RAPID APPRAISAL OF CAPITATION PAYMENT IN ASHANTI REGION

By Rapid Assessment Team for Regional Director Ashanti.

Objective of presentation

1) The objective of our presentation is to answer the question “Capitation as a payment module, the implementation in Ashanti Region as pilot, the lessons learnt and finally the implications for the proposed national roll-out”.

INTRODUCTION

- CAPITATION was piloted in Ashanti Region for the following reasons;

1) Improve Cost containment and sustainability of NHIS

2) Introduce manage competition among providers and choice for patients

3) To share risk between NHIS and Health providers and subscribers

4) Simplify claims processing and address difficulty in forecasting and budgeting time

5) Improve efficiency and effectiveness of health service through a more rational use of resources

Main Components of Capitation

1. Package of primary care services.
2. Base per capital rate of 0.99 GH₵ in January and increased to 1.30 per member per month in April 20129 (15.60 GH₵ PMPA).
3. Enrollment of clients to Preferred Primary Providers(PPP) .
4. General and financial management and reporting systems (Common management Arrangement)
5. Quality monitoring system

Main Components of Capitation

- Payment of all outstanding debts to Health Facilities in the Region before the start of capitation to enable the health facilities to stock supplies.
- Advance payment of agreed capitation rate (one week before the start of the capitation month or at most in the first week of capitation month).

IMPROVE COST CONTAINMENT

- Our assessment team could not show that Cost was contained particularly looking at the bigger hospitals finances.
- Our findings as a team indicate that bigger health facilities (Hospitals) appeared to have made more money than they did before capitation.
- The findings of our team also showed that if cost is contained by NHIA, it did that at the expense of the patients (clients) through “out of pocket” payment.

Managed Competition of providers and choice for patients

- Out team findings indicate this did not occur for both providers and patients as NHIA was the body that registered members and shared them to the providers .
- Subscribers (Patients), even though were asked to make three choices at the start, they ended up with NHIA allocating them to a preferred provider.
- In the case of fund management, this was partly but not whole achieved because of delay payment of capitation rates in most part of the capitation pilot period.

Simplify claims processing, address difficulty in forecasting and budgeting

- Our team could not determine achievements or otherwise of the above, because of the time and material limitation for the work.
- The team proposes a much wider and comprehensive study to determine the above.
- However, the team canr infer that because advances of funds were not smooth, forecasting and budgeting was affected.

Improve efficiency and effectiveness health care and rational Resource use

- The team found out that some providers achieved efficiency in resource use by printing folder which are half the size and price of what was in use.
- Shopping for less expensive material but of quality medical supplies.
- Efficiency and effectiveness in quality care was not assessed because of limitation of time and resources.
- Team can however state that investigations was greatly reduced and patient were made to pay “out of pocket” for some under capitation

Utilization of service

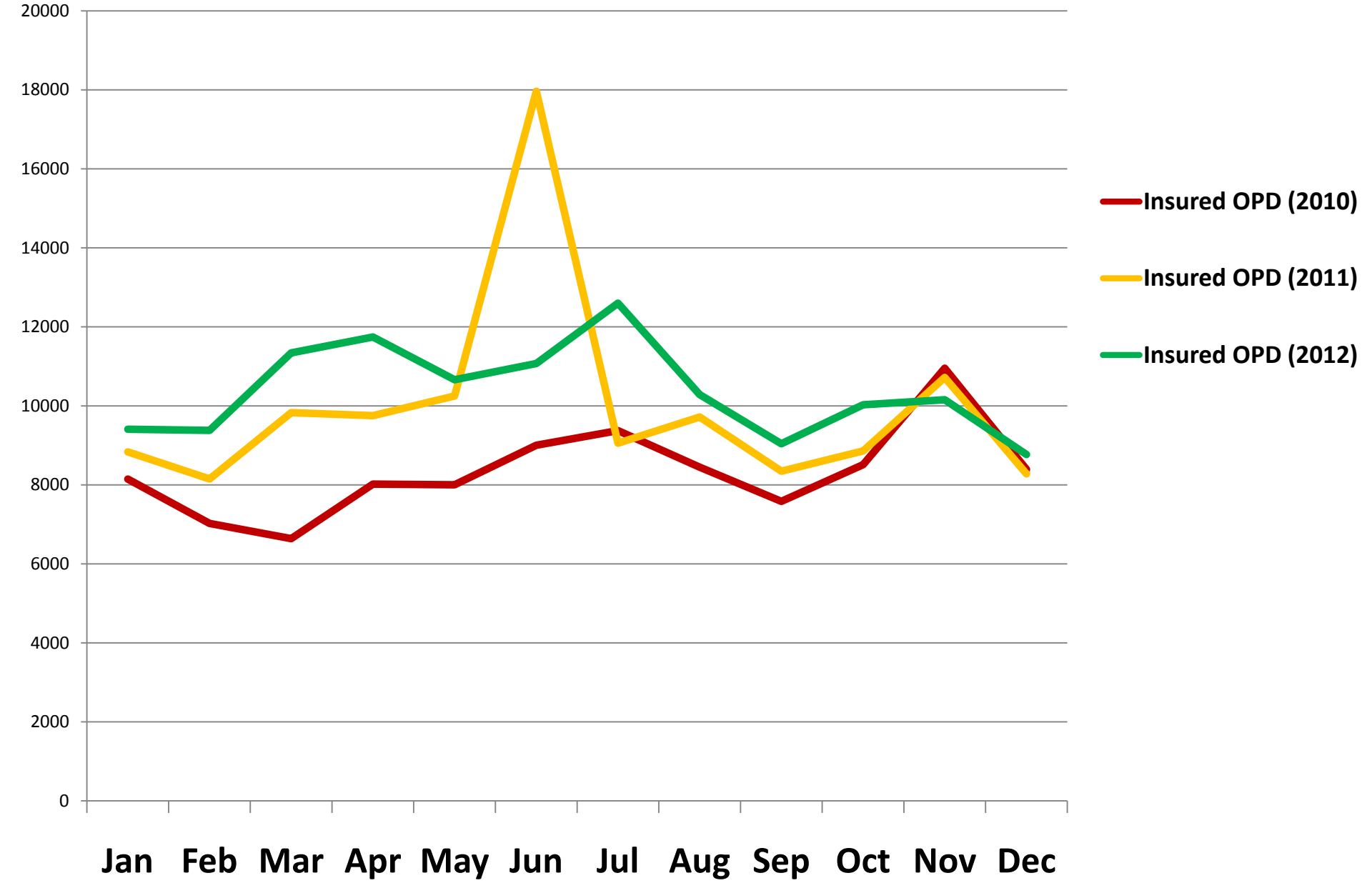
Utilization of health service in Sampled Facilities;

1. A City hospital (A)
2. District hospital (B)
3. Health centre in a district with district hospital (A)
4. CHPS in a district with a district hospital (A)
5. Health centre in a district without hospital (B)
6. CHPS in a district without a hospital (B)

Hospital OPD

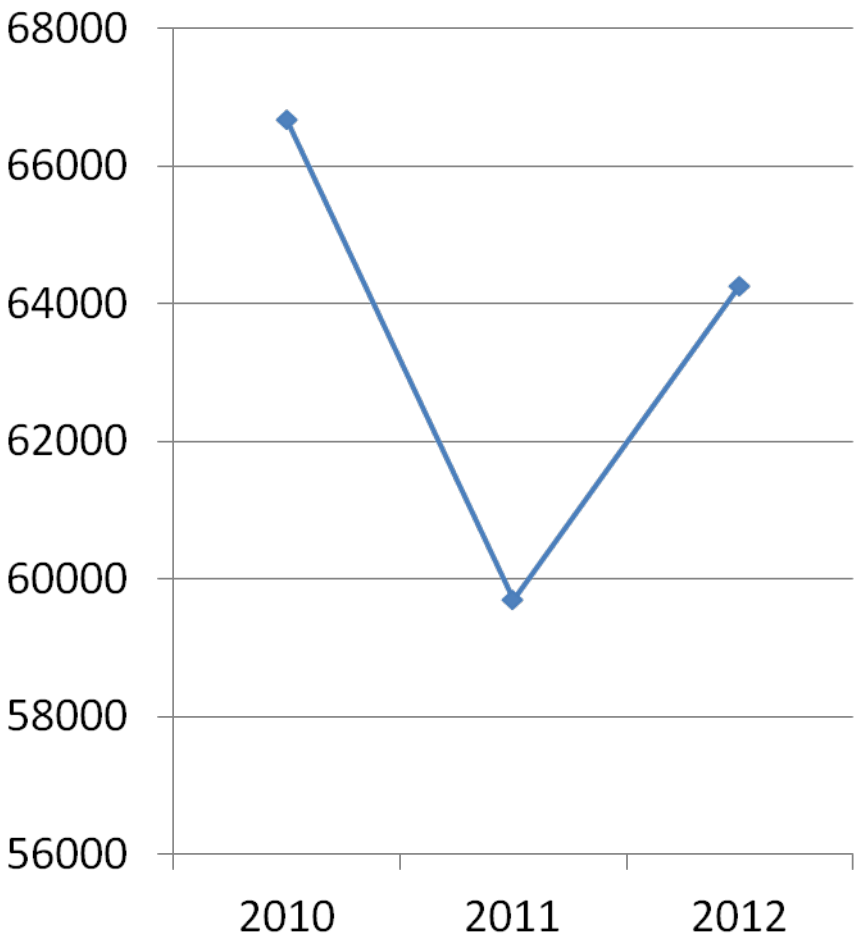
	Insured OPD (2010)	Insured OPD (2011)	Insured OPD (2012)
Jan	8146	8836	9409
Feb	7025	8149	9380
Mar	6639	9829	11341
Apr	8020	9751	11744
May	8003	10251	10662
Jun	9002	17966	11073
Jul	9374	9055	12601
Aug	8448	9718	10286
Sep	7582	8346	9041
Oct	8512	8857	10026
Nov	10953	10719	10154
Dec	8393	8278	8768
Total	**100,097**	**119,755**	**124,485**

Hospital (A) OPD, 2010-2012

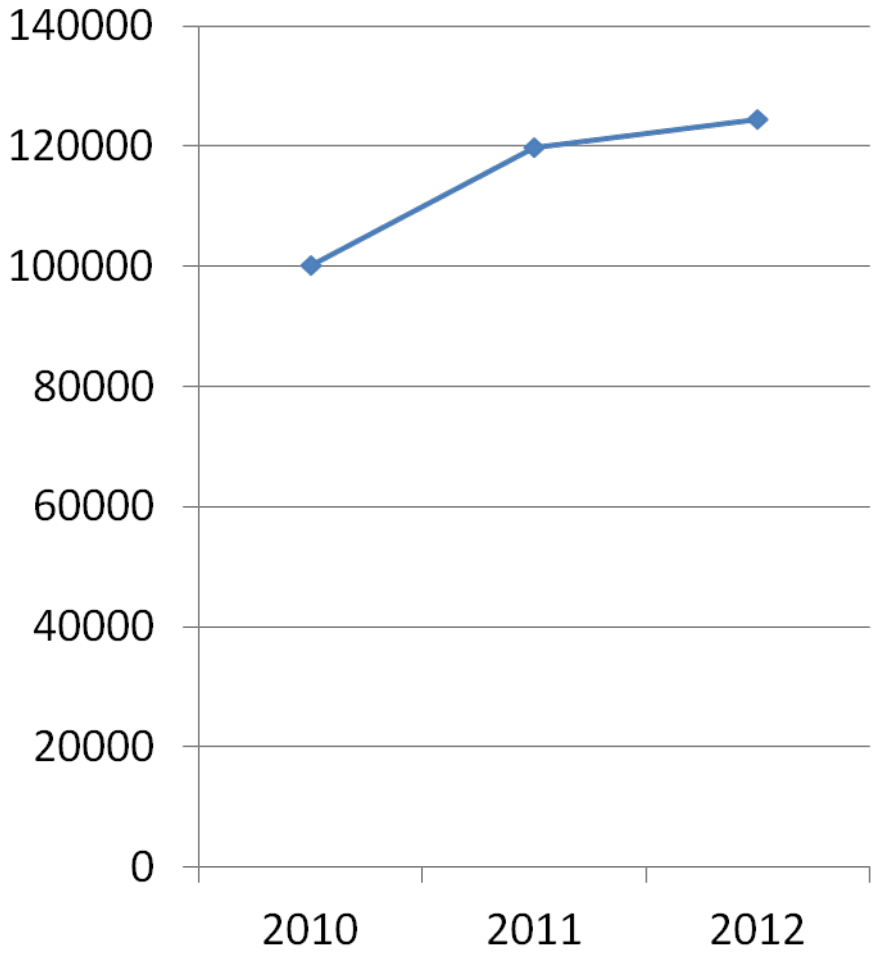


OPD Attendance

Hospital (B)



Hospital (A)



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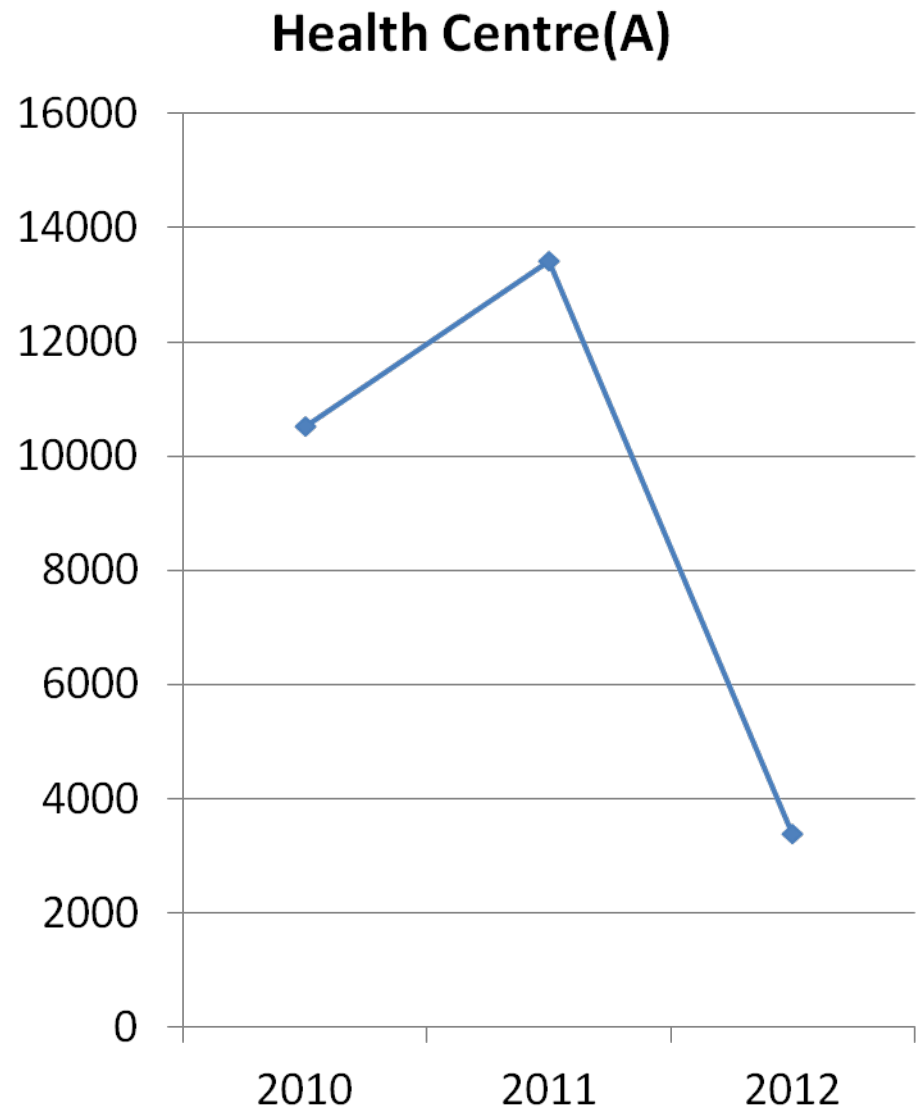

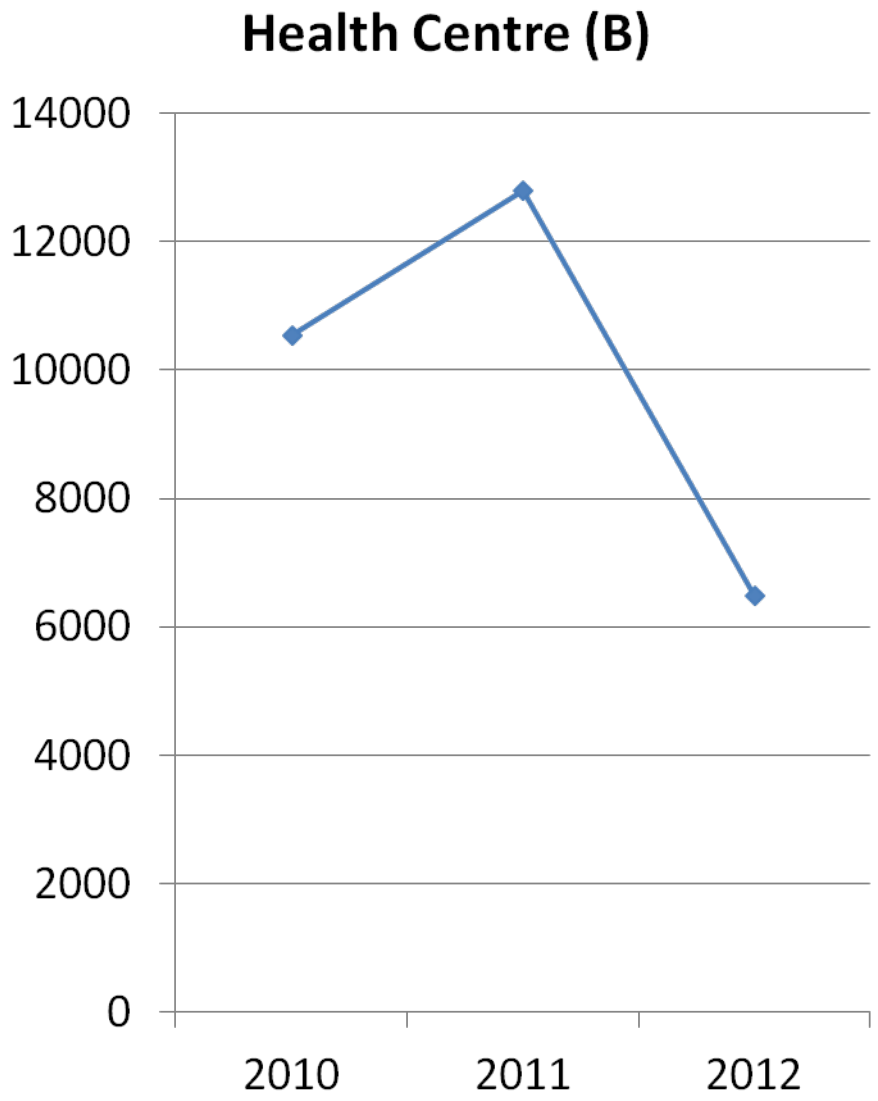

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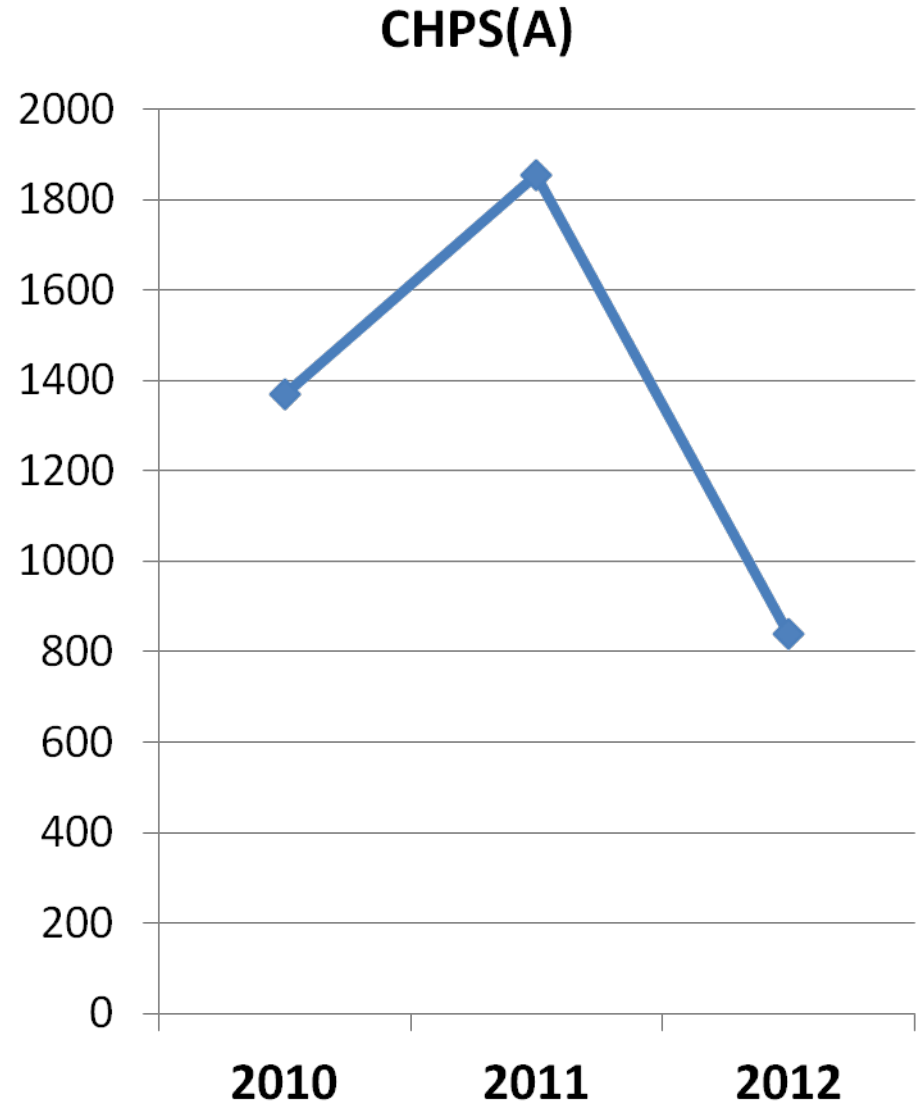
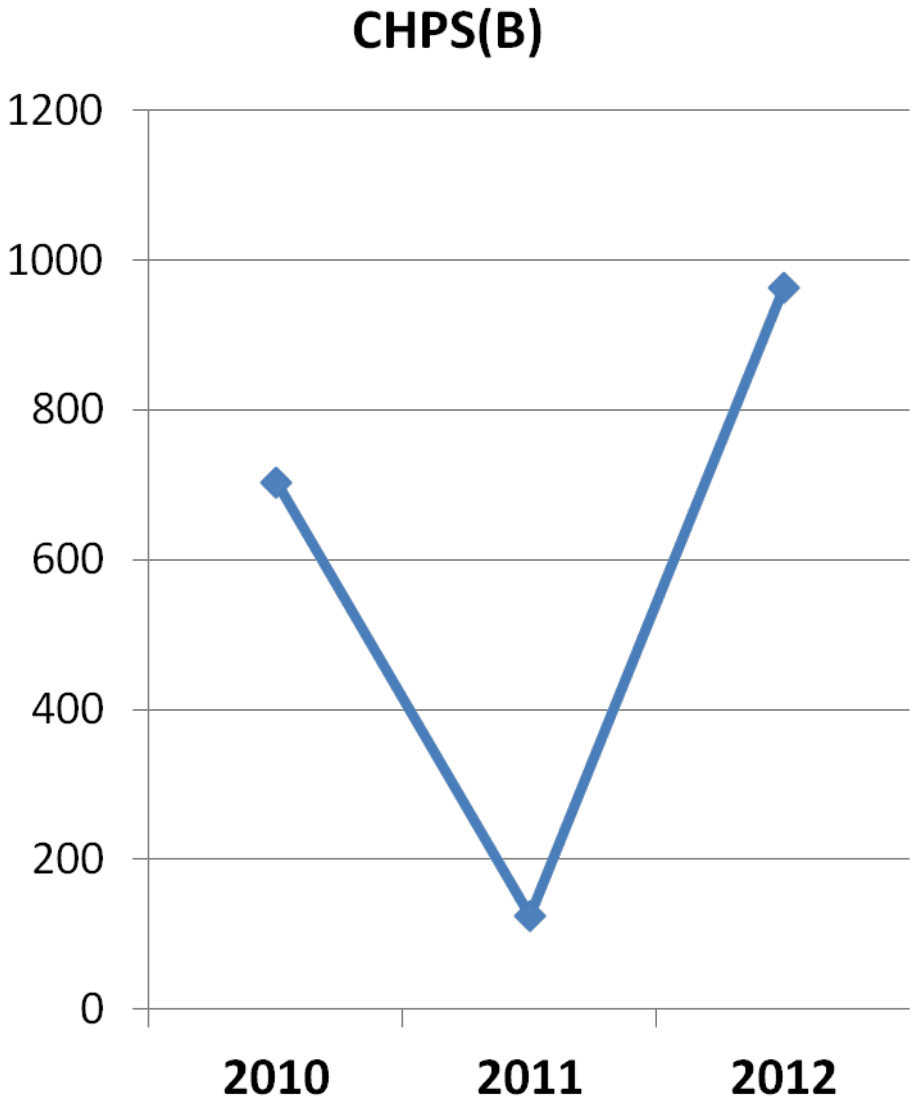
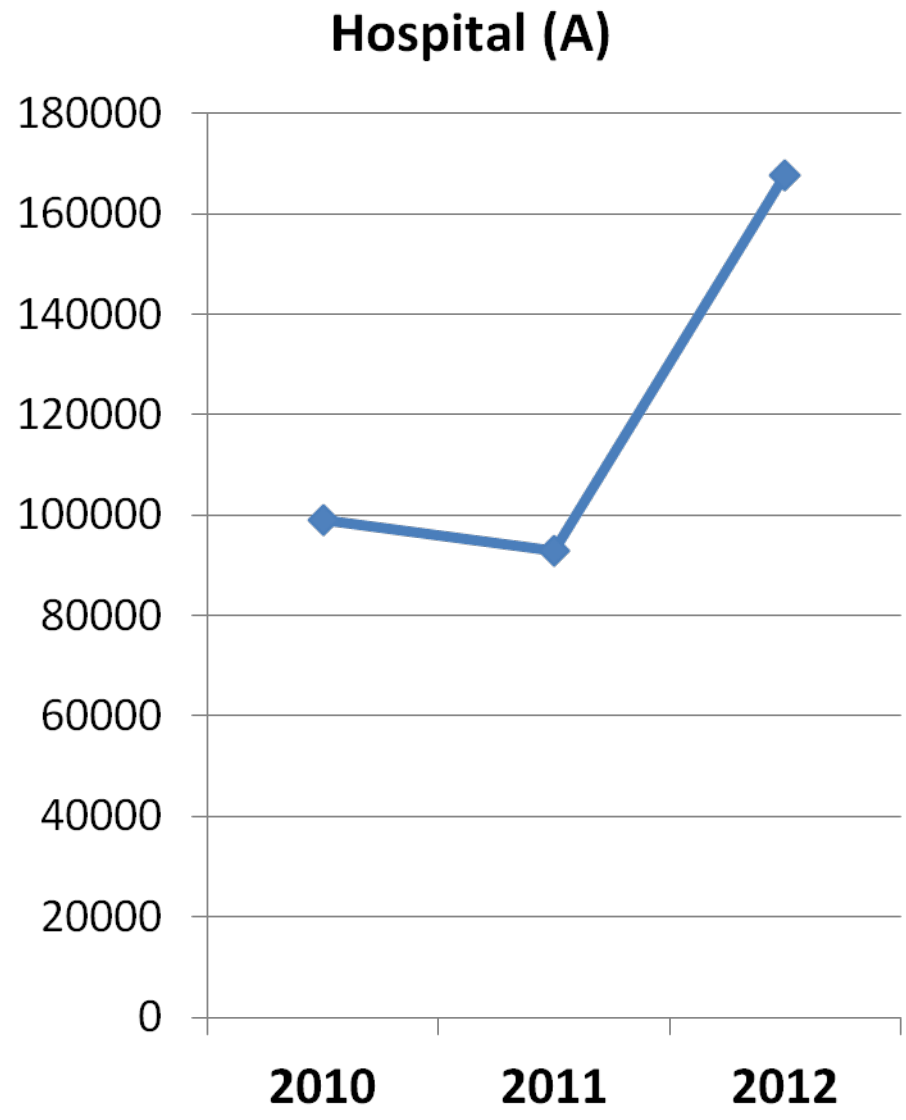
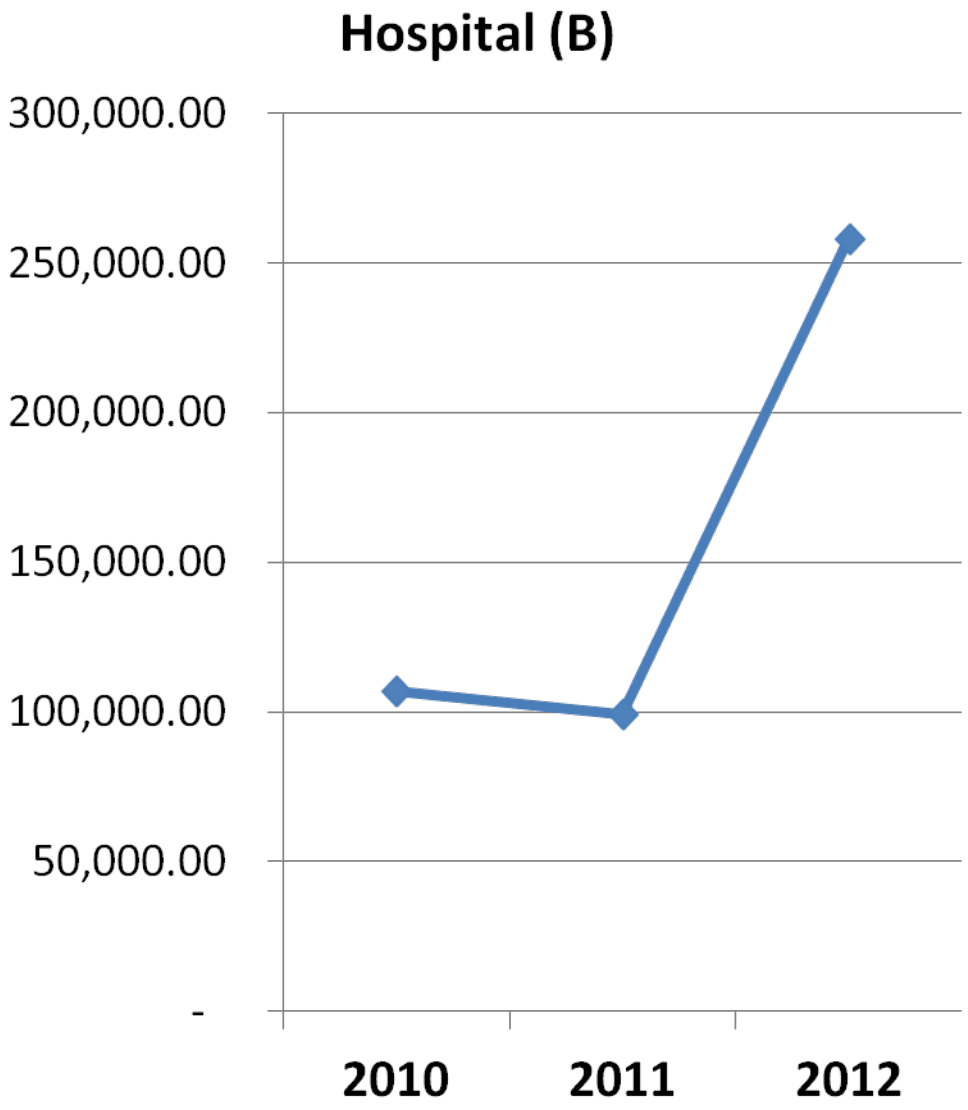




Cash and Carry Services





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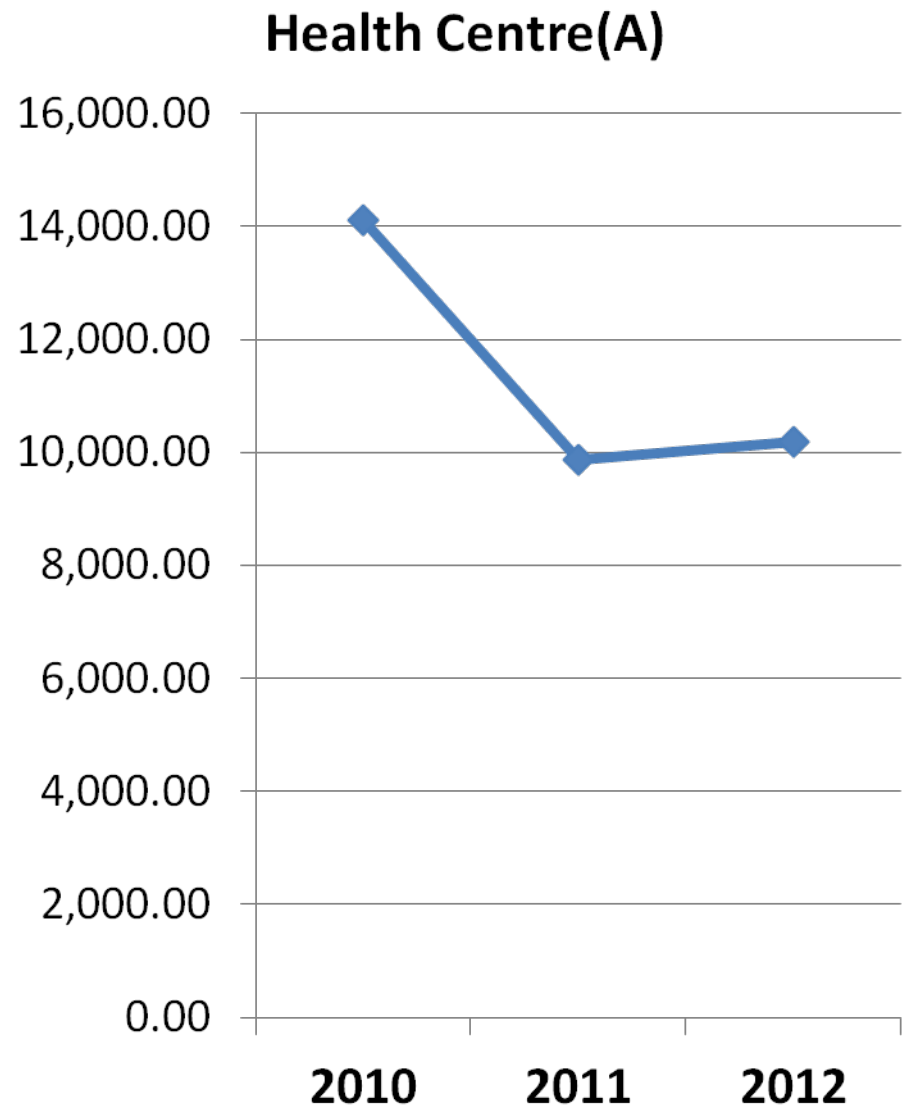

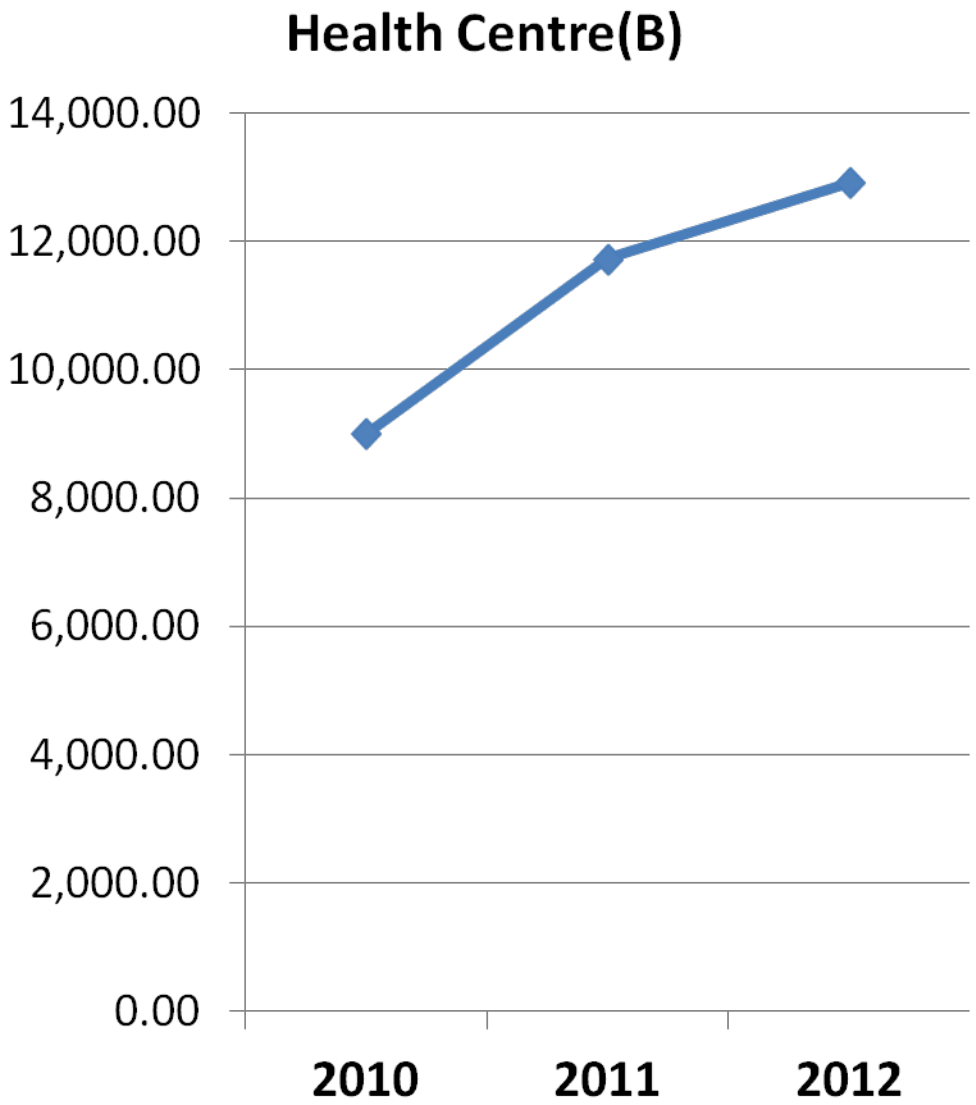

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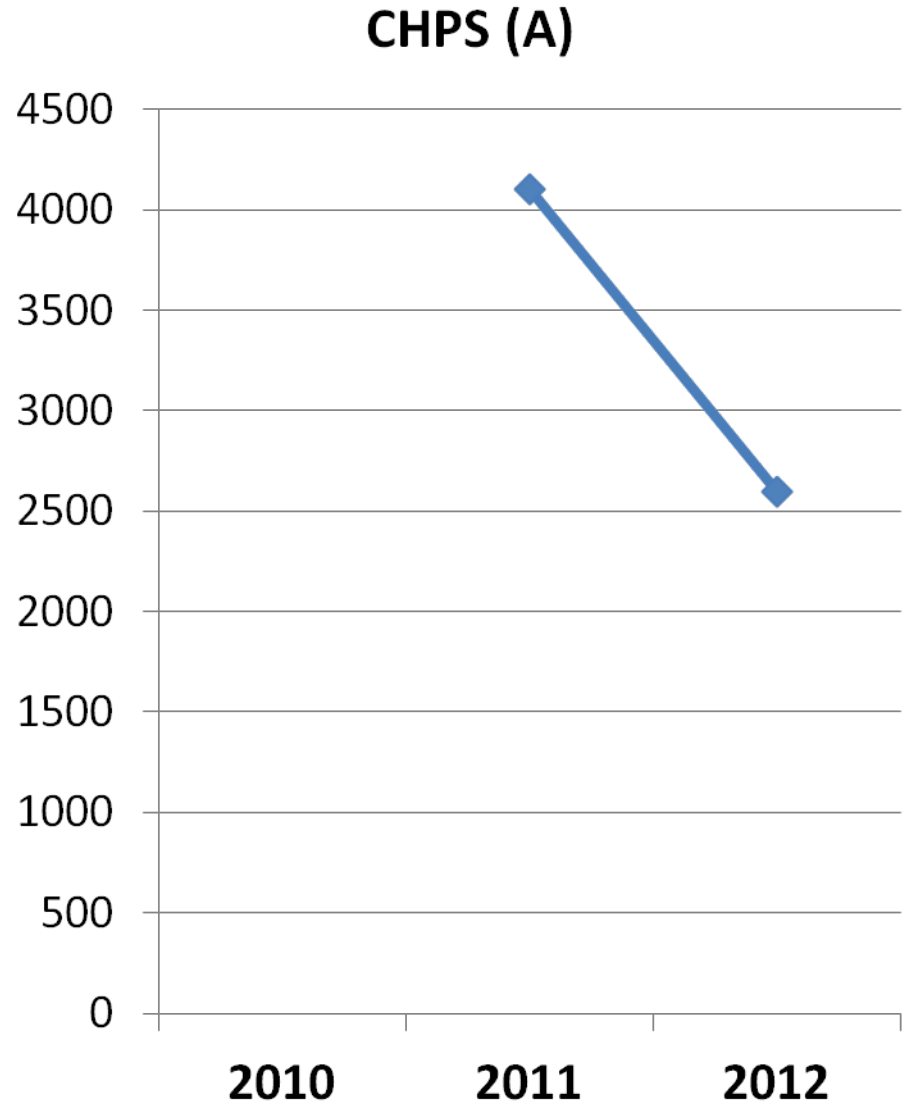

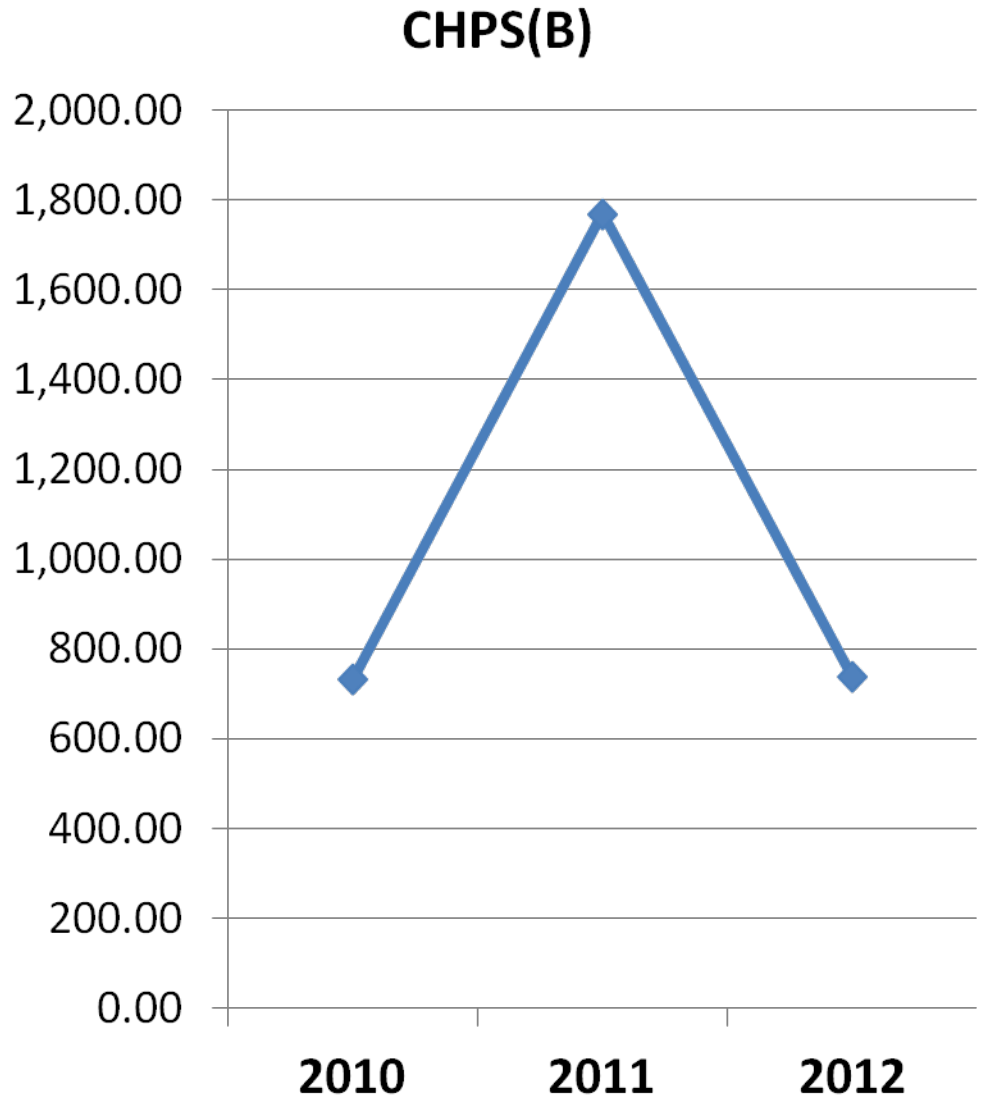

Conclusions (Utilization of services)

- Capitation did not affect OPD attendance in big hospitals
- Capitation did not affect OPD attendance in health centers in districts without hospitals, but, there was reduction in OPD attendance in health centers in districts with hospitals
- Capitation did not affect OPD attendance in CHPS compounds in districts without hospitals, but, there was reduction in OPD attendance in CHPS compounds in districts with hospitals

Conclusions (Revenue mobilization)

- Cash and carry collections has more than doubled in the big hospitals
- The picture is mixed in the health centers
- There is reduction in cash and carry in the CHPS compounds in both districts with hospitals and those without hospitals.
- The results show that subscribers are made to pay out of pocket thus defeating the objective NHIS.

Conclusions (Understanding /Acceptance)

- The acceptance of capitation was very poor by the two major stakeholders ; Health Providers and the subscribers in Ashanti Region.
- The theory of capitation may be good, but the refusal of the major stakeholders (Providers and Subscriber) in Ashanti Region to accept and pilot has made the pilot inconclusive to use the results to roll out capitation country wide based on what has happened.

Recommendations

- Capitation is meant for primary care and clients should be educated and encouraged to choose facilities closer to them.
- Before arriving at the capitation rate and benefit package, NHIA and providers need to freely discuss the capitation rate and benefits package to come to an amicable agreement.
- The data used in the calculation should be acceptable to both the providers and NHIA to arrive at an acceptable capitation rate.

Recommendations

- Health facilities will require to be upgraded and new ones established and provided with basic equipment, logistics and staff with skills to deliver a quality benefit package to members.
- GHS should be seen to be protecting their health facilities and staff against the NHIA in order not collapse health facilities particularly the smaller or lower ones.

Recommendations

- There is the need to institute regular stakeholders meetings among the providers and NHIA to ensure that questions are answered and challenges addressed during the process of implementation.
- Capitation pilot should be preceded with PPP for a year or two before applying capitation rate.

Recommendations

- The health providers recommend the setting up of an independent consultant/arbiter to lead the process of implementing of capitation.
- If the NHIA decides to roll out capitation payment across the country, there should be more time spent with providers in preparing the process for capitation rate.

Recommendations

- If NHIA want to continue the operation of capitation, they should ensure prompt payment of the capitation funds with sufficient financial advice on funds transferred to providers.
- The government need to first provide some GOG funds for health providers to put the necessary structures, equipment and logistics in place to ensure that facilities are at par

Recommendations

- NHIA should repackage the capitation concept and the rate with emphasis on education to all stakeholders including durbars to enable subscribers, providers and Schemes/NHIA to fully understand the concept of capitation.
- NHIA should remove secondary and teaching or referral units (regional and teaching hospitals) from participating in capitation implementation.

Recommendations

- It is recommended that NHIA should provide training to all stakeholders; subscribers and health providers.
- The implementation of capitation should be depoliticise by not bringing politicians to educate the public on capitation.
- In Ashanti region, Capitation should be repackage and proper education carried out.

Recommendations

- We recommend the setting up of a strong combined monitoring teams at the National level, Regional level and District level with well define tools and finances to enable them carry out effective monitoring .
- GHS should seek for resource for a comprehensive assessment of the pilot in Ashanti Region.

Recommendations

- The lower health facilities (Health Centers/CHPS) should be ring fenced and supported with operational funds so they can continue to carry their mandate .
- Lower facilities (Health Centers/CHPS) should enter into Capitation with the District Hospital as one capitation unit.

THE END

THANK YOU