

Including Family Planning in Ghana's National Health Insurance – from policy to practice

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Acknowledgments

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Introduction

In recent years the Universal Health Coverage agenda has focused governments' attention on what is needed to achieve good health for all. In many countries this focus has translated into efforts to design and roll out national health financing approaches such as national health insurance (NHI). Ministries of Health and Finance and Health Insurance agencies are making important decisions about which services are covered in benefits packages and how those services are to be paid for. The government of Ghana is seen as a leader in this in sub-Saharan Africa. Its National Health Insurance Scheme (NHIS) was established by an Act of Parliament in 2003 to secure financial risk protection from cost of healthcare services. The benefits package is exceptionally comprehensive, but contraception was excluded from the original design. Free maternity services were added for all pregnant women in 2008, however

contraception was still excluded. The Act was revised in 2012 – NHIS Act 852 and mandated the Minister of health to include coverage of relevant clinical methods of family planning services in the list of NHIS benefits. However, implementation of the 2012 Act has stalled and contraceptive services continue to be paid out-of-pocket in public and private facilities across Ghana up to the present day.

It is well documented that out-of-pocket payments are a barrier to uptake of health services. In the public and some private sector, health facilities FP commodities have been donor funded, but these funds are dwindling. Thus, there is a present need to establish how FP should be paid for through public funding e.g. NHI. This discussion is relevant across the region and beyond as countries develop their 'UHC mechanisms' and make decisions about what services to include in initial benefits packages.

Developing a 'pilot' of FP in the NHIS

In 2017 Marie Stopes Ghana (MSIG) saw an opportunity to help the NHIS implement the Act 852. However, in order to understand why it had not progressed, they first asked key stakeholders why. It emerged that there were two, interrelated challenges. Firstly, the National Health Insurance Authority (NHIA) were not sure how best to action the Act; which FP services to include in the benefit package, and how to practically integrate those FP in existing systems and processes. Secondly, there was concern about the impact of providing FP free of charge on health seeking behaviour and, ultimately, cost to the NHIS. MSIG saw that, by applying its understanding of FP service delivery to the first challenge, it could provide valuable data and insights to assist in addressing the second.

Building National Ownership

MSIG's initial investigation showed that there was appetite for action to move forward on putting Act 852 into operation, but that success was less likely if it was seen as an MSIG initiative. Thus, MSIG proposed that it would support the delivery of a pilot to demonstrate how FP services could be included in the NHIS benefits package. This would be led by the NHIA on behalf of the Ministry of Health (MoH), with inputs from Ghana Health Services (GHS), MSIG providing administrative, technical and financial inputs and Population Council (PC) joining the team to conduct an independent evaluation. At the same time MSIG engaged other stakeholders e.g. donors to keep them informed and ensure alignment with their work. This proposal was embraced by the other partners and the NHIA convened and chaired a technical working group (TWG) to review the pilot design and to coordinate and monitor implementation.

Pilot Design

In May 2018, the TWG started implementing a pilot project to remove the out of pocket (OOP) costs of FP services. Under this pilot:

- All modern clinical FP methods (e.g. injectable, implant, IUD, and sterilization) were added to the NHIS benefits package and expensed by facilities through the claims process.
- FP services are free at all NHIS accredited public and private facilities in 7 districts. Insured clients are entitled to counselling, the FP method of their choice and follow up visits if needed.
- The government took responsibility for ensuring sufficient FP commodities to all clinics.
- MSIG provided costing data to set the reimbursement tariffs
- Providers receive case-based payments for FP services provided – with each case including counselling, method, follow up and removal where required.

- All reporting, claims submission, claims processing, and payments are delivered through the NHIS systems as with existing services; with MSIG covering the reimbursements costs.

Soon after implementation began the TWG recognised that other demand and supply side factors were in danger of distorting any impact of addressing financial barriers/incentives and thus needed to be addressed. Of note were a lack of capacity among providers in the pilot districts to provide long acting reversible contraception (LARC) of family planning; and a lack of awareness and importance of FP in pilot facility catchment areas. For this reason, it was decided to introduce LARC training for providers in a sub-set of pilot districts and community level demand generation activities in another sub-set.

Independent Evaluation

The pilot is being evaluated by a team from the Population Council. Their study has three research objectives:

1. Measure if the NHIS FP benefits package is associated with facility-level method mix and equity of access, especially for young women, poor women, and women of differing parity
2. Explore NHIS FP beneficiaries understanding of their entitlements and barriers to FP service utilization beyond the immediate benefit of removing OOP payments
3. Estimate the costs savings to the NHIS from inclusion of FP services and averted unintended pregnancies each year

Table 1: Interventions deployed in the 10 FP Pilot intervention and control districts

Intervention	FP Pilot Districts									
	Bolgatanga	Nabdram	Bawku West	Obuasi	Mfantsiman	Ekumfi	Adaklu	Upper Denkyira East	Upper Denkyira West	Mamprusi West
Claims Reimbursable FP Services	X	X	X	X	X	X	X			
Demand Generation	X	X	X	X					X	
LARC Training	X						X	X		
Facilities	30	14	27	14	12	12	13	25	11	10

Note: The FP Pilot intervention considers facilities that provide FP services and credentialed by NHIA

The pilot will run to the end of April 2020.

Analysis of routine and survey data will take place up until the end of the pilot and findings will be shared by the end of 2020.

Early results and findings

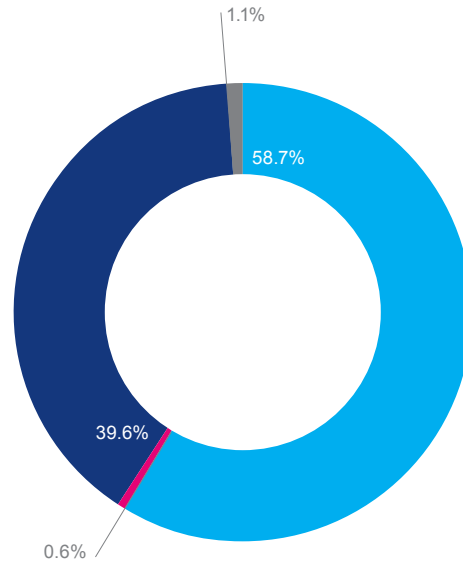
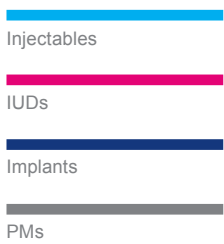
Much has been learned from the process of developing the pilot to date in terms of practical lessons, and initial analysis of routine service data suggests that provider and client data is being influenced in positive ways by including FP in the NHIS package.

Changes in service uptake

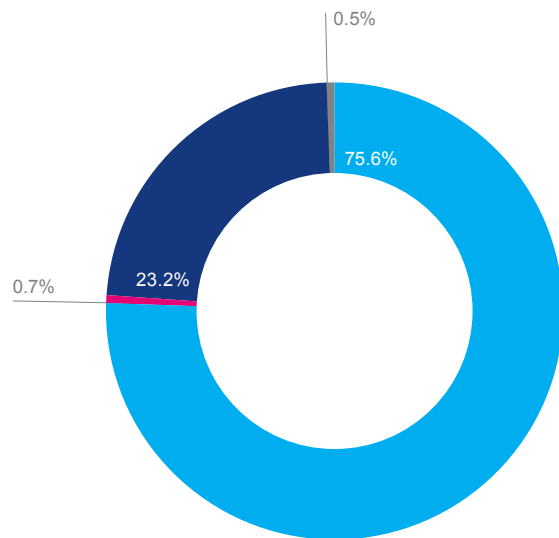
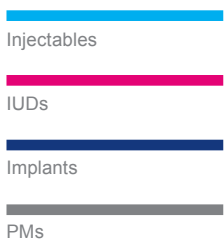
MSIG analysed service data from 145 health facilities in 7 pilot districts over a period of 12 months to see if the removal of user fees and differential payments for different FP methods had any effect on uptake of services. This simple analysis showed an initial pattern of greater uptake of long acting methods of contraception among NHIS insured clients i.e. those for who any method is free at the point of service – see figure 1.

Figure 1: FP method uptake among insured and uninsured clients

% Insured clients using FP by method



% Uninsured clients using FP by method



Additionally, an early analysis by the Population Council of service data indicates that, in facilities that are part of the pilot, FP uptake (measured by new acceptors of 58.7 FP) among all clients is up to 16% greater than in facilities in control districts¹.

Ensuring National Ownership

MSIG recognised very early on that success in this initiative would not be possible if it were not led by the NHIA and the wider MoH. Thus, significant time and energy was invested in forging relationships with decision makers and supporting their initiatives to take the work forward. MSIG held individual and group consultations and supported the formation of a technical working group through which key stakeholders could input into the design of the pilot.

As a result, the pilot has been led by representatives from the NHIA and MoH, with MSIG providing administrative and budget support. The extent of the sense of ownership felt is shown in the fact that:

- the pilot has been put forward by the MoH as one of their FP2020 commitments
- NHIA and GHS have presented the work as their own in international fora

Challenges to seamless implementation

As the pilot was put into operation a number of challenges became clear that had the potential to impact on its effectiveness and the opportunity to learn from it. The TWG decided to address these challenges so as to prevent them detracting from the influence of the interventions of interest. Table 2 outlines these challenges and the steps the pilot implementers took to address them.

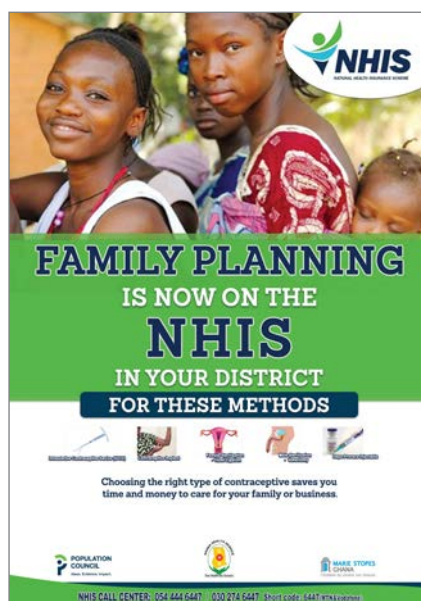


Table 2: Challenges and mitigation

Challenge	Mitigating measures taken
As part of the FP pilot implementation activities, a provider baseline survey was conducted in the 7 pilot districts and 3 control districts to assess provider capacity and gaps in FP service provision at the facility level. The provider survey identified lack of provider capacity in insertion and removal of Long Acting Reversible Contraceptives (LARCs) as a major barrier to uptake of LARCs particularly in rural and hard to reach communities.	Three districts with the lowest capacity amongst providers to provide LARC were identified and staff in the pilot facilities were trained in the insertion and removal of implants and IUDs.
The first M&E visit to the pilot district, 3 months after commencement of the pilot identified lack of awareness of the FP pilot in some communities and inadequate demand generation for FP services as the two main challenges affecting FP uptake in the pilot communities.	In two districts FP providers were trained in FP demand generation and are being supported financially to conduct continuous demand generation around their clinics. In five other districts MSIG conducted intensive awareness creation activities in the communities to increase awareness of the pilot among community members.
Most facilities at the lower level (Health Centres and Community Health Planning and Services (CHPS) compounds did not have government FP registers and daily log books for recording family planning services.	MSIG printed and distributed at least 2 registers and 2 daily log books to each of the pilot facilities
FP clients were being asked to report at the outpatient department for NHIS authentication before FP services were provided. This proved to be a barrier to women going for FP services as many did not feel comfortable explaining, in a non-private space, that they were seeking FP services.	Facilities were immediately advised by the NHIA to authenticate FP clients at the family health unit only, using their register to ensure confidentiality.
Due to miscommunication about where to source the FP commodities for the pilot from, some facilities did not start until June 2018 because they were waiting for "free" FP commodities from the NHIS	GHS was tasked to ensure that the right information about the supply of commodities to pilot facilities was provided. They subsequently sent a letter to all the regional health directorates of the 4 pilot regions, and to the districts, about the arrangements for the requisition and supply of FP commodities to FP pilot facilities
Several public facilities did not have sufficient contraceptives, or insertion kits for LARC.	GHS took responsibility to supply insertion kits and support facilities to order and receive their contraceptive supplies in good time

Lessons learned

Designing, delivering and evaluating this pilot of FP services in the Ghana NHIS has given those involved an opportunity to reflect on the process and what can be learned and applied to other country contexts. The authors would like to draw the reader to the following:

Adding a service to a benefits package is complex and resource (time and money) consuming. Thus, key services, especially those that are considered a public good, must be included from the outset.

- Adding a service can have significant financial implications. This fact needs addressing in conversations with decisions makers early on.
- The omission of a service from a benefits package sends a message to health providers about priorities. Such an omission can mean that approaches to awareness raising, service provision, record keeping etc. (that are often of low standard) become established and significant training and people management efforts are required to change this. It also means that numerous stakeholders need to be involved to ensure these changes become institutionalised – and this consultation takes time.

To address the concerns of those who have to implement policy the discussion should also focus on how inclusion will work in practice.

- When advocating for benefits package change it is not enough to talk just about the why of inclusion of FP to the package.

UHC is not just about financing: a holistic/multi-pronged approach is required to ensure access to quality FP services and this requires stakeholders working in partnership.

- A prevalent narrative at present around strategic purchasing is that, getting the purchasing right will make a big difference to uptake and quality of services. It is true that strategic purchasing is very important, but clear from the pilot that other building blocks need to be in place to optimise the impact of good purchasing practice.

Technical design can be trumped by fiscal/political considerations.

- FP pilot tariffs were used to feed into a parallel PHC benefits package actuarial analysis that was done in 2019. There is a strong possibility that, based on this analysis, a flat reimbursement rate will be agreed for all PHC services. While this is better than FP not being included it is likely to detract from provision of LARC.



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