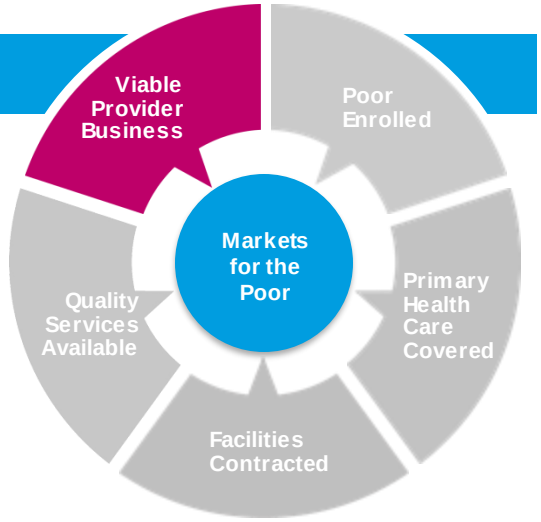
Snapshot 20

Perspectives among BlueStar providers on the capitation pilot



Ghana's National Health Insurance Agency (NHIA) piloted a capitation scheme in Ashanti Region from 2013 - 2017. In a survey conducted by MSIG, BlueStar facilities who participated in the pilot were asked to report on their experiences.

This snapshot shares the results of the survey conducted by Marie Stopes International Ghana (MSIG), to assess perceptions of the capitation pilot among 24 participating BlueStar providers.

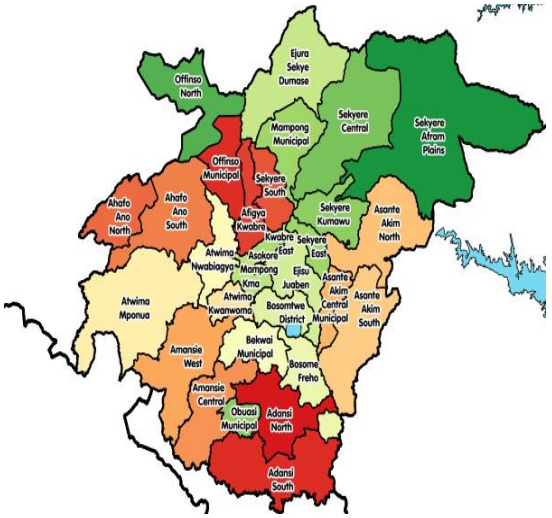
Intervention

The government of Ghana established the National Health Insurance Scheme (NHIS) in 2003 as part of the national strategy to achieve Universal Health Coverage. Between 2013 and 2017, the National Health Insurance Authority (NHIA) piloted a capitation payment mechanism in the Ashanti region. The scheme allowed clients to indicate a preferred provider, and the NHIA made monthly payments to providers in advance to cover clients' primary health care (PHC) outpatient services, based on the number of clients registered to the facility (Capitation Implementation Report 2013). Specialist and inpatient services continued to be paid for by other mechanisms. One of the main drivers of this initiative was to reduce costs for the NHIS.

Due to a lack of education and sensitisation to the pilot scheme, there was a great deal of initial opposition. Ultimately the pilot was suspended in 2017 in favour of a fee-for-service system. Capitation had led to increasing financial burden on providers themselves, and in most districts providers anecdotally reported a decrease in NHIS membership due to a decline in the quality and range of services provided.

All 24 of the BlueStar facilities in the Ashanti region participated in the capitation pilot. Of those, 21% opted into the scheme and the rest were selected by the NHIA. Following the pilot, MSIG approached these facilities, to learn more about their experiences of capitation, asking a series of questions regarding providers' perceptions of the scheme and the impact on their facilities.

On average, there were two survey respondents per facility.



Ashanti Region, where the capitation pilot took place

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Results

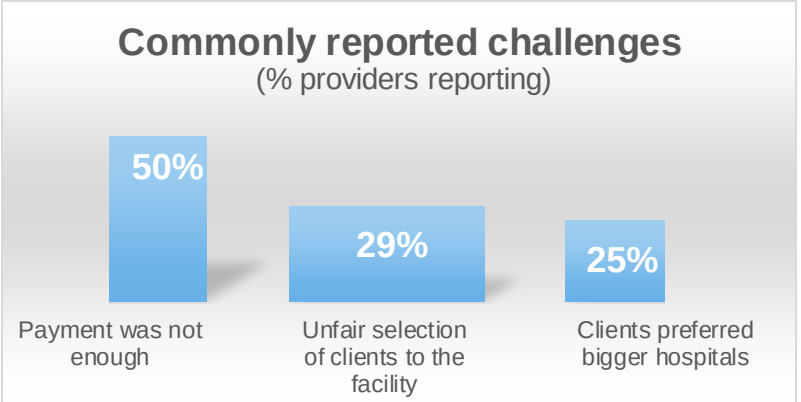
All the survey respondents reported that NHIA had discussed the capitation rate and benefit package with them prior to implementation; 63% found this discussion helpful in understanding the pilot.

83% of respondents said that capitation was paid regularly and in a timely manner. However, survey results reflected wider reports that the capitation rate was insufficient, with 75% of facilities perceiving a shortfall in their facility's overall income and 89% of individual respondents reporting that they were required to seek co-payments with clients. 92% said they made more money under the fee-for-service mechanism, and 96% reported making more money under the Diagnostic-Related Group scheme which took place prior to the capitation pilot.

MSIG's survey indicates that, under the pilot, maternity homes (small to medium sized mid-wife led private providers) struggled to meet staffing requirements and to deliver the range of PHC services required to benefit from capitation, requiring them to refer clients elsewhere for services they were unable to provide. Smaller less resourced facilities in urban areas, faced with competition from larger facilities, saw a loss in income. Larger urban facilities that were already well staffed and equipped benefited the most and saw an increase in their income. (Rural facilities with little local competition saw insignificant change in their income.)

Due to the geographic limits set on clients' choice of facility, those facilities which clients had previously travelled long distances to attend lost clients, whilst others gained them. This was perceived as unfair by some providers. Furthermore, there were also anecdotal reports of fraud, whereby officers in local health authorities were giving preference to some facilities over others when making the final decisions on where clients would be capitated. This severely disadvantaged less connected providers.

Examples and Evidence



Understanding Capitation

Capitation is a payment scheme in which providers are paid a fixed amount on the basis of the number of clients registered to their facility. The mechanism assumes that some clients will require services and other will not, pooling the financial risk.

Some providers perceived the capitation rate as insufficient because they believed that services to a client were to be suspended when the cost of those services reached the individual capitation rate. They didn't always appreciate that savings made from clients not requiring services could be used to deliver services to clients with higher needs. These perceptions both betray a misunderstanding of the way capitation functions.

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Lessons Learned

- Information disseminated to providers participating in the capitation pilot was insufficient, and many providers appear to have misunderstood how the mechanism functioned. This led to some providers cutting corners to save money. **More thorough communication and sensitisation is required before future changes in payment mechanisms are implemented.**

- Capitation can have negative effects on small private providers who are unable to provide a full range of PHC services, particularly those competing with larger facilities in urban areas. It can also have negative effects on providers such as maternity homes, which are less equipped to deliver the range of services required to benefit from a capitated payment mechanism. **Healthcare purchasers can consider the impacts of including or excluding these kinds of facilities from capitation schemes.**

- It is not inherently negative to see smaller urban facilities go out of business as a result of client decision-making, if larger facilities in the area are effectively delivering the quality services that clients require. However, it is problematic if a decrease in income leads to a decline in the quality of services delivered or co-payments which present a barrier to the poorest. It is also a problem if this reported decline in quality and increase in co-payments applies to these larger facilities as well. **In future, such pilot schemes should be accompanied by close monitoring of service quality and business viability in order to assess the sustainability of the payment mechanism.**

Outlook

The Government of Ghana decided to end the capitation pilot and commence reimbursement of claims in 2017. With plans to introduce universal PHC, it is not yet clear how these services will be purchased. At this stage, it seems likely that a basic fee-for-service mechanism will be used, whereby all PHC services will be purchased at the same fixed rate.