AN ASSESSMENT OF FACTORS AFFECTING IMPLEMENTATION OF CAPITATION PROGRAMME IN PROVISION OF THE HEALTH CARE SERVICES; A CASE OF NAIROBI COUNTY ACCREDITED HEALTH FACILITIES

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CBM/12/10121/11

A Thesis Submitted to the Graduate School in Partial Fulfillment of the Requirement for the Award of Master of Business Administration Degree, Faculty of Commerce

Kisii University

September, 2014
DECLARATION AND RECOMMENDATION

This research thesis is my original work and has not been presented for examination in any other university nor institution of higher learning.

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SUPERVISOR’S RECOMMENDATION

This research thesis has been submitted for examination with our approval as university supervisors.

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DEDICATION

I dedicate my Masters work to my dear wife Nyaboke, daughter Emily Kamwana, currently a student at the University of Eastern Africa, Baraton and my Late Son Evans Ondieki who inspired and encouraged me to undertake the post graduate studies offered at Kisii University.
ACKNOWLEDGEMENT

I wish first and foremost to appreciate the Almighty God who has constantly served as my source of inspiration and hope, I extend my appreciation to my supervisors, Dr. Yambo and Charles Ongiyo for their scholarly, expertise and consistent encouragement that they have extended to me during the tough times of writing this research thesis. Secondly I can’t afford to leave out my wife Nyaboke and children Emily Kamwana and Evans Ondieki for allowing me to be out of the family issues just to concentrate on my studies and by encouraging me when I was low. I want also to appreciate the work done by my friends who made sure my affairs were taken health care of throughout this time and edited this work. Lastly, I will not miss to appreciate my classmates for working closely with me. They encouraged me to pursue the thesis title to the end whenever I was in the verge of giving up. And all those who worked with me unknowingly I wish to appreciate your work.
The emergence of the managed health care industry, which now is the model for the delivery of the medical health care to over half of the nation’s citizens and in some areas approaches 85 percent market penetration, has posed vexing problems for physicians, their patients, and third-party payers whether private or governmental. Managed health care, in all its variations, combines the business of the insurance industry with the delivery of professional health services. Capitation method of health financing was introduced in Kenya three years ago to be administered by NHIF however, its implementation created a lot of resistance from both politicians and common citizens as a result of selection of service providers. This study investigated the factors affecting implementation of capitation programme in the provision of health care in Kenya. Specifically, to examine the impact of government related factors e.g. accreditation of facilities and budgetary allocations on the levels of implementation of capitation programme in the provision of health care in Kenya, to investigate the influence of patient related factors e.g. forgery, magnitude of the claim on the levels of implementation of capitation programme in the provision of health care in Kenya, to examine the impact of service provider related factors on the levels of implementation of capitation programme in the provision of health care in Kenya and to find out the influence of management related factors on implementation of capitation programme in the provision of health care in Kenya. The research design was descriptive survey and the target population was health employees in Nairobi County in facilities accredited to NHIF capitation programme with a sample size of 130 respondents selected by stratified random sampling method. The study used one set of simple structured questionnaires and administered them to the various categories of respondents by physical drop and pick by research assistants. The validity of the research instruments was pre-tested to free them from ambiguity through a pilot study carried one week earlier and having been checked by other research experts. For reliability prerequisite test-retest reliability was carried out within a small time frame for consistence. It concluded therefore the factors affecting the levels of implementation of capitation include: government stewardship, political inclination, financing the programme, ignorance, reluctance and resistance, employment member contracts, types of ailment and self ego. Others are non adherence, lack of transparency. The study therefore recommends adoption an all inclusive approach in the a credential process, accredited centers should be published and frequent audit of patient records to be carried out, establishment of an accrediting committee, set aside enough funds, education on employees, set up a board of trustee and set minimum standards for accredited centers.
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<th>Description</th>
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<tr>
<td>ACBRPs:</td>
<td>Average-Cost Based Reimbursement Plans</td>
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<td>CCs:</td>
<td>Capitation Contracts</td>
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<td>DRGs:</td>
<td>Diagnosis Related Groups</td>
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<td>EFA:</td>
<td>Exploratory Factor Analysis</td>
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<td>FFS:</td>
<td>Fee For Service</td>
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<td>HMO:</td>
<td>Health Maintenance Organization</td>
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<td>IPA:</td>
<td>Independent Practice Association</td>
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<td>MCO:</td>
<td>Managed Health care Organization</td>
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<td>MAR:</td>
<td>Missing At Random</td>
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<td>NHIF:</td>
<td>National Health Insurance Funds</td>
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<td>PHOs:</td>
<td>Physician-Hospital Organizations</td>
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<td>PMPM:</td>
<td>Per Member/Per Month</td>
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<td>RBRVS:</td>
<td>Resource-Based Relative Value Scale</td>
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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Capitation refers to a form of health care payment system. In a capitation model, a provider or hospital is paid by the insurer (or other payer) an amount per patient during a period of time. Capitation is a payment arrangement for health care service providers such as physicians or nurse practitioners. It pays a physician or group of physician a contracted or agreed amount for each enrolled person assigned to them, per period of time, whether or not that person seeks health care. These providers generally are contracted with a type of health maintenance organization (HMO) known as an independent practice association (IPA), which enlists the providers to health care for HMO-enrolled patients (Custer’s and Klazinga 2007). The amount of remuneration is based on the average expected health care utilization of that patient, with greater payment for patients with significant medical history. Rates are also affected by age, race, sex, type of employment, and geographical location, as these factors typically influence the cost of providing health care, the physician, hospital, or other health care provider is paid a contracted rate for each member or nature of services provided.

The contractual rates are usually adjusted for age, gender, illness, and regional difference. Under a capitation, an HMO or managed health care organization pays a fixed amount of money for its members to the health care provider. Also referred to as capitation agreement, capitation contract and managed health care capitated contracts. Capitation is a fixed prepayment, per patient covered, to a health care provider to deliver medical
services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.

Capitation payments are used by managed health care organizations to control health care costs. Capitation payments control use of health care resources by putting the physician at financial risk for services provided to patients. At the same time, in order to ensure that patients do not receive suboptimal health care through under-utilization of health care services, managed health care organizations measure rates of resource utilization in physician practices. These reports are made available to the public as a measure of health care quality, and can be linked to financial rewards, such as bonuses (Alman, 2003). Providers who work under these plans focus on preventive health care, as there is greater financial reward in prevention of illness than in treatment of the ill. Such plans avert providers from the use of expensive, newly developed treatment options that may be less effective or have only a marginally higher success rate than alternative.

The financial risks providers accept in capitation are traditional insurance risks. Provider revenues are fixed, and each enrolled patient makes his or her claims against the full resources of provider. In exchange for this fixed payment, physicians essentially become the enrolled clients’ insurers, who resolve their patients’ claims at the point of health care and assumed the responsibility for their unknown future health care costs. Large providers tend to manage this risk better than do smaller providers, because they are better prepared for variation in service demand and costs, but even large providers are
inefficient risk managers in comparison to large insurers. Providers tend to be small in comparison to insurers, and so are more like individual consumers, whose annual costs as a percentage of their annual cash flow fluctuated far more than do those of large insurers (Harold, 2009).

Physicians and other health care providers lack the necessary actuarial, underwriting, accounting and finance skills for insurance risk management, but their most severe problem is the greater variation in their estimates of the average patient cost, which leaves them at a financial disadvantages as compared to insurers whose estimates are far more accurate. Because their risks are a function of portfolio size, providers can only reduce their risks by increasing the number of patients they carry on their rosters, but their inefficiency relative to that of the insurers’ is far greater than can be mitigated by these increases. To manage risk as efficiently as an insurer, a provider would have to assume 100% of the insurer’s portfolio (Christensen and Grönvall 2011). HMOs and insurers manage their costs better than risk-assuming health care providers, and cannot make risk-adjusted capitation payments without sacrificing profitability. The risk transferring entities will only enter into such agreements if they can maintain the levels of profits they achieve by retaining risks (Custers and Klazinga, 2007).

Providers cannot afford reinsurance, which would further deplete their inadequate capitation payments, as the re-insurer’s expected loss costs, expenses, profits and risk loads must be paid by the providers. The goal of reinsurance is to offload risk and reward to the re-insurer in return for more stable operating results, but the provider’s additional
costs make this impractical (Harold, 2009). Reinsurance assumes that the insurance-risk-transferring entities do not create inefficiencies when they shift insurance risks to providers. Absent any induced inefficiencies, providers would be able to pass on a portion of their risk premiums to reinsurers, but the premiums that providers would have to receive would exceed the premiums that risk-transferring entities could charge in competitive insurance markets. Re-insurers are a way of contracting with physicians, as they believe that providers think they can collect more than they pay in premiums, they would tend to revert to the same excesses encouraged by fee-for-service payment systems (Johns Hopkins, 2011).

The benefits to capitation for a doctor or insurer are mostly the decreased costs of bookkeeping. Doctors don’t have to pay huge staffs of billing people, nor do they have to wait to be reimbursed for any specific services. Their actual cost to health care for their patients may decrease (Altman, 2003). There are few benefits of capitation system to a patient. The detriment is that the doctor begins to make decisions about what health care he will or won’t provide because he will make more money by providing less health care, a form of health care rationing. While a capitation system might not ordinarily be of interest to patients, it is becoming more so due to its inclusion in some of the health care reform models being discussed (Cox, 2012).

The application of capitation to physicians’ practices can result in the provision of cost-effective, quality medical health care. It is important to note, however, that the potential for conflict exists under such systems. Managed health care organizations and the
physicians who contract with them should attempt to minimize these conflicts and to ensure that capitation is applied in a manner consistent with the interests of patients (Maarse, 2006). Physicians have the obligation to evaluate a health plan’s capitation payments prior to contracting with that plan to ensure that the quality of patient health care is not threatened by inadequate rates of capitation. Capitation payments should be calculated primarily on relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary health care. Furthermore, the predictable costs resulting from existing conditions of patients should be considered when determining the rate of capitation. Different population of patients has different medical needs, and the costs associated with those needs should be reflected in the per-member per-month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all necessary health care, and should refuse to sign agreements that fail in this regard (Custers and Klazinga 2007).

Physicians must not assume inordinate levels of financial risk, and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by the physicians evaluating a plan, as well as in determinations of the per-member per-month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence the probability and the behavior of larger systems. Similarly, length of time will influence the predictability of patient expenditures and should be considered accordingly. Capitation rates calculated for large plans over an extended period of time are able to be more accurate and therefore
preferable to those calculated for smaller groups over a short time period (Harold, 2009). There are several types of capitation such as Primary, Secondary and Global capitation with various variations but all of them have a similar purpose as the name implies. However, Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide service in a health plan (Maarse, 2006).

1.2 Statement of the Problem

The emergence of the managed health care industry, which now is the model for the delivery of the medical health care to over half of the nation’s citizens and in some areas approaches a big percentage market penetration, has posed vexing problems for physicians, their patients, and third-party payers whether private or governmental (C0x, 2010). Managed health care, in all its variations, combines the business of the insurance industry with the delivery of professional health services. Capitation method of health financing was introduced in Kenya three years ago however, its implementation faced resistance from both politicians and common citizens as a result of selection of service providers. It is on the basis of these challenges that the study was carried out to investigate the factors affecting capitation programme in provision of health care services in Kenya.
1.3 Objective of the Study

The purpose of the study was to assess factors affecting implementation of capitation programme in the provision of health care in Kenya. The specific objectives include:

1. To examine the impact of government related factors e.g. accreditation of facilities and budgetary allocations on the implementation of capitation programme in the provision of health care in Kenya.

2. To investigate the influence of patient related factors e.g. forgery, magnitude of the claim on the implementation of capitation programme in the provision of health care in Kenya.

3. To examine the impact of service provider related factors e.g. selection criterion on the implementation of capitation programme in the provision of health care in Kenya.

4. To find out the influence of management related factors on implementation of capitation programme in the provision of health care in Kenya.

1.4 Research Questions

To meet the above objectives the following research questions were formulated:

1. What is the impact of government related factors e.g. accreditation of facilities and budgetary allocations on the implementation of capitation programme in the provision of health care in Kenya?

2. What is the influence of patient related factors e.g. forgery, magnitude of the claim on the implementation of capitation programme in the provision of health care in Kenya?

3. What is the impact of service provider related factors on the implementation of capitation programme in the provision of health care in Kenya?

4. What is the influence of management related factors on implementation of capitation programme in the provision of health care in Kenya?
1.5 Significance of the Study

The findings of this study will be used by different stakeholder such as the government to formulate policies and strategies of implementation of capitation, the patients to access health services and the service providers to use capitation to effectively access the patients. It will be used by policy makers to make policies which will guide the implementation of capitation in healthy sector. It will be used by service providers to embrace capitation as a way of financing health health care services which in turn will enable them to meet the needs of many patients. It will be used by doctors and other medical practitioners to underscore the importance of capitation in financing healthy services. Researchers will use it to establish the relationship between capitation and efficient provision of health care services.

1.6 Scope of the Study

The study was carried out in the accredited Health facilities Nairobi County in the Republic of Kenya. Covered factors which affect implementation of capitation in health care in terms of Government related factors, patient related factors, service provider related factors and Management related factors. It was carried out in the month of August, 2014.

1.7 Limitations of the Study

The study faced limitations of suspicion of the respondents as regards the intention of the study, the accessibility of patient records due to ethical problems, and the limitation of the period of implementation between the years 2010 and 2013. The study covered only those years when the implementation of capitation was done; the target population was
just the employees of the National Hospital Insurance Fund Nairobi county, Administrators of accredited Facilities Nairobi county and Members/Patients at these facilities. It also faced time limitation and cost implications. The findings therefore will only be generalized to all accredited health facilities in the Republic of Kenya. The respondents were assured that any information given will be kept confidential and will be used for the purposes of this study only.

1.8 Operational Definition of Terms

**Capitation:** is a payment arrangement for health care service providers such as physicians or nurse practitioners. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks health care.

**Global Capitation:** it’s an arrangement where accredited health providers are found in different countries.

**Health care providers:** these are those institutions which provides health care services mainly the primary health care.

**Incentives:** Under capitation, physicians are given incentive to consider the cost of treatment. Pure capitation pays a set fee per patient, regardless of their degree of infirmity, and gives physicians an incentive to avoid the most costly patients.

**Medical practitioners:** in this study this refers to those individuals who provide health services
**Primary health care:** this is the type of health care which is preventive and in most cases for out patients.

**Secondary Capitation:** it’s a higher level of capitation where the accredited health provider provides accommodation and services of non preventable diseases.
CHAPTER TWO

LITERATURE REVIEW

2.1 Theoretical Review

2.1.1 Risk Theory of Capitation

In today's rapidly changing medical marketplace, managed health care plans are not the only entities assuming risk for the health care of enrollees through capitation (Anderson and Weller, 1999). Increasingly, managed health care plans are transferring this risk to their primary health care and specialty physicians by paying them on a fully or partially capitated basis. Although their views on capitation provided a strong incentive for physicians to provide cost effective health care, there are concerns that capitation may place some physicians at considerable financial risk.

Similarly, according to Garrett and Laurie (2007), capitation contracts and average cost based reimbursement Plans, such as Diagnosis Related Groups have existed for decades, they create risks for health providers and consumers that are not incidental but integral, though analysts have incorrectly identified and appraised these risks. These financing mechanisms have dire effects on providers and consumers, and have also affected the insurance industry, its operations and regulation. The long term consequences, however, have been little explored and this study has addressed some of these issues from the standpoint of nursing and nurses. Viewing ACBR plans as insurance contracts, reveals serious flaws. Such a view will help to demystify these mechanisms, open new vistas of research activity, and potentially contribute to ending the use of these harmful efforts at
cost containment. The unequal knowledge bases of the contractees also raise very serious ethical, legal, professional, and business concerns.

Providers engaged in CCs or ACBR plans agree, often involuntarily, to health care for clients, trading fixed payments for uncertain costs, creating and assuming many risks; some are predictable, and some are far from predictable (Richard et al., 2003). Predictable, though rarely predicted, risks reflect variations in health costs related to factors such as age, gender, employment status, or chronic illness status. The variation in this study is to analyze risks include the operating characteristics of the provider, which vary from unit to unit, shift to shift, based on patient acuity, staffing, resource management, and availability of needed supplies. Other risks include: self-selection biases, financial adversities when borrowing, and liabilities due to unplanned resource needs. Interestingly, providers tend to poorly manage these risks. Few discussions however, direct attention to the major risk source that inadequately resourced providers have entered the insurance business and adequately resourced insurers left the insurance business with no regulatory oversight or action.

2.1.2 Agency Theory of Capitation

Agency Theory and Payment Incentives Methods of payment constitute a form of incentive contract, linking the individual physician with the larger organization-be it an insurer, a medical group, or a governmental health benefits program. As such, the analysis and interpretation of physician payment falls within the larger economic literature on contracts and financial incentives, known as agency theory (Milgrom and
Roberts 1992; Pratt and Zeckhauser 1985; Sappington 1991). The essence of incentive contracting is the effort by one individual or organization the principal to induce and reward certain behaviors by another the agent. Financial rewards are only one, albeit an important one, among a variety of mechanisms for eliciting the desired behavior; other mechanisms include screening, socialization, and threats of contract termination (Farmer et al., 2006). This study has therefore distinguished between the level of payment the total amount expected to be paid by the principal to the agent and the structure of payment the manner in which payment is linked to specific measures of performance.

The level of payment ultimately must be set equal to or greater than the compensation that the agent could achieve in other settings and in the case of physician payment, will be determined by implicit social judgments concerning the expenditures necessary for attracting talented individuals into the profession (Tulenko et al., 2012). The structure of payment, which is the concern here, is designed to provide the highest reward to the agent at the lowest cost to the principal. Variations across occupations and industries in the structure of compensation are interpreted by economic theory as reflecting the characteristics of the tasks and the individuals who perform them, including the extent to which performance is easily monitored and measured, the extent to which individuals are averse to risk, the extent to which the desired behavior consists of one or multiple tasks, and the extent to which cooperation among multiple agents is a central feature of the work to be accomplished.
According to MacNeil (1978), the simplest form of payment conceptually one that provides powerful and easily understandable performance incentives is compensation linked directly to effort, as measured in the number of shirts sewn or boxes of fruit picked. Piece-rate payment is analogous to spot contracting among firms, and aligns incentives well in contexts where the desired behavior is simple and easily monitored. Piece rates can be adapted to quite complex work contexts, so long as the various tasks can be measured individually and compared to one another in a cardinal index. The most obvious example of piece rates in complex settings, of course, is fee-for-service payment for physician services, where the Current Procedural Terminology (CPT) code assigns a unique identifier to (almost) every clinical task and the Resource-Based Relative Value Scale (RBRVS) permits indexing and conversion into dollar units.

2.1.3 Capitation Models

There are basically two kinds of capitation models: Global Capitation and Partial or Blended Capitation. Each can be applied in various scenarios. Under global capitation, whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis. Generally, providers sign a single contract with a health plan to cover the health care of groups of members, and then must determine a method of dividing up the capitated check among the provider group (Vance, Howe, and Dellavalle, 2009). Under a partial or blended capitation model, a single payment is made for a defined set of services, while other services involved in a patient’s health care are paid for on a fee-for-service basis. Under each model of capitation, risk adjustment is essential to adequately compensate
providers for the risk they take-on. Payments are differentiated based on the characteristics of the enrollees in each provider patient group. Common risk adjustment factors include age, sex, health status, and prior health care utilization, as well as socio-demographic factors such as residence, income, etc.

**Global Capitation:** A global capitation model is applicable in a health maintenance organization (HMO) structure. The HMO is paid a specified amount per patient to deliver services over a set period of time. Usually the payment is determined on a per member/per month (PMPM) basis. The rates are generally calculated from projections of the services and costs of the provider’s patient population, based on historic costs. The payments vary to reflect the total number of patient for a provider and the demographic and acuity factors of the patient population. In some cases, co-payments may also be collected from embers for certain services. Under global capitation all health care is covered under the fee including primary health care, hospitalizations, specialist health care and ancillary services (Cox, 2011).

**Partial or Blended Capitation:** Under partial or blended capitation models, only certain types or categories of services are paid on a capitated basis. Typical scenarios under which partial capitation applies include primary health care capitation where a capitation amount is paid to primary health care practices for primary health care services and in some cases, ancillary services provided under the direction of the primary health care practice. Alternatively, specialists may be paid on a capitated basis for services they provide while the primary health care services are paid fee-for-service. Other carve-out
Capitation arrangements may involve paying for certain health care such as mental health on a capitation basis (Custer’s and Klazinga 2007). This differs from episode-based payment in that all the services included to health care for a patient by the mental health provider are covered.

2.2 Empirical Studies

2.2.1 Individual Related Factors

Many physicians misunderstand the theory of capitation and argue that patients will be denied needed services because the incentive once the capitation payment is received is to withhold medical services. In contrast, MCOs have complained that even under discounted fee-for-service arrangements the cost of health care has not decreased. Physicians and specialists in particular may even increase the volume of services to make up for the decrease in their per service reimbursement. In an attempt to control the volume of services, many insurance carriers have used preauthorization or second opinion programs for procedures. Paying for specialty services with monthly per member compensation allows the MCO to offload the risk for changes in the volume and associated cost (Sanderson, Colin Gruen and Reinhold 2006).

Those who believe that capitation is anti-patient are only thinking about the short-term incentives to withhold health care (Cox, 2011). All capitation contracts are renegotiated after one or two years based on the actual utilization of services by a member population. If the volume of services is smaller than that used to calculate the initial capitation rate, the MCO is justified in asking for a lower capitation rate in the subsequent contract.
Capitation arrangements allow physician groups to share the savings that high-quality, cost-effective medical health care produces. Groups that can quantify the costs of specific services and manage the utilization of those services through patient intervention and disease management techniques are most likely to be successful in risk contracts. Gastroenterologists across the United States are being asked to participate in health plans that put their practices at financial risk for the cost of services needed by their patients. Specialists can participate in capitation payment systems as part of a whole-life capitation contract to a multispecialty health system or as a separate specialty capitation. In either case, the specialist must be committed to providing health care under a system that endeavors to measure quality, manage disease, and provide all appropriate services on a fixed budget.

A specialty capitation contract tends to cover a large number of member lives spread out over a region. To satisfy the MCO's needs, this usually requires a network of specialists to ensure reasonable access for all eligible members. If the provider group plans to do nothing but turn the capitation pool into a discounted fee-for-service arrangement, the MCO is successful only in limiting their cost for specialty professional services (Custer’s and Klazinga 2007). In addition to regional coverage and controlled costs for professional services, MCOs want the group to control the expenditures for ambulatory facilities, which in gastroenterology can typically approach the same cost as professional reimbursement. The prospective physician group should consist of board-certified specialists prepared to consider alternative payment incentives and ready to institute utilization and quality review.
Capitation can affect the delivery of health care services by influencing individual provider decisions, by fostering innovation in disease management, and by encouraging integration of various components of the health delivery system. Physicians vary widely in their use of diagnostic tests, choice of medication, and therapeutic procedures (Vinten-Johansen, Peter, et al. 2003). The variation in practice style does not necessarily mean that one provider is appropriate and the other is inappropriate. Mirvis suggests that the differences between providers more likely are due to the uncertainty of outcomes and disagreement about the preferred course of action. On the continuum of resource utilization, there is a range of uncertainty that allows for differences in practice style. Outside this range lies practice patterns more clearly agreed by all as underutilization and overutilization. One of the obvious influences that affect physician decision and resource utilization is financial incentive. Specialty capitation places the responsibility of determining the acceptable range of practice in the hands of the physicians rather than the managed health care insurance company. Financial incentives can be aligned to avoid both underutilization and overutilization. Narrowing the range of uncertainty and acceptable practice pattern is better left to basic research in clinical science and outcomes (Sanderson, Colin Gruen and Reinhold 2006).

The magnitude of risk under capitation should not be so great as to influence an individual physician to make clinically imprudent choices for an individual patient. The primary aim of a capitated contract directly involving physicians should be to encourage peers to exchange information about their own patterns of health care, to support group learning about clinically prudent options, and to increase the likelihood of cooperation
among physicians and between physicians and managers to develop better programs of health care (Custer’s and Klazinga 2007). The services covered under capitation contracts should be those about which the risk-bearing entity can make relevant, clinically prudent choices, not those over which the entity has little or no influence. Capitation can encourage better decisions and facilitate the productive redesign of systems for the delivery of health care. Managed health care growth has affected physicians most dramatically in the way they are paid for the services provided to patients (Vinten-Johansen, Christensen, 2011). The phases of managed health care penetration into a region are characterized to a great degree by the change in payment methods. Markets see their traditional fee-for-service payment replaced by discounted fee schedules and eventually are dominated by per member fixed dollar prepayments to contracted physicians. In exchange for a guaranteed monthly capitation payment, physicians or physician groups are required to provide all contracted services to the extent needed by any patient of the member population.

Capitation payments can take different forms depending on the agreement with the managed health care organization (MCO). Most physicians are familiar with MCO direct capitation to individual providers for primary health care services. In most plans, other services remain the responsibility of the MCO to be paid on a fee-for-service basis. Alternatively the MCO can arrange a specialty capitation contract for specific services with specialty physician groups. The MCO can effectively offload almost all of its risk, keeping a significant percentage of the premium dollar for the marketing of the plan and coordinating the various capitated contracts (Cox, 2011).
Although the number of at risk specialty contracts is currently small, they are increasing in frequency and have had significant influence on other health care payment strategies. Capitation can align the incentives of patient, provider, carrier, and purchaser to keep covered members as healthy as possible at the least cost possible. The responsibility of cost-effectively managing resource utilization can rest in the hands of the providers (Turnoc and Bernard 2009). It is the providers who have the scientific training, clinical knowledge, and history of being patient advocates. A multi physician group may be paid by an MCO on a global or whole-life capitated basis and divide the pool of funds internally on a fee-for-service basis. The fee schedule is typically set using a relative value system. The payments for services are usually adjusted on a monthly basis depending on the total amount of relative value units provided by the entire physician group. Any needed service not provided by a physician within the group must be paid out of the pool to a subcontracted provider.

2.2.2 Service Provider Related Factors

Service provider related factors when the primary health care provider signs a capitation agreement, a list of specific services that must be provided to patients is included in the contract. The amount of the capitation will be determined in part by the number of services provided and will vary from health plan to health plan, but most capitation payment plan for primary health care services include the following: Preventive, diagnostic, and treatment services, Injections, immunizations, and medications administered in the office, Outpatient laboratory tests done either in the office or at a
designated laboratory, Health education and counseling services performed in the office and Routine vision and hearing screening (White, Franklin, Stallones, Lorann, Last and John, 2013).

It is not unusual for large groups or physicians involved in primary health care network models to also receive an additional capitation payment for diagnostic test referrals and subspecialty health care. The primary health care physician will use this additional money to pay for these referrals. Obviously, this puts the primary health care provider at greater financial risk if the overall cost of referrals exceeds the capitation payment, but the potential financial rewards are also greater if diagnostic referrals and subspecialty services are controlled. Alternatively, some plans pay for test and subspecialty referrals via fee-for-service arrangements but are more typically paid via contractually agreed-upon fee schedules that are discounted 10% to 30%, compared to the local usual and customary fees (Turnoc and Bernard 2009).

Capitation-based reimbursement significantly influences the practice of medicine. As physicians, we need to assure that payment models do not jeopardize the health care we provide when we accept higher levels of personal financial risk. Reimbursement for primary health care physicians should recognize both individual patient encounters and the administrative work of patient health care management; Reimbursement for subspecialists should recognize both access to subspecialty knowledge and expertise as well as patient health care encounters, but in some situations, subspecialists may provide the majority of health care to individual patients and will be reimbursed as primary health
care providers; Groups of physicians should accept financial risk for patient health care only if they have the tools and resources to manage the health care; Physicians sharing risk for patient health care should meet regularly to discuss health care and resource management; and Physicians must disclose the financial relationships they have with health plans and medical health care organizations, and engage patients and communities in discussions about resource allocation (Vinten., 2003). As a payment model, capitation offers opportunities for primary health care physicians to influence the future of health care by improving the management of resources at a local level.

The financial risks providers accept in capitation are traditional insurance risks. Provider revenues are fixed, and each enrolled patient makes his or her claims against the full resources of the provider (Sanderson, Colin Gruen and Reinhold 2006). In exchange for this fixed payment, physicians essentially become the enrolled clients' insurers, who resolve their patients' claims at the point of health care and assume the responsibility for their unknown future health care costs. Large providers tend to manage this risk better than do smaller providers, because they are better prepared for variations in service demand and costs, but even large providers are inefficient risk managers in comparison to large insurers.

Providers tend to be small in comparison to insurers, and so are more like individual consumers, whose annual costs as a percentage of their annual cash flow fluctuate far more than do those of large insurers (Richard Wilkinson; Michael and Marmot, 2003). Physicians and other health care providers lack the necessary actuarial, underwriting, accounting and finance skills for insurance risk management, but their most severe
problem is the greater variation in their estimates of the average patient cost, which leaves them at a financial disadvantage as compared to insurers whose estimates are far more accurate. Because their risks are a function of portfolio size, providers can only reduce their risks by increasing the numbers of patients they carry on their rosters, but their inefficiency relative to that of the insurers’ is far greater than can be mitigated by these increases.

Providers cannot afford reinsurance, which would further deplete their inadequate capitation payments, as the re-insurer's expected loss costs, expenses, profits and risk loads must be paid by the providers. The goal of reinsurance is to offload risk and reward to the re-insurer in return for more stable operating results, but the provider's additional costs make this impractical. Reinsurance assumes that the insurance-risk-transferring entities do not create inefficiencies when they shift insurance risks to providers (Cox, 2001). Absent any induced inefficiencies, providers would be able to pass on a portion of their risk premiums to reinsurers, but the premiums that providers would have to receive would exceed the premiums that risk-transferring entities could charge in competitive insurance markets. Re-insurers are wary of contracting with physicians, as they believe that if providers think they can collect more than they pay in premiums, they would tend to revert to the same excesses encouraged by fee-for-service payment systems.

Capitation has the potential to increase patient health risk because there are incentives to reduce services and incentives to defer health care beyond the prepayment interval. Counterbalancing these incentives are the theoretical incentives to invest in medical
health care that can decrease long-term medical costs through disease prevention and early treatment. Practices reporting a larger proportion of income from capitated contracts are more likely to base primary health care physician compensation on measures of quality and utilization. Unfortunately, the incentives to make these investments are mitigated by the relatively high rates of turnover, as patients move from plan to plan, precluding long-term financial benefit. Society's financial risk is minimal in the short term. In the long term, society may save money if capitation results in increased investments in prevention and early treatment, or society may lose money if delayed health care produces more expense. Physician personal financial risk can be high, particularly if a few patients develop high cost illness. Since financial risk is transferred to the physician level, there are financial disincentives for a physician or a group to take on the health care of complex or chronically ill patients (Custer’s and Klazinga 2007).

Accountable Health care Organizations are entities that accept responsibility for both the cost and quality of health care provided to a defined population of patients and provide the data on performance. A managed health care organization’s priority is to provide medical necessary health care to individuals in the context of limited, controlled resources and population-based rationing decisions. The ethical framework for such rationing decisions must balance concerns for patient autonomy and justice, providing for the judicious and equitable use of distribution of resources revolutionary (Sanderson, Colin Gruen and Reinhold 2006). The widespread implementation of capitation, as an integral part of the attempt to reduce or stabilize the cost of health health care, creates an ethical dilemma for the medical profession that has never been faced before. Moreover,
the expansion of a pre-payment methodology that shares the cost of treatment risk between the managed health care organization and the physician and the patient. The inclusion of the managed health care organization into the social contract for health care services creates a wedge between the physician and the patient, that being the fiduciary considerations of the physician on behalf of these sharing the risk, be they fellow physicians or the managed health care organizations. The physician’s dilemma of serving two masters can result. Capitation poses a definitive dilemma—the consent choice between cost-efficient service and medically necessary treatment (Custers and Klazinga, 2007).

In the United States, physician-hospital organizations (PHOs) were formed in the 1990’s largely as contracting mechanisms to negotiate with health plans. Most PHOs consist of a subset of the voluntary medical staffs of hospitals.

As managed health care pressures subsided, many of these organizations went out of existence, but it is estimated that nearly 1,000 PHOs exist to this day. Some, such as Advocate Health System in Chicago, Illinois and Middlesex Hospital in Connecticut, function similarly to the multi-specialty group practice in terms of their focus on reorganizing health care delivery to achieve more cost-effective health care coordination. While generally less well-suited than integrated delivery systems or multi-specialty practices, some PHOs could also structure themselves so as to become eligible to serve as an ACO (Custer’s and Klazinga 2007).
Independent practice associations (IPAs) are comprised of individual physician practices that come together for purposes of contracting with health plans. They exhibit a great deal of variation in the extent to which they actively engage in practice redesign, quality improvement initiatives, and exchange of information to improve health care delivery (Cox, 2010). While many remain networks of practices that exist for contracting purposes only, some such as Hill Physicians Group in Northern California and Health care Partners in Southern California function similarly to multi-specialty group practices (Robbins, 1975). Thus, some IPAs could qualify as an ACO and others may move in that direction given strong financial incentives and technical assistance support. Finally, independent small physician practices, mostly located in rural areas, can organize to become virtual physician organizations. This can be accomplished through the leadership of an individual physician in a rural area, a local medical foundation, a state Medicaid agency, or similar body that serves to provide the leadership and resources for helping small rural practices redesign their health care, share information, and provide more cost-effective health care (Johns, 2011).

2.2.3 Government Related Factors.

A health system, also sometimes referred to as health care system or health care system is the organization of people, institutions, and resources to deliver health care services to meet the health needs of target populations. There is a wide variety of health systems around the world, with as many histories and organizational structures as there are nations. In some countries, health system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions,
charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary (Sanderson, Colin Gruen and Reinhold 2006).

In capitation payment systems, GPs are paid for each patient on their list, usually with adjustments for factors such as age and gender. According to OECD, these systems are used in Italy (with some fees), in all four countries of the United Kingdom (with some fees and allowances for specific services), Austria (with fees for specific services), Denmark (one third of income with remainder fee for service), Ireland (since 1989), the Netherlands (fee-for-service for privately insured patients and public employees) and Sweden (from 1994). Capitation payments have become more frequent in managed health care environments in the United States.

According to OECD, Capitation systems allow funders to control the overall level of primary health expenditures, and the allocation of funding among GPs is determined by patient registrations. However, under this approach, GPs 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. Freedom of consumer choice over doctors, coupled with the principle of money following the patient may moderate some of these risks. Aside from selection, these problems are likely to be less marked than under salary-type arrangements (Simmons, 2009).
Fee-for service arrangements prevailed as the preferred vehicle for financing health care services since World War II. As employers began to offer health insurance, premiums were fixed in such a way that most patients did not bear the full cost of their health care. As employer premiums rose to meet the escalating cost of health care services, efforts by government, business and the insurance industry focused on controlling utilization and reducing health care cost (Cox, 2001). Group health cooperatives were formed as early precursors of the modern health maintenance organization. As managed health care became more widespread, methods of cost containment became more prevalent by defining medical necessity, coverage policies, practice guidelines, practice profiling, and risk-sharing arrangements. Capitation, as a method of risk sharing provided new ethical dilemmas in medical decision making. Fee for service reimbursement presented ethical challenges by assuring reimbursement for utilization of services and procedures that were ordered for the health benefit of the patient. Economic insurer incurs the financial risk and cost of a fee-for service system. These costs were typically shifted to the purchasers of health care services, such as employers and the government (Cox, 2010).

Capitation arrangements pose an ethical challenge through the risk-sharing model of encouraging economic incentive via reduced utilization of services, to the financial benefit of the physician and the managed health care organization that share the risk. While some applaud the inherent incentive within the capitation risk-sharing system to increase efficiency and reduce over-utilization of resources, others suggest that there exists within a capitation system the insidious incentive to under treat patients and avoid patients with chronic or extreme illness (Altman, 2003).
Legislation primarily at the state level has attempted to negate some of the more blatant transgressions that managed health care systems have posed, such as gag clauses in contracts, and requirements of economic credentialing by hospitals and health care plans (Harold, 2009). These legislative attempts have met with limited success. As a society, we have a right to determine what amount of gross domestic product (GDP) should be allocated to health care by the purchase of private insurance with premium dollars, and the appropriation of tax revenue for the health care of indigent citizens. The ministry of health, through NHIF Conducted a six month out-patient pilot Project in Nairobi and Mumias in 2009. The two regions were chosen to represent the urban and rural settings due to diversity the region present in terms of Public/Private Sector employers and taking health care of members from various Socio-economic groups. One of the out-patient cover Pilot objectives was to determine the most appropriate and sustainable method of Provider Payment Fee for service (FFs) or Capitation and possibly how mix of both can work.

Without intending to enter into legal discussions or ethical discussions, it is clear that these contracts exist between parties that have unequal understandings of the risk theoretic consequences of these contracts. Many private practices, hospitals, and nursing homes have become financially vulnerable because of these inherently unfair financial contracts. In many cases, these provider organizations have been faced with Take it or leave it contracts imposed by insurer organizations. These contracts have negatively affected providers, legitimate risk assuming and retaining insurers and the public. It
would appear appropriate for litigation to test the validity and fairness of these contracts in the courts and if deemed appropriate, that victims of these contracts, providers and disenfranchised consumers, be compensated for their losses. (Sanderson, Colin Gruen and Reinhold 2006).

Average-cost based reimbursement plans are similar to insurance contracts in terms of the risk transfer.

They are dissimilar to insurance contracts in that the party accepting the risk for the average cost is less capable of managing the risk. Provider contractees are smaller, more financially vulnerable and harmed by the greater probability of excessive losses they face. Using a normal distribution as an approximation to the experience under a CC, this author compared risk susceptibility between providers and insurers. Capitated health care providers face higher probabilities of financial loss and this can only be moderated by the delivery of a lower level of service than paid for in these agreements. Over time, one would expect these contracts to result in necessary reductions in both the quantity and quality of services. Properly viewed as reinsurance agreements rather than service contracts, ACBR plans will result in financial ruin, takeovers and consolidation of health providers as well as reductions in available services, the effects observed in the past two decades (Custer’s and Klazinga 2007).

Public policy should treat CCs and ACBRs as reinsurance agreements. If providers do not have the financial capacity to effectively manage their risk under these contracts, these contracts should be impermissible. Capitation agreements, average cost reimbursement plans, and diagnosis related group finance plans are inappropriate mechanisms for cost
control and public policy should reflect this fact (Richard, Wilkinson, Michael and Marmot, 2003). Placing providers in the position of insurers, absent regulation and financial capability to fulfill this role is inappropriate and harmful to consumers, providers and insurers. Although much has been written about the negative aspects of capitation, particularly the incentive to withhold needed services, it must also be recognized that there are positive aspects to capitation. Here are some potential benefits associated with capitation: Providers receive a fixed payment regardless of whether services are actually rendered.

Capitation revenues are predictable and timely, and thus are less risky than revenues from conventional payment methodologies that are tied to volume. Capitation payments are received before services are rendered, so, in effect, payers are extending credit to providers rather than vice versa, as under conventional reimbursement (Tulenko et al. 2012). Capitation supports national health care goals primarily increased emphasis on cost control as well as wellness and prevention Capitation may ease the reimbursement study work burden, and hence reduce expenditures on administrative costs. Capitation aligns the economic interests of physicians and hospitals because risk-sharing systems are typically established that allow all providers in a capitated system to benefit from reducing costs and Similarly, capitation encourages utilization of lower-cost treatments, such as outpatient surgery and home health care, as opposed to higher-cost inpatient alternatives. Thus, capitation creates incentives to use those services that are typically preferred by patients when such alternatives are clinically appropriate.
2.2.4 Capitation and Improvement of Patient Health care

Cost containment efforts will continue to drive changes in health care as employers, state and federal governments, and other payers demand more restraint of expenditures. Physicians have a central role, but that role may take 2 forms. Physicians may become de facto employees of health care delivery organizations and deliver health care according to external regulation, or physicians may proactively develop the collaborative relationships that will allow them to practice good medicine, achieve efficiencies in health care delivery, and substantially influence the organizations in which they practice. Believing that our work as physicians is central to the success of health care delivery in our society, the task force members favor a proactive approach, beginning with and rooted firmly in a commitment to patient health care, collaboration with professional colleagues, and participation in practice operations (Sanderson, Colin Gruen and Reinhold 2006).

There is a compelling economic logic to capitation because it allows many different types of payers to prospectively individualize payment for health care, but there are tremendous challenges to the process of pooling financial risk at the practice level. Ideally, risk-adjusted capitated payments will be developed to reflect the higher costs for individual physicians or practices who disproportionately health care for sicker patients. Because even the best available risk adjustment procedures can explain only part of the variation in an individual's medical costs, the financial viability for physicians or groups is dependent on the ability to pool risk over a sufficient number of patients. Reimbursement for primary health care physicians should recognize both individual patient encounters and the administrative work of patient health care management. to make capitation more
efficient it’s important to disclose financial relationship and give evidence of physician practice (Custer’s and Klazinga 2007).

Physicians must disclose the financial relationships they have with health plans and medical health care organizations and actively engage patients and communities in discussions about resource allocation. Given the evidence that physician practice is strongly influenced by financial incentives, patients have the right to know the financial constraints under which their physician practices. Survey data have indicated that patients usually do not know how their physicians are compensated and that 76% of respondents think that a bonus paid for ordering fewer tests would adversely affect the quality of health care. To the degree that capitation provides physicians with financial incentives to restrict patient health care, patient trust in physician decision making, though not clearly measurable, may be undermined. Among physicians, there is an increasing awareness that financial concerns can unsettle the patient-physician relationship. The criteria developed by the American College of Physicians to guide our professional relationships with the pharmaceutical industry can be applied to our new relationships with capitated health care payments (Margaret Stacey 2004).

2.2.5 Using the Capitation Experience to Improve Access

The patient health care coordination skills developed as a necessity from sharing capitated risk may improve our health care for those with insurance, but there remains the challenge of caring for the uninsured. As physicians, we should not maintain a health delivery system that segregates our patients by the presence or absence of health
insurance coverage. Almost a quarter of those with whom we share virtually all other resources including the economy, the environment, and the educational system are excluded from routine health care because they are uninsured or underinsured. Our active participation in the development of capitated reimbursement, specifically the local application of the incentives of capitation in our own practices and the development of new forms of collaborative health care and resource management, needs to be coupled with a simultaneous commitment to extend health care access to all members of our society. Responsible efforts to manage health care efficiently and effectively will be an essential component of any system of universal access. Improving the management of health care resources for the insured should free resources to help health care for the disenfranchised and allow society to more accurately calculate and manage the costs of providing universal health care (Richard, Wilkinson, Michael and Marmot, 2003).

Capitation affects all aspects of medical practice. It has the potential to clarify the boundaries between primary health care physicians and their consulting subspecialist colleagues. It will certainly expand the financial risks faced by all practitioners. It will probably force changes in the allocation of health care resources, perhaps leading to a more accurate determination of true costs. Realistically, the necessary conditions for capitation to function as an acceptable and sustainable reimbursement model may never be achieved (Turnock, 2009). Our task is to actively participate in the reengineering of health care delivery while maintaining our personal and professional standards in order to create a system that will work for everyone in our society.
2.3 Conceptual Framework

The study used a conceptual framework where factors were itemized as independent variable and levels of implementation as a dependant variable. Factors were further classified into government related factors, patient related factors, service provider related factors and management related factors. They are therefore varied. The level of implementation is indicated by accessibility, costs and quality services as shown in figure 2.1 below.

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government related factors</td>
<td>Health Service Implementation</td>
</tr>
<tr>
<td>- Accreditation of facilities</td>
<td>- Accessibility of services</td>
</tr>
<tr>
<td>- Budgetary Allocations</td>
<td>- Levels of costs</td>
</tr>
<tr>
<td>- Political Interference</td>
<td>- Quality of services</td>
</tr>
<tr>
<td>- Bureaucracy</td>
<td></td>
</tr>
<tr>
<td>- Inadequate information</td>
<td></td>
</tr>
<tr>
<td>Patient related factors</td>
<td></td>
</tr>
<tr>
<td>- Illiteracy</td>
<td></td>
</tr>
<tr>
<td>- Ignorance</td>
<td></td>
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<tr>
<td>- Cultural believes</td>
<td></td>
</tr>
<tr>
<td>- Lack of employment</td>
<td></td>
</tr>
<tr>
<td>Service provider related factors</td>
<td></td>
</tr>
<tr>
<td>- Infrastructure</td>
<td></td>
</tr>
<tr>
<td>- Organizational Bureaucracy</td>
<td></td>
</tr>
<tr>
<td>- Lack of specialists</td>
<td></td>
</tr>
<tr>
<td>Management of service provider related factors</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.1: Conceptual Framework.

Source: Self Conceptualization (2014)
CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Research Design

The study applied a descriptive survey method. The design allowed for a holistic in-depth study of the organizations, which are similar in many aspects in a single outfit and the findings, are hoped to be generalized to other areas. The design was chosen because it involved investigation of factors affecting capitation implementation in healthy sector. It has the ability to answer as to why and how and what can be done to the situation involved.

3.2 Study Area

The study area was in Nairobi which is the capital city of Kenya. Nairobi is the capital city of Kenya and East Africa's most populous city (3.5 million). Nairobi was founded in 1899 as a railway stop en route to Mombasa. Within a decade it grew to become the capital of British East Africa and became Kenya's capital after independence in 1963. Nairobi is a major business hub and many Aid agencies headquarter here as well. Nairobi has a modern city center, some beautiful suburbs, as well as Africa's largest slum. The city is built on a plateau and it stays pleasantly cool year round. Both English and Swahili are widely spoken. The county has a cosmopolitan population with different economic levels. It was chosen as the study area because it would give a fair representation scenario as it has the highest number of health facilities of all levels accredited to NHIF.
3.3 Target Population

The target population was health employees in Nairobi county in facilities accredited to NHIF capitation programme.

3.4 Sample Size and Sampling Procedure

A sample size of 130 respondents was selected to arrive at the sample size. This was calculated according to Yamane (2007), who developed a formula that was used to calculate the sample size. This method was also adopted by (Altman, 2003) who did a study of cost sharing in Health care. This method is ideal for population size that is smaller than 500. This formula is given as;

\[ n = \frac{N}{1+N(e)^2} \]

Where \( n \) is the required sample size

\( N \) is the population size

\( e \) is the error margin

Where \( N=416 \)

\( e=0.10 \)

Hence \( n=\frac{416}{1+416(0.1)^2}=130 \)

This study used stratified random sampling method where the respondents were selected as follows: 15 top managers at NHIF headquarters, 100 employees of NHIF, 101 Managers of accredited health centers and 200 enrolled members/patients. This is shown in table 3.2.
Table 3.2 Sample Size

<table>
<thead>
<tr>
<th>Department</th>
<th>Target population</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHIF managers at headquarters</td>
<td>15 x 0.327</td>
<td>5</td>
</tr>
<tr>
<td>Employees of NHIF-Nairobi county</td>
<td>100 x 0.327</td>
<td>30</td>
</tr>
<tr>
<td>Managers of accredited health centers</td>
<td>101 x 0.327</td>
<td>30</td>
</tr>
<tr>
<td>Enrolled members/patients</td>
<td>200 x 0.327</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>416</td>
<td>130</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

To sample the respondent from each stratum the names of the subject was put in a basket and shaken then the required number was picked where each subject had equal chance to be selected. The researcher distributed the research instruments to the respondents.

3.5 Data Collection Procedure

3.5.1 Data Collection Instruments

The study used one set of simple structured questionnaires and administered them to the various categories of respondents by physical drop and pick by research assistants. An introduction letter was provided to accompany each questionnaire from Kisii University, indicating the area of research to be undertaken by the researcher and confirming that the research information was treated confidentially and is for academic purposes. The instrument contained closed and open ended questions. It was administered to the departmental managers and other staff at the NHIF headquarters, Administrator of health facilities of capitation programme and members/patients who sought services at the facilities.
The choice of structured questionnaire were due to its ease of administration, analysis and time saving. According to Mugenda and Mugenda (1999) the questionnaire tool was most appropriate since a quantitative data capture is a necessity, which can only be obtained directly from the respondents. Closed ended questions in the questionnaire were used to help standardize and quantify responses from the research. The open ended questions in the questionnaire ensured that an in depth data that is detailed and explorative of all aspects of the variable(s) under study is obtained. This yielded very useful information for these study and future studies. It took health care of the human nature of the respondent of wanting to express their personal views and feeling important as a participant of the research. This helped during data interpretation and clarifying numerical data collected.

3.5.2 Administration of Data Collection

After sampling the staff the researcher formulated research instruments to assist, collect data. The researcher sought permission, discuss and sensitize target respondents. This was meant to reduce suspicion and enhance co-operation. The researcher personally administered the research instruments after prior visit that assisted in defining timings at interview and distribution of questionnaires. The visit provided a rough picture of the expectations. The researcher agreed with the respondents when the research instruments could be collected. The filled questionnaires were collected after two days.
3.6 Instrumentation

3.6.1 Validity of Data Collection Instruments
According to Mugenda and Mugenda (1999) the validity of research is concerned with the extent to which that data measures what they are supported to measure, while the rest of reliability is concerned with the extent to which the researcher can depend confidently on the information gathered through various source of data, adopted to obtain for the study. To test the validity of the research instruments the questionnaire was prepared and submitted to the supervisor and other research experts for cross checking and also to assess the reliance of the content. The questionnaires were pre-tested through a pilot study; the findings were modified to free them from ambiguity. The pilot study was carried out one week earlier in other accredited health facilities outside Nairobi.

3.6.2 Reliability
To taste reliability a prerequisite for test-retest reliability was carried out within a small time frame so that the concept being measured could not change. Test-retest reliability is appropriate for traditional assessments as well as for interactive tailored patient assessments that measure implementation of services as provided by the respondents.

3.7 Data Analysis And Presentation
The data collected for the purpose of the study was adopted and coded for completeness and accuracy. Descriptive Statistical method of mean standard deviation and factor analysis were used for data analysis and interpretation. Frequency distribution table was prepared for open ended questions so as to convey meaning of the data.
CHAPTER FOUR

PRESENTATION OF FINDINGS AND DISCUSSIONS

4.1 Response Rate

The study sought to investigate factors affecting implementation of capitation programme in the provision of health care services. In line with the process of data analysis, data were first collected and cleaned. This was then followed by an analysis of the respondent’s demographic profile. Exploratory Factor Analysis (EFA) with principal components was used to establish the factor structure underlying the collected data in order to extract the factors affecting implementation of the capitation programme. Descriptive statistics were then used to examine the perceived level of the identified factors among respondents.

Data were screened in order to establish whether among others, data accurately reflected the responses elicited, whether all data were in place and accounted for, whether there was a pattern to the missing data, and whether there were any unusual or extreme responses present in the data set that could distort understanding of the phenomena under study. In this regard, data were screened for response rate, missing value, outliers and normality.

A sample of 130 respondents was targeted comprising of NHIF top managers based at the headquarters, employees of NHIF based in Nairobi, administrators of accredited health centres, and enrolled members/patients. Consequently, 130 questionnaires were administered across this sample. A total of 124 questionnaires were returned for which 3
were further discarded for lack of response. The researcher ended up with 121 questionnaires which were used for further analysis. The usable proportion of questionnaires was therefore 93.1%. This response rate was considered suitable on the basis of recommendations by Fowler (2002) that the whole point of conducting a survey is to obtain useful, reliable and valid data that makes it possible to analyze and draw conclusions about the target population. Table 4.1 presents the summary of the response rate as described above.

**Table 4.1: Response Rate**

<table>
<thead>
<tr>
<th>Category of Respondent</th>
<th>Issued Questionnaires</th>
<th>Returned Questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHIF Top managers-Headquarters</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>NHIF Employees-Nairobi county</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Administrators of accredited health centers</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Enrolled members/Patients</td>
<td>65</td>
<td>62</td>
</tr>
<tr>
<td>Total sample</td>
<td>130(100%)</td>
<td></td>
</tr>
<tr>
<td>Total responses</td>
<td>124(95.4%)</td>
<td></td>
</tr>
<tr>
<td>Un usable</td>
<td>3(2.3%)</td>
<td></td>
</tr>
<tr>
<td>Total usable questionnaires</td>
<td>121(93.1%)</td>
<td></td>
</tr>
</tbody>
</table>

**Source: Author, (2014)**
4.2 Missing Values

According to Allison (2002), missing values are common in many areas of social research and may seriously affect results of statistical analyses. Missing values arise due to several reasons. Respondents may refuse to respond to questions when they deem them personal, some may even feel incompetent to respond for lack of knowledge on a particular item, or may simply decline to respond. Missing values in the current study were evaluated with respect to variables with the assumption that missing data were missing at random (MAR). Inspection of the data for missing values revealed that none of the variables had missing data.

4.3 Univariate Outliers

Outliers are defined in literature as cases that have data values that are different from the data values for a majority of cases (Stevens, 2002). Outliers were detected using guidelines suggested by Stevens (2002). Consequently, a case was deemed an outlier if its standardized score fell outside the interval -3.0 to +3.0. A case with a univariate outlier was subsequently deleted from further analysis. Analysis of the major study variables did not reveal any outlier. All the cases were therefore used in further analyses.

4.4 Respondents Background Information

Analysis of respondents’ background information centered on establishing the respondents; gender, age bracket, education level, specialized profession, and years of working experience for the sampled respondents. These according to the researcher were
fundamental to interpreting and discussing factors affecting the capitation programme in provision of health care services.

4.4.1 Gender of respondents

Results of the gender distribution of respondents presented in Figure 4.1 revealed that 60.3% of total sampled respondents were male while 39.7% were female. This result seems to suggest that most players in the capitation programme are male.

Figure 4.1: Distribution of Respondents by Gender

Source: Author, (2014)
4.4.2 Respondents Age Bracket

Results of the age distribution of sampled respondents presented in Figure 4.2, show that most of respondents (55.4%), were aged between 31 to 40 years. Those in the age bracket of 21 to 30 years were 19% while those aged between 41 to 50 years were 13.2% of the total sampled respondents; 12.4% of the sampled respondents were younger than 21 years; these findings show that the respondents were old enough to answer questions focusing on capitation programme.

Figure 4.2: Distribution of Age Bracket

Source: Author, (2014)
4.4.3 Education Level Distribution

Education was considered a key background characteristic that may influence capitation programme in provision of health care as a result; education level distribution was analyzed in order to establish the level of education among the respondents.

As shown in figure 4.3 below which presents the distribution of the level of education among respondents, 49.6% of respondents had tertiary level of education, 37.2% had post university level while 13.2% had university level education.

![Figure 4.3: Distribution of Education Level](image)

Source: Author, (2014)
4.4.4 Respondents’ Distribution by Professional Qualification

Professional qualification brings the dimension of understanding of the capitation programme and its contribution in the provision of health care services. Studies have shown that there exists a direct correlation between malpractice claims and patient communication issues (Finkelstein and Saxston 2003). The choice of respondent’s professional qualification as background characteristics was therefore informed by such findings.

Results of the analysis of respondents professional qualification presented in Figure 4.3 below reveals that 41.3% of respondents were medicine professionals, 18.2% were purchasing professionals, 14.9% were accountants, 13.2% of the respondents were marketing professionals while 12.4% were professionals in IT. These results confirm that respondents had necessary professional qualifications that could oversee the success of the capitation programme.
4.5 Factors Affecting Implementation of the Capitation Programme in Provision of Health care in Nairobi County

The main purpose of the current study was to investigate factors influencing implementation of the capitation programme in provision of health care services in Kenya. In this regard, Exploratory Factor Analysis (EFA) with principal components was
used to extract Government, patient, service and management related factors that affect implementation of the programme.

4.5.1 Government Related Factors Affecting Implementation of the Capitation Programme in the Provision of Health care

Research objective one sought to establish government related factors influencing implementation of the capitation programme in provision of health care services. Accordingly respondents were asked to indicate their agreement/disagreement to suggested items identified to measure government related factors. Responses were elicited on a 5 point scale (1- Strongly disagree, 2- Disagree, 3- neither disagree nor agree, 4- Agree, 5- Strongly Agree). EFA was used in assessing the factor structure of the set variables so as to identify government related factors.

Table 4.2 below shows results of the EFA analysis, three factors were extracted and explained 86.4% of the total variance in government related factors. All factor loadings were above 0.6. Besides, the Keiser-Meyer-Olkin measure of sampling adequacy was 0.503, and the Bartlett’s measure of sphericity (2004.021) was significant. This indicates that data were adequate for factor analysis. The extracted factors were designated as stewardship, political inclination and financing. These findings are consistent with those of Cox (2010) that revealed that political inclination and financing highly influence implementation of capitation programme.
Table 4.2 Underlying Factor Structure of Government Related Factors Affecting the Capitation Programme

<table>
<thead>
<tr>
<th>Government factors</th>
<th>Loading</th>
<th>Eigen values</th>
<th>Variance explained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewardship</td>
<td></td>
<td>4.49</td>
<td>44.901</td>
</tr>
<tr>
<td>There is general insecurity in accredited health facilities</td>
<td>.802</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some accredited centres are located where there is no security</td>
<td>.803</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The funds allocated are misappropriated before they reach the health centres</td>
<td>.964</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The government has unclear policies on the choice of medical consultants</td>
<td>.931</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is unwarranted classification of health centres</td>
<td>.916</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political inclination</td>
<td>2.606</td>
<td>70.963</td>
<td></td>
</tr>
<tr>
<td>The government accredited politically correct centres with poor conditions</td>
<td>.830</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The government delays disbursement of funds to accredited health centres</td>
<td>.827</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The government has undefined policies on the management of accredited health centres</td>
<td>.819</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td>1.546</td>
<td>86.425</td>
<td></td>
</tr>
</tbody>
</table>
The funds allocated to accredited centres are inadequate.

There are complicated procedures/beauracracies in disbursing funds to accredited health centres

Kaiser-Meyer-Olkin MSA

Bartlett’s test of sphericity

Source: Author, (2014)

Stewardship

Five items loaded highly on the stewardship factor. Means and standard deviations were used to analyze response towards these items. The mean response score for most items was approximately 4.00 which indicate that the respondents agreed to the items in question. In particular, results presented in Table 4.3 show that most respondents tended to agree that accredited centres are located in insecure areas (M =4.91 SD = 0.922), that the government had unclear policies (M = 4.02 SD = 0.826), that there is unwarranted classification of health centres (M=3.95, SD=0.884); that general insecurity in accredited health facilities (M = 3.88 SD = 0.791); and that there are complicated procedures/beauracracies in disbursing funds to accredited health centres (M=3.66, SD=0.525)
Table 4.3 Factors as A Result of Government Stewardship on Implementation of Capitation Programme

<table>
<thead>
<tr>
<th>Factors</th>
<th>mean</th>
<th>Std-deviat</th>
</tr>
</thead>
<tbody>
<tr>
<td>there are complicated procedures/beauracracies in disbursing funds to accredited health centres</td>
<td>3.66</td>
<td>.525</td>
</tr>
<tr>
<td>Some accredited centres are located where there is no security</td>
<td>4.09</td>
<td>.922</td>
</tr>
<tr>
<td>There is general insecurity in accredited health facilities</td>
<td>3.88</td>
<td>.791</td>
</tr>
<tr>
<td>The government has unclear policies on the choice of medical consultants</td>
<td>4.02</td>
<td>.826</td>
</tr>
<tr>
<td>There is unwarranted classification of health centres</td>
<td>3.95</td>
<td>.884</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Political Inclination

Three items loaded highly on the political inclination factor, mean response scores for most items in this factor approximated to 4.00 which indicate respondents’ agreement to the items. As shown in Table 4.4, most respondents tended to be in agreement that government had undefined policies on the management of accredited health centres (M = 4.37, SD = 0.518); that the government accredited centres politically (M = 3.93, SD = 0.787); and that there is delay in funds disbursement by government to accredited health centres (M = 3.88, SD = 0.798).
Table 4.4: Factors Arising Out of Political Inclination

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The government accredited politically correct centres with poor conditions</td>
<td>3.93</td>
<td>.787</td>
</tr>
<tr>
<td>The government delays disbursement of funds into accredited health centres</td>
<td>3.88</td>
<td>.798</td>
</tr>
<tr>
<td>The government has undefined policies on the management of accredited health centres</td>
<td>4.37</td>
<td>.518</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Financing

Two items loaded highly on this factor, mean response scores for the two items approximated to 4.00 which indicate the respondents tended to agree with the items. More specifically, Table 4.5 shows that respondents seemed to agree that funds allocated are misappropriated before they reach the health centres (M = 4.08, SD 0.331) and that funds allocated to accredited centres are inadequate (M = 3.99, SD 0.241).
Table 4.5: Government Financing Factors Affecting Implementation of Capitation Programme

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The funds allocated are misappropriated before they reach the health centres</td>
<td>4.08</td>
<td>.331</td>
</tr>
<tr>
<td>The funds allocated to accredited centres are inadequate</td>
<td>3.99</td>
<td>.241</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

The results reported above implies that among the government related factors affecting implementation of the capitation programme in provision of health care services in Nairobi County are government stewardship of the programme, political inclination by those tasked with the responsibility to oversee the implementation and financing of the programme.

Under stewardship, respondents particularly felt that accredited centres were located in insecure locations, and that classification of the centres was unwarranted. A key factor emerging under stewardship is that there are no clear policies that are used to select medical consultants.

Another key factor identified as government related is that of political inclination. It was revealed that politically correct centres some in poor conditions were accredited. Political
inclination means that more often, fund disbursement to accredited facilities is delayed. Besides, policies on management of accredited centres remain undefined, possibly for political reasons.

Financing was also identified as a key factor attributable to the government. Respondents revealed that in most cases, funds allocated are misappropriated before they reach the respective health centres. In addition, the allocated funds are usually inadequate for the needs of the capitation programme.

4.5.2 Patient Related Factors Affecting Implementation of Capitation Programme in Provision of Health care Services.

Objective two of the current study, sought to establish factors that accrue from patients in relation to the capitation programme for health care service provision. Respondents were asked to indicate whether they agree or disagree to proposed items to measure patient related factors. Responses were elicited using a five point scale (1- Strongly disagree, 2- Disagree, 3- neither disagree nor agree, 4- Agree, 5- Strongly Agree). EFA was used in evaluating the factor structure of the given variables so as to classify patient related challenges.

Results of the EFA are shown in table 4.6. Three factors were extracted from the nine items proposed, and explained 91.095% of the total variance in patient related factors. All factor loadings loaded above 0.6. The Kaiser Mayer Olkin measure of sampling adequacy was 0.761 and the Bartlett’s measure of sphericity was significant. This indicates
adequacy of data for factor analysis. The three factors were designated as patient ignorance, motivation and attitude.

Table 4.6 Underlying Factor Structure For Patient Related Factors

<table>
<thead>
<tr>
<th>Patient Related Factors</th>
<th>Loading</th>
<th>Eigen values</th>
<th>Variance explained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignorance</td>
<td>3.604</td>
<td>40.048</td>
<td></td>
</tr>
<tr>
<td>Most patients are ignorant of the existing capitation programme</td>
<td>.926</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most patients are ignorant of the accredited health facilities to the capitation programme</td>
<td>.862</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some employees are naturally resistant to any programme</td>
<td>.909</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient commitments</td>
<td>2.975</td>
<td>73.106</td>
<td></td>
</tr>
<tr>
<td>Patients have self ego regarding tailor made programme of capitation</td>
<td>.862</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some patients are on contract making them not to qualify for capitation programme</td>
<td>.738</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some patients have complicated diseases not</td>
<td>.734</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
accommodated in some accredited health facilities

Attitude

The patients have a negative perception of the costs of capitation programme
Cultural beliefs deter them from using the capitation programme
Some patients have negative attitude of any government programme

Kaiser-Meyer-Olkin MSA 0.761
Bartlett’s test of sphericity 0.000

Source: Author, (2014)

Ignorance

The first patient related factor identified through EFA is ignorance in both patients and service providers regarding the potential utility of capitation in health care services. Three items loaded highly on this factor, the approximate mean score for most items was 4.00. This implies that respondents tended to agree with all the items under this category. As seen from the results shown in table 4.7, respondents tended to agree that most patients are ignorant of the existing capitation programme (M = 4.30, SD = 0.493), that most patients are ignorant of the accredited health facilities (M = 3.88, SD = 0.755), and that some employees are naturally resistant to any programme (M=3.85, SD=0.771)
Table 4.7: Factors Affecting Implementation of the Capitation Programme On Account Of Patients Ignorance

<table>
<thead>
<tr>
<th>Factors</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most patients are ignorant of the existing capitation programme</td>
<td>4.30</td>
<td>.493</td>
</tr>
<tr>
<td>Most patients are ignorant of the accredited health facilities to the capitation programme</td>
<td>3.88</td>
<td>.755</td>
</tr>
<tr>
<td>Some employee are naturally resistant to any programme</td>
<td>3.85</td>
<td>.771</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Patient Commitment

Patient commitment was identified as the second patient related factor facing implementation of the health services capitation programme. Three items loaded highly on this factor and averaged a response score of 4.00 (Table 4.8). This indicates that respondents found them agreeable. Respondents tended to agree that some patients are on contract making them not to qualify for capitation programme (M=3.83, SD=0.799); that some patients have complicated diseases not accommodated in some accredited health facilities (M = 3.85; SD = 0.771), and that some patients have self ego regarding tailor made programme of capitation (M = 3.59, SD = 0.520).
Table 4.8: Factors Affecting Implementation of Capitation Programme on Account of Patient Commitments

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients have self ego regarding tailor made programme of capitation</td>
<td>3.59</td>
<td>.520</td>
</tr>
<tr>
<td>Some patients are on contract making them not to qualify for capitation programme</td>
<td>3.83</td>
<td>.799</td>
</tr>
<tr>
<td>Some patients have complicated diseases not accommodated in some accredited health facilities</td>
<td>3.85</td>
<td>.863</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Attitude

The third factor identified and attributed to patients is attitude, three items loaded highly on this factor. Once again, the mean response scores for the two items approximated to 4.00 (Table 4.9). This indicates that respondents’ agreement to the items. Respondents tended to be in agreement that some patients have negative attitude of any government programme (M = 4.17, SD = 0.415); patients have a negative perception of the costs of capitation programme; and that cultural beliefs deter them from using the capitation programme (M = 3.54, SD = .753).
Table 4.9: Factors Facing Implementation of The Capitation Programme as a Result of Patients Attitude

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural beliefs deter them from using the capitation programme</td>
<td>3.54</td>
<td>.753</td>
</tr>
<tr>
<td>Some patients have negative attitude of any government programme</td>
<td>4.17</td>
<td>.415</td>
</tr>
<tr>
<td>The patients have a negative perception of the costs of capitation programme</td>
<td>3.65</td>
<td>.863</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Results of the factor analysis identified three patient related factors that affect implementation of capitation programme. First, it was established that patients are ignorant of the capitation programme as well as on the accredited health facilities. In addition, some employees frustrate implementation of the programme by virtue of their reluctance to change.

Second, the study revealed that other commitments made patients not to embrace the programme. For instance, it was reported that some patients work on contract and this bars them from qualifying for the programme. Other patients suffer from complicated ailments that may not be handled in the accredited centres. It was also noted that some patients have an ego regarding the tailor made programme of capitation.

Third, the study identified patient attitude as another major factor affecting the capitation programme from a patient perspective. Respondents noted that besides having a negative
attitude to the programme, patients perceive the costs associated with the programme negatively. Besides, it was also revealed that cultural beliefs deterred some of them from using the programme.

4.5.3 Service Related Factors

The third objective of this study was to establish service related factors affecting capitation programme in provision of health care services. Respondents were asked to indicate their views whether in agreement or disagreement towards items selected to measure the variable. Responses were elicited from a five point scale (1- Strongly disagree, 2- Disagree, 3- neither disagree nor agree, 4- Agree, 5- Strongly Agree). In assessing the factor structure of the given variables in order to identify service related factors, EFA was again used.

Table 4.10 below shows results of the EFA. Three factors were extracted and explained total variance of 91.819% in service related factors. All factors loaded above 0.8, the Kaiser Mayer Olking measure of sampling adequacy was 0.601 which proves data adequacy for factor analysis. Three factors extracted were designated as accessibility, quality and accreditation. These findings are consistent with those of John et al., (2013) that revealed that most services provided are of low standard.
### Table 4.10: Underlying Factor Structure Of Service Related Factors

<table>
<thead>
<tr>
<th>Service Related factors</th>
<th>Loading</th>
<th>Eigen values</th>
<th>Variance explained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres have limited specialists or non at all.</td>
<td>5.559</td>
<td>61.766</td>
<td></td>
</tr>
<tr>
<td>The accredited health centres have rigid bureaucracies</td>
<td>951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The management and ownership of the health accredited facilities is politically motivated</td>
<td>.892</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres are in a poorly dilapidated state</td>
<td>.808</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres are not easily accessible</td>
<td>.800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres have poor facilities</td>
<td>.948</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres have limited medical equipment and facilities</td>
<td>.894</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres are non existence</td>
<td>.916</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The procedures of accrediting the health centres was not above board</td>
<td>.877</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser-Meyer-Olkin MSA</td>
<td>.601</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bartlett’s test of sphericity</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Author, (2014)*
Accessibility

The first service factor to implementation of the capitation programme for health provision identified is accessibility of service deliverly. Respondents appeared to agree with most of the five items which loaded highly on this factor. More particularly (Table 4.11), respondents agreed that accredited health centres have limited specialists or none at all (M = 4.01, SD = 0.861), that the accredited health centres have rigid bureaucracies (M = 3.93, SD = 0.838), that the management and ownership of the health accredited centers are politically motivated (M = 3.83, SD = 0.799), that the accredited health centres are in a poor and dilapidated state (M = 3.62, SD = 0.521), and that the accredited health centers are not easily accessible (M = 3.65, MD = 0.478). These findings are consistent with those of Frank et al., (2013) that showed that the easiness with which patients access health facilities has a major dimension on capitation programme.

Table 4.11: Factors Affecting Implementation Of Capitation Programme as a Result Of Accessibility Of Services

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The accredited health centres have limited specialists or none at all</td>
<td>4.01</td>
<td>.861</td>
</tr>
<tr>
<td>The accredited health centres have rigid bureaucracies</td>
<td>3.93</td>
<td>.838</td>
</tr>
<tr>
<td>The management and ownership of the health accredited facilities is politically motivated</td>
<td>3.83</td>
<td>.799</td>
</tr>
<tr>
<td>The accredited health centres are in a poorly dilapidated state</td>
<td>3.62</td>
<td>.521</td>
</tr>
<tr>
<td>The accredited health centres are not easily accessible</td>
<td>3.65</td>
<td>.478</td>
</tr>
</tbody>
</table>

Source: Author, (2014)
Quality

The second service related factor identified was quality of service offered. Two items loaded highly on this factor. On the basis of the mean response scores (Table 4.12), respondents tended agree with the two items. In particular, respondents tended to agree that the accredited health centres have poor facilities (M = 3.72, SD = 0.809) and that the accredited health centres have limited medical equipment and facilities (M = 3.79, SD = 0.808).

Table 4.12: Factors Affecting Implementation Of Capitation Programme as a Result of Quality of Services

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>The accredited health centres have poor facilities</td>
<td>3.72</td>
<td>809</td>
</tr>
<tr>
<td>The accredited health centres have limited medical equipment and facilities</td>
<td>3.79</td>
<td>808</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

Accreditation

The third service related factor extracted from EFA is accreditation. Most respondents showed discontent on the manner in which accreditation was made. Specifically, respondents agreed that the procedures of accrediting the health centres was not above board (M = 3.94, SD = 0.488) and that some of accredited health centres are non-existing (M = 4.13, SD = 0.386). These results are summarized in Table 4.13 below.
Table 4.13: Factors Affecting Implementation of Capitation Programme as a Result of Accreditation of Health Centres

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The procedures of accrediting the health centres was not above</td>
<td>3.94</td>
<td>.488</td>
</tr>
<tr>
<td>board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The accredited health centres are non existence</td>
<td>4.13</td>
<td>.386</td>
</tr>
</tbody>
</table>

Source: Author, (2014)

The study therefore identified three major service related factors which affect implementation of the capitation programme in health provision services. First, the study established that accessibility of services was a factor. They noted that most facilities had limited specialists and some even had no specialist at all. Furthermore, respondents indicated that some of the accredited centres have rigid bureaucracies that render services un-accessible. The poor and dilapidated nature of some of the facilities puts off some patients from accessing them. This is consistent with the arguments of Sanderson et al., (2006) that accessibility and rigid bureaucracies influence implementation of capitation programme.

Second, the study identified quality as another key service related factor to implementation of the capitation programme. Respondents observed that most of the accredited centres had poor facilities which cannot guarantee quality services. They further noted that the accredited centres also have limited medical equipment which compounds the quality factor further. This was also noted by Kazinga (2007) who
recognized that quality of services are associated with quality physicians and both influence implementation of capitation programme.

### 4.5.4 Management Related Factors

Kenyan health system is administered from the top down by the Ministry of Health (MOH). Health facilities are distributed regionally, with the most sophisticated services available at the national level. While the worst graded in health care are health centers, dispensaries, and at the bottom of the heap, community health organizations. Visiting this low level facilities, stark disparities are apparent both vertically, between the different levels of health care, and also horizontally, from facility to facility in different regions particularly Nairobi (Dustin, 2010).

The inclusion of management related factors in the current study was thus effected to establish managerial issues that contribute to challenges encountered in capitation programme in provision of health health care services. Respondents in this case were asked to indicate whether they agreed or disagreed to the items that measured management factors related to capitation programme in provision of health services. A five point scale was used to elicit respondents’ response (1- Strongly disagree, 2- Disagree, 3- neither disagree nor agree, 4- Agree, 5- Strongly Agree). In evaluating the factor structure of the given variables, EFA with principal components extracted two factors which explained 89.723% of the total variance in management related factors. All factor loadings were above 0.8, and the Kaiser Mayer Olkin measure of sampling adequacy was 0.697 indicating that data were adequate for factor analysis. As shown in
Table 4.14, the two extracted factors were designated adherence to standards and transparency in the capitation process.

**Table 4.14: Underlying Factor Structure of Management Related Factors**

<table>
<thead>
<tr>
<th>Management Related Factors</th>
<th>Loading</th>
<th>Eigen values</th>
<th>Variance explained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-adherence to standards</td>
<td></td>
<td>2.940</td>
<td>58.804</td>
</tr>
<tr>
<td>The accredited health centres do not incorporate the officials of civil servant union in formulating policies regarding management of the capitation programme</td>
<td></td>
<td>.870</td>
<td>.945</td>
</tr>
<tr>
<td>Some accredited health centres do not meet certain standards’ before being allowed to run the capitation programme</td>
<td></td>
<td>.945</td>
<td>.958</td>
</tr>
<tr>
<td>The accredited health centres do not provide audited patient record through publication</td>
<td></td>
<td>958</td>
<td></td>
</tr>
<tr>
<td>Transparency in Capitation Process</td>
<td>1.546</td>
<td>89.723</td>
<td></td>
</tr>
<tr>
<td>The employees are not involved in accrediting health centres</td>
<td></td>
<td>.804</td>
<td></td>
</tr>
<tr>
<td>The government has not set up a board of trust to manage capitation funds to reduce bureaucracies in disbursement</td>
<td></td>
<td>.900</td>
<td></td>
</tr>
<tr>
<td>Kaiser-Meyer-Olkin MSA</td>
<td></td>
<td>.697</td>
<td></td>
</tr>
<tr>
<td>Bartlett’s test of sphericity</td>
<td></td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Author, (2014)*
Non-adherence to standards

The first management challenge identified is non-adherence to standards. Three items loaded highly on this factor. The approximate mean response score was 4.00 in all the items. Consequently, results presented in Table 4.15 indicate that respondents tended to agree that the accredited health centres do not incorporate the officials of civil servant union in formulating policies regarding management of the capitation programme (M = 3.75, SD = 0.83); that accredited health centres do not provide audited patient record through publication (M = 3.31, SD = 0.463); and that some accredited health centres do not meet certain standards’ before being allowed to run the capitation programme (M = 3.29, SD = 0.491). This was inline with the findings of Hopkins (2013) that some health facilities did not adhere to spelt out standards expected from them.

Table 4.15: Factors Affecting Implementation of Capitation Programme on Account of Management Non-Adherence To Standards

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std.Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The accredited health centres do not incorporate the officials of civil servant union in formulating policies regarding management of the capitation programme</td>
<td>3.75</td>
<td>0.829</td>
</tr>
<tr>
<td>Some accredited health centres do not meet certain standards’ before being allowed to run the capitation programme</td>
<td>3.29</td>
<td>0.491</td>
</tr>
<tr>
<td>The accredited health centres should provide audited patient record through publication</td>
<td>3.31</td>
<td>0.463</td>
</tr>
</tbody>
</table>

Source: Author, (2014)
Transparency in Capitation process

The second management related factor identified was lack of transparency in the capitation process. Two items loaded highly on this factor, mean response scores for the two items in this factor approximated to 4.00 (Table 4.16). This indicates that respondents’ tended to agree with the items. The employees are not involved in accrediting health centres (M = 3.83, SD = 0.519) and that the government has not set up a board of trust to manage capitation funds to reduce bureaucracies in disbursement (M = 3.81, SD = 0.466). This was similar to the findings of Khazungu (2007) that well paid physicians are highly transparent in the implementation of the capitation process.

Table 4.16: Factors Affecting Implementation of the Capitation Programme on Account of Managements Lack of Transparency in Capitation Process

<table>
<thead>
<tr>
<th>Factors</th>
<th>Mean</th>
<th>Std. deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The employees are not involved in accrediting health centres</td>
<td>3.83</td>
<td>.519</td>
</tr>
<tr>
<td>the government has not set up a board of trust to manage capitation funds to reduce bureaucracies in disbursement</td>
<td>3.81</td>
<td>.466</td>
</tr>
</tbody>
</table>

Source: Author, (2014)
CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of the Findings

5.1.1 Factors Affecting Implementation of the Capitation Programme in Provision of Health care.

The result showed that the EFA analysis, three factors extracted and explained 86.4% of the total variance in government related challenges. All factor loadings were above 0.6. Besides, the Keiser-Meyer-Olkin measure of sampling adequacy was 0.503, and the Bartlett’s measure of sphericity (2004.021) was significant.

The mean response score for most items was approximately 4.00 which indicated that the respondents agreed to the items in question. In particular, results showed that most respondents tended to agree that accredited centres are located in insecure areas (M = 4.91 SD = 0.922), that the government had unclear policies (M = 4.02 SD = 0.826), that there is unwarranted classification of health centres (M = 3.95 SD = 0.884); that general insecurity in accredited health facilities (M = 3.88 SD = 0.791); and that there are complicated procedures/ beauracracies in disbursing funds to accredited health centres (M = 3.66 SD = 0.525).

Of the three items loaded highly on the political inclination factor, the findings showed that mean response scores for most items in this factor approximated to 4.00 which indicate respondents’ agreement to the items. Most respondents tended to be in agreement that government had undefined policies on the management of accredited health centres (M = 4.37 SD = 0.518); that the government accredited centres politically
(M = 3.93, SD = 0.787); and that there is delay in funds disbursement by government to accredited health centres (M = 3.88, SD = 0.798).

The result showed that of the two items loaded highly on this factor, mean response scores for the two items approximated to 4.00 which indicate the respondents tended to agree with the items. More specifically, Table 4.5 shows that respondents seemed to agree that funds allocated are misappropriated before they reach the health centres (M = 4.08, SD 0.331) and that funds allocated to accredited centres are inadequate (M = 3.99, SD 0.241).

5.1.2 Patient Related Factors Affecting Implementation of Capitation Programme In Provision of Health care Services.

Objective two of the current study, sought to establish factors that accrue from patients in relation to the capitation programme for health care service provision. Respondents were asked to indicate whether they agree or disagree to proposed items to measure patient related challenges. Responses were elicited using a five point scale (1- Strongly disagree, 2- Disagree, 3- neither disagree nor agree, 4- Agree, 5- Strongly Agree). EFA was used in evaluating the factor structure of the given variables so as to classify patient related challenges.

Results of the EFA are shown in table 4.6. Three factors were extracted from the nine items proposed, and explained 91.095% of the total variance in patient related challenges. All factor loadings loaded above 0.6. The Kaiser Mayer Olkin measure of sampling adequacy was 0.761 and the Bartlett’s measure of sphericity was significant. This
indicates adequacy of data for factor analysis. The three factors were designated as patient ignorance, motivation and attitude.

The first patient related factor identified through EFA is ignorance in both patients and service providers regarding the potential utility of capitation in health care services. Three items loaded highly on this factor, the approximate mean score for most items was 4.00. This implies that respondents tended to agree with all the items under this category. As seen from the results shown in table 4.7, respondents tended to agree that most patients are ignorant of the existing capitation programme (M = 4.30, SD = 0.493), that most patients are ignorant of the accredited health facilities (M = 3.88, SD = 0.755), and that some employees are naturally resistant to any programme (M=3.85, SD=0.771)

Patient commitment was identified as the second patient related factor affecting implementation of the health services capitation programme. Three items loaded highly on this factor and averaged a response score of 4.00 (Table 4.8). this indicates that respondents found them agreeable. Respondents tended to agree that some patients are on contract making them not to qualify for capitation programme (M=3.83, SD=0.799); that some patients have complicated diseases not accommodated in some accredited health facilities (M = 3.85; SD = 0.771), and that some patients have self ego regarding tailor made programme of capitation (M = 3.59, SD = 0.520)

The third factor identified and attributed to patients is attitude, three items loaded highly on this factor. Once again, the mean response scores for the two items approximated to
4.00 (Table 4.9). This indicates that respondents’ agreement to the items. Respondents tended to be in agreement that some patients have negative attitude of any government programme (M = 4.17, SD = 0.415); patients have a negative perception of the costs of capitation programme; and that cultural beliefs deter them from using the capitation programme (M = 3.54, SD = .753)

Results of the factor analysis identified three patient related factors that affect implementation of capitation programme. First, it was established that patients are ignorant of the capitation programme as well as on the accredited health facilities. In addition, some employees frustrate implementation of the programme by virtue of their reluctance to change.

Second, the study revealed that other commitments made patients not to embrace the programme. For instance, it was reported that some patients work on contract and this bars them from qualifying for the programme. Other patients suffer from complicated ailments that may not be handled in the accredited centres. It was also noted that some patients have an ego regarding the tailor made programme of capitation.

Third, the study identified patient attitude as another major factor affecting the capitation programme from a patient perspective. Respondents noted that besides having a negative attitude to the programme, patients perceive the costs associated with the programme negatively. Besides, it was also revealed that cultural beliefs deterred some of them from using the programme.
5.1.3 Service Provider Related Factors

The results of the EFA showed that the total variance of 91.819% in service related factors’

All factors loaded above 0.8, the Kaiser Mayer Olking measure of sampling adequacy was 0.601 which proves data adequacy for factor analysis. Three factors extracted were designated as accessibility, quality and accreditation.

On accessibility Respondents appeared to agree with most of the five items which loaded highly on this factor. Respondents agreed that accredited health centres have limited specialists or none at all (M = 4.01, SD = 0.861), that the accredited health centres have rigid bureaucracies (M = 3.93, SD = 0.838), that the management and ownership of the health accredited centers are politically motivated (M = 3.83, SD = 0.799), that the accredited health centres are in a poor and dilapidated state (M = 3.62, SD = 0.521), and that the accredited health centers are not easily accessible (M = 3.65, MD = 0.478).

On quality of the service, two items loaded highly on this factor. On the basis of the mean response scores respondents tended agree with the two items. Respondents tended to agree that the accredited health centres have poor facilities (M = 3.72, SD = 0.809) and that the accredited health centres have limited medical equipment and facilities (M = 3.79, SD = 0.808)

On accreditation most respondents showed discontent on the manner in which accreditation was made. Respondents agreed that the procedures of accrediting the health centres was not above board (M = 3.94, SD = 0.488) and that some of accredited health centres are non-existing (M = 4.13, SD = 0.386).
5.1.4 Management Related Factors

In evaluating the factor structure of the given variables, EFA with principal components extracted two factors which explained 89.723% of the total variance in management related Factors. All factor loadings were above 0.8, and the Kaiser Mayer Olkin measure of sampling adequacy was 0.697 indicating that data were adequate for factor analysis. The two extracted factors were designated adherence to standards and transparency in the capitation process.

On non-adherence to standards three items loaded highly on this factor. The approximate mean response score was established to be 4.00 in all the items. Consequently, the results indicate that respondents tended to agree that the accredited health centres do not incorporate the officials of civil servant union in formulating policies regarding management of the capitation programme (M = 3.75, SD = 0.83); that accredited health centres do not provide audited patient record through publication (M = 3.31, SD = 0.463); and that some accredited health centres do not meet certain standards’ before being allowed to run the capitation programme (M = 3.29, SD = 0.491).’

On transparency two items loaded highly on this factor, mean response scores for the two items in this factor approximated to 4.00. This indicates that respondents’ tended to agree with the items. The employees are not involved in accrediting health centres (M = 3.83, SD = 0.519) and that the government has not set up a board of trust to manage capitation funds to reduce bureaucracies in disbursement (M = 3.81, SD = 0.466).
5.2 Conclusion

It is concluded therefore that the government related factors affecting implementation of the capitation programme in provision of health care services in Nairobi County are government stewardship of the programme, political inclination by those tasked with the responsibility to oversee the implementation and financing of the programme. Under stewardship the factors include location of accredited centers and clear policies. On political inclination the factors identified include interference in funds disbursement to accredited facilities which is normally delayed. Besides this, policies on management of accredited centres remain undefined, possibly for political reasons. Financing was also identified as a key factor attributable to the government especially in adequacy of finance.

The patient related factors that affect implementation of capitation programme include ignorant of the capitation programme as well as on the accredited health facilities, reluctance to change, employment contract of the patients, type of ailments and self ego that may not be handled in the accredited centres. It was also noted that some patients have an ego regarding the tailor made programme of capitation. Other patients perceive the costs associated with the programme negatively, and cultural beliefs which deter some of them from using the programme.

Management related factors include non adherence to standards, transparency in capitation process. Non adherence to standards its concluded that the accredited centres and the government did not incorporate all stakeholders in formulating policies of accredited health centres, there was no the pre-qualification to credential and lack of audited patient records, on lack of transparency its concluded that employees are not
involved in credential process and there is no clear ceiling of the costs of drugs and related expenses.

5.3 Recommendation

Based on the above findings the study therefore recommends the following:

1. The government should adopt an all inclusive approach of facility accreditation process by involving officials of trade unions, managers of accredit facilities, government officials and any other stake holder.

2. Accredited centres should be published and frequent audit of patient records to be carried out so as to assess the efficiency and accessibility of the services by members; this will encourage transparency in the capitation process.

3. There should be establishment of an accredential committee consisting of officials from the medical and doctor’s board to prescribe the aspects of qualification for accredited centres, this will ensure ample representation of the patients by their doctors and other consultants, the results will be efficiency and positive attitude by accredited centres and patients.

4. The government should set aside enough funds for accredential and spell policies regarding political interference, this will deter those who use political incarnations to accredit healthy service providers which do not qualify.

5. Education on employees: civil servants should be educated regarding the benefits of capitation and information regarding accredited centres should be provided from a central designated office.
6. Resident representative from the government should be posted to accredited centres to monitor the progress and the services provided by the accredited centres.

7. The government should set up a board of trustee to manage capitation funds to reduce beurocracies in disbursement.

8. Minimum standards for accredited centres should be set so as to ensure that accredited service provider healthy centres meet the necessary requirements to encourage patients to frequent them when they are sick or when they require medical consultation.

5.4 Suggestion for Further Study

A study of such magnitude cannot be exhaustive by carrying out a single study, the researcher therefore recommends that other studies be carried out on the evaluation of capitation programme on levels of terminable diseases.
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Dear Respondent,

The researcher is carrying out a study of AN ASSESSMENT OF FACTORS AFFECTING IMPLEMENTATION OF CAPITATION PROGRAMME IN PROVISION OF THE HEALTH CARE SERVICES; A CASE OF NAIROBI COUNTY ACCREDITED HEALTH FACILITIES. The study is purely for academic purpose and the information obtained from you will be treated with uttermost confidentiality. Kindly fill in the questionnaire below and thank you for your co-operation and time.

Section A: Background Information

1. What is your gender?
   - Male □
   - Female □

2. Your marital status?
   (a) Single □
   (b) Married □
   (c) Other □

3. What is your age bracket?
   - 0 - 20 yrs □
   - 21 - 30 yrs □
   - 31 - 40 yrs □
   - 41 – 50 yrs □
   - 50 yrs and above □
4. What is your Level of Education?
Secondary □ University □
Tertiary □ post -University □
Others specify ……………………………………………………………………………………………

5. What is your professional qualification?
Purchasing □ Medicine □
Accounting □ IT □
Marketing □ Management □

6. How many years have you worked in your current employment?
0-10 □ 20-30 □
11-20 □ Over 30 □

SECTION B: SPECIFIC RESEARCH QUESTIONS

7. Individual patient Challenges facing implementation of capitation programme in the Likert scale 5 to 1 representing 5 strongly agree, 4 Agree 3 Undecided, 2 Disagree and 1 Strongly agree To what extent do you agree that the following are the individual related challenges of health care capitation programme?

<table>
<thead>
<tr>
<th></th>
<th>5- Strongly agree</th>
<th>4- Agree</th>
<th>3- Undecided</th>
<th>2- Disagree</th>
<th>1- Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignorance</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lack of permanent employment</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Illiteracy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cultural believes</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Any other specify………………………………………………………………………………

8. Service provider Challenges facing implementation of capitation programme In the Likert scale 5 to 1 representing 5 strongly agree, 4 Agree 3 Undecided, 2 Disagree and 1 Strongly agree To what extent do you agree that the following are the service provider related challenges of health care capitation programme?

<table>
<thead>
<tr>
<th></th>
<th>5- Strongly agree</th>
<th>4- Agree</th>
<th>3- Undecided</th>
<th>2- Disagree</th>
<th>1- Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found in long distance</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lack of specialist</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lack of drugs</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Organizational bureaucracies</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

9 Government related Challenges facing implementation of capitation programme In the Likert scale 5 to 1 representing 5 strongly agree, 4 Agree 3 Undecided, 2 Disagree and 1 Strongly agree To what extent do you agree that the following are the government related challenges of health care capitation programme?

<table>
<thead>
<tr>
<th></th>
<th>5- Strongly agree</th>
<th>4- Agree</th>
<th>3- Undecided</th>
<th>2- Disagree</th>
<th>1- Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Inappropriate allocations</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Government bureaucracies</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Political interference</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
10. Which policies do you suggest to be adopted to effectively manage capitation programme in Kenya?