KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY KUMASI-GHANA

COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICAL SCIENCES
DEPARTMENT OF COMMUNITY HEALTH

EXEMPTION POLICY AS IT AFFECTS PREGNANT WOMEN IN ST MARY'S HOSPITAL, JAMAN DISTRICT, GHANA

BY

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SEPTEMBER, 2005

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A DISSERTATION SUBMITTED TO THE SCHOOL OF MEDICAL SCIENCES, DEPARTMENT OF COMMUNITY HEALTH, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY KUMASI-GHANA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE (MSc) DEGREE IN HEALTH EDUCAITON AND PROMOTION.

BY

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SEPTEMBER 2005

DECLARATION

I declare that this dissertation is the result of my own work carried out in the School of Medical Sciences under the Supervision of Dr Easmon Otupiri.

References cited or views adopted in this study have all been acknowledged. No part of this project work has either been presented in whole or in part to any other institution for any award.

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DEDICATION

This work is dedicated to the Glory of Almighty God whose love and grace have brought me this far and to!

The Department of Community Health

And

My Course Director Professor(Mrs). E. A. Addy.

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ABBREVIATIONS/ACRONYMS

ANC	–	ANTENATAL CLINIC
CHAG	–	CHRISTIAN HEALTH ASSOCIATION OF GHANA
DDNS	–	DEPUTY DIRECTOR OF NURSING SERVICES
DHMT	–	DISTRICT HEALTH MANAGEMENT TEAM
DDHS	–	DISTRICT DIRECTOR OF HEALTH SERVICES
DHA	–	DISTRICT HEALTH ADMINISTRATION
FM	–	FREQUENCY MODULATION
FP	-	FAMILY PLANNING
GSS	–	GHANA STATISTICAL SERVICE
HMT	–	HOSPITAL MANAGEMENT TEAM
LIC	–	LOW INCOME CARD
MOH	–	MINISTRY OF HEALTH
NCHC	–	NATIONAL CATHOLIC HEALTH COUNCIL
NMIMR	-	NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
OPD	–	OUT PATIENT DEPARTMENT
POW	–	PROGRAMME OF WORK
RDHS	–	REGIONAL DIRECTOR OF HEALTH SERVICE
RHA	–	REGIONAL HEALTH ADMINISTRATION
SD	-	STANDARD DEVIATION
SHSA	–	SENIOR HEALTH SERVICE ADMINISTRATOR
SMO	–	SENIOR MEDICAL OFFICER
SPSS	-	STATISTICAL PACKAGE FOR SOCIAL SCIENCES
STD	–	SEXUALLY TRANSMITTED DISEASES

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ABSTRACT

The exemption policy is meant to improve financial access to health care and utilization of health services. However, the achievement of this objective continues to be in doubt as the target beneficiaries find it difficult to access the exemption funds.

The study examined the implementation of the exemption policy as it affects the pregnant women in the Drobo St Mary's Hospital.

The study was descriptive with a cross- sectional design. Data was colleted at one point in time. Qualitative and quantitative methods were used.

Questionnaire and personal interviews were used to collect data. A sample size of one hundred and ninety-six (196) was chosen. This was made up of five (5) Hospital Management Team members, (41) Hospital staff and one hundred and fifty (150) pregnant women. Systematic random sampling technique was used to select the pregnant women while purposive sampling technique was used for the selection of Hospital Management Team and Hospital Staff. Out of one hundred and ninety-six only one of the management team members failed to respond to the questions.

The study revealed that most (98%) of the potential beneficiaries had not benefited from the exemption policy at St Mary's Hospital for the past three years largely due to lack of reimbursement and ignorance resulting from inadequate public education on the policy.

The study therefore recommended that Hospital Management Team and staff should extend exemption to cover ANC and sick pregnant women. This should be done during ANC attendance and beneficiaries should be totally exempted from all bills.

The Health Exemption Committees should reimburse the amount spent on the exemptions to the providing health institutions. This should be done on quarterly basis. The total bill together with the total attendance should be presented to the committees by the providing institutions.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

Making health care accessible to all manner of people has been one of the major challenges facing countries all over the world. Health being a public good requires that as many people as possible get access to it as and when needed without difficulties. This assertion is emphasized by a provision in the World Health Organization's (WHO) constitution cited in Green (1992) that the enjoyment of good health is the fundamental right of every human being without distinction of race, religion, political belief, and economic or social condition.

However, the worsening global economic conditions and the subsequent restructuring measures adopted by most African countries have prevented them from making this provision in the WHO constitution a reality (Bennett and Ngalande-Banda, 1994). The importance attached to health sends a signal to policy makers that the implementation of any policy on cost recovery in any form in Ghana should be friendly to the needy so as to ensure easy financial accessibility. It is in respect of this that any user fee policy made in Ghana also has an element of exemption to take care of the poor and the vulnerable.

The decision to exempt some categories of patients from the payment of hospital fees started since the inception of user fees. The Hospital Fee Act1971 (Act 387) and the subsequent Hospital Fee Regulation (LI1313) makes provision for three broad categories of exemption. These are:

1. Exemption from all fees for:
    - Patients suffering from leprosy and tuberculosis

- Immunization against any disease (excluding vaccination against international travel)
- Storage of bodies at the request of any department of state.

2. Exemption from all fees except for the cost of prescribed drugs for :

(a). Malaria (b) cholera (c) Malnutrition (d) Typhoid (e) Venereal diseases (f) Rabies (g) 18 other conditions usually referred to as diseases of public health importance

3. Exemption from all fees except the cost of hospital accommodation and catering services for

i. Antenatal and postnatal services

ii. Treatment at child welfare clinics.

The regulation does not make explicit provisions for paupers, however with respect to health service personnel including trainees, the Act provides exemption for all special amenities (the regulation does not define these special amenities). The Act also provides that where the release of a dead body is delayed due to post mortem examination, the coroner's report or difficulty in tracing the relatives, the medical officer in-charge may use his discretion to waive the fees for cold storage. It must be noted that even for diseases of public health importance, the regulation does not exempt the payment for drugs and antenatal and postnatal services are practically not exempted during out patient services.

In 1997, the president in his sectional address to parliament directed that children under five years of age, the aged (70 years or above), pregnant women and paupers be exempted from paying user fees and thereby introducing other categories into the exemption policy (Gbeve, 1997). Thus currently the Ministry of Health operates six clearly defined exemption benefits. These are:

- Exemption from disease deemed to be of public health importance (which in principle should include all the 24 health conditions outlined in the LI1313.
- Exemption for children under five years
- Exemption for the aged (70 years or above)
- Exemption for paupers and vulnerable
- Exemption for snake bites and bites by dogs.

These services are expected to be provided by both the government and the mission health facilities to all eligible patients and be reimbursed on the presentation of the bill. Despite the existence of these exemption facilities, health care has not been financially accessible to the beneficiaries. Studies in Ghana have confirmed this assertion.

There have been drastic reductions in the patronage of the hospitals especially since the introduction of the "cash and carry" (De Bethune et al., 1989, Waddington et al., 1989). Asenso-Okyere (1998) supported this fact with the finding that due to the introduction of user fees, patients delay going to the hospital and clinics until they become emergency cases.

Again, Okyere – Mireku (2001) conducted a study on the exemption policy in cost recovery system of the Ministry of Health, at Kwahu Atibie Government Hospital. The aim was to find out whether or not the implementation was in line with the policy. He found that there is a wide variation in the implementation of the exemption policy in all regions as well as poor management practice and providers attitude. The various implementation and managerial problems have rendered the policy useless because the right people are not benefiting.

The studies were conducted mainly in the government health institutions outside the Brong Ahafo Region. In few situations where mission health facilities were involved very little work was done on the managerial and administrative aspects to reveal the real situation.

1.1 PROBLEM STATEMENT

The exemption policy aims at providing financial accessibility to the pregnant women. Even though the policy has been in all the user fee laws passed in Ghana since independence, it did not receive any serious nation-wide support until 1997 when the then president gave some exemption directives in his address to parliament. About six years after the nationwide implementation of the policy, it is still estimated that out of the 18% of the total population who require health care at any given time only 20% of them are able to access it. This implies that about 80% of Ghanaians who need health care cannot access it (MOH, 2002).

The Jaman District is a rural district with high maternal mortality rate of 241/100,000 (Drobo St Mary's Hospital Annual Report 2003) as compared to the national mortality rate of 214/100,000 (GSS, et al 2003). The under five-mortality rate of the district 189/1,000 (Drobo St Mary's Hospital Annual Report 2003) is also higher than the national rate of 111/1,000 live births (GSS, et al 2003). In addition, the record of Antenatal coverage in the past years (2002-2004) has shown a declining trend indicating low utilization of service by pregnant women.

Table 1.1: ANC coverage, St Mary's Hospital, Jaman District, 2002-2004

	Expected # of pregnancies	# Of ANC Attendants	% Coverage
2002	6,882	5,592	81.3
2003	7,020	5,163	73.5
2004	7,100	4,714	66.4

Source: Annual Report, 2002-2003

The St Mary's is a Catholic and the major hospital in the Jaman District. The Hospital is supposed to implement the exemption policy to improve access to quality care by pregnant women. However from 2002 up to date, the hospital has not been reimbursed with the exemption claim for pregnant women to the tune of twenty-eight million cedis (¢28m).

Table 1.2: Exemption Claims from St Mary's Hospital, Hospital, 2002-2004

	Expected amount	Amount Received	Balance/Arrears
2002	68.4m	40.4m	28m
2003	-	-	-
2004	-	-	-

Source: Annual Report, 2002-2003

The lack of reimbursement of claims could hinder the implementation of the Exemption Policy by the Hospital Management and therefore may lead to inconsistencies with government policy. This could be an obstacle or impediment to the objective of providing quality antenatal care to pregnant women to improve the health status of women and children in the district. This study therefore looks at how the New Drobo St Mary's Hospital as a mission hospital in Brong Ahafo Region is implementing the policy.

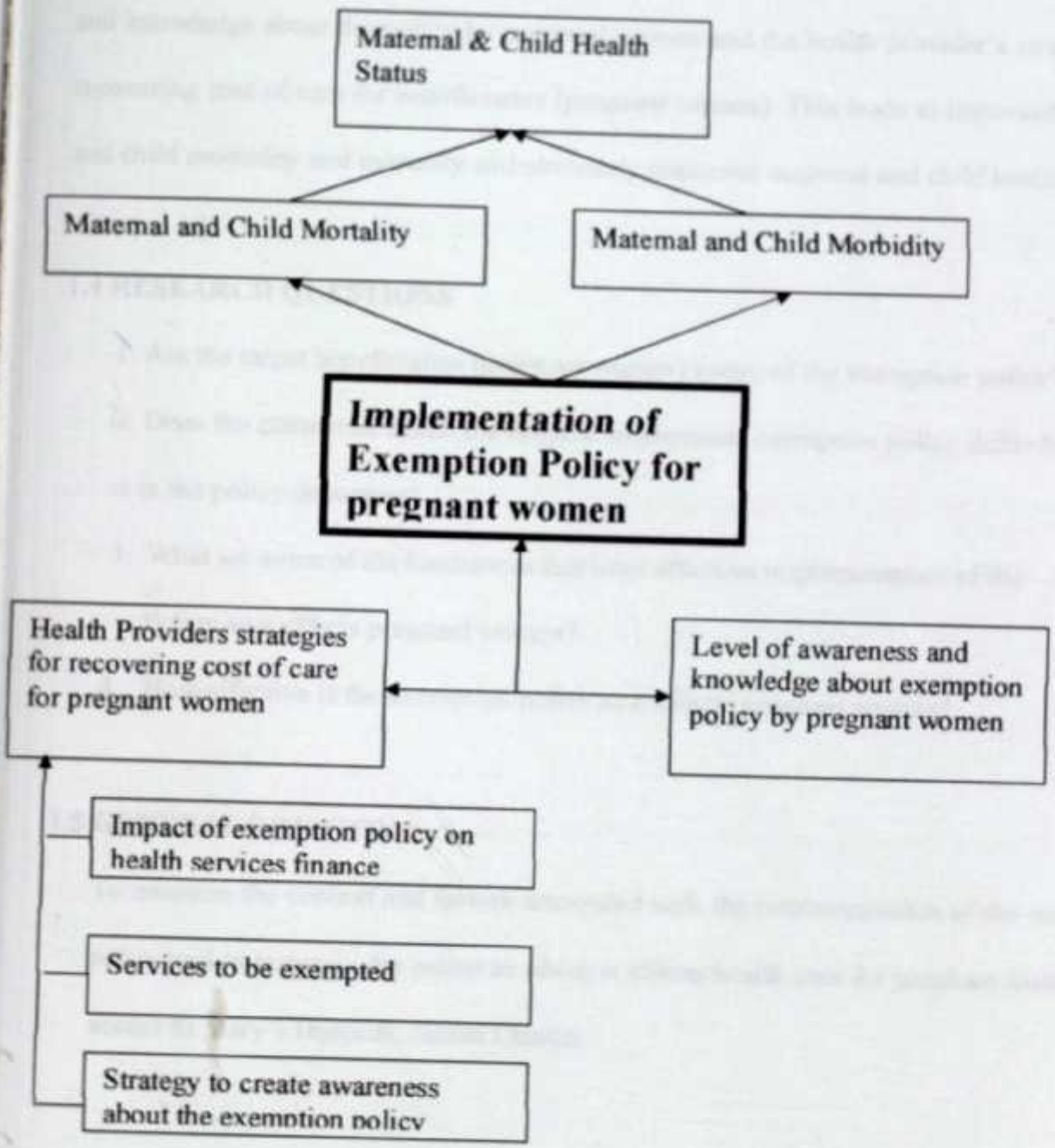
1.2 RATIONALE OF THE STUDY:

The study was necessitated by the prevailing problems in the implementation of the exemption policy in the Ghanaian health institutions. Therefore the result of the study will provide useful information that will assist health managers in their effort to implement the exemption policy.

Secondly, by the findings of this study health providers will be able to assess their managerial approach to the concept of exemption policy as a whole.

1.3 CONCEPTUAL FRAMEWORK

FIGURE 1.1 Conceptual Framework of factors contributing to effective *implementation of exemption policy as it affects pregnant women in ST Mary's Hospital*



Source: Author's Construct, 2005

Implementation of exemption policy for pregnant women has not been easy for most hospitals. In this study, the model (fig1.1) above was developed to show the linkages of factors that influence the exemption of health care in the Ghana Health institutions. Managerial functions include planning, monitoring, implementation and evaluation. Managerial decisions affect how exemption for pregnant women is implemented.

Essentially, the efficient functioning of exemption policy depends on the level of awareness and knowledge about the policy by pregnant women and the health provider's strategies for recovering cost of care for beneficiaries (pregnant women). This leads to improved maternal and child morbidity and mortality and ultimately improved maternal and child health status.

1.4 RESEARCH QUESTIONS

1. Are the target beneficiaries (pregnant women) aware of the exemption policy?
2. Does the context in which the hospital implements exemption policy differ from what is in the policy document?
3. What are some of the hindrances that limit effective implementation of the Policy as it affects pregnant women?
4. How effective is the exemption policy as it affects pregnant woman?

1.5 GENERAL OBJECTIVE

To examine the context and factors associated with the implementation of the exemption policy and to ascertain the extent to which it affects health care for pregnant women who access St Mary's Hospital, Jaman District.

1.6 SPECIFIC OBJECTIVES

1. To determine whether the content of the policy has been communicated to the health personnel and target beneficiaries.
2. To examine whether the context within which the policy is implemented is in line with the policy document.
3. To identify some of the problems encountered in the implementation of the exemption policy as it affects pregnant women.
4. To evaluate the effectiveness of the implementation of the exemption policy as it affects pregnant women in St Mary's Hospital.
5. To recommend ways in which the implementation of the policy can be improved.

1.7 PROFILE OF THE STUDY AREA.

1.7.1 LOCATION OF JAMAN DISTRICT.

The Jaman District is one of the administrative districts in the Brong Ahafo Region. The District is located between latitudes 7^0 27' N and $8^0$27' N and Longitudes 2^0 32' W and 2^0 66 W. It borders Wenchi District in the North-East, Berekum District in the South East Dormaa District in the South and La Cote D'loire in the West.

The district has a total land area of about 1,035 square kilometers. Drobo which is the district capital is about 40 kilometers and 80 kilometers from Berekum and Sunyani the Brong Ahafo Regional Capital respectively. The main gateway to the district when coming from the Southern Ghana is through Berekum.

1.7.2 CLIMATE

The district is within the wet semi-equatorial region having a mean annual rainfall ranging between 1200 mm- 1780 mm. The district has its major rain season from April to October. The month of August experiences a short dry season, and the prolonged one in December to March. Though temperature is generally high in the district the average annual temperature is about 26^0C with a range of 14^0C.

1.7.3 VEGETATION

There are two types of vegetation in the district. These are the semi-deciduous forest and savanna woodland. Parts of the original semi-deciduous forest have become broken forest or a secondary type of vegetation as a result of extensive lumbering and agricultural activities. This secondary type of forest is made up of shrubs and grasses with few original tree species of odum, wawa and mahogany. Towns located in this vegetation type include Goka, Adamsu, Drobo, Komfourkrom and Yaamiensa. The savanna woodland is located in the northern part of the district. Elephant grass, shrubs and a few scattered trees ranging between 14m to 27m high characterize it. Towns in this area are Sampa, Jamera, Jinini, Suma-Ahenkro and Buko.

1.7.4 POPULATION

According to the 2000 population and housing census the district population is 148,327 made up of 72,200 males and 76,127 females. The population is youthful as the mean and modal ages are 22.5 and 19 respectively. The Bonos form majority of the population in the district constituting about 88.6% of the entire district population. The other significant ethnic groups are Dagomba, Frafra and Dagaaba. In terms of religion, the residents of the district are predominantly Christians accounting for about 87.9% (District development plan 2000).

1.7.5 AGRICULTURE

Agriculture is the backbone of the district's economy. It employs about 50% and 88% of labour force in the urban and rural areas respectively. The district produces a wide range of food with special reference to plantain, cassava, cocoyam and maize for internal market.

1.7.6 DROBO ST MARY'S HOSPITAL

The Drobo St Mary's Hospital officially started as a clinic in 1952 through the combined efforts of the Drobo Traditional Council and the then catholic Bishop of Kumasi. The clinic directly came under the catholic Diocese of Sunyani immediately after the consecration of the Late Right Rev. James Kwodwo Owusu as the Bishop of Sunyani Diocese in 1973. It was raised to hospital status in 1989. In 1991 St Mary's Hospital was upgraded to a District Hospital when the Jaman District was created out from the Berekum District by the Ministry of Health (MOH) in Ghana to serve as referral hospital for the Jaman District.

1.7.7 MANAGEMENT

As a Catholic health institution the highest decision making body for the Drobo St Mary's Hospital is the Ministry of Health; the Catholic Bishops Conference, the National Catholic Health Council (NCHC) and the Christian Health Association of Ghana (CHAG), they co-ordinate health activities at the national level. At the diocesan level there is a Diocesan Health Service Board that makes health policies within the general policy framework of the Catholic Bishops Conference and the Ministry of Health.

The day-to –day running of the hospital rests on a management team, which is made up of the Health Services Administrator, the Nursing Service Administrator (Matron) and the Chaplain as the core members. Others are the District Director of Health Services and a representative from the Medical Mission Sisters in Kwasibourkrom.

1.7.8 CATCHMENT AREA

The Drobo St Mary's Hospital as a district hospital serves as a point of first call for health services and referral point to the whole of the District as well as parts of La Cote De Ivoire that share boundary with the district.

1.7.9 ROLES AND SERVICES

It is an 86 – bed hospital with seven (7) wards namely male, female, children, surgical, emergency, maternity and special ward. It offers a wide range of services including curative, promotive, preventive and rehabilitative and serves as a referral point for all formal health institutions in the district. The hospital has a surgical specialist with a bias for orthopaedic surgeries. It has 26 State Registered Nurses, 30 ward assistants and 73 non-medical staff. It offers laboratory and X – ray services. The hospital is responsible for providing primary health care services to the Jenjemireja sub-district, Yaamansa sub-district and Abirikasu sub district of Jaman District. It collaborates with the District Health Management Team (DHMT) in the area of heath logistics. It sees to over 33,000 clients at the outpatient department (OPD) in a year.

TABLE 13 TOP TEN OUTPATIENT MORBIDITY IN JAMAN DISTRICT FOR 2002, 2003 AND 2004

2002			2003			2004		
DISEASE	**CASES**	**RATE**	**DISEASE**	**CASES**	**RATE**	**DISEASE**	**CASES**	**RATE**
MALARIA	59,877	55%	MALARIA	61063	56.4%	MALARIA	69926	56.7%
PREGNANCY AND RE.COMPLICATION	6,592	6%	UTRI	4593	4.2%	UTRI	6233	5.1%
UTRI	4,724	4.3%	DIARRHEA DISEASES	3437	3.2%	ACUTE EYE INFECTION	4415	3.6%
ACUTE EYE INFECTION	3,445	3%	ACUTE EYE INFECTION	3306	3.2%	DIARRHOEA	3530	2.9%
DIARRHEA DISEASES	3,370	3%	PREGNANCY AND REL. COMPLICATIONS	2712	2.5%	SKIN DISEASES	2976	2.4%
INTESTINAL WORMS	2,882	3%	ACCIDENTS	2712	2.5%	INTESTINAL WORMS	2649	2.1%
ACCIDENTS	2,802	3%	SKIN DISEASES	2626	2.4%	ACCIDENTS	2616	2.1%
SKIN DISEASE	1,409	2%	INTESTINAL WORMS	2617	2.4%	RHEUMATISM	1319	1.1%
EAR INFECTION	1,408	1.3%	GASTRO ENTRITIS	1139	1.1%	GASTRO ENTERITIS	1300	1.1%
GYNAECOLOGICAL DIS.	1,269	1%	ANAEMIA	1132	1.1%	MALARIA PREGNANCY	1254	1.0%
TOTAL	88,426	82%	TOTAL	85337	79%	TOTAL	96290	78.0%
ALL OTHERS	19,804	18%	ALL OTHERS	22825	21%	ALL OTHERS	27119	22.0%
GRAND TOTAL	109230	100%	GRAND TOTAL	108162	100%	GRAND TOTAL	123409	100

Jaman District Annual Health Report,(2002-2004)

1.7.10 PUBLIC EDUCATION

The Jaman District is blessed with two FM radio stations namely the OMEGA FM and KISS FM. Through these FM stations, the hospital reaches the communities within the serving areas with various topical issues which foster understanding between the public and the hospital. The public also has the opportunity to publicly and freely express opinions on the operations of the hospital through the local radio stations. The hospital also has permanent airtime on the OMEGA FM on Wednesdays and Fridays on KISS FM. Other issues that need immediate clarification are discussed immediately as they occur.

1.7.11 COLLABORATION

The Drobo St Mary's Hospital has been able to sustain operation due to laudable assistance it receives from St Jansdal Hospital based in Holland. This organization assists St Mary's Hospital in the supply of hospital equipment such as ultra sound machines, refrigerators and laboratory instruments. It also assists in the construction of staff bungalows and offers sponsorship to students to pursue medical courses in Ghanaian universities.

1.8 THE SCOPE OF THE STUDY:

In broad terms, the study sought to investigate into the exemption policy as being implemented in the New Drobo St Mary's Hospital. However, in view of the limited time allowed for Students thesis, this study can only look at the policy as it affects pregnant women who visit the hospital for antenatal care for only one year (2004) within the whole

period of implementation. Nevertheless, the finding of this study may be a good reflection of the whole implementation period and may also be applicable to other health institutions in Ghana.

1.9 ORGANIZATION OF REPORT

After the introdutory chapter which included profile of the study area, chapter two reviews the literature on both theoretical and empirical work done in the areas of health exemptions. This chapter illustrates the relevance to the various areas of specific objectives.

Chapter three gives methodology of the study. It shows how valid data are collected to address the key specific areas of the topic. Chapter four provides the findings and results of the data collected on sources of exemption policy as it affects pregnant women. This chapter also seeks to illustrate whether the findings in the study are the true reflection of what the researcher actually set out to doin the study.

Chapter five focuses on discussion of all the factors that may be significant to the understanding of exemption for pregnant women. Chapter six is devoted to concluding and making recommendation to ensure adequate implementation of exemption policy for pregnant women.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 CONTENT OF HEALTH EXEMPTION:

Exemption is the means by which some specific and vital social services are made accessible to some group of people free of charge who otherwise would find it very difficult to have reasonable access.

Exemption in Ghana can be seen in some social sector policies including that of education and health. This has mainly come about as a result of the privatization process that has resulted in inequity of access to such social services. Health exemption has been in the laws of Ghana since independence but very little impact has been made. It can be treatment based – in other words certain treatments such as those for tuberculosis and leprosy are provided without charge in recognition of the high cost of the treatment and the public health risk. They can be offered to a specific group of the population such as the pregnant women and the poor (Goodman and Waddington 1993).

Studies conducted indicate that many countries recognize the need to offer exemption for the treatment of certain diseases and to the poor and the vulnerable so as to ensure reasonable access to health care. This indeed should be encouraged because by its regressive nature user fees are likely to exclude the poorest who may be the most in need of health services.

Government plays a central role in this context by ensuring that those people have equal access to essential health care. This role is translated into making funds available for exempted groups (Banka et al 2002). Okyere Mireku, (2001) shared the above opinion with the idea that exemption policy is implemented to ensure that the indigents get access to the needed health care so as to curtail the excessive hardship that health seekers may encounter.

Again, Bennett and Ngalande- Banda (1994) stated that in order to ensure that user fees are reasonably equitable; a system of exemption is likely to be required to protect the poor who cannot afford to pay the regular fee. They went on to say that exemptions may also be used for diseases of public health importance such as tuberculosis and for high priority services such as matemal and child health as well as family planning. Even the most optimistic studies on people's willingness and ability to pay find out that some proportion of the population requires assistance. The most obvious groups are the mentally ill, who are unable to care for themselves, paupers and the indigent and those unable to raise cash or even in-kind payment when severe illness strikes (Shaw and Griffin, 1995).

In francophone Africa few countries have defined exemption schemes (Mali, Mauritania, Niger, Rwanda, and Senegal). Normally, local health committee or the commune or a local administrator decides who should be exempted, but few countries have clear-cut guidelines as to who should be counted as needy. There is little information on the frequency of exemptions but in Mali up to 30% or 50% of patients at some hospitals are

exempted. Anglophone countries appear to have more defined exemption schemes (including Ethiopia, the Gambia, Ghana, Kenya, Lesotho, Namibia, Swaziland and Zimbabwe). In these countries it is more likely to be the facility staff who chose the people to exempt, but village health committees, chiefs and administrators also play a role. Again the definition of who is needy is left quite unclear, only Zimbabwe specifies an income level below which a person may be exempted. In practice, it would appear that although these schemes are defined centrally, they also leave a considerable degree of freedom to the local level in implementation. Who is exempted from fees is likely to be a fairly political question. Often, groups are exempted who are not poor. This was the case in Ghana and several other countries where government employees were exempted. The experience in Ghana shows that exempting people by their employment category rapidly depletes the pool of potential income for health. This was partly due to the fact that exemption system was poorly defined. A recent paper on Kenya used household income level to establish appropriate exemption criteria and estimated that 12% to 34% of the population may need to be exempted (Huber, 1993).

In a survey conducted by Shaw and Griffin (1995) in official cost recovery policies for health care system in African countries, it was found that exemptions were remarkably low and uncommon. They found that only one out of twenty-one health care systems had an official income ceiling below which people were exempted. Twelve countries reported that their national health policies provided for exemptions but there were no clear criteria for determining who qualified for them. The remaining eight countries provided exemption only as part of local projects or facilities and there were no well-established

criteria for exemption and as such the criteria were determined on an adhoc or community basis.

2.2 CONTEXT OF EXEMPTION

The central difficulties in the implementation of the exemption policy are defining such beneficiary group of people, working out an acceptable formula for providing subsidies and effectively administering the exemptions. In most countries, tested and low cost models for identifying those who simply cannot afford to pay for health care are as rare today as they were a decade ago.

A closer look at the existing exemption practices also raises questions of rational fairness. In a study conducted by Shaw and Griffin, (1995) they found in Lesotho for example that relatively strict criteria have been used to distinguish between the poor and the non-poor. Exemptions are awarded only to people with no income and no land, livestock or other belongings. It was found that only 200 people had received this certification. However, almost, 30,000 people comprising 99 doctors, 620 nurses and 5120 village health workers and all their children under ten years paid no fees.

According to Waddington and Enyimayew, (1990) in Ghana during 1986 most statutory exemptions from user fees were granted to employees of the Ministry of Health and their dependants. The revenue that would have been collected had the exemptions not existed would have been about 12% of total collections for those years (1986-1989). In Central African Republic, 80% of the cost of health care for civil servants is supposed to be

covered by the appropriate Ministry and 20% by the patient. However, neither the Ministries nor the patients managed to receive free or heavily subsidized care despite regulations requiring them to pay (Shaw and Griffin 1995).

The government of Malawi includes low – income exemptions as part of its user fees programme, first in central hospitals then in district hospitals and finally in health centres. The core poor are exempted from fees and the government examines the landholding structure to identify those who qualify. The core poor, defined, as families farming less than 5.0 hectares comprise an estimated 500,000 households, or about 19% of all households in Malawi. In areas where these households dominate affordable fees schedules are determined in collaboration with the communities (Ferster et al, 1991). Private Voluntary hospitals and dispensaries in Tanzania also report that up to half of their patients may have some difficulty making full payments. Most facilities accept alternative forms of payment including deferred payment, payment in kind with crops or temporary employment (without pay), (Mujinja and Mabala, 1992).

Targeting by type of service rather than to worry groups is also considered a possibility. This approach heavily or fully subsidizes those services needed disproportionately by low – income households, such as prenatal and delivery services, management of sick children and treatment for sexually transmitted diseases (STDs) and tuberculosis. Better Health Care in Africa has identified several components of a basic package of services that are believed to contain strong public benefits and therefore might be exempted from fee or at least heavily subsidized for the poor (Bennett and Naglande – Banda, 1994).

The central problem is to determine which services should be publicly subsidized or exempted from fees, since many health services yield both private and public benefits and which authority should carry out and administer any exemptions policy. In a research conducted by Ensor and Sam, (1996) in Northern Vietenam, they found that the government provided a list of groups that should be given exemption from charges. They included invalids, disabled and families that have lost a son as a result of war. In addition communes have discretion over offering exemption to other categories such as the elderly or poor.

In Thailand, people who qualify for exemption were identified through the low-income card (LIC). Through the LIC scheme the poor could apply for cards that qualified them for free care at public health facilities. Only those with an income level lower than a specified threshold were eligible to receive the card and they were identified through a community based screening procedure that gave a key role to community leaders. It was found that there was broad effectiveness of the low-income card although about 20% of those with an income lower than the poverty line had not received a card and from 1992 indication was that cardholders were distributed between regions inequitably In Indonesia, the people refused the free exemption card due to the stigma to be identified as poor (Abel-Smith et al, 1988).

In Ghana, the exemption depends mainly on the subjective assessment of the health workers and they consider the appearance as a criterion to identify the poor. In few situations, assessment is done by social workers if they exist. In a study conducted by

Waddington and Enymayew, (1990) in the Volta Region, they found that the heads of health facilities were mandated to use their discretion to decide who qualifies as a pauper or a beneficiary. Banka et al, 2002 found that exempted cases purely on the grounds of poverty were the least catered for because in using their discretion, health workers often tend to target the easily identifiable groups. The lack of information necessary to determine the eligibility for exemption made the health workers apply their subjective criteria.

Even when someone who is eligible for exemption could be identified there are other factors that influence the targeting effectiveness in Ghana. The stigma of being poor and the behaviour of the providers towards the poor, make them reluctant to access the exemption (Bertson-Eleeza, 2000).

In some studies the community described or defined a pauper as a person with dirty clothes, blind, disabled or mad and who says that he/she cannot afford the cost of health care. This emphases the point that the truly poor does not always come forward for help (Walker 1985).

2.3 PROBLEMS OF INPLEMENTATION OF EXEMPTION

There is extremely limited capacity to administer exemptions in most Sub-Saharan African countries and this explains the low utilization of the exemption facility. The key problems identified are the inadequate targeting of the fund and lack of institutional will to open this up for the poor (Banka et al 2002). Bennett and Ngalanda –Banda, (1994) also attributed low utilization of the exemption to the complex process involved in the

planning and implementation of the exemptions. This is because in many countries identifying who is poor is not a straight- forward task. Poorly defined exemption mechanisms may protect those who are not poor and therefore lowering revenues unnecessarily or not protect those who are poor and therefore adversely affecting equity.

The current exemption policy is difficult to implement because the implementers cannot define who is a pauper and even tell the real ages of the beneficiaries. (Bertson – Eleeza, 2000).

At the Senior Health Managers Conference held in Accra from Tuesday 18th to Friday 21st March 2003, the situational analysis of the exemption policy as at December2002 was discussed. It is clear from the report of all the ten regions that there are wide variations in the implementation of the policy with serious implementation difficulties. The aged group has been scaled down from 70 years to 60 years whilst the caesarean section has been included for the pregnant women in the Upper West Region. In the Brong Ahafo Region the mission health institutions offer exemption to only the pregnant women with a financial ceiling for each first and subsequent visit. In the Northern Region the free antenatal care has been extended to cover delivery and postnatal care. Again the village volunteers working on the Guinea worm surveillance have been included as a category for exemption. It came to light that the inadequate fund to reimburse the health institutions that provide the exemptions is a serious threat to the sustainability of the policy. For more than a year funds have not been released for reimbursement. For

example, the government was in arrears to the tune of 1.89 billion cedis to only the Upper West Region as at the end of 2002 and similar situation existed in all the other regions. The situation was affecting the operations of the health institutions so adversely that the Eastern Region was compelled to suspend exemption at the end of 2002 and indications are that other regions may do the same if the situation does not improve in the near future. It was agreed that the policy needs urgent review and this has been stated as one of the objectives of the current programme of work (POW) of the Ministry of Health. The situational report of the exemption policy confirms the accusation in the Ghanaian Times of Thursday January 23, 2003 that the exemption policy is not working according to the Hospital Fee Act 387 of 1971 by Norman Cooper.

2.4 PERCEPTION OF EFFECTIVENESS OF EXEMPTION POLICY

In Kenya, 38% decline in Ministry of Health hospital outpatient and health centre attendance followed the December 1989 fee introduction (Bennett and Ngalande Banda, 1994). In Ghana it is estimated that nation-wide outpatient utilization dropped more than half after the 1985 fee increase (Dakpalla, et al, 2002). In urban areas, utilization recovered after several months, but it took several years for attendance in rural areas to reach their previous levels.

The implementation of the exemption policy has always been a matter of concern. Many studies have concluded that the Health Ministries lack the capacity to manage exemptions leading to poor uptake of services by those the policies were designed for. There is difficulty in identifying who is beneficiary because while the Social Welfare Department

actively seeks care for identifying vulnerable on the barriers of disability, the Ministry of Health recognizes any patients who expresses or shows that he or she is unable to pay for services at the time of seeking care in health facility. The first barrier in accessing the exemption provision is the courage to go to the health facility even if you have no money. Many potential users of the exemption facility simply drop out at this stage. The second barrier has to do with the need for the individual to establish proof of eligibility especially for the poor and the aged. The frustration compels potential beneficiaries to drop out. (Dakpallah et al, 2002).

There have been situations where people who were bold to establish eligibility were denied access to exemption in Ghana public Health Institutions. The Government of Ghana was sued at an Accra High Court by the Legal Resource Centre (a health for the poor campaign group) for failing to implement the Hospital Fee Act that exempts certain category of Ghanaians from paying medical bills. The Center went on to say that the exemption was rarely ever enforced in the country's public hospitals and even if provided at all, the ministry of health often found it difficult to reimburse the public hospitals that provided such exemptions (the Ghanaian Times, Thursday, January, 23, 2003 page 1).

It has been observed that the public sector is typically weak in organizing activities that will reach the poor especially when the poor are illiterate, unorganized and live in inaccessible area. The task of informing, educating and mobilizing them to demand services is exceedingly difficult and will call for a degree of motivation and commitment that is unlikely to be found in most public health sector institutions. Grass root organizations like the Non-Governmental organizations (NGOs) because of their

flexibility and size, tend to have a comparative advantage in this and may assist government programmes by mobilizing and educating the poor and the vulnerable (Adams, 2002).

Banka et al, (2002) studied the effects of the exemption policy on utilization of hospital services in the three Northern regions of Ghana from 1998 to 2000. The researchers obtained their data through the services and exemptions expenditure records of the health facilities. They found that the three Northern regions known as the three of four poorest regions in Ghana have taken steps since 1998 to improve the implementation of the exemption policy. Outpatients' attendance per capita and hospital admission rate demonstrated interaction between demand and supply of hospital care and thus represent an important starting point in the analysis of factors affecting service utilization. Outpatient services showed an upward trend (from 0.39 visits per capita in 1998 to 0.46 in 2000) at the national level.

The pattern of utilization of hospital services in the northern belt as measured by outpatient attendance per capita and hospital admission rate showed a significant increase over the two years. Wider implementation of the exemption policy in 1999 and 2000 was described in the reports from the Northern, Upper East and Upper West Regions with a 904% overall increase in amount spent on exemption in the three northern regions during the 1998 –2000 period (from 421 million in 1998 to 3,809 million in 2000). This general increase was the result of different trends across the three regions with a monotonic steep increase in the northern region (from 108 million in 1998 to 2,269 million in 2000). A

steep increase was also observed in Upper West Region in 2000 (from 53 million in 1998 to 754 million in 2000). While the Upper East Region showed an increase in 1999 and a downward fluctuation in 2000 (from 258 million in 1998 to 782 million in 2000) consistent upward trends in the number of outpatient visit and hospital admission in the three Northern regions were observed from 1998 to 2000. The experience of the three regions demonstrates that a good design and implementation of the exemption scheme has the potential to improve access to health care and better utilization of health services.

According to Dakpallah et al (2002), the policy has proven administratively difficult to implement in practice more especially in mission health institutions because of several factors including financial, administrative, logistic and behavioral factors. Some critical issues like inadequate dissemination of information on exemption, delay in reimbursement and poor knowledge of exemption by health providers have affected the effective implementation of the policy.

Again, due to multiple points of payment, users in some exemption category end up paying for one or more services to which they have free entitlement. Poor exemption guidelines have led to inadequate targeting of funds and therefore some deserving people do not benefit. Adams, 2002 in his article had this to say: "in a country where about 30% of the population are classified as poor, the coverage proportion of out- patient visits which are granted exemption purely on the grounds of poverty, is way below 1%. Indeed, paupers consume less than 10% of total amount spent on exemption annually. Indeed, some health providers in many respects see exemptions as lost income and a potential threat to the viability of the revolving drug fund in particular. For some health managers,

as disclosed in the study by Dakpallah et al, (2002) effective financial management is defined in terms of ensuring high level of revenue generation and free services to users in exempt categories without assurance of immediate refund, are usually considered as ineffective financial management.

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY TYPE AND DESIGN:

The study was descriptive with a cross- sectional design. It was facility-based research. Data was collected at one point in time. Qualitative and quantitative methods were used.

3.2 DATA COLLECTION TECHNIQUE AND TOOLS

The study used structured interview guide to collect primary data and dummy table for hospital medical records on antenatal care, the hospital financial records on exemption and reimbursement and the beneficiaries of the antenatal care at the hospital to collect secondary data. The structured interview guide made use of two types of questions, close ended and open ended. This was done to capture much information and to offer flexibility in the data collection process. The questionnaire for the pregnant women was interviewee administered while that of the management and staff was self-administered.

3.3 STUDY POPULATION

The study population comprised pregnant women who utilized Antenatal Services at the St Mary's Hospital, the Hospital Management Team and Staff.

TABLE 3.1 VARIABLES AND INDICATORS

Variables	Indicator	Scale of Measurement
Level of awareness	Response to questions asked	Ordinal (high, adequate, low)
Implementation difference	Response to specific questions put to respondents	Nominal (consistent with policy, inconsistent with policy).
Implementation problems	Response to specific questions put to respondents	Nominal (reimbursement not regular, under-reimbursement, service have high toll on IGF, fraud, poor documentation)
Effectiveness of the policy	Response to questions asked	Ordinal i. most effective ii. more effective iii. effective iv. ineffective

3.4 SAMPLE SIZE

The sample size was calculated from the information obtained from Table 1.1. The ANC coverage in the Annual Report of St Mary's Hospital from 2002-2004 gives a population variance of 192,755. Thus, taking z value of 1.96, which is 95% confidence interval and a class width of 10 units, the sample size is given as

$$N = Z^2\sigma^2/d^2$$

Where N= sample size, Z^2= confidence interval, d= class width and σ^2= variance

$$N=1.96^2 * 192755/ 10^2$$

$$N= 3.8416*192755/100$$

N=7405 pregnant women

Out of these sample size the researcher decided to choose196 pregnant women due to limited amount of resources and time available for the study.

3.5 SAMPLE UNIT

Pregnant women who had registered on three antenatal clinic days within a week, Hospital Management Team and staff who usually attended to the pregnant women during the antenatal clinic days at the Outpatient Department formed the sample unit.

3.6 SAMPLING TECHNIQUE

Sampling techniques for the study were both probability and non-probability. Under probability sampling technique, systematic random sampling was used to select 150 pregnant women. The sample of 150 pregnant women was selected from estimated total number of 300 pregnant women who attended antenatal care for the first one month of my arrival to administer the questionnaire. The sample size that was selected was 150. The sampling fraction was

$$\frac{\text{150 sample size}}{\text{300 study population}} = \frac{1}{2}$$

The sampling interval was therefore 2. This means that every 2nd pregnant woman was selected to form part of the sample size. The number of the first pregnant woman was chosen randomly by blindly picking one out of the two pieces of paper. If paper numbered 2 was picked then every 2nd pregnant woman was included in the sample, starting with pregnant woman number 2, until 150 pregnant women were selected. The numbers that were selected include 2, 4, 6, 8, 10, 12, 14 and so on. This method was used to save time and beat down cost.

The sample size of 5 and 41 were selected from the management and staff using purposive sampling technique. Purposive sampling was used because a conscious effort needed to be made to interview management and staff with adequate knowledge about the topic under study. Also the small size of the management and staff population did not make it possible to use probability-sampling technique. They were mainly hospital officers and auxiliary staff who usually attended to the pregnant women during the antenatal clinic days at the Outpatient Department (OPD)

3.7 PRE-TESTING

The structured interview guide was pre-tested in a sister hospital, Wenchi Methodist Hospital, a typical mission hospital. The structured interview guide was updated and modified to generate appropriate responses.

3.8 DATA HANDLING, PROCESSING AND ANALYSIS

The data from the structured interview guide for the pregnant women, the management and staff were properly organized and entered into designed forms on the computer. Processing was done by SPSS Statistical programme (SPSS 11.0 Version). The relevant information was presented in standardized form such as tables, histograms and bar charts.

3.9 ETHICAL CONSIDERATION

Permission to carry out the study was sought from the Regional Director of Ghana Health Service, Brong Ahafo, Jaman District Health Management Team and St Mary's Hospital Management Team with a letter from the Department of Community Health.

The privacy of the interviewees was ensured during the interview process. Information collected were depersonalized and kept confidential. Subjects were urged to participate at will without duress.

3.10 LIMITATION

Regardless of the fact that purposive sampling of the staff and management was done to establish adequate knowledge about the topic under study it was non-probability and therefore unrepresentative. Secondly, since the study was conducted in the mission health facility which had different managerial and administrative structures and relies more on the internally generated fund for it operation the findings may not be the same as the government health facilities.

3.11 ASSUMPTIONS

The following were the assumptions of the study,

- Interviews and questionnaire administration were generally similar in all cases and under all circumstances.
- Respondents were cooperative with the researcher
- Respondents provided correct and unambiguous answers
- Enough fund was available to facilitate the research
- There was no external influence such as political
- Data collection was not hindered by any natural occurrences such as disputes and rainfall.

CHAPTER FOUR

4.0 RESULTS

4.1 ANALYSIS OF DATA

This chapter analyses the data obtained from the study.

The study was about the implementation of the exemption policy as it affects the pregnant women who attended antenatal clinic at Drobo St Mary's Hospital.

Three categories of respondents were involved in this study namely

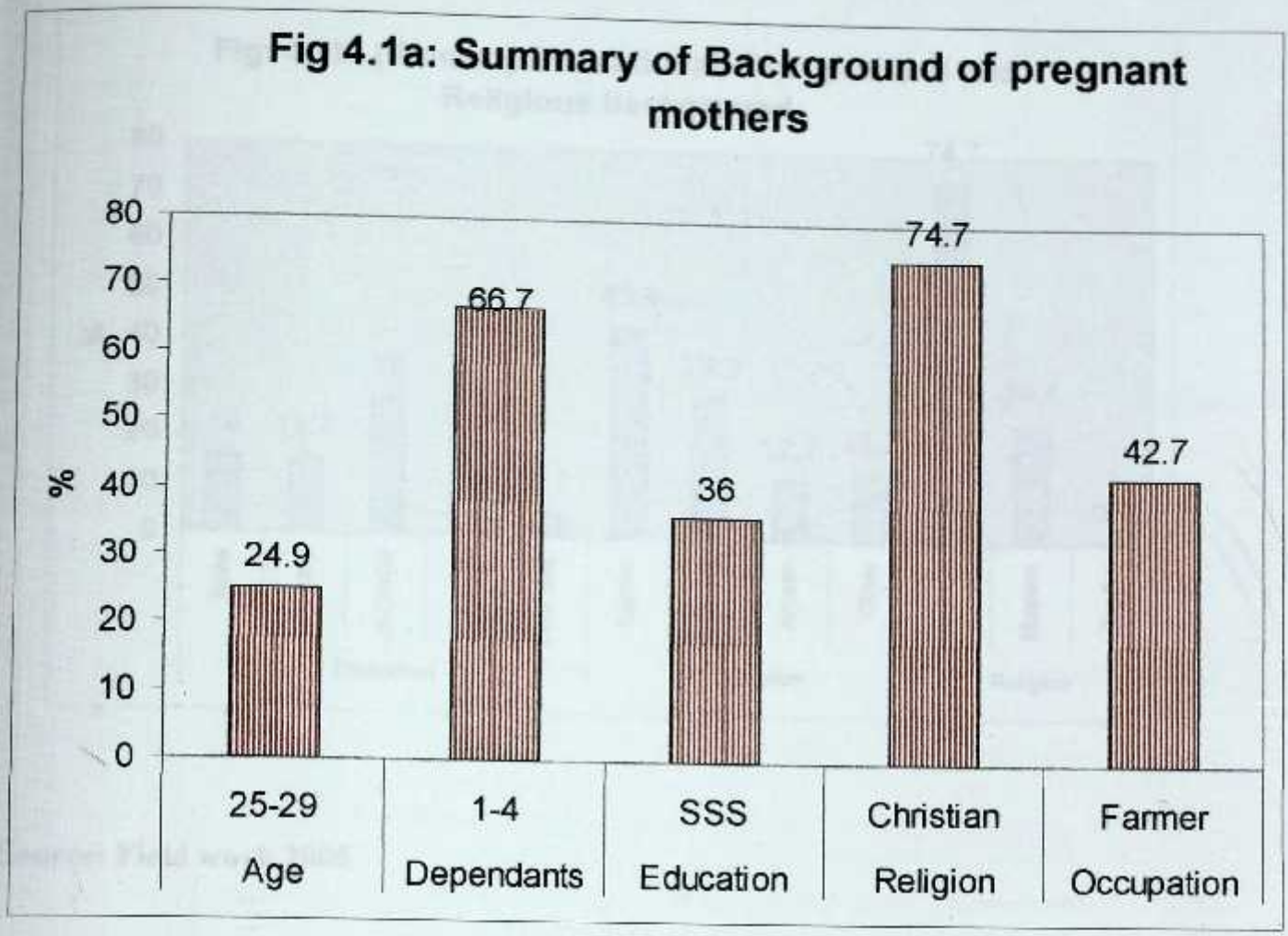
(i) The pregnant women who visited the Drobo St Mary's Hospital for antenatal care

(ii) The staff of the Drobo St Mary's Hospital and

(iii) The Management Team of the Drobo St Mary's Hospital. The sample size for the study was one hundred and ninety-six (196) persons made up of one hundred and fifty (150) pregnant women, forty-one (41) hospital staff and five (5) members of the management team. Out of the sample size of (196), one hundred and ninety five (195) responded to the administered questionnaires. Only one member of the management team failed to respond.

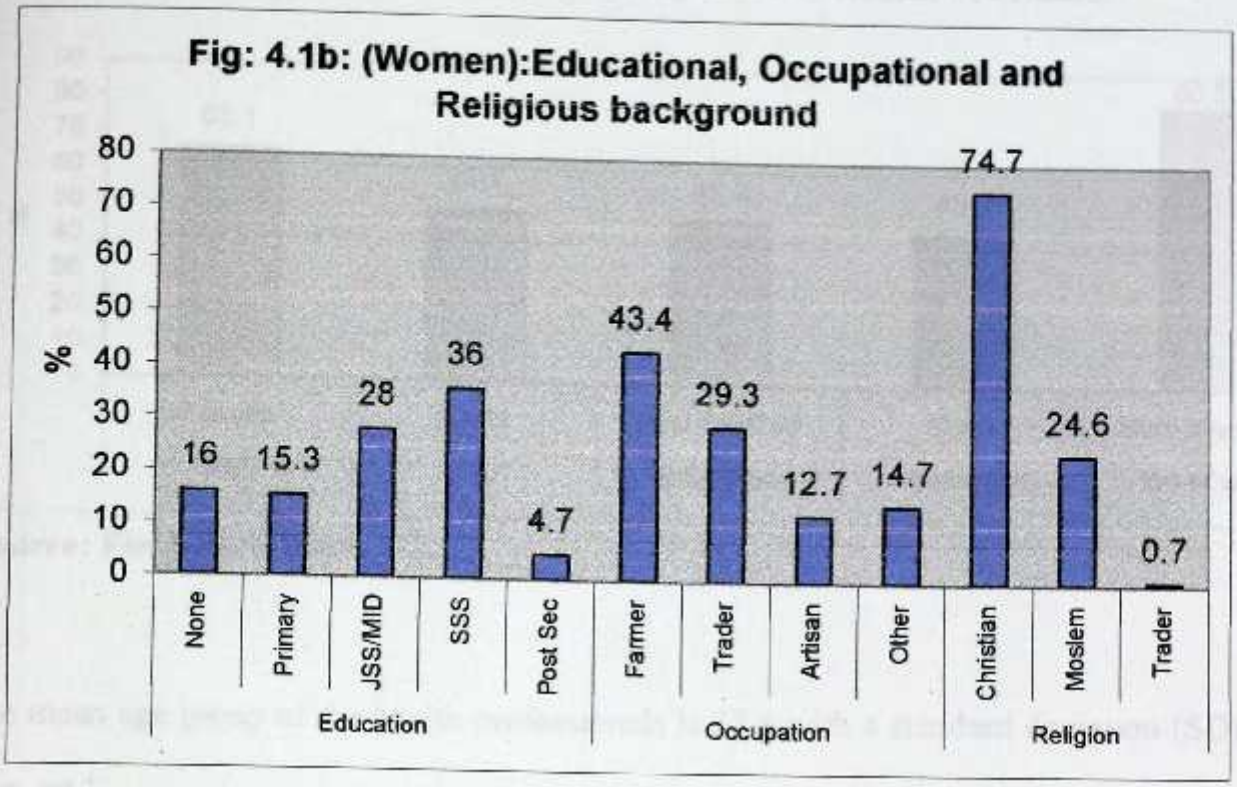
The data from the questionnaires administered to the above three groups were coded and analyzed with the statistical package for the social Sciences 11.0 version.

4.2 BACKGROUND VARIABLES



Source: Field work 2005

The mean age of the pregnant mothers was 27.92 with a standard deviation (SD) of 7.26. As shown in fig 4.1a, the age group 25-29, representing twenty five percent (24.9%) forms the majority. More than sixty percent (66.7%) of the women had 1-4 dependants. Thirty six percent (36%) o f them had Senior Secondary School education. More than seventy percent (74.7%) of the women were Christians and more than forty percent (42.7%) were farmers.

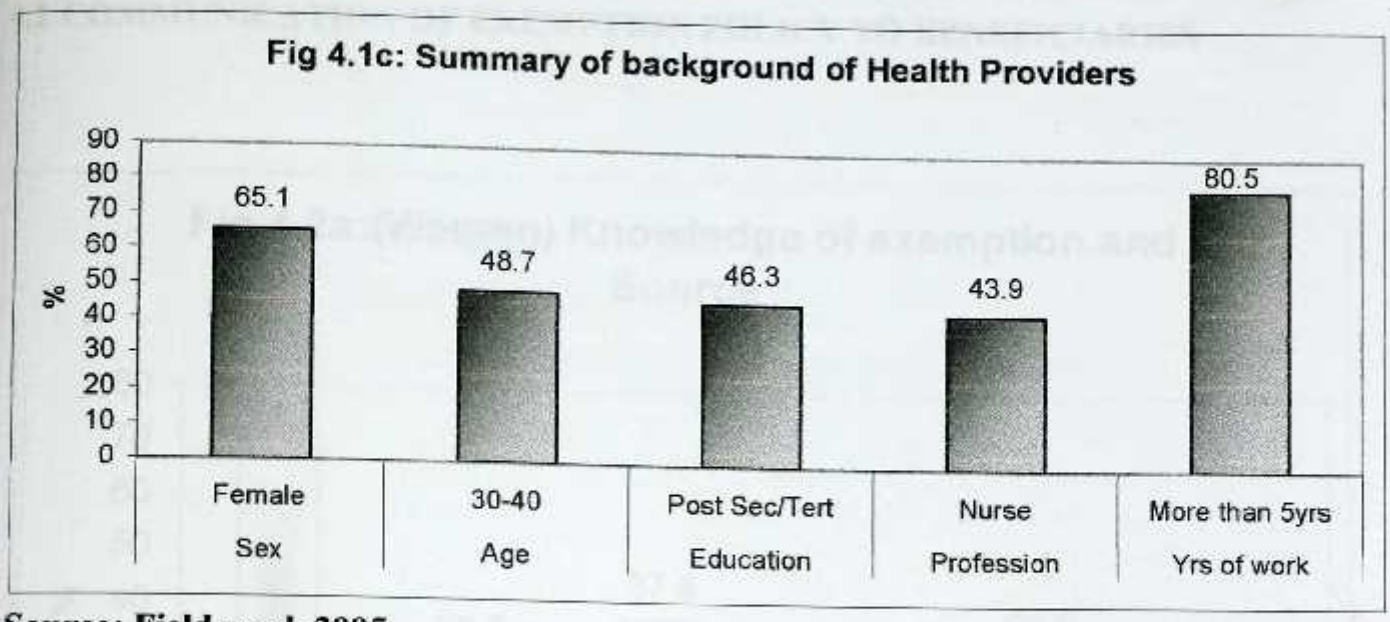


Source: Field work 2005

Of the one hundred and fifty pregnant women interviewed, 24 (16%) had no formal education,

23 (15%) had primary school education, 42 (28%) had middle / JSS School education, 54 (36%) had Senior Secondary School Education, and 7 (4.7%) had post-secondary school education.

Under employment status, 65 (43.4%) of the pregnant women were farmers, 44 (29.3%) were traders, 18 (12.7%) were Artisans and 22 (14.7%) being others. Their employment status is a reflection of their low education background.

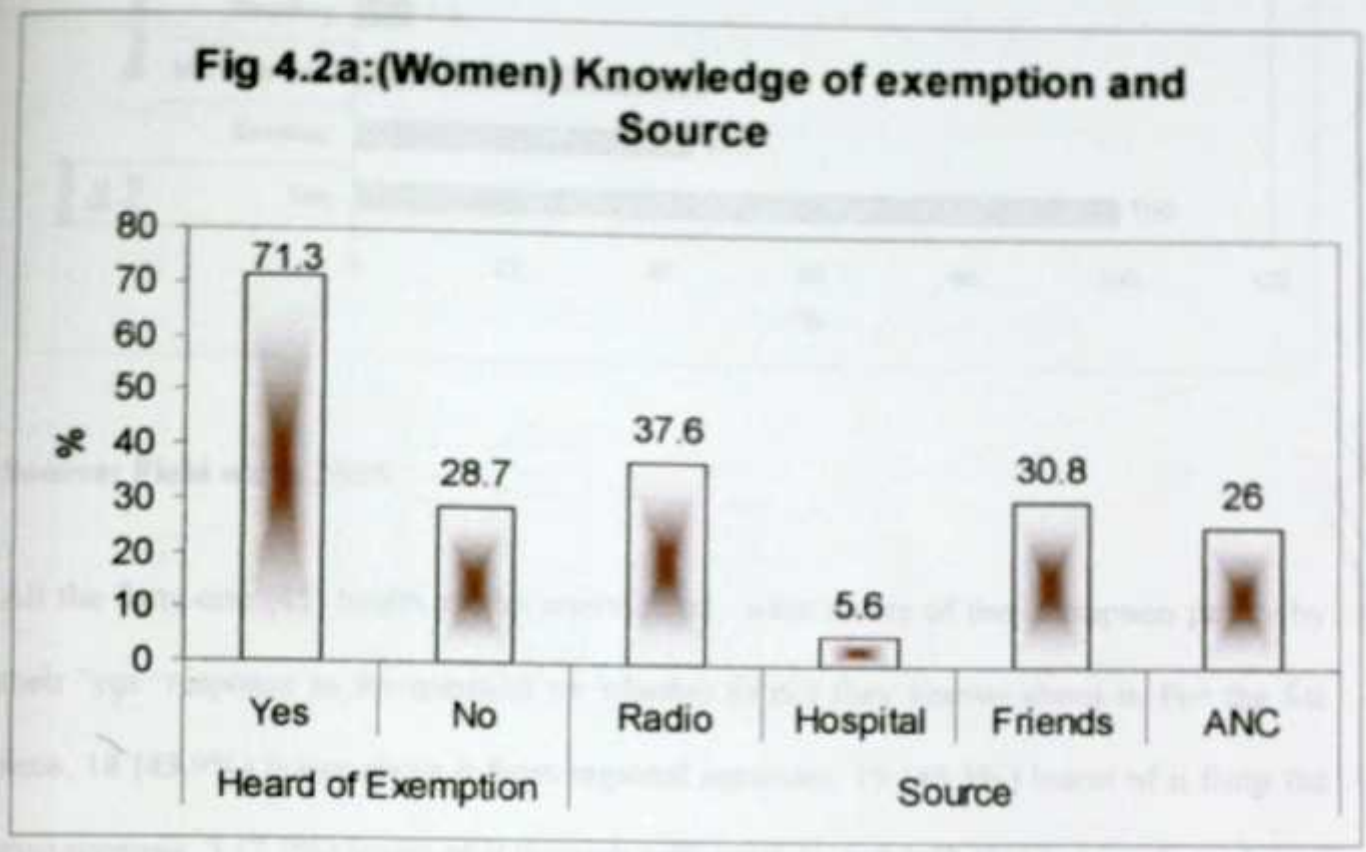


Source: Field work 2005.

The mean age group of the health professionals is 38.6 with a standard deviation (SD) of 7.20. The average years of working experience was 9.4 years with SD of 7.12.A total of forty-one (41) members of staff were interviewed of the total 27 (65.1%) were female, 20 (48.7%) were within the age group 30-40, Nineteen of the staff interviewed had post secondary/ tertiary education and this represented (46.3%). Nurses constituted 43.9%.

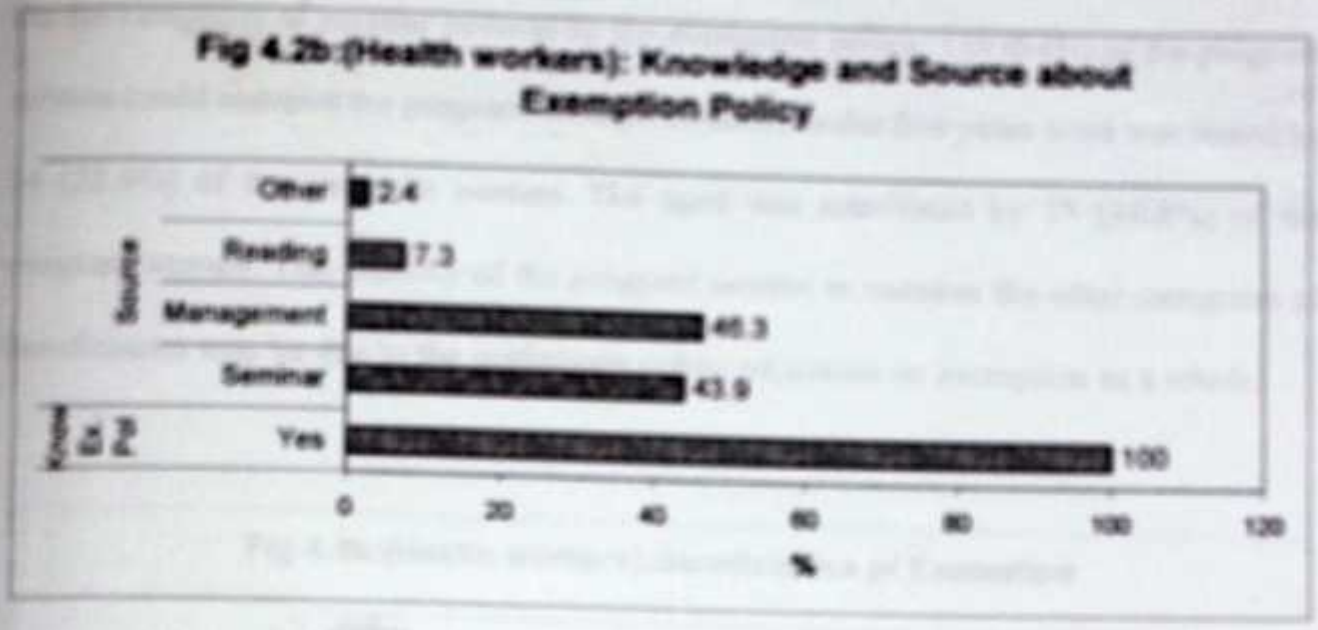
Out of four respondents of the Hospital Management Team 3 were males while 1 was a female. Under their education background one of the respondents had education up to post Graduate level; Two (2) respondents had their education up to graduate level and one (1) up to post Secondary level. Of the four respondents, one (1) was a Deputy Director of Nursing Services (DDNS), one (1) was a Senior Medical Officer (SMO) and the remaining two (2) were Senior Health Service Administrators (SHSA) and Rev. Father. One respondent had worked for five months, another one had worked for three years while the remaining two respondents had worked for six years each.

4.2 COMMUNICATION OF EXEMPTION POLICY TO BENEFICIARIES



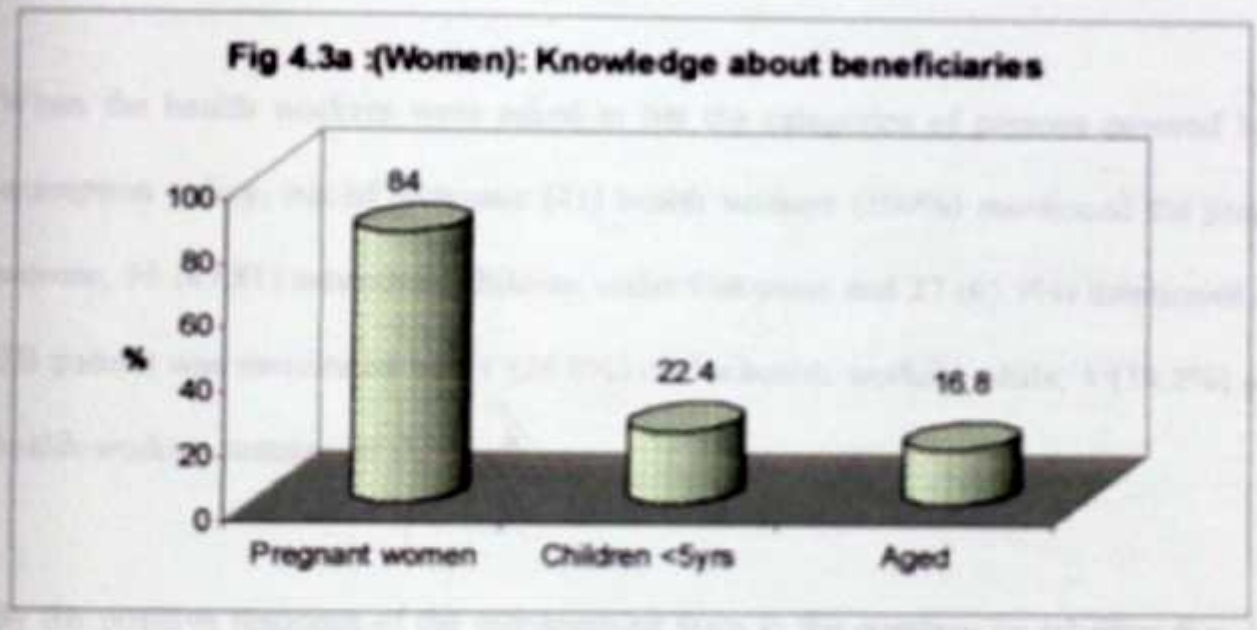
Source; Field work 2005.

A question was posed as to whether or not the respondents had knowledge about the exemption policy in the Health delivery system of Ghana. Out of the one hundred and fifty respondents 107 (71.3%) said yes while 43 (28.7%) said no. As to how they got the knowledge about it for the first time, 56 (37.6%) said they the knowledge through the local Frequency Modulation (FM) radio station, 46 (30.8%) of them had it from friends and 39 (26%) had it during antennal clinic (ANC).



Source: Field work 2005.

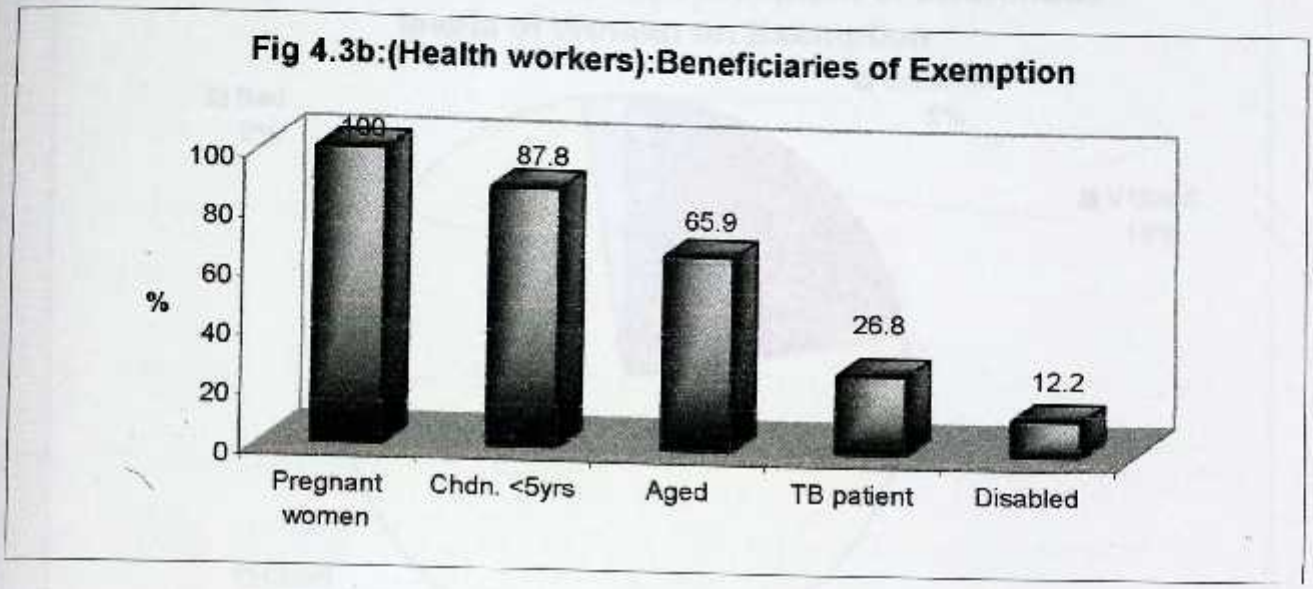
All the forty-one (41) health works interviewed, were aware of the exemption policy by their 'yes' response to the question on whether or not they known about it. For the fist time, 18 (43.9%) learnt about it from regional seminars, 19 (46.3%) learnt of it from the management, 3 (7.3%) learnt of it through self -reading and 1 (2.4%) being others, learnt from friends.



Source: Field work 2005.

On the categories of persons covered by the exemption policy, 126 (84%) of the pregnant women could mention the pregnant women. Children under five years were mentioned by 34 (22.4%) of the pregnant women. The aged was mentioned by 25 (16.8%) of the pregnant women. The inability of the pregnant women to mention the other categories of beneficiaries may be due to the inadequate public education on exemption as a whole.

Fig 4.3b:(Health workers):Beneficiaries of Exemption

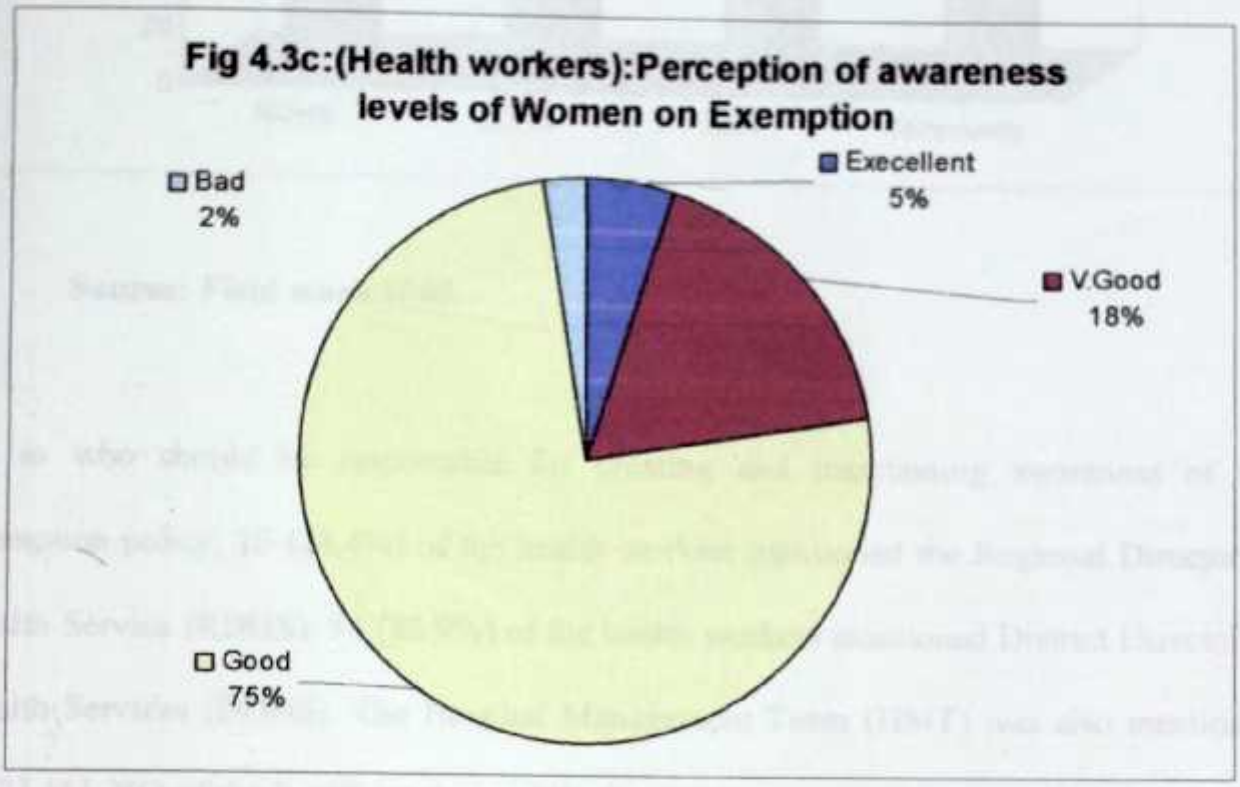


Source: Field work 2005.

When the health workers were asked to list the categories of persons covered by the exemption policy, out of forty-one (41) health workers (100%) mentioned the pregnant women, 36 (87.81) mentioned children under five years and 27 (65.9%) mentioned aged. TB patient was mentioned by 11 (26.8%) of the health workers while, 5 (12.2%) of the health workers mentioned disabled.

By the positive response of the management team to the question on whether they knew of the exemption policy or not, all the four (4) respondents had knowledge of it. When

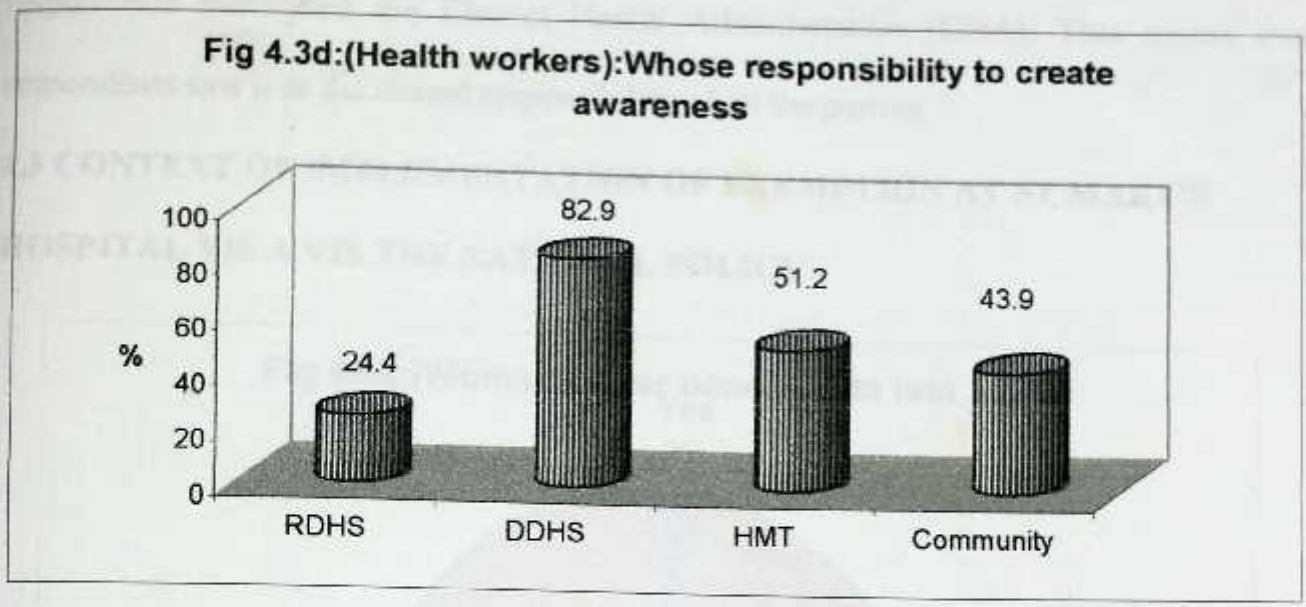
respondents were asked to list the categories of the people covered by the policy, the pregnant women, children under five and the aged were mentioned by each of the three respondents. The paupers, the TB and leprosy patients and the disabled person were each mentioned by one respondent.



Source: Field work 2005.

On the question of awareness of the exemption policy, out of the forty-one health workers, 31 (75%) perceived awareness to be good, 7 (18%) perceived it to be very good, 2 (5%) perceived it to be excellent while 1 (2%) perceived awareness to be bad.

Fig 4.3d:(Health workers):Whose responsibility to create awareness



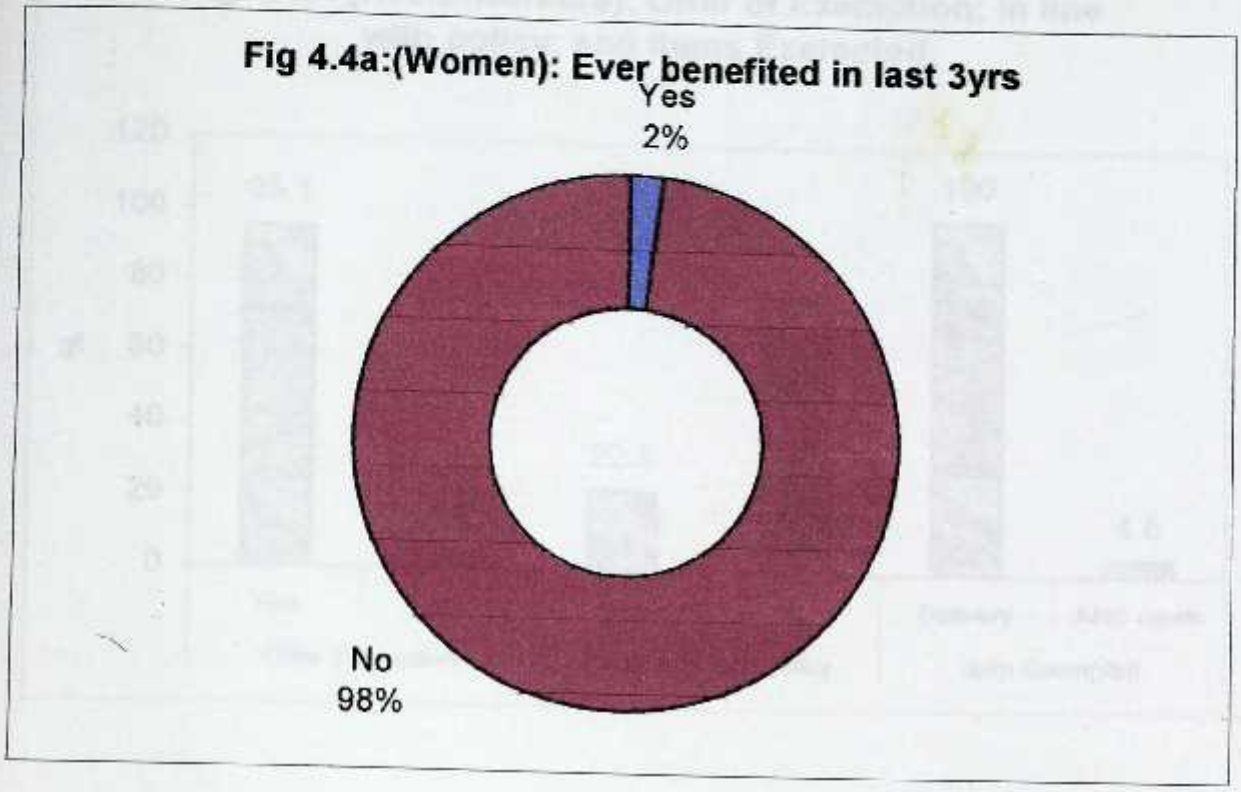
Source: Field work 2005

As to who should be responsible for creating and maintaining awareness of the exemption policy, 10 (24.4%) of the health workers mentioned the Regional Director of Health Service (RDHS). 34 (82.9%) of the health workers mentioned District Director of Health Services (DDHS). The Hospital Management Team (HMT) was also mentioned by 21 (51.2%) of the health workers while the community was mentioned by 18 (43.9%) of the health workers.

Two respondents of the Management Team perceived awareness of the health workers as very good; one person saw it as good while the other one perceived it as bad. On the awareness of the pregnant women about the policy, two respondents perceived it as bad. As to who is responsible for creating and maintaining awareness for the health workers, the Regional Health Administration (RHA), the Hospital Management Team (HMT) and the community were mentioned by three (3) respondents while all the four (4)

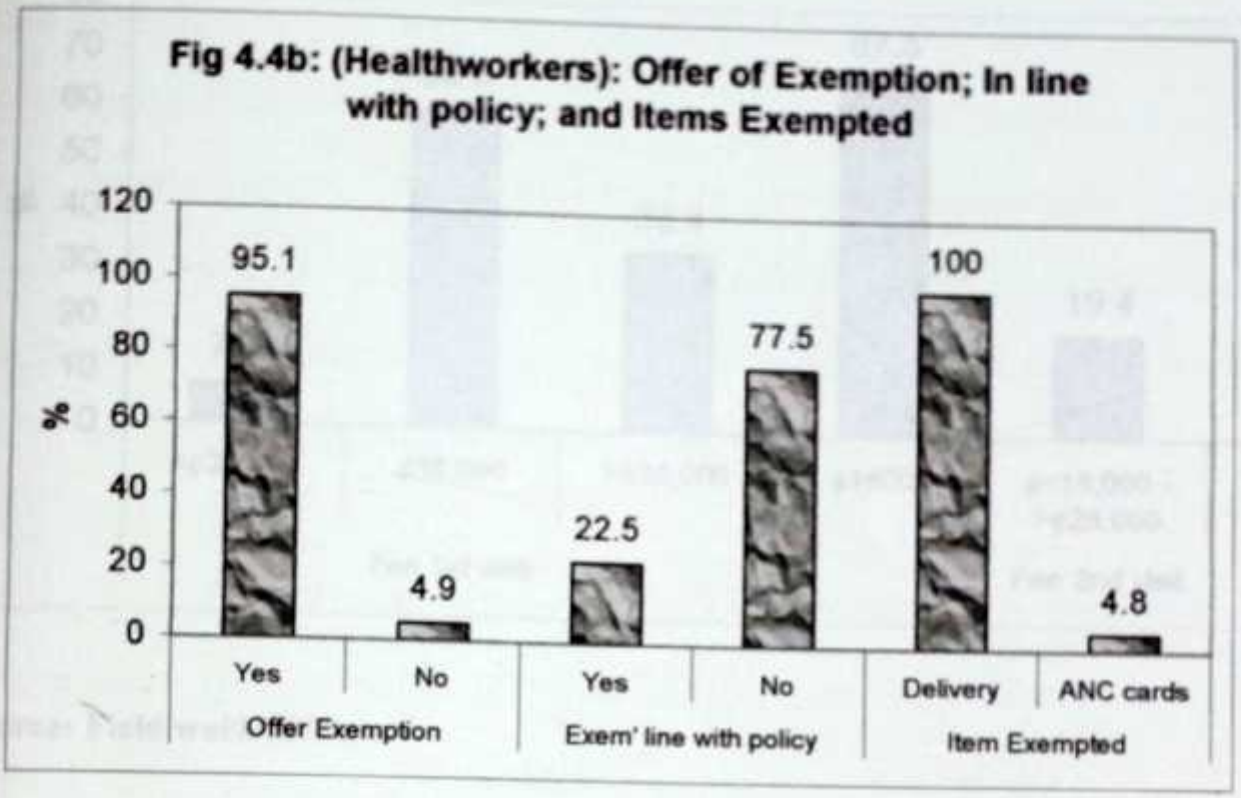
respondents mentioned the District Health Administration (DHA). This means that respondents saw it as the shared responsibility of all the parties.

4.3 CONTEXT OF IMPLEMENTATION OF EXEMPTION AT ST MARY'S HOSPITAL VIS A VIS THE NATIONAL POLICY



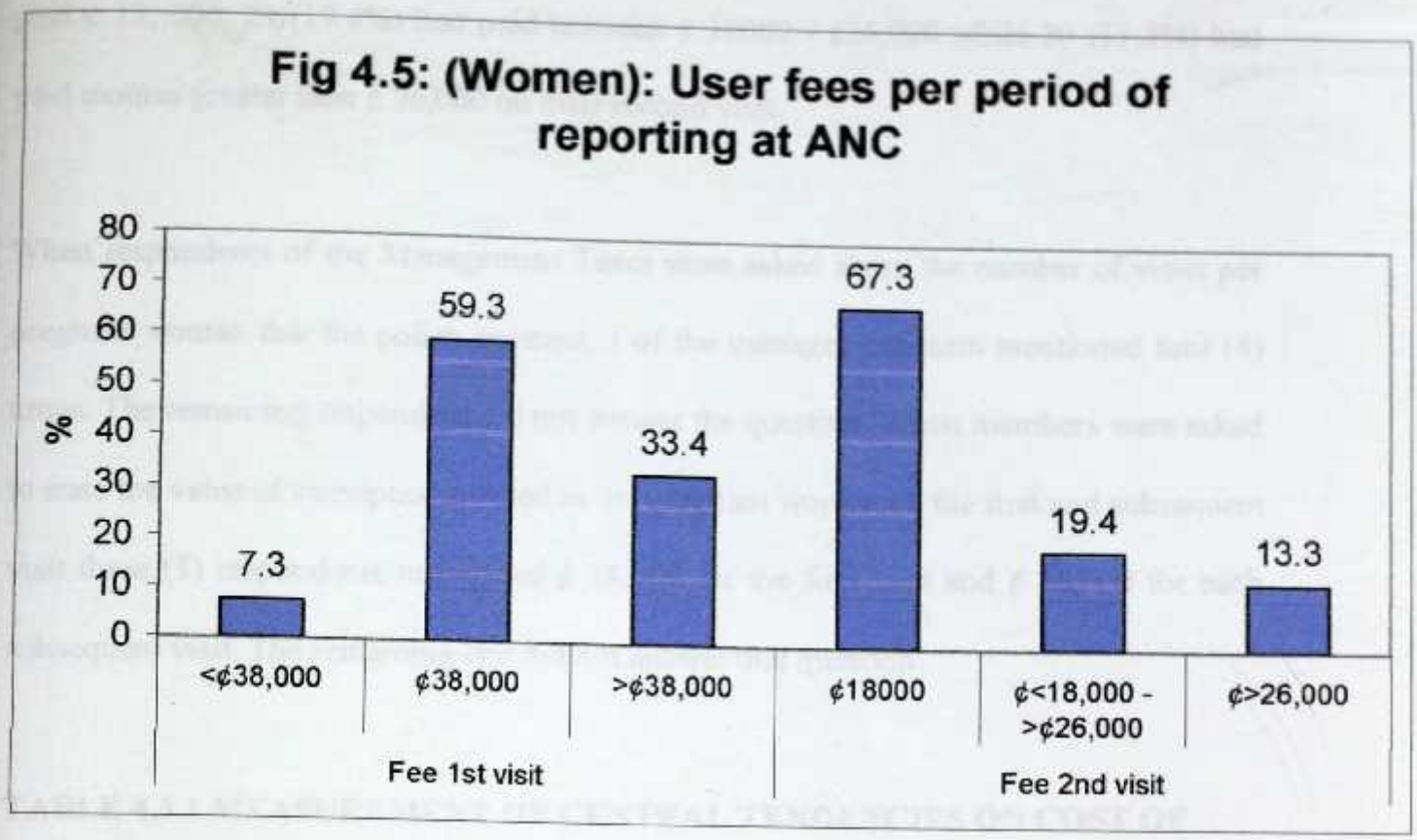
Source: Field work 2005.

The question as to whether the pregnant women had benefited from exemption in the last 3 years or not, 147 (98%) pregnant women said no while 3 (2%) of the pregnant women said yes. This was supported by the exemption claims for ANC in Table 1.2 where from 2003 – 2004 the hospital did not present any ANC bill for reimbursement.



Source: Field work 2005

The question on as to whether or not exemptions were offered to the pregnant women 39 (95.1%) of the health workers said no while 2 (4.9%) said yes. As to whether the implementation of the policy was in lined with the policy, 9 (22.5%) of the health workers said yes while 32 (77.5%) of the health workers said no. Given the items on which pregnant women were exempted 41 (100%) mentioned delivery while 2 (4.8%) mentioned ANC.



Source: Field work 2005.

A question was posed to find out the value of the exemption granted and all one hundred and fifty (150) respondents had no idea. They could perceive that exemptions were not given for ANC from the significant increase in the bills they were paying on the clinic days. Even though respondents were aware that they were entitled to free antenatal care, bills given to them were paid without any question as to why they should pay.

Records on their antenatal cards indicated that 11 (7.3%) of the respondents had paid monies greater than ¢ 38,000 on their first visit, 89 (59.3%) had paid ¢ 38,000 while 50 (33.4%) had paid less than ¢ 38,000. For the second or subsequent visit, 101 (67.3%) had

paid ¢ 18, 000, 29 (19.4%) had paid between ¢ 18000 - ¢26,000 while 20 (13.3%) had paid monies greater than ¢ 26,000 on their second visit.

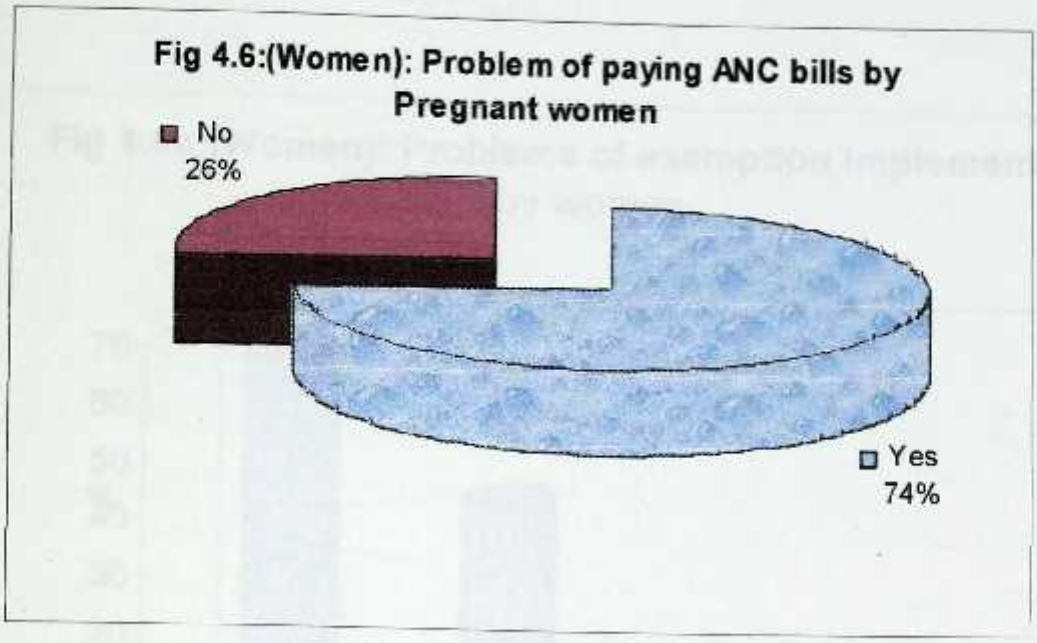
When respondents of the Management Team were asked about the number of visits per pregnant woman that the policy covered, 3 of the management team mentioned four (4) times. The remaining respondent did not answer the question. When members were asked to state the value of exemption offered to the pregnant women on the first and subsequent visit three (3) respondents mentioned ¢ 38,000 for the first visit and ¢ 18,000 for each subsequent visit. The remaining one did not answer that question.

TABLE 4.3.1 MEASUREMENT OF CENTRAL TENDENCIES ON COST OF FIRST VISIT AND SECOND VISITS TO ANC AT THE HOSPITAL

Stats	First visit	Second visit
Mean	¢38,000.00	¢18,000.00
SD	¢ 2,526.66	¢4,500.93
Minimum	¢28,000.00	¢18,000.00
Maximum	¢42,000.00	¢38,200.00

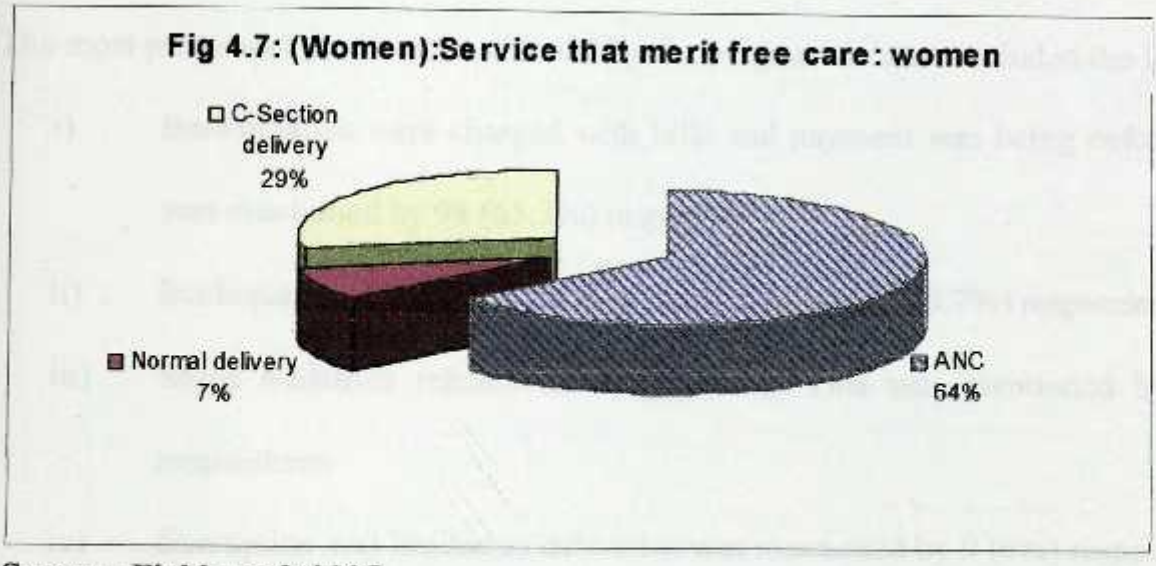
Source: Field work 2005.

4. 4 PROBLEMS IN THE IMPLEMENTATION OF EXEMPTION POLICY.



Source: Field work 2005

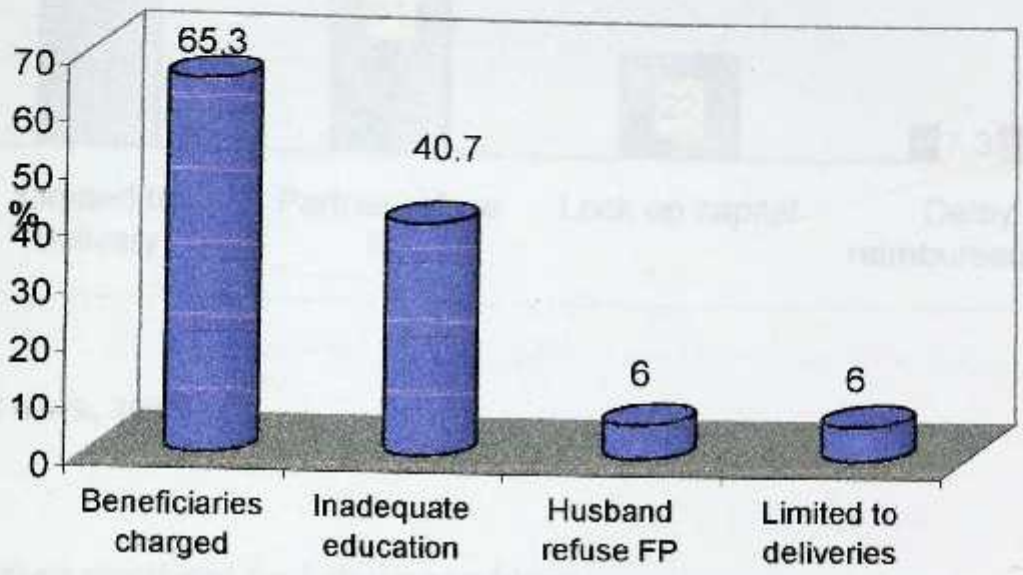
The question of whether or not respondents perceived payment for antenatal care to be a problem, 111 (74%) respondents said yes while 39 (26%) said no.



Source: Field work 2005

As to which pregnancy related services they considered most important to merit free care, 96 (64%) chose ANC, 44 (29%) chose caesarean section while 11 (7%) chose normal delivery.

Fig 4.8a:(Women): Problems of exemption implementation by women



Source: Field work 2005

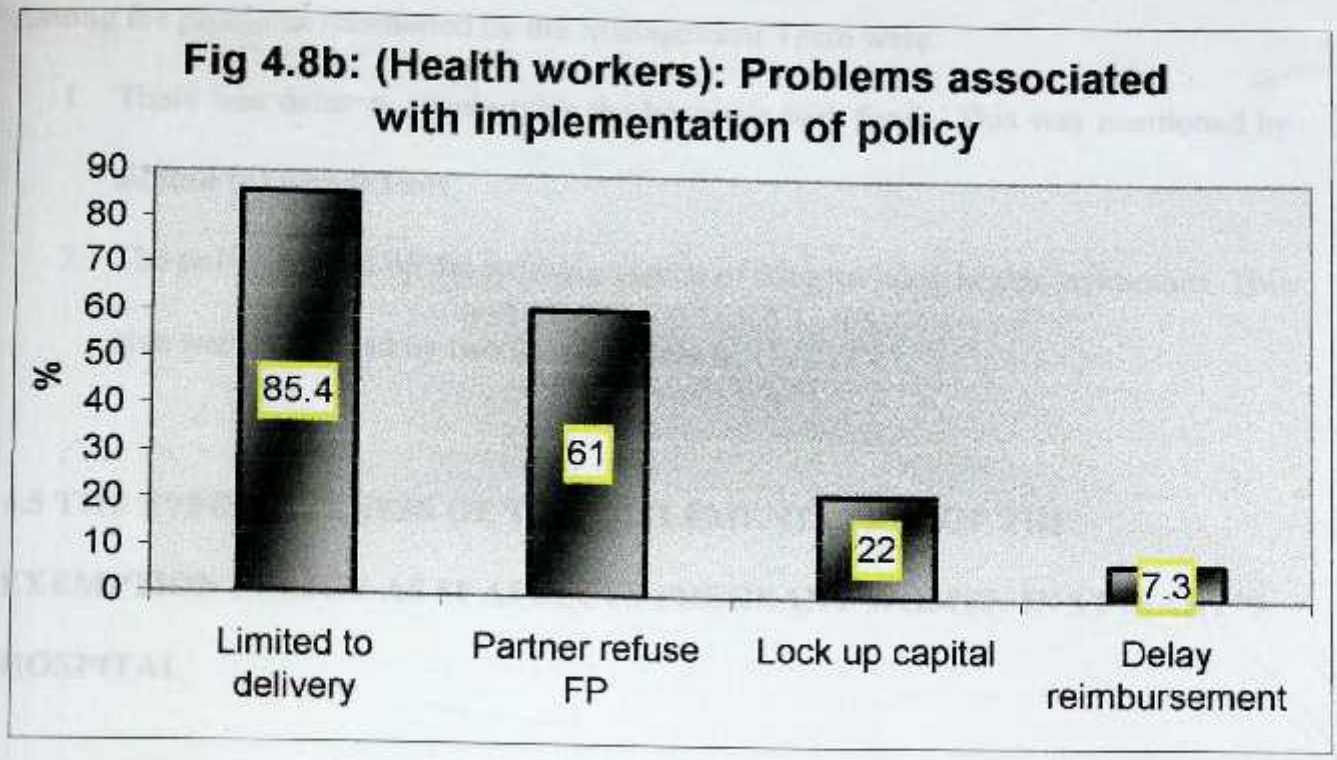
The most prominent problems mentioned by the pregnant women included the following:

i) Beneficiaries were charged with bills and payment was being enforced. This was mentioned by 98 (65.3%) respondents.]

ii) Inadequate public education was mentioned by 61 (40.7%) respondents.

iii) Some husbands refused family planning. This was mentioned by 9 (6%) respondents

iv) Exemption was limited to deliveries was mentioned by 9 (6%) respondents.



Source: Field work, 2005

The health workers mentioned the following problems.

i) Implementation of the policy was limited to delivery services. This was mentioned by 35 (85.4%) respondents.

ii) Some partner(s) refused family planning due to the policy. This also was mentioned by 25 (61%) respondents

iii) The policy locked-up the working capital of the providing health institutions was mentioned by 9 (22%) respondents.

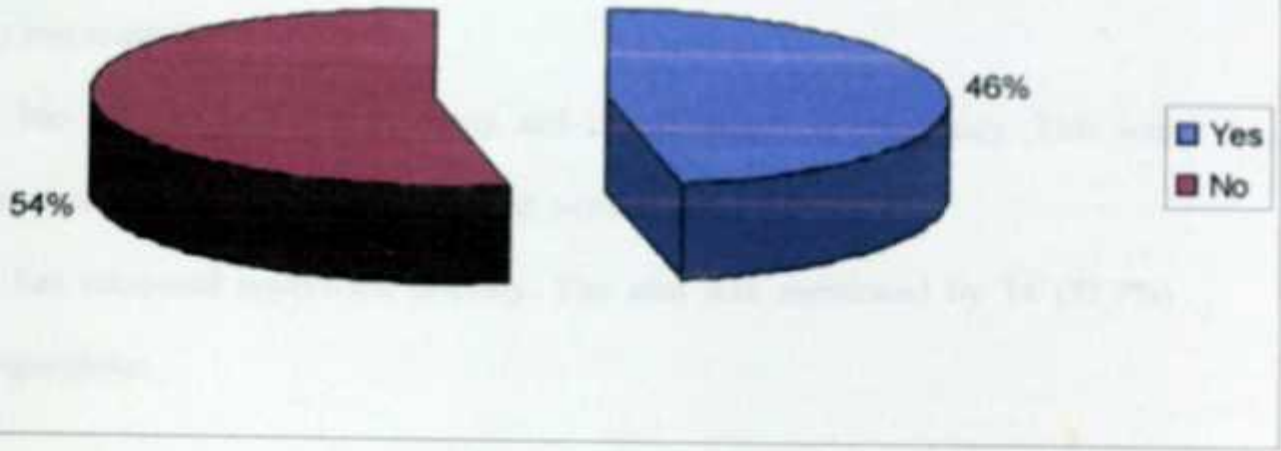
iv) There was delay in reimbursing providing health institutions with the exemption fund. This also was mentioned by 3 (7.3%) respondents.

Among the problems mentioned by the Management Team were:

1. There was delay in reimbursing the hospitals with funds. This was mentioned by all four (4) respondents.
2. The policy locked-up the working capital of the providing health institutions. This also was mentioned by two (2) respondents.

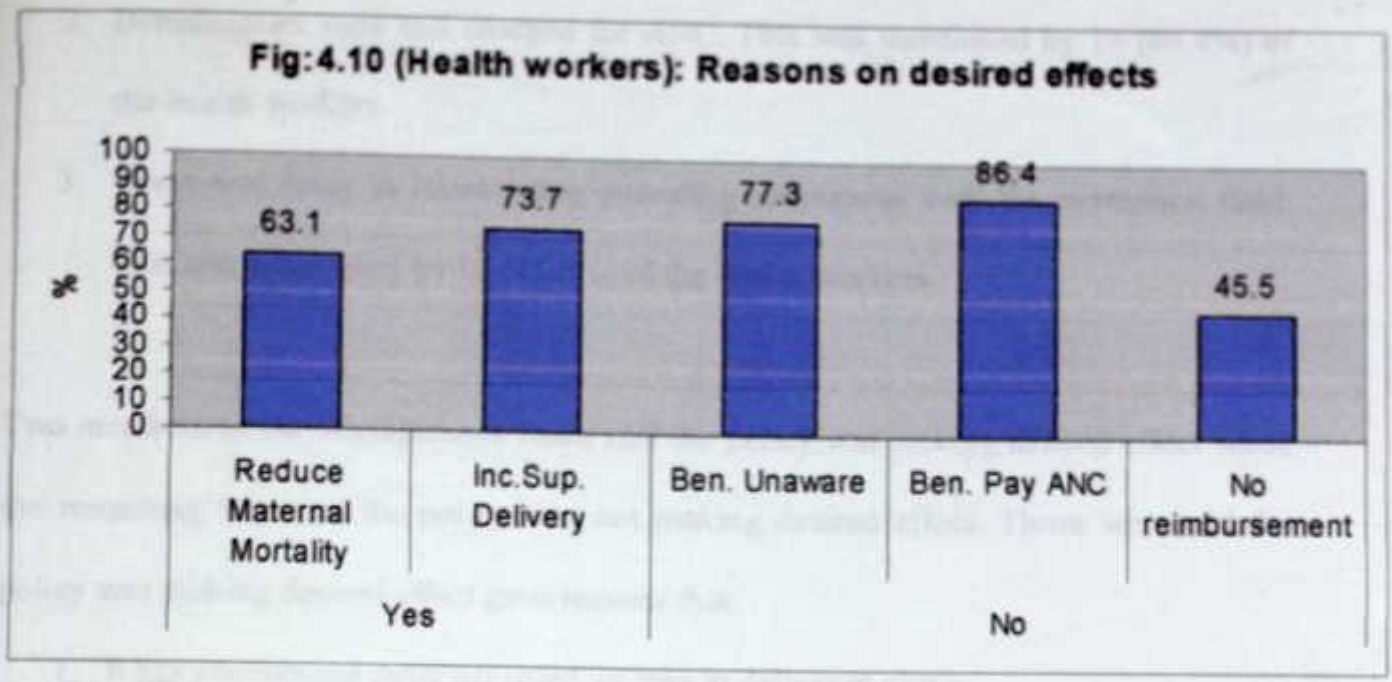
4.5 THE EFFECTIVENESS OF THE IMPLEMENTATION OF THE EXEMPTION POLICY AS IT AFFECTS PREGNANT WOMEN IN ST MARY'S HOSPITAL

Fig 4.9 (Health workers): Exemption making desired effects



Source: Field work, 2005

When respondents were asked whether they thought the exemption policy was having the desired effect, 22 (54%) said no while 19 (46%) said yes.



Source: Field work, 2005

Respondents who thought the policy was having the desired effect mentioned the following two reasons.

1. It has reduced maternal mortality and complications in pregnancy. This was mentioned by 12 (63.1%) of the health workers res.
2. It has increased supervised delivery. The also was mentioned by 14 (73.7%) respondents.

Respondents who thought the policy was not having the desired effect gave the following reasons:

1. Most beneficiaries were not aware of the details of the policy because of inadequate public education. This was mentioned by 17 (77.3%) of the health workers.

2. Beneficiaries were still charged for ANC. This was mentioned by 19 (86.4%) of the health workers.
3. There was delay in reimbursing providing institutions with the exemption fund. This was mentioned by 10 (45.5%) of the health workers.

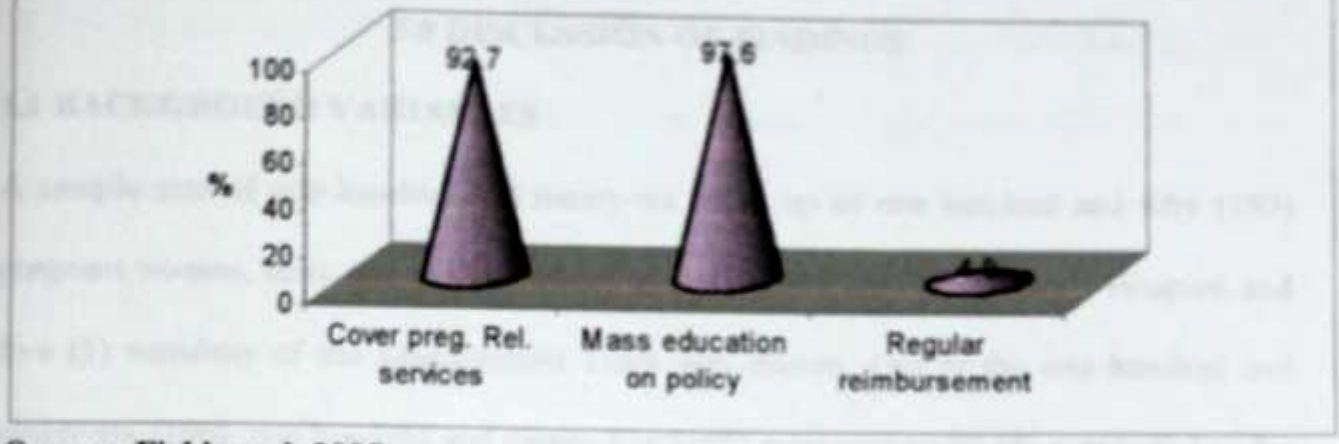
Two members of the Management Team said the policy was making desired effect while the remaining two said the policy was not making desired effect. Those who said the policy was making desired effect gave reasons that:

1. It has encouraged more pregnant women to deliver at clinic.
2. It has also reduced maternal mortality and pregnancy complications.

The members of the Management Team who said the policy was not making desired gave the following reasons:

1. Most pregnant women were not aware of the details of the policy because of inadequate public education.
2. Beneficiaries were still charged and payment was enforced.
3. Reimbursements were not made in good time.

Fig 4.11 (Health workers); How to improve implementation of the policy



Source: Field work 2005

On the question of how the implementation could be improved the following suggestions were given.

1. Exemptions should be extended to cover ANC services. This was mentioned by 38 (92.7%) respondents
2. There should be mass education to improve the knowledge of the pregnant women on the policy. This was also mentioned by 40 (97.6%) respondents.
3. Reimbursement should be made at appropriate time to the providing health institutions. This was again mentioned by 16 (39%) respondents.

The same suggestions were also made by the hospital management team.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 BACKGROUND VARIABLES

A sample size of one hundred and ninety-six made up of one hundred and fifty (150) pregnant women, forty-one (41) members of staff of the Drobo St Mary's Hospital and five (5) members of the Management Team was chosen. Out of the one hundred and ninety-six (196), one hundred and ninety-five (195) representing 99.5% responded to the administered questionnaire. One Management Team member failed to respond. The age of the pregnant women ranged from 15 years to 44 years with mean of 27.92 and the standard deviation of 7.26, and the mode of 27 years.

As many as 74.7% of the pregnant women were Christians while Moslems constituted 24.6%. Traditionalists formed only 0.7%. 31 (20.6%) had not delivered before. 100 (66.7%) had 1-4 children whilst 19(12.7%) had five children or more.

The dependant mean and mode were 2.44 and 2 respectively. The standard deviation was 1.86. Generally their education levels were low with (36%) of them having Secondary School education.4.7% had Post Secondary education, 28% had JSS/MID education while 15.3% and 16% had primary and no formal education respectively. In line with their education background, most of them were in the informal sector with 43.4% being farmers. 29.3% were traders, 12.7% were artisan while the remaining 14.7% constituted the others.

Six-five percent oft he health workers were females. Many of them (48.7%) were within the age group 30 -40 years. This gave the mean age group of the health professionals as 38.6 with a standard deviation of 7.20. 80.5% of the hospital staff interviewed had more than 5years working experience. This gave the average working experience of 9.4 years with SD of 7.12. The greater proportion (46.3%) had post Secondary and Tertiary Education.

Respondents were a cross section of all the health professionals and the auxiliary staff who saw the pregnant women on their visit to the ANC. Nurses formed (43.9%) of the total respondents.

The management team members were 3 males and 1 female. They had high educational background. 1post graduate, 2 graduates and 1 other post secondary.

They were all in the senior and managerial positions. Only one respondent has worked in the hospital for five months the rest had worked for more than two years in the hospital.

5.2 COMMUNICATION OF EXEMPTION POLICY TO BENEFICIARIES

On the questions pertaining to awareness and knowledge of the policy (71.3%) of the pregnant women said they had heard of the exemption policy and were able to mention at least one of the categories of people who were to be exempted, mainly the pregnant women. A greater proportion (37.6%) of them heard of the exemption policy through the two local FM radio stations, 30.8% heard of it from friends while 26% heard of it during their visit to ANC. This observation showed that the exemption policy has been communicated to the pregnant women.

In the case of the health workers, all the 41 (100%) respondents interviewed had some knowledge about the exemption policy. The management of the hospital was the source of information to (46.3%) of the respondents, 43.9% of the respondents had the information through seminar. Each of the respondents could mention at least one of the beneficiary groups.

Again the Management group responded positively to the question on the knowledge of the policy. They could mention at least two of the beneficiary groups. The good knowledge that the management and staff of the hospital had about the policy, goes contrary to the finding by Dakpallah et al (2002), that health providers in the mission health facilities had poor knowledge of the exemption policy.

5.3 CONTEXT OF IMPLEMENTATION OF EXEMPTION AT ST MARY'S HOSPITAL VIS A VIS THE NATIONAL POLICY

The questions to assess the context within which the policy was being implemented in the hospital, 95.1% of the hospital staff said yes exemptions were offered because pregnant women who came to deliver at St Mary's Hospital paid no fees. However 98% of the pregnant women said they were not exempted from ANC. According to the administrator of the hospital, Rev. Father Boakye Djan, pregnant women were only exempted from delivery but not ANC.

As to whether implementation was in line with the policy 77.5% of the health workers responded no while 22.5% said yes.

When the respondents were asked to give items on which exemptions were given, delivery had 100% responses from both the hospital staff and members of the Management Team, while ANC had 4.8% and 25% from hospital staff and members of the management team respectively. The question to know whether pregnant women had ever benefited in the last three years, 98% of the pregnant women said no while only 2% said yes. Among the 2% of the pregnant women who said yes as to whether they exempted them fully or not they said no. None of the respondents could tell the value of the exemption granted during the first and subsequent visit to the clinic. ANC financial records of the hospital indicated that 7.3% of the pregnant women had paid ¢ 38,000 on the first visit while 33.4% had paid less then ¢ 38,000 on their first visit. In the second or subsequent visits 67.3% had paid ¢ 18,000, 19.4% had paid between ¢ 18,000 to ¢ 26,000 while 13.3% had paid greater than ¢ 26,000. These charges were based on no other services than consultation basic laboratory services (hemoglobin estimation, sickle cell status, blood film for parasites and routine urine testing). This is contrary to the circular from the then Minister of Health (see appendix 4) which stated among other things that "the benefit package for antenatal will be limited to free consultation, free basic laboratory services (hemoglobin estimation, sickle cell status, blood film for parasites and routine urine testing). It is proposed that this should cover an average of four visits per pregnant women".

Following the Minister's Circular, an agreement was reached between the Brong Ahafo Regional Health Administration and the Regional branch of the Christian Health Association of Ghana (CHAG), that any pregnant woman who attended ANC should pay

¢8,300 and ¢ 3,600 for each first and subsequent visit respectively (see appendix 5). This agreement was reviewed on 1st June, 2001 to increase the exemption for the pregnant women to ¢ 18,300 and ¢ 7,100 for each first and subsequent visit respectively (see appendix 6).

However, there is no limitation to the number of visits per pregnant woman in the region and a beneficiary can access the fund as many times as she visits the ANC. This is contrary to the findings by Okyere-Mireku (2001) that in Kwahu Atibie hospital the pregnant women could access the fund for only four visits as stated in the circular from the then Minister of Health.

5.4 PROBLEMS IN THE IMPLEMENTATION OF EXEMPTION POLICY

With regard to how respondents perceived payment of ANC bill as a problem 74% said yes while 26% of the pregnant women said no. Given the chance to make choice as to which pregnancy related services should merit free care 64% of the pregnant women mentioned ANC, 29% mentioned caesarean-section while 7% said normal delivery. This means a greater proportion of the respondents saw payment of ANC bills as a problem. This has been confirmed by ANC attendance record at the hospital from 2002 to 2004 where attendance continued to reduce due to the increase in ANC bills for the pregnant women.

Inadequate public education, beneficiaries were still charged for ANC, exemption was limited to delivery were some the problems raised by the pregnant women. The health workers and management team also mentioned; exemption locked up working capital of

the providing health institutions, and delay in reimbursing health institutions with the exemption fund as some of the problems encountered in the implementation of the policy. Refund of exemption to the providing health institutions was not regular. This confirmed to the financial records of the hospital which indicated that out of the total exemption of ¢ 68.4m granted and submitted to Sunyani in 2002, only ¢ 40m was refunded. This was in respect of antenatal attendance of 6,882. As at 31st December 2002 the government was in five months arrears to the hospital to the tune of ¢28.1m. The situation in the Drobo District Health Administration was worse in terms of delay of refund. This confirmed the finding by Banka et al (2002) in the three northern regions that delay in the refund was hampering the smooth implementation of the exemption policy.

5.5 EFFECTIVENESS OF THE IMPLEMENTATION OF THE EXEMPTION POLICY AS IT AFFECTS PREGNANT WOMEN IN ST MARY'S HOSPITAL

On the question of whether or not the exemption policy is making desired effects 22 (54%) of the health workers and 2 of the management team members said no.

On the other hand 19 (46%) of the health workers and 2 of the management team members said yes.

The health workers who said no gave reasons that beneficiaries were not aware about the details of the exemption policy, most beneficiaries were made to pay for ANC while as 2 of the Management Team said there was lack of reimbursement. This confirmed that the policy, which was supposed to exempt the pregnant women from paying ANC bills, was not implemented in the St Mary's Hospital. However, both the health workers and the Management Team who said yes also based their reason on the fact that supervised

delivery has increased. This also confirmed that pregnant women were exempted from paying delivery fees. The variation in the implementation of the exemption from the original policy prompted the legal Resource Centre, a health for the poor campaign group, to sue the government for failing to implement the Hospital Fee Act, which exempts certain categories of Ghanaians from paying medical bills.

The writ was seeking the court to compel the government through the Ministry of Health (MOH) to exempt pregnant women, the elderly and children under fire years from paying medical fees (Ghanaian Times Thursday, January 23, 2003)

Assessing the effectiveness of the implementation of the exemption policy as it affects pregnant women in St Mary's Hospital within the context of national health exemption policy and agreement between the Brong Ahafo Regional Health Administration and the Regional branch of the Christian Health Association of Ghana then the policy has not made desired effect because the pregnant women were still charged for ANC.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

Health as a product is inevitably consumed by all manner of people either rich or poor. It therefore falls on the government to put in place some polices like the exemption to make health accessible to the poor and vulnerable.

The study revealed that the policy has been communicated to the health personnel and the target beneficiaries because 100% of the health personnel and 71%of the beneficiaries have head of the exemption policy. However there was a gap in communication between the St Mary's Hospital and the beneficiaries, as the beneficiaries did not know the details regarding the context within which the policy was implemented.

The study again revealed that the context within which the policy was implanted was not in line with the National Health Exemption Policy. Although exemptions were offered at St Mary's Hospital 98% of the beneficiaries had not benefited from it as it affected them in the past three years. Exemption was limited to delivery service ignoring ANC with percentages of 100% and 4.8% respectively. Averagely 56.3% and 63.3% of the beneficiaries had paid ¢ 38,000 and ¢ 18,000 in their first and second visit to ANC respectively.

The study revealed that 65% of the beneficiaries were still charged for ANC while 40% of the pregnant women were not having adequate public education as major problems

facing beneficiaries. There were also delay in reimbursement of fund to the providing health institutions, and the exemption was found to be limited to delivery services.

The study revealed that the implementation of the exemption policy as it affects pregnant women in St Mary's Hospital was not making desired effect, indicating 54%. This was because most beneficiaries did not know the details of the policy due to inadequate public education, most potential beneficiaries were still charged and payment was enforced and there was delay in reimbursing providing institutions with exemption fund. These had the percentages of 77.3%, 86.4% and 45.5% respectively.

The result of the study finally revealed that the people in Jaman District who access health in the Drobo St Mary's Hospital have not benefited fully from the exemption policy. Apart from pregnant women being charged for ANC all other categories of beneficiaries could not benefit from exemption facility in the St Mary's Hospital.

6.2 RECOMMENDATIONS.

6.2.1 HOPITIAL MANAGEMENT TEAM AND STAFF ROLE

1. Exemption should be extended to cover ANC and sick pregnant women. This should be done during ANC attendance and beneficiaries should be totally exempted from all bills. Implementation of this recommendation to some extent may avoid the situation where pregnant and sick pregnant women may delay in coming to hospital. This would improve maternal and child health status.
2. There is the need to bridge the gap in communication between Drobo St Mary's Hospital and the beneficiaries on the exemption policy implementations. This should be done through health education on the local FM radio stations at least

two times a month. Besides there is the need to display at the Out Patient Department (OPD) and the casualty Department, the details of the value of exemption to the pregnant women as well as what is exempted and what is not exempted. This may help both the pregnant women and health personnel to get in-depth knowledge about the exemption policy.

6.3 DISTRICTS AND REGIONAL HEALTH EXEMPTION COMMITTEE

3. Reimbursing the amount spent on exemption should be made regular to the providing health institutions. It should be done every four months within a year. The total bill together with the total attendance should be presented to the Committee for onward transmission to regional and finally national. Reimbursement should not take more than three months when the necessary document reached the head-office. This may reduce the financial constraints of the providing institutions and ensure continuity of the policy.
4. To make sure that the exemption policy is implemented in line with the national health exemption policy there should be regular follow-up by the Health Exemption Committee in the providing institutions. This should take the form of surveillance at least every six months. It may make it easier to detect early any variation in the implementation of the policy.

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QUESIONNAIRE FOR THE PREGNANT WOMEN

The study of the exemption policy as it affects pregnant women in the St Mary's Hospital in Jaman District.

The researcher is a student of the Department of Community Health, School of Medical Sciences, Kwame Nkrumah University of Science and Technology, who is conducting a research as part of the requirement for the award of a Masters degree in Health Education and Promotion. Your effort to provide the necessary information to the questions below will be highly appreciated. All information provided will be treated as strictly confidential and will be used for academic purposes only. Thank you for your expected co-operation.

Please indicate your answer with a tick (√) in the appropriate "box" and write where necessary

1. Age.....

2. Number of children already delivered

.....

3. Education background

a. No school [ ]

b. Primary [ ]

c. Middle/ JSS [ ]

d. Secondary [ ]

e Tertiary [ ]

4. Current employment /occupation

a. Farmer [ ]

b. Trader [ ]

c. Artisan [ ]

d. Unskilled labour [ ]

e other (specify) [ ]

5. Religion

a. Christian [ ] b. Moslem [ ] c. Traditional [ ] d. other (specify) [ ]

6. Have your heard about the exemption policy in the health delivery system of Ghana?

Yes [ ] No [ ]

7. If yes, how did you hear of the exemption policy for the first time?

a. Through the radio/Local FM [ ]

b. On visit to the hospital [ ]

c. From friend [ ]

d. On attending antenatal clinic (ANC) [ ]

e others (specify) [ ]

8. List the categories of persons covered by the exemption policy.....

.....

.....

.....

9. Have you ever benefited from this exemption policy as a pregnant woman in the last three?

Yes [ ] No [ ]

10. If yes, were you exempted in full for all visits?

Yes [ ] No [ ]

11. If No to question 10, what was (were) the limit(s)?

Visit	Limits
First Visit	.....
Subsequent Visit	.....

12. How much was your bill on your last visit?.....

.....

13. Do you consider payment for antenatal care (ANC) to be a problem?

Yes [ ] No [ ]

14. Given the chance to make a choice, which pregnancy related service will you consider the most important to merit free care (exemption)?

a. ANC [ ]

b. Normal delivery [ ]

c. Abnormal delivery [ ]

d. Others (specify) [ ]

15. List any major problems you see with the implementation of the exemption Policy

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16. Comment

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QUESTIONNAIRE FOR THE HEALTH WORKERS

The study of the exemption policy as it affects pregnant women in the St Mary's Hospital in Jaman District The researcher is a student of the Department of Community Health School of Medical Sciences, Kwame Nkrumah university of Science and Technology, who is conducting a research as part of the requirements for the award of a Masters degree in Health Education and Promotion. Your effort to provide the necessary information to the questions below will be highly appreciate. All information provided will be treated as strictly confidential and will be used for academic purposes only. Thank you for your expected co-operation.

Please indicate your answer with a tick (√) in the appropriate

"Box" and write the space provided where necessary.

1. Sex Male [ ] Female [ ]

2. Age.....

3. Marital Status

   a. Single [ ]

   b. Married [ ]

   c. Widowed [ ]

   d. Divorced [ ]

4. Education background

   a. Primary [ ]

   b. Middle/JSS [ ]

   c. Secondary [ ]

   d. Tertiary [ ]

5. Job title/grade.....

6. How long have you been working in the hospital .....

7. Do you know about the exemption policy in the health delivery system in Ghana?

Yes [ ] No [ ]

8. If yes to question (7) how did you know of it for the first time?

a. Regional Seminar [ ]

b. From the management [ ]

c. Self reading or research [ ]

d. Others (specify) [ ]

9. List the categories of persons covered by the exemption policy.....

.....

.....

.....

.....

10. How will you consider the awareness of the pregnant women about the policy?

a. Excellent [ ]

b. Very good [ ]

c. Good [ ]

d. Bad [ ]

11 What account for low attendance of antenatal care at the hospital?

12. Who is (are) responsible for creating and/ or maintaining awareness of the policy?

a. RDHS [ ]

b. DDHS [ ]

c. HMT [ ]

d. Community [ ]

13. Do you offer exemption for pregnant women at your health facility Yes [ ] No [ ]

14. If yes, does the context in which the exemptions are implemented in St Mary's Hospital in line with the policy document? Yes [ ] No [ ]

15. Give items on which pregnant women are exempted from:.....

16. Do you think the exemption policy is having the desire effects? Yes [ ] No [ ]

17. Give reason for your answer to question (16)

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18. What are some of the problems encountered in the implementation of the policy as it affects the pregnant women?

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19. How can the implementation of the policy be improved?

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20. comment

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QUESTIONNAIRE FOR THE HOSPITAL MANAGEMENT TEAM

The study of the exemption policy as it affects pregnant women in the St Mary's hospital in Jaman District researcher is a student of the Department of Community Health, school of Medical Sciences, Kwame Nkrumah University of Science and Technology, who is conducting a research as part of the requirements for the award of a master's degree in Health Education and Promotion. Your effort to provide the necessary information to the questions below will be highly appreciated. All information provided will be treated as strictly confidential and will be used for academic purposes only. Thank you for your expected co-operation.

Please indicate your answer with a tick (√) in the appropriate "box"

1. Sex Male [ ] Female [ ]
2. Education level [ ]
   a. Postgraduate [ ]
   b. Graduate [ ]
   c. Post secondary [ ]
3. Job title/ grade.....
4. How long have your been working in this hospital?.....
   .....
5. Do you know of the exemption policy in the health care delivery system in Ghana?
   Yes [ ] No [ ]

6. List the categories of persons covered by the exemption policy.....

.....

.....

7. What pregnancy related services(s) are covered by the policy?

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.....

8. What maximum number of visits per pregnant woman does the policy cover?.....

.....

.....

9. Above what bill may a pregnant woman be required to pay for the excess on:

i. First visit?.....

ii. Subsequent visit?.....

10. How aware are the health workers and the pregnant women on the policy?

Group	Excellent	Very good	Good	Bad
Health work				
Pregnant women				

11. Who is responsible for creating and maintaining awareness of the policy?

Group	RDHS	DDHS	HMT	Community
Health works				
Pregnant women				

12. Do you think the exemption policy is having the desire effect on pregnant woman?

Yes [ ] No [ ]

13. Give reasons for your answer to question 12

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14. List four problems encountered in the implementation of the exemption policy as it affects pregnant women

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15. How can the implementation of the policy be improved to assist the pregnant women?

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16. Comment.....

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APPENDIX 4

GUIDELINES ON USE OF GOVERNMENT [illegible] FOR EXEMPTED PATIENTS

1 As you are aware, Government is keen to reduce the [illegible] especially the needy, through exemption and subsidies in respect [illegible]

2 The Ministry has made a variety of consultations with [illegible] purchase of the necessary [illegible]

For this year, a modest amount of [illegible] has been allocated [illegible]

3 It has therefore been decided that [illegible] will be limited at ordinary health care facilities [illegible] hospitals in the public sector.

a The basket package for subsidies will be [illegible] free basic laboratory services [illegible] examination, sickness certificates, blood pressure and [illegible] that this should cover an average of 4 visits [illegible]

b The package for the aged [illegible] limited to [illegible] consultation, basic laboratory [illegible] drugs for acute illnesses.

c For children under five [illegible] at child welfare clinics. These will be [illegible]

4. Appendix A is a breakdown of the [illegible] the BMCs concerned and inform the office of the Minister [illegible] of the exercise.

As in the case of health workers [illegible] the BMCs [illegible] Expenditure under Appendix B

[illegible]
MINISTER OF HEALTH

cc: Deputy Ministers (2)
Deputy Minister (3)

Distribution

All Directors
Regional Directors
Medical Superintendents, Central Hospitals
District Directors
Heads of Institutions

APPENDIX 5

ase of reply
e number and the date of this letter
ould be quoted

MINISTRY OF HEALTH
P.O. BOX 145
Sunyani

Telephone: 061 - 70 79
Fax: 061 – 70 79
e-mail:moh-bar@africaonline.com.gh

REPUBLIC OF GHANA

14 June, 1999

Your Ref No.
Our Ref No. SG/12

RE – GUIDELINES ON GOVERNMENT BUDGETARY SUPPORT FOR PREGNANT WOMEN – AVAILABILITY OF FUNDS

As you may be aware the above facility which became operational in the Government Health Institutions and Wenchi Methodist Hospital, has been facing a lot of problems with implementation in the other Mission Institutions, because of disparities in prices. This came up strongly at the February, 1999, Annual Health Manager's Seminar.

A meeting involving the Regional Health Administration and Representatives of the Mission Institutions was held towards the middle of March, 1999, to resolve the problems encountered and agree on uniform rates, towards a smooth implementation of the exemption policy. The necessary arrangements have now been put in place to allow all Mission Hospitals in the Region to participate in the exemption policy.

The attached schedule of fees as agreed upon is published for your guidance. It also serves as a guide on standard services to be provided and the costs.

Also attached are copies of formats which are to be used for the claims, as well as summary sheets to facilitate your reports.

I am pleased to inform you that funds are now available for refunds of your bills and you are advised to start implementing the exemption for Pregnant women with effect from 1st July 1999. **Kindly adhere to the agreed fee levels till further notice.**

The claims can be submitted monthly, bimonthly or quarterly, depending on the amount involved in a total claim. DDHS and District Accountants are however advised to avoid unnecessary delays. Where a Hospitals claim is substantial you may forward that for settlement while compiling those of Sub-District Facilities.

I count on your cooperation and support to make this exercise a success.

DR. I. K. ASARE
REGIONAL DIR. OF HEALTH SERVICES

HEADS OF ALL HOSPITALS (MISSION AND GOVT)
ALL DDHS

CC REG. ACCOUNTANT, MOH, SUNYANI

Received
16/06/99

BRONG AHAFO REGIONAL HEALTH SERVI

SERVICES AND COSTS AGREED FOR REFUND:

BASIC TESTS	COST(GHC DIS)
Hb	1,000
Urine R/E	1,500
Stool	1,000
Grouping	1,000
Sickling	1,000
TOTAL	5,500

DRUG (For 1st Visit)	UNIT COST(GHC	AL COST DIS)
Fersolate	7	500
Folic Acid	3	100
Multivite	7	200
Chloroquine 4,4,2 then 2 weekly	20	400
		1,300

Urine Alb using Albustix = 500

First visit	
Service	Cost (Cedis)
Basic Lab Tests	5,500
Drugs	1,300
Consultation fee	1,000
ANC Card	500
TOTAL	8,300

Re-Visits	
Service	Cost (Ce
Lab Hb & Urine Alb with Albustix	1
Fersolate, FA & MV	
Chloroquine 2wkly x 4	
Consultation fee	1
TOTAL	3,0

The costs agreed as above are to be used for all claims for refunds with regards to ANC above for 1st and 2nd visits

DR I. K. ASARE
REGIONAL DIRECTOR OF HEALTH SERVICES

APPENDIX 6

In case of reply
the number and the date of this
letter
should be quoted

REGIONAL HEALTH ADMIN
GHANA HEALTH SERVICE
POST OFFICE BOX 145
SUNYANI-GHANA

June 8, 2001

REPUBLIC OF GHANA

My Ref No. G 2887/1
Your Ref No.

E-Mail Address:
Mohbar@africaonline.com.gh

Telephone: 061-27079/27120
/23400
Fax: 061 – 27079

ALL DISTRICT DIRECTORS OF HEALTH
HEADS OF HOSPITALS (CHAG & GOVT)
PRIVATE MAT HOMES

REVIEW OF ANC CHARGES UNDER THE EXEMPTIONS POLICY

The current fees charged for antenatal services in our institutions were set two years ago. Overtime, these fees were found to be highly inadequate to meet the cost recovery programme for these institutions.

It is for this reason that two meetings were held with the various stakeholders to fix new fees in line with the current economic trend.

Please find in the attached schedule the fees agreed on.

In fixing the fees the following were taken into consideration:

1. Antenatal cards will be issued to institutions from RHA to be given free to patients
2. For drug charges the mark up for Government institutions is 15% while that of the Chag institutions is 30%.

Also attached are decentralized Budget allocations to each district.

The institutional claims will be submitted to the various District Directors for refund.

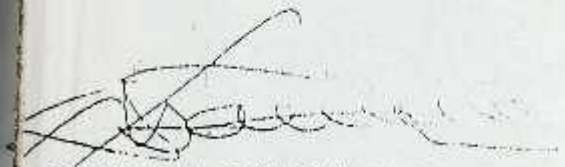
The Regional Monitoring team will [illegible] during its routine rounds to ensure smooth implementation of the programme.

The new charges take effect from [illegible]

(1)

If you have any difficulties do not hesitate to contact this office.

I count very much on your cooperation and support to make this exercise a success.



REGIONAL DIRECTOR OF HEALTH SERVICES
BRONG AHAFO REGION
(DR. I. K. ASARE)

cc: Regional Monitoring Team
Regional Internal Auditor
Ministry of Health
Sunyani

APPENDIX 7

Govt sued over Hospital Fees Act

By Norman Cooper

THE government was yesterday sued at an Accra High Court for failing to implement the Hospital Fees Act which exempts certain category of Ghanaians from paying medical bills.

The plaintiffs are the Legal Resource Centre, a health for the poor campaign group.

The writ is seeking the court to compel the government, through the Ministry of Health (MOH), to exempt pregnant women, the elderly and children under five years from paying medical fees.

The Centre has also petitioned the Commissioner for Human Rights and Administrative Justice (CHRAJ) to investigate an alleged human rights violation of a patient who was detained at the Ridge Hospital for his inability to pay ¢2.3 million as medical fees after he had been discharged.

At a news conference in Accra yesterday, the Field Co-ordinator of the Centre, Ms Nihad Swallah, quoted the Hospital Fees Act 387 of Act 1971, as providing exemption from medical fees for pregnant women, the elderly of 70 years and above, children under five years and paupers.

The exemption, she contended, was rarely ever enforced in the country's public hospitals and even if provided at all, the Ministry of Health often found it difficult reimbursing the public hospitals that provided such exemptions. Ms Swallah said that as a result, most poor people were denied medical treatment or chose not to seek medical treatment as they did not have the money to pay. The Centre cited Muhammed Zakari, 75, as a victim of human rights to health care.

Muhammed Zakari, a pauper, was allegedly detained at the Ridge

Cont. on Page 3, Col. 6

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Hospital Act

Contd. from Page 1, Col. 6

Hospital since December 12, last year until Tuesday.

Ms. Swallah also cited Danladi, who was shot by a soldier during a military-police patrol in April, last year but was denied exemption at the Korle Bu Teaching Hospital in Accra.

The Legal Resource Centre, she said, had embarked on the two legal actions at CHRAJ and the High Court with the aim to help improve the overall health of the poor.

Mr Zakari later recounted his experience at the Ridge Hospital where he underwent surgery and was asked to pay a medical bill of ¢2.3 million.

He said that it was only on Tuesday (January 21, 2003) that a philanthropist who heard of his plight, went to his rescue and paid the said amount that he was released.

to the source were the effect of the fuel price increase [illegible] and the need to have realistic wages and salaries.

The source was hopeful that the Technical Group, which begins work today, would come up with realistic and acceptable wages.

President

Contd. from Page 1, Col. 2

impact by sending a message to the world that, Africans were committed to taking responsibility for their own development.

He noted that peace, stability and security were prerequisites for economic and social development and said the goal of NEPAD could not be achieved without them.

President Mogae called for the deepening of democracy and respect for human rights, adding that, unemployment, lack of economic opportunities and abject poverty, were major determinants of insecurity.

The solution to these problems, he said required concerted and collective actions by Africans and non Africans alike.

STATISTICS FOR AGE AND NUMBER OF DEPENDANTS OF PREGNANT WOMEN

	Frequency (N=150)	Percentage (%)
Age group		
< 20yrs	22	14.7
20-24yrs	34	22.7
25-29yrs	37	24.7
30-34 yrs	26	17.3
35+yrs	31	20.6
Mean	*27.92*	
Median	*27.0*	
Mode	*27*	
Standard Deviation	*7.26*	
Minimum	*15*	
Maximum	*44*	
Dependants		
0	31	20.6
1-4	100 **54**	66.7
5+	19	12.7
Mean	*2.44*	
Median	*2.0*	
Mode	*2*	
Standard Deviation	*1.86*	
Minimum	*0*	
Maximum	*7*	

Source: Author, 2005.