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Bridging Gaps in Universal Maternal Care: Evaluating Ghana's NHIS and Free Maternal Health Policy

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Abstract: Ghana's National Health Insurance Scheme (NHIS) and the Free Maternal Health Care Policy (FMHCP) were established to remove financial barriers to maternal and neonatal healthcare. After twenty years, challenges remain in turning policy coverage into real protection. This paper critically assesses Ghana's progress toward universal maternal healthcare from 2010 to 2025, using current data from the Ministry of Health and the World Health Organization (WHO), and comparing outcomes with Ontario, Canada's publicly funded midwifery model. The results show significant improvements in antenatal visits and facility-based deliveries; however, ongoing inequalities persist due to delayed reimbursements, stock shortages, and workforce gaps. Recommendations include adopting digital claims systems, decentralizing funding processes, and expanding community midwifery services.

Keywords*:* Maternal health coverage, NHIS, free maternal policy, midwifery, Ghana, universal health coverage, equity.

I. INTRODUCTION

Universal health coverage (UHC) has become a key goal in global health efforts, outlined in Sustainable Development Goal 3.8. Its main purpose is to provide access to essential health services without financial hardship. Ghana's National Health Insurance Scheme (NHIS), launched in 2003 and operating nationwide by 2005, is one of the earliest large-scale initiatives in sub-Saharan Africa to establish universal health coverage for maternal care (1). In 2008, Ghana introduced the Free Maternal Health Care Policy (FMHCP) under the NHIS, which removed premium costs for pregnant women and offered comprehensive prenatal to postnatal health services (2). This study evaluates how effectively the FMHCP has worked in practice through 2025 by analyzing financing, access, and quality outcomes, and by comparing it with Ontario's well-established, midwifery-funded universal health coverage model.

II. METHODS AND DATA SOURCES

A comprehensive review of policy and system performance was conducted using the following sources:
• Ghana Health Service (GHS) annual health sector reports (2018–2025)
• NHIS Claims Directorate data (2023–2025)
• Peer-reviewed literature (2020–2025)
• World Health Organization (WHO) Global Health Observatory indicators (2025)
• Comparative data from the Ontario Ministry of Health (2024–2025)
The indicators evaluated included maternal mortality ratio (MMR), skilled birth attendance (SBA), NHIS enrollment, out-of-pocket (OOP) expenditures, and midwife-to-population ratios.

III. GHANA'S NHIS AND FREE MATERNAL HEALTH POLICY: OVERVIEW

3.1. Structure and Funding

The National Health Insurance Scheme (NHIS) is financed through a 2.5% levy on the scheme, a 2.5% deduction from social security contributions in the formal sector, and annual premiums paid by informal workers (3). Under the Family Medical Health Coverage Program (FMHCP), all pregnant women are exempt from premiums and are eligible for an expanded maternal care package.
• Antenatal consultations, laboratory investigations, and ultrasounds;
• Skilled birth attendance during delivery;
• Postnatal and neonatal care for a duration of 90 days;
• Emergency obstetric surgical interventions when necessary.

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Although the legal foundation for these provisions is robust, financial instability and delays in reimbursement processes have compromised the consistency and reliability of services.

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3.2. Coverage Achievements

Since 2008, facility-based deliveries increased from 43% in 2005 to 84% in 2024, and antenatal care visits (four or more) rose from 62% to 91%. However, only 63% of women of reproductive age were active NHIS members in 2024, leaving gaps in financial protection (GHS 2025).

IV. CURRENT MATERNAL HEALTH INDICATORS (2024–2025)

Table 1 – Key Maternal and Midwifery Indicators: Ghana 2024–2025

Indicator	2020	2024/25	Target (SDG 3.1)
Maternal Mortality Ratio (per 100,000 live births)	308	264	< 70
Skilled Birth Attendance (%)	78	84	≥ 90
NHIS Active Enrolment (WRA %)	58	63	≥ 90
Out-of-Pocket Expenditure (%)	36	29	< 15
Midwife-to-Population Ratio	1:15,500	1:12,800	1:5,000

Sources: Ghana Health Service 2025; World Bank 2024; WHO 2025.

Although Ghana has made notable progress, its maternal mortality rate (MMR) remains more than 40 times higher than Ontario's 6 per 100,000, highlighting significant structural inequities.

V. BARRIERS TO EFFECTIVE UNIVERSAL MATERNAL CARE

5.1. Financing and Reimbursement Delays

Hospitals and clinics often experience NHIS reimbursement delays of 3–6 months, which disrupts procurement and results in informal fees (5). A 2024 Health Policy and Systems study found that 47% of facilities charged extra for drugs that should have been covered, while 18% demanded unofficial "delivery fees."

5.2. Medication and Supply Shortages

Periodic drug stock-outs continue, particularly for oxytocin, magnesium sulfate, and antibiotics (6). These shortages lead clients to make out-of-pocket purchases, which conflicts with FMHCP principles.

5.3. Workforce and Infrastructure Constraints

By 2025, Ghana had roughly 4,800 registered midwives, unevenly distributed, with the Northern, Upper East, and Savannah Regions remaining understaffed (7). Training numbers are improving through the Midwifery Training Institutes Expansion Project, but retention and rural deployment continue to lag.

5.4. Administrative and Technological Barriers

NHIS membership requires biometric card renewal annually. Digitalization started in 2022 but is still incomplete in rural areas, leading to lapses in coverage during pregnancies (8).

VI. COMPARATIVE ANALYSIS: GHANA VS. ONTARIO

Table 2 – Comparison of Universal Maternal Care Frameworks (2025)

Category	Ghana (NHIS + FMHCP)	Ontario (Canada)
Funding Model	National Health Insurance Scheme + tax levy	Public tax funding through Ontario Midwifery Program
Eligibility	NHIS membership required; premium waiver for pregnant women	All residents (including uninsured)
Payment System	Reimbursement per service to facility	Direct "course of care" funding to midwives
Provider Status	Salaried public sector employees	Independent contractors in community practice
Average OOP Share of Maternal Expenditure	≈ 29 %	< 1 %
MMR (per 100,000)	264	6
Client Coverage Equity	Moderate; urban bias	High; uninsured included by policy

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Ontario's integrated funding and autonomy ensure predictable quality and steady financial protection, while Ghana's reimbursement-based system remains susceptible to liquidity shocks.

VII. POLICY IMPACT AND EMERGING REFORMS

Ghana's Ministry of Health (2025) introduced the Digital NHIS E-Claims Platform, thereby reducing claim-processing time by 35%. The Health Financing Strategy 2025–2030 is aimed at:

- Transition to direct provider payment for priority maternal care.
- Establish a Maternal Health Equity Fund for poor and remote clients.
- Expand community midwifery deployment in 50 districts.

These measures align with lessons from Ontario's contractor model, shifting focus from bureaucratic reimbursement to direct service financing (9).

VIII. DISCUSSION

8.1. Strengths

The FMHCP successfully increased skilled attendance, antenatal care utilization, and institutional births. It remains a key contributor to Ghana's decline in MMR from 485 (2000) to 264 (2024).

8.2. Limitations

The "policy-to-practice gap" continues. Nominally free care is undermined by reimbursement delays and unequal resource distribution. Financial hardship caused by unofficial fees and transportation costs remains common, especially in northern Ghana.

8.3. Lessons from Ontario

Ontario's direct-funding model demonstrates how midwifery independence can exist alongside public oversight. Using this approach in Ghana could involve testing district midwifery funds that pay providers directly after verified service completion, avoiding NHIS delays.

8.4. Future Directions

Expand digital enrollment by completing mobile NHIS registration by 2026 in order to minimize lapses. Revise provider payments by introducing bundled "course-of-care" packages for midwives, aligning with Ontario's CoC model. Scale rural recruitment incentives through the provision of housing and career pathways for rural midwives. Foster public–private collaboration by contracting faith-based facilities to deliver NHIS services and expand reach.

IX. CONCLUSION

Ghana's NHIS and FMHCP mark significant milestones in the path toward universal maternal health. The reforms have reduced barriers to direct payments and boosted service utilization, but the quality of coverage remains uneven. Achieving true universality depends on consistent funding, timely reimbursements, and strategic investment in the midwifery workforce. Ontario's experience demonstrates that universality is not just about coverage on paper but about ongoing, equitable, and financially protected access. By 2025, Ghana faces a crucial decision: although the policy framework is strong, sustainable implementation will determine whether every woman, regardless of region or income, can deliver safely within the scope of universal care.

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