

# Start-stop funding, its causes and consequences: a case study of the delivery exemptions policy in Ghana<sup>†</sup>

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## SUMMARY

This article looks at the issue of sustaining funding for a public programme through the case study of the delivery exemptions policy in Ghana. The Government of Ghana introduced the policy of exempting users from delivery fees in September 2003 in the four most deprived regions of the country, and in April 2005 it was extended to the remaining six regions in Ghana. The aim of the policy of free delivery care was to reduce financial barriers to using maternity services. Using materials from key informant interviews at national and local levels in 2005, the article examines how the policy has been implemented and what the main constraints have been, as perceived by different actors in the health system. The interviews show that despite being a high-profile public policy and achieving positive results, the delivery exemptions policy quickly ran into implementation problems caused by inadequate funding. They suggest that facility and district managers bear the brunt of the damage that is caused when benefits that have been promised to the public cannot be delivered. There can be knock-on effects on other public programmes too.

Despite these problems, start-stop funding and under-funding of public programmes is more the norm than the exception. Some of the factors causing erratic funding—such as party politics and intersectoral haggling over resources—are unavoidable, but others, such as communication and management failures can and should be addressed. Copyright © 2007 John Wiley & Sons, Ltd.

**KEY WORDS:** sustainability; funding; exemptions; deliveries; Ghana

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## INTRODUCTION

Sustainability has long been a mantra in development circles, but public funding for programmes is insecure, both in developing countries and in the West. In Britain, for example the current government is criticized for starting a plethora of initiatives without adequate follow-through. The syndrome of starting programmes without planning for their long-term financial viability is not, therefore, confined to low-income countries, but is more acute in the context of very limited public funds.

This article looks at the issue of sustaining funding for a public programme through the case study of the delivery exemptions policy that was introduced in Ghana in 2003. Using materials from key informant interviews, it examines why this 'short-termism' occurs and the impact that it has on different actors in the health system. The themes that are drawn out here are likely to be of wider international relevance.

## BACKGROUND

The Government of Ghana introduced the policy of exempting users from delivery fees in September 2003 in the four most deprived regions of the country, and in April 2005 it was extended to the remaining six regions in Ghana. The aim of the policy of free delivery care was to reduce the financial barriers to using maternity services. It was expected that this would lead to a reduction in maternal and perinatal mortality, as well as contributing to poverty reduction (Ministry of Health, 2004a).

One of the Millennium Development Goals is to reduce maternal mortality by three-quarters by 2015 (<http://www.un.org/millenniumgoals/>). So far, relatively little progress has been made, and donors and governments are looking for cost-effective and sustainable approaches which can reduce maternal mortality. One of the main challenges here is increasing the proportion of women who deliver with a skilled attendant. This is a key component of the Safe Motherhood Initiative (<http://www.safemotherhood.org/>). Ghana has a persistently high maternal mortality rate and growing social inequalities, with rates of skilled attendance either stagnant or declining for poorer women (Graham, 2004). While financial barriers are only one of the constraints to seeking skilled care during deliveries, they are believed to be one of the most important factors (UNFPA/MoH, 2004).

The exemptions policy was funded through the Highly Indebted Poor Country (HIPC) debt relief funds, which were channelled to the districts<sup>1</sup> to reimburse facilities—both public and private—according to the number of deliveries that they performed each month. A tariff was approved by the Ministry of Health that set reimbursement rates according to the type of delivery (such as 'normal', 'assisted delivery' or 'caesarean section') and the facility type (mission and private facilities are reimbursed at a higher rate, in recognition of the fact that they are not in receipt of

<sup>1</sup>The local political authority was used at first but later funds were transferred through the Ghana Health Service.

public subsidies) (Ministry of Health, 2004a). Apart from the costs of reaching facilities, women are supposed to face no direct costs for their deliveries.

Initiative for Maternal Mortality Programme Assessment (IMMPACT) is a global research initiative that seeks to strengthen the evidence base for policy decision-makers on cost-effective intervention strategies to reduce maternal mortality. IMMPACT has been working in partnership with local stakeholders to identify and evaluate strategies with potential to significantly reduce maternal and perinatal mortality. In Ghana, the government policy of providing free deliveries for all women was selected for evaluation. The aim of the overall IMMPACT evaluation was to assess how the free delivery policy has affected utilization, quality of services and health and non-health outcomes for households (especially poorer households) (Noguchi Institute and IMMPACT, 2005).

## METHODS

This article is based on the first stage of IMMPACT research, in which key informant interviews were conducted in Central and Volta Regions and at national level in October and November 2005 (Witter et al., 2005). The study is a qualitative one using an in-depth method of interview. The aim was to establish the state of implementation of the exemption policy for deliveries and to seek the views of some key stakeholders. This would inform the next stage of the evaluation research.

The regions were chosen to reflect the experiences of the first regions to join the delivery exemption scheme (Central) and that of the more recent wave (Volta). Within each region, six focus districts were chosen, matched for characteristics such as population size, poverty status, urban profile and health infrastructure (Noguchi Institute and IMMPACT, 2005).

The 65 key informants were chosen purposively based on their roles and level of the health system at which they operate (see Table 1). They included national policy-makers, representatives of regional and district health authorities, representatives of the District Assemblies through which the funds had been channelled (in Central Region), and a sample of facility heads. The facilities were selected to represent each of the six focus districts and also to cover a range of types of facilities.

A team of four researchers carried out the interviews using an open-ended question check list. The questions were varied by level of interviewee. At the national level, the focus was on perceptions of the programme, its successes and failures, implementation issues, allocation of resources, disbursement mechanisms, sustainability and future funding options, degree of priority which the programme should receive, impact on services and staff, interaction with health insurance in future and suggestions for future changes.

At regional level, these questions were supplemented with more detailed probing about the process of establishing the programme, how it is currently being implemented, the adequacy of funding, degree of dissemination in the community and impact on quality of services.

At district and facility levels, questions were added about dates of operation, whether patients were making contributions of any kind, delays in funding, whether

Table 1. Summary of key informants

Level	Category	Number
National level KI	Ministry of Health	3
	Ghana Health Service	3
	Donors	2
	Mission sector	1
Regional KI	Regional directors of health services, deputies and Senior Medical Officers	4
	Regional hospital directors and administrators	2
	Regional accountants	1
	TOTAL	7
District KI	District Director of Health Services and senior public health staff	17
	District Assembly staff and accountants	16
	TOTAL	33
Facility KI	In-charges, matrons and senior facility staff	16
Total	National level	9
	Central Region	24
	Volta	30
	Overall	65

funding is ring-fenced, appropriateness of reimbursement tariffs, how it has affected defaulter and referral rates, whether reimbursement covers loss of user fee income, whether revenue is shared with staff in facilities, impact on private midwives and traditional birth attendants, how cumbersome the scheme is to manage and other programmes in the district which might affect supervised delivery rates.

The responses were analyzed by topic, level and region and presented, initially in an internal report for IMMPACT (Witter et al., 2005) and then in a policy brief (PHS work programme, 2005).

## MAIN FINDINGS

In Central Region, the policy had been in place for just under 2 years, whereas in Volta, it had only been operational for 6 months. In both cases, implementation had been fairly smooth, and key informants were positive about the policy, seeing it as an effective approach to an important problem.

‘It was the right policy. It was good to exempt deliveries’ (national KI)

Utilization was reported to have risen by between 20% and 500% in different facilities and facility managers reported that women were presenting earlier and that they were, therefore, better able to manage any complications. They perceived the policy to have had a positive effect on maternal mortality and other indicators, such as postnatal coverage.

‘Was it successful? It did raise supervised delivery coverage’ (national KI)

In Central Region, quality was reported to have improved as a result of the policy, mainly because funds were received regularly and in bulk, which from a facility perspective was far preferable to chasing individual women for payment and having to accept a certain proportion of defaulters. When the programme was funded, it improved the availability of funds for drugs and supplies. In Volta, the short life of the programme so far meant that no change in quality was noted.

The main constraint, and one which was causing a crisis of confidence in the policy, was the shortfall and unpredictability of funding.

‘The exemption scheme was a politician’s whim, to please the people, with no thought for sustainability’ (district KI)

‘The whole design was poor from the beginning: they didn’t ask the regions how much they needed. We in the region developed our own criteria, based on past utilisation, but we have never received any funds since then’ (regional KI)

However the argument from the Ministry of Health’s perspective is that when they started the programme they had every reason to believe that HIPC funds would continue to be available to fund the programme.

Why didn’t we foresee these problems? We were optimistic and there was a strong political element. HIPC funds were there, and the donors were eager. At that time, there was no sense of resource constraints’ (national KI)

‘It is now threatened by the flow of funds and adverse changes in the financial environment’ (National level KI)

In Central Region, the first funds were received from the District Assemblies in early 2004. It was not clear how long the funds were supposed to last or when the next allocation would come. Districts started to run out of funds to reimburse facilities towards the end of the year, but managed to continue the scheme until the second instalment in February 2005, which arrived via the Ghana Health Service. This time, funds ran out more quickly as there were already outstanding debts to facilities to be repaid. By mid-year, some districts had exhausted the funds and were starting to charge clients again. At the time of the key informant interviews, in October, three of the districts visited had run out of funds in the previous few months, and the other three were on the verge of running out.

In Volta, the experience was shorter, but similar. The delivery exemptions had started in April–June 2005, but funds had already run out in the majority of districts by October, and managers were again unsure of whether or when they would get any more. At the time of the interviews, staff reported that deliveries were still free, but it would not be surprising if some facilities had started to charge again, given the irregularity of reimbursement, as reported by them.

‘It is a laudable policy, but our credibility is on the line. If you are going to start it, only to stop on the way, then the earlier you stop it, the better’ (district KI)

Rough calculations suggest that the funding which was received was adequate for 6 months, but only one allocation was received in the whole year. Finance officers at the national level must have known that allocations would not be adequate.

‘The national level pretends it doesn’t know that the lower levels are in trouble, as it doesn’t have any additional funding’ (donor KI)

This was having negative effects at all levels of the system. Patients, having been told they would receive free services, were angry when they are asked to pay, and suspected staff of misusing the funds whilst staff in facilities wondered if the funds had been siphoned off higher up the system.

‘It is difficult to charge now, as people will think you are cheating them. But what do I do when I have no drugs left?’ (facility KI)

Facility managers worried about the build up of debts (deliveries are costly and used to provide substantial revenue for the facilities).

‘My only problem is getting money for services rendered’ (facility KI)

District staff were trying to keep the facilities happy, while hoping that further funds or even communication about funds would come. Regional directors were writing letters to the national level, requesting further funds, but were in the dark as to whether any would arrive. Debts to medical stores were building up.

The confidence of the private and mission providers in government schemes was reported to be eroding, which may also affect future schemes, such as health insurance.

‘Health insurance is facing similar problems to exemptions. The local levels are struggling to make it real, without any proper support from the national level’ (donor KI)

General cynicism was growing, particularly given that this came on top of on-going problems with other exemptions schemes, such as under-5s and ante-natal care, which were heavily in arrears and had been problematic for years (Garshong *et al.*, 2001).

‘It can end up like the other policies, whereby the first two or three chunks of money come, and later it takes years’ (facility KI)

## DISCUSSION

The delivery exemptions programme was a high-profile national programme, which had raised the expectations of the public and the donor community. The fact that it was selected for evaluation by IMMPACT shows the importance attached to it by government stakeholders too. Why then was it allowed to run out of funds (or at

minimum—if funding resumes—to face inadequate and uneven funding) after such a short life-span? After all, most stakeholders would agree that the goal of reducing maternal mortality is one that requires a long-term effort. Five main explanatory factors are suggested below, based on the context in Ghana, but common in many other environments too.

#### *Unpredictable financial environment*

The general problem facing policy makers in many countries is that the financial environment is unstable and unpredictable, and flexible money for new activities is rare. Although common basket funders provide a more predictable source of donor funding, most of this is committed to core health system activities, and so cannot be reallocated. Non-basket donors are less predictable and make commitments that they often do not keep. It is estimated that the Government of Ghana gets an average of 60% of committed aid (MOH, 1999). Planning services in this environment is not easy.

In this case, the HIPC fund allocations, which are controlled by the Ministry of Finance, were cut for the health sector in 2005, partly because contributions from formal sector workers for the National Health Insurance fund were beginning to build up, and the health sector was, therefore, not seen as a priority for additional resources. (These funds are earmarked though, and so do not represent flexible funds that can be used by the Ministry.)

#### *Competing policies*

It is also common for competing policies to be established more or less at the same time, partly because of uncertainty about their timing and success rate. An example of this is the timing of the delivery exemption policy, which has been introduced alongside the development of national health insurance in Ghana. The aim of NHI was to provide cover for all services currently provided by public facilities in Ghana, including delivery care. Once established and successful, there would be no need for both policies.

However, NHI takes a long time to establish—it was initiated originally in 2002 (Ministry of Health, 2004b) and has only just been launched formally, late in 2005. Coverage is still low—an estimated 15–20% nationally. While it is being developed, delivery exemptions are still needed as an important source of financial relief for women and their households. However, funding for the policy has been undermined by unrealistic expectations of the arrival and widespread coverage of health insurance. It is hard to argue for budget allocations for delivery exemptions when each year there is an expectation that health insurance will finally materialize and take over the burden of providing coverage for the poor.

#### *Different interests and perspectives*

It became clear in the key informant interviews that officials at different levels of the health system have very different perspectives and face different incentives.

At national level, policy-makers have an incentive to come up with new initiatives that will generate public approval for the government and will attract donor interest and funding. They are, therefore, innovators and risk-takers by trade, rather than having to worry about practical implementation issues, which are generally muffled at grassroots level by the poor communication up and down the hierarchy.

District managers and facility in-charges are on the whole more conservative, as they face the practical costs of failure. They have a more hard-headed view, based on experiences of broken promises.

From the top, there is a cynicism about the entrepreneurial behaviour of facility managers. They are seen as profit-maximizers, raking in subsidies and user fee income ('internally generated funds', as they are called in Ghana) and other funding, such as for the free delivery programme, while failing to make sacrifices for pro-poor public policies.

At lower levels, there is jealousy of national officials, who are seen as prime beneficiaries of such resources as are available, in terms of funds and knowledge.

### *Communication and management failures*

Researchers found that health staff at regional, district and facility levels were completely uninformed about the flow of resources for this programme, which made it hard for them to make appropriate decisions. If there are funding problems at national level, they should be informed. Similarly, they need to be informed how long funds are expected to last, so that they can manage them appropriately. Managers were also unaware of how the programme was expected to dovetail with the new health insurance programme, due to be launched at the end of 2005. In this respect, the situation at regional level does not appear to have improved since 1992, when a study concluded that 'management at regional, district and facility level worked in a highly constrained environment of uncertainty, mistrust, limited power and frustration' (Waddington, 1992).

If information is not flowing down reliably, it is also not flowing up. Managers at regional level and above were not aware of the financial state of the programme—for example, whether districts were still holding funds and able to make reimbursements for deliveries or not. This kind of information should be routine monitoring data, but the familiar combination of poor systems, overburdened staff, fragmented programmes and lack of funds for transport mean that managers have to rely on externally funded evaluations to provide them with basic information, such as whether a programme is fully operational or not. This contributes to erratic programming.

Even horizontal information flows have been problematic. Better communication between the Ministry of Health and the Ministry of Finance might have been able to identify some sources of additional funds to rescue the programme in mid-year. Similarly, donors have expressed surprise that they were not approached by the Ministry with requests for additional funds for a programme on which they had placed a high emphasis.

Although national guidelines were issued in 2004 for the delivery exemptions, there was no written plan for how long the programme would continue, how much it

would cost or where the funds would come from. Similarly, although the guidelines included a demand for regular reporting from the districts, there has been very little support or supervision of implementation, and at the national level, there is no data available about how the policy has been interpreted, how funds have been disbursed, and how many deliveries have been exempted.

*Multiple agencies: the 'no blame game'*

In Ghana, as in most countries, there are many organisations involved in the health system and many channels of funding, which fudges the lines of responsibility for a particular programme and reduces the likelihood of it being closely supervised and managed. Each agency can blame the other and not take direct responsibility. For example, the Ministry of Health can blame the Ministry of Finance for not releasing enough money. The mission sector can blame the Ministry of Health for not informing it of the release of funds and how they were to be used. The Ghana Health Service can blame the district assemblies for sitting on funds. If district mutual health insurance organisations take over the operation of exemptions, as is currently under discussion, then much of the blame will no doubt be deflected onto them.

While there is much literature on defining, measuring and evaluating sustainability (LaFond, 1995, for example), and on general underlying factors such as health financing trends (World Bank, 2006), there are few studies which consider why individual programmes are sustained or not and the effects of intermittent and unpredictable funding. The Ghana case study demonstrates that what is irrational from a societal point of view can arise from the rational interests of different actors in the system as well as from organisational culture.

## CONCLUSIONS

The key informant interviews suggest that the free delivery policy in Ghana was not just 'a politician's whim'. It was an appropriate response to the low supervised delivery rates and high maternal mortality in Ghana, and one which commanded support from communities and health staff. Despite that, it has run into serious implementation problems due to inadequate funding. The funding problems reflect real resource constraints, but also avoidable management failures.

Although this is only one case study, the situation that is described here is familiar to policy-makers in many developing countries and to a lesser extent in developed countries too. It is so common for initiatives to start and then stop when funding is removed that this situation is regarded as normal. However, the result of the factors described here is highly sub-optimal policy-making. The start-up costs and the loss of government credibility when a high-profile public programme 'fails' mean that it is not sensible to start a programme which may only have funding for a short period. The costs of starting and abruptly stopping implementation are very real at the local level, and in terms of 'social capital', and national level decision-makers should recognise this.

Where these factors can be tackled, that should be a priority. For example, there have already been a number of changes to the way that aid is delivered which increase its predictability and usability for governments (Foster *et al.*, 2000). These should be extended. Similarly, longer-term budgeting has been introduced into many national planning exercises, and this should be used to develop realistic funding plans for new ventures. The issue of competing policies is linked to some extent with unpredictable financing: it is rational, if you are not sure how different 'pots' of money will progress, to bid for activities funded from different sources, so that some at least will survive. Improving financial planning and predictability should reduce conflicting policies. Improved communication within the health system would also help greatly in allowing feedback to policy-makers and the fine-tuning of policies. Management systems for supervising and monitoring implementation can be simplified and strengthened, with clearer lines of responsibility laid down for tracking the progress of new initiatives.

Some things never change—party politics, unforeseen circumstances and haggling between sectoral priorities, for example, cannot be abolished, nor is it unnatural that stakeholders at different levels face different pressures and play different roles. However, some of the factors favouring instability can and should be mitigated. An active media can also play its role in following up on some of the high-profile initiatives that politicians launch and then forget.

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