Ghana's Experience with Changing Provider Payment to Capitation in Primary Health Care

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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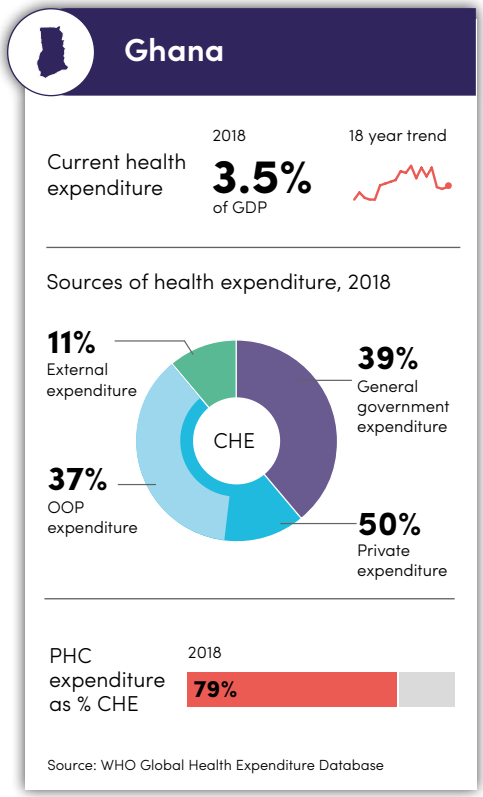
Although universal health coverage has been a central health goal in Ghana since its independence in 1957, payment for both public and private health care has often relied on user fees, resulting in the underutilisation of services and poor health outcomes. Ghana's National Health Insurance Scheme (NHIS) was introduced in 2003, bringing together a number of district insurance schemes, in an attempt to provide universal health coverage and eliminate the use of pre-payment charges for health care. Since its inception, the NHIS has struggled to contain the costs of paying health providers, both through fee-for-service (FFS) then Diagnostic Related Group (G-DRG) mechanisms.

In 2012, a capitation payment system was piloted in the Ashanti region in Ghana with the aim of improving the efficiency, effectiveness and utilisation of primary health care services and thus containing costs. This paper provides a comprehensive account of Ghana's experience in implementing the pilot capitation system including its historical context, design, implementation and impact.



DESIGN AND IMPLEMENTATION OF THE CAPITATION SYSTEM

The capitation system covered a defined package of common PHC services including consultations, diagnostic tests and routine care for diabetes and hypertension, to be provided by NHIS accredited health facilities. Following negotiations with service providers, the package of benefits was altered to exclude medicines, which were funded through FFS, and maternity care. In addition, the per capita monthly rates for government health institutions, mission facilities, and private providers were amended upwards to placate dissatisfied providers. Several features of the design, including a risk-adjustment mechanism (to compensate providers for treating more costly groups) and a monitoring and evaluation system, were not implemented during the pilot due a lack of information and preparedness.

IMPACT OF CAPITATION ON QUALITY OF CARE, OUT-OF-POCKET PAYMENTS AND UTILISATION

The documented evidence about the effects of capitation suggests that the pilot was not successful in achieving its objectives and the reform was eventually suspended in 2017. Research found that perceived quality of care, for both health care providers and clients, was lower in the Ashanti region compared with two other regions in Ghana. Another comparative study that focused on out-of-pocket payments, found that clients exposed to capitation in the Ashanti region had a 10% higher probability of encountering out-of-pocket payments than their counterparts in a non-capitated region, likely due to informal charges by providers. Overall, it is not clear if the capitation actually led to cost containment or improved the quality of care and further studies are required including a comprehensive cost-effectiveness analysis of the reform.

Several factors hindered implementation of the capitation scheme. In relation to the health system, many accredited facilities were not sufficiently equipped or staffed to provide the services defined in the benefit package, especially those in rural areas. Health care providers displayed resistance to the capitation scheme, especially the level of fee per capita and the cost-sharing role they were expected to take on. Political factors also played a role: the choice of Ashanti region, a stronghold for the opposition political party, fuelled mistrust in the government's reform, and the government did not prioritise nor provide sufficient funding for its implementation. There was not enough budget for training health care providers and NHIS workers, leading to a lack of understanding of the implementation process and

confusion, especially with regards to the difference between the per capita rate and the per encounter rate.

In theory, capitation can be effective in containing costs by incentivising competition amongst healthcare providers and the provision of health promotion and disease prevention services. In practice, however, many factors are required to ensure the achievement of efficiency gains. Several important lessons can be learned from Ghana's experience, all of which are underpinned by the need for a clear budget and adequate funding for the design and implementation of the payment system.

LESSONS LEARNED

1. **Support health facilities to acquire staff and equipment to deliver capitated services.** If facilities lack the essential personnel, equipment or infrastructure to provide services, they will not be able to participate competitively in attracting clients, limiting the potential benefits of capitation. An alternative solution in densely populated areas is to consider allowing groups of providers to function as a single entity, offering the full range of capitated services across several facilities.
2. **Collect data prior to implementation.** It is necessary to collect population data to facilitate the development and use of a risk-adjustment mechanism, as well as data on all the health facilities and their capabilities so that they can be supported. In Ghana, these systems were not in place and required funding to set up. The data that was collected was not translated into a useful/understandable format.
3. **Provide training to all relevant stakeholders.** Ensure that providers have adequate understanding of the capitation reform, including what is meant by a per-capita rate, as well as knowledge of financial management and reporting practices required to manage the capitation funding. Involving providers in the planning stages of the reform will help to enhance their understanding of the concept of capitation.
4. **Implement monitoring and evaluation systems to measure the quality of services and utilisation rates.** This requires the allocation of funding to both the purchasing organisation and healthcare providers to budget for their own monitoring and evaluation systems.
5. **Ensure timely provision of per capita funding to healthcare providers.** Timely payment of the capitation fee to providers improves trust in the payment method and discourages charging of co-payments.
6. **Clearly communicate the intended reform and its benefits to the population.** Traditional leaders and opinion leaders can play an important role in educating the general public about how the capitation system works and achieving support for the reform.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

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