Health Policy and Planning, 36, 2021, 869–880
doi: 10.1093/heapol/czab016
Advance Access Publication Date: 6 May 2021
Original Article

Why did Ghana's national health insurance capitation payment model fall off the policy agenda? A regional level policy analysis

Gilbert Abotisem Abiiro[1,2,*], Kennedy A Alatinga[2,3] and Gavin Yamey[4]

[1]Department of Planning, Faculty of Planning and Land Management, Simon Diedong Dombo University of Business and Integrated Development Studies, P. O. Box UPW 3, Wa, Ghana
[2]University for Development Studies, P. O. Box TL 1350, Tamale, Ghana
[3]Department of Community Development, Faculty of Planning and Land Management, Simon Diedong Dombo University of Business and Integrated Development Studies, P. O. Box UPW 3, Wa, Ghana
[4]Center for Policy Impact in Global Health, Duke Global Health Institute, Duke University, Durham, NC 27701, USA

*Corresponding author. Department of Planning, Faculty of Planning and Land Management, Simon Diedong Dombo University of Business and Integrated development Studies, Faculty of Planning and Land Management, Department of Planning, Post Office Box UPW 3, Wa, Upper West Region, Ghana. Tel: +233209014931, E-mail: gilbiiro@yahoo.com

Accepted on 1 February 2021

Abstract

Provider payment reforms, such as capitation, are very contentious. Such reforms can drop off the policy agenda due to political and contextual resistance. Using the Shiffman and Smith (Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* 2007; 370 1370–9) framework, this study explains why Ghana's National Health Insurance capitation payment policy that rose onto the policy agenda in 2012, dropped off the agenda in 2017 during its pilot implementation in the Ashanti region. We conducted a retrospective qualitative policy analysis by collecting field data in December 2019 in the Ashanti region through 18 interviews with regional and district level policy actors and four focus group discussions with community-level policy beneficiaries. The thematically analysed field data were triangulated with media reports on the policy. We discovered that technically framing capitation as a cost-containment strategy with less attention on portraying its health benefits resulted in a politically negative reframing of the policy as a strategy to punish fraudulent providers and opposition party electorates. At the level of policy actors, pilot implementation was constrained by a regional level anti-policy community, weak civil society mobilization and low trust in the then political leadership. Anti-policy campaigners drew on highly contentious and poorly implemented characteristics of the policy to demand cancellation of the policy. A change in government in 2017 created the needed political window for the suspension of the policy. While it was technically justified to pilot the policy in the stronghold of the main opposition party, this decision carried political risks. Other low- and middle-income countries considering capitation reforms should note that piloting potentially controversial policies such as capitation within a politically sensitive location can attract unanticipated partisan political interest in the policy. Such partisan interest can potentially lead to a decline in political attention for the policy in the event of a change in government.

Keywords: Provider payment, capitation, policy analysis, Shiffman and Smith, regional level, Ghana

KEY MESSAGES

- Technically framing capitation as a cost-containment strategy with less attention on its health benefits attracted a politically negative reframing of it as a strategy to punish fraudulent providers and opposition party electorates.
- A regional level anti-policy community, a weak civil society mobilization and low trust in then political leadership constrained the pilot implementation of capitation in Ghana.
- Anti-policy campaigners drew on very contentious and poorly implemented characteristics of the policy to demand the policy cancellation.
- A change in government in 2017 created the political window for the suspension of the policy.
- Although, technically justified, it was politically risky to pilot the policy in the stronghold of the main opposition party.

Introduction

A number of low- and middle-income countries (LMICs) including Ghana have adopted health insurance as a strategy for mobilizing domestic revenue for health (Lagomarsino *et al.*, 2012). However, cost containment remains a major challenge to the sustainability of these health insurance schemes (McIntyre, 2007; Kutzin, 2013). Within current global debates on strategic purchasing, capitation is promoted as a preferred provider payment mechanism that can contain healthcare costs (Andoh-Adjei *et al.*, 2016; Etiaba *et al.*, 2018). Capitation is a prospective provider payment mechanism in which a flat payment per person is predetermined and paid to a provider to cover a defined benefit package of services for all persons registered under the provider over a given period of time (Jegers *et al.*, 2002). Theoretically, capitation can promote cost containment and efficiency gains; however, it can also provide an incentive for providers to under treat and to provide poor-quality services thereby negatively affecting overall access to healthcare (Barnum *et al.*, 1995; Jegers *et al.*, 2002; Robyn *et al.*, 2013; Bastani *et al.*, 2016; Etiaba *et al.*, 2018).

Similar to many health policy reforms, capitation and other provider payment reforms are often controversial and highly contentious within LMICs (Thomas and Gilson, 2004), including Ghana (Agyepong and Adjei, 2008; Sodzi-Tettey *et al.*, 2012; Abiiro and McIntyre, 2013; Koduah *et al.*, 2015, 2016). These controversies arise because such reforms involve decisions on the sharing of financial risks (costs) and healthcare benefits among various actors (Thomas and Gilson, 2004). It can, therefore, be very difficult to attract policy attention towards an issue such as capitation and to get it on the agenda unless these inherently political controversies are addressed (Green-Pedersen and Wilkerson, 2006; Liu *et al.*, 2010; Parkhurst and Vulimiri, 2013; Koduah *et al.*, 2015; Gilson *et al.*, 2018). Likewise, a policy issue can easily drop off the policy agenda due to political and public resistance to its implementation (Koduah *et al.*, 2016).

This study explains why a health insurance capitation payment policy reform that rose onto the policy agenda in Ghana, and that was being piloted at a regional level before a nationwide scale-up, lost political (governmental) attention and hence dropped off (suspended from) the policy agenda. We specifically used the Shiffman and Smith (2007) framework, to assess the (1) framing and portrayal of the policy idea; (2) stakeholders' interests, positions and power dynamics; (3) the characteristics of the policy issue and implementation procedures and (4) the nature of the regional political context within which the policy was piloted. We discussed how these issues interacted at the regional level to influence the suspension of the policy from the policy agenda.

The pilot NHIS capitation payment policy reform in Ghana

Since its inception in 2004, all the health services in the Ghana National Health Insurance Scheme (NHIS)'s benefit package were purchased by the National Health Insurance Authority (NHIA) using the fee-for-service (FFS) mechanism (Sodzi-Tettey *et al.*, 2012). In 2008, the Ghana Diagnostic-Related Groups (G-DRGs) was introduced for primary care services while medicines and other services were still purchased through FFS at NHIS accredited healthcare facilities (Sodzi-Tettey *et al.*, 2012), with the Community-based Health Planning and Service (CHPS) compound as the lowest level of the gatekeeper system. Due to the continuously increasing cost (claims) to the NHIS (Agyepong *et al.*, 2014), in 2010, the NHIA with support from the World Bank's Health Insurance Project, established a technical committee to design a capitation policy for the NHIS (Koduah *et al.*, 2016). By January 2012, a capitation policy was designed and piloted by the NHIA in the Ashanti region to test the effectiveness of a capitation payment system in containing healthcare cost in Ghana (Anson, 2010; Aboagye, 2013; Koduah *et al.*, 2016).

The piloted capitation policy required each NHIS client to choose three facilities within his/her district of residency as potential Preferred Primary care Providers (PPPs) but only one of them was assigned to the client as his/her PPP (National Health Insurance Authority, 2012). Clients could only change their PPPs after 6 months of assignment (twice in a year) except in the event of a change of residence when a permanent or temporary certificate of membership transfer was issued by the NHIA office (National Health Insurance Authority, 2012). An annually determined capitated rate was paid monthly to providers based on the number of people enrolled under each provider (National Health Insurance Authority, 2012). The capitation payment covered services and medicines only for outpatient primary healthcare at the client's PPP (National Health Insurance Authority, 2012). The G-DRGs or FFS were used to pay for emergency services (National Health Insurance Authority, 2012). Inpatient care provided at higher-level facilities such as district, regional, specialist and teaching hospitals with evidence of a referral from a PPP and specialized outpatient services were paid using the G-DRGs and the associated medicines paid for using FFS (National Health Insurance Authority, 2012; Koduah *et al.*, 2016).

In 2015, the NHIA started scaling up the capitation policy to three other regions (Upper West, Upper East and Volta regions) (Frimpong, 2013; *Ghana News Agency*, 2014; Takyi and Danquah, 2015; Sackey and Amponsah, 2017). Public sensitization prior to the scale-up was done in these regions and people registering with

the scheme were made to choose their PPPs in preparation for the roll-out of the capitation policy in such regions (*Ghana News Agency*, 2015a; Sackey and Amponsah, 2017). However, public concerns led to a suspension of the implementation of the policy in 2017 until further studies established its feasibility (Citifmonline.com, 2017).

During the policy implementation, a small number of studies assessed the general debates and actor dynamics surrounding the implementation of the policy at the regional level and reported some actor resistance towards the policy implementation (Dodoo, 2013; Atuoye *et al.*, 2016; Koduah *et al.*, 2016). However, since the suspension of the capitation policy in 2017, no comprehensive policy analysis has documented the factors that resulted in this policy losing political attention and falling off the government agenda although capitation as a policy option is still on the NHIA decision agenda.

Methodology

The guiding policy analytical framework

The guiding framework for this policy analysis is an adaptation of the Shiffman and Smith (2007) framework that was developed for global level policy analysis. While this framework is usually used to understand why an issue *gains* political attention, in our study, we used it to explain why an issue (the capitation policy) that already received policy attention at the national level (Koduah *et al.*, 2016) *fell off* the policy agenda during a regional level pilot implementation.

According to Shiffman and Smith (2007), the power of policy actors, the power of the ideas used to frame the policy issue, the nature of the political context in which the policy issue is being considered, and the characteristics of the policy issue determine its likelihood of getting onto the policy agenda. In this analysis, we assumed that these same issues interact to explain why a policy issue drops off the policy agenda. As illustrated in Figure 1, our policy analysis framework puts emphasis on the interactions that exist within the four elements of the Shiffman and Smith (2007) framework. As acknowledged by Walt and Gilson (1994), policy actors

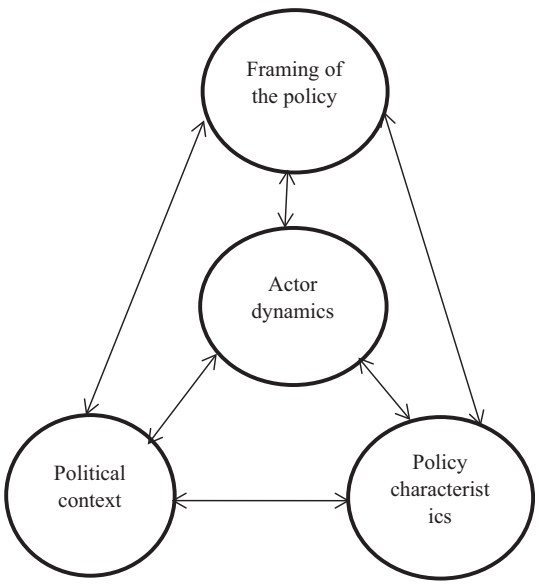

Figure 1 Analytical framework of the study.

Source: Shiffman and Smith (2007) and Walt and Gilson (1994).

are at the centre of all interactions that take place in the policy process. Under the actor component of our model, we focused on identifying the key regional level policy actors; mapping their interests (gains and losses), positions (neutral, supportive or opposed), power [level (high, medium or low) and sources] and influence (strategies and impacts) on the policy implementation and suspension. We assessed the framing of the policy issue/ideas by focusing on the internal technical and the external political/public understanding and portrayal of the policy issue and the rationale for its implementation within the regional context. To assess the political context, we examined the involvement of political parties in the policy implementation at the regional level; the relative electoral strengths of these political parties at the regional level; featuring of the policy issue in political party manifestos and electioneering campaigns; electoral victories and changes in governments and local-level political leadership. To assess the characteristics of the policy issue, we focused on stakeholders' perceptions about the appropriateness of the various characteristics of the policy design and their implementation successes within the regional context.

Study design and setting

We used a retrospective cross-sectional qualitative design, comprising a review of media reports and field data collection in the Ashanti region. The Ashanti region was purposively selected since it was the site of the pilot phase of the capitation policy. According to the Ghana Statistical Service (2012), the total population of the Ashanti region was 4 780 380 in 2010, representing 19.4% of the Ghanaian population. There were 25 districts in the region with functional NHIS district offices (Andoh-Adjei *et al.*, 2018b). As of 2014, about 34% of the regional population were active members of the NHIS (Andoh-Adjei *et al.*, 2018b). We purposively selected two districts in the region for data collection, the urban Kumasi Metropolis located in the regional capital and the rural Ahafo Ano South district, to reflect the urban-rural differences in the regional population. In 2010, the total population of the Ahafo Ano South District was 121 659, representing 2.6% of Ashanti's regional population, while that of the Kumasi Metropolis was 1 730 249 representing 36.2% of Ashanti's regional population (Ghana Statistical Service, 2012). About 90% of Ahafo Ano District is rural while the Kumasi Metropolis is the most urbanized area in the Ashanti region (Ghana Statistical Service, 2012).

The Ashanti region is the stronghold of the New Patriotic Party (NPP). The NPP consistently had landslide victories in the presidential and parliamentary elections in this region since Ghana returned to multi-party democracy in 1992. At the time of the introduction of the capitation policy in 2012, the National Democratic Congress (NDC) was the ruling political party while the NPP was the main opposition party. However, in 2017, the NPP took over power from the NDC.

Study population and sampling

The study targeted key stakeholders of the capitation policy at the regional, district and community levels in the Ashanti region. A stakeholder was considered as a person or group of persons within the Ashanti region, who had an interest in (i.e. was affected by) the capitation policy and had the power to influence its implementation (Brugha and Varvasovszky, 2000; Hyder *et al.*, 2010). We purposively selected the clearly visible stakeholders of the capitation policy from a literature review and identified the invisible ones through snowball sampling during data collection. We defined these visible stakeholders as actors who (1) played active roles during the

implementation of the capitation pilot in the Ashanti region (Dodoo, 2013; Takyi and Danquah, 2015; Atuoye *et al.*, 2016; Koduah *et al.*, 2016) and/ (2) have previously influenced other healthcare financing policy reforms in Ghana (Agyepong and Adjei, 2008; Abiiro and McIntyre, 2013). As illustrated in Table 1, we identified 25 key stakeholders at the regional, district and facility levels who we invited for an interview, of whom 18 stakeholders responded. The stakeholders' institutions were contacted by phone or by a physical visit to purposively identify the key persons that were directly involved in the implementation of the policy for inclusion in the study. With the assistance of community leaders and gatekeepers, community-level policy beneficiaries, who were active members of the NHIS between 2012 and 2017, were purposively selected for focus group discussions (FGDs), which are described further below.

Data collection and analysis

Semi-structured interviews were conducted with the 18 stakeholders reported in Table 1. Media reports on stakeholders' opinions and reactions to the policy implementation were reviewed for triangulation with stakeholder interviews and to collect additional and complementary data. We sought permission from the NHIA to access letters, petitions and minutes of all stakeholder meetings on the capitation policy, but unfortunately, the NHIA did not grant us such permission. The NHIA staff at the regional and district levels did not also grant us informed consent for the interviews because the NHIA did not give them permission to do so. Four FGDs were organized with community-level policy beneficiaries. Two FGDs (one comprising men and the other women) were conducted in a sampled community within the rural district and the other two (one with men and one with women) were conducted in a sampled community within the urban district. The size of an FGD ranged from 9 to 12 people.

An interview guide, an FGD guide and a secondary data extraction sheet were developed as instruments for data collection. The instruments covered: (1) stakeholders' understanding of the policy, (2) reasons for the policy implementation and the choice of Ashanti region for the piloting, (3) the interests/concerns, position, power and influence of various stakeholders as these related to the policy implementation, (4) the positive and negative effects of policy implementation, (5) other issues that affected policy implementation and how those issues contributed to the suspension of the policy. The interviews and FGDs lasted a maximum of 45 minutes and one hour, respectively. All data collection instruments were pre-tested, and the quality of the data enhanced through member checking, where recorded responses were read by data collectors for further validation by the respondents. All interviews and FGDs were conducted in secured venues free from distractions. All interviews were conducted in English while FGDs were done in Twi (the local language). All interviews and FGDs were audio-recorded under consent and transcribed verbatim, and FGDs were translated into English language for analysis. The field data collection took place in December 2019. The lead author with the assistance of a trained research assistant (RA) conducted the interviews and the document reviews. Another RA who is fluent in the local language was recruited and trained to assist the other RA to conduct the FGDs.

We conducted thematic analysis of the transcripts. NVivo 12, a qualitative data analysis software, was used to assist the data analysis. Both deductive and inductive coding were done to identify the main and sub-themes. The deductive codes were based on the key postulates of our analytical framework outlined in Figure 1. Context-specific issues relating to each of these broad codes were identified through inductive coding. For the sake of analytical

Table 1 Stakeholders contacted for the study

Stakeholder category	Stakeholder's role within the organization	No. of people targeted	Number of people interviewed	Stakeholder views reported by media
Ministry of Health	Representative	1	0	No
Ashanti regional health directorate	Director and/staff	1	2	Yes
Incumbent political party (NPP)	Party leadership	1	1	Yes
Opposition Party (NDC)	Party leadership	1	1	Yes
Academics and health researchers	Health Economists(s)/System and Policy	2	1	Yes
Health insurance staff	Regional manager, claims, Public Relation Officer (PRO)	1	0	No
Christian Health Association of Ghana (CHAG)	Executive Director/representative	1	N/A	Yes
Ghana Registered Midwives Association	Leadership	1	1	Yes
Society of Private Medical and Dental Practitioners (SPMP)	Leadership	1	1	Yes
Coalition of non-governmental organizations (NGO) in Health	Regional representative	1	1	Yes
Ashanti Development Union (ADU)-Regional level pressure group	Leadership	1	1	Yes
Ghana Medical Association	Leadership	1	0	Yes
District health directorate	Director/Public Relation Officer/ representative	2	2	Yes
District health insurance office	Manager/claims/M & E officer	2	0	No
Public health facilities	Medical Director/in-charge/ administrator	4	3	No
Private providers	Managers/staff	2	2	Yes
CHAG providers	Managers/staff	2	2	No
Total		25	18	

triangulation, the second author with experience in qualitative research triangulated the coding done by the lead author by coding half of the transcripts. Differences in themes were reconciled by the two analysts and the third author did a thorough review of the outcome of the coding by the two authors.

Results

Stakeholders' framing of the capitation policy

As shown in Table 2 (themes ordered in terms of dominance), technically, stakeholders framed the capitation policy concept as a strategy to contain healthcare costs, enforce a healthcare gatekeeper system, prevent medical shopping, support facility-level planning and budgeting, improve healthcare quality and prevent fraud. Stakeholders reported that an assessment of the expenditure of the Scheme through its clinical audit process revealed a 'sky-rocketing' expenditure pattern on NHIS claims reimbursement. The NHIA believed that the high claims reimbursement resulted from medical shopping by clients and fraudulent claims by providers, which were made possible due to inherent lapses in the existing FFS and DRGs payment systems. The NHIA, therefore, introduced the capitation policy to correct these flaws in order to contain healthcare cost.

> *It is a way of checking the system as a gate keeper. So, it [. . .] will at the end of the day cut cost in terms of preventing the patient from visiting a lot of facilities at the same time* (Ashanti Development Union).

Some stakeholders, especially healthcare workers and administrators, were conscious of the medical benefits of capitation. These stakeholders argued that an effective capitation system will reduce overcrowding and workload at health facilities, improve the accuracy of medical diagnosis and ensure proper record keeping and continuity of care at all levels of the health system. However, they argued that these medical benefits were less emphasized by policy implementers during public education on the policy. Stakeholders also argued that capitation was meant to introduce competition among health facilities to improve quality of care and ensure that resources are made available to healthcare facilities for planning and budgeting purposes.

Despite the positive views about the policy by many stakeholders (see Table 2), during the pilot implementation, the then opposition party and the NHIS clients in the region portrayed the policy idea as a strategy by the then ruling government to restrict clients' access to quality healthcare so as to send them to their early graves. The policy was therefore described as a 'murderous' policy by the NPP and the NHIS clients as widely reported in the media (Awuah, 2012; Gadugah, 2014; Buachi, 2016) and in all our FGDs with NHIS clients.

> *It was NDC* [the then ruling party] *as a party that brought it to kill us* (Female FGD, Kumasi Metropolis).

In terms of the choice of the region for the pilot, it was widely reported in the media (Anson, 2010; *Ghana News Agency*, 2012a; Dapatem, 2014) and in our stakeholder interviews and FGDs (Table 2) that the rationale for choosing Ashanti region for the pilot was that the region is located in the middle of Ghana with a heterogeneous ethnic population and a variety of different levels and types of health facilities, thus reflecting the Ghanaian context.

Table 2 Stakeholders' framing of the pilot capitation policy in Ashanti region

Type of framing	Frame (during pilot implementation 2012–17)	Stakeholders the frame appealed to
Framing capitation as a policy issue		
Technical (Positive) framing	Cost-containment strategy	Academics; ADU; Regional and District Health Administrations; Health facilities; NDC; NPP
	Healthcare gatekeeper system	Academics; ADU; SPMDP, Health facilities, labour unions; Regional and District Health Administrations, Coalition of Health NGOs
	Prevention of medical shopping	Academics; Regional and District Health Administration; Health facilities; Coalition of Health NGOs; SPMDPs; ADU
	Support planning and budgeting	Regional and District Health Administration; SPMDP; Health facilities; Coalition of Health NGOs
	Quality healthcare delivery strategy	Health facilities; NDC; Academics; Coalition of Health NGOs; Regional and District Health Administrations; ADU; NHIS Clients; NPP
	Fraud prevention strategy	NDC; Coalition of Health in NGOs
Public/political (Negative) framing	Murderous policy	NHIS clients; NPP
Framing the rationale for choosing the Ashanti region for the pilot		
Technical (Positive) framing	Regional population is reflective of the Ghanaian context	Regional and District Health Administration; Health facilities; NDC, Coalition of Health NGOs
	Presence of variety of health facilities in the region	Health Facilities, Health Administration
	Ashanti region generates the highest NHIS claims expenditure	NDC
Public/political (Negative) framing	Unethical to use a large region as Ashanti for a pilot	Academics, ADU, NHIS clients, NPP, Health Administrators; Health facilities; SPMDPs
	Labelling Ashanti as a fraud region	NHIS clients; NPP; SPMDPs; ADU, Regional and District Health Administrations; Healthcare providers
	Discrimination against an opposition stronghold	NPP; NHIS clients

> *Ashanti is cosmopolitan, aside being the centre of the country; it is very fairly representative of the entire country [. . .]. Looking at the dynamics of the Ashanti region, anything that is piloted here especially social cases like this one and it is successful, there are higher chances that if it is expanded, we can equally see positive results* (NDC).

As reported in the media (*Daily Post*, 2012) and confirmed by some stakeholders in our study, the highest claims' expenditure to the NHIS originated from the Ashanti region. Since the capitation was primarily aimed at containing cost, the Ashanti region was perceived as the right candidate for the capitation pilot.

On the other hand, except the then ruling Party (NDC), all stakeholders (see Table 2) argued that it was unethical and against the principles of pilot studies to use a large region such as Ashanti for a pilot. This view also dominated media debates on the policy (Alhassan, 2011; *Daily Guide*, 2012; KAD Africana, 2012; Public Relations Committee NPP-USA, 2014). The NPP and NHIS clients, therefore, reframed the rationale for the choice of the region, as a deliberate political strategy of discrimination against an opposition stronghold.

> *To be honest, the selection of Ashanti region was not good because when you are coming to start something you don't select a big region, you select a small one when it succeeds then you spread it. In some way, I will say it's because of politics that is why they selected Ashanti region* (Male FGD, Kumasi Metropolis).

> *We the Ashantis always vote against him* [the then President from the NDC party], *so coming into power he wanted to pay us back by squeezing us hard* (Male FGD, Ahafo Ano South).

Given that capitation was also technically framed by the NHIA as a strategy to control fraud (*Ghana News Agency*, 2015b), some regional level stakeholders such as NPP, health administrators, labour unions, providers and NHIS clients viewed the choice of the region for the pilot as a way of labelling Ashanti as a region full of fraud. This view was also reported in the media (Appiakorang, 2012; *Daily Post*, 2012; Peacefmonline, 2012).

> *Instead of telling the (medical) benefits of capitation, they were saying capitation is going to address faults [. . .]. If you are saying, you are going to prevent fraud people from getting money then why did they choose Ashanti region? Politically, maybe, it is not wise* (Regional Health Directorate).

Actor interests, positions and power dynamics

As shown in Table 3, the dominant expectations of key stakeholders from the policy were adequate understanding of the policy, adequate involvement in the policy design and implementation and a guaranteed quality of care. However, many stakeholders argued that these specific expectations were not met.

> We *were not well-informed, not well-educated, not prepared and we were not directly involved in the implementation* (Society of Private Medical and Dental Practitioners).

> *From day one, what they wanted to implement, a lot of people did not understand it* (Male FGD, Kumasi Metropolis).

Secondary-level health facilities (hospitals) were happy with the policy because they could attract more capitated clients and handle referral cases as well; hence they received high capitated payments. Urban health centres located within the same vicinity of these secondary hospitals were disadvantaged in terms of client enrolment and revenue generation. This differential impact of the policy on healthcare facilities also explains the mixed interests of the Regional and District Health Administrations towards the policy. It did not matter whether the facility was public or private, the size of the facility and the ability of the facility to attract clients defined the perceived impact of the policy on the facility.

Table 4 presents the positions of the various stakeholders on the idea of the capitation policy, the choice of Ashanti for the pilot, the pilot implementation and the suspension of the policy. Overall, the positions of stakeholders were motivated by their perceptions of the impact of the policy on them. In relation to the policy idea, only the NHIS clients clearly opposed a capitation policy concept arguing that limiting them to one provider was not beneficial and demanded that the policy idea should be completely discarded.

> *The capitation is not something beneficial that we have to tolerate, we should put it aside. We should dig a hole and burry it* (Male FGD, Ahafo Ano South).

All other stakeholders supported the concept of capitation but differed in their positions on the choice of the region and the pilot implementation. Apart from the NDC that strongly supported the choice of Ashanti region for the pilot, all other stakeholders either opposed the choice of the pilot site or remained neutral. During the pilot implementation, majority of the stakeholders comprising the NPP, Ashanti Development Union (ADU), Society of Private Medical and Dental Practitioners (SPMDP), NHIS clients, labour unions and primary healthcare facilities opposed the policy while the NDC, health service administrators, Non-Governmental Organisations (NGOs) in Health and secondary-level health facilities supported the implementation. There is also currently wide support for the suspension of the policy because of the challenges encountered during the pilot and hence the need to address such challenges before a nationwide scale-up.

> *At the academic community, we believe that there was the need for the capitation, but I don't think it should have started in the Ashanti region and I don't think it was well implemented* (Academic).

Although stakeholders such as academics, NGOs and the Regional and District Health Administrations were either neutral or supported the pilot implementation, they also supported the suspension of the policy because of the inability of the NHIA to scale it up after 4 years of pilot implementation. The NDC party had not expressed a clear position on the suspension of the policy. However, some secondary-level health facilities expressed opposition to the suspension of the policy arguing that the challenges encountered during the pilot could have been addressed while the policy was still ongoing instead of suspending the policy. Although the association of private healthcare providers (SPMDP) strongly opposed the capitation pilot, the individual private facilities were divided in their positions on the policy. Those private health facilities that were large and well-equipped to attract more clients supported the policy while those private facilities that were small in size strongly opposed the policy.

As shown in Table 5, those stakeholders (NDC, NPP and the NHIS clients) who derived their power from political/electoral sources had relatively higher power to influence the policy. Those stakeholders that opposed the policy organized press conferences, public demonstrations and wrote petitions against the pilot implementation (Appiahkorang, 2012; Owusu, 2012). Using a platform created by the ADU, the opponents formed an alliance to put pressure on the NHIA and the government to withdraw the policy. SPMDP led the private providers to boycott the capitation system and to charge

Table 3 Perception of impact of policy implementation on stakeholders' interest

Stakeholder	Key interest (expectations)	Perceived policy impact on stakeholder's interest
Academics	• Adherence to proper piloting principles • Empirical evidence on pilot success/failures	Negative
ADU (pressure group)	• Adequate public understanding of the policy • Financial protection in the region • Sustainability of all health facilities • Safety and welfare of regional population • Adequate stakeholder involvement in policy	Very negative
NGOs in Health	• Adequate public understanding of the policy • Equity in access to quality care • Adequate stakeholder involvement in policy	Negative
Society of Private Medical and Dental Practitioners	• Adequate understanding of the policy • Business sustainability • High client's enrolment in private facilities • High revenue • Adequate stakeholder involvement	Very negative
Health administration (regional and district)	• Health promotion and prevention • Revenue for health facilities • Quality healthcare delivery • Sustainability of all health facilities	Mixed (both positive and Negative)
Secondary-level facilities (hospitals) Primary-level facilities (urban) Primary-level facilities (rural)	• Effective delivery of quality care • High clients' enrolment • Revenue generation	Positive Very negative Neutral
Labour unions in health sector	• Adequate understanding of policy • High revenue for health facilities • Welfare of health workers	Negative
NDC (the ruling political party)	• Defend government policy • Provide education on government policy • Protect party legacy • Re-election of party	Very positive
NPP (Current ruling party)	• Adequate public understanding of the policy • Demonstrate support to electorates • Maintain social contract with electorates • Protect political interest	Very negative
NHIS registered members	• Adequate understanding of the policy • Unrestricted access to quality healthcare • Financial risk protection • Portability of NHIS membership • Survival after treatment • Unrestricted freedom of choice of PPP	Very negative

out-of-pocket payments for their services. However, a lack of consensus among the private providers made this strategy less effective.

On the other hand, supporters of the policy such as NGOs and NDC continued to defend the policy in the media and provided public education on the policy whilst the healthcare providers actively canvased and supported clients to enrol onto the scheme.

> *Sometimes we sponsor [. . .], we invite the NHIS personnel to our facility and then make announcement for all those who chose [name omitted] and their insurance have expired [. . .] we will renew it for you, and they were coming* (Private Hospital, Ahafo Ano South).

Although NGOs and other civil society organizations supported the policy and provided education on the policy, their overall influence on the policy implementation was low because of the inability of the NHIA to adequately mobilize, involve and form alliance with them.

> *We were just told that they (NHIA) we're going to pilot a project [. . .] they didn't actually engage some of us* (Coalition of NGOs in Health).

Policy characteristics and implementation issues

We identified six policy characteristics and implementation issues that contributed to the suspension of the policy. First, although stakeholders such as SPMDP, ADU, provider unions and health administrators acknowledged participation in a sensitization workshop organized by the NHIA prior to the policy implementation, stakeholders argued that they did not receive enough education on the policy. The NHIS clients maintained that there was no community-level engagement before the introduction of the policy. The NHIA clients mainly received information on the policy through radio announcements, which did not offer them opportunities to have their concerns addressed.

Table 4 Stakeholders' positions on the policy

Stakeholder	Policy idea	Choice of Ashanti region for pilot	Pilot implementation	Suspension of policy
Academics	Strongly supported	Opposed	Neutral	Supported
ADU	Strongly supported	Strongly opposed	Strongly opposed	Strongly supported
NGOs in Health	Strongly supported	Neutral	Supported	Supported
SPMDP	Strongly supported	Strongly opposed	Strongly opposed	Strongly supported
Health administration	Strongly supported	Neutral	Strongly supported-supported	Support-opposition
Secondary-level facilities (hospitals)	Strongly supported	Neutral	Supported	Neutral-opposition
Primary-level facilities (Health centres/CHPS compounds) located close to secondary-level facilities-in urban areas	Supported	Neutral	Strongly opposed	Strongly supported
Primary-level facilities (Health centres/CHPS compounds) located far from secondary facilities-Rural	Supported	Neutral	Supported	Supported
Labour unions in health sector	Strongly supported	Neutral	Neutral-opposition	Supported
NDC (the ruling political party)	Strongly supported	Strongly supported	Strongly supported	Neutral
NPP (Current ruling party)	Supported	Strongly opposed	Strongly opposed	Strongly supported
NHIS registered members	Opposed	Strongly opposed	Strongly opposed	Strongly supported

> They *did not educate us at the grassroots, they just woke up and said you have to choose one health facility […]. If you don't explain it well to me, how will I see the benefits it has?* (Male FGD, Kumasi Metropolis).

Second, key stakeholders including providers and clients did not understand some of the design provisions of the policy and hence such provisions were misinterpreted and not effectively implemented. These provisions include procedures for assignment of clients to providers, emergency service delivery and the portability provisions. The NHIS clients complained of difficulty in accessing emergency care and being assigned to facilities without their knowledge.

> *I went to Suntreso hospital and they told me my preferred primary care provider was County hospital and I told them I did not select anything like that and more so I have never sought care there, but because they insisted that was where they selected for me, they did not take care of me, so I had to pay money before they treated me* (Female FGD, Kumasi Metropolis).

Third, the exclusion of medicines from the capitation benefit package gave providers a dis-incentive to control cost and prevent diseases. Providers could not also differentiate between the capitation rate and the tariffs for reimbursements under DRGs and FFS systems and hence argued that the capitation rate was woefully inadequate.

> *If the clients don't visit the hospital, you have that component of service alone, your drugs will be there but the department that gives the hospital money is not the service, it is the drugs department* (Health Center, CHAG, Ahafo Ano South).

Fourth, stakeholders argued that the capitation policy was incompatible with some of the existing health system characteristics of Ghana. They argued that the poor Ghana Health Service gatekeeper system, the limited prescription responsibilities of primary healthcare facilities and the uneven geographic distribution of health facilities and personnel negatively affected the pilot implementation. These health system-wide flaws worked to the disadvantage of rural residents and lower-level health facilities.

> *The hospitals were getting more of clients than the CHPS because if I choose your facility (CHPS), there are certain drugs I can't get them unless you refer me (*District hospital, public, Ahafo Ano South).

> *I don't even understand why they even implemented this capitation policy here, because they know our community is a village and all the good doctors are in cities* (Male FGD, Ahafo Ano South).

Fifth, most of the stakeholders supported the suspension of the policy because of the delayed completion of the pilot phase and the nationwide scale-up. Whilst some stakeholders argued that it was wrong for the NHIS to start the pilot without a clear end date, others argued that the pilot was initially meant to last for only 2 years but because of the inability of the NHIS to learn positive lessons from the pilot, they could not scale up the policy to other parts of the country. This delay in scaling up the policy made stakeholders argue that the policy was weak and hence needed to be cancelled (Myjoyonline.com, 2017).

> *What people were saying is that […], we have been on pilot for about 4-5 years so if the policy is good, extend it to everywhere* (Accounts staff, Public Hospital, Kumasi Metropolis).

Last, some unintended negative consequences were reported by the NHIS clients and other stakeholders about the pilot implementation. These consequences included increasing healthcare costs, low patronage of primary healthcare facilities, mortality due to challenges in accessing care and out-of-pocket healthcare payments.

Table 5 Stakeholders' power and influence on the policy implementation

Stakeholder	Source of power	Strategies employed to influence policy	Level of influence	
			2012–16	2017–Date
Academics	• Technical knowledge • Research skills	• Research on impacts of pilot • Presentations at conferences	Low	Low
ADU	• Influence over public opinion • Ability to mobilize the public • Technical knowledge	• Press conferences • Public demonstrations • Led alliance of opponents	High	High
NGOs in Health	• Influence over public opinion • Community mobilization	• Public education on the policy	Low	Low
SPMDP	• Implementation power • Control over private facilities	• Media debates • Initial boycott of capitation • Charging of illegal co-payments • Lobbying of new government • Joined alliance of opponents	High	High
Health administration	• Control over public facilities • Regulator of private health facilities • Member of regional level capitation implementation committee	• Provided technical and administrative support for capitation • Petition letters • Press conference on impact of capitation on health facilities	Medium	Medium
Healthcare facilities	• Implementation power • Influence over public opinion	• Encouraging and sponsoring enrolment onto capitation • Petitions/complains about low tariffs	Medium	Medium
Labour unions in health sector	• Influence over health workers • Implementation power	• Joined alliance of opponents • Media interviews	Medium	Medium
NDC (then ruling political party)	• Control over NHIA management • Involvement in policy design and implementation • Parliamentary representation • Political authority	• Public education and defense of policy in the media	Very high	low
NPP (Current ruling party)	• Political dominance in the region • Representation in parliament • Control over NHIA management • Political authority	• Joined alliance of opponents • Petitions, press conferences and public demonstrations • Political campaigns against capitation • Lobbying of new government	High	Very high
NHIS registered members	• Ultimate beneficiaries of policy • Voting power	• Public demonstration • Dropout of NHIS in the region • Protest at facilities and in media • Voted against the then ruling party	High	Very high

> *Our studies showed that even the cost that was supposed to be reduced actually went up [. . .] the cost per unit was just escalating* (Academic).

> *The capitation wasn't helping the smaller facilities (health centres) because the money coming to the facilities was reduced because of the low total turn out of clients coming to those facilities* (Administrative staff, Health Centre, Kumasi Metropolis).

The regional political context

Stakeholders argued that choosing the stronghold of the main opposition party as the only region for the pilot implementation attracted partisan interest in the policy and resulted into suspicion and misinterpretations that surrounded the pilot implementation. Box 1 presents quotations from stakeholders' views about the political context of the policy.

The NPP as a political party initially supported the policy through its parliamentary representation on the Health Committee. When it was being piloted, regional level stakeholders such as SPMDP, the ADU and the NHIS clients started raising various concerns about the impact of the policy. In response, the NDC sent its national executives and its regional party communicators onto the radio at the regional level to educate the public about the policy and defend the policy. The regional executives of the opposition NPP interpreted that as a political activity and had to provide counter-arguments against the capitation pilot. The regional level stakeholder debates against the pilot, which started on technical grounds, then became political, compelling the NPP Members of Parliament from the Ashanti region to withdraw their initial support for the pilot and to call for its suspension/review (*Ghana News Agency*, 2012b; allAfrica.com, 2014; The Herald Team, 2014; Tv3network.com, 2014). However, the NDC argued that, since the policy received bipartisan approval in parliament, its role in defending the policy was technical rather than political.

Box 1 Key quotations from stakeholders on the political nature of the capitation policy

Politics came in because of the choice of the region, the stronghold of the opposition party (Academic).

The NDC sent their party officers [...] to flood the radios of Kumasi and they had interviews to explain the capitation. So, we were looking at it, if capitation is by the NHIA and you have national officers, regional officers (of the NDC) being the ones that are spearheading the communication, then it is political (NPP).

I was surprised when our colleagues in the NPP then did not join us to defend the capitation particularly when their members of parliament sat on the health committee and subsequently the plenary before that capitation was finalized (NDC).

The whole thing became politics because sometimes when you listen to radio discussions you could see that a politician will come and sit and be speaking just his/her mind and when you listen to the person very well, you could see that the person doesn't really understand the policy. So, they were fighting for their political interest (District hospital, Public, Kumasi Metropolis).

The current government who was then in opposition joined the crusade against it, so it was one of its promises once it joined the crusade. So, it made the then government so unpopular [...] they (NPP) came to power and had little to do than to suspend it (Ashanti Development Union).

When he (current president) was campaigning, people were complaining and he promised he will cancel it so when he came, he cancelled it (FGD with males, Ahafo Ano South).

We said they should cancel the capitation policy, but they did not, and it is also a reason why they lost the elections [...] and lots of votes in Ashanti region because they did not listen to us (FGD, Male, Kumasi Metropolis).

So, when they came into power, the regional minister here was very vocal against capitation so I think that it is the political stand that they obeyed. Now that he as a regional minister says he doesn't want it in his region, before we realized they suspended it (Regional Health Administration).

During the 2016 parliamentary and presidential elections, various officers of the NPP at both the regional and national levels, including then NPP presidential candidate (now president), made statements on political campaign platforms against the capitation policy and promised to cancel it if the party was voted into power (*Daily Guide*, 2012; Peacefmonline, 2012; Buachi, 2016). In our FGDs, the NHIS clients argued that they voted against the NDC party for failing to listen to them and withdraw the capitation policy from the region. The NDC party subsequently lost the December 2016 elections to the then opposition NPP. The coming into power of the NPP in January 2017 meant that the current government had entered a social contract with the electorate in the Ashanti region to cancel the capitation policy. The new government appointed some of the anti-capitation campaigners into key positions (Alhassan, 2011; Gadugah, 2014). Changes were also made in the top management of the NHIA. Stakeholders argued that these new government appointees and the regional party executives of the NPP put pressure on the new government to take a cabinet decision to suspend the policy. This cabinet decision was first announced at the NPP party's Ashanti Regional Conference by the Senior Minister (Myjoyonline.com, 2017).

Discussion

Our policy analysis is among the few that focused on how a policy issue drops off the policy agenda after receiving political attention (Bump *et al.*, 2013; Smith, 2014; Koduah *et al.*, 2016). To the best of our knowledge, it is also the first to adapt the Shiffman and Smith (2007) framework to explain sub-national (regional) level policy dynamics. Below, we discuss four key lessons from this Ghanaian policy experience and their implications for health policy reforms in similar LMICs.

First, in line with the Shiffman and Smith (2007) model, our study confirms a multi-faceted and varied technical and political framing of the capitation policy and its implementation rationale within the Ashanti region (Koduah *et al.*, 2016). Framing capitation as a technical strategy of containing cost resonated internally (Shiffman and Smith, 2007) and strongly appealed to the NHIA and other stakeholders with technical knowledge of health insurance. However, this cost-containment frame did not fully resonate externally and therefore gave rise to a politically negative reframing of the policy as a strategy to punish fraudulent providers and opposition party electorates. The dominance of the then opposition party in the pilot region fuelled this politically reframing (Koduah *et al.*, 2016). Partisan politicians often ladder on controversial policy language and labels to engage in what Seddoh and Akor (2012) referred to as 'symbols manipulation' in order to preserve their political constituencies. Although technically justified, it was politically risky to have selected the stronghold of the main opposition party for the capitation pilot. This Ghanaian policy experience elucidates the fact that technical, financial and economic justifications of policies can be politically interpreted differently by policy actors, which can cause confusion around reform intents and derail stakeholder's commitment to a policy (Grindle and Thomas, 1989; Thomas and Gilson, 2004; Koduah *et al.*, 2016).

Second, our results confirm stakeholders' recognition of a problem with the current NHIS provider payment system that requires policy reform and capitation as a potential policy solution (Kingdon, 1985; Parkhurst and Vulimiri, 2013). However, the failure of the pilot capitation policy to meet key stakeholder expectations (adequate understanding and involvement) attracted strong stakeholder opposition to its implementation. Similar to the findings of earlier policy analyses in Ghana (Agyepong and Adjei, 2008; Seddoh and Akor, 2012; Abiiro and McIntyre, 2013; Koduah *et al.*,

2016), we confirm that those stakeholders that derived their power from political/electoral sources (political parties and voters) had the greatest influence on the suspension of the policy. According to Shiffman and Smith (2007), a cohesive collaborative policy community, strong mobilization of civil society and a widely accepted leadership around an issue are required to ensure issue attention. Our study rather discovered a cohesive community of anti-policy actors, weak civil society mobilization and an existing political leadership that was not trusted at the regional level. An anti-reform (Shiffman, 2019) alliance that emerged became an anti-policy entrepreneurial group (Oborn *et al.*, 2011) exploring various favourable moments of policy change opportunities to shut the capitation policy window (Kingdon, 1985; Shiffman and Smith, 2007).

Third, the anti-policy campaigners/entrepreneurs drew on contentious, poorly understood and poorly implemented characteristics of the policy to request for its cancellation. Controversies surrounding the adequacy and computation of the capitation rate were reported (Koduah *et al.*, 2016). Similar to the findings of Parkhurst and Vulimiri (2013), we confirm that unfavourable health system characteristics constrained the implementation of the capitation policy in Ghana. The delay in scaling up the policy was interpreted as a policy failure and hence the need to suspend the entire policy for a possible review (Ghana News, 2017; Myjoyonline.com, 2017). The removal of medicines from the capitation basket as a response to actor contestation (Koduah *et al.*, 2016) defeated the overall cost-containment objective of the policy; hence the poor policy impact on cost containment (Andoh-Adjei *et al.*, 2018a).

Finally, our analysis shows that implementing a potentially controversial policy such as capitation within a politically sensitive location, dominated by supporters of an opposition political party, can attract unanticipated partisan political interest in the policy especially if partisan political actors get involved in policy communication. This unanticipated partisan interest can shift the debates of the merits of the policy from the technical domain to a political domain. Once the policy issue becomes political, a change in government (Smith, 2014) and its consequential changes in actor power, can bring a closure to the existing window for policy implementation. The limitations of the study are presented in the Supplementary file published online.

Conclusion

We conclude that technically framing capitation as a cost-containment strategy with less attention on portraying its health benefits resulted in a politically negative reframing of the policy as a strategy to punish fraudulent providers and opposition party electorates. The emergence of an anti-policy community, weak civil society mobilization and low popularity of the then political leadership at the regional level constrained the capitation pilot implementation. Drawing on very contentious, poorly understood and poorly implemented characteristics of the policy, the anti-policy community demanded the policy cancellation. A change in government in 2017 created a window of opportunity for the suspension of the policy. Although technically justified, we conclude that it was politically risky to have selected the stronghold of the main opposition party for the capitation pilot. Other LMICs contemplating capitation reforms should note that piloting a potentially controversial policy such as capitation within a politically sensitive location, dominated by supporters of an opposition political party, can attract unanticipated partisan political interest in the policy, which can potentially lead to a fall in political attention for the policy in the event of a change in government. Although very essential for learning lessons to inform policy scale-up, piloting of major health system reforms should be implemented in politically less sensitive and relatively smaller locations within a clearly defined and well-communicated timeframe that would be strictly adhered to. To obtain stakeholder support for those reforms, stakeholder expectations must be incorporated into the designs and implementation processes of the reforms. The reforms should be externally framed to reflect their broader benefits to the public rather than just the internal technical reform objectives.

Supplementary data

Supplementary data are available at *Health Policy and Planning* online.

Conflict of interest statement. The authors declare no conflict of interest.

Acknowledgements

The data collection was supported by a small family foundation grant administered by the Center for Policy Impact in Global Health, Duke Global Health Institute, USA. We are very grateful to our RAs, Faisal Abdallah Kaamah and Mohammed Salifu for supporting the data collection.

Ethical approval. The Ghana Health Service Ethics Review Committee granted ethical clearance (GHS-ERC009/10/19) for the study. The Ashanti Regional Health Director and all stakeholder organizations granted us permission to conduct the study. Written informed consent was obtained from each respondent before the administration of the data collection instruments and audio-recording of the responses.

References

Abiiro GA, McIntyre D. 2013. Universal financial protection through National Health Insurance: a stakeholder analysis of the proposed one-time premium payment policy in Ghana. *Health Policy and Planning* **28**: 263–78.

Aboagye AQQ. 2013. Capitation in HealthCare financing in Ghana. *East African Medical Journal* **90**: 156–63.

Agyepong IA, Adjei S. 2008. Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. *Health Policy and Planning* **23**: 150–60.

Agyepong IA, Aryeetey GC, Nonvignon J *et al.* 2014. Advancing the application of systems thinking in health: provider payment and service supply behaviour and incentives in the Ghana National Health Insurance Scheme—a systems approach. *Health Research Policy and Systems* **12**: 35.

Alhassan I. 2011. Ex-KATH CEO chides government over NHIS Capitation Policy. *Ghanaian Chronicle*.

allAfrica.com. 2014. Ghana: parliament calls for review of NHIs capitation programme. *allAfrica.com*.

Andoh-Adjei F, Boudewijns B, Nsiah-Boateng E *et al.* 2018a. Effects of capitation payment on utilization and claims expenditure under National Health Insurance Scheme: a cross-sectional study of three regions in Ghana. *Health Economics Review* **8**: 17.

Andoh-Adjei F-X, van der Wal R, Nsiah-Boateng E, Asante FA, van der Velden K, Spaan E. 2018b. Does provider payment method affect membership retention in a health insurance scheme? a mixed methods study of Ghana's capitation payment for primary care. *BMC Family Practice* **18**: 52.

Andoh-Adjei F-X, Spaan E, Asante FA, Mensah SA, van der Velden K. 2016. A narrative synthesis of illustrative evidence on effects of capitation payment for primary care: lessons for Ghana and other low/middle-income countries. *Ghana Medical Journal* **50**: 207–19.

Anson AA. 2010. NHIA to adopt capitation system of payment | Post Election News | Ghana | africanelections.org|. *Daily Graphic*.

Appiahkorang J. 2012. NPP protest NHIS capitation policy. *Today Newspaper*.

Atuoye KN, Vercillo S, Antabe R, Galaa SZ, Luginaah I. 2016. Financial sustainability versus access and quality in a challenged health system: an

examination of the capitation policy debate in Ghana. *Health Policy and Planning* **31**: 1240–9.

Awuah J. 2012. NDC introduced capitation system to send people to their early graves—Ex-KATH Boss. *peacefmonline.com*.

Barnum H, Kutzin J, Saxenian H. 1995. Incentives and provider payment methods. *International Journal of Health Planning and Management* **10**: 23–45.

Bastani P, Samadbeik M, Kazemifard Y. 2016. Components that affect the Implementation of Health Services' Strategic Purchasing: a comprehensive review of the literature. *Electronic Physician* **8**: 2333–9.

Brugha R, Varvasovszky Z. 2000. Stakeholder analysis: a review. *Health Policy and Planning* **15**: 239–46.

Buachi B. 2016. Mahama fingered for rising mortality due to failed NHIS Capitation experiment. *Raw Gist*.

Bump JB, Reich MR, Johnson AM. 2013. Diarrhoeal diseases and the global health agenda: measuring and changing priority. *Health Policy and Planning* **28**: 799–808.

Citifmonline.com. 2017. NHIA capitation programme suspended in Ashanti Region. *Citi 97.3 FM - Relevant Radio*.

Daily Guide. 2012. Nana Addo angry over NHIS capitation in Ashanti. *Daily Guide*.

Daily Post. 2012. Akufo-Addo's plot against NHIS thwarted! *Daily Post*.

Dapatem DA. 2014. Prez explains use of Ashanti to pilot NHIS capitation. *Graphic Online*.

Dodoo JNO. 2013. A stakeholder analysis of the capitation pilot under Ghana's National Health Insurance Scheme in the Ashanti region. *MPH Thesis*. University of Ghana.

Etiaba E, Onwujekwe O, Honda A *et al*. 2018. Strategic purchasing for universal health coverage: examining the purchaser–provider relationship within a social health insurance scheme in Nigeria. *BMJ Global Health* **3**: e000917.

Frimpong ED. 2013. NHIS to extend capitation to 2 more regions. *Graphic Online*.

Gadugah N. 2014. Mass murder or failed NHIS? Minority rallies Ghanaians to rise up. *Myjoyonline.com*.

Ghana News Agency. 2012a. Controversy over NHIS capitation deepens in Ashanti Region. Ghana News Agency.

Ghana News Agency. 2012b. Parliamentarians calls for suspension of NHIA capitation policy in Ashanti. Ghana News Agency.

Ghana News Agency. 2014. NHIA to roll out capitation to three other regions. Ghana News Agency.

Ghana News Agency. 2015a. SEND-Ghana sensitises people of UWR on NHIS capitation. Modern Ghana.

Ghana News Agency. 2015b. Capitation is to promote NHIS objectives | Ghana News Agency (GNA). Ghana News Agency.

Ghana Statistical Service. 2012. *2010 Population and Housing Census: Summary Report of Final Results*. Accra: Ghana Statistical Service.

Gilson L, Orgill M, Shroff ZC. 2018. *A Health Policy Analysis Reader: The Politics of Policy Change in Low- and Middle-Income Countries*. Geneva: World Health Organization.

Green-Pedersen C, Wilkerson J. 2006. How agenda-setting attributes shape politics: basic dilemmas, problem attention and health politics developments in Denmark and the US. *Journal of European Public Policy* **13**: 1039–52.

Grindle MS, Thomas JW. 1989. Policy makers, policy choices, and policy outcomes: 'The political economy of reform in developing countries'. *Policy Sciences* **22**: 213–48.

Hyder A, Syed S, Puvanachandra P *et al*. 2010. Stakeholder analysis for health research: case studies from low-and middle-income countries. *Public Health* **124**: 159–66.

Jegers M, Kesteloot K, De Graeve D, Gilles W. 2002. A typology for provider payment systems in health care. *Health Policy* **60**: 255–73.

KAD Africana. 2012. Group suspends demo against NHIS Capitation in Ashanti. *Modern Ghana*.

Kingdon A. 1985. *Agendas, Alternatives, and Public Policies*. Boston: Little, Brown.

Koduah A, van Dijk H, Agyepong IA. 2015. The role of policy actors and contextual factors in policy agenda setting and formulation: maternal fee exemption policies in Ghana over four and a half decades. *Health Research Policy and Systems* **13**: 27.

Koduah A, van Dijk H, Agyepong IA. 2016. Technical analysis, contestation and politics in policy agenda setting and implementation: the rise and fall of primary care maternal services from Ghana's capitation policy. *BMC Health Services Research* **16**: 323.

Kutzin J. 2013. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization* **91**: 602–11.

Lagomarsino G, Garabrant A, Adyas A, Muga R, Otoo N. 2012. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet* **380**: 933–43.

Liu X, Lindquist E, Vedlitz A, Vincent K. 2010. Understanding local policymaking: policy elites' perceptions of local agenda setting and alternative policy selection. *Policy Studies Journal* **38**: 69–91.

McIntyre D. 2007. Learning from experience: health care financing in low-and middle-income countries. Geneva: *Global Forum for Health Research*.

Myjoyonline.com. 2017. Gov't to cancel NDC's capitation policy for healthcare. *Ghana|myjoyonline.com*.

National Health Insurance Authority. 2012. *Capitation Enrollment Regulations: National Health Insurance Scheme*. Accra: National Health Insurance Authority.

Oborn E, Barrett M, Exworthy M. 2011. Policy entrepreneurship in the development of public sector strategy: the case of London health reform. *Public Administration* **89**: 325–44.

Owusu M. 2012. NPP Demo Hits NHIS Capitation. *Daily Guide*.

Parkhurst JO, Vulimiri M. 2013. Cervical cancer and the global health agenda: insights from multiple policy-analysis frameworks. *Global Public Health* **8**: 1093–108.

Peacefmonline. 2012. NDC can be dangerous to your health. . .pray you don't fall sick for 4 years if you vote for them—Akufo Addo | Politics | Peacefmonline.com. *Peacefmonline.com/Ghana*.

Public Relations Committee NPP-USA. 2014. NPP-USA Fully Supports Chairman Wontumi. Ghanaweb.com.

Robyn PJ, Sauerborn R, Bärnighausen T. 2013. Provider payment in community-based health insurance schemes in developing countries: a systematic review. *Health Policy and Planning* **28**: 111–22.

Sackey FG, Amponsah PN. 2017. Willingness to accept capitation payment system under the Ghana National Health Insurance Policy: do income levels matter? *Health Economics Review* **7**: 38.

Seddoh A, Akor SA. 2012. Policy initiation and political levers in health policy: lessons from Ghana's health insurance. *BMC Public Health* **12**: S10.

Shiffman J. 2019. Political context and health financing reform. *Health Systems & Reform* **5**: 257–9.

Shiffman JL, Smith S. 2007. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *The Lancet* **370**: 1370–9.

Smith SL. 2014. The emergence, growth and decline of political priority for newborn survival in Bolivia. *Health Policy and Planning* **29**: 951–9.

Sodzi-Tettey S, Aikins M, Awoonor-Williams JK, Agyepong IA. 2012. Challenges in provider payment under the Ghana National Health Insurance Scheme: a case study of claims management in two districts. *Ghana Medical Journal* **46**: 189–99.

Takyi E, Danquah A. 2015. Rolling out the capitation payment system in Ghana: lessons from the pilot implementation in Ashanti Region. *Available at SSRN 2641605*. 10.2139/ssrn.2641605, accessed 27 January 2020.

The Herald Team. 2014. NPP MPs caught in Kumasi ethnocentric demo. *Herald*.

Thomas S, Gilson L. 2004. Actor management in the development of health financing reform: health insurance in South Africa, 1994-1999. *Health Policy and Planning* **19**: 279–91.

Tv3network.com. 2014. Parliament suspends debate on 'Capitation' motion.

Walt G, Gilson L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning* **9**: 353–70.