated a willingness to participate others did not participate.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATION

6.1 CONCLUSIONS

Stakeholders who were directly affected by the pilot implementation of capitation in the Ashanti Region were identified as NHIA (National and regional offices), providers (Facility managers) and beneficiaries. The media, parliamentary select committee on health (both majority and minority caucus), frontline workers (public sector) were also identified as secondary actors. Stakeholders' awareness of the pilot implementation of capitation in the region was generally high. However, the study revealed that stakeholders' understanding of the policy was different across the various phases of implementation. Lack of stakeholder understanding of some aspects of the policy concept was identified as one of the main challenges of the pilot implementation.

The study also revealed that stakeholders' had different levels of interest in the policy issue which to a large extent influenced their position as opponents or proponents. It is therefore possible to conclude on the feasibility and sustainability of the planned scale-up implementation of the policy since many of the stakeholders are certain about its impact and have taken clear positions on the policy issue.

The NHIA and the policy-drivers need to consider the interest of key stakeholders (especially primary stakeholders) in order to build consensus on the way forward and to further ensure the reduction of stakeholders' resistance.

6.2 RECOMMENDATIONS

The following recommendations are made based on the findings of the study:

1. The policy issue needs to be depoliticised. Selection of the next regions must be done by taking into consideration geo-political factors. Independent studies and public debates must be organised on the policy to facilitate a successful scale-up implementation.
2. Efforts must be made towards targeting the entire population with education on capitation, addressing the various concerns of key stakeholders and correcting misconceptions, rumours, falsehood and misinterpretations of various aspects of the policy as evident in the Ashanti pilot.
3. A proper evaluation of the pilot implementation of the policy in the Ashanti must be undertaken to mitigate similar implementation challenges from affecting nationwide scale-up.
4. A prospective stakeholder analysis must precede the nationwide implementation of the capitation policy to guide policy drivers in their negotiations in order to ensure successful scale-up.

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APPENDIX A

Informed Consent Form – Interviews (key stakeholders)

This form will be read out to the participant before conducting the interview. After reading it out, the participants will be asked whether they have any questions or concerns about their participation in the study and if there are any concerns, they will be appropriately addressed before the interview. The consent form will be signed by the participant in the presence of the principal investigator. A copy of the consent form will be left with the participant.

General Introduction

You have been contacted to participate in a study on the scale-up implementation of the capitation policy in Ghana. This study is being conducted by me, an MPH student of the School of Public Health, University of Ghana for my Masters dissertation. As an important stakeholder of health insurance issues in Ghana, it is important for me to obtain your opinion and that of your organization/institution/department on the proposed capitation policy. You are therefore being invited to participate in the interviews for this study which are administered to only key stakeholders.

Purpose and process

This study is conducted to explore the opinions of various stakeholders with regards to the capitation policy in Ghana. If you decide that you will like to participate in this study you will be interviewed by me. The questions that I will ask you are basically around:

- Your understanding of the capitation policy
- Your interest in the capitation policy

- Your position and concerns about the policy
- Your opinion about the position and concerns of other stakeholders about the policy
- What you anticipate the prospects and challenges for the implementation of the policy to be.
- Other interesting issues on the policy that might come out during our discussion about the above topics.

I plan to conduct about 25 to 30 interviews to produce a comprehensive report on the opinions of the major stakeholders on the policy. Each interview will take approximately 60 minutes.

Potential risks of your participation

There is very minimal risk of participating in this study. The study will ensure that all information gathered from these interviews is treated confidentially and the findings will be presented in a way that individuals/organisations will not be identified by names with their opinions. There will be no cost element for participating in the study except that you may have to forgo other activities in order to respond to the interviews.

Potential benefits of the research

There are no direct material benefits to you as an individual of participating in this study. However, since the results will be made available to the National Health Insurance Authority to assist in finalizing the policy, this study offers you a potential platform to make known your opinion on the proposed policy issue. Also, your opinion and that of others, if taken into account by the policy drivers, will increase the possibility of coming out with a health insurance policy that will be widely acceptable to all Ghanaians. Hence your participation in this study offers wider benefits to the Ghanaian society.

Participation and withdrawal

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study had been fully explained and you are asked to freely consent to it. You also have the option to discontinue your participation in the interview at any time without any adverse consequences.

Is there any other information you will like to know about the study?

Do you agree to participate in the study?

This study has been granted ethical approval by the Ethics Review Committee of the Ghana Health Service, Accra, Ghana (see contact addresses below).

Should you have any questions after the interview you are welcome to contact the following:

Joseph Nii Otoe Dodoo (P1)

College of Health Sciences

School of Public Health

University of Ghana

0242882292

The Administrator

GHS- Ethical Review Committee

Miss Nana Abena Kwaa Addai-Donkor

0244712919

Statement of Consent (the one granting consent)

I declare that I have understood all that has been read out and explained to me. I am willing to participate in the study and I therefore grant my concern to participate in the study.

Signature Participant: ----- Date-----

Signature Principal Investigator ----- Date-----

APPENDIX B

Informed Consent Form – FGDs (Clients)

This form will be read out to the participant before conducting the interview. After reading it out, the participants will be asked whether they have any questions or concerns about their participation in the study and if there are any concerns, they will be appropriately addressed before the interview. The consent form will be signed by the participant in the presence of the principal investigator. A copy of the consent form will be left with the participant.

General Introduction

You have been contacted to participate in a study on the scale-up implementation of the capitation policy in Ghana. This study is being conducted by me, an MPH student of the School of Public Health, University of Ghana for my Masters dissertation. As an important stakeholder of health insurance issues in Ghana, it is important for me to obtain your opinion and that of your organization/institution/department on the proposed capitation policy. You are therefore being invited to participate in the interviews for this study which are administered to only key stakeholders.

Purpose and process

This study is conducted to explore the opinions of various stakeholders with regards to the capitation policy in Ghana. If you decide that you will like to participate in this study you will be interviewed by me. The questions that I will ask you are basically around:

- Your understanding of the capitation policy
- Your interest in the capitation policy
- Your position and concerns about the policy

- Your opinion about the position and concerns of other stakeholders about the policy
- What you anticipate the prospects and challenges for the implementation of the policy to be.
- Other interesting issues on the policy that might come out during our discussion about the above topics.

I plan to 2 FGD to produce a comprehensive report on the opinions of the Clients on the policy. Each interview will take approximately 45 minutes.

Potential risks of your participation

There is very minimal risk of participating in this study. The study will ensure that all information gathered from these interviews are treated confidentially and the findings will be presented in a way that individuals/organisations will not be identified by names with their opinions. There will be no cost element for participating in the study except that you may have to forgo other activities in order to respond to the interviews.

Potential benefits of the research

There are no direct material benefits to you as an individual of participating in this study. However, since the results will be made available to the National Health Insurance Authority to assist in finalizing the policy, this study offers you a potential platform to make known your opinion on the proposed policy issue. Also, your opinion and that of others, if taken into account by the policy drivers, will increase the possibility of coming out with a health insurance policy that will be widely acceptable to all Ghanaians. Hence your participation in this study offers wider benefits to the Ghanaian society.

Participation and withdrawal

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study had been fully explained and you are asked to freely consent to it. You also have the option to discontinue your participation in the interview at any time without any adverse consequences.

Is there any other information you will like to know about the study?

Do you agree to participate in the study?

This study has been granted ethical approval by the Ethics Review Committee of the Ghana Health Service, Accra, Ghana (see contact addresses below).

Should you have any questions after the interview you are welcome to contact the following:

Joseph Nii Otoo Dodoo (P1)
College of Health Sciences
School of Public Health
University of Ghana
0242882292

The Administrator
GHS- Ethical Review Committee
Miss Nana Abena Kwaa Addai-Donkor
0244712919

Statement of Consent (the one granting consent)

I declare that I have understood all that has been read out and explained to me. I am willing to participate in the study and I therefore grant my concern to participate in the study.

Signature Participant: ----- Date-----

Signature Principal Investigator ----- Date-----

Translator (only applicable to Community level FGDs)

I declare that I read this document to the participant and answered the participants' questions to the best of my knowledge. This conversation was conducted in Twi.

Signature Fieldworker----- Date-----

APPENDIX C

Data Collection Instruments

Interview Guide

Date: ----- ID #: -----

Category of stakeholder-----

Organisation-----

Position in organisation-----

1. Have you heard about capitation?
2. What do you expect from the capitation policy?
3. What do you think is expected of you in a capitation policy?
4. In your opinion, what did the capitation policy seek to achieve?
5. Who in your opinion, who were the key actors during the pilot implementation?
(probe for who were not)
6. Which stakeholders do you think supported the pilot implementation? (Probe for whether support was the same at each phase)
7. Why do you think they supported the pilot implementation? (again probe for what they gained at each phase as in above)
8. Which stakeholders do you think are likely to support the scale-up implementation of the policy? (Probe for what they stand to gain).
9. Why do you think each of those stakeholders will support the scale-up implementation of the policy? (Probe for what they stand to gain)
10. Which stakeholders do you think opposed the pilot implementation of the policy? (Probe for whether opposition was the same at each phase)
11. Why do you think they opposed the pilot implementation of the policy? (Probe for what they feared they could lose or gain)
12. Were they able to influence the pilot implementation in any way? If, so how? (Probe for whether the actors (stakeholders) are mobilized and for possible alliance with other actors)
13. Do you think those stakeholders have the ability to influence the nationwide roll-out? How? (Probe for sources and level of power)
14. First, ask how capitation has affected him/her? (Probe for what their views on the policy are, are you in favour or not and probe for whether support was the same across each phase)
15. What is the reason for your support for the pilot implementation of the policy? (Probe for the reasons at each phase)
 - a) Were you able to demonstrate this support? If, so, how? (Probe for sources of influence and how stakeholder support will be demonstrated and probe for possible alliances with other actors)

- b) Are there any conditions under which you will tend to oppose the nation-wide roll-out of the policy instead of supporting it? (If yes, probe for such conditions)

If indicates opposition

- 16. What is the reason for opposing the implementation of the policy in the region?
- 17. Are you able to demonstrate this opposition? If, so, how? (Probe for sources of influence and how stakeholder opposition will be demonstrated and probe for possible alliances with other actors)
 - a) Are there any conditions under which you will tend to support the nation-wide roll-out instead of opposing it? (If yes, probe for such conditions)
- 18. What do you think were the benefits of the capitation policy? (Probe for prospects)
- 19. What do you think were the disadvantages of the capitation policy? (Probe for challenges)
- 20. Do you have suggestions/recommendations that will aid effective nationwide roll-out?

Thank you very much for your time.

FGD Guide (Clients)

Date: ----- ID #: -----

Category of stakeholder-----

Organisation-----

Position in organisation-----

1. Have you heard about capitation?
2. In your opinion, what did the capitation policy seek to achieve?
3. Who in your opinion, who were the key actors during the pilot implementation? (probe for who were not)
4. Which stakeholders do you think supported the pilot implementation? (Probe for whether support was the same at each phase)
5. Why do you think they supported the pilot implementation? (again probe for what they gained at each phase as in above)
6. Which stakeholders do you think opposed the pilot implementation of the policy? (Probe for whether opposition was the same at each phase)
7. Why do you think they opposed the pilot implementation of the policy? (Probe for what they feared they could lose or gain)
8. Were they able to influence the pilot implementation in any way? If, so how? (Probe for whether the actors (stakeholders) are mobilized and for possible alliance with other actors)
9. Do you think those stakeholders have the ability to influence the nationwide roll-out? How? (Probe for sources and level of power)
10. First, ask how capitation has affected him/her? (Probe for what their views on the policy are, are you in favour or not and probe for whether support was the same across each phase)
11. What is the reason for your support for the pilot implementation of the policy? (Probe for the reasons at each phase)
12. Were you able to demonstrate this support? If, so, how? (Probe for sources of influence and how stakeholder support will be demonstrated and probe for possible alliances with other actors)
13. If indicates opposition
14. What is the reason for opposing the implementation of the policy in the region?
15. Are you able to demonstrate this opposition? If, so, how? (Probe for sources of influence and how stakeholder opposition will be demonstrated and probe for possible alliances with other actors)
16. Do you have suggestions/recommendations that will aid effective nationwide roll-out?