Immpact
Initiative for maternal mortality programme assesment

Immpact briefing note: June 2008

Extending coverage of maternal health care through the National Health Insurance Authority in Ghana: lessons from the Immpact evaluation of the free delivery care policy

The case for exempting pregnant women

Reducing maternal mortality and reaching the MDG5 target by 2015 is proving a serious challenge for many countries, including Ghana. The estimate of MMR in Ghana in 2005 was 560 per 100,000 live births (range: 200-1,300) (WHO et al. 2007), putting it clearly in the category of countries with a high-burden of maternal mortality. In this year's Aide Memoire, the Hon. Minister of Health declared the high maternal mortality in the country as a national emergency and highlighted the need to accord greater priority to reproductive health services.

DHS figures for the 10 year period from 1993 to 2003 show a steady improvement in the supervised delivery rate one of the two proxy indicators for tracking MDG5. Recent figures however indicate that this trend has been reversed. According to the independent review of 2007, the proportion of deliveries attended by skilled health personnel declined from 54% to 35% between 2005 and 2007. In parallel, institutional mortality rates and the proportion of births attended by TBAs are reported to be increasing. The recent Countdown to 2015 report indicates that Ghana has only half of the recommended minimum national provision of Emergency Obstetric Care services.

This decline in skilled care at delivery may be linked to the under-funding and then abolition of the exemptions policy for delivery fees, which was introduced in 2004, as well as the health worker strike of 2007. An external eyaluation found that the exemptions were effective in raising utilisation significantly, with some modest equity gains (Penfold et al. 2007).

In addition to concerns about the direction of change for crude indicators, there are continuing and increasing inequalities in access to skilled care' at delivery. In Ghana, the absolute differences between the bottom and top quintiles in terms of delivery by a health professional, as evidenced by DHS data, increased from 60% in 1993 to 68% in 1998 and nearly 70% in 2003. This compares with an average poor-rich gap of 42% for a selection of sub-Saharan African countries (Gwatkin et al. 2007).

There is a growing movement, globally and in the region, to reduce financial barriers to health care generally, but with particular emphasis on high priority services and vulnerable groups. In Burundi, free services for pregnant women and the under-fives were introduced in 2006, and utilisation appears to have

increased as a result, though no formal evaluation has been undertaken (Batungwanayo & Reyntjens 2006). In Zambia, fees were suspended for rural districts in 2006. In Burkina Faso, an 80% subsidy policy for deliveries was launched in 2006 (Ministere de la Sante 2006). Other countries have followed suit, though with varying target groups, and all still at the stage of being elaborated. In Kenya, for example, various Changes have been made to the user fee regime most recently, in 2007, deliveries were announced to be free, though there is no evidence yet of implementation or impact. Liberia suspended fees for primary care in 2007. Niger announced free care for children late in 2007. Sudan announced free care for caesarean sections and children in January 2008.

Funding is available to support such initiatives to reduce financial barriers as part of the international effort to improve progress towards the MDG goals. Examples include the International Health Partnership and bilateral aid, as evidenced by the recent UK grant of £42.5m to Ghana. Part of this grant is being used to support the policy of free medical care for pregnant women announced by the President in May 2008. The policy will be implemented through the NHIA.

Lessons from Immpact's evaluation of Ghana's free delivery care policy

Between October 2005 and November 2006, Immpact conducted an evaluation of the policy in six districts each in the Central and Volta regions (Armar-Klemesu et al. 2006). The findings, especially relating to implementation of the policy, provide useful lessons for this new initiative.

Ensuring adequate funding flows

The previous exemption scheme was under-funded, causing debts at facility level and partial and intermittent suspension of the scheme (Witter and Adjei 2007). This created friction between communities and health staff and between facility managers and higher levels of the health system. There is a risk of this scenario being repeated under the new insurance-based approach.

This should be addressed by realistic costing in advance, and by regular feedback on service uptake. One critical area will be the extent to which pregnant women utilise other non-pregnancy related health services. There will thus be the need for a strong monitoring and evaluation component from the beginning, involving the Ministry of Health as the commissioner of services but building on the NHIA management information system. A reliable and long - term source of funding is also essential. This will necessarily require stronger inter-ministerial negotiations with the Ministry of Finance and Economic Planning.

Analysis of Immpact's evaluation data from the delivery exemption policy suggests that, in 2005, overall expenditure in Central region was $22 per delivery (of all types) and $62 per additional delivery (a crude measure of cost-effectiveness) (Witter, Armar-Klemesu, & Dieng 2008). However, future costs will be higher as a more integrated care package is on offer through the NHIA.

Building institutional ownership

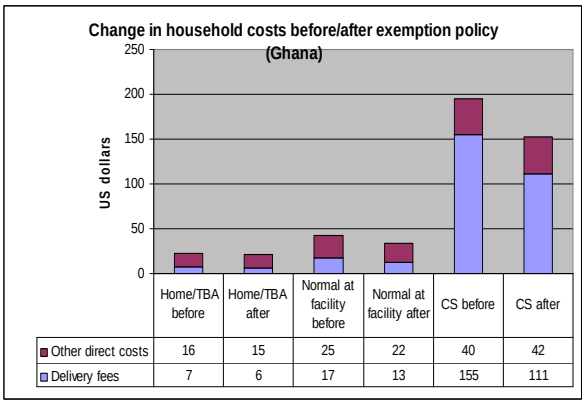
Establishing clear lines of responsibility early will be crucial, with individual units or even individuals having a specific responsibility to develop, fine-tune, manage and monitor the policy. Previous exemption systems have suffered from lack of ownership (Witter & Adjei 2007).

Producing substantial reductions in household costs

The exemption does not address non-facility costs. This is reasonable in most areas with easy access to services. The Immpact study found that facility costs formed the majority of overall household costs for deliveries, particularly for more expensive procedures (40% of costs for normal deliveries, but 80% for caesarean sections) (Asante et al. 2007). These are the procedures which are potentially catastrophic for households.

However, the household survey also found that facility costs were not entirely reduced to zero by the exemption policy the reduction was 28% for caesarean sections and 26% for normal deliveries (see Figure 1).

Figure 1 Delivery costs before and after exemption, Ghana



Source: (Asante et al., 2007)

This points to the need to assess real impact on households to ensure that subsidies are adequate and that they are being passed on in reality to users. Analysis of funding flows to the delivery exemption policy found an average public expenditure on the scheme of $22 per delivery compared with an average 'benefit' to clients of around $10 per delivery (Witter, Armar-Klemesu, & Dieng 2008). Minimising such loss of benefits within the system is crucial. Maintaining community confidence in a clearly defined and predictable benefits package is essential, and this has been problematic in the past.

Addressing equity issues

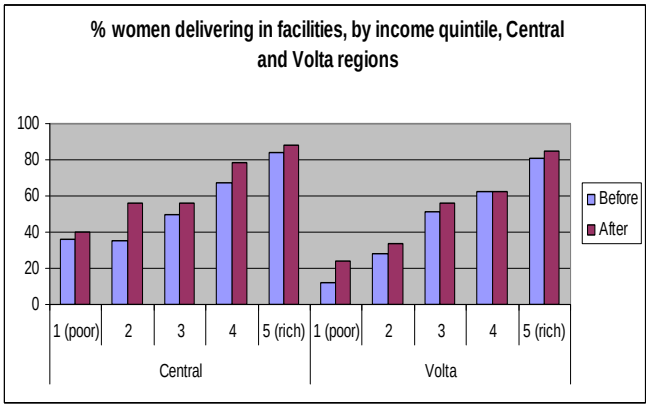
The results from the delivery exemption evaluation by Immpact suggest that inequalities can decrease in response to a universal exemption (see figure 2). After fee exemption the largest increase in facility utilisation in Volta Region was amongst the poorest (first quintile), while in Central Region it was amongst the poor (second quintile). However, to reach the poorest and the poor in some areas, additional demand-side cost issues such as transportation costs, need to be addressed. In addition, the exemptions package should clearly be defined in advance to increase transparency and accountability.

Motivating Staff

The costing of the recently announced NHIA-based exemptions is based on the assumption that salary costs are not affected by the policy – that staff can cope with an increase in workload. This is likely to be unrealistic in the medium term, particularly given the increase in wider service utilisation brought about by the growth of the NHIA.

Previous workload increases were supported by a rising general pay level (Witter, Kusi, & Aikins 2007). In future, increased numbers of core health staff and increased pay levels may be required and these are costs which will fall on the Ministry of Health.

Figure 2 Proportion of women delivering in health facilities before & after fee exemption, by income, Central and Volta regions



Source: (Penfold, Harrison, Bell, & Fitzmaurice 2007)

Improving Quality of Care

The Immpact research included a number of components investigating quality of maternity care, all of which concluded that the exemption policy had not led to a deterioration, but that quality of care - before as after - was an area of great concern (Bosu et al. 2007 ;Tornui et al. 2007). A look at scores obtained for five care components of labour and delivery care at health centre level revealed that when compared with their respective maximum expected scores, the lowest scores were obtained for management of the first stage of labour, use of the partograph, and for immediate post partum monitoring of mother and baby (Deganus & Tornui 2006). Confidential enquiry techniques also found that women received poor quality care in hospitals, resulting in many potentially avoidable deaths (Tornui et al. 2007). However, health systems factors, such as availability of consumables and basic equipment for providing comprehensive emergency obstetric care, were generally found to be adequate. Qualitative investigations found very variable relationships between health workers and clients, ranging from very positive to very antagonistic.

Involving TBAs

The community investigations for the evaluation of the delivery exemption policy found widespread trust in TBAs (Arhinful et al. 2006). Some districts were actively using TBAs to refer pregnant women, thus ensuring continuity of care. This is particularly important in more remote areas, where access to facilities is problematic.

Conclusion

The recent Presidential announcement on making delivery care free to all women is a bold and timely action which is strongly supported by evidence from within and beyond Ghana. The potential for this to translate into reduced mortality for mothers and babies fundamentally depends on the effectiveness of its implementation. There are clear pointers from the Immpact evaluation of the previous exemption scheme, which can help strengthen the shift to using the NHIA to provide coverage of pregnant women. This shift also offers new possibilities for a more comprehensive package of care than previously on offer, and for expanding demand in future for the NHIA.

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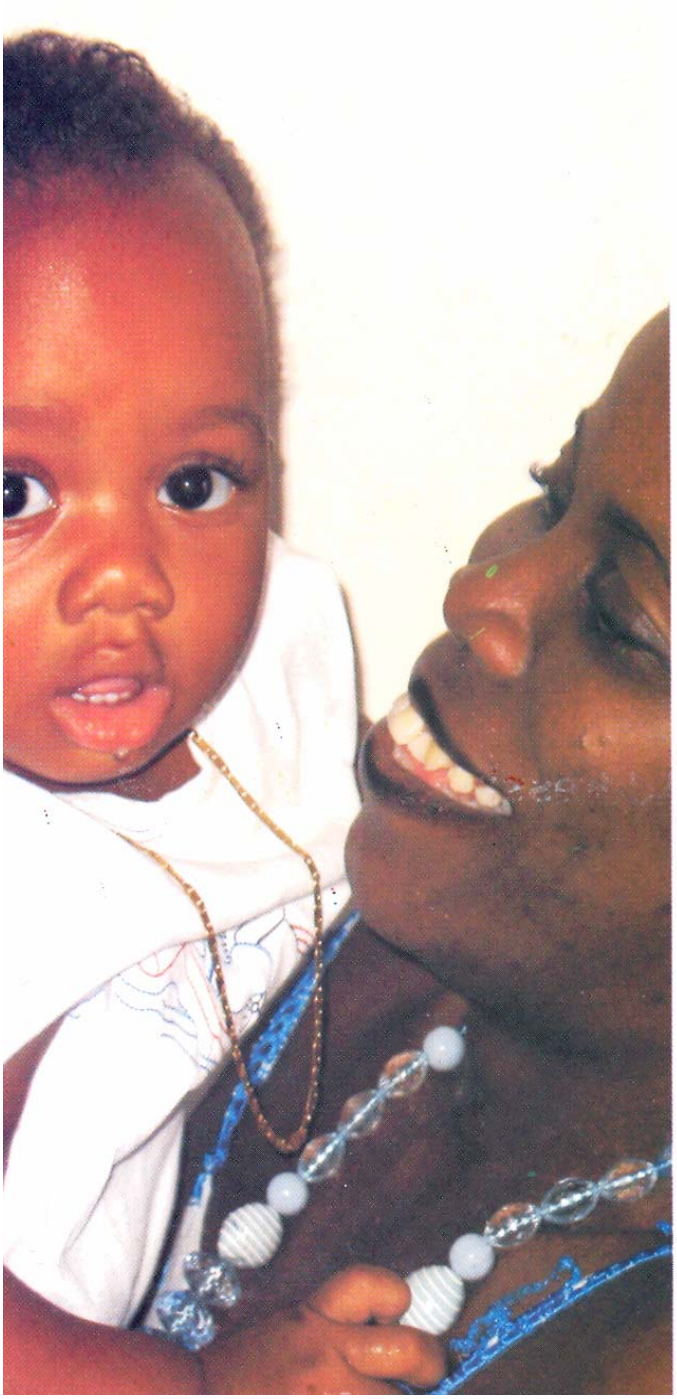

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