KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

KNUST SCHOOL OF BUSINESS

ASSESSMENT OF THE FINANCIAL MANAGEMENT AND FINANCIAL SUSTAINABILITY OF THE CAPITATION SYSTEM OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE ASHANTI REGION, GHANA

THESIS SUBMITTED TO THE DEPARTMENT OF ACCOUNTING AND FINANCE, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION (FINNACE OPTION)

BY

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DECLARATION

I, Afia Dei-Kwarteng, hereby declare that this submission is my own work towards the degree of Master of Business Administration and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for an award for another degree of the University, except where due acknowledgement has been made in the text.

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DEDICATION

This thesis is dedicated to my beautiful daughter Abena Amoah Osei-Addae whom I started this journey with.

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ABSTRACT

The importance of Capitation in reducing financial waste and abuse of resources as well as improving the efficiency of health delivery cannot be overemphasized. The purpose of this research was to examine the financial sustainability of the NHIS capitation in the Ashanti region. Using questionnaire for a sample population of 152 people, various data relating to financial management under capitation the capitation, clients understanding of the capitation, satisfaction received during health care services, type of services received etc. were gathered and used for the analysis. The study showed that Capitation system is financially sustainable due to its inherent control mechanism that eliminates fraud in provider claims under the NHIS. However lack of proper and adequate education on the Capitation has led to many misconception and confusion about scheme. This has consequently affected clients' level of access and reduction in healthcare utilization under the scheme. The study further showed that about 75% of patients who visited the hospital were satisfied at the healthcare services they received. This phenomenon is consonance with earlier argument that Capitation is likely to improve health care delivery because hospitals in attempt to win more clients to their hospitals under the capitation will offer more efficient healthcare services. In this way, capitation, apart from reducing financial malpractice in the NHIS also led to improved services. However challenges still remain with achieving universal health coverage since most prospective clients do not fully understand how the capitation system works.

CHAPTER ONE

INTRODUCTION

1.1 Background Study

The importance of finance in any socio-economic endeavour including the provision of health cannot be overemphasized. There is a popular saying that "health is wealth". Mahatma Gandhi once said 'it is health which is real wealth and not a piece of gold or silver. As a matter of fact, health is at all point in time more important than wealth. Health does not however mean the nonexistence of ailment but the form of total physical, mental and social wellbeing. Within the concept of a healthy individual lies being part of happiness and with it one lives longer, acquires more wealth and contributes to society. Any society or individual who overlooks health in its or his quest for more wealth ends up losing both. Improving the health of their citizens is a significant social obligation for all nations whether developed, developing or underdeveloped. The notion of continuous development of health does not only credit an individual but goes on to benefit an entire community or on a broader note beneficial to a nation thus improving the economic growth and national development.

Malnutrition –i.e. undernourishment, undernourishment in addition to overnourishment is said to have total over thee and a half trillion dollars in production and healthcare cost annually (FAO, 2014). The contribution of health to the overreaching goal of poverty reduction was firmly acknowledged by the United Nations. It was in recognition of this that the UN tasked its member countries to allocate a minimum of 8% of their GDP toward public health. The development of a healthcare system that provides efficient and sustainable delivery of health services for every citizen is of paramount importance.

According to a WHO report, a healthcare system in its definition is the organization of people, institutions, and resources that deliver healthcare services to meet the health need of a target population (WHO (2010 & Knieps (2012)). The report puts across the aims of a health system as providing good health for the citizens, receptiveness to legitimate expectation of the citizenry, and reasonable system of funding procedures. The extent to which healthcare systems are able to achieve the above aim depends greatly on how well the system is able to perform the following four key functions: Provision of healthcare services, Resource generation, Financing and Stewardship (Chan, 2009). The stewardship function of a healthcare system recognizes the fact that responsibility of healthcare rests largely in the hand of the individual who in a sense own their health. The success of a healthcare system is measured by quality, efficiency, acceptability, coverage, equity and sustainability (Prowle and Harradine, 2015). The overall objective of public healthcare system is the reduction of premature death, minimization of the effect of disease, disability and injury (WHO, 2001).

In Ghana, the healthcare system has undergone remarkable changes since independence. Most of these changes were made with regard to how to finance the public health sector Tettey (2003). The stewardship model as has been proposed by the WHO indicates that government should not coerce people or restrict their freedom unnecessarily. It stresses that government has the responsibility of providing a condition under which people can lead healthy lives.

According to a 58th World Health Assembly (WHA58.33, 2005) in May 2005, there has been a global outlook on financial protection against the expenditure on unforeseen ill health; based on this a consensus was built to motivate fellow federations to "plan the transition to universal coverage of their citizens". Primarily, an essential part of considering risks associated with financial protection is to make sure there is a fair distribution of healthcare financing in consideration to how much it is paid for.

There has been increase in the population size and treatment cost over time and primarily as a result of that, the provision of funds to public hospitals by the government has become progressively challenging. There has been substantial support financially to hospitals geared towards the provision of quality healthcare. According a report from parliament, close to 15% of the last half a decade's national budget has annually been devoted to the sector of health in the provision of high quality and affordable healthcare (Parliamentary Audit Report, 2011). Healthcare reforms such as the National Health Insurance (NHI) have provided health insurers with incentives to become prudent purchasers of healthcare services. It is consider interest presently in the exploration of assessable and affordable healthcare within underdeveloped and developing economies especially for African nations.

Before 1957 when Ghana had independence, clients or patients of public health facilities were charged for using the services rendered. There was free healthcare to public health after independence and the machinery of taxation and donor support was used in financing (ISSER, 2013). This however was not sustainable in terms of the eminence and conveyance of services. Subsequent to the overall improvements disseminated with the World Bank and the International Monetary Fund (IMF) in 1985, the Ghana Ministry of Health (MOH) introduced the out-of-pocket expenses (fees for users) at points-of-service in public health amenities. This was aimed at recovering at least 15% of recurring costs of operations. The characteristics of this form of financing was that the payments made by patients/clients still occurred as with the previous form of payment but these payments were minimum and were considered as more of symbolic, and admittance and utilization research displayed substantial decrease within the usage of medical amenities particularly in rural parts following the re-introduction of fees with which clients of these facilities would pay (Alatinga & Williams, 2014). The effect of this happening was that individuals attended the health facilities only

when their sickness got worse and near fatal. During the end of the 1980s, the Ministry of Health started considering health insurance as an alternate of financing scheme for the existent scheme where clients made payments for the use of facility and facility services. This was advanced with viability and feasibility tests of some pilot schemes which saw quite a number of community-based pre-charging systems came forward and by the year 2002, there were up to 159 health organizations with 67 districts which were mutual capturing close 1% (220,000) of the Ghanaian populace (ILO Report, 2005).

The terminology "universal health coverage" popularly UHC has registered a lot of popularity across the globe in the last five years. Within this concept of universal health covering, all individuals are to be assessable to healthcare irrespective of their ability to afford these services. This has been seen across the globe to be a key determinant to the delivery of improved health; thus a proposal was therefore made for nations participating to investigate or sort out a universal financial scheme covering healthcare. This proposal was made at the 66th World Health Assembly held in Geneva during 20 – 28 May 2013 by executive body of WHO. This growing need for the extension of the accessibility of healthcare across every square inch of the nation sparked an acknowledgement by the 189 United Nations representative nations in September 2000 following a declaration of the Millennium Development Goals (MDG) numbering eight (8). These MDGs were geared towards the improvement of social and economic conditions by the year 2015. There were three of these goals which centred on health and two others which featured health related matters i.e. sustainability of the environment and poverty alleviation.

Based on the intuitive movement to drive towards improved health, the National Health Insurance was birthed via the National Health Insurance Act (Act 650, 2003). This was fully functional by the year 2005 and was acknowledged by the WHO Executive Board in a report

to the 66th World Assembly noting Ghana as one of the nations which have taken key steps in the aim of realizing the universal health coverage. There is almost one-third of Ghanaians who are actively members of the scheme; in the face of this, financing of the NHIS being a social health scheme has been very challenging.

1.2 Problem Statement

The need for healthy lives has been well acknowledged by all. There has been a general cry for Universal Health Coverage. However, a key important factor in achieving universal health coverage is finance. The Ghanaian health sector has gone through various systems all in attempt to address the financial need of the health sector. After the country attained independence in 1957, the government converted to a tax-dependent financing and completed health services to all public sector being free (Agyepong & Adjei, 2007). Primarily because of economic unproductivity with the initial period of the 1970s, the tax revenue of the country dwindled (World Bank, 2013). As a result, government could not support the tax-based health financing system impacting negatively service delivery in the health sector.

In 1983, due to an IMF and World Bank funded economic retrieval programme, an adoption was made by the PNDC government which resulted in the 'cash and carry' scheme within which clients had to make overall payment given the cost of drugs and some medical consumables when they visited communal health centres though government absorbed the cost of salaries, consultations and emoluments for doctors, nurses and other healthcare workers in state hospitals (Waddington and Enyimayew 1989). This reduced accessed to healthcare because only the rich could access healthcare and poor only went to hospital when they are seriously sick or about dying for lack of money to pay for healthcare services.

In order to improve access to healthcare there was the commencement of the National Health Insurance Scheme (NHIS) which geared up in 2004: an idea which had been conceived in 1996. During the same period, Capitation payment system was considered as an alternative to the NHIS. One would have expected that after ten years of implementing the plan, public health institutions would have been adequately resourced financially. The general perception has been that the health system is collapsing due to financial constraint which has led to the introduction of the Capitation system as pilot project in the Ashanti region. In spite of this introduction, there has been no assessment of how sustainable the NHIS Capitation program is locally on a financial note. This has left key stakeholders in this regime in the dark especially on relevant subjects such as the challenges and the financial sustainability of the capitation system.

1.3 Objectives

The objective of this study pinned in the assessment of the financial sustainability of the NHIS Capitation in Ghana. Specifically, the research hopes to:

1. Examine Patients' understanding of the Capitation system
2. Assess the financial sustainability of the Capitation payment system.
3. Identify challenges facing the capitation system in the Ashanti Region

1.4 Research Questions

1. What is the level of patients' understanding of the capitation system?
2. Is the Capitation system financially sustainable?
3. What are the challenges facing the Capitation in the Ashanti region?

1.5 Research Hypothesis

H_O: The Capitation system is financially sustainable.

H_i: The Capitation system is *not* financially sustainable.

1.6 Significance of the Study

The Capitation scheme is a system where clients or patients registered under the scheme would be allowed to select their preferred health facility. This is form of system is intended to simplify the claims process because facility would be responsible for the primary healthcare needs. The establishment of the understanding of the clients and other key stakeholders of the problem is important. This study will put forward the extent to which the scheme is financially sustainable and therefore aid in whether the pilot project should be extended nationwide or be held within the pilot areas until sustainability is established. In this way, the research generally hopes to provide stakeholders in the health industry with relevant information that can help them prioritize the various sources of funds to their respective institutions. There is a high possibility that new financial instrument can be developed through this research. Other researchers in this area will also have relevant resource materials to fall on for review with this research serving as an extension of literature in health administration.

1.7 Scope of the Study

The study area is limited to the health sector in the Ashanti region where Capitation is been practiced with special emphasis on the sustainability of the Capitation system. This scope has an inherent limitation since results might not be readily replicated elsewhere within the same country or even across borders.

1.8 Organization of the Study

This research is divided into five main chapters. The first chapter is the introduction which provides a brief background about the goal, the need for the study, key benefits of the study and a skeletal framework on how the research was undertaken. The literature review which is the focus of chapter two provides a review of the related literature regarding the health

systems, how the health sector operates, the history and the development of the Ghanaian health sector, how the public health sector is funded and the major expenditure components of the health sector. The third chapter deals with the research design, population and sampling, instrumentation, with methods used in sourcing and analyzing data, mode of data collection, and method of data analysis and presentation of results. At the heart of this research is the discussion of findings which is provided by chapter four. The chapter five provides the summary and conclusion of the findings.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The status of health of an economy is a determinant of the economic development of that economy with research showing that living healthy is fundamental to basking in a healthy productive life. The way and manner in which an economy advances is pinned on the health status of its populace. It is very obvious that good health is fundamental to leading a healthy, productive life. The creation of a sustainable healthcare system by government in order to provide social and economic benefits to its populace is of paramount importance. The main purpose of this research is to investigate the effectiveness of the current health systems that has been adopted in Ghana with regard to their financial sustainability. Various literatures relating to healthcare systems, health infrastructure, health economics, and financial management in the health sector have been identified and reviewed. The review is to provide a theoretical perspective under which the research will be carried.

2.1 Health Systems

Also known as the health system, the healthcare system according to Roemer (1991) refers to "the permutation of organization, resources, financing and management that concludes within the delivery of health services to the populace". This is not so different from the World Health Organization (2000) definition which recognizes a healthcare system as "all activities which has a primary objective of promoting, restoring and maintaining health". A solid and well-built healthcare system is structured within the delivery of quality services to all people, the point of needing and at the time within which this is needed. A good healthcare system also provides a financially fair and reliable framework and at the same time has a component of

quality customer services. When this structure is in place, there is recognition that the lives of the citizens are improved continuously. The whole responsibility of structuring an efficient healthcare system is with the government which in turn relies on subsystems such as the local government agencies, various health facilities, regional ministries and municipalities.

On frequent notes there has been a definition of the health system in terms of reductionist view thus a reduction to a healthcare system. According to Frenk Global Health (2000) who worked on the development of some arguments towards the expansion of health systems, there should be extra dimensions considered to the existing framework as follows:

- There should be existent an expression of the health system not only with respect to their respective components but additionally inclusive of their interrelationships.
- The objectives of the health system comprising health improvement should also include equity, legitimate expectations which is responsive, dignity which is respected and a form of financing which is impartial, etc.
- The definition of the health systems must be held within its functions which includes services provided which are direct; irrespective of it being medical or public health services

The precise definition of the services within the health system changes from nation to nation, but a fascinating fact is that irrespective of it being medical or public health services, a solid financing machinery or scheme, an adequately trained and financially motivated working force, adequate information based on which sound decisions and policies are built, adequately maintained amenities and logistics that provide and move medicines and state of the art technology are needed to run such a system. The requirements for a properly structured health system may appear a handful but every component listed is essential to forming a solid

financing structure. The logistics are key determinants of the survival and sustainability of the system.

As a system, the healthcare industry is a major banner under which several other sub-systems come under. Based on the United Nations' International Standards Industrial Classification (2008), the components of healthcare are hospital activities, medical and dental practice activities, and "other human health activities". The final class involves activities of, or under the supervision of, nurses, midwives, physiotherapists, scientific or diagnostic laboratories, pathology clinics, residential health facilities, or other allied health professions, Additionally, based on the industrial classifications (i.e. Global Industry Classification Standard and the Industry Classification Benchmark), there is an inclusion of medical equipment, instruments and services as well as biotechnology, diagnostic laboratories and substances, and drug manufacturing and delivery within the categorization of the healthcare.

2.2 Healthcare and History of Health Systems in Ghana

Healthcare in its core definition captures the diagnosis, treatment, and inhibition of sickness, illness, injury, and other physical and mental impairments in humans and is administered by medical persons in various sectors including allied, health, dentistry, midwifery, medicine, nursing, pharmacy, optometry and other health professionals. Accessibility to healthcare changes across nations, individuals and groups and this to a large extent is impacted with the presence of factors such as economic and social conditions and also highly influenced by the policies concerning health within that nation. Different nations have varying policies relative to personal healthcare and healthcare based on the entire population.

Guaranteeing that the citizenry has their health prioritized is the primary responsibility of every government. This is basically because when the citizenry are healthy, it goes a long way

to be beneficial to positively impact economic growth and the development of the nation. Several countries such as Ghana have recognized this and have investigated and are currently running a couple of healthcare systems with supportive policies targeted at ensuring every citizen whether within rural or urban setting gets quality healthcare and most importantly, the healthcare system is sustainable financially. There has been round of changes in the healthcare system within Ghana but the differences in these changes are basically the way in which these have been financed; these include a tax based system, the cash and carry system and the National Health Insurance Scheme (NHIS). The following subsections are considerations of some key characteristics under these different systems practiced in Ghana.

2.2.1 Tax Based System

After Ghana attained independence in 1957, the government in an attempt to achieve universal health coverage changed to a financing system that was tax-based which rendered free usage of all public health facilities. Health services delivered by private facilities within this period was payable by individuals who patronized them. Economic stagnation throughout the early 1970s caused government tax revenue to fall. This consequently affected the government's ability to render a solidly backed health financing system that was based on tax and this affected the health sector negatively. In 1983, the PNDC government had no choice but to adopt an IMF and World Bank sponsored economic recovery programme which led to a rise in the costs of healthcare services in majority of public health institutions- hence, the cash and carry system was introduced.

2.2.2 The Cash and Carry System

Under this system referred to as "Cash and Carry", clients who used hospital facilities and services were to bear absolute cost of drugs and other medical consumables. This was aimed

at recovering at least 15% of the cost of healthcare provision. Therefore consultations costs, salaries and emoluments for doctors, nurses and other healthcare workers in public hospitals were the responsibility of the government. However, it was realized that during the cash and carry system, individuals waited for their sickness to worsen or became near fatal before they sought healthcare. Thus as a result of financial constraints, many people who were sick could not access timely healthcare. In an attempt to increase accessibility to healthcare especially for very deprived individuals and communities, the government found the need to introduce the National Health Insurance Scheme (NHIS).

2.2.3 The National Health Insurance System (NHIS)

The National Health Insurance Scheme (NHIS) was introduced by an Act of Parliament 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; to establish a national health insurance fund that will provide subsidy to licensed district mutual health insurance schemes; to impose a health insurance levy and to provide for purposes connected with these" (National Health Insurance Act, 2003 Act 650).

The implementation of the NHIS was advanced in 2004. Prior to this, the foundations had been laid for this scheme from 1996 to 2000. This included piloting the NHIS in the Dangme West District of the Greater Accra Region and the Nkoranza District in the Brong-Ahafo Region. The National Health Insurance Act, 2003 (Act 650) is the statutory enactment that established the NHIS. Under this system, individuals 18 years and above pay an annual obligatory minimum premium which gives them the right to get almost free medical care at an

accredited healthcare provider. The premium is renewable annually. Additionally, a small administrative fee is charged for registration unto the scheme. However elderly citizens over 70 years and children under 18 years (whose parents are registered members of the scheme, and indigents are exempted from paying premiums but have the right to access healthcare at no fee at accredited providers once they are registered members of the scheme.

For about a decade now, the NHIS has been the system of healthcare financing in Ghana. The National Health Insurance Scheme seeks to replace the 15% of health care financing that is obtained from Internally Generated Funds (IGFs) through the "Cash and Carry" system. Essentially, it does not abolish cost recovery but it replaces direct out-of-pocket payment at the point of service use (MOH, 2004). General tax revenue therefore continues to be a source of funding for health care provision in the country.

The funds used in running the NHIS are a 2.5% health insurance levy (NHIL) added to Value Added Tax)VAT), 2.5% of the 18.5% Social Security and National Trust (SSNIT) contribution made by formal sector employees (the 18.5% contribution is made up of a 13% contribution from employers and 5.5% contribution from employees), member premiums of between 7.20 to 48.00 Ghana Cedis annually (USD5.00 – USD34.00) and money that accrues to the fund from investments made by the National Health Insurance Council. Other sources of funding for the scheme include funds allocated to the scheme by the Government of Ghana via Parliament, the central exemptions fund, formerly used to provide exemptions from user fees for those classed as 'indigent' and donor funds (few details on these donor funds are available)

The business of health insurance in Ghana was entrusted to the NHIA with the mandate to control and implement the scheme. There is no doubt the NHIS has greatly improved and

increased access to healthcare by a majority of Ghanaians. Thus the universal health coverage which has been the cry of nations all the world is been gradually attained in Ghana. However, the scheme has gone and continues to go through several challenges. Some of these challenges have to do with *moral* and *morale* hazards that are most often associated with insurance in general. For instance there have been reported cases of double billing by NHIS accredited service providers, abuse of the system by clients who use their cards to utilize healthcare at different facilities at the same time for the same conditions. There are also those clients who obtain medicine from the scheme only as a precaution or for prophylaxis. Apart from the above challenges, the inability of the NHIS to settle bills submitted by providers timely seems to be the biggest challenge facing the scheme. All these challenges have financial implications on the smooth running of the scheme. In theory, all things being equal, one would expect that in the absence of the above challenges the scheme should run smoothly and attain greater subscription leading to improved accessibility and greater utilization of healthcare. In an attempt to improve the running of the scheme and find solutions to some of the above challenges the Capitation system of payment was introduced.

2.3 The NHIS Capitation

The NHIS Capitation is a health insurance payment system that was introduced in 2012 with the purpose of replacing the ongoing tariff or Ghana Diagnosis Related Groupings (GDRG) system. The Capitation system is currently being piloted in the Ashanti region. By definition Capitation is a fixed amount of money per patient per unit of time paid in advance to the health provider for the delivery of healthcare services as captured by the American Academy of Dermatology, AAD (2000). Within this definition capitation sum is applied to cover the costs that is incurred by the provision of fore-determined set of services irrespective of the

amount that is given out. The rates that are charged within the capitation form of insurance are modelled locally and therefore differ from one jurisdiction to another or one community to another. Within the contract of the capitation insurance, there exists a range of services that is agreed to be provisional to the clients whenever the need arises and the rates for these range of services are dependent on the nature of the services available within the contract. The management of the Capitation payments are left to care organizations in order to control healthcare costs. In order to ensure quality services balanced with payments made by the clients of the health industry, the nature of the control with capitation is handled by administering financial risk for the serviced delivered to the clients solely within the responsibilities of the physician. On the side of the patients, optimal care is delivered within the best usage of the healthcare services are given by the care or watch organizations constantly measuring rates of the use of the materials or resources within the practice of the physician. Based on these activities, there are regular reports that are sent out publicly to ensure the quality of healthcare is achieved.

The idea of Capitation has received much public attention and debate among all stakeholders in the health sector of Ghana. There has been advocacy by the NHIA to the public to enable it use Capitation as an engine for the payment of varying healthcare providers and services. This advocacy is to ensure that there is drastic reduction in the alarming costs borne by the scheme and to warrant the sustainability of financing healthcare through the NHIS.

The concept of Capitation is quite striking, in lay terms, it is a form of healthcare payment to health related service providers of an agreed amount for an individual who has been registered and it is regardless of whether that individual seeks the health service rendered or not; within an agreed period. This form of payment system is used as remuneration by health insurance

institutions for health providers. The payments are issued in accordance with the plans of the Health Maintenance Organization (HMO) (Admin, 2010). The contractual agreement under the capitation form of insurance maintains that the NHIS makes available some agreed payment for each individual registered at its accredited providers, who have a contract with the NHIA, on the scheme. Upon receipt of the monthly payment of the agreed amount by the provider, the client gets to enjoy the utilization of healthcare services which are also agreed on including three (3) visits per month. The rate charged or payment issued is calculated depending on the mean expected healthcare usage of the client. Factors such as medical records, race, age, employment, location and key factors that impact on the cost of the healthcare provision are factored in this calculation.

The main aim of employing the Capitation as an option for remunerating healthcare providers is the reduction of costs which goes to the NHIA. It is argued that when healthcare providers are not given additional payments for the extra working visits, there is the likelihood for them to be conventional in treating their clients. The inclusion of clients with complicated and otherwise expensive medical conditions will be negligible primarily because the health providers know they will be obligated to absorb all extra costs. Additionally a major effect or advantage of this form of contract i.e. the Capitation, is that medical practitioners are more geared towards pre-emptive care for their clients; this is because when clients become ill, it is directly indicative of extra cost for the doctors. Therefore focussing on promotive health activities like exercising, eating well and quitting smoking become a prerogative of healthcare providers. And this is what Capitation should do. It is important to point out that the healthcare providers also derive some advantage this form of payment in view of the reduction of administrative costs associated with filing claims among others.

However, critics of Capitation vehemently make an argument based on its possibility to result in poor quality of healthcare services by providers simply because these providers may worry concerning the recommendation of extra measures or medical care; the worth of the clients' care suffers specifically in the case when there exists some sort of defence. Relatively, there is so much risk with running a capitation scheme, precisely risks associated with financing. Health service providers seem to have constant revenue and every registered client has their claim made against the absolute resources of the health service provider. The personnel in charge or the health care be they physicians or providers are not trained professionally in the handling of things associated with actuarial, underwriting or accounting and therefore lack skills related to managing insurance risks thus rendering them functioning sub-optimally.

There is a lot of discouragement on the side of physicians with the provision of healthcare under a capitation system of payment as opposed to a fee for service system or eve n tariff system. As much as possible the individual health care provider may want to discharge, wilfully quality healthcare but the consideration of gains financially may conflicting with the wellbeing of their clients. On the bright side there is a choice on the part of the health care provider to opt for clients with relatively low risk and to avoid higher risk clients and in the long run restrict accessibility by those clients.

In spite of the fact that the enrolment of the NHIS has shot up, there is however no surety that the implementation of a new payment method is the panacea to any challenges faced. This is basically because the nature of new clients will also need to be assessed. All things being equal, if majority of clients of the scheme fall within the higher risk bracket then there will be a need for larger sustainable funds. Premiums and other current sources of funds may not be sufficient, since most of Ghana's workforce is located within the informal sector. Some

clients still find premium payment to be expensive. The successful implementation of the Capitation system borders on the key issue of financial sustainability of the system. Premiums also remain another hurdle for the scheme with reference to its affordability and modes of payment.

2.4 Financial Management in the Health Sector

The financing services related to healthcare are of grave worry to all governing agencies within the light of increment in the costs of healthcare. For nations that are still developing where living healthy is rendered as a poverty reduction strategy, it becomes essential for the medical facilities armed with the disbursement of health related services to be adequately financed in order to have this task accomplished. In 2008, a study of College of Healthcare Executives in American listed financial difficulties as the number one worry in managing the subject under study. The difficulties commence with repayment from chief payers. Healthcare costs do not only rise for patients, but for hospitals also, since costs associated with medications and supply items are continually push ascendant.

Financial management remains a key portion of every activity whether economic or uneconomic; this in turn guides on the decision of prudent procurement and utilization of finance in a way that profits. Khan and Jain (1991) define finance as the art and the science of management of money. According to the Oxford dictionary, the word ‘finance indicates ‘management of money’. This definition above brings to light the need for the term Financial Management. However for the sake of emphasis, the term has been used to stress its importance.

In the view of Paramasivan and Subramanian (2010), there are two major parts of finance:

private finance and public finance. To them, Private Finance concerns the financing decisions of individuals, firms and businesses or Corporate entities aimed at meeting objectives. Public Finance on the other hand deals with the disbursement and revenue of governmental agencies such as central government, state government and Semi-Government Financial matters. This implies that the health system in Ghana is made up both private and public healthcare institutions and this affects the financing management system adopted.

In well-established organizations, Financial management decisions are taken by financial managers. However, in most developing countries like Ghana, the function of financial management has to a large extent been left to accountants.

2.5 Funding the National Health Insurance Scheme (NHIS)

As already stated, the sources of funds for the NHIS are the NHIL, 2.5% of SSNIT contributions, premiums, Money that accrues to the fund from investments made by the NHIC, funds allocated to the scheme by the Government of Ghana via Parliament and donations among others.

Premium payments represent the primary, but not largest, source of fund for the NHIS. The NHIA has set the DWMHI annual premium levels at a minimum of 7.20 Ghana Cedis and a maximum of 48.00 Ghana Cedis (approximately $5-$34 in 2009) per adult member, to be determined by income status. The NHIA website states that this can be paid as a lump sum, or in 12 monthly instalments (www.nhis.gov.gh). In practice, varying flat premiums are paid by districts across the country, with rich districts paying higher than poor districts. Based on the level of one's income, specific obligatory premiums are paid This was done so that premium payments remain affordable to all and that no individual is obliged to continue "cash and

carry. This also implies that premium collections may change from place to place depending on prevailing economic conditions or income levels. The current groupings of premium charges do not take into consideration the disease burden of specific localities. To facilitate the contribution of every citizen to the scheme, the NHIL was made a law so that the funds generated would be contributed to the NHI Fund in order to provide additional funds to the (DMHIS) District Mutual Health Insurance Schemes.

2.6 Sources of Funds to Health Institutions

Sources of funds refer to ways by which healthcare institutions obtain funds. Healthcare institutions in their social services obtain funds from two or three main sources depending on whether it is a private or public institution. These sources include the Government of Ghana (GoG), Internally Generated Funds (IGF) and Donor Pool Funds (DPF).

2.6.1 Funds from Government of Ghana

Funds from GoG usually known as government subvention are funds allotted to state institutions that have been mandated by the state to perform certain public services whether regulatory or direct service delivery. In the healthcare sector, funds from GoG may come in the form of salaries or emoluments to the staff of health institutions, provision of improved health infrastructure in the country and special public health awareness services like immunisation. The amount and timing of funds from GoG depend on the financial strength of the economy as measured by the GDP. Over the past three years, government in compliance to the WHO resolution aimed at achieving universal health coverage has dedicated 15% of total GDP to finance the health sector. The 15% of GDP commitment to the health sector alone, although commendable has not yielded the expected results as the GDP has been generally low. This means that it will only amount to little even if government should

dedicate about 25% of GDP to the health sector.

2.6.2 Donor Pool Funds

The second source of funds to healthcare institutions or organizations has been funds from donors also known as Donor Pool Funds (DPF). These funds are non-obligatory sources of funds given voluntarily by charitable institutions and or individuals. Therefore the danger of this source of funding is that donors may withdraw at will without recourse to the institution they support. It can fairly be inferred from the review of the above two sources of funds to the health sector that overdependence or reliance on GOG and DPF sources of funds has the high tendency of robbing the healthcare institutions of the power to decide their own course and excel in their mandate of providing prompt and efficient quality and efficient healthcare services to the public.

2.6.3 Internally Generated Funds

In view of the Auditor General Dept. (2011), an Internally Generated Fund (IGF) is non-taxable revenue that is generated through the activities of public institutions as an added basis of funding. This is aimed at alleviating financial challenges that confront the public sector with the delivery of quality health care by the introduction of IGF into public institutions in 1895. Various stakeholders in the public sector have recognized the need for internally generated funds in public institutions. It was in this vein that the government through an Act of Parliament permitted public institutions to generate their own funds out of services they render to the public.

For example in March 18, 2014, a conference tagged as ‘Consultative Conference’ was organized in Kumasi on IGF with the caption ‘Maximizing Internally Generated Revenue

Potentials for Improved Local Service Delivery'. There were more than five hundred stakeholders from metropolitan-municipal and district assemblies (MMDAs), public sector institutions and other key participants. The aim of the conference was to elicit opinions from participants with the effect of enabling the Ministries of Local Government and Rural Development and Finance advance an all-inclusive tactical outline in the guidance of IGFs employment exertions. Decentralization is all about delegated power and authority.

In December 2013, the Technical Committee of Controller and Accountant General's Department (CAGD) organized a 3-day-workshop, with the aim of developing structures to position Internally Generated Fund (IGF) onto the Ghana Integrated Financial Management Information System (GIFMIS). This programme was also to deliberate how the government allocation may be bridged up with the GIFMIS system.

The GIFMIS project is making use of a centralised incorporated Information Communication Technology supported financial system that is connecting the Ministries, Departments and Agencies (MDAs) as well as Metropolitan, Municipal and District Assemblies to the CAGD in ensuring an efficient and transparent factor is webbed into the expense of public funds. The Minister for Finance, Mr Seth Tekper, indicated that IGF are also government revenue and it was imperative that it should be accounted for properly by the CAGD and the Director of Budget- thus the need to deploy it on the GIFMIS system.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

The importance of a Health System on the efficiency or utilization of healthcare delivery and their financial sustainability cannot be overemphasised. The chapter provides the methods and techniques used in examining and presenting both descriptive and quantitative analysis of the financial management and sustainability of the Capitation system of payment under the NHIS. Methods of data collection are also elaborated. The chapter specifically describes the research design, research population, sample size and sampling techniques, data collection tools and the various sources of data. Furthermore, the chapter discusses the techniques and the models used in analyzing the data obtained.

3.1 Study Area

The study area encompasses the entire health sector in Ghana with special emphasis on the financial management and sustainability of the Capitation system of payment in the NHIS. The Ashanti Region is the only region piloting the Capitation system; hence, the study focuses on the Ashanti Region. The Capitation system is being piloted as an alternative to the current GDRG or tariff system and is regulated by the NHIA. As a statutory organization, the (NHIA) was established under the National Health Insurance Act 2003, (ACT 650) as a corporate frame. The NHIA is the sole authority responsible for the administration of the NHIS. As a body corporate, the authority in the performance of its function may acquire and hold movable and immovable property and may enter into a contract or any other transaction. In October 2012, the ACT 650 was replaced by a new law: Act 852 for the purpose of consolidating the NHIS, removing administrative bottlenecks, introducing transparency,

reducing opportunities for corruption and gaming of the system and to provide mechanisms for more effective governance of the schemes.

3.2. Profile of the Study Area

Ashanti is one of ten political administrative regions in Ghana. It lies between longitudes 0.15W and 2.25W, and latitudes 5.50N and 7.46N and is thus located in the middle belt of Ghana. The region shares boundaries with four other regions; Brong-Ahafo region in the north, Eastern region in the east, Central region in the south and Western region in the south west.

3.2.1 Demographic Data

Ashanti is the most populated region in Ghana with a population of 4,415,554 for 2006 (Ghana Statistical Service, 2000). Kumasi has the highest population of 1,430,241 (32.4%) of the regional total. About 47% of the population is in the rural areas. The region has a large proportion of hard to reach areas especially in the Afram Plains sections of Sekyere East, Ejura Sekyedumase, Sekyere West and Asante Akim North districts. Three new districts namely Adansi North, Atwima Mponua and Amansie Central were created in 2005. This has raised the number of districts to twenty-one (21) districts with one hundred and fourteen (114) sub-districts.

The population of the region is concentrated in a few districts. Slightly over half, 51.5 per cent, of the entire population of the region is in four (4) districts. While more than half of the population in the region resides in urban areas, in fifteen (15) of the twenty-two (22) districts, the rest of the population live in rural areas. The high level of urbanisation in the region is due mainly to the high concentration of the population in the Kumasi metropolis. Males outnumber females in eleven (11) districts. The age structure of the population in the districts

is skewed towards the youth. The dependent population in the districts is high, ranging from 42.2 per cent in the Kumasi metropolis to 57.3 per cent in the Ahafo Ano South District.

3.2.2 Socio-Economic Activities

The proportion of the economically active population varies from 71.4 percent in the Kumasi metropolis to 85.2 percent in the Amansie West District. Only five (5) districts have proportions lower than 80.0 percent. The major occupation in all the districts is Agriculture/Animal Husbandry/Forestry, except in the Kumasi metropolis, where commerce dominates. The proportion of females in all sectors of employment is higher than that of males. Residents in the rural areas are mostly in Agriculture whereas those in urban areas are mainly in commerce which includes wholesale and Retail trade, manufacturing and community, social and personal services. Majority of the economically active population are self-employed, mainly in the private informal sector, which provides job opportunities, particularly for females with little or no formal education.

3.2.3 Health Facilities

There are five hundred and thirty (530) health facilities in the region. Of these, one hundred and seventy (170) are owned by government, seventy-one (71) by missions; Christian Health Association of Ghana (CHAG), two hundred and eighty-one (281) by private individuals and organizations and the last eight (8) are classified as quasi government. The Ghana Health Service (GHS) operates about 32% of all health facilities in the region. Kumasi has the highest number of facilities of two hundred and one (GHS, 2012). These facilities include hospitals, clinics, maternity homes and laboratories.

3.3 Types and Sources of Data

Types of data used in the analysis include both primary and secondary data from the various stakeholders within the health sector. Primary data in the form of first hand information or opinions of respondents comprising health providers, health professionals and the public consisting of out-patients and in-patients were gathered. This primary data was gathered using questionnaires and one-on-one personal interviews and personal observations. Secondary data was also gathered in the form of already published information from the NHIA including their website. This secondary data consists mainly of guidelines for the establishment of the Capitation system and Policy information on the Capitation system.

3.4 Sample Techniques and Sample Size

A sample is a representative part or a single item from a larger whole or group especially when presented for inspection or shown as evidence of quality (Merriam-Webster Dictionary, 2015). Sampling is that part of statistical exercise that concerns with the choice of an unbiased or arbitrary subset of individual observations within a population of individuals intended to yield some knowledge about the population of concern, especially for the purposes of making predictions based on the sample frame. Within this context a sample survey was carried out to back up the secondary sources of data. Three different but interrelated sample surveys were carried out. These sample surveys were carried out on three categories of sample population consisting of patients (i.e. both in and out patients), health providers and health professionals. A total of 166 respondents were contacted during the study with 152 people responding between the period October and December, 2014. Random sampling techniques were used in the analysis from the 152 respondents.

3.5 Method of Data Analysis

Data analysis involves the use of both quantitative and qualitative methods. According to Williams (2007), quantitative research method is the type of method involving a numeric or statistical approach to research design. This form of research preserves the assumption of an empiricist pattern. It seeks explanations and predictions that will generate to others. The intent of conducting a quantitative study lies in the establishment, confirmation or validation of relationships in order to create generalizations that back practice and theory. Additionally, conducting a qualitative study is an all-inclusive approach that may involve discovery Williams (2007). It happens in a usual location and observations that requires the investigator to recruit a level of depth that emanates from higher participation in real-time experiments. In qualitative approach, societal phenomena are researched from participants view point. It is mostly common approach in social science researches. The data collected in the form of field notes through observation, questionnaire and interviews were transcribed into narrative and descriptive forms.

Quantitatively, the data are analyzed using tables, graphs and charts. Statistical tools such as SPSS and MS Excel are used for the analysis. This will make for easy understanding of the presentation of the findings of the study. Qualitatively, discussions will be done on both the figures presented by the quantitative analysis and on primary data gathered.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OFFINDINGS

4.0 Introduction

The efficiency of the NHIS largely depends on its financial sustainability. Since the introduction of the National Health Insurance Scheme (NHIS) in 2003, Capitation was suggested as implementation alternative in order to make the scheme financially self-sustaining in view of the high cost involved in running the NHIS resulting from asymmetry of information and its resultant moral hazards. The purpose of this research was to critically examine the financial sustainability of NHIS Capitation as an alternative to addressing the challenges faced by the NHIS. This chapter seeks to provide detailed analysis of the data gathered. Data relating to the public perception of the Capitation, level of understanding and financial demand of the Capitation gathered. Effectiveness of Capitation as a solution to the challenges faced by the NHIS is greatly dependent on the level of awareness, acceptance and co-operation it receives from the populace especially those who are benefit directly from the scheme.

4.1 Data Presentation and Analysis

4.1.1 Background Characteristics of the Respondents

There are two categories of respondents from whom data was gathered: the general patients and health providers. For the purpose of providing clear perspective under which the research was undertaken, demography characteristics of the population have been briefly analyzed. This demographic analysis takes into consideration the age, level of education, literacy level, marital status and occupation of the population. Gender analysis of the respondents indicates that 41% of the respondents are male while 59% female. This implies that females visit the

healthcare providers more frequently. The reason may be liken to the fact that apart from all the health related problems that everyone suffers from, females have to access the hospital because of pregnancy. Again it is important to note that majority of the respondents (86%) are between the ages of 18 and 45 with most of them (i.e. 40%) in the ages of 26 to 35 followed by those between 36 and 45 years (34%). Respondents with age group between 46 and 55 years occupy a lower percentage of 8. Analysis of marital status indicates that 52% of respondents are married while 39% are single. Further analysis shows that 6% of them are separated while 3% of them are either divorced or widowed.

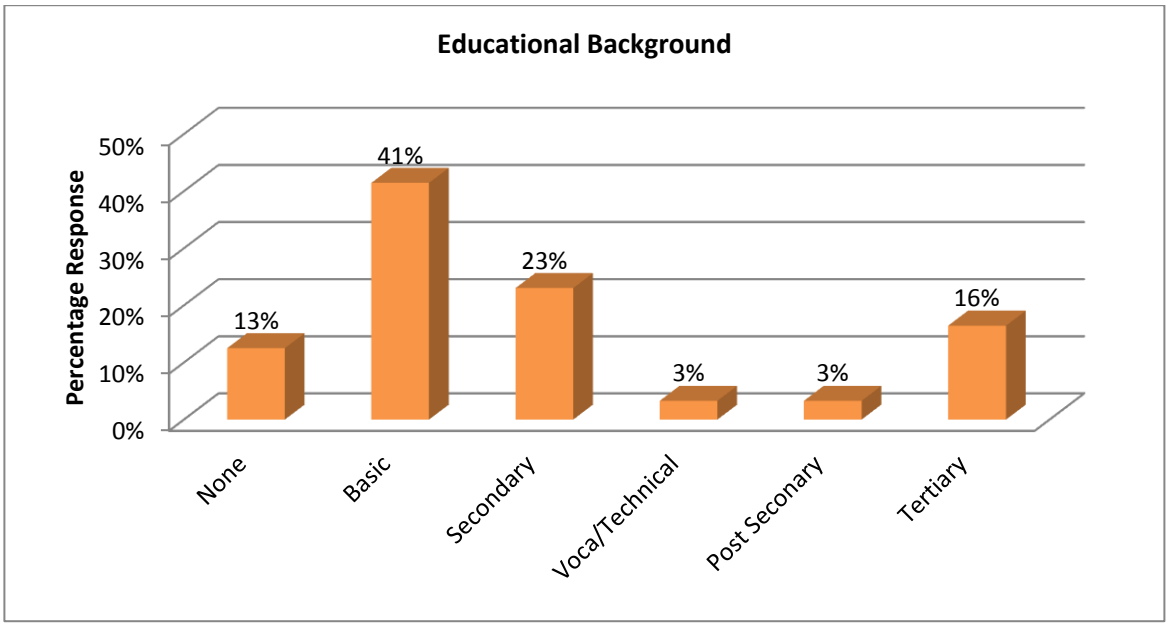

Figure 4.1: Educational Background of Respondents

Source: Researcher's Own Construct, 2015

Analysis of their educational level shows that 12% of respondents have never been to school while 88% have undergone various level of education at various levels from Basic all the way to the Tertiary level. This means that majority of the respondents have had some form of formal education.

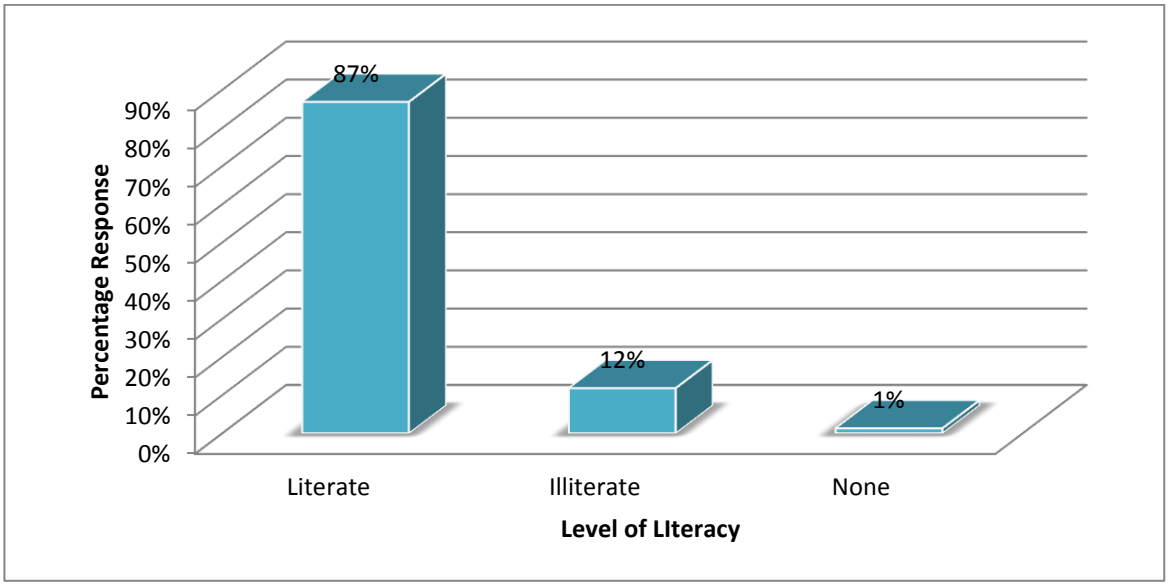

Figure 4.2: Literacy of Respondents

Source: Researcher's Own Construct, 2015

Figure 4.2 shows the distribution on the level of literacy of the respondents sampled for the research. The figure indicates 87% of the respondents are literate while 12% are illiterate which are consistent with the foregoing distribution of respondents on their level of education of which majority of the same percentage were formally educated. Analysis of their occupation shows that, 14% are unemployed while 24% of them are still in school. The remaining proportion of 62% are employed in the various vocations ranging from farming/fishing (1%), civil servant (11%), entrepreneurs/traders (44%), Artisan (6%). This represents not only one section of the general section of working classes given that government workers, the private sector, students and the unemployed are all represented in the sample.

Based on the information collected on the background of the respondents, this sample represents a good representation with a dominant female representation in the sample as several studies including Ii (1996), Ellis and Mwabu (1991) and Mwabu et. al (1994) have

shown that females were slightly more likely to use health services than males. Majority of the respondents were formally educated and also literate and the sample had representation of students, unemployed individuals, government workers and individuals involved in their own business. The respondents therefore represent a good mix to provide responses on the understanding and sustainability of the Capitation Scheme.

4.2 Patients Understanding of the Capitation System

The study indicates that a significant number of the respondents (96%) have heard of the Capitation. Sadly, only 3% of these respondents understand how the Capitation system works. This finding confirms earlier findings of Agyei-Baffour et al (2013). Their findings indicate that a majority representing 97.9% of the clients sample were well aware of Capitation. The lack of understanding from those who are to benefit from the scheme is likely to endanger the level of acceptance and support they give to the scheme. According to Agyei-Baffour et al (2013), although awareness of the Capitation was high among clients, attitudes towards the Capitation payment system were somewhat poor. This is shown by the huge number of insurance cardholders who either forget or do not know when to renew their cards. Agyei-Baffour et al (2013) further support the view that a good understanding of the Capitation payment system is crucial to ensuring client and provider acceptance and smooth implementation of the system. The most cited source of information is the mass media: highlighting the usefulness of media in providing information on healthcare to clients. As shown by this study, the attractiveness of the scheme is somewhat a determinant of appear as the most cited reasons why other clients do not renew their insurance policy.

Clients' attitude towards the payment system which is a measure of the level of importance clients attach to the Capitation system is found to be low. Low per capita rates, restriction of

clients to one facility (PPP), low service provision are some of the reason provided by clients for the poor attitude toward the scheme. Negative perceptions about Capitation payment system among clients as reported in this study are reiterated by evidence from interview with the providers who also believe that some clients do not like the Capitation payment system and believe this is due to their misconception that it has been politicized, people not given primary providers of their choice and Capitation having limited benefit package. These assertions are however not consistent with the policies stipulated by the NHIA which indicate that subscribers of the NHIS, after registering with the scheme voluntarily choose their service provider(s) with added flexibility of changing the provider periodically. Under this payment system, incentives are created for managers to control expenses while achieving their set targets. Key motivations for the adoption of Capitation system include: creating incentives for providers to improve efficiency through more rational use of financial resources, increasing healthcare promotion and disease prevention mechanism, and rendering of higher-quality services with the resources available. Restricting clients to a single primary provider ensures reduction in the abuse of services and increases equity in health utilization. Any mistake arising from incompetency on the part of a healthcare provider could have a continuous debilitating influence on the client as long as the client remains with that provider. However, it is worthwhile to stress that clients have the liberty to switch healthcare providers at reasonable times if they are continuously not satisfied with the health services they received from a particular provider.

In addition to the above, the study shows that some healthcare providers affirm the fact that Capitation simplifies claim processing and improves primary healthcare (PHC) delivery and quality of care and promoted the growth and development of various hospitals. According to health providers, Capitation has reduced workload by at least 50%. Since payment is

determined prospectively without recourse to the number of services provided, physicians who stint on healthcare are overpaid and those who provided many complex services may be consequently underpaid. This is because providers of services incur extra costs and hence lower net income, for treating patients with more severe underlying diseases and greater need for time and services.

The NHIA receives its inspiration from the school of thought that says Capitation system improves cost containment, shares financial risk among scheme, providers and subscribers, and introduces managed competition for providers and choice for patients. Creating or strengthening PHC institutions to operate autonomously and provide comprehensive, integrated, first-contact care for individuals and the wider community is however a primary goal of the Capitation payment system and thus needs to maintained. The study further reveals two dissenting views held by clients and health providers. Whereas a majority of clients realign themselves with the negative view point of the Capitation system, most health providers view the Capitation positively in terms of its role in garnering resources for service provision and improving quality healthcare.

4.3 NHIS Capitation and Finance

The financing of healthcare services has been of a major concern to all governments in the face of increasing healthcare costs. In developing countries, where good health is considered as a poverty reduction strategy, it is necessary that the hospitals used in the delivery of healthcare services are well-financed to accomplish their tasks. In 2008, a poll of College of Healthcare Executives in American listed financial challenges as the number-one management concern in the health sector. The challenges start with reimbursement from major payers. Healthcare costs do not only rise for patients, but also for hospitals, since costs

associated with medications and supply items are continually pushed upward usually due to inflation. There are also the rising costs for retaining trained and expert professionals.

Financial management is an essential part of the economic and non-economic activities in a country which helps to decide the efficient procurement and utilization of finance in a profitable manner according to Kansal (2014). In order to ensure effectiveness of this study, it is important to consider the definition of business finance which "as an activity concerned with planning, raising, controlling, and administering of the funds used in the business" (Kansal, 2014). The spirit behind the introduction of NHIS Capitation is to help radically reduce the financial challenges faced by the NHIS. The effectiveness of Capitation with regard to healthcare financing and its operation demonstrates a strong relationship between healthcare financing and cost control. This is because the demand for healthcare is a derived demand, depending on the demand for health – on the prescription of the health provider who himself is insulated from the cost of the healthcare. Due to asymmetry of information, the patients usually accept whatever the provider prescribes as final. However, Capitation places the entire health of the patients in the hand of the health provider.

Capitation is different from the ordinary NHIS both in terms of healthcare utilization and the payment system. Under Capitation, all healthcare seekers are assigned a specific healthcare provider of their choice in the region in which they reside. Healthcare providers are paid in advance, a predetermined fixed amount to provide services for a given period. The amount is paid irrespective of client's access to healthcare within the payment period. According to NHIA, the Capitation payment system is to reduce abuse in the payment system under the NHIS by service providers leading to false payment claims amounting to millions of Ghana Cedis. According to Agyei Baffour et al (2013), about 40% of the healthcare providers

indicate that Capitation was not important to them. However a majority of health providers deem Capitation as an important health financing strategy. The amount paid to healthcare providers is based on the average expected healthcare utilization of the patient under the scheme. As at January 2014, the NHIA paid GHC 2.70 per month on each member of the scheme regardless of whether they visit the hospital. Currently, the National Health Insurance Authority (NHIA) is to increase the insured amount per head by the Health Insurance Service Providers Association of Ghana (HISPAG).

The introduction of Capitation is expected to compel healthcare providers to focus on the holistic health need of their patients. This means that doctors will be more concern about health status of their patients because falling sick will cause healthcare providers more to treat. Hence they will encourage patients to get healthier by losing weight, exercising frequently, eating well etc. Capitation also benefits service providers in terms of reducing administrative cost associated with the processing of files for claims.

A Capitation system in place gives the funding parties absolute control over the level of basic healthcare expenses, and apportionment of funds within health facilities are primarily decided by the registration of clients. Healthcare providers can enroll several clients and not offer them the appropriate service, make a selection of low risk clients and make references on clients who may be treated by the General Practitioner directly. Autonomy of client preference over medical officers, attached with the attitude of "money following the patient" can restrain some of these risks. Aside selecting, some of these challenges are likely to be less patented with salary-type provisions. GPs are working based on salaries; salary provisions make it possible for funding parties to take absolute control of basic care costs rightly. In spite

of this, there may be a leading to under-provision of services, excessive referrals to inferior providers and lack of consideration to the predilections of client.

4.4. Capitation and Healthcare Utilization

If Capitation is properly understood by the service provider and the patient or potential healthcare seeker, it could lead to either an increase or decrease in utilization. It is important to emphasize that healthcare utilization is simply the measure of population's use of healthcare services available to it. This implies the use hospital resources. Healthcare utilization is measured by the number of times patients visit the hospital to receive health care attention. Healthcare utilization and health status are used to examine how efficiently a health system produces health in a population. Healthcare providers incur more cost any time patients visit the hospital. Under Capitation, no additional fee is charged for the increase in the number of times a patient's visits the hospital. Healthcare providers are paid a fixed amount on each patient that they register. In view of this, healthcare providers are expected to provide preventive health services or counselling for their insured patients in order to reduce the number of visits to the hospital.

Patients' utilization of hospitals was analyzed and presented in figure (3). From the figure, it can be seen that majority of healthcare seekers utilize private clinics and mission hospitals more than other service providers. This majority group represents a proportion of 43%.

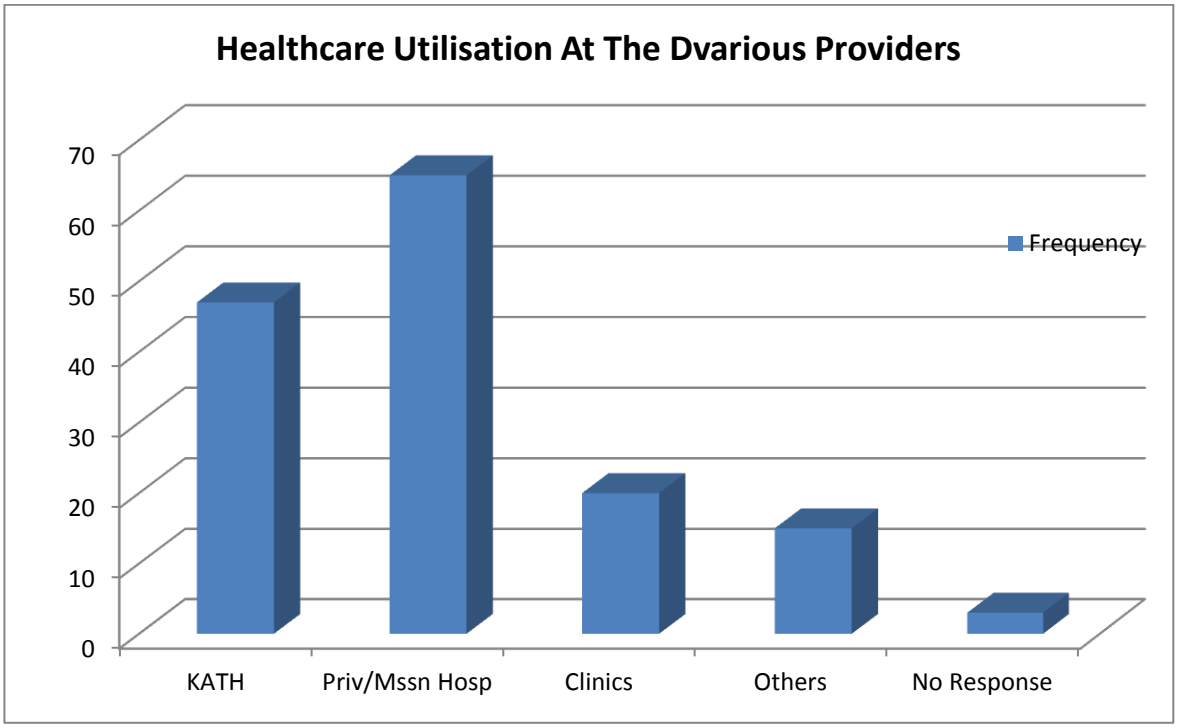

Figure 4.3: Patients Utilization of Healthcare Services

Source: Researcher's Own Construct, 2015

4.5 Healthcare Services Received

Health services are the most visible function of any health system both to users and the general public. In most developing economies like Ghana, most people go to hospital only when they are sick. Healthcare services received during these times of visit to the hospitals include consultation and laboratory test. Consultation involves the diagnostic and treatment of diseases, illness, injury and other physical and mental impairment. The study analysis shows that 81% of visitors at the hospital do so in order to receive consultancy services while 13% go for lab test as may be requested of them. This is further made clear by the figure below.

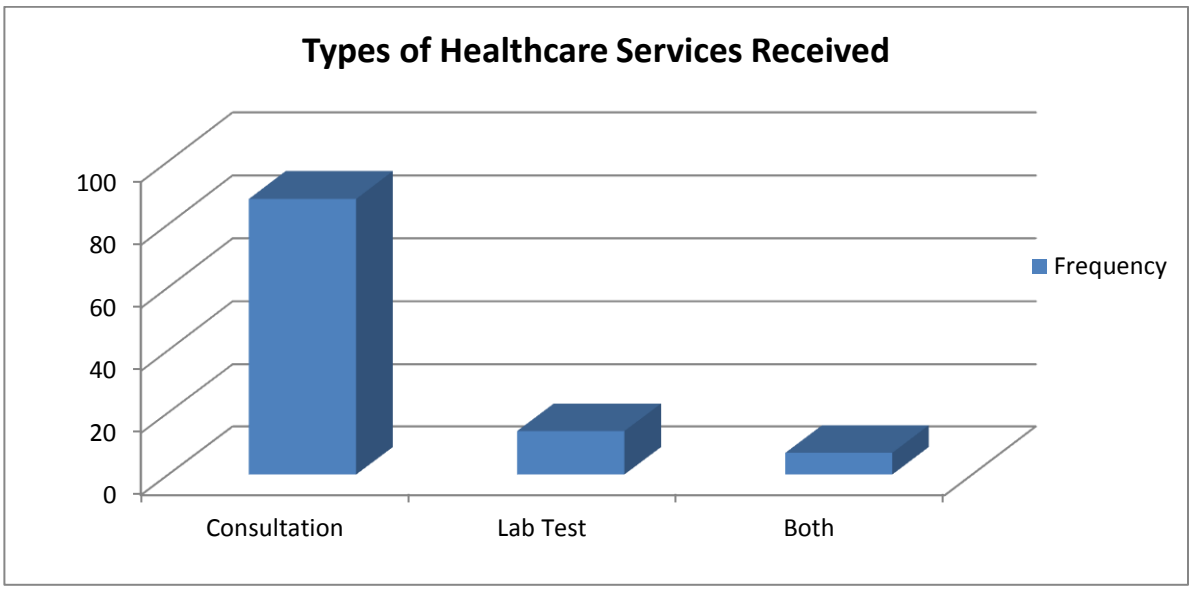

Figure 4.4: Healthcare Services Receive at Hospitals;

Source: Researcher's Own Construct, 2015

4.6. Level of Satisfaction Received On Visit to the Hospital under the Capitation

The quality of healthcare reforms can be estimated that is patient satisfaction with the quality and type of healthcare services received and people's satisfaction with the healthcare system more generally. Quite often consumer satisfaction has focused exclusively on patients' experience – thus an aspect of the healthcare experience such as waiting times, quality of basic amenities, and communication with healthcare providers. These factors help identify tangible priorities for quality improvement. This does not really capture patients' responsiveness to the health system itself. Research on health system satisfaction has focused on ways to improve health, reduce cost, and implement reform. It has been acknowledged that patients who are satisfied with the system itself are likely to complete treatment regimens and be more compliant and cooperative. There has been an increasing importance of patients experience and sustained interest in comparing people's satisfaction with health systems across different countries. Analysis of the patients experience at the hospital shows that

overall, 75 % are satisfied with the healthcare they receive at the hospital though, 36% of these satisfied patients are satisfied but with exception. A relatively smaller proportion of 25% said they are not satisfied with the healthcare they received.

Figure 4.5: Satisfaction Received by Patients on Visit to the Hospital

Source: Researcher's Own Construct, 2015

The figure above shows that majority (75%) of patients who visit the hospital were satisfied at the health services they received at the hospital. This however is not in consonance with respondents' general perception about the satisfaction of the system itself. This means that though respondents are not satisfied with the Capitation health system itself, they are satisfied with the healthcare services they receive at the hospital. Agyei-Baffouret al (2013) confirm the above findings. The table below is an extract from the findings of Agyei-Baffour et al (2013). The table shows the responses of at least 800 respondents under the Capitation

regarding Staff Availability, Staff Reception, Service Availability, Overcrowding, Benefit Package, Cost of care, Prompt access to care.

Table 1: Perception of Quality of Service under the Capitation Payment System

Quality variable	Greatly improved	Improved	Just okay	Worsen	Worst
Staff availability (n = 804)	4 (0.5)	54 (6.7)	686 (85.4)	50 (6.2)	8 (1)
Staff reception (802)	18 (2.2)	210 (26.2)	472 (58.9)	88 (11.0	14 (1.8)
Service availability (n = 801)	10 (1.3)	42 (5.2)	674 (84.0)	58 (7.2)	18 (2.2)
Overcrowding (n = 802)	38 (4.7)	202 (25.2)	250 (31.2)	264 (32.9)	48 (6.0)
Benefit package (n = 800)	2 (0.3)	30 (3.8)	664 (83.0)	90 (11.3)	14 (1.8)
Cost of care (n = 800)	14 (1.8)	62 (7.8)	572 (71.5)	136 (17.0	16 (2.0)
Prompt access to care (n = 802)	8 (1.0)	100 (12.5)	364 (70.3)	110 (13.7)	20 (2.4)

Source: Agyei-Baffour *et al, 2013*

The above is represented by the bar chart below. From the above table and the bar chart below, 48.5% of respondents indicate that staff attitude toward patients has improved. A similar proportion of 48.5% also maintain the view that staff attitude toward patients remains unchanged under the Capitation while a meagre proportion of 2.9% opine that staff attitude toward patients is worse. Careful observation of the table and the chart indicates that 57.4% and 50.7% say both service quality and waiting respectively is improved under the Capitation while a smaller proportion of 37.4% and 36% maintain that service quality and waiting time shows no improvement. Further observation of the table and chart shows that while 56.2% agree that cost of care has improved greatly.43.8% disagree as they suggest that, cost of care

shows no improvement or has worsened. On the whole however, one can confidently say that Capitation system has improved staff attitude toward patients, service quality, waiting time and above all cost of care.

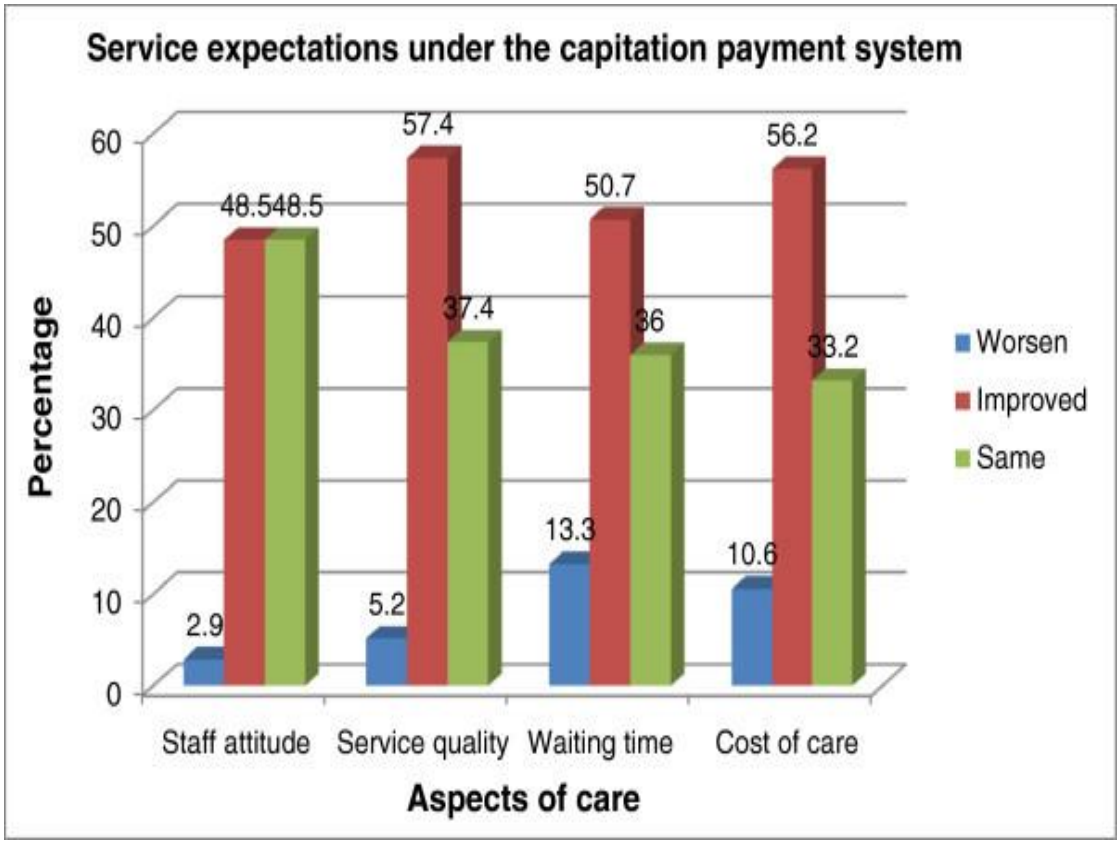

Figure 4.6: Distribution of Aspects of Healthcare

Source: Agyei-Baffour Et Al (2013).

4.7. Challenges Facing the Capitation in the Ashanti Region

Although, Capitation has been considered as an alternative to NHIS with reference to healthcare financing in Ghana given its primary nature, it is not without challenges. Approximately 85% of the respondents admit that the Capitation is not without challenges while 9% indicate otherwise and 6% are indifferent. Most of the challenges faced by the Capitation are not related to the efficiency of the Capitation system itself but the implementation and acceptance of the Capitation by the stakeholders. Due to the challenges

faced by the Capitation, 92% of the respondents claim that the Capitation is not able to achieve its intended purpose which is perceived by respondents to be universal health coverage.

The challenges faced by the Capitation system in the Ashanti Region stem from the people's lack of comprehension of the system. This is because much education has not been carried out on the Capitation system. Much of what is known about Capitation system only come from the public debate that have gone on regarding the introduction of the Capitation which inadvertently has left many to be rather confused about the system. For example, most patients go to the hospital only to be told that their cards have expired simply because they are not aware that they have to renew their cards bi-annually. The result is that patients are denied access to healthcare or forced to pay for health services out-of-pocket. The Capitation system appears more financially burdensome to insurance holders. This is because each renewal comes with a fee and sometimes renewal fees accumulate and hence may be very daunting to patients. Furthermore, respondents find the idea of being assigned to a particular healthcare provider very restrictive. This they claim prevents them from accessing healthcare from other healthcare providers in case their assigned healthcare providers are not providing satisfactory health service until after some period.

Despite the above claim by respondents, 52% say there is a high prospect for the success of NHIS Capitation in Ghana. This implies that if the Capitation system is accepted by stakeholders and is allowed to function the way it should, it will ultimately lead to efficiency in health delivery and ensure universal health coverage and financial sustainability of the health system in general. This is again affirmed by the 60% of respondents who say they actually prefer the NHIS Capitation to the NHIS.

CHAPTER FIVE

SUMMARY OF FINDNGS, CONCLUSION AND RECOMMENDATION

5.0 Introduction

The effectiveness of Capitation as an alternative to the GDRG has long been debated by the various stakeholders of the Ghanaian health sector. This study is aimed at examining the financial sustainability of the Capitation System. This chapter presents summary of findings, conclusion and recommendation.

5.1. Summary of Findings

The effectiveness of Capitation as a solution to the challenges faced by the current payment system greatly depends not only on the efficiency of healthcare delivery but also its financial sustainability. Financial management is an essential part of the economic and non-economic activities in a country which helps to decide the efficient procurement and utilization of finance in a profitable manner. The spirit behind the introduction of NHIS Capitation is to help radically reduce the financial challenges faced by the NHIS. The effectiveness of Capitation with regard to healthcare financing and its operation demonstrates a strong relationship between healthcare financing and cost control. This is because the demand for healthcare is a derived demand, depending on the demand for health –on the prescription of the health provider who himself is insulated from the cost of the healthcare. Due to asymmetry of information, the patients usually accept whatever the provider prescribes as the best choice. However, under the Capitation system, the provider and patient become partners in improving the health of patients since any additional cost becomes the cost of the health provider.

All insured are assigned a specific healthcare provider of their choice in the region in which they reside. Healthcare providers are paid in advance, a predetermined fixed amount to provide services for a given period. The amount is paid irrespective of client's access to healthcare within the payment period. According to NHIA, this payment system is to reduce abuse in the payment system under the NHIS by service providers leading to false payment claims that amounted to millions of Ghana Cedis. A majority of health providers deem Capitation as an important health financing strategy. The amount paid to healthcare providers is based on the average expected healthcare utilization of the patient under the scheme. The introduction of Capitation is expected to compel healthcare providers to focus on the holistic health need of their patients. Doctors are more concerned about health status of their patients because falling sick will cause healthcare providers more to treat thereby encouraging patients to get healthier by losing weight, exercising frequently, eating well etc. Capitation also benefit service providers in terms of reducing administrative cost associated with processing files for claims.

Capitation system allows funders to control the overall level of primary health expenditures, and the allocation of funds among hospitals based on patient registrations. Healthcare providers may register too many patients and under-serve them, select the better risks and refer on patients who could have been treated by the GP directly. However, freedom of client choice of doctors, coupled with the principle of "money following the patient" moderates some of these risks. Aside selecting, these problems are likely to be less marked than under salary-type arrangements.

Health insurance reforms resulting in the introduction of the Capitation have faced various misconceptions and misinformation which tend to hinder the efficient implementation and

running of the scheme. Although 96% of respondent indicated that they have heard of the Capitation, only 3% understand how the Capitation works. Healthcare utilization is grossly measured by the number of times patients visit the hospital to receive healthcare services. Healthcare utilization and health status are used to examine how efficiently a health system produces health in a population. In Ghana, one must first be recognized as insured before he or she can have access to healthcare under the NHIS and the Capitation. The study shows that only 73% of the respondents are insured. Statically, 71% of the respondents indicated that the level of visit to the hospitals has reduced. It is easy to assume that if the number of visit to hospitals has reduced, then it means the health status of patients has improved which is a good measure of the efficiency of a healthcare system. However, 62% of insured patients indicate that they have difficulty accessing the scheme. Healthcare services received during these times of visit to the hospitals include consultation and laboratory test. The analysis shows that 81% of visitors at the hospital do so in order to receive consultancy services while 13% go for lab test as may be requested of them.

Although, Capitation has been appraised as the best alternative to healthcare financing in Ghana, it is not without challenges. Approximately 85% of the respondents admit that the Capitation is not without challenges while 9% indicate otherwise and 6% are indifferent. Due to the challenges faced by the Capitation, 92% of the respondents claim that the Capitation is not able to achieve its intended purpose attaining universal health coverage. Despite the above claim by respondents, 52% say there is a high prospect for the success of NHIS Capitation in Ghana. This is again affirmed by the 60% of respondents who say they actually prefer the NHIS Capitation to the GDRG. A total of 75% of the patients are satisfied with the health services they receive under the Capitation which confirms findings of Agyei-Baffour et al (2013).

5.2. Conclusion

The ability of the Capitation system to achieve effective healthcare delivery depends greatly on its financial sustainability. The study shows the Capitation system is financially sustainable due to its inherent control mechanisms that eliminate fraud in provider claims under the NHIS. The study also shows that Capitation promotes market efficiency in the health system in Ghana since providers are able to acquire more clients depending on the quality of health service they provide. The study further shows that lack of proper and adequate education on the Capitation leads to misconception and confusion about the scheme; this has made it difficult for the system to have its desired health impact.

5.3 Recommendations

National Health Insurance Scheme (NHIS) Capitation, if it is to be implemented the way it should with all the cooperation from stakeholders especially clients, it is believed that it will achieve better efficiency in healthcare delivery than it witnesses presently. In helping to attain the above following are recommended.

Firstly, there should be a massive public education and awareness creation about the benefits and operations of the Capitation. This helps the public to fully understand the Capitation and accept with whole heartedness the Capitation as an alternative to NHIS in Ghana. NHIS registration and renewal points should make it their priority to educate their clients on the Capitation.

Secondly, the National Health Insurance Authority is advised to make prompt payment to health providers under the Capitation to avoid frequent complaints and demonstrations from health providers. These complaints and demonstrations tend to negatively affect public perception about the health system.

Thirdly, emphasis should be stressed on the public to be a steward of its own health. Thus, the public must be made aware of the need to take responsibility for its own health needs. This will ensure full participation and cooperation of the public in achieving efficient health system.

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APPENDIX

QUESTIONNAIRE FOR THE STUDY

SCHOOL OF BUSINESS

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

Research Questionnaire

This questionnaire is designed to solicit valuable information on the topic **Financial Management and Sustainability of the NHIS under Capitation.** Respondents are assured that all information provided will be handled with the highest form of confidentiality and used only for academic purposes.

DIRECTION: Please tick (□) where appropriate**.**

1. Gender: Male □ Female □
2. What is your level of education?
    a. None□
    b. Basic □
    c. Secondary□
    d. Vocational/Technical □
    e. Tertiary□
3. Literacy

    Literate□ Illiterate□ Not Sure□
4. Marital status

    Married□ Not Married□ Separated□ Divorced□ Widowed□

5. How old are you? Tick the range

    a. 1-18 ☐

    b. 19-25 ☐

    c. 26-35 ☐

    d. 36-45 ☐

    e. 46-55 ☐

    f. 56-65 ☐

    g. 66 and above ☐

6. Employment status

    Employed ☐ Unemployed ☐ Still in School ☐ Unemployable ☐

7. What is your profession/work

    Farming/Fishing ☐ Civil Servant ☐ Trader/Entrepreneur ☐ Artisan Private Sector ☐

8. Have you heard of the Capitation?

    Yes ☐ No ☐

9. What is the Capitation about? ……

    ……

    ……

    ……

10. Which is your preferred healthcare facility?

    KATH ☐ Private Hospital ☐ Mission hospital ☐ Others ☐ No response ☐

11. What kind of Health care services did you receive?

Consultation ☐ Lab test ☐ Both ☐

12. To what extent are you satisfied with healthcare delivery?

a. Highly Satisfied ☐
b. Satisfied ☐
c. Satisfied but with exception ☐
d. Not Satisfied ☐
e. Highly not satisfied ☐
f. No response ☐

13. Do think capitation will increase access to healthcare?

Yes ☐ No ☐

Give reason ……..

……

……

……

……

14. Do you think the Capitation is financially self-sustaining?

Yes ☐ No ☐

15. What is your preferred healthcare system?

a. Capitation ☐
b. NHIS (Before the introduction of Capitation) ☐

c. Cash and Carry ☐

16. Give reason for the above answer

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17. Interviewee's comment on the Capitation

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Assessment of the financial sustainability of the NHIS Capitation in Ghana

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