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Original Articles

# The Experience of Ghana in Implementing a User Fee Exemption Policy to Provide Free Delivery Care

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## Abstra

In resou cess to skilled a the impover are expe ternal healt a in 2003 to exempt ission and private p greed tariff. The pap on interview , district and facility le on mechani roblems with disbursing and sustaining the funding, and with budgeting and management. Staff

workloads increased as more women attended, and levels of compensation for services and staff were important to the scheme's acceptance. At the end of 2005, a national health insurance scheme, intended to include full maternal health care cover, was starting up in Ghana, and it was not yet clear how the exemptions scheme would fit into it.


## Résumé

Dans les pays pauvres, le montant élevé des contributions demandées aux patientes pour les accouchements limite l'accès à des soins de qualité, tout en contribuant à la mortalité maternelle et néonatale et à l'appauvrissement des ménages vulnérables. Un nombre croissant de pays expérimentent différentes méthodes pour lever les obstacles financiers aux soins de santé maternelle. Un projet novateur, introduit au Ghana en 2003, exonérait toutes les femmes enceintes du paiement des accouchements et prévoyait que les praticiens publics, privés et des missions pouvaient récupérer leurs honoraires perdus, conformément à un barème convenu. L'article présente une partie des conclusions d'une évaluation de cette politique, sur la base d'entretiens avec 65 informateurs clés dans le système de santé aux niveaux national, régional, des districts et des maternités, notamment des responsables politiques, des gestionnaires et des praticiens. Le mécanisme d'exonération a été bien accepté et était satisfaisant, mais il connaiss du financen du personn t les niveaux nts pour l'accepta vant couvrir totaleme e dont le projet d'



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pueden reclamar ingresos perdidos de tarifas de usuarias, de acuerdo con una tarifa acordada. Se expone parte de los resultados de una evaluación de la política basada en entrevistas con 65 informantes clave (incluidos formuladores de políticas, administradores y prestadores de servicios) del sistema de salud a nivel nacional, regional, distrital y local. El mecanismo de exención fue bien aceptado y apropiado, pero hubo problemas importantes con el desembolso y sustento del financiamiento, así como con los presupuestos y la administración. El volumen de trabajo del personal aumentó a medida que se atendían más mujeres, y los niveles de remuneración por servicios y personal fueron esenciales para la aceptación del plan. A fines de 2005, se estaba iniciando en Ghana un plan nacional de seguro médico, con el objetivo de incluir cobertura completa de servicios de salud materna, pero aún no era claro cómo el plan de exenciones se integraría a éste.

Key Words:

delivery care | user fees | health financing | Ghana

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Barriers to women delivering in health facilities include poor quality services, negative attitudes [illegible] Financial barriers [illegible] es of whether [illegible] rvices and at what [illegible]

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If full removal of user fees is considered untenable, there is a case for partial removal of fees for specific services such as maternity care, which have high social priority. Maternity care exemptions would be expected to contribute to reducing maternal mortality (by increasing supervised deliveries) and reducing the impoverishing effect on households of high and unpredictable payments for deliveries (especially complicated deliveries).

This paper describes an innovative scheme introduced recently in Ghana to exempt all women from delivery fees and the findings from the first stage of an evaluation of it, using key informant interviews.

## Background

Ghana has persistently high maternal mortality ratios, estimated to range from 214 to 800 per 100,000 live births.[7] Ghana also has growing social inequalities for this indicator, with rates of skilled attendance either stagnant or declining for poorer women.[8] While deliveries with health professionals rose from 85% to 90% from 1993 to 2003 for the richest quintile, according to Demographic and Health Survey data, deliveries with health professionals for the poorest quintile dropped from 25% to 19%. Nationally, 45% of births were attended by a medical practitioner (79% in urban areas, 33% in rural); 31% by traditional birth attendants (TBAs) and 25% were unsupervised. There w[illegible] have the highest [illegible] pervised deliveri[illegible]

In the Gh[illegible] by health centres, [illegible] alth centre or post s[illegible] As continue to carry[illegible] s. Com[illegible] s and regional[illegible] Ghana Health S[illegible] ly in more remote r[illegible] son has private c[illegible] c inputs into the serv[illegible]

Financia[illegible] to seeking skilled care during delivery in Ghana.[7] A study costing maternal health care in one

district in 1999 found cost recovery rates of between 152% for deliveries and 211% for caesareans in mission hospitals, but did not shed light on affordability relative to women's income.[10] Problems such as under-funding of exemptions from user fees in general have also been found,[11–13] which have meant that exemptions are available in theory but not always in practice if the provider is not reimbursed for lost income.

The Government of Ghana introduced exemptions from delivery fees in September 2003 in the four most deprived regions of the country, which in April 2005 was extended (without formal evaluation) to the remaining six regions. The aim was to reduce financial barriers to using maternity services to help reduce maternal and perinatal mortality and contribute to poverty reduction.[14]

The policy was funded through Highly Indebted Poor Country (HIPC) debt relief funds, which were channelled to the districts to reimburse public, mission and private facilities according to the number and type of deliveries they attended monthly. A tariff was approved by the Ministry of Health which set reimbursement rates according to type of delivery (e.g. normal, assisted or caesarean section) and type of facility. Mission and private facilities were reimbursed at a higher rate, because they did not receive public subsidies.[14] Women would then only have to bear the costs of reaching facilities.

In 2005, an evaluation by IMMPACT of the free delivery policy was initiated.[15] The first stage wa te of impleme . These findings lows, a househo ations in commur were complet

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## Metho

For the evaluation two regions were chosen: one of the four regions to join the exemption scheme first (Central) and the other from the more recent wave (Volta). Six focus districts from each region (roughly half of the districts in each region) were chosen, and matched for population size, poverty status, urban profile and health infrastructure.[15]

The 65 key informant interviews were conducted from September–December 2005. The key informants included key stakeholders in the Ministry of Health, Ghana Health Services, mission sector and development partners[9]; Regional Directors of Health Services, Senior Medical Officers, regional hospital directors and administrators, and regional accountants[7]; and District Directors of Health Services and senior public health staff, District Assembly staff and accountants.[32] A sample of in-charges, matrons and senior facility staff were also interviewed at facility level.[16] The facilities were selected by a process of stratified random sampling, to represent each of the six focus districts and to cover a range of facility types, including district hospitals, health centres, mission hospitals, private maternity homes and mission clinics.

The authors carried out the interviews using a semi-structured questionnaire. The questions covered:

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The responses were analysed by topic, level and region and triangulated, where possible, with figures available from facility records or annual reports. The findings were initially presented in an internal report for IMMPACT[18] and then in a policy brief.[19]

For a qualitative process, 65 is a relatively large number and should give findings that are representative for those regions (though not necessarily nationally). Discussions at national level suggest that the findings in these two regions were not exceptional. Findings from such qualitative research need to be set in the context of other data gathering tools, and this is done to some extent in the discussion, comparing findings from interviews with other evaluation component findings.

## Findings

### Overall perceptions

There was generally a positive reception of the free delivery policy as an effective approach to an important problem, which allowed for early reporting and better handling of complications. Stakeholders within the health system found the administration of the scheme manageable and there was reasonable consistency in the interpretation of the policy. These informants were only able to provide weak evidence on community perceptions, but their view was that communities were both informed and enth onal rulers, broadca es. The trends ir , when it stopped charging regime.

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because they were relatively expensive procedures that had brought in much of the facility revenue.

The failure to reimburse adequately and promptly had negative effects at all levels of the system. Patients, having been told they would receive free services, were reported to be angry when they were asked to pay, and staff were suspected of taking a cut of the funds. Facility staff wondered if the funds had been siphoned off higher up the system. District and regional health managers were caught between facilities accumulating debts and the need to persist with the policy.

> “It is difficult to charge now, as people will think you are cheating them. But what do I do when I have no drugs left?”

As a consequence of the funding shortfall, three out of six districts visited in Central Region had reverted to charging, and the others were close to joining them. The regional hospital claimed to have substantial amounts owing from the district funds for referral care provided free. Having provided items on credit, the regional medical store found it could not be reimbursed by districts whose exemption funding had run out. Analysis of funds received in Central in 2005 compared with expected delivery numbers and unit costs suggested that the funds would be adequate only for one-third of the year.

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instructions for their use. In Volta, there was confusion about the funding channels stated in the national guidelines and the actual channel through which funds arrived. In addition, guidelines for monitoring were not enforced. At national level, oversight information on numbers of deliveries carried out and delivery types and reimbursement amounts were not available. In Volta, concerns were expressed that there was no additional funding for the administration of the scheme.

## Allocation of funds to districts

The 2004 national guidelines applied a per capita allocation of 1,510 per capita (US$0.17) for the poorer regions (including Central), and a lower rate for the relatively richer regions (including Volta) of 1,354 (US$0.15). However, in practice, there seemed to be some local adjustment. In Central Region, districts with more facilities had received a higher allocation. Despite this, they had exhausted their funds more quickly. An agreed system for funding cross-border patient flows was also needed. This was particularly relevant when the policy was limited to certain regions; women were said to be coming from Accra to deliver in Central, for example, when Accra was not yet included in the policy.

In Volta, funds were allocated on a per capita basis to the districts, with no variation for facility number or size.

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but complications and caesarean sections were paid at less than the national rate. In the other, the opposite approach had been taken, with discontent about the rates for normal deliveries, but top-end rates being paid for complicated cases. Satisfaction amongst providers correlated with these differences.

Some mission in-charges in Central were dissatisfied with the payments for more complex deliveries, compared to what they had charged women before. Others were receiving repayment rates well above previously charged user fees. In addition, at least while funds were available for the policy, the facilities did not have to worry about chasing the 25–50% of women who were struggling or unable to pay (particularly for caesareans).

Volta drew up its own reimbursement rates, based on the national guidelines, but also included a provision to pay trained TBAs for deliveries at a lower rate. Of the six districts visited by the research team, only one was including the TBAs, however. Facilities were billing according to materials used, rather than at fixed rates. There was at least one report of inappropriate billing for procedures carried out before the policy was in effect, emphasising the need for vetting and auditing. Key informants in Volta cited lower but still substantial defaulter rates prior to the policy, higher for hospitals than health centres, which find it easier to enforce payment, being closer to households.

## Impact

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## Quality

Changes to quality of care were measured by other evaluation components, but the key informant interviews probed perceptions of changes. The view in Central was that quality was improved by the more reliable funding flows for services, while the policy was adequately funded, even though staff workloads but not staffing levels were increased. In general, the brain drain and issues of retention were the biggest headache faced by managers, though this was a wider issue, not directly related to the exemptions scheme. Tiredness and overload were reported, but most in-charges felt they were still able to cope and had not reached breakdown levels.

Attitudes were less positive in Volta. The staff felt that quality of care was more or less the same, and that workloads were too heavy before and had not been improved. The scheme had not added sufficient extra resources to have had any beneficial effect. Some dissatisfaction was expressed with the quality of services, e.g. with poor use of partograms, and negative attitudes of midwives towards women, but these were not seen as affected by the scheme.

## Informal payments

Informal payments by women, an important feature of the health system prior to exemptions, were reported to be diminished or removed in Central Region, where exemptions had been in place for longer. In Volta, which was only just starting the scheme nformal paymen

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level facilities, could be claimed back, even if the delivery eventually took place elsewhere.

In Central, exemption funds were held by districts, and the regional hospital was experiencing difficulties getting reimbursements from the districts. In Volta, the system operated differently, and 5% of funds were top-sliced to a separate account in advance to pay for referrals. At the time of the research, this fund was still in credit.

## Impact on mission and private sectors

The mission sector is increasingly being incorporated into the public health system on a par with public facilities. Thus, mission hospitals and clinics were participating in the exemptions policy, though some smaller clinics complained they had not been well informed. Private midwives were also participating, but their numbers were limited. In some districts in Volta, mission facilities had reportedly opted not to join the scheme as they were dissatisfied with the repayment rates offered.

Prior to the exemptions policy, many mission facilities operated a “poor and sick fund”, which raised funds locally and internationally to pay for those deemed unable to pay. This used to cover about 15–20% of deliveries, according to national level mission informants. If new schemes undermine the old and are not sustained, there will be a net loss

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those respective years). The district hospital in Abura/Asebu Kwamankese also reported a doubling of numbers of caesareans. For Central region as a whole, 3.8% of supervised deliveries were caesareans in 2004. The regional reproductive health report showed a declining trend in facility-based maternal mortality: 450 per 100,000 in 2001, dropping to 206 in 2002, 159 in 2003 and 134 in 2004.

Given the short period of implementation, it was harder to assess changes in utilisation in Volta. Informants reported substantial increases in utilisation (it had doubled, according to the regional director). For specific facilities though, the picture was more mixed. For a private midwife located near a district hospital, it meant the halving of her business, as women could access free services at a better-equipped facility. In one district where funds ran out at the end of June, utilisation, which had increased, was reported to be on the decline again.

## Recommendations by informants

Some informants suggested broadening the approach to cover all health care in pregnancy to include, for example, malaria treatment for pregnant women and post-partum care. Others suggested that some transport funds should be added to enable women in remote areas to benefit. However, the main concern was the sustainability of the scheme, and to that end, respondents suggested reducing overall costs by targeting

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## Relationship to the National Health Insurance Scheme

At the end of 2005, a national health insurance scheme was starting up in Ghana.[20] It was not clear to most stakeholders how the exemptions scheme would fit into this new initiative which, in time, was intended to provide full maternal health care cover. Formal sector workers were automatically enrolled, but coverage for the informal sector (the majority of Ghanaians) was voluntary and at low levels. In principle, exemption funds could be re-routed in future to provide free or subsidised cards to pregnant women, but details of this were still under discussion.

Many of the issues highlighted by the review of the exemptions programme are relevant to the health insurance scheme. For example, the mission sector was concerned that reimbursement rates under health insurance would be low and that quality would be compromised, leading to a preference for fee-paying patients. Large increases in attendance were already being reported by mission facilities in some areas where the national health insurance was functional.

The development of national health insurance complicated the process of raising funds and budgeting for exemptions, as there were unrealistic expectations about how quickly health insurance could take over this social protection mechanism. The build-up of formal sector health insurance funds, based on contributions from employees and a levy on V ue for continue

## Discuss

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The decision in Ghana to cover all deliveries, initially within poorer regions and later nationally, reflects awareness of the documented difficulties of individual targeting,[26] but it also increased the cost of the scheme. It is debatable whether the decision to extend the scheme to the remaining six regions so quickly was appropriate, given funding constraints and the fact that the first stage had not yet been evaluated. The evaluation of financial flows found that the policy was under-funded by 34% in 2004, rising to 73% in 2005 when all ten regions were covered.[27]

Analysis of utilisation changes from the household survey, comparing the 18 months before introduction with the 18 months afterward, found an increase of around 12% in women delivering in facilities in Central Region but not in Volta, presumably due to the short period of implementation. It also found significant reductions in mean out-of-pocket payment by patients for delivery care (direct and indirect payments) at health facilities, both for spontaneous vaginal delivery and caesarean section. The total payments for caesareans fell by 21.6% and normal deliveries in health facilities by 18.9%, and there was a reduction in the number of households having to make catastrophic payments for deliveries.[16] Other out-of-pocket payments for deliveries remained, but were reduced from 4.78% to 4.15% of household income during the implementation of the policy in these two regions for the poorest quintile, while for the wealthiest quintile, they fell from 3.3% to 2.59%. Given the relatively high cost-recovery emphasis on reduc ute the largest c

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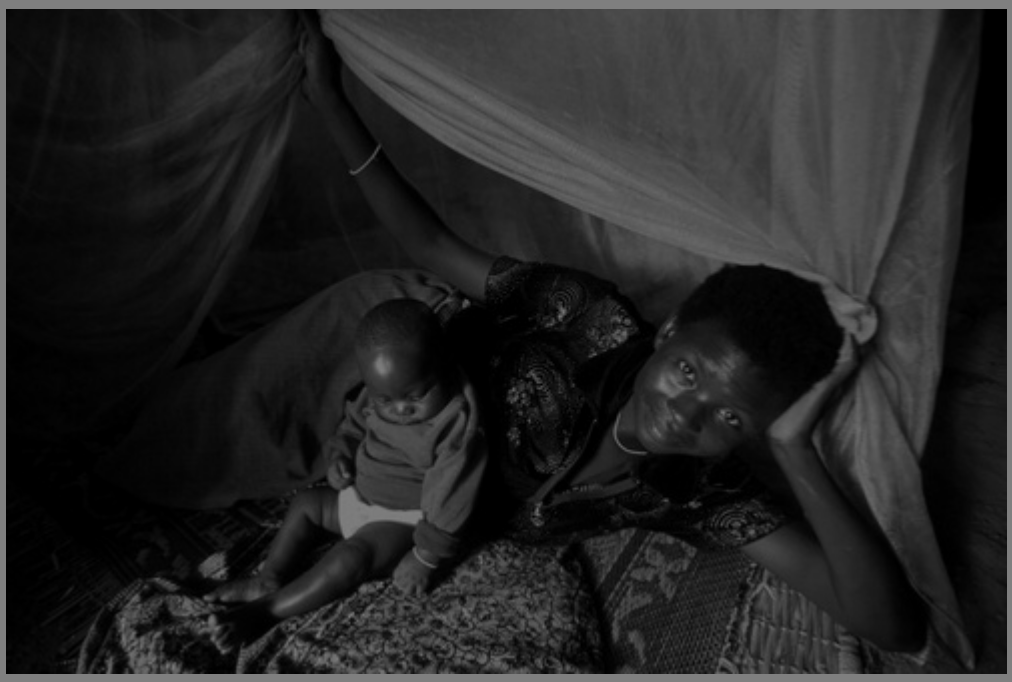
The impact on maternal mortality has not been established, but case note extraction in a sample of hospitals and routine data collected in health centres indicated that quality of care was unchanged on the whole, and poor,[16] e.g. routine monitoring of labour in hospitals occurred in only 31% of cases.

Ghana, 2003



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International reviews of waivers and exemptions have already noted the importance of providing a strong incentive ser fees have been inc vices income in 2003. in source of flexible f sential to the runn me- generati e will need to of d taking into ac

Ghana h even, in some ar d be included coverage. There ar more remote n if deliveries were free; they are less costly to reimburse; and there are often strong

cultural preferences for home deliveries. There is a strong case for including those whose quality of care is good and whose referrals are appropriate and timely.

Anecdotal evidence suggests that the findings in Central and Volta regions were typical of other regions. One informant said the scheme had more or less come to a halt nationally. There were also reports that delivery fees were being exempted in some areas, but that this was now interpreted narrowly, so that items such as drugs, food, bed nets and admission costs were being charged again.

## Conclusion

Underlying the specific budgeting and management problems noted by the stakeholders in Ghana are the more general issues of overloaded systems and poor capacity, which any kind of additional vertical programme exacerbates. The exemptions policy, while not separate in terms of service delivery, had a separate funding channel and reporting requirements, and to that extent added to the workload of struggling officials. The detailed design and management of this kind of scheme is critical to its success, and there is a need for improved communication, both vertically within the health system and across regions, so that the policy can be reviewed and adapted in light of successes and failures. Strong national leadership is also a critical element in sustainability. The experience of Ghana shows the potential of schemes to increase skilled a ome of their most co



## Acknow

We woul uchi Institute for Me in particular Marg to the key informa and also to those wh ndertaken as part of a nal Mortality Program epartment for Inter ers have no respons The views expresse

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