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Why "free maternal healthcare" is not entirely free in Ghana: a qualitative exploration of the role of street-level bureaucratic power

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Abstract

Background Ghana introduced a free maternal healthcare policy within its National Health Insurance Scheme (NHIS) in 2008 to remove financial barriers to accessing maternal health services. Despite this policy, evidence suggests that women incur substantial out-of-pocket (OOP) payments for maternal health care. This study explores the underlying reasons for these persistent out-of-pocket payments within the context of Ghana's free maternal healthcare policy.

Methods Cross-sectional qualitative data were collected through interviews with a purposive sample of 14 mothers and 8 healthcare providers/administrators in two regions of Ghana between May and September 2022. All interviews were audio-recorded, transcribed and imported into the NVivo 14.0 software for analysis. An iteratively developed codebook guided the coding process. Our thematic data analysis followed the Attride-Sterling framework for network analysis, identifying basic, organising themes and global themes.

Results We found that health systems and demand-side factors are responsible for the persistence of OOP payments despite the existence of the free maternal healthcare policy in Ghana. Reasons for these payments arose from health systems factors, particularly, NHIS structural issues – delayed and insufficient reimbursements, inadequate NHIS benefit coverage, stockouts and supply chain challenges and demand-side factors – mothers' lack of education about the NHIS benefit package, and passing of cost onto patients. Due to structural and system level challenges, healthcare providers, exercising their street-level bureaucratic power, have partly repackaged the policy, enabling the persistence of out-of-pocket payments for maternal healthcare.

Conclusions Urgent measures are required to address the structural and administrative issues confronting Ghana's free maternal health policy; otherwise, Ghana may not achieve the sustainable development goals targets on maternal and child health.

Keywords Out-of-pocket payments, Maternal healthcare, National Health Insurance Scheme, Street-level bureaucrats, Ghana

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Background

The Sustainable Development Goals (SDGs) prioritize reducing maternal mortality and ending preventable deaths of newborns and children under 5 years by the year 2030 [1, 2]. Even so, financial barriers to accessing essential maternal and child healthcare services continue to hinder global and national progress in reducing maternal and child mortality and morbidity [3, 4]. Removing these financial barriers, particularly out-of-pocket (OOP) payments and ensuring universal health coverage for maternal healthcare, are some of the surest ways to achieve these health outcomes [5, 6]. Consequently, in 2008, Ghana implemented a free maternal care (FMC) policy under its National Health Insurance Scheme (NHIS), aiming to remove financial barriers to accessing maternal and newborn healthcare services [7, 8]. The FMC offers free healthcare to pregnant women from conception through 6 weeks after delivery to women enrolled in the NHIS or enrolled during their pregnancies, while their newborns are covered for 90 days after birth [8, 9]. The FMC policy covers all general services listed under the NHIS benefit package including consultations, hospitalization and laboratory tests and medications during pregnancy, labour, birth (including caesarean sections) and up to 3 months postpartum. However, it excludes transportation services such as ambulance service and other related incidentals [8].

Even though evidence shows that Ghana's NHIS has contributed to reducing OOP payments for primary healthcare in public health facilities, substantial OOP payments still exist [10]. Dalinjong et al. [7, 9, 11] report that women are still making OOP payments for maternal healthcare services and that it is unclear whether the FMC policy has significantly altered OOP payments for maternal healthcare services. Our recent quantitative study within the Ashanti and Upper West regions of Ghana also confirmed the persistence of OOP payments for maternal-related medical and non-medical services including supplies [12].

This study aimed to explore the underlying reasons for the persistence of OOP payments for maternal healthcare services in both rural and urban Ghana. Unlike previous research which primarily focused on the prevalence of such payments, this study delves deeper to uncover the factors contributing to these expenses. For example, Kumbeni et al. [13] reported a high prevalence of OOP payment among women who sought skilled delivery in public health facilities in Ghana, even though these women had active health insurance cards, and that one out of every five pregnant women made OOP payments during skilled delivery. Building on these affordances, our study provides critical insights into the factors influencing OOP payments for maternal healthcare by collecting empirical qualitative data from mothers accessing these services in both rural and urban areas, and from both public and private facilities, as well as including accounts from healthcare providers. We believe that data from these diverse groups provide a rich source of evidence that highlights the disconnection between policy formulation and implementation, and may ultimately guide mechanisms for improving policy-making and practice. The disconnection between policy formulation and implementation is perhaps appropriately explained by the street-level bureaucratic theory [14].

Street-level bureaucrats (SLBs) are frontline lower-ranking employees of public services who have autonomy and some degree of discretion to determine actual policy [15, 16]. According to Lipsky [14], SLBs are "public service workers who interact directly with citizens in the course of their jobs and who have substantial discretion in executing their work". Workers such as teachers, nurses, doctors and health administrators may fall into this category. It is argued that these SLBs should be considered policy-makers instead of policy implementers because policy reform remains on paper until the SLBs have delivered it to the citizens [14]. When policy reform is delivered to citizens, it is often in the form that the SLBs want the citizens to see it. For this reason, actual policy can be distorted due to the substantial discretion that SLBs have in executing their daily operations. Rice [17] elucidates this point, suggesting that SLBs are the last link in the policy-making chain because it is in the interaction between SLBs and clients that formal social policy comes to life. One major factor that influences this discretionary behaviour of SLBS is the organizational context that sets the goals, rules, budgetary and time resources for bureaucratic action [14]. In consonance with organizational context, specifically with reference to budgetary and time resources, our study explores the extent to which SLBs influenced the successes or otherwise of Ghana's FMC policy implementation [18]. Importantly, this study is very relevant now because it promises to provide a fertile ground for the ongoing health system reforms in Ghana, especially in the area of healthcare financing and maternal healthcare services. By providing a deep understanding of the factors influencing OOP payments, this research offers valuable insights for policy-makers and healthcare providers striving to achieve universal health coverage. The findings can inform evidence-based strategies to reduce the financial burden of healthcare on individuals and families, improve access to quality maternal healthcare and strengthen the overall health system.

Methods

Study setting

The study was conducted in the Ashanti Regional capital (Kumasi) and the Upper West Regional capital (Wa) in Ghana between May and September 2022. The Ashanti Region is located in southern Ghana. It is the second most urbanized and prosperous region in the country, while the Upper West Region is located in the northwestern corner of Ghana and is one of the least urbanized and among the poorest regions of Ghana [19]. As of 2020, the Ashanti Region also had the highest active NHIS membership of 2.2 million, while the Upper West region had the lowest active membership of 0.47 million [20]. The choice of the study sites was motivated by the fact that these two areas represent a balance of a relatively prosperous urban setting and a poor rural setting to provide diverse perspectives for this exploratory research.

The Ghana Health Service, under the leadership of its Director General and Council, oversees the management of all public health facilities in Ghana, excluding teaching and military hospitals [21]. Ghana employs a decentralized health system with 16 regional teams led by directors. Regions are divided into districts, each managed by a director accountable to the regional health director. Districts are further split into sub-districts overseeing community-based health services [21]. The National Health Insurance Authority (NHIA) is in charge of managing the NHIS, including granting credentials to healthcare providers and facilities that provide healthcare services to members of NHIS, registering and supervising private health insurance schemes and ensuring the collection of premiums and payment of insurance claims to healthcare providers. Both the Ghana Health Service and the NHIA function under the Ministry of Health, which provides strategic, policy and administrative oversight. In operationalizing the FMC, all pregnant women are exempted from paying annual health insurance premiums or contributions. All maternal healthcare related services – antenatal care, delivery and postnatal care – are to be provided free of charge to mothers at all NHIS accredited health facilities, both private and public.

Study design

This study deployed a cross-sectional exploratory qualitative research design. This study design was chosen because it facilitated the exploration of various perspectives and experiences of mothers, health administrators and service providers regarding the FMC policy. In particular, this research design enhances a comprehensive understanding of the phenomenon under investigation – reasons for OOP payments in the presence of the FMC – and thus was suitable for contributing to the improvement of research outcomes.

Target population and sampling procedure

The target population for the study consisted of mothers who had recently delivered and in their post-partum period who reported making OOP payments during their period of maternal care seeking, and healthcare providers and administrators drawn from four purposively chosen health facilities (two public, two private) in the Ashanti and Upper West regions. Government and private health facilities were selected to maximize the diversity in the responses. Facility names have been replaced as follows: Upper West Public, Upper West Private, Ashanti Public and Ashanti Private to satisfy the ethical condition of anonymity. Mothers attending post-natal care at each facility and managers (providers and administrators) of these facilities were purposively selected. Specifically, out of the women incurring OOP payments, purposive sampling with maximum variation carried out [22, 23]. According to Benoot et al. [22], purposive sampling with maximum variation helps identify how cases vary from each other, as well as in high-quality detailed descriptions of each case, which are useful for documenting uniqueness and important shared patterns that cut across cases because of their heterogeneity. For this reason, we used purposive sampling with maximum variation to enable us establish and document any patterns and uniquenesses within and across cases to reflect the rural/urban and north/south dynamics in our study context. Healthcare providers were nurses or midwives who directly provided healthcare services to maternal healthcare seekers.

In addition to mothers, facility administrators and healthcare personnel were selected on the basis of their knowledge of maternity care services, experience with costs and reimbursements and availability of supplies. In the Upper West region, four administrators/health providers and six mothers were interviewed. In the Ashanti region, four administrators/health providers and eight mothers were interviewed. In all, 22 interviews were conducted, 8 with health providers/administrators and 14 with mothers, guided by the principle of data saturation [24].

Data collection

Trained research assistants used semi-structured interview guides to collect qualitative data from participants. For the mothers, in-depth interviews (IDIs) were used to collect data, while key informant interviews (KIIs) were used to elicit the views of health facility administrators/healthcare providers. The interview guide for mothers included questions about why women paid out-of-pocket for healthcare and the types of services paid for.

For each of the above topics, the interviewers probed the reasons underlying each response. The interview guide for hospital administrators and healthcare providers included questions about the process of funding and reimbursement through the NHIS, what types of things that are covered or not covered by the NHIS, experiences with differential costs based on whether something is included in the NHIS formulary and how they perceived costs to affect patient care. The interview guide also contained questions underlying why women pay for maternal healthcare despite the existence of the FMC policy.

The interviews with the healthcare providers/administrators were done in English. Interviews with mothers were done in local languages, such as Twi in Kumasi and Wali in Wa, and were later translated and transcribed simultaneously into English by experienced, bilingual qualitative researchers. All interviews were audio recorded.

Data analysis

While no identifying information was recorded for any of the interviews, transcripts were reviewed to ensure the anonymity of the participants. All research team members read through transcripts, and two researchers (C.A.M., V.H.) worked with the larger team to identify and define codes. A detailed codebook was created, discussed and revised iteratively with the research team. The codebook and all transcriptions were imported into the NVivo 14.0 software for coding and analysis. One researcher (V.H.) led the coding process, with a second researcher (C.A.M.) coding a subset of the data and discussing any inconsistencies to ensure uniform coding. Thematic analysis was used on the basis of the specific themes that emerged from the data [25]. The thematic analysis followed the Attride-Sterling framework for network analysis, which focuses on basic themes, organizing themes and global themes [26]. Such thematic analysis helped the research team to unearth the salient themes, as well as how themes related to one another, and to present the analysis in a systematic and robust manner. The framework analysis is particularly relevant for policy-oriented research such as ours [27].

Results

Demographic characteristics of respondents

The results mirror the perspectives and experiences of mothers, healthcare providers and administrators in terms of OOP payments, costs and reimbursements regarding the free maternal healthcare policy in the context of the NHIS. The ages of the women ranged between 23 and 40 years, while the ages of the healthcare providers and administrators ranged between 43 and 55 years; nine of the women (64%) did not have formal education and five of them (34%) had primary education. None of the women were employed in the formal sector but were engaged in trading and farming activities. All the women interviewed were married. All the eight healthcare providers and administrators attained tertiary education status.

Factors contributing to OOP payments in Ghana

Table 1 presents a summary of factors contributing to OOP payments.

As presented in Table 1, this study found a number of factors that contributed to OOP payments despite the existence of the FMC policy in Ghana. Thus, following the Attride-Sterling framework for network analysis, these factors are presented as global and organizing themes to enhance a clear and coherent understanding of the findings. For this reason, two main global themes – health systems and demand-side factors – and a number of organizing themes emerged from the data analysis. The two main global themes and their organizing themes are presented in Table 1 and detailed below.

Health system factors contributing to OOP payments

Health systems factors constitute one of the global themes contributing to OOP payments. This theme is anchored on the following organising themes: NHIS structural issues such as delayed and insufficient

Table 1 Summary of factors contributing to OOP payments in Ghana

Health systems factors (NHIS structural issues)	Demand-side factors
Delayed reimbursements	Mother's/client's lack of knowledge on NHIS benefit package
Insufficient reimbursements	Costs are passed on to the patients • Payments made for ante-natal tests and scans • Purchase of materials for birth, and drugs/medicines
Inadequate NHIS benefit coverage • Medications not included in the NHIS formulary	Repackaging of "cash and carry" model of care • Pay-as-you-go model for service • Leads to reduced care
Stockouts and supply chain challenges	

Source: Authors' fieldwork (2023)

reimbursement, inadequate benefit package, supply chain and stockout issues as presented below.

Delayed and insufficient reimbursement

As reported in Table 1, our study found that structural issues such as delayed and insufficient reimbursements within the NHIS constitute major health systems factors that contribute to the need for OOP payments for maternal care. In particular, participants identified issues in two areas: delayed and insufficient reimbursements to facilities (identified by providers and administrators) and inadequate benefit package, supply chain and stockouts (identified by mothers). With regard to delayed reimbursements, respondents emphasized that these structural challenges created a gap between the time services are rendered by health facilities and the time funds are released to hospitals. Because healthcare providers and administrators have to find a way of running the health facilities, they need to identify other sources of income to preserve cash flow, resulting in a situation in which mothers seeking maternal healthcare are charged additional fees. These delayed reimbursements were identified in both regions and across both public and private health facilities. The following quotes illustrate the above claim:

> *"If you look at it currently, NHIA (National Health Insurance Authority) is owing facilities, I think the last payment was in July last year, that is what they have reimbursed to the facilities. So [it is] almost 8 months now [of payments] they are owing facilities. It would automatically force facilities to take a token from their clients and then the pregnant women are no exception." –(Ashanti public hospital administrator)*
>
> *"I am sure you should have known by now that [payment] from NHIS authority is very erratic… Because the majority of the consumables [which are fast-moving consumable items] we use here are not reusable [we cannot recycle them] and when we need to replace them and we don't have money, what do we do? Do we have to close down the facility? No! as managers we must find a way of running the hospital." –(Upper West public hospital administrator)*
>
> *"When the insurance scheme was first introduced, at least every month or two, the facility would be reimbursed. But now, it can take more than a year before reimbursement would come." –(Ashanti Private Clinic Nurse)*

Inadequate NHIS benefit package

Similarly, an incomplete set of coverage benefits was the second structural factor identified as leading to OOP payments for maternal healthcare. This manifested due to a gap in coverage, such that maternal healthcare seekers need additional payments for medicines that are not included in the NHIS benefit package. A key example of the gap in coverage highlighted was the frequent need for additional medications, which the NHIS does not cover. Respondents also reported that many of the drugs covered by the NHIS are not the most efficacious options, meaning that clients have to make additional OOP payments to get more effective medications. The quotes below support these claims.

> *"As midwives, we have a list of drugs that we are supposed to give them and there are other drugs we cannot do anything about because it's out of our control. So, if you give that medication to the client, then you explain to her the situation at hand. You do that by telling her which medication is free and which one is not. So … if you go beyond this medication, then you should show some willingness to pay…" –(Ashanti private hospital nurse)*
>
> *"Let's say paracetamol … and NHIA is paying for 1 cedi, although you the prescriber knows … 1 cedi paracetamol cannot cure some ailments. In this sense, the pharmacist has to come in … and procure a higher or stronger drug for the facility which there must be a top-up. … Most of the drugs on the NHIS are weaker drugs when I say weaker their strength (is) very, very weak. You will not be doing 'good' to a client…" –(Ashanti public hospital administrator).*

Stockouts and supply chain challenges

Another important NHIS structural issue contributing to OOPs highlighted in this study speaks to stockouts and supply chain challenges. For example, at the hospital level, respondents highlighted frequent stockouts of key medications, resulting in a need to purchase products from outside the hospital. To get appropriate care, mothers seeking maternal healthcare often needed to visit locations where NHIS reimbursement was unavailable. Some respondents remarked as follows:

> *"The other thing I can say is that, there might be shortage or the medicines might be out of stock and therefore I was made to buy it from outside the facility." –(Ashanti public hospital mother)*
>
> *"So, if the medicine is out of stock, what we do is to check if the medicine is on NHIS, we prescribe it on the NHIS prescription form and let them have it. However, if it is not on the NHIS, we reach out for the usual prescription and write it." –(Ashanti public hospital pharmacist)*
>
> *"There were three particular drugs (folic acid, multivites and one other routine drug) they used to*

always prescribe for me anytime I visit but which were always out of stock at the pharmacy which I used to buy at the chemical stores." –(Upper West public hospital mother)

Demand-side factors contributing to OOP payments

Demand-side factors constitute the second global theme that emerged from this study. Three organizing themes – mother's/client's lack of knowledge on NHIS benefit package, costs being passed to patients and "cash and carry" repackaged – give meaning to this global theme as presented below.

Mother's/client's lack of knowledge on NHIS benefit package

Table 1 presents that mother's/client's lack of knowledge on NHIS benefit package has been reported as one the demand-side factors contributing to OOP payments in Ghana. In fact, our study established that mothers in both regions and in both public and private hospitals did not fully understand what services are covered and those that are not covered by the NHIS. Consequently, these mothers did not push back on additional charges the hospitals requested for services. The following quotes attest to these claims.

"I was told that I would spend more if I was not on the insurance scheme. I believe I am spending this amount of money which is less because I am on the insurance scheme. So, I did not ask them any question about the expenses I was making." –(Ashanti private hospital mother)

"I have no idea what is listed as essential medication under the NHIS, I don't know." –(Upper West private hospital mother)

"Being a first-time mother, I had no idea what procedures were involved but I was expectant that I would make some out-of-pocket payment for the ANC booklet which I did not even pay for…I was not prepared that much to pay for all the services I was asked to pay for so, I had to call back home for them to send me a cash transfer to enable me to conduct the scans and the laboratory examinations." –(Upper West public hospital mother)

As the quotes above show, mothers' lack of knowledge of services covered or not covered by the NHIS meant that they paid for whatever they were asked to pay for, without questioning the health providers, thus contributing to OOP payments for maternal services.

Costs are passed on to the patient

Table 1 captures the practice of passing costs onto the patient as the second organizing theme under the demand-side factors. As a result of the NHIS structural and health system challenges identified above, health facilities sought OOP payments from expectant mothers to maintain financial stability. These costs included paying for ante-natal care tests and scans outside the health facility (private labs) and purchasing medications not included in the list of drugs covered by NHIS, as well as materials for birth. Respondents frequently alluded to the need to pay for scans and medications, often before diagnostic tests or procedures would be conducted, as shown in the quotes below.

"It is part of the NHIS record that women must be scanned (pregnancy test) before they are given cards for free maternal health services and in this case… taking the scan for the first time means they would have to pay. However, subsequent scans are normally not paid for because we use the insurance card number to do registration and fill the forms for those scans so that clients would take it to wherever the insurance covers." –(Ashanti private hospital nurse)

"I normally pay for my scan and imaging, laboratory test, a urine test can and rubber. The scan cost me averagely 100 cedis, the laboratory test also costs me an average of 180 cedis and the urine test can was 15 cedis and the rubber [used to cover the delivery bed] too like 10 cedis throughout my ANC." –(Ashanti public hospital mother)

For delivery, respondents from all hospitals (both public and private and urban and rural) referenced a list of materials expectant mothers were required to purchase that added to OOP costs. These included a range of items from disposable linens to medications and materials for the new baby, amounting to several hundreds of Ghana cedis.

"I got some of the items from the house before I went to the facility but to my surprise, I was asked to make payments for additional items at the facility. I took to the facility clothes, delivery mats, delivery pads, baby napkins and the others. At the facility, I bought gloves and also vitamin K which I was told is not in stock at the facility so, I bought it outside at GH¢ 12.00 at the time. The gloves cost me GH¢ 5.00 (for 2 pairs). All the items I bought from home for the delivery would also amount to GH¢ 400.00." –(Upper West private hospital mother)

"When I went to give birth at the government hospital, I was made to buy some additional items such as eye drops, spirit and cotton which was not in the list provided by the private hospital (of the things women should bring to delivery)[…]. I was made to buy IV fluids and some medicines when I went for delivery. I was also made to pay for the

hospital cloths and aprons because they said they could not use it on any other person." –(Ashanti public hospital mom)

The experiences of mothers in both regions, and also in both private and public health facilities regarding OOP payments in the context of the FMC, are similar. Mothers in both contexts highlighted the fact that they had to incur additional OOP despite the existence of the free maternal healthcare policy. This additional OOP burden predominantly related to ante-natal and delivery care services, with little mention of postnatal care and/or paediatric care costs. Similarly, a comparison of the health providers and administrators' experiences echoed that delayed and insufficient reimbursements, stockouts and supply chain challenges occasion the need for additional charges to keep the health facilities running in both regions as well as in both private and public health facilities. The fact that health providers and administrators have the autonomy to charge patients additional fees to keep health facilities running contrary to the free maternal healthcare policy speaks to the street-level bureaucratic theory because as indicated above, when policy reform is delivered to citizens, it is often in the form that the SLBs want the citizens to see it.

"Cash and carry" repackaged

The issues highlighted by respondents suggest a repackaging of the "cash and carry" model for maternal care, despite the establishment of the NHIS in Ghana.

"With the drugs, scans and laboratory tests you have to pay before you receive the service. I have never asked them why and I think that's the norm in most settings. So, I don't see it strange to me. I even normally pay before I receive any service." –(Ashanti public hospital mother)

"You pay the money and send the receipt to the laboratory for the scan and test so basically you have to pay before you receive the services. … I normally prefer to pay before I receive the service because I don't want any embarrassment. If you don't have money, they will tell you to go home your next visit you get prepared and pay before you get the laboratory services." –(Ashanti private hospital mother)

"It's stated that maternal healthcare delivery is free under the National Health Insurance Scheme but sometimes when it comes to laboratory screening, for instance, it's not free… they have to make some out-of-pocket payments before they get their laboratory examinations (especially the routine examinations) conducted." –(Upper West private hospital nurse)

Such practices can lead to reduced care-seeking (such as limiting ante-natal care visits), which can lead to challenges in providing high-quality care.

"Other mothers however, find it difficult to pay the little that is charged on some of the services. This makes the work difficult especially during delivery because in some circumstances, you have to attend to women who haven't gone through routine ANC examinations; you don't know her haemoglobin (HB) level, Rhesus factor (Rh factor) etc, which puts you in a difficult situation because you don't know if she is anaemic or not and if she runs into postpartum haemorrhage (PPH) during delivery, what happens?" –(Upper West private hospital nurse)

Putting it all together, these results provide a fertile ground to present a conceptual model for why patients pay for services in a "free maternity care" environment as illustrated in Fig. 1.

As illustrated in Fig. 1, these results reflect how health systems and demand-side factors have impacted the current NHIS system to effectively repackage the previous "cash and carry" healthcare system in Ghana, contributing to reduced and/or costly care for mothers seeking maternal healthcare services, even in a system designed to provide free maternal and child healthcare.

Discussion

This qualitative research explored why women still make OOP payments for maternal healthcare services in the era of the "free maternal healthcare policy" under Ghana's flagship NHIS. The study identified two overarching themes, namely health systems and demand-side factors, which contribute to OOP payments. The health system factors comprise structural issues. For example, structural issues, such as delayed and insufficient reimbursements and stockouts and supply chain challenges within the NHIS, appear to be the major reasons for OOP payments for maternal healthcare. Inadequate funding from the NHIA leads healthcare providers and administrators in both public and private health facilities to charge additional fees from clients to keep the health facilities functioning.

This discretionary behaviour of health providers/administrators to charge additional fees fits neatly within the street-level bureaucratic theory. Derkyi-Kwarteng et al. [15] explain that SLBs often face difficult choices because they do not have the requisite resources to execute their duties; hence, they develop coping strategies to manage the resource challenges. Derkyi-Kwarteng et al. [15] contend that these coping strategies may unavoidably and unintentionally affect the expression of the policy they are supposed to implement. Derkyi-Kwarteng et al.

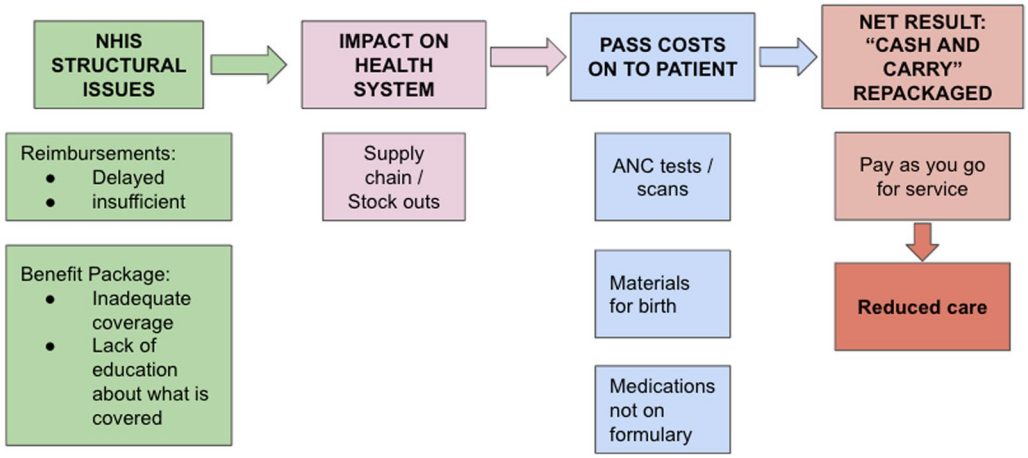

Fig. 1 Conceptual model for why patients pay for services in a "free maternity care" environment

[15] reported that SLB discretion essentially explained the reasons for the central-policy-unintended OOP payments for maternal healthcare services in Ghana and other African countries.

For these reasons, even though the organizational goal of the NHIS is to ensure free maternal healthcare for all, OOP payments are becoming a norm rather than an exception. It is argued that SLBs will continually adapt and bend the rules in ways that they perceive best, and their actions and inactions may work to maintain or perpetuate divisions and inequalities within society [28]. Our findings are consistent with Cooper et al. [26] because healthcare providers/administrators perceive the introduction of OOP payments as the best way of sustaining the functioning of health facilities, serving the needs of clients in the face of delayed and insufficient reimbursements and addressing inadequate coverage of essential services by the NHIA. These findings are of critical policy interest because delays in claims reimbursement have been cited as a major reason for OOP payments in health facilities in the presence of clear insurance or fee exemption policies for maternal healthcare in Ghana and Burkina Faso [29, 30].

Demand-side factors constitute the second important reason for the persistence of OOP payments for maternal healthcare in the context of the FMC policy in Ghana. For the purposes of emphasis, the demand-side factors include patients' lack of knowledge of the NHIS benefit package, costs being passed onto patients and "cash and carry" repackaged. Patients' lack of awareness about what is or is not covered by the NHIS in both public and private health facilities is a major reason for the persistence of OOP payments for maternal healthcare. Here, because patients lack knowledge about the services covered by the NHIS, they are not able to hold health providers/administrators accountable or resist the extra fees/charges requested by the health facilities at the point of demanding healthcare. This finding is well grounded in SLB theory. For example, Rice [17] asserts that the amount and kind of benefits a citizen receives from the welfare state are a function of the client's knowledge of the policy and familiarity with the social security system in place. This scenario is true in our study context because, as the results illustrate, some clients did not even ask questions about the extra expenses they made as they had no idea of what was listed as essential medications in the NHIS benefit package. Our results echoed earlier studies on the subject matter. For example, Derkyi-Kwarteng et al. [15] attribute OOP payments for maternal healthcare in Ghana and other African countries to misunderstanding of the policy by clients, poor communication to clients about the benefit package and poor dissemination for policy implementation. These issues border on policy content and policy processes, suggesting that perhaps there was not enough grassroots (local-level stakeholder) engagement about the NHIS benefit package.

The actions of street-level bureaucrats fuel these structural issues. In this case, health providers and administrators impact the health system's performance, characterized by shortages or stockouts of essential medications, which expectant mothers must purchase from outside health facilities. Our findings confirm previous studies that reported that shortages of NHIS listed medicines and supplies in health facilities compel expectant mothers to purchase these drugs out-of-pocket on a pay-as-you-go basis outside the facilities attended [5, 6].

The second demand-side reason for the persistence of OOP payments is that the structural issues and their concomitant effects on the health system's performance

dovetail into passing costs on to patients. As the results demonstrate, these costs are usually for ante-natal laboratory tests and scans and purchasing or paying for materials such as delivery mats, gloves, spirit and cotton, hospital cloths and aprons and IV fluids, amongst others, in both private and public health facilities. These costs, as the results showed, are substantial and threaten the march towards UHC. These findings confirm earlier evidence which suggested that OOP payments for maternal healthcare in Ghana are highly prevalent despite Ghana's free maternal healthcare policy [12]. Relatedly, our findings reported that nurses and midwives, acting as SLBs, compel women to buy all material needed for delivery, without which they will not be attended to. These results are largely consistent with other literature showing that OOP payments for maternal health services often persist, even in the context of policies ensuring free maternal healthcare [31, 32]. In particular, previous studies have established that additional OOP payments for maternal healthcare remain a significant barrier to UHC in Ghana [30, 33, 34]. Another study in the Upper West Region of Ghana found that OOP payments are still common even under the NHIS FMC policy and that 21% of households spent more than 10% of their monthly income on childbirth [35].

Our study has significant implications for public health policy and practice because the preceding discourse suggests a repackaging of the hitherto "cash and carry" system. Healthcare providers/administrators, nurses and midwives, acting as bureaucrats, use their autonomy and discretionary power to charge clients additional OOP cost to avoid the collapse of health facilities and to ensure the sustainable supply of essential services. Though well intended, these actions echo the "cash and carry" system, and are thus at variance with the objectives of the FMC because women who are not able to afford these OOP payments may be deprived of essential services [15]. Remarkably, these OOP payments are not uniform across time and space and may disproportionately affect poorer women, perpetuating health inequalities and inequities which the FMC sought to address [10]. This scenario reflects Hart's inverse care law half a century ago, where he observed that the poor and disadvantaged populations needing healthcare the most often receive less of it [36]. In fact, Frimpong et al. [37] and Ganle et al. [38] report that financial challenges remain major barriers to accessing maternal healthcare services in Ghana. By implication, poor women may not seek ante-natal care and/or may deliver at home [39]. It is logical and reasonable to suggest that the hitherto "cash and carry" system has been partly repackaged because mothers seeking essential care still have to make additional OOP payments, thus questioning the effectiveness of the free maternal healthcare policy in Ghana.

Study limitations

This study has some limitations. First, the fact that our study design was cross-sectional in nature and our sample purposive may have yielded findings that would differ if other individuals had participated at different points in time. Put differently, as with all qualitative studies, the interpretation of these results has to be done cautiously because our purposive sample of two regions may occasion respondents' biases resulting in the difficulty of generalizing the findings beyond the study contexts. Again, translator biases may affect the interpretation of our results because of the fact that the interviews were translated from local languages into English. Nevertheless, our findings raise important questions that warrant further population-level research. Importantly, as Merriam [40] points out, the primary objective of qualitative research is to explain phenomenon; to bring about an understanding in the current state of things. To this end, our study has successfully explained and clarified our understanding of the reasons for the persistence of OOP payments for maternal healthcare in Ghana despite the existence of the free maternal healthcare policy.

Conclusions

This paper explored the reasons why women with active health insurance cards still had to make OOP payments for maternal healthcare in the face of the FMC policy in Ghana, drawing insights from Lipsky's street-level bureaucratic theory. The study established that health systems and demand-side factors occasion OOP payments for maternal healthcare. In particular, NHIS structural issues such as delayed and insufficient reimbursement to health facilities, stockouts and supply chain issues give rise to OOP payments for maternal healthcare. Within the context of the street-level bureaucratic theory, health providers/administrators find themselves in a difficulty situation as they have to charge patients extra fees to sustain the functioning of health facilities in the face of inadequate funding from the NHIS. These additional fees lead to something akin to a "pay-as-you-go" model ("cash and carry"). The fact that these additional costs are passed onto patients run counter to the objectives of the NHIS, which are to make maternal healthcare entirely free for all. These affordances establish a clear disconnect or gap between the maternal healthcare policy formulated by technocrats and that implemented on the ground by bureaucrats, that is, financial barriers to accessing maternal healthcare services still persist in Ghana. We proffer

three recommendations to address the policy formulation and implementation gap. First, we encourage the NHIA to collaborate with the Ministry of Health and the Ghana Health Service to prioritize maternal healthcare to ensure timely and more efficient reimbursements for health providers. Second, the NHIA needs to do broader stakeholder engagements to educate patients about what is covered and what is not under the NHIS. Finally, the NHIA also needs to identify the poorest women and prioritize covering all of their expenses related to pregnancy and childbirth. These recommendations represent critical pathways to ensuring the effectiveness of the free maternal healthcare policy, ensuring no one is left behind, and in particular, ensuring that Ghana does not fall short on SDG 3 by 2030.

Abbreviations

FMC	Free maternal care
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OOP	Out-of-pocket
SDGs	Sustainable Development Goals
SLBs	Street-level bureaucrats
WHO	World Health Organization

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Availability of data and materials
The datasets during and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This study was reviewed and approved by the Ghana Health Service Ethics Review Committee (GHS-ERC-019/09/21) and the University of Michigan Institutional Review Board (HUM00218991). As part of recruitment, all participants were taken through a detailed informed consent process. The purpose and objectives of the study and the data collection processes were described. Participants who agreed to participate provided written informed consent.

Consent for publication
Not applicable.

Competing interests
We have no competing interests.

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