ISSN: 2349-2147

Modern Research Studies

An International Journal of Humanities and Social Sciences
An Indexed & Refereed e-Journal
www.modernresearch.in

Title: National Health Insurance and Free Maternal Healthcare in Ghana: Responses from Women and Health Workers in Akropong

Author/s: SAMUEL ADU-GYAMFI
EDWARD BRENYA
GIFTY NUAKO ADJEI

Volume 2, Issue 4
December 2015

pp. 696–737.

Email: editor@modernresearch.in
mrsejournal@gmail.com

ISSN: 2349-2147
Modern Research Studies:
An International Journal of Humanities and Social Sciences

National Health Insurance and Free Maternal Healthcare in Ghana: Responses from Women and Health Workers in Akropong

Dr. SAMUEL ADU-GYAMFI*
mcgyamfi@yahoo.com

Dr. EDWARD BRENYA
ebrenya@gmail.com

and

GIFTY NUAKO ADJEI

*Department of History and Political Studies
Kwame Nkrumah University of Science and Technology, Kumasi-Ghana

Abstract: The government of Ghana from the 1990s has tried a lot of policies to finance healthcare in Ghana. Different policies were introduced by different governments until 2003 when President John Agyekum Kuffour introduced the National Health Insurance Scheme (NHIS). The study was carried out to find out the impact of NHIS on maternal healthcare at the Akropong Health Centre. The study adopted the descriptive survey design using the case study approach. In all fifty (50) participants were selected for the study which included health workers as well as expectant and lactating mothers who seek medical attention from the Akropong Health Centre in the Ashanti Region of Ghana. Responses were coded and analysed using tables and percentages. The findings point to an increasing or regular access of health care, free drugs, lower cost of healthcare and improved health status of women.

Keywords: National health Insurance, Maternal Health, healthcare, Ghana, Akropong.

Introduction

The government of Ghana has tried a lot of policies to finance health care in the country since the 1990s. These policies to finance healthcare in Ghana started with "free" healthcare for all its citizens in 1957 (Gajate-Garrido & Ahiadeke 4). This meant that Ghanaian citizens were not to make any form of payment when they visited the hospital. The government was to finance healthcare through government tax revenue. However this policy declined due to the scarcity of the country's resources. After the decline of the "free" policy the government of Ghana introduced another policy called the user fee and it was introduced in 1969. In this policy of a relic, fee was charged on health service (Darkpani 2011). Although the first three polices declined the government of Ghana introduced a full cost recovery for drugs as a way of producing income to address the shortage of drugs (Mensah 2013). This new system of payment was called the "cash and carry"[1] and was introduced in 1985. This policy worsened the situation of health services in Ghana because many Ghanaians were excluded from accessing healthcare. In the 1990s Ghana experienced economic shocks and began the Structural Adjustment Programs and therefore the government introduced nominal payments for health services. In this regard a Community-based mutual health insurance scheme was introduced in the 1990s. This policy also failed. Therefore, in 2000, the high out-of-pocket expenditure on health was introduced and this brought about a very low utilization of health services (Mensah 2013). Finally in 2003 the government under President John Agyekum Kuffour introduced the National Health Insurance Scheme (NHIS). The National Health Insurance Scheme was established under the National Insurance Act 650 of 2003 now Act 852 and operates under the National Insurance Regulation (Legislative Instrument-L.1.1809) 2004. The objective of the National Health Insurance Scheme is to provide financial access to all residents in Ghana, especially the poor and the vulnerable, with quality basic healthcare services. Under the National Health Insurance Scheme the rich subsides the poor, the healthy

[1] "Cash and carry"- means a type of health system where the individual pays for the cost of health service enjoyed.

subsides the sick and the economically active pays children, the aged and the indigents (Atwima Nwabiagya 2014).

According to World Health Organization maternal health refers to the health of women during pregnancy, childbirth and the postpartum.[2] The fifth goal of the Millennium Development Goals (MDGs) is to improve maternal health and its target is to reduce the mortality ratio by three quarters between 1990 and 2015 (Ghana Statistical Service 2010). The policy of free medical care for pregnant women under the NHIS was introduced in Ghana on July 1, 2008. This policy was introduced by President John Agyekum Kuffour after his trip from the United Kingdom where the British government promised to give the country £42.5 million in support of her efforts to reduce maternal mortality as conceived by the Millennium Development Goal (Yeboah & Appiah-Adjei 2008). According to World Health Organization health is generally defined as a state of complete physical, mental, and social well-being and not merely the absence of diseases (WHO). Health care on the other hand is defined by the medical dictionary as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.[3] Health insurance is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. The mode of payment of the health insurance depends on the type of health insurance coverage; either the insured pays costs out-of-pocket and is then reimbursed, or the insurer makes payments directly to the provider.[4] Many women die each year during pregnancy and childbirth mainly because they had little or no access to skilled routine and emergency care. Before the introduction of the free maternal care most pregnant women waited till very late into their pregnancy before they announced their presence for ante-natal care while others failed to go at all because of financial problems. Maternal mortality arises due to complications of pregnancy or delivery. This

[2] WHO. "Maternal Health." Last modified August 2013. http://www.who.int/topics/maternal_health/en/.
[3] "Health Insurance." Medical dictionary. Accessed on October 3, 2014. http://medical-dictionary.thefreedictionary.com/health+care.
[4] Ibid.

problem was one of the targets the Millennium Development Goals wanted to abolish in the country. The main reason why the "free maternal care" was introduced was because the government of Ghana wanted to facilitate access to free and quality maternal care delivery services to all mothers. Secondly the government also wanted to help reduce the number of women and children who die from preventable death during pregnancy and labor related problems. Finally the last reason why the government of Ghana introduced this policy was because the government wanted to encourage women to seek antenatal and post natal care as well as delivery at health care facilities. In July 2008 when this policy was introduced in Ghana it was open to all pregnant women resident in Ghana. Those who had access to this program were all pregnant women who have registered under the policy, nursing mothers registered under the policy and all babies born to mothers registered under the program up to ninety days after birth. These women who benefited from this policy were eligible to free health service in all NHIS accredited healthcare facilities. These facilities could be public, mission or private. This "free maternal care" policy lasted from the point the woman was certified by a doctor, nurse, or midwife to be pregnant up till three months after child birth. This policy also covered emergencies during delivery and all other medical problems that would arise within this period. Again, these pregnant women also benefited from exemption from payment of the NHIS premium, exemption from payment of the registration fee, waiving of waiting period between registration and accessing of the services, free medical services and medicines during antenatal period, free medical services and medicines during delivery (including Caesarean delivery), free medical services and care for the newly born baby on the mother's ticket (as a member of NHIS) for ninety days after which baby must be registered, and free medical services and medicines during postnatal period. Postnatal period is the six weeks following delivery. These pregnant women were to access this free maternal program by obtaining a pregnancy confirmation note from a Medical Officer, Midwife or Nurse and submit pregnancy confirmation note to the nearest NHIS office or agent for free registration and insurance of NHIS membership card. They then had to attend NHIS accredited hospital, clinic or maternity home with NHIS card and receive free ante-natal care.

Newly-born babies were to continue to access free health care for the first three months after which their parents were required to register them at no cost for NHIS membership card for further" FREE" health care till age 18.[5] Since the introduction of this policy under the National Health Insurance Scheme Ghana seems to have made some improvements in the reduction of maternal mortality. An estimation taken in 2001 showed that maternal deaths in the year 2000 stood at 740 per 100 000 live births. According to the 2010 World Health Organization Report, maternal mortality has reduced to 560 per 100 000 live births in the country (Mensah, R.T. 2011). Since the inception of the free medical care for pregnant women under the National Health Insurance Scheme it has contributed in diverse ways to improve maternal health in Ghana. Therefore, this research seeks to unveil the impact of the National Health Insurance Scheme on maternal health by using Akropong in the Atwima Nwabiagya District as a case study.

The eudemonia of mothers is a very essential topic in this world. Their welfare determines the health of the next generation and can help foretell future public health challenges for families, communities, and the health care system. The aims of the maternal health are to address diverse conditions such as health behaviors and health systems signals that affect health, wellness, and quality of the life women. This topic will help the government to know both the positive and negative impacts the NHIS had brought on maternal health and make reforms, if necessary. Also this research will also help the NGOs to know the impact the National Health Insurance Scheme had brought on maternal health and channel more income in this area to help the government. Again, this research will also help the Ghanaian citizen to know the progress NHIS had brought on maternal health. Therefore, this research will enlighten Ghanaians about the improvements the National Health Insurance Scheme has brought on maternal heath since its inception.

While motherhood is often positive and a fulfilling experience for many women it is also associated with suffering, ill-health and even death. According to the World Health Organization the direct cause for

[5] "Free Maternal Care Policy." Ghana Health Nest, last modified on September 8, 2012. http://ghanahealthnest.com/2012/09/08/what-is-the-free-maternal-care-policy/

maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor.[6] This is why it is one of the objectives of the Millennium Development Goal to reduce the mortality ratio by three quarters between 1990 and 2015 (Ghana Statistical Service 2010, 35). The government of Ghana under President John Agyekum Kuffour's administration saw the importance of maternal health and hence introduced this policy. This was because maternal health was not in a proper condition and so the government had to intervene to make it better. Although people had written about maternal health, no attention had been paid to the analysis of trends in a historical way on this topic. Again, even though the government introduced the free maternal care under the National Health Insurance, the outcome of it needs to be researched into. Its problems also need attention. The people who have benefited and how long they have benefited as well as its problems should be given much attention.

This research seeks to explore the history behind the setting of the National Health Insurance Scheme. It also seeks to find out how the National Health Insurance has helped improve maternal healthcare in Akropong. The following research questions have been designed to help the discussion:

- What were the conditions of maternal healthcare before the National Health Insurance Scheme in Akropong?
- What are the effects of National Health Insurance Scheme on Maternal healthcare in Akropong?
- To what extent does maternal healthcare depend on the National Health Insurance Scheme?
- How is maternal healthcare run under the National Health Insurance Scheme in Ghana?

Delimitation and Approach

The period of this research is from the second half of twentieth century to date. This is because this research seeks to find out the

[6] WHO. "Maternal Health." Last modified August 2013. http://www.who.int/topics/maternal_health/en/.

conditions of maternal health during the cash and carry system and how maternal health has improved since the introduction of the "free maternal care" under the National Health Insurance Scheme. In this research Akropong Health Centre was used as the case study to find out how the NHIS has helped to improve maternal health care in the town.

Akropong Health Centre is located at Akropong in the Ashanti region which can be found in the Atwima Nwabiagya District of Ghana. There is one hospital which is the Akropong Health Centre which serves as the health facility for the inhabitants of Akropong and other neighboring towns such as Bankyease, Kapro, Dwenewoho, Mfensi, Ntensere, Sokwai, and Owabi. The main occupation of the residents in the area is farming, particularly subsistence farming.

This study focuses on the impact of NHIS on maternal health in Akropong in Ghana. The qualitative approach was very useful in this research. Both primary and secondary sources were used. Relevant information from articles, journals, internet, hospital records, videos and many more were used in this research. A combination of tools was used to collect information. Questionnaires were administered to both the expectant and lactating mothers as well as health workers at the Akropong Health Centre. Different sets of questions were administered to both the health workers and the lactating and expectant mothers. The questionnaire was administered to women who had given birth during the "cash and carry" era from the year 2000 at the Akropong Health Centre, expectant and lactating mothers who were enrolled on the NHIS at the Akropong Health Centre and also health workers who were working during the 2000s. Women who were given the questionnaire were those who were attending antenatal care and those who had come to weigh their babies at the Akropong hospital. Again, the questionnaire was translated into Twi language to allow for understanding and effective response. The questionnaire survey was used mainly to collect numerical data about the opinions of the lactating mothers, health workers and expectant mothers concerning the impact of the National Health Insurance on maternal health in Akropong. The type of questionnaires used in this research was both closed and open-ended. By using this type of questionnaire the respondents were able to give much details about the concerning maternal health in the Akropong

area. It also helped to assess their opinions about the impact of the National Health Insurance Scheme on maternal health in the Akropong community.

Also the criterion for the distribution of the questionnaires was based on the birth factor of these expectant and lactating mothers, and the duration of years of the health workers – that is women who had given birth in the 2000s, women who were presently pregnant, and health workers who were working in the 2000s. This criterion was chosen because this type of population knew about the conditions of maternal health during the "cash and carry" era and could draw an effective comparison between the National Health Insurance and its impact on maternal health since the "free maternal care" was rolled. A sample size of fifty people was used in this research. It included fifteen health workers and thirty-five lactating and expectant mothers. After all the questionnaires had been administered and collected it was compared to the maternity records to compare whether the responses received from the questionnaires tallied with the records at the maternity. The records were collected from the maternity archives at the Akropong health centre. Since the health centre lacks a proper repository, some of the records for some years such as 2008 antenatal and delivery records were missing. Also most of the records were torn and very dirty.

Again, as indicated earlier, the study used qualitative research methodology, and was supplemented with quantitative research method. Qualitative data gathered from the open ended questionnaire was first analyzed using description and content analysis. This was because data analysis in qualitative research provides ways of discerning, examining, comparing, contrasting, and interpreting meaningful themes in research results. Also quantitative data gathered from the closed ended questions was analyzed by coding the data into the computer for analysis with the help of Statistical Package for the Social Sciences (SPSS). This helped to give a comprehensive knowledge about the impact of the National Health Insurance Scheme on maternal health in Akropong.

The Literature on the History of Health Insurance and Its Implementation in Ghana

According to Daniel Kojo Arhinful, before the advent of colonial rule, the native Gold Coaster was used to indigenous medicine provided by the traditional healer whose cosmology was based on physical as well as social causation of illness. Traditional healers could pass their skills to others through training. Since the British neither understood nor appreciated their efforts during the colonial period they tried to abolish it (Arhinful 30-40). The British campaigned against the traditional healers that they were insincere quacks. As a result of the slander against these traditional healers they tended to operate in secrecy and isolation (Arhinful 30-40). However, Arhinful continues to argue that initial commencements of modern health care can be drawn from the time of structured European presence in Ghana. It dates back to the fifteenth century when the Portuguese constructed a fort at Elmina in the central region of present day Ghana in 1481 under the voyage of Don Diego D'Azambuja (Arhinful 30-40). Successively, the Dutch, British, Danes and others arrived on the coast to construct forts and castles for the purpose of trade in spices, gold and, later, slaves. Historical accounts of commercial activities along the West African Coast show that European ships and castles became centres for the spread of diseases like small pox, syphilis and yellow fever. Subjective accounts of the chaos Europeans writhed from the fevers in West Africa got the area the reputation of "white man's grave" in colonial history (Arhinful 30-40).

Arhinful argues that in the beginning Ghanaians found this new method of healthcare strange and therefore were not using it. He further supports his argument that most of the indigenous people were used to the local medicines. Also most of the indigenous people admitted usually died since they reported late for treatment. In 1898 the dispensary fee was enacted. The fees prescribed for government officials and their dependents was a small per Diem only in the case of admissions while non-official Africans paid between six pence to three Shillings and sixpence per day depending upon the type of occupation and status (Arhinful 30-40). Arhinful goes on to argue that this fee was expensive for ordinary Africans. However, it must be noted that the

type of healthcare introduced by the colonial government was a private one where people had to pay for healthcare themselves. This was because there was no National Health System in Britain at that time and so such was the practice there (Arhinful 30-40). It was in the 19th century that Britain recognized National Health System that the colonial governments also followed suit to administer it in their colonies. Firm foundations for medical services in Ghana began in the 1920s and continued to the period of the 1950s (Arhinful 30-40).

Joseph Mensah, though not contrasting the argument of Arhinful, has argued that Ghana's independence in 1957 led to the emergence of the free health care for all its citizenry. The implication of this was that there was no direct out-of-pocket payment at the point of consumption of health care. It was financed through government tax revenue. There was a decline in the economy due to competing demands on the country's resources. Therefore, the User Fees was introduced in 1969 when the first law, Hospital Fees Decree, 1969 (NLCD360), which enabled the collection of fees for health services was implemented (Mensah, J. 2011). The following years brought about a number of other laws such as the Hospital Decree, the 1969 (Amendment) Act, 1970 (Act 325), the Hospital Fees Act 1971, (Act 387) and this resulted in the Legislative instrument particularly the Hospital Fees regulation 1985 (LI1313) which mandated fees to be charged for consultation, laboratory and other diagnostic services, medical surgical and dental services, medical examination and hospital accommodation (Mensah, J. 2011). Patients were also charged for drugs given at a full cost. The user fee brought about a decline in delivery of health services in the economy. However, according to Joseph Mensah, the government instituted full cost recovery for drugs as an alternative for generating revenue to deal with the problem of shortage of drugs. The payment mechanism which was put in place was termed "Cash and Carry". The "Cash and Carry" worsened the health delivery problem by creating some financial access barrier to access health delivery. As a result of the problems brought by the cash and carry the government thought of abolishing the out of pocket payment of healthcare at the point of service. To compensate for the negative effects of the cash and carry

system, the government authorized various studies into other options, especially, insurance-based ones (Mensah, J. 2011).

Joseph Mensah further argues that at the beginning much effort was committed into investigating the feasibility of National health Insurance Scheme. Proposal to establish a National Health Insurance have been there for quite a long time since the early 80s. Many experts, both local and international, were signed up by the Ministry of Health to investigate and make recommendation to establish and operate a National Health Insurance Scheme Organization. The International Labor Organization (ILO), World Health Organization (WHO), European Union and London School of Hygiene and Tropical Hygiene – all visited and provided technical advice at the request of the Ministry. The NHIS pilot project was formally launched in 1997 in the Eastern region intended to cover four districts – New Juaben, Suhum-Kraboa-Coaltar, South Birim and South Kwahu (Mensah, J. 2011).

However, according to Irene and Sam the first community health insurance in Ghana was started in Nkronza by the St. Theresa Catholic Mission Hospital in 1992 in the Brong Ahafo Region. This was an option for financing healthcare to restrict out-of-pocket payments by clients, especially the poor who had difficulties in making payments to keep the hospital afloat. The success of the Nkoranza Scheme provided the impetus for the establishment of other such Schemes in Ghana (Agyepong & Adjei 154). Irene and Sam further argue that after 2001 several community health insurance called the Mutual Health Organization started to evolve in Ghana. Most of them were sponsored by Faith-based Organizations. Some of the development partners that played a major role in the support include DANIDA (Danish International Development Assistance) and PHR-plus (Partnership for Health Reform plus). These two organizations also helped in the development of training manual for administrators and governing bodies. Most of these Mutual Health Organizations were in Brong Ahafo and Eastern Region (Agyepong & Adjei 154). This review is significant to this study because it helps to give a clear historical background of healthcare delivery in Ghana.

It is important to point out that Arhinful did an extensive research about the topic under study by tracing the historical information about how health system began in Gold Coast. Again, Joseph, Irene and Sam in their research also did an extensive research by continuing to trace historical information about how the native Gold Coaster was able to accept this new kind of health system and how they were able to firmly establish it.

Utilization of Maternal Care in Ghana

Efua A. Opoku's (2009) research on Utilization of maternal care services in Ghana was based on regions. This research was based on data examined from the 2006 Annual Statistics data from the Multiple Indicator Cluster Survey Ghana (2006) and the Ghana Health Services (GHS) half-year 2006, 2007 and 2008 reports. These data helped to supply information on what has happened at the regional levels. In this research percentages were calculated from the original data sets in order to know the different situations occurring in the regions (Opoku 2009).

In Opoku's research the fundamental findings included the following. It was known that skilled personnel delivered about half the births in the two years prior to the Multiple Indicator Cluster Survey (MICS). This percentage was highest in the Greater Accra Region (83%) and Ashanti Region (60%) with seven of the regions below 50% (Western, Central, Volta, Eastern, Northern, Upper East and Upper West). The Upper West showed the lowest percentage of any skilled attendance (29.1%). The Greater Accra Region showed the highest percentage of deliveries in a health facility at 83.1 percent followed in second at 59.6 percent by the Ashanti Region (Opoku 2009). The Upper West Region showed the lowest percentage at 28.4 percent followed by the Northern Regions at 34.4 percent. The Greater Accra and Ashanti region dominated with high percentages of deliveries in Government facilities, private hospitals and had a high total percentage of deliveries in a facility. The Upper West and Upper East had the lowest percentage of deliveries in Government facilities, private hospitals and a low percentage of deliveries in a facility (Agyepong & Adjei 154).

Opoku's research showed clear detachment between the two urban areas and the two rural areas. It showed that care was concentrated more in the urban areas than the rural areas since there were not as many facility options in the rural. Most pregnant women received ANC services at GHS facilities and the teaching hospitals. Ghana Health Service and the Teaching Hospitals accounted for 69.6% of ANC registrants in 2006, an increase over that of 2005 (64.9%). The Teaching Hospitals alone accounted for 2% (Agyepong & Adjei 154). The CHAG (Faith-Based health institutions) and quasi-government institutions registered a slight decrease in their contribution (14.8%) as compared to that of 2005 (15.5%). There was also a decrease in the contribution from Private hospitals and maternity homes for the year 2006 (10.9%) as compared to 2005 (11.7%) (Opoku 2009).

However, according to Opoku's research it was known that contribution by trained Traditional Birth Attendants continued to decline. In 2006 TBA contribution was 4.4%, a slight decline from that of the previous year (4.9%). The data showed some of the issues with maternal care in urban and rural trends. The Greater Accra and Ashanti Region exposed the highest coverage for assistance during delivery in the year 2006 to 2008 (Opoku 2009). This was because both regions had a greater amount of facilities which was evident in their higher rate of total facility deliveries based on the 2006 annual statistics. Northern and Upper West region showed low percentages of sites available for delivery, total facility delivery and assistance during delivery (Opoku 2009). The significance of this review to this research is that since the introduction of NHIS there has been a decline in the contribution of trained Traditional Birth Attendants. This shows that since the inception of the NHIS most women have shown an interest in seeking health care at the hospitals than consulting TBAs during deliveries.

However, Opoku's study failed to put across whether her research was able to reveal that there was an increase or decrease in maternal and infant mortality. Therefore, based on this shortfall this research seeks to find out the direct impact of the National Health Insurance Scheme on maternal mortality. Again, Opoku's study showed that an extensive research was done on the subject matter. This was because the study

investigated all the situations in all the regions in Ghana. However, Opoku's study failed to account for some of the constituents of maternal care utilization, especially postnatal care utilization by pregnant women in the regions.

Effect of the Free Exemption Policy

The fee exemption policy on the utilization on maternal services in Ghana was looked into by Karen Grepin, a PhD candidate in Health Policy. The study used data from the 2006 Multiple Indicator Cluster Survey (MICS), and the 2003 Demographic and Health Survey (DHS). In 2003 the Ghana Demographic and Health Survey gathered a careful utilization of maternal service data on six births of eligible women. Also in 2006 the Multiple Indicator Cluster Survey gathered a careful maternity service utilization data on the last birth of surveyed women (Grepin 2009). The time period of interest in this evaluation is a period of twenty months prior to the introduction of the Delivery Fee Exemption Policy (DFEP) as well as the twenty months following the initial roll-out of the policy. The research showed that coverage of supervised deliveries was much lower in the early intervention regions than in the other regions prior to the introduction of the DFEP. The general tendency in the two groups of regions showed to be similar outside of the policy intervention time period (Grepin 2009). Also, the introduction of the Delivery Fee Exemption Policy showed an increase in the early intervention regions during the time period. Again, the introduction of the Delivery Fee Exemption Policy seemed to have had a positive and significant impact on the ratio of births supervised by trained medical professionals which had increased by roughly 14–17%, the ratio of births delivered in any institution also increased by 16%, the proportion delivered in a public institution also increased by 19%, and the proportion of births delivered in a hospital increased by 14%.

According to Karen, the policy was able to achieve its pro-poor objective because among targeted health services there was not any major differential effect of this policy on wealthier patients, which suggests that the policy did not appear to have had any significant effect on maternal health services not directly targeted by the policy,

strengthening the argument that it was the Delivery Fee Exemption Policy that increased coverage of targeted health services. Therefore, the policy appears to have increased both the level of professionalization and institutionalization of deliveries in the targeted regions, both of which are believed to play an important role in reducing maternal mortality (Grepin 2009). This review is significant to this research because it proves the impact of the Delivery Fee Exemption Policy which was enrolled on the NHIS since it proves that the policy has increased the ratio of deliveries in both government and private hospitals.

Grepin's study entailed some shortcomings. Firstly, the time frame used in the research which was twenty months pre- and post-implementation of the Free Maternal Delivery Policy was too small for such an important research. Secondly, the research only indicated increased utilization of maternal health services including supervised delivery but failed to report on other maternal health indicators such as maternal mortality, antenatal and postnatal utilization as a result of the Delivery Fee Exemption Policy implementation. Again, six births cannot be used to generalize the findings since six births cannot pinpoint all the impact that the NHIS has brought on maternal health. Therefore, this research seeks to increase the study population in order to get a clear picture of the impacts of the National Health Insurance on Maternal Health.

Effectiveness of the Free Delivery Policy

Initiative for Maternal Mortality Program Assessment (IMMPACT 2005) evaluated the potency of the free delivery policy and, especially researched into the extent to which it can be pronounced to have affected utilization, quality of services and health outcomes. They conducted interviews with experts who were involved in implementing the policy in the Central and Volta Regions in early October 2005. They interviewed fifty-five key informants including representatives of regional and district health authorities, representatives of the District Assemblies through which the funds had been channeled, and a sample of heads of facilities. The fundamental findings were that the free

delivery policy was seen as an effective approach to an important problem by the key informants because it was believed to have increased the utilization of sustainability of skilled care for delivery.

However, the research done by IMMPACT (2005) also indicated cash flow problems as a result of shortfalls and unpredictability of funding. For instance, in the Central Region, they saw that first funds were received from the District Assemblies in early 2004. Interviewees were not comprehensible about how long the funds were supposed to last and when the next allocation would come. On the whole, the staff interviewed seemed to lack confidence about the policy. They uttered the interest that lack of financial stability may lead to mistrust by clients towards providers because some districts that had spent their funds had been forced to begin charging clients again. The inability to recoup adequately and promptly could, therefore, have negative effects at all levels of the system. In addition, managers and staff referred to insufficient clarity about reimbursement rates, which some believed to be different across the two regions.

The criticism from this research on assessment of the fee exemption policy on Maternal Health services in Ghana in 2005 can be considered too early since introduction or implementation of a new policy will initially be fraught with challenges of implementation and gradually overcome some of the challenges overtime. It will take some adequate time to be effective. Hence, criticism based on their assessment can be considered to be too early. Secondly, the research only conducted their survey in two out of ten regions in Ghana which was not nationally representative and with a sample size of fifty-five interviewees which is too small to assess the impact of this policy. Thus, the survey could have been extended to cover about five or six out of the ten regions in Ghana and the sample size of interviewees increased to cover the numerous stakeholders concerned in this research in order to assess this policy effectively. The research also reports only challenges in the operations of the Free Maternal Delivery Policy and increased utilization of skilled care for delivery but fails to report its findings on the impacts of the policy on maternal deaths, antenatal and postnatal records since it surveyed sample regions. Lastly, it only reported

increased utilization of services but did not report on quality of services and health outcome as was stated in its objectives. Therefore, based on these shortcomings this research seeks to give facts which will help to unravel the impacts of the NHIS on maternal deaths, antenatal care, and post natal care. This will help the government and NGOs in drawing their plans towards maternal health.

Financing of Ghana National Health Insurance Scheme

According to C. Jehu-Appiah et al., for Ghanaians to help solve the financial issues for the poor and equity in access to healthcare in Ghana, the National Health Insurance law authorized the establishment of schemes that charged a minimum premium of roughly US$8 per adult for non-Social Security and National Insurance Trust (SSNIT) contributor to cover the premium. Those aged below eighteen, over seventy, pensioners, pregnant women are exempted from the premium fees. The NHIS has integral mechanism which helps to ensure equity in financial contributions by subscribers paying income adjusted premiums. Members do not pay any deductibles. SSNIT contributors' contributions are collected at the central level via pay-roll deductions of 2.5% of SSNIT contributions proportional to their income. Still, they have to pay a registration fee in other to be enrolled and access benefits. Enrollment is legally mandatory (C. Jehu-Appiah et al. 2011, Samuel Adu-Gyamfi, et al, 2015).

Several authors have supported the fact that the National Fund is managed by the National Health Insurance Council. The fund relies on four main sources of which two are from imposed levies; one from parliamentary approval from government annual budget, as well as from the income generated from investing the National Health Insurance funds and the fifth source is the benefactor dominations.[7] However, Jehu-Appiah et al. have argued that the National Health Insurance is financed through a National Health Insurance levy instituted by the central government (Jehu-Appiah et al. 2011). The National Health Insurance Authority proposes the formula for the

[7]Centre for Health and Social Services. "Ghana's Health Insurance Scheme: Views on Progress, Observation and Commentary", The Rockefeller Foundation, 2011. 60-61

expenditure for the fund. The Ministry of Health then reviews and recommends the formula to the parliament who upon deliberations approves it. The formula makes clearly the areas in which the fund is applied.[8]

Jehu-Appiah et al. makes it clear in their research that the NHIA mandates a predefined benefit package that covers 95% of the disease burden in Ghana. Services covered by the NHIS include outpatient's consultations, essential drugs, inpatient care, shared accommodations, maternity care (normal and caesarean delivery), eye care, dental care, and emergency care. Accredited healthcare providers are contracted to by the District Mutual Health Insurance Scheme (DMHIS) to deliver services to its members and reimburse them after submission of claims for services. To increase transparency the system purchases provision functions across different stakeholders. At the centralized level the NHIS is regulated by the NHIA which plays the function of guiding management of the NHIF. Revenues for the NHIF are used to provide reinsurance mechanism for the District Mutual Health Insurance Scheme and premiums for exempt groups (Jehu-Appiah et al. 2011).

Moreover, it is very essential to point out that these researchers did an extensive research about the subject matter. This is because they make it clear the role each individual or group plays in the financing of the National Health Insurance.

Structure of Health Care in Ghana

Two governmental bodies oversee health care infrastructure and delivery in Ghana. These governmental bodies are the Ministry of Health (MOH) and Ghana Health Services (GHS). Until 1996, the MOH oversaw the direct provision of health service delivery in Ghana. Today, health service delivery is provided by Ghana Health Service (GHS). The goal of MOH is, "to improve the health status of all people living in Ghana through effective and efficient policy formulation, resource mobilization, monitoring and regulation of delivery of health

[8] Centre for Health and Social Services. "Ghana's Health Insurance Scheme: Views on Progress, Observation and Commentary", The Rockefeller Foundation, 2011. 60-61

care by different health agencies.[9] MOH works on policy formation, the monitoring and evaluation of health service delivery throughout the country, resource allocation for health services and the regulation of health services delivery. MOH also develops the framework for the regulations of food, drugs and health service delivery (Pehr 4-7). The following organizations are under the oversight of MOH: Ghana Health Services, Korle-Bu Teaching Hospital (located in Accra), Okomfo Anokye Teaching Hospital (located in Kumasi) Christian Health Association of Ghana and Ghana Ambulance Service. The others include Ghana Medical and Dental Council, The Pharmacy Council, Ghana Registered Nurses and Midwifes Council as well as the Traditional and Alternative Medicine Council.

With the passing of Act 525, the responsibilities of health service delivery were consolidated within GHS. According to MOH, there was not a great deal of actual separation of service provision, and in order to fully carry out the Ministry's duty of policy formation and regulation oversight, there was a need to rethink the role of MOH in Ghana's health care delivery system.

The second governmental body that works with health care in Ghana is GHS, an autonomous Executive Agency responsible for implementation of national policies under the control of the Minister for Health through its governing Council - the Ghana Health Service Council. The GHS continues to receive public funds and thus remains within the public sector. This organization is the service provision arm of the health care system in the country, and works to implement national health care policies, provide health care services and manage resources for health care delivery. There are three administrative levels of GHS and five functional (service distribution) levels of health care in Ghana.[10]

Health Administration in Ghana is divided into three administrative levels: the national, regional and districts levels. It is further divided into five functional levels of national, regional, district, sub district and

[9] Ministry of Health, Republic of Ghana. http://www.moh-ghana.org/pages.aspx?id=3
[10] Ministry of Health, Republic of Ghana. http://www.moh-ghana.org/pages.aspx?id=3

community levels. All the levels of administration are organized as Budget and Management Centres (BMCs) or cost centres for the purpose of administering funds by the Government and other stakeholders. There are a total of two hundred and twenty-three functional BMCs and one hundred and ten sub-district BMCs. With the headquarters of the Ghana Health Service (GHS), there are ten Regional Health Administrations, eight Regional Hospitals, one hundred and ten District Health Administrations and ninety-five District Hospitals. All of these are run as BMCs (Salisu & Prinz 2009).

The Ghana Health Service (GHS) is in charge of transport, equipment and infrastructure provision, delivers information and provides support and guidance for the design of policies and strategies to the Ghana Health Service Council. The activities of the various organs under the Ghana Health Service are coordinated and administered by the Ghana Health Service Council supervised by the Minister of Health. Its main objectives are to implement approved national policies for health delivery in the country, increase access to improved health services and manage prudently resources available for the provision of health services. External contributors of the health service such as the National Health Insurance secretariat and the auditing offices and controlling services work directly with the council. The Health Ministry is responsible for policy planning processes and information management, particularly concerning the areas of financing, human resources and infrastructure (Salisu & Prinz 2009).

History of Ghana National Health Insurance Scheme

Health insurance is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. Depending on the type of health insurance coverage, either the insured pays costs out-of-pocket and is then reimbursed, or the insurer makes payments directly to the provider. In health insurance terminology, the "provider" is a clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy. The "insured" is the owner of the health insurance policy; the person with the health insurance coverage (Nordqvis 2012).

The National Health Insurance Scheme in Ghana is viewed as one of the legacies of President John Kufuor's administration. Seeking the mandate of the people in the 2000 elections, President Kufuor promised to abolish what was known at the time as the "cash and carry system" of health delivery. When President Kufuor won the election in 2000 he was determined to get rid of "cash and carry" system and replaced it with an equitable insurance scheme that ensured that treatment was provided first before payment. Despite Kufuor's determination his government was only able to pass the National Health Insurance Act about three years after his election. But he lived up to his promise to abolish "cash and carry" and today, the Health Insurance Scheme in Ghana is seen as one of the positive legacies President Kufuor.[11]

The National Health Insurance Scheme was established under the National Insurance Act 650 of 2003, now Act 852, and operates under the National Insurance Regulation (Legislative Instrument-L.1.1809) 2004. The objective of the National Health Insurance Scheme is to provide financial access to all residents in Ghana, especially the poor and the vulnerable, with quality basic healthcare services. Under the National Health Insurance Scheme the rich subsidize the poor, the healthy subsidize the sick and the economically active pays children, the aged and the indigents (Atwima Nwabiagya Mutual Health Insurance 2014).

Types of Health insurance in Ghana

There are three main categories of health insurance in Ghana. They are district mutual health insurance scheme, private commercial health insurance and private mutual health insurance.

District Mutual Health Insurance

The district mutual health insurance scheme is the first and most popular, and is operational in every district in Ghana. This is the public or non-commercial scheme and anyone resident in Ghana can register

[11] "Health Insurance in Ghana." Ghana Web. Accessed October14, 2014. http://www.ghanaweb.com/GhanaHomePage/health/national-health-insurance-scheme.php

under this scheme. If one registers in 'District A' and moves to 'District B', he or she can transfer his or her insurance policy and still be covered in the new district. The district mutual health insurance scheme also covers people considered to be indigent that is too poor, without a job and lacking the basic necessities of life to be able to afford insurance premiums. Apart from the premium paid by members, the district mutual health insurance schemes receive regular funding from central government. This central government funding is drawn from the national health insurance fund. Every Ghanaian worker pays two and a half percent of their social security contributions into this fund and the VAT rate in Ghana also has a two and a half percentage component that goes into the fund (Adu-Gyamfi, Brenya and Amoah 2015).

Private Commercial Health Insurance

This category of health insurance comprises the private commercial health insurance schemes operated by approved companies. One can access this type of health insurance by purchasing health insurance in any of such companies. Commercial health insurance companies do not receive subsidy from the National Health Insurance Fund and they are required to pay a security deposit before they start operations.[12]

Private Mutual Health Insurance Scheme

The third category of health insurance is known as the private mutual health insurance scheme. Under this type of health insurance any group of people, for instance members of a church or social group can come together and start making contributions to cater for their health needs, providing for services approved by the governing council of the scheme. Private mutual health insurance schemes are not entitled to subsidy from the National Health Insurance Fund.[13]

[12] "Health Insurance in Ghana." Ghana Web. Accessed October14, 2014. http://www.ghanaweb.com/GhanaHomePage/health/national-health-insurance-scheme.php.
[13] Ibid.

Policies on Maternal health in Ghana

The Government of Ghana has mandated in the 1992 Constitution to ensure fair treatment of men and women. A number of international instruments and guidelines were made by the government of Ghana to promote gender equality which also has implications on the development and promotion of health for all its citizenry. These include the United Nation's Convention on the elimination of all Forms of discrimination against women (CEDAW), the Safe Motherhood Conference in Nairobi (1987), the Cairo-Population Conference (1994), and the International Conference on Population and Development. Significantly, Ghana has backed the Beijing Platform of Action, which impulses all governments and other development actors to vigorously endorse a visible policy of mainstreaming gender perceptions in all policies and programs (Ameyaw 38).

As an indication of its obligation to the international treaties and conventions, the Government of Ghana has introduced an Affirmative Action Program (AAP) and also established a Ministry of Women and Children's Affairs (MOWAC). The ministry has developed a National Gender and Children's Policy framework which has set a national agenda to typical gender concerns in the upgrading process in order to improve the social, legal or civic, political, economic and cultural situations of the people of Ghana, predominantly women and children, which is a vital part of the national development policy. As per this constant obligation of the government of Ghana on gender uniformity on policies, health providers of the country have set gender policies to help deliver quality health care for all especially on maternal health (Ameyaw 38).

The Government of Ghana presented exemptions from delivery fees in September 2003 in the four most underprivileged regions of the country. In April 2005 this was protracted (without formal evaluation) to the remaining six regions. The intention was to reduce economic blockades to consuming maternity services to help lessen maternal and prenatal mortality and subsidize to poverty lessening. This policy was subsidized through Highly Indebted Poor Country (HIPC) debt relief funds, which were focused to the districts to refund public, mission and

private facilities agreeing to the number and type of deliveries they attended monthly. A charge was sanctioned by the Ministry of Health, which set repayment rates according to type of delivery – whether normal, assisted or caesarean section, and type of facility (Ameyaw 38).

However, on the 1st of July 2008, the Free Maternal Care Policy was announced by President J. A. Kufuor after a trip to the United Kingdom where the British Government pledged £42.5 million to support efforts at reducing maternal mortality as envisaged in the Millennium Development Goals (MDGs). This package was organized by the NHIS to give mothers treatment for antenatal, prenatal and postnatal care. This policy was presented as one of the implements in addressing maternal and infant mortality (Yeboah & Appiah-Adjei 2008).

The intentions of the free maternal care policy were to enable access to free and quality maternal care delivery services to all mothers, help decrease the number of women and children who die from inevitable pregnancy and labor correlated complications and to inspire women to seek antenatal and post natal care as well as delivery at health care facilities. The NHIS Free Maternal Care program is exposed to all pregnant women resident in Ghana. Those who can access care under the program are pregnant women who have listed under the policy, nursing mothers listed under the policy and all babies born to mothers listed under the program up to ninety days after birth. Expectant mothers are permitted to free health service in all NHIS endorsed healthcare facilities. These facilities may be public, mission or private.

From the period the women is certified by a doctor, nurse, or midwife to be pregnant up till nine months after child birth. Predicaments during delivery and all other medical problems that would arise within this period would be covered under the program. The advantage these women enjoy from this package is that they are discharged from payment of the NHIS, discharged from payment of the registration fee, free medical services and medicines during antenatal period, free medical services and medicines during delivery (including Caesarean delivery), free medical services and care for the newly born baby on the mother's ticket (as a member of NHIS) for ninth days after

which baby must be listed and free medical services and medicines during postnatal period. (Postnatal period is the six weeks following delivery).[14]

These pregnant women access this package after they acquire pregnancy validation note from Medical Officer, Midwife or Nurse. After submission of the pregnancy validation note to the nearest NHIS office or agent, a registration and insurance membership card of NHIS is issued to them to attend any NHIS accredited hospital, clinic or maternity home with NHIS card and obtain free ante-natal care. Furthermore, newly-born babies will continue to access free health care for the first three months after which parents would be required to register them at a small cost, for NHIS membership card, for further free health care till eighteen years of age.[15]

Discussions

A sample size of fifty (50) persons was selected for questionnaire administration and all the fifty (50) were returned. The questionnaire was designed in two different forms. The first part was administered to thirty-five (35) expectant and lactating mothers and the second part was administered to fifteen (15) Health workers at the Akropong Health Centre. Below is the analysis of the results.

Demographic Characteristics of Expectant and Lactating mothers

The individual respondents for this questionnaire were all females and they were thirty-five in number. This was because the main focus of this research was centred on women.

The respondents were from fifteen different residents. The largest respondents were from Akropong representing 17.1% followed by Kokoben 14.3%, Manhyia 8.6% and Mfensi 8.3%. Respondents from other residence included Koforidua representing 5.7%, Mankranso 5.7%, Adugyama 5.7%, Daaban 5.7%, Sokwai 5.7%, Kapro 5.7%

[14] "Free Maternal Care Policy." Ghana Health Nest. Last modified September 8, 2012. http://ghanahealthnest.com/2012/09/08/what-is-the-free-maternal-care-policy/
[15] Ibid.

Bokankye 2.9%, Apatrapa 2.9%, Abuakwa 2.9%, Esaase 2.9%, and Kwadaso 2.9% respectively. This means that the individual respondents were dominated by people from Akropong. This is because the hospital is located there and also it was also the main focus of this study.

Educational levels were aggregated into four basic categories. These included those with Basic education 20 (57.1%), no formal education 2 (5.7%) and secondary education 7 (20.0%), tertiary 5 (14.3%) respectively. One respondent chose neither of the categories and this represented (2.9%). The largest group is therefore those with basic education. This further indicates that the level of illiteracy is still quite high in the district.

For the sake of convenience, the age of the respondents has been categorized into two groups. The largest cohort, 94.1% of the individual respondents, were those of age 19 years and above, followed by those below 18 years (8.6%). This is because the research sought to gain the response of women who had given birth during the Cash and Carry era and women who had given birth since the introduction of the NHIS.

Out of the 35 respondents, 15 (42.9%) were single, 16 (45.7%) were married and 4 (11.4%) were divorced. This means that the research was dominated by married women. This will certainly influence their responses in the ensuing pages as the discussion continues. However the women who were categorized as single were made up of women who were cohabiting with men whom they are not legally or traditionally married to and also women who live alone. Again, since the main occupation at Akropong is subsistence farming the introduction of the free maternal health policy will help reduce the financial burden of these women. However, in Karen Grepin's research about effect of the free exemption policy in Ghana, it showed that the coverage of supervised deliveries was much lower in the early intervention regions than in the other regions prior to the introduction of the Delivery Free Exemption Policy (Grepin 2009). Furthermore the introduction of the Delivery Fee Exemption Policy seemed to have had a positive and significant impact on the ratio of births supervised by trained medical professionals in Ghana which had increased by roughly 14 to 17%, the ratio of births delivered in any institution in Ghana also

increased by 16%, the proportion delivered in a public institution also increased by 19%, and the proportion of births delivered in a hospital increased by 14% (Grépin 2009). This showed that generally free maternal delivery affected women in communities in general including Akropong.

With regards to religion, those who responded to the questionnaire were 34 (97.1%) Christians and 1 (2.9%) Muslim. This indicates that the research was dominated by Christians. This is because the study area is dominated by the Christians.

Conditions of Maternal Health Service before the Introduction of the Free Maternal Policy

Out of the 35 respondents 19 (53.4%) responded that they have been members of the NHIS for more than five years, 10 (28.6%) responded that they have been members for four years, 4 (11.4%) responded that they have been members for three years, 1 (2.9%) responded she has been a member for two years and lastly 1 (2.9%) respondent responded that she has been a member for only a year. This indicates that the women who registered five years ago enjoyed much benefit of the free maternal policy than those who had registered two years and one year ago. Again it showed that most clients at the Akropong Health Centre had been members of the NHIS for a long time.

Also 23 (65.3%) of the respondents responded that they gave birth before the introduction of the NHIS, 8 (22.9%) responded that they did not give birth before the introduction of the NHIS and 4 (11.4%) chose neither of the two options. This shows that most of the respondents had a fair idea about the Cash and Carry System and the National Health Insurance Scheme.

Out of the thirty five respondents 24 (68.8%) responded that they went for antenatal care once every month, 4 (11.4%) also responded that they went for antenatal care twice every month, 2 (5.7%) also responded that they went for antenatal care thrice every month, 5 respondents (14.3%) did not respond to this question. A mother should attend antenatal clinic once a month during the first 7 months, twice a

month, during the next month; and thereafter, once a week, if everything is normal. However, since these women accessed healthcare for free anytime they were not feeling well, they visited the health centre to access healthcare for free. In a research conducted by Brugiavini and Pace on positive outcomes of NHIS on maternal health care in Ghana it was found that members of the NHIS were "more likely to use prenatal care, deliver in hospitals and be attended by trained professionals compared with non-members (Brugiavini & Pace 2010).

Again, 23 (65.7%) respondents responded that they had difficulties in seeking for antenatal care before the introduction of the NHIS, 5 (14.3%) respondents responded that they did not face any difficulties in seeking antenatal care before the introduction of the NHIS, and 7 (20.0%) respondents chose neither of the two. This indicates that before the introduction of the NHIS most expectant and lactating mothers faced some challenges in seeking antenatal care at the hospital.

Table 1. Challenges encountered before the introduction of the Free Maternal Health on the NHIS

	FREQUENCY			PERCENTAGE (%)		
	YES	NO	TOTAL	YES	NO	TOTAL
Non-availability of health facilities	27	8	35	77.1	42.9	100
Cost of health service	33	2	35	94.3	5.7	100
Distance to health facilities	30	5	35	85.7	14.3	100
Poor quality of health service	8	26	35	22.9	77.1	100
Doctor patient ratio	29	6	35	82.9	17.1	100

Source: Field work, 2014.

Table 1 indicates that out of the thirty-five respondents 27 (77.1%) responded that non-availability of health facilities was one of the challenges they faced before the introduction of the NHIS in other to access antenatal and post natal care. 8 (42.9) also responded that non-availability of health facilities was not one of the challenges they faced. Also 33 (94.3%) out of the thirty-five respondents stated that cost of healthcare was one of the challenges they faced before the NHIS was

introduced in order to access antenatal and post natal care. In a research made by Health Systems 20/20 on the evaluation of the effects of the National Health Insurance in two Ghanaian regions, which compared baseline data collected in 2004, just before the implementation of the NHIS, and end line data collected in 2007 it was unveiled that significant decreases in out of patient pocket (OOP) expenditures by individuals enrolled in NHIS compared to those not enrolled. In patient exit surveys, the study found that "OOP expenditures among those seeking outpatient cares in formal health facilities decreased substantially, from 21,293 cedis in 2004 to 13,748 cedis in 2007. At the end line, the study found that patients covered under NHIS paid approximately 20 percent of the amount paid by the uninsured (Dietrich-O'Connor 2010, 10-11). However, 2 (5.7%) also responded that cost of healthcare was not part of the challenges they faced. Again, out of the thirty-five respondents 30 (85.7%) responded that distance to health facilities was one of the problems they faced before the introduction of NHIS in order to access antenatal and post-natal care. Whereas 5 (14.3%) also responded that distance to health facilities was not part of the problems they faced in order to seek antenatal and post-natal care. Moreover 8 (22.9%) out of the thirty-five respondents responded that poor quality of health service was one of the challenges they faced while 26 (77.1%) of the thirty-five responded that quality of health service was not part of the problems they faced. Lastly, 29 (82.9%) of the thirty-five responded that doctor patient ratio was one of the problems they faced before the introduction of NHIS in order to access antenatal and post-natal care while 6 (17.1%) responded that doctor patient ratio was not part of the challenges they encountered. This indicates that before the introduction of the NHIS most expectant and lactating mothers faced some challenges before they could access healthcare.

Benefits from the Introduction of the Free Maternal Policy on the NHIS

Out of the thirty-five respondents who answered the questionnaire 33 (94.3%) responded that indeed the introduction of the free maternal healthcare on the NHIS has been very helpful to them and their entire

families while 2 (5.7%) responded that the introduction of the free maternal policy on the NHIS has not been helpful to them. However, in a research done by IMMPACT (2005) the fundamental findings were that the free delivery policy was seen as an effective approach to an important problem by the key informants because it was believed to have increased the utilization of sustainability of skilled care for delivery. This generally indicates that the enrollment of the free maternal healthcare has been very beneficial to most of the expectant and lactating mothers in all communities in Ghana including Akropong.

Table 2. Benefits from the introduction of the Free Maternal Policy on the NHIS

	FREQUENCY			PRECENTAGE		
	YES	NO	TOTAL	YES	NO	TOTAL
Access to regular healthcare	32	3	35	91.4	8.6	100
Free drugs	33	2	35	94.3	5.7	100
Lower cost of healthcare	35		35	100		100
Improved health status	31	4	35	88.6	11.4	100

Source: Field work, 2014.

From the table above 32 (91.4%) out of the thirty-five respondents responded that one of the benefits they enjoy from being a member of the NHIS is access to regular healthcare. 3 (8.6%) responded that regular access to healthcare is not one of the benefits they enjoy from being a member of the NHIS. Again, out of the thirty-five respondents 33 (94.3%) responded that free drugs is one of the benefits they enjoy from being a member of the NHIS. While 2 (5.7%) responded that free drugs are not part of the benefits they enjoy from being a member of the NHIS. All the 35 (100%) responded that lower cost of healthcare is one of the benefits they enjoy from being a member of the NHIS. Lastly, 31 (88.6%) of the respondents responded that since the enrollment of the free maternal policy on the NHIS one of the benefits they have enjoyed is improved health status, while 4 (11.4%) responded that improved

health status is not part of the health benefits they enjoy from being a member of the NHIS. This indicates that the introduction of the free maternal health policy on the NHIS has really helped most expectant and lactating mothers.

Perceptions about the Free Maternal Policy enrolled on the NHIS

Out of the thirty-five respondents 32 (91.4%) responded that they have never regretted joining the National Health Insurance Scheme (fig 1.1), 2 (5.7%) responded that they have regretted joining the scheme. This shows that the NHIS has been very beneficial to most expectant and lactating mothers because of the numerous benefits they enjoy during pregnancy and after pregnancy. The two respondents who stated that they have regretted joining the scheme was because they were asked to pay some money for some services enjoyed at the hospital. In Brugiavini and Pace research on effects of the national health insurance scheme in Ghana, they suggested that enrollment in NHIS has a weak effect of OOP expenditure. They speculated on two potential explanations of the weak correlation:

- Some of the accredited facilities might not provide for free all the general outpatient and inpatient services;
- The indirect costs of the service (informal payments to obtain the service, the cost of food during the stay in hospital, etc. (Brugiavini & Pace 2010).

Table 3. Perceptions about the Free Maternal Policy enrolled on the NHIS

	FREQUENCIES(PERCENTAGES)						
	Poor (10-30%)	**Very fair (40%)**	**Average (50%)**	**Good (60%)**	**Very good (70%)**	**Excellent (80+)**	**Total**
Accessibility	0	3 (8.6%)	2(5.7%)	3(8.6%)	9(25.7%)	18(51.4%)	35(100%)
Payment of medical bills	3 (8.6%)	5 (14.3%)	6(17.1%)	5(14.3%)	6(17.1%)	10(28.6%)	35(100%)
Improvement of health status	0	0	9(25.7%)	9(25.7%)	4(11.4%)	13(37.1%)	35(100%)

Quality of health service	0	6 (17.1%)	8(22.9%)	2(5.7%)	8(22.9%)	11(31.4%)	35(100%)

Source: Field work, 2014.

Table 3 shows both the expectant and lactating mothers agreed in different opinions how the enrollment of the free maternal healthcare on the health insurance has helped them in terms of accessibility, payment of medical bills, quality of health service, and improvement in the health status. 18 (51.4%) of the expectant and lactating mothers respondents said that since the introduction of the NHIS regular access to health care has been excellent, 9 25.7%) responded that it has been very good, 3 (8.6%) responded that it is good, 2 (5.7%) responded it is average and 3 (8.6%) said it is very fair. With regards to the payment of medical bills both the expectant and lactating responded that the introduction of the free maternal healthcare has helped to reduce the cost of medical bills. From the table above 10 (28.6%) responded that it is excellent, 6 (17.1%) said very good, 5 (14.3%) responded that it is good, 2 (5.7%) responded that it is average, 5 (14.3%) stated that it is very fair, and 3 (8.6%) said it was poor. As can be seen from the table above, both expectant and lactating mothers stated that there has been an improvement in their health status. As a result 13 (37.1%) stated it is excellent, 4 (11.4%) said it is very good, 9 (25.7%) responded it is good, and 9 (25.7%) said it is average. Again from the table in terms of quality of service 11 (31.4%) stated that it is excellent, 8 (22.9%) said it is very good, 2 (5.7%) said good, 8(22.9%) responded it is average, and 6 (17.1%) responded it is very fair. This therefore indicates that the introduction of the free maternal healthcare on the NHIS has helped to reduce the number of maternal morbidity since most women are less likely to experience birth complications and infant deaths (Dietrich-O'Connor 2010, 11).

Furthermore, 29 (82.9%) out of the thirty-five respondents responded that there are some things about the National health insurance scheme that they do not like. For instance, most of them (82.9%) responded *"there are some kinds of drugs that are not covered by the health insurance"*. Again 6 (17.1%) also responded that they like everything about the National Health Insurance.

Demographic Characteristics of Health Workers

All the fifteen respondents of the questionnaires were health workers at the Akropong Health centre. Out of the fifteen respondents at the Akropong Health centre, 14 (93.3%) hinted that the facility was a health centre, but 1 (6.7%) responded that the facility is a hospital.

Again out of the fifteen respondents 11 (73.3%) responded that the level of care at the Akropong Health centre was primary care, 3 (20.0%) responded that the level of care at the Akropong Health centre was secondary care and 1 (6.7%) responded that the level of care at the Akropong Health centre was tertiary. However the Akropong Health Centre provides primary care because it is a formal care which is the first point of contact for people in the community but some people have the perception that they provide secondary and tertiary care.

Operations and Delivery Rates

6 (40.0%) out of the fifteen respondents stated that they have been in the health profession for 11-15 years, 5 (33.3%) responded that they have been in the health profession for 2-5 years, 3 (20.0%) said that they have been in the health profession for 2-5 years and 1(6.7%) also responded that she had been in the health profession for only one year. This indicates that majority of the health workers had been in the profession for a long time and therefore had a fair idea about the condition of maternal health service before and after the introduction of the free maternal health policy on the NHIS. Since majority had an idea about the condition of maternal health before the introduction of the NHIS they stated that the introduction of the NHIS have increased their workload since most women now visit the health centre when they are pregnant as compared to when it had not been introduced. As a result of this the logistics available at the health centre is not enough and hence makes their work very difficult.

Also all of the respondents (100%) responded that they serve only insured patients. The Akropong health centre serves both insured and non-insured patients but for expectant women they serve those who are members of the NHIS. Therefore, any expectant women who visit the health centre without the NHIS card is asked to go back to the NHIS

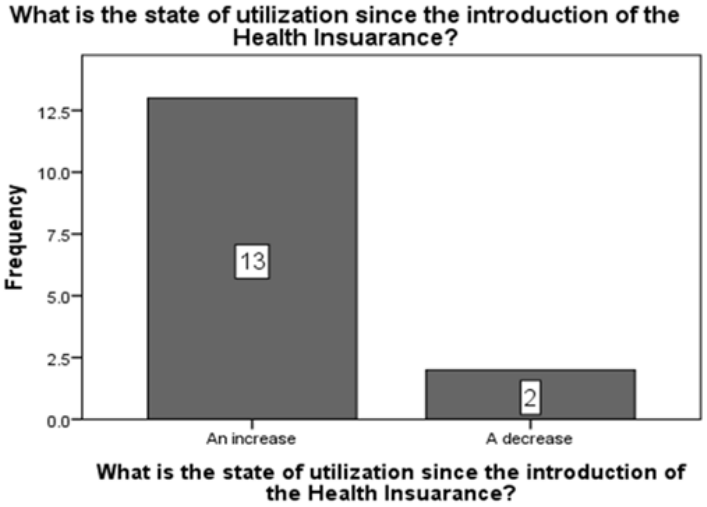
registration centres and register before she can access healthcare at the Akropong health centre.

Again, 6 (66.7%) out of the fifteen health workers respondents responded that they worked 5-8 hours a day, 3 (20.0%) respondents said they worked less than 4 hours, and 2 (13.3%) responded that they worked more than 13 hours. This indicates that majority of the health workers work 5-8 hours a day, even though the health centre operates 24 hours a day.

Moreover 9 (60.0%) out of the fifteen respondents said they served 60-79 patients a day, 3 (20.0%) said they served 40-59 patients a day, 1 (6.7%) said she served 21-39 patients a day, another 1 (6.7%) said she served more than 80 patients and also still another 1 (6.7%) said she served less than 20 patients. This indicates that majority of the health workers served 60-70 patients. These health workers stated that the introduction of the NHIS and the enrollment of the free maternal policy have compelled most women to visit the hospital to access healthcare for free – hence the pressure and workload on them.

State of Utilization after the introduction of the Free Maternal Policy on the NHIS

Fig 1.2



Source: field work, 2014

From figure 1.2, out of the fifteen health workers who responded to the questionnaires 13 (86.7%) responded that there has been an increase in the state of utilization of maternal healthcare, and 2 (13.3%) responded that there had been a decrease in the state of utilization of maternal healthcare. In a research conducted by Afua A. Opoku on the Utilization of Maternal Healthcare in Ghana the fundamental finding of that study showed that skilled personnel delivered about half the births occurring in the two years prior to the Multiple Indicator Cluster Survey (MICS). This percentage was highest in the Greater Accra Region (83 %) and Ashanti Region (60%) with seven of the regions below 50% (Western, Central, Volta, Eastern, Northern, Upper East and Upper West) (Opoku 2009). This indicates that the introduction of the free maternal healthcare on the NHIS has helped many women to patronize maternal health services in all communities in Ghana including Akropong.

Also out of the fifteen health workers who responded to the questionnaires 13 (86.7%) responded that the increase in maternal health service is a result of the introduction of the free maternal healthcare on the health insurance while 2 (13.3%) responded that the increase in maternal health service is not the result of the introduction of the free maternal healthcare on the health insurance.

Table 4. Reasons for the Improvement in the Quality of Maternal Health Service

	FREQUENCIES			PERCENTAGES		
	YES	NO	TOTAL	YES	NO	TOTAL
Introduction of health insurance	14	1	15	93.3	6.7	100
Improvement in quality of health service	10	5	15	66.7	33.3	100
Easy accessibility of health facilities	9	6	15	60.0	40.0	100

Reduction in the cost of health care	10	5	15	66.7	33.3	100

Source: Field work, 2014.

Again from the table above, 14 (93.3%) said that the increase in maternal health service at the Akropong Health Centre was due to the introduction of the free maternal healthcare on the NHIS. They also said that besides the introduction of the free maternal healthcare on the NHIS there are other factors which have accelerated the increase in maternal health service at the Akropong Health Centre and these include the improvement in the quality of maternal health service, easy accessibility of maternal health service and the reduction in the cost of maternal health service. This indicates that the introduction of the NHIS has improved the quality of maternal services.

Table 5. Condition of Maternal Health before the Introduction of Health Insurance

		FREQUENCY	PERCENT	VALID PERCENT
Valid	Poor	7	46.7	46.7
	Average	5	33.3	33.3
	Good	2	13.3	13.3
	Excellent	1	6.7	6.7
	Total	15	100.0	100.0

Source: Field work, 2014.

Condition of Maternal Health before the Introduction of Health Insurance

From table 5 it could be seen that 7 (46.7%) respondents said that the condition of maternal healthcare before the introduction of the NHIS at the Akropong Health Centre was very poor, 5 (33.3%) stated that it was average, 2 (13.3%) said it was good, and 1 (6.7%) said it was excellent. This indicates that the introduction of the free maternal healthcare on the NHIS has brought about a massive improvement in the condition of maternal healthcare at the Akropong Health Centre..

Additionally, 10 (66.7%) of the respondents said that they strongly agree that the introduction of the free maternal healthcare on the NHIS has influenced maternal health service at the Akropong Health Centre, 3

(30.0%) also responded that they agree that the introduction of the free maternal healthcare on the NHIS has influenced maternal health service at the Akropong Health Centre, and 2 (13.3%) disagreed that the introduction of the free maternal healthcare on the NHIS has influenced maternal health service at the Akropong Health Centre. This indicates that most of the health workers strongly agree that the improvement in maternal service at the Akropong health centre is as a result of the introduction of the free maternal health care on the NHIS

Table 6. Delivery Records from 2003-2014

BEFORE INTRODUCTION OF FMP					AFTTER INTRODUCTION OF FMP			
Month	YEARS							
	2003	2004	2006	2007	2009	2010	2013	2014
January		14	20	18	9	20		28
Febuary	9	22	11	25	21	16	19	16
March	21	15	22	19	19	14	23	30
April	18	16	23	24	15	11	18	17
May	17	23	26	23	28	10	22	20
June	15	12	24	17	22	12	12	30
July	21	14	12	16	18	24	14	23
August	26	17	17	22	20	19	17	21
September	12	9	14	10	14	24	9	18
October	12	9	15	19	14	32	9	21
November	20	15	14	19	18	24	15	21
December	15	12	19	16	14	17	12	29
TOTAL	174	178	164	228	212	223	170	225
TOTAL	747				830			

Source: Delivery records of the Akropong Health Centre.

Table 6 compares the first four years before the introduction of health insurance from (2003 to 2007) to 4 years after the introduction of the free maternal policy on the health insurance from (2005 to 2009). After administering all the questionnaires to the lactating and expectant mothers and the health workers, the hospital records were also consulted to verify whether the responds received from the questionnaire administered tallied with the hospital records for convenience. The years under review were four years before the

introduction of the National Health Insurance and four years after the introduction of the National Health Insurance and the enrollment of the Free Maternal Policy on it. From table 6 above the number of women who came to deliver at the Akropong Health Centre were recorded each month and totaled at the end of the year. It could be seen from the above table that the total number of women who gave birth four years before the introduction of the NHIS was seven hundred and forty seven (747) while the total number of women who delivered after the introduction of the NHIS was eight hundred and thirty (830). This, therefore, indicates that the number of women who delivered after the introduction of the NHIS had increased. It could be seen form table 4.7 that the records for January 2003 and January 2013 are blank. This was because the records for these months were missing, the reason being that the Akropong Health Centre lacks a proper archival system.

Conclusion

The study explored the conditions of Maternal Health Service before the introduction of the National Health Insurance Scheme and majority of the respondents who answered the questionnaires had given birth as well as were working before the introduction of the NHIS and, therefore, they had a fair idea about the condition of Maternal Health Service before and after the introduction of the NHIS. From the study it was found out that there was poor maternal health service before the introduction of free maternal health service on the NHIS. However, the introduction of the policy has enhanced the service.

Majority of the respondents stated that prior to the introduction of free maternal healthcare; they were required to make payment for every health service enjoyed. The study revealed that most women encountered some challenges before they could access healthcare of which included non-availability of health service, distance to health facilities, cost of health service, and doctor patient ratio. The study revealed that the condition of maternal health service at the Akropong Health Centre was very poor and that majority of the respondents stated that the introduction of the free maternal policy on the NHIS has helped to improve it.

The study pointed out that the introduction of the National Health Insurance Scheme has been very beneficial to most women and some of these benefits enjoyed by majority of these women include regular access to healthcare, free drugs, lower cost of healthcare and improved health status. The study unveiled that majority of the respondents stated that they have never regretted joining the NHIS. Hence, majority of the respondents agreed in different opinions how the enrollment of the free maternal policy on the NHIS has helped them in terms of accessibility, payment of medical bills, quality of health service and improvement in health status.

The study also postulated that the state of utilization of maternal health service has increased since the introduction of the NHIS and this increase in the state of utilization of maternal health service is a result of the introduction of the National Health Insurance Scheme, easy accessibility of maternal health services, improvement in the quality of health service, and reduction in the cost of healthcare.

It has been established by the study that Free Maternal Healthcare Policy implemented in 2008 by the Government of Ghana to curtail the high maternal mortality in the country has had a significant impact on maternal health service at the Akropong Health Centre. However, the government should establish more registration offices which will help make the registration process easier and faster. There should be strong information Technology systems to monitor and track patients' records, and also ensure proper archiving system to prevent the regular loss of information or data on patients. This would have to be properly addressed to ensure efficiency both for effective administration of the health insurance for maternal and infant care and also for regular patients that go for treatment or medical care at the Health Centre.

References:

Adu-Gyamfi, Samuel, Edward Brenya, and Aikins Amoah. 2015. "National Health Insurance Scheme of Ejisu-Juaben and

Matters Arising." *International Journal of Social Science Studies*, *3.5*: 40-60.

Agyepong, Irene A., and Sam Adjei. 2008. "Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme." Health Policy and Planning, 23.2: 150–60. Accessed October 27, 2014. doi:10.1093/heapol/czn002

Ameyaw, Emmanuel Asante. 2011. "An Assessment of the Effect of the Free Maternal Care Policy on the Utilization of Maternal Care Services in the New Juaben Municipality." Thesis. Kumasi, Ghana: Kwame Nkrumah University of Science and Technology.

Arhinful, Daniel Kojo. 2003. *The Solidarity of Self-Interest: Social and Cultural of Rural Health Insurance in Ghana*. 30-40. Leiden: African Studies Centre. Accessed November 2, 2014. http://hdl.handle.net/11245/1.223520.

Atwima Nwabiagya. 2014. National Health Insurance Scheme Benefit Package. Atwima Nwabiagya District. picture.

Brugiavini, Agar, and Noemi Pace. 2010. "Extending health insurance: effects of the national health insurance scheme in Ghana." Paper prepared for the conference on *Promoting Resilience through Social Protection in Sub-Saharan Africa,* organised by the European Report of Development in Dakar, Senegal, 28-30 June, 2010:1–35. Accessed April 30, 2015. http://erd.eui.eu/media/BackgroundPapers/Brugiavini-Pace-Extending%20Healt%20Insurance.pdf

Centre for Health and Social Services. 2011. *Ghana's Health Insurance Scheme: Views on Progress, Observation and Commentary*. Accra, Ghana: The Rockefeller Foundation.

Darkpani, Paul. 2011. "Sustainability of Health Insurance in Ghana: A case study of the Sekyere East District Mutual Health Scheme."

Dissertation, Ghana: Kwame Nkrumah University of Science and Technology.

Dietrich-O'Connor, Frances. 2010. "An Evaluation of the National Health Insurance Scheme in Ghana." Accessed April 30, 2015. https://www.academia.edu

"Free Maternal Care Policy", Ghana Health Nest, last modified on September 8, 2012. http://ghanahealthnest.com/2012/09/08/what-is-the-free-maternal-care-policy/

"Free Maternal Care Policy." Accessed October 3, 2014. http://vibeghana.com/2012/01/18/free-maternal-health-policy-is-it-really-working/

Gajat-Garrido, Gissele, and Clement Ahiadeke. 2012. "The effects of Parent Insurance on Healthcare Utilization: Evidence from Ghana." Accessed August 14, 2014. http://dx.doi.org/10.2139/ssrn.2158824

Ghana Statistical Service. 2010. "Millennium Development Goals." Accra, Ghana: Ghana Statistical Service.

Grepin, Karen. 2009. "The Effect of a Delivery Fee Exemption Policy on the Utilization of Maternal Health Services in Ghana." Thesis. Cambridge, MA: Harvard University.

"Health Insurance." Medical dictionary. Accessed October 3, 2014. http://medical-dictionary.thefreedictionary.com/health+care

"Health Insurance in Ghana." *Ghana Web*. Accessed October 14, 2014, http://www.ghanaweb.com/GhanaHomePage/health/national-health-insurance-scheme.php.

Jehu-Appiah, C., Genevieve Aryeetey, Irene Agyapong, Ernst Spaan & Rob Baltussen. 2011. "Household Perception and their Implication for the enrollment in the National Health Insurance Scheme in Ghana." *Health Policy and Planning, 27.23*: 222-233. Accessed October 10, 2014. DOI:1093/heapol/czr032.

Mensah, Joseph. 2011. "The Impact of Health Insurance Scheme on Health Delivery in Brong Ahafo: A case study of Jaman North." Thesis. Ghana: Kwame Nkrumah University of Science and Technology.

Mensah, Robert T. 2011. "How Ghana is dealing with maternal mortality? *GhanaWeb*. Accessed October 3, 2014. http://www.ghanaweb.com/GhanaHomePage/NewsArchive/How-is-Ghana-Dealing-with-Maternal-Mortality-207385

Mensah, Sylvester A. 2013. "National Health Insurance Scheme in Ghana Reforms and Achievement." Proceedings of 2013 International Conference on 10 years of Financial Access to Quality Healthcare, *Towards Universal Health Coverage: Increasing Enrollment whilst ensuring Sustainability, November 4-6, 2013.* Accra International Conference Centre, Accra, Ghana.

Nordqvis, Christian. 2012. "What is Health Insurance." Accessed October 23, 2014. http://www.medicalnewstoday.com/info/health-insurance/

Opoku, E. A. 2009. "Utilization of Maternal Care Services in Ghana by Region after the Implementation of Free Maternal Care Policy." Thesis. Fort Worth, Texas: University of North Texas Health Science Centre. Accessed October 20, 2014. http://digitalcommons.hsc.edu/theses/78

Pehr , Jennifer L. 2010. "Health care and Infrastructure in Accra." Advanced Issues in Urban Planning, Ghana, 27 April, 2010. Accessed January 14, 2015. http://mci.ei.columbia.edu/files/2013/03/Health-Care-and-Infrastructure-in-Accra-Ghana.pdf

Salisu, Abdallah, and Vannesa Prinz. 2009. "Health Care in Ghana." Accessed January 14, 2015. http://www.ecoi.net

WHO. "Maternal Health." Accessed October 3, 2014. http://www.who.int/topics/maternal_health/en/

WHO. "World Health Organization definition of health." Accessed October 3, 2014. www.who.int/about/definition/en/print

Yeboah, Lucy Adoma & Gifty Appiah-Adjei. 2008. "More Pregnant Women Register under Free Maternal Health Care Program." *Modern Ghana*. 19 July 2008. Accessed October 3, 2014. http://www.modernghana.com/news/174979/1/more-pregnant-women-register-under-free-maternal-h.html