

Understanding the NHIS provider payment system and Capitation

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1.0 PROVIDER PAYMENT MECHANISMS

Health insurance is a way of pre-paying for the health services used by residents. In health insurance, payments made are spread over the subscribers and over time in the form of some agreed regular contribution. Services are provided according to need.

Important issues to address in setting up an effective and efficient health insurance system are:

- How money is collected from residents and pooled to pay for services
- What services are covered by the insurance or the benefit package
- How these services are purchased or paid for on behalf of the citizens who are part of the insurance scheme; also known as the provider payment method

The Provider payment method is therefore “The mechanism used to transfer funds from the purchaser of health care services to the providers.” There are several different methods that can be used to pay providers under a health insurance scheme. These include Fee for service (this is often itemized), Diagnostic Related Groupings (DRG) and Capitation.

There is no one perfect method and each method has advantages and disadvantages. Typically therefore most successful health insurance schemes use a combination of methods. Each method has advantages and disadvantages, and a skillful mix of methods taking into account each unique country context, including economics and history is the

best approach. Effectively and efficiently managed health insurance schemes therefore provide often for a mix of provider payment methods, in a way that allows the advantages and disadvantages of the different methods to balance each other.

Current provider payment methods actually in use in Ghana currently are:

- Itemized Fee for service (FFS) for non insured clients for both services and medicines
- Diagnosis Related Groupings (DRG) for insured clients (Services only)
- Itemized Fee for service (FFS) to pay for medicines for insured clients

These methods are explained briefly below.

1.1 Fee for service

In a fee for service provider payment method, the provider typically lists the different services that they have provided for the client and the cost of each service and requests payment. To use an illustration from day to day life, it is rather like picking up the items you want from a supermarket shelf and then going to the payment counter for the individual cost of each item to be entered into the cash register and added up so that you pay your final bill. The difference between purchasing health care services by fee for service and purchasing items in the supermarket is that because of the specialized knowledge of the health service provider, which the client or patient often does not share, the service provider chooses the "items" for the client.

The advantage of the fee for service payment method is that the provider has no incentive to leave anything off the "shopping list". The disadvantage is that precisely for this reason, since the provider is also often the "owner" of the shop and the one choosing the items to be purchased for the client (because of the issues related to specialized knowledge); it is possible for the provider to provide unnecessary services to maximize profit. It does not mean that the provider will do this, but it is a known weakness of this system. Experience all over the world over time shows that it is a system that can lead to very rapid inflation of costs and threaten the sustainability of health insurance. Countries that use Fee for Service successfully in their health

insurance scheme, an example of which is Germany, often devise very complicated methods to counteract this tendency.

Despite its well established disadvantage of causing rapid cost inflation which can be a major threat to sustainability - and sometimes leading to unnecessary provision of services because it requires very little technical expertise to implement - fee for service is a common payment mechanism in many low income countries.

1.2 Diagnosis Related Groupings (DRG)

In the DRG payment method, related diagnoses are grouped together and the average cost of treatment in that group determined. Providers are therefore paid according to the diagnosis they give their client. Many developed countries e.g. USA and U.K, use DRG as part of their payment systems

Under the DRG system providers have to fill claims forms for reimbursement after providing the services. The claims made by the providers are then checked (vetted) for accuracy and genuineness before payment. The process is administratively complicated and makes a heavy demand on the time of both provider and scheme staff and the NHIA. The DRG for services also still holds some incentives for cost escalation though they are less than under itemized fee for service. Since medicines at all levels remain under itemized fee for service, the potential of major cost escalation is also strong.

1.3 Capitation

Capitation is a provider payment mechanism in which providers in the payment system are paid, typically in advance, a **pre-determined fixed rate** to provide a **defined set of services** for each individual enrolled with the provider for a **fixed period of time**. The amount paid to the provider is irrespective of whether that person would seek care or not during the designated period.

The fixed amount is typically expressed on a Per Member Per Month (PMPM) basis. The member refers to NHIS subscribers assigned to the accredited providers. Under this payment system, the member or subscriber selects a preferred primary provider (PPP) to provide all the services under the capitation basket in exchange for the capitation rate. The total capitation amount is transferred to the provider at the

beginning of the service period. The amount is calculated based on the total number of members who have selected a given provider.

Capitation is a well established provider payment method in several countries – high as well as middle income - and Ghana, in introducing capitation is walking a tried and tested road that many other countries have already successfully walked. The British National Health Service has used capitation for decades. The British system has become more complicated over time with several generations of reform but the basic principle is one of capitation. Thailand which is lauded internationally as a middle income country that now successfully covers virtually all its citizens with health insurance, uses capitation as the base of its provider payment system and reserves methods such as DRG for the higher referral level. Chile and Estonia are other examples of middle income countries successfully using capitation as one of their provider payment methods; and that have been successful in attaining universal or near universal coverage with health insurance.

1.4 Support Systems

A good provider payment method has to address and be implemented within strong support systems. Wider systems issues of importance in developing and implementing a successful provider payment method include:

- Governance and Accountability
- Financial management
- Stakeholder relationships
 - Clients
 - Schemes
 - Providers
- Management information systems
- Monitoring and Evaluation
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The provider payment system is the payment method combined with all these supporting systems.

2.0 PAYMENT SYSTEMS UNDER THE NHIS

2.1 Fee for Service & DRG

Ghana started off its national health insurance with paying for all services by fee for service. Under this payment method, after the

provider had seen the insurance client, they would send a bill listing everything that had been done for the client and how much was being charged for it and request payment. All over the world fee for service is known to have a tendency to cause a rapid rise in costs and is therefore a significant threat to the sustainability of any health insurance scheme if it is applied alone as the payment method without any controls or balances by mixing other methods. Not surprisingly, there was rapid cost inflation in the Ghana NHIS. The lack of standardization of the fees charged was also a source of confusion and controversy.

In 2007/2008, the NHIA introduced the Ghana Diagnostic Related Groupings (G-DRG) for services and standard itemized fees for medicines for NHIS clients. Thus the medicines remained under the fee for service system, but their prices were an agreed uniform standard across the country. Diagnostic related groupings (DRG) means that payment rates to providers are fixed for a given group of diagnosis.

The Ghana-DRG payment method is used at all levels from the primary care right up to the tertiary (teaching) hospitals.

2.2 Capitation

The NHIS law that established National Health Insurance in Ghana provided for the institution of multiple payment methods including capitation. LI 1809 specifically mentions capitation as one of the provider payment methods to be considered for use under the NHIS. This is international best practice given there is no perfect provider payment method.

The proposed reform in Ghana does not do away with any of the already existing provider payment methods. Rather it introduces capitation for a specific level of care – the primary level of walk in outpatient care, which is the fundamental base of the health care systems, and reserves the DRG for services and Itemized Fee for medicines system to the higher levels of care. Under the proposed capitation system, the amount paid to providers will cater for selected **OPD primary care cases**.

The advantages of introducing per capita payments for first level outpatient primary care as a complementary payment method to the already existing methods in the Ghana NHIS include the following:

- It will reduce the current massive administrative and staff time costs of claims preparation, submission, vetting and reimbursement involved in using G-DRG and fee for services for medicines to pay for first line OPD care
- It will improve the ability of the NHIA to forecast and budget
- It will eliminate the current problems of delayed payment of claims – for the services in the per capita basket. This is because monies are now being advance paid to providers
- By tying clients to a PPP of their choice it reduces fragmentation of care and introduces continuity of care for clients. It will also enable proper implementation of a referral system
- By enforcing the implementation of the gatekeeper system – which is already part of the policy of the ministry of health, it will reduce some of the current misuse of care and resultant costs and wastage. For example under the current system a client can visit several providers with the same condition – even on the same day, consuming staff resources and medicines at each point. This is a duplication and waste of scarce staff and financial resources.
- The sharing of risk between schemes/NHIA, providers and clients under a per capita system has a better potential to ensure the financial sustainability and preservation of the NHIS

The major disadvantage of a per capita system is that the provider may be tempted to provide less than needed services to the client. A close monitoring of quality of care is therefore essential in a per capita payment system. It is also necessary to continuously monitor the per capita rate to make sure that it is and remains fair for the package of services covered.

An examination of the costs to providers and the NHIS in terms of skill and staff time in claims processing, suggested the need to revisit and work out a way of implementing the capitation payment method which was proposed for use in Ghana at the time the LI 1809 that accompanied Act 650 was drawn but which remained unimplemented.

In summary the payment methods reform involves:

- a. Introducing Capitation (Per capita payment) to replace DRG for service & FFS for medicines **at the primary care level**
- b. Retaining DRG for Services & Fee for service (FFS) for medicines at Specialist OPD clinics, Hospital referrals and

inpatients (district, regional, specialist and teaching hospitals).

The methods reform is supported by Systems reform that covers:

- a. Accountability – Financial management and reporting systems
- b. Strengthening of routine management information systems data completeness, quality, analysis and use
- c. Built in monitoring and evaluation for continuous quality improvement
- d. Improving Clarity in stakeholder roles and relationships, communication

Ghana's objective in introducing capitation into its provider payment systems under the NHIS stem out of the already described advantages of capitation which are to:

- Improve cost containment and viability of NHIS
- Share financial risk between schemes, providers and subscribers
- Introduce managed competition for providers and choice for patients (compatible with portability) to increase the responsiveness of the health system
- Improve efficiency and effectiveness of health services through more rational resource use
- Correct some imbalances created by the G-DRG e.g. OPD supplier-induced demand
- Simplify claims processing
- Address difficulties in forecasting and budgeting
- Better provider-patient relationship

3. The capitation package and the per capita rate

3.1 Starting Package of services under Ghana's per capita model

In Ghana, capitation is being introduced as the payment method for first line basic walk-in care (out-patient). It is important that a base package of services that can be reasonably made accessible to every Ghanaian, whether they live in a complex urban metropolis or a remote rural area, is paid for by the standard capitation rate across the country. Based on a mapping of provider service location and availability, a basic minimum package of services that is reasonable to expect to be made available at every walk-in outpatient department (OPD) has been defined. This defined package will be subject to regular review and modification to fit the experiences and the evolving context of Ghana rather than fixed and for ever unchangeable.

The package of services referred to as the Primary Health Care (PHC) bundle comprises:

- General OPD consultation with a trained primary care prescriber for
 - Most common Primary Health Care diagnoses. A detailed list of these diagnoses is available.
 - Routine maintenance care for non insulin-dependent diabetes and hypertension (ambulatory care sensitive chronic conditions) on specific simple medications that can be used at the primary care level such as Metformin, Amlodipine and the thiazide diuretics. Treatment at the primary care level will occur after clients have been stabilized by a trained and competent provider (General practice doctor or specialist doctor) and instructions provided to the primary care level on maintenance treatment. Periodic review by a doctor in a specialist OPD clinic and related laboratory tests beyond the basic in the PHC bundle will be covered by DRG.

- Maternity consultation and services with a midwife or doctor for Antenatal and Postnatal care. (*Normal delivery that was originally to be included in the PHC bundle to be provided by PPP has been removed from the PHC bundle in response to concerns raised by providers about quality of care and MDG, and will be paid for by DRG. The effects of its exclusion will be closely monitored as part of the M&E of the capitation*)
- Selected laboratory examinations that match the selected primary care conditions and that can be carried out even where there is not laboratory because rapid test kits that do not require a laboratory Can be used for the tests, which are:
 - Blood film for Malaria parasites
 - Hemoglobin estimation
 - Blood Sugar
 - Urine routine examination
 - Pregnancy test
 - VDRL
- Selected medicines for the most common diagnoses at PHC level and antenatal and postnatal conditions

3.2 Per capita rate

In dealing with averages, the denominator used to calculate the average matters. The per capita rate is an average rate per person who has chosen a particular PPP and has been enrolled. It is a **per head rate based on active NHIS subscribers**. It is therefore different from the reimbursement per visit which is a **per encounter rate based on actual visits** to a provider by active NHIS subscribers. The denominator for calculating the two rates are different. To compare the per capita rate directly with what providers earn/charge per client visit is as inappropriate as comparing apples and oranges by the same parameters.

Calculation of the per capita rate is based on the total outpatient claims that were paid for outpatient services rendered to NHIS subscribers in Ashanti region. Under capitation the total cost of providing care under the defined basket of services is divided by the total number of subscribers registered with the Preferred Primary Provider (PPP).

The comparison of the per capita rate of GHC1.75 for accredited private providers to the cost per OPD encounter or visit is erroneous. The per capita rate has been presented to the general public as if it is the cost per OPD encounter. It is worthy of note that the per capita rate is **paid to every provider every month for all NHIS subscribers** who have chosen that provider as their PPP **whether or not** they fall sick.

Health care services utilization data for NHIS subscribers as well as utilization data of the Ghana Health Service and other research findings indicate that, on average, subscribers use OPD services twice in a year. The GHC 1.75 per capita amount translates to GHC 21 per annum and this amount will be transferred for all subscribers enrolled with a PPP to cater for only OPD cases that are included in the capitation basket. Since providers will be paid in advance on monthly basis for all subscribers enrolled with the provider irrespective of whether or not they fall sick and seek medical care, the capitation amounts are based on enrolment and not encounters or visits.

It is also important to note that the per capita amount was calculated based on the current payment for outpatient services and covers outpatient non-specialty cases only. The initial per capita rate calculated was adjusted by 22% to cater for the interim tariff increase announced by the Honorable Minister of Health and implemented in

July 2011. The program will be closely monitored and the necessary adjustments made. Providers will still be reimbursed for all OPD specialty cases that are not included in the capitation basket as well as all inpatient cases under the prevailing method of payment, that is, the Ghana Diagnostic Related Groupings (G-DRG).

3.3 Enrolment

Enrolment refers to the process by which a client is linked to a PPP. Under the Ghana capitation model, clients are being asked to voluntarily choose their PPP. A client can only have one PPP. In the choice clients were asked to chose a first, second and third choice not because they could use all 3, but so that if for any reason they could not be tied to their first choice PPP, it would be clear which new PPP to tie them to.