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## Issues for consideration in the scale-up of the inclusion of family planning in the National Health Insurance benefits package in Ghana

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# ISSUES FOR CONSIDERATION IN THE SCALE-UP OF THE INCLUSION OF FAMILY PLANNING IN THE NATIONAL HEALTH INSURANCE BENEFITS PACKAGE IN GHANA

## BACKGROUND

Ghana is working towards achieving universal health coverage (UHC). This is driven, in part, by the Sustainable Development Goals (SDGs), specifically SDG 3 - Good Health and Well-Being, which seeks to ensure healthy lives and promote well-being for all at all ages. Achieving this feat will improve equity of access as people, especially the poor can access quality health services without financial hardships (Holtz & Sarker, 2018).

SDG 3.7 indicates that by 2030, countries are to ensure universal access to sexual and reproductive health-care services, including for family planning (FP), information and education, and the integration of reproductive health into national strategies and programmes. Commitments by countries to achieve the universal health coverage (UHC) are grounded in the principle that access to health, including FP is a human right issue and that investments in health have tremendous human and economic benefits to countries (Holtz & Sarker, 2018). In Ghana, unmet need for FP remains high—30 percent of married and 42 percent of unmarried sexually active women who want to avoid or delay pregnancy are not using FP (GSS, GHS, & ICF International, 2015). The high unmet need for FP can be attributed to various factors including misconceptions, side effects or health concerns, cost, and access. Modern contraception is a key strategic lever for development as it is a tool that can empower women, improve investments in children, and ultimately contribute to poverty reduction.

Ghana's National Health Insurance (NHI) Act was designed to minimize out-of-pocket (OP) expenditure at the point of use of service, thus reducing the financial barrier to health service utilization (Agyepong & Adjei, 2008). The NHI Act passed in 2003 (Act 650), amended in 2008 (Act 753) and revised in 2012 (Act 852), which indicated that healthcare benefits include FP. The expectation was that over 800,000 women of reproductive age would be eligible to benefit from FP inclusion in the National Health Insurance Scheme

(NHIS) between 2016 and 2020 (FP2020, 2018). Although FP is included in the NHI Act, the policy is yet to be implemented in practice.

Under the leadership of the Ministry of Health (MOH), the National Health Insurance Authority (NHIA), Ghana Health Service (GHS), MSI-Ghana (MSIG) and Population Council (the Council) implemented a pilot project to better understand the dynamics of including FP in the NHI benefits package.

## FAMILY PLANNING PILOT INTERVENTIONS

The FP Pilot intervention commenced with the assumption that cost was a barrier to FP uptake, therefore if the NHIS reimbursed FP services as a measure of eliminating OP cost at the point of service delivery FP uptake will improve especially long-acting reversible contraceptives (LARCs). The pilot design was however flexible in its implementation approach such that when other important barriers to uptake were identified during implementation, the design was adjusted to incorporate new interventions to remove the identified barriers. The new intervention(s) were then incorporated into the pilot evaluation matrix.

All NHIS credentialed health facilities within the seven of the nine selected FP Pilot districts were authorised to provide FP services under the NHIS and submit claims for re-imburement. The FP Pilot covered clinical FP methods (Vasectomy, BTL, Implants, IUD, and the 3-months and 1-month Injectables). FP commodities were procured by Government of Ghana and donors and supplied to participating healthcare facilities through the Ghana Health Service Family Health Division.

Three different interventions were implemented in the FP Pilot intervention. The main intervention was the OP cost removal for FP services, demand

generation, and training on long-acting reversible contraceptives (LARCs) in the selected districts.

### Removal of out-of-pocket cost for FP services

This was the primary intervention of the FP Pilot implemented in seven FP Pilot districts: Bolgatanga, Nabdram, Bawku West, Mfantseman, Ekumfi, Obuasi, and Adaklu. The FP Pilot removed the OP payment by asking credentialed public and private healthcare providers to provide clinical methods of FP services to NHIA insured clients and submit claims for reimbursement.

### LARCs provider training in selected facilities

This was an additional intervention implemented in three districts: Bolgatanga, Adaklu and Upper Denkyira East, where selected providers received LARCs training. The trained providers were selected community health nurses (CHNs) and midwives lacking formal training in LARCs service provision.

### Demand generation for FP Pilot

The additional demand generation intervention was implemented in two districts: Bolgatanga and Upper Denkyira West. The demand generation intervention included education activities to address FP myths and misconceptions through mass media and other campaigns.

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## COMBINATIONS OF INTERVENTIONS

Three different interventions were implemented—OP cost removal for FP services, demand generation, and provider training on long-acting reversible contraceptives (LARCs) service delivery.

However, five different combinations of the three interventions were implemented in the nine intervention districts:

- i. OP cost removal for FP services + demand generation + LARCs training in *one district*;
- ii. OP cost removal for FP services + LARCs training in *one district*;
- iii. OP cost removal for FP services only in *five districts*;
- iv. Demand generation only in *one district*; and
- v. LARCs training only in *one district*.

## EVALUATION OF THE FP PILOT INTERVENTION

The evaluation of the FP Pilot employed a quasi-experimental time series design. The overall study period was from January 2017 to February 2020 split into two phases: pre-intervention (January 2017 to April 2018), and intervention (May 2018 to February 2020) periods. The evaluation used monthly FP service data from Ghana Health Service's District Health Information System (DHIMS) for the assessment of the FP Pilot interventions. Using controlled interrupted time series (ITS) models the evaluation assessed the impact of the different combinations of the interventions on total new FP service uptake and method specific uptake.

The evaluation showed that the FP Pilot intervention had a positive impact by significantly increasing the number of new FP acceptors as well as an increase in uptake of specific methods (especially LARCs). The FP Pilot also demonstrated a successful process of including FP into the NHI benefits package and its claims processing.

As stakeholders consider scaling up the intervention of including FP into NHI benefits package, it is important to keep in mind some possible issues that may pose challenges to a smooth scale-up. This project brief outlines possible issues and challenges of the scale up of FP inclusion in the NHIS.

## ISSUES FOR CONSIDERATION

Evidence suggest that various factors must be considered in efforts to include FP in health insurance as there may be issues and challenges that can derail the scale up such as credentialling of health facilities, provider payments, increase in uptake of FP services and equity of access:

### Inability of some facilities to qualify for credentialling

The credentialling process of Ghana's NHIA ensures that healthcare providers are in a position to provide basic quality health services as specified by the NHIS benefits package to insured members. The process promotes quality health care delivery, nurtures a healthy competition among service providers as well as increases public confidence in the health system. However, to qualify for credentialling, a provider must complete an application, with requisite documentation such as:

- i. Current primary regulators certificate and a copy of retention indicating healthcare provider is in good standing (e.g., Health Facilities Regulatory Agency, Pharmacy Council certificate);
- ii. Current certificate from Registrar General (where applicable) and proof of renewal for Private Providers;
- iii. Current association membership certificate and proof of renewal of membership (e.g., Christian Health Association of Ghana);
- iv. Must pay required fees for requested level of credentialing; and
- v. Provide photocopies of certificates of professionals practicing at the facility and proof of retention with their appropriate regulatory bodies.

The stringent application of such credentialing requirements position under resourced providers to miss the mark of being credentialed. However, the exclusion of such facilities especially in underserved areas will be a missed opportunity for reaching service users as these facilities are in many instances within the geographic reach of poorer groups. Hence, it is important the NHIA in collaboration with GHS consider the inclusion of trusted community-based service providers as they play a critical role in expanding access of FP services to underserved populations in the country. The NHIA and particularly the GHS may have to take a critical look at identifying and supporting these community-based service providers to meet the requirements for credentialing and support them in filing in their application for credentialing.

### Delays in provider reimbursement

In Ghana, there is evidence of health providers suspending health service provision to NHIA insured clients as a result of delay(s) in reimbursing service providers (Akweongo et al. 2021). Suspensions in health service provision including FP services will disrupt access to FP services which will have serious implications. Hence, measures will have to be put in place to ensure that service providers are timely reimbursed.

### Crowding out short-term methods

The system of payment by insurance schemes to reimburse providers may also create a situation where service providers will lean towards providing specific types of FP services to the neglect of others. For instance, input-based financing (paying health worker

salaries and providing state-procured or donated commodities) could affect the provision of certain types of contraceptive methods, that is long-acting, reversible, or permanent methods as they may perceive there is limited benefit spending more time and effort providing them compared to the provision of short-term methods to clients (Mazzilli et al., 2016).

The 2014 Ghana Demographic and Health Survey revealed that short-term FP methods were the most common among service users—for instance, for long term FP methods, current users of IUD was 0.8% and implants, 5.2%. With respect to short-term FP methods, current users for injectables were 8.0% and pills, 4.7% (GSS et al., 2015). Analysis of data from the FP Pilot intervention shows that the inclusion of FP into the NHI benefit package resulted in a shift from short term FP methods to long term FP methods. Hence, in planning for scale up, conscious efforts should be made to meet potential increase in demand for long term FP methods.

As FP services shift from short term methods to long term methods, it means that more health workers trained in providing FP services will be needed especially in underserved areas.

### Increase in uptake of FP services

Evidence from the FP Pilot intervention districts suggests that the inclusion of FP within the NHI benefit package led to an increase in demand for FP services. While the current evidence suggest that there was no surge but rather a gradual increase in uptake, we cannot rule out the possibility that the increase in demand for FP services can overwhelm health facilities during scale-up. It is important that the GHS and partners put in place measures to respond to the potential increase in service users in especially underserved areas.

### Commodity insecurity

Following the potential increase in uptake of FP services; there could be the likelihood of shortage of commodities as the potential increase may not have been planned for. Thus, the GHS and stakeholders should ensure the availability of FP commodities to meet the potential increase demand.

### Inequity of access

In Ghana, the NHIS was introduced to address the issue of inequity in healthcare access. Although Ghana's NHI premium is heavily subsidized and provides exemptions for the poorest, evidence suggest that they are usually the least enrolled in the NHIS because they are not

aware of the exemption. Moreover, when they visit a health facility to seek health care, they are referred to go and get their exemption to enable the facility to get their money before they are taken care of. This usually discourages clients and may have negative implications for FP services if not addressed to create awareness about exemptions and how to make use of them (Kotoh & Van Der Geest, 2016).

### Misconceptions about FP

Misconceptions about FP will also need to be addressed to achieve the equity in FP service provision especially in underserved areas. For example, in some communities there are beliefs that women might become unfaithful if they accept FP services, hence deterring service users in need of FP (Duah & Yeboah, 2017). Educational campaigns will have to be designed and implemented to dispel these misconceptions during scale up to achieve the desired results.

## CONCLUSION

Ensuring equitable access to FP is essential to securing the well-being of women and supporting the health and development of communities. One pathway to ensuring equity is the inclusion of FP in affordable insurance. While the inclusion of FP in the NHIS is critical to the equity of FP distribution, the issues identified in this study would have to be addressed before or in the course of scale-up to achieve the desired results.

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