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"*We charge them; otherwise we cannot run the hospital*" front line workers, clients and health financing policy implementation gaps in Ghana

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ABSTRACT

Objectives This paper examines policy implementation gaps of user fees plus exemptions and health insurance in providing financial access to primary clinical care for children under five in Ghana.
Methods: Methods included analysis of routine data, focus group discussions, in-depth interviews, and administration of a structured questionnaire.
Results: Providers modified exemptions policy implementation arrangements, sometimes giving partial or no exemptions. Clients who knew or suspected exemption entitlements failed to request them because of fear of negative reactions from providers. Providers attributed their modification of implementation arrangements and negative reactions to the threat posed to the financial viability of their institutions by reimbursement uncertainty and delays. At the time of the study insurance coverage was low and frontline workers were not noticeably modifying implementation arrangements. However, the underlying goal conflicts, resource scarcity, conditions of work and relationships between frontline workers and clients that fueled the exemptions policy implementation gaps were unchanged. The potential for the health insurance policy to stumble over implementation gaps as happened with the exemptions policy therefore remained.
Conclusions: Policies that do not take into account the incentives for frontline worker adherence and align them better with policy objectives may experience implementation gaps.

1. Introduction

Despite documented inequities associated with user fees [1–6], they remain an important financing mechanism in low and middle income countries (LMIC) not easily decreed away [7]. To protect vulnerable groups from their negative effects many LMIC have user fee exemptions policies. These policies often face implementation difficulties that make their objectives only imperfectly attained [3,8–11]. There is growing interest in social and community health insurance as policy alternatives [12–19]. But will they prove more viable policy alternatives?

Lipsky [20] searched into the collective behavior of public service agencies where agency workers interact regularly with the public and have wide discretion over public policy implementation arrangements. Out of his work, he developed street level bureaucracy theory of how and why

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some types of public service agencies perform contrary to their own rules. Lipsky defines street level bureaucrats as "*Public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work*". Public service agencies with a large percentage of workers who are street level bureaucrats are street level bureaucracies. Because of the combination of considerable discretion in decision making, regular contact with citizens and relative autonomy from organizational authority, the sum of the individual decisions, actions and inactions of street level bureaucrats becomes agency policy in practice. At the same time, their conditions of work tend to induce coping behaviors that modify policy in implementation and produce results different from stated agency objectives. These conditions of work include inadequate resources, and demand for services that tend to increase to meet supply. Agency goals may be ambiguous, vague or conflicting. Clients are non voluntary with limited alternatives and control over frontline worker behavior.

Ghana with estimated GNI per capita (Atlas method) of US$ 630 [21]; per capita health expenditure of approximately US$ 23, one doctor to 13,500 and one nurse to 1350 population [22] has a public sector health service that is typically a street level bureaucracy. Frontline workers are in constant daily contact with citizens and frequently have to make individual decisions with a large amount of professional discretion. The social distance between workers and clients can be wide because of knowledge asymmetry. Despite improvements in recent years, workers remain poorly paid in relation to the cost of living providing strong incentives to increase their wages by 'creating' time to do other jobs or earn extra money unofficially on the job using methods such as unauthorized fees. Their potential clientele are more than their ability to process given staff and other resource shortages, and incentives to discourage all potential clients from using services can be strong. Agency goals can be conflicting and ambiguous e.g. being required to be efficient and recover operating costs through user fees and at the same time equitable by exempting those unable to contribute to cost recovery goals. Many clients are non voluntary with limited financial and geographic access to alternative formal sector services.

2. Study questions

The general objective was to describe and understand effectiveness of user fees plus exemptions and health insurance in removing financial barriers for children under five. Children under five were selected because of their high mortality. In the five years preceding this study (1999–2003), there was an estimated 111 deaths in children under five for every 1000 live births. The rate for the period 2004–2008 was only slightly reduced at 80 deaths/1000 live births [23].

We postulated that policy as designed may not be policy as experienced at the operational level, but will be influenced by hindering and enabling factors in implementation related to context and frontline workers who are effectively 'operational translators' of policy. It will also be influenced by factors related to clients and their interactions with frontline workers.

3. User fee exemptions and health insurance in Ghana

The hospital fees regulation LI1313 [24] of 1985 instituted a range of user fees. The funds generated from these fees were referred to as Internally Generated Funds (IGF). IGF became and has remained an essential part of the viability of public sector facilities in Ghana. Medicines and non medicine consumables are recovered at full cost with a percentage overhead. The money is retained by the facility for new purchases and other recurrent costs, which can include within prescribed limits, payment of some staff incentives.

Despite providing needed revenue, these fees were observed to create inequities in access [25–27]. LI 1313 defined groups such as the indigent to be exempted from user fees. Over time exemptions were extended to primary clinical outpatient services for children under five years, the elderly and pregnant women. Provider payment for fee exemptions was retrospective fee for service. Providers filed reimbursement claims through the regional offices of the health service to the Ministry of Health and reimbursements were sent back through the same pathway. Reviews of user fee exemptions policies in Ghana have documented difficulties in implementation that include inadequate information provision to beneficiaries, weak supervision and monitoring of implementation, beneficiaries not getting exemptions and delays in reimbursement of providers [28–31].

In 2001, the government of Ghana decided to institute a national health insurance scheme (NHIS) as a replacement for user fees. The National Health Insurance law [32] was passed by parliament in 2003. Health Insurance in Ghana is described in several publications [33–38]. It was not possible to abolish user fees overnight, given that nationally 15% or more of public sector health financing is estimated to come from these fees. The percentage is higher at facility level. The national health insurance policy was therefore allowed to run alongside the user fees and the user fees exemption policies. Reflecting the policy priority given to children under five, they were among vulnerable groups exempted from premium payments.

At the time of the study, NHIS payment was retrospective fee for service. Providers filed claims to and were reimbursed by District Mutual Health Organizations (DMHO). Payments to providers become part of the facility IGF. Enrolment in MHO nationwide has increased with holders of valid insurance ID cards rising from 6% of the population in 2005, to 20% in 2006 and 42% in 2007 [39]. Accompanying the increases in enrolment have been increases in service utilization driven mainly by the insured (see Fig. 1).

There are also accumulated unpaid provider bills. The 2008 external review of the health sector estimated that nationwide, about GH¢ 49,000,000 (approximately US$ 35,000,000), equal to 3 to 4 months of IGF was owed providers [29]. There have been instances of providers pub-