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# Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act

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Negotiating Change

An Analysis of the Origins of Ghana's National Health Insurance Act

by

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**Abstract**

Given the neo-liberal ideologies of the majority party and global trends toward market-based approaches to social services, the passage of Ghana's National Health Insurance Scheme, which provides coverage for all, seems anomalous. To answer the questions raised by this legislation, I analyze evidence from the government and consulting agencies. I find that a shift in international focus to allow social service reform combined with domestic electoral political influences. The scheme's foundation of district mutual health organizations evolved from a USAID-funded consulting agency's work, and may additionally reflect creative borrowing from the United States' failed healthcare reforms of 1993.

## Introduction

In early 2003, the Ghanaian parliament passed the National Health Insurance (NHI) Act, outlining plans for a healthcare system that would provide universal coverage to all Ghanaian citizens, regardless of ability to pay. Prior to the adoption of this healthcare plan, access to healthcare had been based almost solely on ability to pay. This previous system, instituted in 1985 and commonly known as the 'cash and carry' system, required those seeking medical treatment to pay upfront before receiving care. The economic situation of many Ghanaians, with 35 percent living in extreme poverty (IMF 2005), severely limited access to the formal healthcare system, ultimately resulting in high mortality rates for infectious and parasitic diseases (Quaye 1991: 306-8) and an infant mortality rate of 86 per 1,000 live births in 1989 (United Nations Development Programme 2005). The effects were especially critical during the 1980s when the Ghanaian economy experienced an acute downturn (Quaye 1991).

I experienced first-hand the negative impacts of the 'cash and carry' system during a two-month internship at the Asamankese Government Hospital in the Spring of 2005. These detrimental effects of the 'cash and carry' system were known for years, as evidenced by the presence of journal articles from the early 1990s discussing the problems (Quaye 1991); however, the system was left more or less intact until 2003. This leads to the question of *why*, after so many years of non-action, the Ghanaian government decided to implement such a sweeping overhaul of the healthcare system. In this article, I investigate possible domestic and international influences that might account for such a change, relying on documentation from the Ghanaian parliament and Ghanaian news sources in addition to publications released by international organizations

such as the International Monetary Fund (IMF), the World Bank, and the United States Agency for International Development (USAID). This is supplemented by interviews with two consultants who have worked with a consulting organization that was involved with the reform effort in Ghana. Additionally, I compare the NHI Scheme to other health care reform plans, notably the United States Health Security Act proposed by President Bill Clinton in 1993.

Research into this topic is much needed, as to date the vast majority of studies dealing with welfare systems are focused on a handful of highly developed countries in the Western world (Esping-Anderson 1990; Katzenstein 1985; Mechanic 1996; Quadagno 1987). Thus, the theories advanced by this research contain significant gaps as they do not address many of the circumstances unique to developing nations, such as the greater limitations on resources for social services and the importance of foreign aid to finance these services. Analyses of welfare state formation in developing countries such as Ghana will do much to overcome this weakness. Ghana's healthcare system development provides an example of the complexity of interactions between developing countries, international organizations and more developed countries. This is especially true given the extreme nature of the healthcare reform, going from a system based on market-based ideologies to one in which the government's duties are envisioned to include ensuring adequate access to healthcare for all. While world polity theory (Meyer et al. 1997) does do much to explain the interactions between and within various countries and international organizations and the resulting diffusion of ideas and knowledge, a more focused study will contribute more detailed information as to the specific ways in which this diffusion takes place within the context of a developing

nation. Additionally, as the successes and failures of Ghana's healthcare system become known in the years to come, an understanding of the policy formation involved in implementing the healthcare system could benefit other countries attempting to reform their healthcare policy while also better elucidating the effects of international aid.

This paper first discusses the origins of the 'cash and carry' system and the key components of the NHI Act. It then provides a brief overview of the relevant literature relating to the various factors involved in Ghana's healthcare shift. I begin my discussion with welfare state formation theory, including the systems/structuralist approach, the institutional approach, the state-centered approach, and the class coalition thesis. I argue, however, that these theories neglect the dynamic international relationships present in Ghana's healthcare reform. As a remedy to this theoretical inadequacy, I present development theory, with a focus on the theory of underdevelopment, and world polity theory. Through a combination of these theories, the various relationships and processes that culminated in the adoption of the NHI Scheme can be better understood.

The paper next analyzes the documentation leading up to and relating to the passage of the NHI Act, examining three potential sources of change. First, I analyze the domestic climate to discern whether the shift in healthcare systems could have resulted from national political, social, or economic changes. Next, I examine instances in which the IMF and World Bank made recommendations relating both explicitly and implicitly to Ghana's healthcare system, in order to assess the impact of international financial institutions. Continuing with this line of inquiry, I investigate the impact of the USAID-funded consulting organization on the development of the NHI Act. Finally, the paper will go on to draw potential parallels between the Clinton Health Security Act and the

Ghanaian NHI Act, speculating about the degree to which the former could have served as a model for the latter. I conclude with an evaluation of the directions further research could take as well as the possible implications of adopting a more appropriate theoretical framework.

### **From Cash and Carry to National Health Insurance**

In order to understand the shift in healthcare systems in Ghana with the implementation of the NHI Scheme, it is important to first analyze the structure of, and influences on, Ghana's previous healthcare system. This system, commonly referred to as the 'cash and carry' system, was initiated in 1985 largely in response to the Structural Adjustment Program (SAP) laid out by the IMF. SAPs are specific guidelines which developing nations were required to follow in exchange for loans. In the early 1980s, Ghana's economic situation took a sharp downturn as profits from cocoa, Ghana's leading export, severely decreased (Quaye 1991: 305). In an effort to salvage the country's struggling economy, the government agreed to the conditions mandated for the loan from the IMF. Ghana's government, under J. J. Rawlings, strictly adhered to the stipulations of its SAP, becoming one of the IMF's model nations in terms of implementing recommended policies.

This period of structural adjustment in the 1980s under the regime of J. J. Rawlings constituted a time characterized by repression, instability, and hardship.<sup>1</sup> During Rawlings' first two years in power, he sponsored rather incoherent socialist and

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<sup>1</sup> Rawlings first came to power on June 4, 1979 in a coup that overthrew the military regime of General Frederick Akuffo. Shortly thereafter, in September of 1979, Rawlings oversaw elections that were won by Hilla Limann. Less than two years later, however, Rawlings once again orchestrated a successful coup, this time remaining in power for nearly twenty years. Although in 1992 Ghana officially became a multi-party democracy, until this time, Rawlings ruled as an authoritarian ruler (BBC News 2005).

populist policies (Herbst 1993: 28). As Ghana's economic situation worsened, however, Rawlings changed course, applying to the IMF for loans and subsequently adhering to the tenets of the prescribed SAP.

The key components of SAPs are deregulation of markets and the reduction of government costs by way of decreasing government employment and cutting social programs such as healthcare. The result in terms of healthcare was the cash and carry system, in which healthcare costs were paid upfront. Consequently, those without the means to pay the often-prohibitive costs of visiting a healthcare facility were left without access to any form of healthcare. This consisted of a large percentage of the Ghanaian population during the period of severe economic decline in the 1980s. Eventually, as the consequences of this program became clear, certain attempts were made to redress these issues. The most notable of these is the exemption policy, implemented in 1997, under which basic services for children under five years of age, women seeking antenatal care, the elderly over 75 years of age, and victims of snakebites were waived.

Despite this improvement, the exemptions policies still left much to be desired in terms of providing adequate healthcare access to all Ghanaians. During my internship at a government hospital in Ghana (March and April 2005), there was a regular system of 'dashes' in place in which a small payment (usually 2000-5000 cedis, or the equivalent of about 20-50 American cents) was required at most of the points of contact with hospital staff. Thus, even if a woman visited the hospital for her "free" antenatal care, she would be forced to 'dash' the staff member at the front desk and at least two of the nurses. While these 'dashes' seem like an insignificant amount of money, many women that I spoke with cited even this small sum of money as more than they could afford and thus



did not attend any antenatal sessions. This assertion that even these small ‘dashes’ served as a significant deterrent is validated by the fact that in 2001 44.8 percent of Ghanaians were living on less than US \$1 a day (IMF 2005).

During my stay in Ghana, a top news story exemplified yet another of the failings of the cash and carry system. A group of premature babies had been born at one of the teaching hospitals, but because their families could not provide sufficient funds to cover the bills, the children were being held in the hospital and officials refused to release them to their families until the hospital was paid for the high costs incurred by the expensive care afforded to the children. Situations such as these are clear indications that the cash and carry system had severe failings in need of redress.

The NHI Scheme was passed into law in 2003 with implementation commencing in March of 2005. The central goal of the scheme is to provide basic healthcare coverage for all Ghanaians, regardless of their ability to pay. The scheme allows for district mutual health insurance schemes, private commercial health insurance schemes, and private mutual health insurance schemes. Every Ghanaian citizen is required to join one of these types of health insurance schemes, and each of the schemes is required to provide basic healthcare benefits as determined by the National Health Insurance Council (hereafter referred to as the Council).

The district mutual health insurance schemes are the focal point of the bill. Ghana is divided into 10 regions that are then divided into 138 districts. The bill calls for a mutual health insurance scheme to be developed and operated in each of these districts, with membership in each of these schemes open to all resident of the district (NHIS 2003: III.29.1 and III.31).

The schemes receive subsidies from the National Health Insurance fund (NHIS 2003: III.33.2). This fund is financed by the health insurance levy (a 2.5% tax on all commercial expenditures and transactions), 2.5% of every person's contribution to the Social Security and National Insurance Trust Fund (SSNIT Fund), money allocated to the fund by Parliament, money accrued from investments, and grants, donations, gifts, and other voluntary contributions. Importantly, one of the central aims of the Fund is to provide for the health care costs of indigents.

Under the scheme, those working in the formal sector make an automatic contribution to the scheme (as a part of the 2.5% deducted from the SSNIT fund contribution), while those in the informal sector pay a graduated amount depending on their assessed income level. Those determined to fall within the poorest segment are exempt from payment, and must only register to receive basic healthcare.

The Council oversees regulation of the health insurance schemes. Specific duties of this body include registering, licensing and supervision of the schemes and management of the Fund. For the management of everyday operations, each scheme has a governing body that answers to the Council.

What accounts for the adoption of the NHI Scheme and for its particular character? While it was adopted after a transition to a newly-elected democratic regime – the New Patriotic Party led by J.A. Kufuor won the 2000 elections over the National Development Council which was led by Rawlings' Vice President John Atta Mills – there was a significant gap in time between the new regime taking power and the passage of the Scheme. Further, why did the NHI have its particular features? The Kufuor government generally promoted more market-based solutions, rather than government-

led programs, yet initiated this national health program. In the next section, I consider theoretical perspectives that may help to answer these questions.

### **Theoretical Perspectives**

The issue of why states have provided such varying degrees of social services to their citizens has provoked much research on the factors that influence policy formation. However, the majority of this research has focused on Western nations that do not face the same unique set of circumstances encountered by developing nations such as Ghana. As a result of this failure to analyze healthcare policy formation in non-Western, and particularly African nations, many of the theoretical frameworks provided by these theorists, while arguably sufficient for Western nations, do not adequately explain the processes undergone by African nations. To combat this shortcoming, I propose that the principles of development theory be applied to discussions of healthcare policy formation, in order to better understand how international relations influence the adoption of certain healthcare systems. To further enhance this understanding of policy formation within an international context, I discuss theories regarding world polity and their possible applications to Ghana's healthcare experience. I will first provide an overview of the four theories that have been posited in relation to welfare state formation, following this with a discussion of the ways in which development and world polity theory better address the issues relating specifically to Ghana.

#### *Systems/Structuralist Approach*

The systems/structuralist approach highlights industrialization and capitalist development as the leading causes of welfare state formation (Esping-Anderson 1990: 13-4; Quadagno 1987: 112), with welfare state referring to the government provision of “services and income security,” or in other words, what are commonly thought to constitute social services (Esping-Anderson 1990: 55). The systems/structuralist approach posits that once a level of industrialization has been attained, the social structures from pre-industrial society such as the family, the church and *noblesse oblige* will be rendered incapable of providing the services they once contributed to society’s well-being. Thus, the state must provide this function, which it is able to do as a result of the rational and efficient bureaucratization that is said to develop alongside industry (Esping-Anderson 1990: 13). Despite the apparent logic of this theory, it has been invalidated by further research. Collier and Messick’s (1975) comparative study of 59 nations revealed that while a certain level of modernization, which is operationalized as industrialization, may be a prerequisite for welfare state development, it cannot be seen as the sole determinant of welfare state formation. Instead, the study argues for a model of hierarchical diffusion in which countries imitate states that are at a higher level of development. This is “reflected in a tendency for each successive adopter to adopt at a progressively lower level of modernization” (Collier et al 1975: 1308). Collier and Messick’s research is valuable in that it accounts for both domestic factors and international trends in explaining why countries adopt welfare states at various points in time. However, it is a very general theory and does not enumerate the specific causal forces involved in creating a welfare state. Thus, while it is useful as a framework in the

Ghanaian case, it contributes little to an understanding of why Ghana adopted the NHI Act when it did.

### *Institutional Approach*

The institutional approach is premised on the belief that “The economy must be embedded in social communities in order for it [human society] to survive” (Esping-Anderson 1990: 15). This theoretical framework sees full citizenship, as evidenced by the presence of social rights, to be a step in the process of nation-building (Esping-Anderson 1990: 15). The overarching theme of this theory, that welfare state structures come in tandem with increased social rights, is in concordance with the Ghanaian example. During the Rawlings era, from approximately 1980 to 2000, many rights such as free speech were curtailed, and it was not until the end of Rawlings’ rule that these restrictions began to be lifted. It is notable that this lessening of social control coincided with the 1997 implementation of the exemption policies, which though largely ineffectual, were an important shift toward government responsibility in the provision of healthcare.

A variation of the institutional approach argues that “small, open economies that are particularly vulnerable to international markets” are more likely to develop welfare states (Esping-Anderson 1990: 15). This tendency to develop welfare states results from these ‘vulnerable’ nations attempting to protect their citizens from outside, and thus uncontrollable, shifts in the economic climate by ensuring their citizens’ basic needs will be met (Katzenstein 1985: 54). While the Ghanaian economy can justly be described as a ‘small, open’ economy that is ‘particularly vulnerable to international markets,’ this was

true for two decades before a new healthcare system was adopted. Furthermore, Katzenstein's analysis is only inclusive of European nations, and thus applying his explanations to the Ghanaian experience must be done with caution.

### *State-Centered Approach*

The state-centered approach holds that the “state is not merely a passive instrument through which various interest groups can press their demands; it is rather a major force shaping the directions of social legislation” (Quadagno 1987: 118). The theory is premised upon three basic components. The first is the importance of bureaucracy in producing policy, and more particularly, the influence civil servants can exert in promoting specific pieces of legislation (Quadagno 118). The second aspect is an acknowledgment of the historical nature of policy formation, or in other words, an understanding of how former state actions have shaped current and future policies (Quadagno 1987: 118-9). The final foundational piece upon which this theory is based is the ways in which the timing of democratization and bureaucratization influence the timing of various welfare initiatives (Quadagno 1987: 119).

Following the reasoning of this approach, one would expect to find that there were key figures whose promotion ensured that the NHI Act would be passed. Furthermore, the emergence of various state structures and of bureaucratization and democratization should provide the foundation upon which a climate was formed in which such legislation could be enacted. However, research thus far has found neither a prominent promotional figure within the government nor a clear case for historical developments in state structures that would lead to such a shift in healthcare policy.

*Class-Coalition Thesis*

The basis of the class coalition theory, which was proposed by Barrington Moore, is that in order for widespread welfare to develop, there must be a joining of forces between strong working class movements and farmer organizations (Esping-Anderson 1990: 18). Though a large percentage of Ghanaians are employed in the farming industries (60 percent), this consists mostly of small farmers who are not politically mobilized (CIA 2005). This combined with the fact that there is not a significantly strong labor movement in Ghana would lead one to hypothesize that Ghana would have virtually no form of welfare, which the development of the NHI Scheme refutes.

*Development Theory*

Each of these theories would greatly benefit from being placed within the context of the development theory framework. There have been numerous theories relating to development that have been put forth over the years, including modernization theory and the theory of underdevelopment, both of which can be applied to Ghana's healthcare history. Modernization theory posits that developing nations need only to adopt the policies of developed nations in order to achieve success. In relation to healthcare, the modernization theory sees limited resources and the existence of traditional beliefs to be the key issues that need to be overcome (Quaye 1991:304). The theory fails to take into account issues of international economic relations that prevent many developing nations such as Ghana from having the ability to adequately carry out this plan (Quaye 1991:304). The theory's relevance to discussions of the Ghanaian health system can be seen in analyses of the 'Cash and Carry' system, which in many ways attempted to follow

Western models of medicine, especially in terms of technology and the use of a free market system of healthcare provision.

Randolph Quaye argues that the theory of underdevelopment provides a much more useful framework with which to analyze the healthcare problems that have affected Ghana over the years. This theory understands underdevelopment as an active process and not just a state or set of circumstances. In other words, developed nations ‘underdevelop’ their less developed counterparts. Through this perspective, a healthcare system is not perceived as “merely a set of tools and technologies,” but is seen to be a part of the broader social context (Quaye 1991: 305). Thus a healthcare system developed with this theory in mind will focus on the broader economic conditions and relations that have created the specific health problems within a population and seek to address these issues. In the case of Ghana, malnutrition, one of the country’s most pressing health issues, has increased as a result of a reliance on a single cash crop, cocoa, at the expense of foodstuff production. This over-reliance on cash crop production is not simply a result of poor internal governance, but rather of outside international pressures, beginning in colonial times and seen more recently in the stipulations of the SAPs adopted in the 1980s. Thus, health issues are necessarily enmeshed with broader social and economic relationships and cannot be adequately addressed without an understanding of international power structures and their effects.

If this understanding of how developing nations such as Ghana interact with more developed nations is applied to the previously discussed theories, these theories become much more effective in explaining the adoption of the NHI Scheme. Especially in each of the first four theories presented (systems/structuralist, institutional, state-centered, and



class-coalition), expanding upon the influences more developed nations and international institutions have had on Ghana would greatly add to the explanatory value of the approaches. For instance, in the systems/structuralist approach, one could examine how the push for development has contributed to the deterioration of social structures. Likewise, within the institutional approach, the ideas of full citizenship, social rights, and democracy could be viewed as components of a 'development package' that includes other, more concrete elements such as structural adjustment. In terms of the state-centered approach and the class-coalition thesis, development theory could help to internationalize the theory by substituting the role of international actors for that of domestic actors.

### *World Polity Theory*

An additional theoretical perspective that can help in understanding the complex relationships that exist between various nations is world polity theory. This theory is premised upon the idea that "nation-states are more or less exogenously constructed entities," with a world culture scripting the processes involved in state and policy formation (Meyer et al 1997:150). This results in four characteristics, the first being a high degree of isomorphism between state policies across development levels and cultures (Meyer et al 1997: 152-3). A further outcome is the idea that the nation-state constitutes a rational actor, as nation-states present themselves as such both internally and externally to gain legitimacy (Meyer et al 1997: 153). Additionally, there is the idea that "Diffusion processes work at several levels and through a variety of linkages, yielding incoherence" (Meyer et al 1997:154). This idea is referred to as 'decoupling' by Meyer

and his colleagues and explains the hypocrisy that is often present between stated policy and concrete action (Meyer et al 1997:154). A last result of this theory of diffusion processes is expansive structuration, or “the formation and spread of explicit, rationalized, differentiated organizational forms” (Meyer et al 1997: 156).

World polity theory can be useful in understanding the healthcare developments in Ghana because it recognizes that states do not operate within a vacuum. Thus, policy formation is necessarily influenced by international organizations and actors both directly and also in a more indirect manner, through the creation of a world culture that encourages certain types of action. As Meyer (2004: 44) argues, “...a whole array of modern programs, policies, organizations and agencies flows around the world. Standardized objectives such as ‘universal public education’ and ‘*health for all*’ become official catchphrases both globally and in individual nations” (emphasis added). Accordingly, if this theory is to be applied in an analysis of the processes leading to the adoption of the NHI Scheme, one should discover that international influences are an effective explanatory tool, even in the absence of significant domestic factors that would suggest such a shift in healthcare.

## **Analysis**

My analysis of Ghana’s adoption of the National Health Insurance (NHI) Scheme seeks to answer two questions: Why did the shift in health policy occur in 2003? Why did Ghana adopt a model of universal coverage through district mutual schemes from which individuals can opt-out (so long as they are covered by a private insurer)?

Drawing on the range of empirical materials, in this section, I analyze these two questions in turn.

### *Explanation of Shift*

When attempting to explain the radical shift in Ghana's healthcare policies, from one that could be categorized as a capitalist model to one falling more within the parameters of a statist system, I examined both international and domestic influences. Starting from the background knowledge of Ghana's history of close relations with the Western world, beginning in colonial times and stretching to present-day associations with the IMF and the World Bank, it was hypothesized that some form of international influence could likely have significantly impacted the Ghanaian government's shift in healthcare policy. International influence was speculated to have taken one or a combination of three forms: 1) a shift in world-wide attitudes toward a more humanitarian and less economic focus; 2) specific guidelines laid out by international organizations, similar to those found in SAPs; and 3) a model healthcare system implemented in another nation. In addition to international influences, it was conjectured that there were likely domestic actions that shaped the adoption of the new healthcare system; political climate was the primary sphere of domestic influence analyzed.

### Domestic Factors

The broader context within which Ghana's new healthcare system emerged was one in which there was a general acknowledgement that the cash and carry system was ineffective and encouraged inequality. This can be seen in various papers commenting

on the myriad of healthcare problems affecting Ghana. However, the ineffectiveness of the cash and carry system had been understood since the early 1990's (Quaye 1991), causing one to speculate as to what, if any, domestic factors changed so dramatically so as to create an environment conducive to the adoption of a more equitable healthcare system.

In the 'Official Report' of the parliamentary debates on the bill, there is evidence that though there was some participation in the development of the act from the Ghanaian citizenry, it was relatively limited. For example, MP Osei-Prempeh claimed the Trades Union Congress (TUC) petitioned the government to delay the passage of the bill and goes on to report that the General Agricultural Workers Union (GAWU) urged workers to "not contribute to cater for this country" (Parliamentary Debates August 19, 2003: 151-2). This directly contradicts the class coalition thesis which would predict that the TUC and the GAWU would be driving forces in urging the passage of the bill. In defense of the bill, Osei-Prempeh argued that other "advanced countries" have health insurance systems (Parliamentary Debates August 19, 2003: 152). This seems much more in line with the world polity literature in that the speaker seems to be seeking legitimacy for his nation by conforming with other, "more advanced" nations.

Despite the seeming absence of involvement by Ghanaian citizens, a report of the Joint Committee on Health and Finance on the NHI Bill reveals that to a certain degree, there was participation. Prior to the second reading of the bill, the Joint Committee toured the country, visiting six regional capitals to solicit views on the bill through public fora (Joint Committee on Health and Finance August 18, 2003). The resulting document contained 44 proposed amendments to the bill, of which 30 were actually submitted and

accepted during debate on the bill (Joint Committee on Health and Finance August 18, 2003). Although this healthcare reform seems to have been mostly of a top-down nature, with little grass-roots mobilization, there was at least an attempt to incorporate the views of the general public. However, the role of international organizations will later be discussed in terms of the extent to which the committee report can be viewed as a pure example of domestic involvement.

In terms of the national political climate, there was a significant shift in power in December of 2000 when J. A. Kufuor defeated J. J. Rawlings, ending Rawlings' 20 year rule. Two years after Kufuor and the New Patriotic Party (NPP) came into power, in early 2003, the NHI Act was passed into law. The NPP's election manifestos suggest that this regime change was an integral part of this healthcare reform.

The 1996 NPP manifesto contains an explicit indictment of the cash and carry system that was maintained under Rawlings, asserting, "The national institutions are insufficient and poorly maintained and the services inefficient and badly managed. The system of cash and carry or cost recovery at the point of service has proved notoriously callous and inhuman" (NPP Manifesto1996:36). The 1996 Manifesto goes on to promise, "The system of financing health care services will be thoroughly overhauled and the cash and carry system reviewed with a view to evolving a more equitable system including health insurance and other repayment schemes" (NPP Manifesto1996:37). Though the incumbent NDC party with Rawlings at its head won this 1996 election, the campaign platforms used by the NPP are significant in light of the fact that a 'more equitable system including health insurance' actually was put into place three years after the NPP came to power.

The 2000 NPP manifesto reveals that though improving health services was a goal of the party, the primary focus of the manifesto was to promote rural development (Accra Mail 2000). This is similar to the 1996 Manifesto, whose central theme was “Development in Freedom,” and only devoted two pages out of nearly fifty to health-related matters (NPP Manifesto 1996). Thus the evidence is mixed as to the priority the NPP placed on healthcare reform. While the implementation of the NHI Scheme supports the view that reform was of a high priority, the lack of focus on the issues surrounding this matter seems to support the opposite view.

A possible explanation can be found in the fact that the 2004 general elections fell directly after the passage of the bill, suggesting that its introduction and passage was a political tool. As occurs in many multi-party democracies, it could be that motivation to win votes by following through with campaign promises was the driving force behind the NHI Act. This theory was supported by an employee of a consulting agency closely involved with the Ghanaian healthcare system who informed me that in the opinion of several consultants, the impending election was the primary reason the bill was proposed and passed. Further evidence that there was a highly politicized climate during the time of the bill’s passage can be found in the fact that though the National Democratic Congress (NDC) party members participated in the development of the NHI bill, they were boycotting parliament during the actual parliamentary debates on the bill. Though the boycott was not in regard to the bill, it adds credence to the notion that there was a politically dynamic setting in which the bill was passed (Parliamentary Debates August 19, 2003).

Despite this, the NPP very clearly adopts a market-oriented stance in claiming that, “A free enterprise economy is the surest guarantee of economic growth and prosperity. Government must create the environment for business to thrive and for effort and initiative to be rewarded. What a person makes legitimately must never be taken away arbitrarily” (NPP Manifesto 1996:4). Traditionally, such support for free market economies would be in discord with universal provision of healthcare. Thus, while it seems that the Kufuor government supported healthcare reform, the seeming lack of priority and focus on this issue leads one to speculate that perhaps domestic factors alone could not have led to the adoption of the NHI Scheme and that instead, it was a collusion of these domestic features with international factors such as promotion by international organizations or consultants.

#### Influences of International Organization

International organizations that specifically refer to Ghana’s healthcare system in their reviews and recommendations include the IMF, the World Bank, and a consulting program funded by the USAID. While the IMF and the World Bank only provide general references to recommended changes in Ghana’s healthcare system, the consultancy seems to have been considerably more active in putting forth specific recommendations pertaining to ways in which Ghana’s healthcare system could be adjusted to increase its efficacy.

The World Bank and the IMF are two of the most powerful international agencies in the world and thus seem to be probable candidates for producing and transmitting international attitudes about how various issues should be approached. Throughout the

1980s, this trend-setting capability could be seen illustrated in the two organizations' focus on capitalist development and the consequent liberalization of developing nations' economies. As the negative humanitarian effects of this neo-liberalization have become increasingly apparent, there seems to have been a discernable shift in the policy recommendations and focuses produced by these two organizations toward policies that concern themselves with the welfare of individuals rather than simply the GNP of nations. This shift was likely brought about as a result of mounting external pressures from nations and organizations worldwide that expressed increasing levels of outcry at the devastation wreaked by SAPs. During a panel discussion on the future of the IMF and World Bank, Jeffrey D. Sachs noted it was necessary to calculate assistance to ensure "an adequate flow of public services in *health*, education, basic infrastructure, policing and public administration" (Fischer et al 2003, 48, emphasis added). This clearly illustrates that the humanitarian impact of economic development has in recent years become a higher priority for these agencies.

With specific regard to IMF and World Bank recommendations to Ghana, improvements in public services such as healthcare are linked to economic productivity. Poverty Reduction Strategy Papers (GPRSP), collaboratively prepared by the Ghanaian government and the IMF and World Bank, make this relationship between economic development and the well-being of Ghanaians clear (Ghana Ministry of Finance 2000; Ghana Ministry of Finance 2003). For example, the paper lists both "accelerating economic growth through the balanced implementation of sound fiscal, monetary, and other macroeconomic policies" and "increasing investment in human resources through improving the quality of and access to nutrition, education, health, water and sanitation



services” as means to achieving the objective of reducing poverty (Ghana Ministry of Finance 2000: 1-2). Publications such as these make apparent that the IMF and World Bank, both organizations with a historically economic emphasis, have shifted to include social welfare as a key component of successful development. It can be conjectured that this shift toward a greater focus on the provision of social services created an atmosphere in which governments such as Ghana’s were given greater freedom to address the needs of their citizens.

In many cases it seems that more than creating a hospitable environment for public policy reform, the IMF and World Bank provided direct encouragement to the transformation of Ghana’s healthcare system. In addition to providing monetary health sector program support in the form of \$79.7 million dollars (IMF 2004: 80), these two organizations have also supplied the Ghanaian government with recommendations and advice on how to carry out programs. In the GPRSP, one of the medium term priorities prescribed for the Ghanaian government is to “Phase out the cash and carry system and replace it with a more humane and effective system of financing health care” (Ghana Ministry of Finance 2003: 145). One year later, after the NHI Act had been passed by Ghana’s parliament, the World Bank’s Country Assistance Strategy (CAS), promises that the World Bank will provide a policy note that “will aim to help the government to develop an implementation strategy for the recently-approved National Health Insurance Act, to ensure its fiscal sustainability and poverty impact” (World Bank 2004: 47). Additionally, the IMF lists as one of its 2004 non-lending services a “report on strategic purchasing of priority health services under the new National Health Insurance Scheme” (IMF 2004, 76). These brief but telling references to Ghana’s health care system make

clear that the World Bank and IMF have played at least a small role in Ghana's formulation and ongoing implementation of the NHI Scheme, even if only to ensure Ghana's economic stability.

The international agency that seems to have most influenced Ghana's development of a new healthcare system is a consulting agency funded by USAID. In 2001, the agency conducted a survey of health financing schemes present in Ghana at the time. While the organization decided to embark on the research independently, "This exercise acquired a renewed importance when the new Minister of Health requested technical assistance from the USAID-funded ... project with the new Government's policy on health care financing" (USAID-funded agency 2001:1).<sup>2</sup> The report ultimately concludes,

While they [Mutual Health Organizations] are not a panacea for resolving health care financing and delivery issues, many of their limitations – small size, limited benefits, and inability to cover all segments of the population, especially the poorest – can be overcome with appropriate design and management. The report recommends ways to encourage sustainability of MHOs, such as regulation, coordination, and reinsurance, and a national underwriting fund. (USAID-funded agency 2001:vi)

Even before conducting this survey, the consultancy agency had a vested interest in the shape Ghana's healthcare system would take, as the project had been working in Ghana to promote mutual health organizations (MHOs) since 1999. Between 2001 and 2003, there was a 238% increase in the number MHOs in Ghana (USAID-funded agency

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<sup>2</sup> To ensure anonymity and in concordance with standard ethical procedure, the name of this USAID-funded agency has been omitted from both the body and the bibliography of this paper.

2002: 6). This can be attributed at least in part to the consulting organization's promotion, largely through workshops, of MHOs. It is important to note that though the rise of MHOs seems to have been as a direct result of this USAID-funded agency, there is a historical precedent within Ghana in the form of mutual aid societies, known as the *susu* system. During opening debates on the bill, Dr. Anane references this system as evidence that the Ghanaian people will be accepting of the new legislation (Parliamentary Debates August 19, 2003: 143-4). Though similar to MHOs, the *susu* system traditionally covers a wider range of social services, including funeral, marriage, and birth costs. It appears the USAID-funded agency favored a de-emphasis of non-health-related social service provision. In one internal report, "It is observed that the proportion of MHOs offering these services has reduced since the last survey from between 13-33% to between 9-13%" (USAID-funded agency 2002: 13). This, taken in combination with the fact that there is no mention of rectifying this decline and that the responsibility of MHOs for these services is said to constitute a risk (USAID-funded agency 2002: 13), indicates that the agency did not envision the *susu* system as a model for MHOs. This further convolutes the question of how much influence is of domestic origin and how much is a result of international encouragement. Though the government explicitly requested the consulting services and was also the second-largest donor to MHOs (USAID-funded agency 2002: 16), it is clear that the government was not acting completely independently in its attempts to reform the healthcare system.

The centerpiece of the NHI Scheme is the establishment of district mutual health insurance schemes. These are essentially district-wide mutual health insurance schemes such as those promoted by the consultants, and their inclusion in the NHI Scheme

illustrates the impact the consultants had upon the Ghanaian government. This is further demonstrated by the final report of the consulting agency: “As a result of numerous discussions, communiqués, and [consulting] technical papers presented to policy makers and Parliament of Ghana, several important changes regarding how the new law would affect MHOs in the country were incorporated into the bill” (USAID-funded agency 2005: 10). However, there is also evidence that policy developments were not simply prescribed and complied with by the government. Instead, the overall opinion gathered through interviews and the final report indicates that the consultants did not feel their advice was adequately taken. This was largely in regard to the impact the scheme would have on already existing MHOs and the top-down, as opposed to grassroots, community-based nature of the insurance scheme. Thus, while the legislation was based upon the principles of reform advocated for by the consultants, the Ghanaian parliament asserted its autonomy by rejecting certain recommendations. Though world polity theory does have explanatory value in understanding the international influences shaping the formation of the NHI Scheme, it does not adequately account for the complex power dynamics evidently coloring the relationship between the consultants and the Ghanaian government.

### International Models

Ten years prior to the adoption of Ghana’s NHI Act, President Bill Clinton unsuccessfully attempted to have passed the Health Security Act in the United States. Though there are clear differences between the two healthcare plans, as historically Ghana and the US have had different healthcare systems and economic capabilities, there

are several key similarities between the two that cause one to speculate as to whether the Clinton plan may have influenced in some way Ghana's conception of national healthcare.

Broadly speaking, the Clinton plan, much like the Ghanaian scheme, had the ultimate goal of ensuring that every citizen receives basic health care. This was a significant departure from the market-oriented ideology to which both countries had been prone to adhere. Though neither country has been purely capitalist, both have tended to limit the extent to which the government provides for the basic needs of its people (albeit for differing reasons). Thus, it is noteworthy that both would attempt (with varying degrees of success) to implement a system in which all citizens, regardless of economic standing, are provided access to basic health benefits.

More specifically, there is a striking similarity in the regional basis on which both systems are grounded. The Clinton Health Security Act would have created a system of state-organized regional health alliances that would manage and monitor the provision of health insurance packages. Every citizen would have been required to either obtain health insurance through these cooperatives or through corporate-sponsored plans of firms with over 5000 employees, which are allowed to create their own alliances in place of the statewide regional alliances (Starr 1994: 70-7).

This seems quite similar to the Ghanaian NHI Scheme's district-based insurance schemes. As in the Clinton Health Security Act, Ghana's healthcare system requires every citizen to obtain health insurance either through a district mutual health insurance scheme (comparable to the regional cooperative proposed by the Clinton plan) or through a private organization.

Additionally, like the United States plan, the Ghanaian plan made provisions for corporate schemes already in effect prior to passage, so long as they carried the minimum required benefits packages determined by the federal governing body. Furthermore, under both systems, schemes that are not a part of the district or regional organizations are not eligible for government subsidies, though they are still bound by the same standards as the regional/district schemes.

Though there is still research to be done to determine whether the Clinton plan directly influenced the Ghanaian scheme, the similarities seem to suggest there is a high probability that the American plan, though ultimately not passed, provided a rough model on which the various actors working to draft the Ghanaian NHI Scheme could reference. This is a further piece of evidence in support of world polity theories, as it suggests there has been a transference of ideas across international actors. Given the presence of United States-based consultants who promoted mutual health organizations in Ghana and who served to help provide the government with policy input, there may be a means through which these ideas about organizing health care diffused. Even if there was no specific incident in which an individual or organization referenced the Clinton Health Security Act, the similarities between the two indicates there is a world culture through which fairly specific 'rational knowledge' is diffused.

## **Conclusion**

Ghana's shift from a market-based 'cash and carry' healthcare system to a nationwide insurance scheme providing universal healthcare provokes the question of what factors led to such a dramatic change. It is clear that while Kufuor and the NPP

campaigns for healthcare reform in both the 1996 and 2000 elections, health concerns did not seem to be of a primary concern in either election and were overshadowed by free market ideology. Despite the seeming low priority of healthcare reform, the 2004 general elections may have created the impetus needed to encourage law-makers to make such sweeping legislative changes so as to demonstrate to constituents their efficacy. These factors alone do not provide a strong enough explanation, however, and thus it is necessary to look outside Ghana for a better understanding of the processes leading to the passage of the NHI Scheme.

Historically, Ghana has had strong ties to the Western world since colonial times. More recently, the IMF and World Bank have been especially influential in encouraging the liberalization of Ghana's economy. The acceptance and implementation of the SAPs of the 1980s led to a drastic reduction in funding and support of social services. In the 1990s there was a modest reaction against the severely negative consequences of these cutbacks, which in healthcare manifested in the form of the exemptions policies adopted in 1997. Given this historical context in combination with the rejection of domestic factors as the sole influence on the new healthcare policies, investigating the role of international organizations and Western countries seems a valid line of inquiry.

While rarely explicitly endorsing or recommending the specific health reforms adopted by Ghana, the IMF and World Bank did clearly provide an environment in which a focus on humanitarian and social services was encouraged. Poverty Reduction Strategy papers and Country Assistance Strategy papers produced by the two organizations contain goals relating to improving the welfare of Ghanaians. It should be noted that though the two organizations seem to have taken a more humanitarian approach to their

policy recommendations, economic success, as determined by measures such as GDP and exports, is still the key feature in virtually all reports. In fact, in many instances, reducing healthcare issues such as high mortality rates from infectious disease and high infant mortality is linked to improving the economy; it is thought that a healthier and larger workforce will be able to make more and better contributions to the economy.

In addition to the accepting atmosphere created by the IMF and World Bank for increased spending on social services, the USAID-funded consulting project provided technical assistance in the development of MHOs as well as presenting explicit recommendations as to the form Ghana's health reforms should take. Though these recommendations do form the foundation upon which the NHI Scheme was designed, the Ghanaian government asserted its autonomy by rejecting certain recommendations, most notably those concerning the extent of centralized government involvement. This illustrates that the interactions between consultants and Ghana was dynamic, with neither institution dominating the other. Furthermore, in the case of analyzing the relationships between international and domestic actors, it is necessary to complicate unequivocal binary definitions of the two. IMF and World Bank papers were prepared in partnership with the Ghanaian Ministry of Finance and many of the individuals employed by the consulting firm are Ghanaian. Thus, in a sense, these international organizations can be interpreted as constituting both domestic and international actors. It is vital to consider this in any analysis of such relationships so as to prevent presenting a one-sided representation in which international organizations are privileged.

Although the link between the Clinton Health Security Act of 1993 and the Ghanaian NHI Act of 2003 is tentative, it does merit further research. There are many



similarities, including universal insurance and what is essentially a two-tiered insurance system with the primary level being regionally based and the second being private. Though there is no direct evidence that the NHI scheme was explicitly based upon the Clinton Health Security Act, it does provide support to world polity theory in terms of the isomorphism between such developmentally different countries.

As in much research, increasing levels of knowledge about the processes leading to the adoption of the NHI Scheme have only revealed further questions, which could be expanded upon in future research. Within the vein of the current study, more in depth interviews with the actors playing significant roles in the legislative process could bring more insights. Possible candidates would include government officials, additional consultants, World Bank and IMF officials, and perhaps (if feasible) a sampling of Ghanaian citizens. Related research that could be conducted includes an analysis of healthcare legislation in West African nations or in developing nations in general. Additionally, an investigation into the perceived shift in IMF and World Bank policy is suggested by this study. Furthermore, the question of where models originate and why they originate and spread from certain entities should be pursued. Finally, within the coming years, an inquiry into the impact of the NHI Scheme will help to elucidate possible further implications of the processes involved in its development.

One aspect of the future development of the NHI Scheme will likely be based upon the issue of accessibility. Even if every Ghanaian citizen is officially covered by health insurance, this does not mean that all citizens will have access to a health facility or to adequately trained practitioners. Specific areas of concern include the lack of doctors (as there is considerable 'brain drain'), poorly trained nurses (as the profession is

generally looked down upon as a job fit for those lacking intelligence), impassable and nonexistent roads, and a general lack of infrastructure. This problem of quality healthcare provision was raised during the opening debates on the NHI Bill, when Mr. S. K. B. Manu explained that the district he represents has just one doctor to attend to over 100,000 people; he went on to urge the Government to increase efforts at recruitment and training of medical personnel (Parliamentary Debates August 19, 2003: 104-5). Though it is notable that this problem was addressed, because no specific legislation or program was developed to combat these issues, it seems unlikely that this represents a real commitment to solving the poor quality of healthcare provision. Adopting a pessimistic outlook results in easily understanding how the world polity idea of ‘decoupling’ (dissonance between policy and reality) could develop.

Such complete understanding of the processes leading up to the adoption of the NHI Scheme is essential as Ghana can be seen to serve as a paradigm for healthcare reform within an African development context. Being as Ghana was one of the strictest adherents to SAPs, including stipulations in regard to the liberalization and de-subsidization of social services, the passage of a bill that so directly contradicts this historical trajectory is particularly pertinent. Revelations as to the forces leading to the adoption of the NHI Scheme can subsequently be applied to situations in other nations. This should be done, however, within the framework of the Comaroffs’ multiple modernities, in which “the interplay of structural constraint and situational contingency” are taken into account with a knowledge of how “forces... [work] themselves out in particular local circumstances” (Comaroff 1991: 313). This allows for distinctive regional characteristics and historical factors to be incorporated into a successful model

of healthcare reform. The research presented in this paper presents a significant theoretical gap within the realm of policy formation in the context of developing nations. The various perspectives presented succeed in explaining only part, if any, of the processes shaping the healthcare reform in Ghana. This undeniably necessitates a reworking of the theoretical perspectives available, as especially with the rise of globalization, policy formation within the developing world is an ever-increasingly vital concern. Drawing from the strengths of world polity and development theory is a starting point for beginning this process. While the idea of diffusion through a world culture is valuable, it neglects power relations that have a significant impact on interactions between developing nations and their more developed counterparts. A possible solution is to frame world polity theory within the theory of underdevelopment. This allows for a more critical analysis of the relationships that exist between various nations and organizations. In this particular case, such a perspective leads to a questioning of how the development industry is benefiting from its ostensibly charitable aid to healthcare reform in a developing nation; because the theory of underdevelopment sees 'underdevelopment' to be an active process, it prevents easy acceptance of the assumption that aid necessarily produces positive change. Further implications of adopting such a theoretical perspective would be to explicitly address the direction of diffusion. Ideas and knowledge seem to flow from the West to lesser developed nations and not vice versa. A critical analysis of this process is necessary to furthering an understanding of the stratification of wealth and power throughout the world.

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