



THE POLITICAL DEVELOPMENT OF THE GHANAIAN NATIONAL HEALTH INSURANCE SYSTEM: LESSONS IN HEALTH GOVERNANCE

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ACRONYMS

CBHI	Community-based Health Insurance
GRNA	Ghana Registered Nurses Association
HIV	Human Immunodeficiency Virus
ILO	International Labor Organization
MOH	Ministry of Health
NDC	National Democratic Congress
NHIA	National Health Insurance Act
NHIC	National Health Insurance Council
NHIS	National Health Insurance System
NPP	New Patriotic Party
PNDC	Provisional National Defense Council
USAID	United States Agency for International Development
VAT	Value-added Tax

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EXECUTIVE SUMMARY

Campaigning on the promise of affordable health care, the leading opposition party in Ghana won the national elections of December 2000, marking Ghana's first democratic presidential change of power. Shortly thereafter, Ghana established a national health insurance system (NHIS). Within two years, over a third of the country had enrolled – an unprecedented accomplishment on the African continent. At the same time, the NHIS was plagued by design flaws and questions of sustainability. Though the development of the NHIS was politically driven, most analyses have focused on design issues. This study examines the political dynamics behind the development of the NHIS, with a particular focus on the role of health sector governance in policy development. Thirty-five interviews with key stakeholders and extensive secondary data analysis was conducted using grounded theory methodology. We find that stakeholders with politically incongruent viewpoints were marginalized while party loyalists were empowered, leaving the process vulnerable to rent-seeking behavior. Thus, this study argues that the political nature of health reform requires strong institutional mechanisms to safeguard transparency and accountability throughout the policy development process. Countries and their development partners must incorporate governance-related activities into their long-term health sector development plans to maximize the impact of public health policy.

I. INTRODUCTION

In August 2003, the Ghanaian Government embarked on a sweeping set of health reforms that aimed to eliminate user fees in favor of a National Health Insurance System (NHIS). Within two years, over a third of the country had enrolled in the NHIS – an unprecedented accomplishment on the African continent. At the same time, the NHIS was plagued by design flaws and questions of sustainability. As other African countries look to develop their own social insurance systems (Wagstaff 2007), the question of how to replicate Ghana’s successes without adopting its failures is of critical importance.

So far, policymakers and analysts have focused most of their attention on the technical design of the NHIS. Far less attention has been paid to the process by which the technical design came to be. Political scientists have long argued that the formation of successful public policy fundamentally depends on the political environment as well as the checks and balances that hold this environment together (Brinkerhoff 2004). While elements of governance, such as accountability and transparency, are often acknowledged by public health researchers as important factors in the design of health policy, few studies have focused on elucidating these issues further (Brinkerhoff and Bossert 2008). In turn, the limited knowledge base on these issues has led developing countries and their partners to devote far greater attention to the health-specific aspects public health interventions than to the governance structures that support them.

Thus, a rigorous analysis of the policy process is important for two practical reasons. First, understanding the policy process can help technical analysts frame their intervention-specific recommendations in a way that is appropriate to the political environment. Reich argues that a narrow focus on the technical aspect of policy reform can leave technical analysts less effective throughout the reform process (Reich 1995). Second, a clear understanding of the policy process can help countries to better design strong governance structures that will protect the integrity of their policymaking process. Specifically, this entails understanding what dynamics exist among stakeholders, where power is concentrated, and what structures and processes are in place to keep these powers from overtaking the policy process (Reich 1996; Walt and Gilson 1994).

This study provides a detailed analysis of the health reform process in Ghana. Specifically, it examines five key questions: What were the political dynamics behind the development of the NHIS? How did these dynamics impact the technical design of the NHIS? Has the implementation of NHIS informed and redefined the policy landscape, or have the political parameters remained constant? Were there adequate institutional mechanisms in place to safeguard transparency and accountability throughout the policy development process? How could these mechanisms be improved in the future?

This following section of this report describes the study’s methodological approach and conceptual framework. Section 3 provides a detailed analysis of the development of the NHIS. With this context in mind, the Section 4 examines the performance of the NHIS after two years of implementation and describes how the implementation of the NHIS has fed back into the policy process. The final section concludes with broad recommendations to improve the policy process.

2. ANALYTIC APPROACH

2.1 RESEARCH METHODS

Grounded theory was used to guide sampling, data collection, and data analysis (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1990). Individuals who served as key players and stakeholders in the development of the insurance policy were sought for interview and identified in several ways. First, individuals listed in ministerial meeting minutes and other documentation during the formation of the policy were selected. Additional contacts were obtained through consultation with senior Ministry of Health (MOH) officials and international agencies that were heavily involved in the process, such as the Danish International Development Agency (DANIDA) and the United States Agency for International Development (USAID). Finally, the heads of vocal stakeholders, such as labor unions, were contacted. This process yielded a total of 27 individuals. Using the snowball technique, 10 additional individuals were identified during the interview process. Out of a total of 38 individuals identified and contacted for interview, three individuals declined, all due to time constraints. The remaining 35 individuals were interviewed using a semi-structured questionnaire in August 2006. All interviewees were asked to rank each actor's level of influence as low, medium, or high. Secondary data were also used for this study. The archives of the two largest newspapers in Ghana, the Ghanaian Times and the Daily Graphic, were searched to collect all articles and editorials of relevance (205 total). Additionally, meeting notes of committee meetings, parliamentary proceedings, position papers, annual reports, and other governmental documents that were made available to the researcher were reviewed.

Constant comparison analysis was used to interpret the data (Glaser and Strauss 1967). The first step, open coding, was achieved by deconstructing each interview sentence by sentence to identify key categories and concepts. These were compared across scripts and with established concepts in the literature. Data collection and analyses were iterative, with new data used to assess the integrity of the conceptual framework. The concepts identified were reintegrated into themes that provide the structure for the results.

The final analysis was presented to a group of 14 individuals from donor agencies, academics, and Ghanaian officials familiar with the development of the insurance policy. They judged the study's analysis to be consistent with their perceptions of the policy process, which indicated a degree of external validity for these findings (Kirk and Miller 1985; Mays and Pope 1995).

2.2 CONCEPTUAL FRAMEWORK

The overall framework used for this analysis adopts an approach that was developed by Walt and Gilson in 1994 (Walt and Gilson 1994). Their framework suggests four broad groups of factors influence policy development: 1) the contextual factors that influence the nature of policy-making within the country, 2) the actors involved in policy; 3) the processes through which policies are identified, formulated, and implemented; and 4) the content of the specific reforms.

This paper adds to Walt and Gilson's framework by further fleshing out its broad "policy process" category. The framework used for analysis of the policy process is derived through constant comparison analysis, but borrows from new institutionalism theory. This theory posits that policymakers are not

simply driven by “income maximization and endurance in power, but also have a normative position about the direction public policy should take” (Gonzales-Rossetti and Bossert 1999). This normative direction is modulated by institutional features, such as networks with civil society, networks with other government agencies, and political party structures (Steinmo, Thelen, and Longstreth 1992). Essentially, these institutional features determine the capacity of societal actors to influence policy as well as policymakers’ ability to act autonomously (Evans 1992).

Practically, policymakers often develop and entrust a core group of individuals to formulate and promote policy reform. This group, often referred to as a “change team” in the political science literature, are often high-level civil servants, share a common view on policy priorities, and have a mix of technical and political skills (Schneider 1991). These teams can take on a variety of forms – from a presidential advisory committee to an interagency task force. Change teams are designed to be free from both political interference as well as the bureaucratic processes of individual government agencies, and thus are seen as speedy instruments to develop reform strategies (Geddes 1996; Gonzales-Rossetti and Bossert 1999). That said, change teams must be politically astute in order to be successful. Many scholars have noted that the change team’s ability to bring about policy reform is highly dependant on their ability to establish and consolidate policy networks with key interest groups (Gonzales-Rossetti and Bossert 1999; Geddes 1996).

This study will examine three types of networks formed by the change team: 1) vertical networks – political support from senior politicians; 2) horizontal networks – cooperative support from peers groups (other government agencies, for instance); and 3) state-society networks – political support from civil society groups intended to buttress the team’s policy agenda (Gonzales-Rossetti and Bossert 1999).

3. ANALYSIS OF THE FORMULATION OF THE NHIS

3.1 POLICY CONTEXT

The Republic of Ghana was the first country south of the Sahara to gain its independence from Britain, in 1957. Upon independence, Ghana implemented a system of free health care. However, economic deterioration in the mid 1960s led to a gradual phase-in of user charges. Economic deterioration also contributed to a string of military coups, of which the longest was that of the Provisional National Defense Council (PNDC) headed by John Rawlings in 1981. Following a series of internal and external pressures on the PNDC regime, multiparty elections under the parliamentary system were held in 1992. Rawlings formed a new party, the National Democratic Congress (NDC), and was elected president in 1992 and again in 1996. By the NDC's second term in office, continued economic distress had led the country to implement a system of full cost recovery (known as cash-and-carry), in which users were charged the full procurement cost for drugs and a partial cost for most services (Nyonator and Kutzin 1999).

As to be expected, the system of cash-and-carry resulted in dramatic reductions in utilization of health services (Waddington and Enyimayew 1990; Waddington and Enyimayew 1989). Service providers began forming their own insurance mechanisms to mitigate against non-payment. In some cases, hospitals were even found to be detaining patients until they were able to pay. By the late 1990s, user charges were recognized as a key national and political issue.

The NDC-controlled government began to experiment with the burgeoning community-based health insurance (CBHI) movement. From just a few schemes in the early 1990s, there grew to be 168 schemes in 2003 (Atim, Grey, and Apoya 2003). The NDC began a series of pilot projects across the country to study the effects and optimal design of CBHI as a means of equalizing risk across populations.

A leading opposition party, the New Patriotic Party (NPP), had grabbed onto the issue of user fees, and promised the abolishment of cash-and-carry as a key campaign promise during the 2000 elections. After a hard-fought campaign that polarized the nation, the NPP won control of the government in runoff elections in January 2000. Immediately thereafter, they began on an aggressive path towards fulfilling their campaign promise.

3.2 POLICY CONTENT

The National Health Insurance Act (NHIA) of August 2003 aimed to establish an insurance fund for each of the 138 districts in Ghana. Existing CBHI funds were given the choice to either become part of a "district mutual health insurance" scheme, or pay nearly \$600,000 to remain private, thus forcing most private schemes to either merge or collapse. The NHIA mandates that all district schemes must charge a premium of roughly \$8 per adult and exempt those under 18, over 70, pensioners, or deemed indigent. An entire family unit must enroll – a family cannot simply enroll its exempt members. There is no cost-sharing beyond the premiums – members do not pay any co-pays or deductibles. All formal sector employees and their dependants are automatically enrolled, and their premiums collected at the

central level via payroll deductions. The NHIA mandates a pre-defined benefits package that covers 95 percent of the disease burden in Ghana. Services covered include outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and cesarean delivery), eye care, dental care, and emergency care. Excluded benefits include echocardiography, renal dialysis, heart and brain surgery, organ transplantation, and HIV retroviral drugs.

Beyond the premiums collected locally, the NHIS is financed through a National Health Insurance Levy instituted by the central government. This 2.5 percent sales tax is collected on most goods and services. In addition, 2.5 percent of the 17.5 percent social security contributions paid by formal sector employees are also automatically diverted to the NHIS.

3.3 POLICY ACTORS

Table I describes the key actors involved in the policy process. Interestingly, actors that were perceived to command a high level of influence were all proponents, while the opponents had either a medium or low level of influence. Two highly influential actors, the consultants, and the MOH-appointed chair of the design process, are worth further discussion.

According to most people involved, the politically connected consultants were among the most influential actors in the process. Previously, these actors had helped the NPP government develop a campaign apparatus that allowed the party to reach rural populations. This apparatus was highly successful, and thus earned these actors a great deal of political capital within the party elite. Thus, their source of influence came from both their political loyalty plus their perceived technical ability to reach rural populations (a fundamental goal of the insurance system). It is important to note that as business owners serving as private consultants, these actors were also financially motivated.

Another high-powered actor was the MOH-appointed chair of the design process. This actor, like the consultants, was also a trusted political ally and given the ultimate responsibility for ensuring that the policy was politically sound and passed quickly and decisively. Both actors, the consultants and the chair of the design process, realized that they could accomplish their respective goals by forming an alliance. This alliance became the most influential force in the policy process.

TABLE I. CATEGORIZATION OF KEY ACTORS IN THE NHIS POLICY PROCESS

Actor	Position on National Health Insurance Act 650	Level of influence	Source of influence
MOH (political)	Strong proponents empowered with political mandate to develop NHIA	High	Political status, technical mandate
MOH (civil service)	Neutral/opponents. Felt that NHIA design was not technically sound. Felt that more time was needed to discuss options. Felt centralized approach was wrong	Medium	Technical knowledge
Incumbent political party	Strong proponents empowered with political mandate to develop NHIA	High	Political status
Opposition political party	Strong opponents. Felt that 2.5% levy does not have adequate accountability controls. Also felt NHIA needs deeper technical analysis. Felt scale-up was too rapid, wanted gradual implementation	Medium	Political status
Existing CBHI schemes	Opponents. Felt that their autonomy would be compromised. Disagreed with key design features.	Low/medium	Civil society
Labor unions	Strong opponents. Felt that 2.5% deduction from their social security contribution was unjustified.	Medium/high	Civil society, economic status
Donors	Neutral/opponents. Felt that NHIA design was not technically sound. Felt that more time was needed to discuss options. Felt centralized approach was wrong	Medium	Financial leverage, technical knowledge
Private sector	Neutral/proponents. Wanted to ensure that provisions such as provider and pharmaceutical reimbursement rates were beneficial to them.	Medium	Economic status
Politically connected consultants	Strong proponents. Empowered with political support, had profit motive to set up schemes.	High	Political status, derived from MoH

Note: For simplicity, this analysis examines the primary and sometimes secondary motivators driving each actor group. However, most individual actors are complex and have many motivators.

3.4 POLICY PROCESS

A descriptive timeline of policy development is represented in the annex. Immediately after the 2000 elections, the new NPP government was empowered with strong political will to fulfill its campaign promise of eliminating user fees through a system of national insurance. Bolstered by strong public support for this reform, national insurance became one of its key policy agendas. Those familiar with the process reported that the political leadership of the NPP was not wedded to any particular technical design, but had three major criteria for the policy:

- I. The policy had to result in the establishment of a national system that could quickly be scaled up to cover the majority of the population.

2. The policy had to be publicly perceived as an NPP initiative, not as a continuation of the previous government's efforts.
3. The policy had to be formulated and passed through Parliament before the next elections in 2004.

In order to ensure a speedy process that was free from the regular bureaucratic channels for inter-sectoral policy formulation, the newly elected government formed and empowered a change team to create the strategy for national health insurance in Ghana.

Change Team I

Formation

In March 2001, a ministerial task team was formed and given the mandate to develop the National Health Insurance System (NHIS) of Ghana. This team, headed by the MOH planning director, comprised mostly technocrats from both central and decentralized levels, including public providers, insurance experts, and health planners. As described by Schneider, change teams are most effective when their members possess a strong mix of both political and technical skills (Schneider 1991). However, according to those involved, the change team and its chair were highly technical actors who placed far greater importance on technical issues than on political ones. Moreover, many change team members were not ideologically aligned on public policy with their political benefactors.

Technical Strategy

After several months of deliberation, the change team pursued a strategy of presenting the most technically sound options with little regard for political considerations. In July 2001, the team presented their final recommendations to the Minister of Health. The team recommended using the already growing CBHI movement as a platform for building a NHIS. They concluded that, because CBHI was a naturally growing initiative, government should offer support, but not control. They also recommended that the government continue to pilot and learn from the experiences of the CBHI schemes. They felt that that, because the CBHI movement was still nascent, there was still much to be learned and that it was too early to nationally scale up.

While this strategy may have been technically credible, it ignored the three critical political considerations. First, CBHI had been an initiative of the previous NDC government, and the current NPP government's key campaign message was to overhaul the previous systems. Thus proposing an expansion of former government policies ignored the driving force behind the new government's political will. Second, the new government had clearly articulated its desire to develop a nationally scaled insurance program. Continuing to pilot CBHI would not lead to the comprehensive system that the government had envisioned. Finally, the timetable for national scale-up of CBHI was undefined, thus the task force's proposal did not offer the quick solution that the politicians had asked for.

Political Maneuvering

According to those involved, the change team was focused primarily on technical design and not on political maneuvering. The limited focus on political considerations combined with team members' ideological differences with the political hierarchy left the change team with weak political support from senior policymakers. Instead, they relied more on their horizontal networks (colleagues from agencies within the government and policy-oriented donors) and state-society networks (colleagues from civil

society and academia). According to the change team members interviewed, the major purpose of forming horizontal and state-society networks was to gain further input into the technical design of the insurance system, but not to garner support for their policy recommendations.

In the end, the inability of the change team to form vertical networks and incorporate political considerations undermined their final policy recommendations. According to one senior NPP official involved at the time, the political leadership was deeply suspicious of the change team's motives. Some questioned their party loyalty, while others questioned their political savvy. The recommendations of the change team were discarded, and the policy process was put on hold.

Change Team 2

Formation

Recognizing the need for a change team that shared the political hierarchy's view on policy priorities, the then-Minister of Health replaced the chair of the change team, and shortly thereafter, added independent consultants to the change team to help develop a more politically acceptable policy alternative. As mentioned in the discussion of actors, these consultants were credited for developing a highly successful voter-turnout strategy for the NPP during the presidential campaign of 2000, and thus were trusted by the political elite. In addition to party loyalty, the consultants came with strong private business interests. Members of the previous change team that were widely respected for their strong technical expertise were retained but had lost the confidence of the MOH.

Technical Strategy

The chair of the change team, together with the consultants, concluded that a community initiative could reach rural populations better than a central-only initiative and proposed the establishment of a centrally regulated district scheme in every district of Ghana. Existing insurance schemes would either have to merge into the new district scheme or, if they wished to remain private, pay large fees, be regulated by the central level, and maintain the same design as the district schemes.

Since the district schemes would be partially financed through the central level, the change team had to look for an additional source of financing. At the same time, they were aware that government was feeling pressure to increase taxes to meet International Monetary Fund revenue targets. Taking these factors into account, the change team proposed to establish a 2.5 percent health insurance levy on goods and services, which would achieve both the political and technical objectives. Additionally, the change team proposed to raise a second source of central financing by diverting a share of the social security contributions of formal sector workers into the central health insurance fund.

Their strategy had the support of the NPP because it satisfied political considerations. It leveraged community infrastructure but maintained central control, thus allowing for national scale-up. It called for immediate scale-up, and thus could be implemented nationally within the political timeframe of the NPP. Finally, it was widely viewed as a unique and innovative approach, not simply a continuation of previous efforts.

Political Maneuvering

The strategy proposed by the chair and the consultants was clearly influenced by the political establishment. However, other members of the change team disagreed with the strategy on technical and ideological grounds. To neutralize this opposition, the consultants leveraged their strong vertical

network and the political leadership's deep suspicion of the technical actors stemming from the first change team, and labeled any actor who attempted to counter their position as foes of the NPP. As a result, most technical members felt that their voices were not heard, and many resigned from the process.

Actors within the change team who felt disenfranchised realized that, though the strategy had strong political support from the NPP, many of the proposed provisions were not popular with several key stakeholders. Labor unions were vehemently against any diversion of their social security contributions. Existing CBHI schemes felt that, as a social movement, their autonomy should remain intact. Donors, many of whom had been supporting CBHI schemes for many years, believed both technically and ideologically that schemes should remain independent and grow organically. As a result, change team members who opposed the consultants' strategy began to develop strong state-society networks, primarily with organized labor, some members of the donor community, and existing CBHI schemes. These state-society networks became the key counterbalance to the vertical network within the change team.

Because of the growing opposition led by the state-society networks, the politically supported members of the change team felt pressure to pass their policy through Parliament as quickly as possible, and therefore sought to limit debate. Knowing that they had a significant majority over the opposition NDC party, the NPP introduced the bill into Parliament in July 2003 and allowed only one week for debate and vote. According to NDC party officials, the NDC parliamentarians opposed this policy on the grounds that they believed 1) it was too radical a reform, with only limited evidence to support it; and 2) adequate checks and balances to ensure the integrity of the proposed insurance fund were lacking. However, because of their minority status, they were powerless, and relied on the state-society networks to slow its passage.

Meanwhile, members of the state-society networks began to form alliances with each other to further increase their power. Some donor projects began to mobilize CBHI schemes and support labor unions to educate their constituency on the policy. Labor unions leveraged their economic status to give public voice to these issues, and staged nationwide demonstrations against the policy. To counter the opposition, the NPP and its supporters used similar tactics as they did in opposing change team members. They sought to undermine the opposition by launching a publicity campaign that labeled those with opposing views as either self-interested enemies of affordable health care or obstructionists with opposing political agendas.

In the end, the labor unions were able to delay passage of the bill and negotiated a premium exemption for their members and dependents in return for the diversion of a share of their social security contributions to the NHIS. They also got assurances that public resources would be available in the event their social security fund became insolvent. However, no compromise was achieved on issues related to technical design, transparency of the new insurance fund, and preservation of autonomy of existing community insurance schemes.

One month later, when the NHIA was reintroduced for vote, parliamentarians voted strictly along party lines. The opposition could not counter the bill and instead protested by walking out without voting.

Change Team 3: Architects of the technical design

Once the NHIA establishing the NHIS was passed through Parliament, the MOH formed a steering committee and several technical committees to develop the specific technical design of the insurance system. The steering committee was chaired by the chair of the second change team, who brought in

the same consultants that had been instrumental in the passage of the NHIA. The technical committees were composed of respected technical experts, as well as the politically connected consultants. Our interviews revealed that, again, the process was highly political and the technical members (which included donor representatives this time) again felt marginalized. According to members of the technical committees, the steering committee announced policies before the deadlines given to the technical teams to complete their work had passed. They commented that the design process was highly political and dominated by the strong vertical network of the chair and consultants.

Our interviews revealed that, in addition to maintaining their strong vertical network, a key strategy by the chair and the consultants was to appease the main stakeholders in the process: health workers, the general public, pharmaceutical companies, and the politicians. This was reflected in an interview with the chair, who commented that the following core principles guided him during the design process:

1. Leverage community-based infrastructure to ensure maximal participation by informal sector in a national insurance system. While some efficiency will be lost through decentralization, equity will be gained.
2. Priority should be given to maximizing enrollment during the formative years of the insurance system.
3. Sustainability and total public cost of the scheme should not be of prime concern in the short term.
4. The NHIS should be financed primarily through taxation since the majority of the country belongs to the informal sector, from which premiums are hard to collect.

With these principles in mind, the following key design features were developed:

Exemptions

The policy of exemptions was developed by the consultants and supported by the chair. Their policy of exempting indigents and pensioners did not meet much resistance. However, their proposal to exempt everyone under 18 and over 70 caused much disagreement among the committee members. The chair and consultants realized that politically, these exemptions would be perceived positively by the public. Technically, they justified the policy by stating that, because people under 18 and over 70 are not of employment age, they lack the means to pay. Because the premiums were double the calculated per capita cost (described below) and it was assumed that there was a 1 to 1 ratio of exempt to non-exempt, they argued that the exemptions would be sustainable.

The technical members of the committee argued that the fundamental analysis underlying the proposed exemption policy was flawed, and that this policy would have a large public cost. However, since the political gain from the exemptions was expected to be highly positive, technical dissent was ignored.

Premiums

The development of the premium structure was largely influenced by the consultants on the task force. They developed a simple method for estimating premiums – national annual user-fee revenue was divided by the total population to arrive at a figure of roughly \$4 per person per year. It was further assumed that the ratio of the exempt (under 18, over 70, indigent, and pensioners) to the non-exempt was 1 to 1; thus, the figure was doubled to roughly \$8.

Technical committee members believed that this method was oversimplified and that the premiums were too low to sustain the system. They felt that actuarial studies needed to be conducted to estimate a sustainable premium. However, this figure resonated well with the political actors, as they believed that setting premiums any higher would be unpalatable to the general public. Sustainability, they felt, was an issue that could be dealt with later, after the insurance system had developed some legitimacy and permanence. Moreover, they believed that even if there were financial shortfalls early on, the 2.5 percent insurance levy would be able to sustain the system. Finally, the design chair believed that, since this was a system of social insurance, that actuarial analysis was irrelevant.

Benefits Package

The development of the benefits package began with an analysis of national health services utilization data. The data showed that 80 percent of the all illnesses in Ghana were low-cost outpatient services that could be provided at the health post/center level. The next 15 percent of illnesses, typically delivered at secondary and tertiary centers, were identified as those that cause the most financial distress to society. A final 5 percent of services were the very expensive (such as heart and brain surgery), and sometimes not of great public health concern (such as cosmetic surgery).

It was agreed by all actors involved that the 15 percent of illnesses that caused the most financial distress should be covered, and that the 5 percent of illnesses that were very expensive should not. However, there was disagreement among the design committee as to whether the remaining 80 percent should be covered. Some technical members felt that, because the majority of catastrophic expenditures were the result of inpatient care, the system should first cover those costs and incrementally add outpatient benefits once the actuarial cost was revealed. Additionally, private insurers felt that the government policy would severely curtail the private health insurance market.

Because of their political promise to abolish user fees, the political actors felt that a system in which 80 percent of illnesses were not covered would not be publicly perceived as a fulfillment of this promise. Not surprisingly, the views of the private insurers and technical experts were ignored. Before the benefits design committee had even presented its recommendations, it was publicly announced that the NHIS would cover 95 percent of all illnesses in Ghana.

Provider Payment

The provider and drug reimbursement committee was among the least transparent, according to those involved in the process. According to those involved and as well as the National Health Insurance Council (NHIC), pre-negotiated fee-for-service was the only mechanism on the table, and the reimbursement rates were largely influenced by service providers and pharmaceutical companies. Representatives from both interest groups were invited to present their analysis on an appropriate reimbursement schedule. Those involved reported that the highest service delivery and pharmaceutical prices from around the country were adopted. Partly, this was a political decision to stave off dissent and ensure smooth passage of the legislative instrument. It was thought that the costs could be sustained by the insurance levy in the short run, and if problematic, reimbursement rates could be changed after passage of the law.

Control of Moral Hazard

Insurance schemes need to avoid the adverse effects of moral hazard, in which the insured tend to use more (often unnecessary) services than they would were they uninsured. In respect to the NHIS, the two prime mechanisms to mitigate moral hazard, co-payments and deductibles, were off the table for

discussion almost immediately. The technical actors pointed to worldwide evidence showing cost-explosion as a result of unrestrained demand. The political actors acknowledged their arguments, but felt that co-payments would be perceived by the public as being no different than the previous system of cash-and-carry. The chair of the design process felt that “since this is social insurance, moral hazard is not important.” He believed that gatekeeping would largely prevent frivolous use. Arguments of sustainability were again brushed aside and would be “dealt with later.”

Control of Adverse Selection

Based on prior experiences with CBHI, the technical actors believed that control of adverse selection was necessary to ensure some degree of risk pooling. They foresaw the possibility that only the exempted would enroll, and saw that pilot CBHI schemes had tried to avoid this by requiring full household enrollment. Similar to his position on moral hazard, the chair of the design process felt that “since this is social insurance, we have adverse selection by default.” Ultimately, the political actors did not offer much opposition to the technical actors on this issue, and the committee established the provision that an entire family unit must enroll.

4. POLICY IMPACT AND EVALUATION

4.1 POLICY IMPACT

Registration

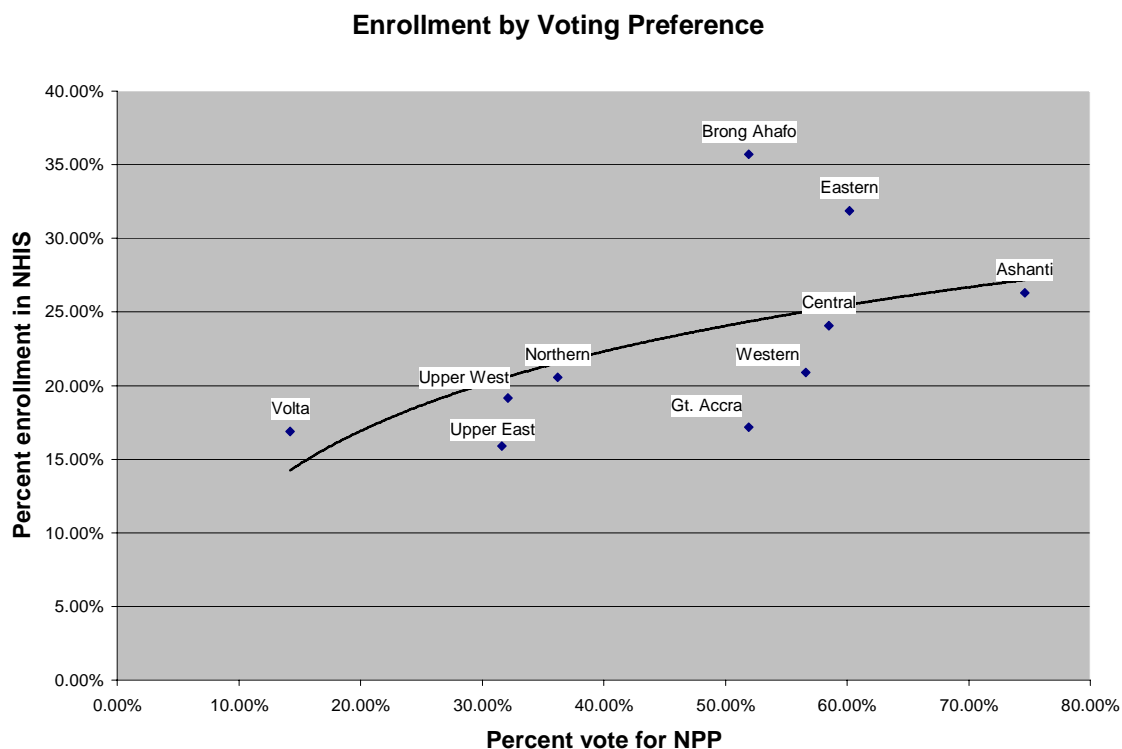
The emphasis that policymakers put on ensuring rapid enrollment into the NHIS has largely been successful. According to the NHIC, as of December 2006, 37.6 percent of the population had enrolled into the program since early 2005. Such increases in coverage in less than two years have not been seen elsewhere on the African continent.

However, while the policy successfully enticed people to enroll, the difficulties in implementation had been underestimated. Many schemes have reported that they were unable to issue ID cards to all of their members. According to NHIS statistics, only 8 percent of the enrolled population received their ID cards during the first year, and 51 percent received their ID cards during the second year.

Many officials interviewed felt that enrollment could have been even higher had the process been more consensus-driven across party lines. According to officials in the MOH and the NHIC, the most successful districts with the highest enrollment rates tend to be those that voted for the NPP. Insurance fund managers claim that one of the biggest constraints in their enrollment drives is the perception that enrolling in insurance means siding with the NPP. Further, they claim that in some areas, respected figures who side with the NDC have called on their populations to not enroll in the program. Figure 1 sharply validates these findings.

Not surprisingly, the majority of those enrolled are in the exempt categories. According to the NHIC, in 2006, 60 percent of those enrolled are exempt, with 40 percent children under 18 years old, 7 percent over 70 years old, 2 percent indigent, 10 percent social security contributors, and 1.4 percent pensioners. This is the result of two major design factors. First, and most obvious, those who are exempt from paying have a greater financial incentive to enroll than those who do not. Second, collecting premiums individually from the non-exempt represents a high administrative and financial burden for insurers, whereas premiums for exempt enrollees are paid through central-level transfers and require comparatively little administrative effort to collect. Thus, insurers also have the incentive to register exempt enrollees over premium-paying ones. The combination of these two incentives threatens to undermine the policy put in place to prevent adverse selection, as insurers have no incentive to prevent families from enrolling only their exempt members.

FIGURE I. RELATIONSHIP BETWEEN 2004 VOTING PATTERNS AND 2006 NHIS REGISTRATION IN THE 10 REGIONS OF GHANA



Note: While this analysis does not correct for income levels, disease burden, or other regional characteristics, it does demonstrate a crude correlation between voting preference and enrollment. High enrollment in Brong Ahafo and Eastern regions can likely be explained by the fact these regions received heavy donor support for CBHI since the 1990s.

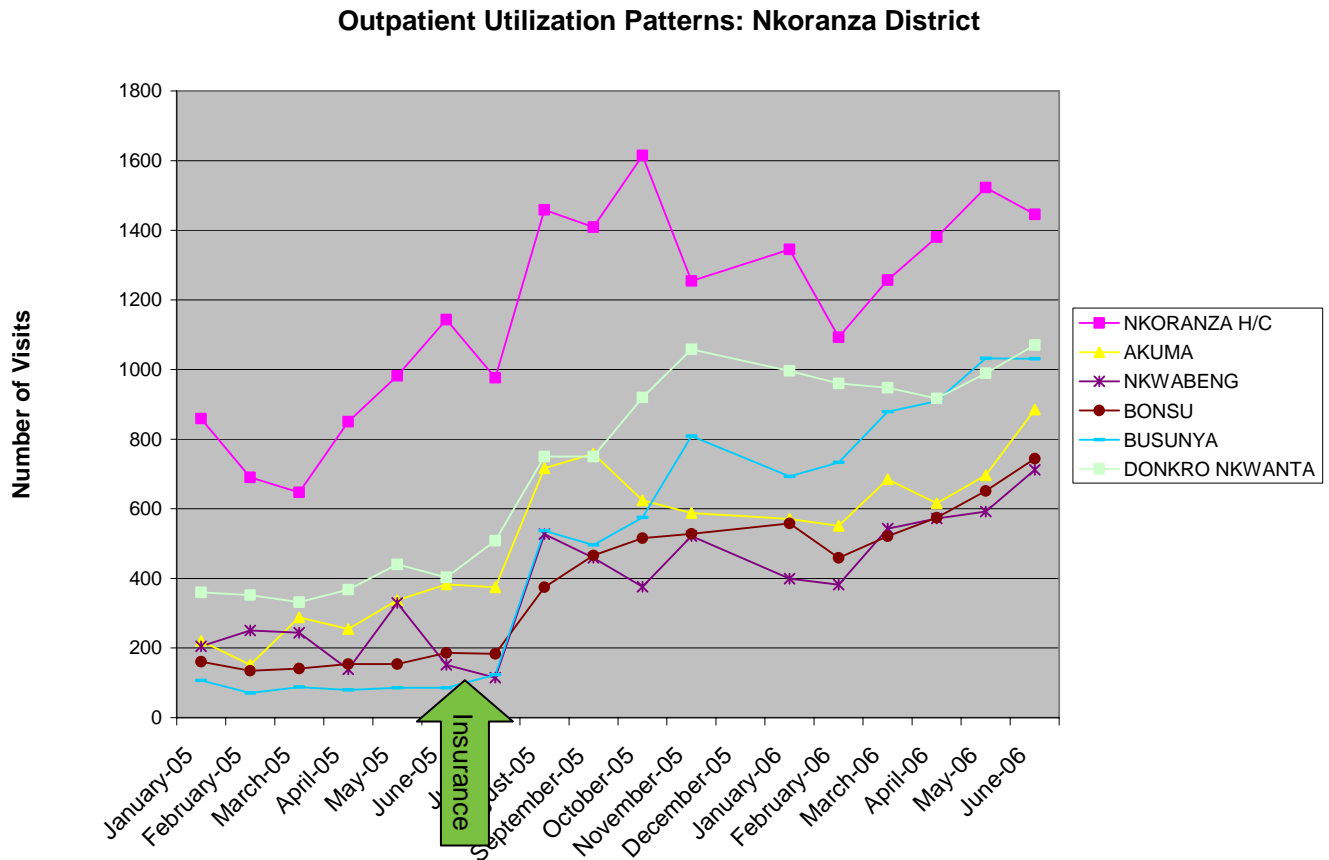
Utilization

Predictably, the increased enrollment into insurance has led to an increased utilization of services nationwide, according to the MOH. For example, Figure 2 describes utilization patterns the seven most frequented health centers and posts in the Nkoranza district.

Increased utilization is seen by many as a highly positive development, especially given the low utilization of formal health care prior to the enactment of this policy. However, our interviews with providers and insurers also reveal a great concern about ineffective gatekeeping, frivolous use, supplier-induced demand, and fraudulent claims. One interviewee from the MOH reflected that, prior to the NHIA, differential pricing by health facilities led patients to prefer services at health posts rather than hospitals, and that the incentives for fraud or frivolous use were minimal. However, in the absence of any cost-sharing, the insured have no disincentive to go straight to hospitals and demand services beyond what they need. Nurses, whose pay does not correspond to their workload, also have limited incentive to enforce their role as gatekeepers. Finally, providers have no disincentive to liberally prescribe drugs – a problem that the NHIC says needs correction. A study by JSA Consultants found that, on average, insured patients in the Brong Ahafo region were charged 33 percent more for outpatient services and 77 percent more for inpatient services than the uninsured (Aikins and Okang 2006). The study found similar results in the Eastern region: insured patients were charged 14 percent more for outpatient and

61 percent more for inpatient than the uninsured (Aikins and Okang 2006). It is unclear whether this study adjusted for case-mix.

FIGURE 2. OUTPATIENT UTILIZATION PATTERS, NKORANZA DISTRICT



Note: Figure shows outpatient utilization patterns at the six most-frequented health centers/posts in Nkoranza District. The arrow indicates the month (July 2005) in which all insurance enrollees of the Nkoranza scheme were able to use their benefits.

Supply Side

The nationwide increase in utilization stemming from greater insurance coverage has increased the workload of nurses. Though anecdotal, editorials in the Ghana Times state that queues for insured patients have grown substantially. According to the Ghana Times, some nurses are offering preferential treatment to the uninsured. The NHIC and Ghana Registered Nurses Association (GRNA) report that this is partly due to the fact that nurses can more easily demand informal fees from the uninsured, whereas many insured patients refuse to pay any additional fees on the premise that they have already paid their premiums. Predictably, the GRNA called for a nationwide strike by nurses in protest of the fact that their pay had not increased correspondingly to their increased workload. Eventually, the government agreed to an increased pay structure.

In addition to human resources, there has also been a scarcity of pharmaceuticals. The MOH reports that increased prescription rates without corresponding increases in pharmaceutical procurement had caused drug availability to drop to 38 percent in mid 2006. Interviews with facilities reveal that they have begun to purchase pharmaceuticals directly from manufacturers, usually at even lower prices than the government prices. Aware of this issue, the MOH is concerned about the quality of the drugs being purchased.

Financial Sustainability

While financial sustainability may have not been a key concern during the policy development, most actors interviewed at the time of this study felt that it is of vital importance. According to the NHIC and media reports, the increased utilization and a comprehensive benefits package coupled with the current premium structure has caused many insurance funds become financially distressed. Most actors interviewed felt that the current premiums are far lower than the actuarial cost of benefits, a situation that has been exacerbated by the lack of cost-sharing mechanisms. In a 2006 study, the International Labor Organization (ILO) projected that in 2010 an additional \$49 million to \$96 million in subsidies for financially distressed schemes will be required for them to remain solvent under the current NHIS structure (Leger 2006).

In order to maintain solvency, the NHIC and scheme managers report that most schemes have increased their premiums, and some have even begun to charge 'administrative' fees. These fees go beyond the premium structure outlined in the legislation. The NHIC reports that they have not received official notice by the schemes of these premium increases, and consider them to be illegal. According to the NHIC, these additional fees tend to be regressive when applied to all citizens uniformly, thus compromising the goal of equity.

At the same time, the NHIC has increased its payment per exempt enrollee from \$8.70 to \$10.90. Moreover, the NHIC has established an "SOS" program, in which schemes must inform the NHIC if they become high-risk for financial insolvency, and will receive financial support to bail them out. According to the NHIC, five of the 135 original schemes (districts were later increased in number to 138) were given \$2.8 million between early 2005 and June 2006. Unofficial reports indicate that the number of schemes facing insolvency in this period has exceeded 20.

The financing for these two corrections by the NHIC – increased exemption reimbursement and SOS bailout – is made available through the central fund for health insurance (financed by the value-added tax [VAT] and payroll deductions). Many of the interviewees expressed concern about the sustainability of this fund, and some in the NHIC feel that additional sources of revenue will soon be needed, especially as enrollment and benefits card distribution increases. The ILO study presented a range of scenarios that projected solvency of the fund for another 5–10 years (Leger 2006).

4.2 POLICY EVALUATION

After two years of implementation, there has been a clear rebalancing of the political landscape. All actors interviewed, even those who were once strong opponents of the policy, agree that the NHIS is important for Ghana. Those who initially opposed the policy are no longer focused on criticizing the policy itself, but rather how the policy is being implemented.

Most interestingly, our interviews revealed that there is a marked shift in the dialog from political toward technical issues. Even those actors who felt that political issues (such as maximizing enrollment

prior to elections) were more important than technical design issues (such as sustainability and public cost) cited mostly technical issues when asked to list the top 10 most critical policy needs. The 10 policy issues facing the NHIS most commonly expressed by all interviewees were (in order of frequency):

1. Development of actuarially based premiums
2. Gradual institution of co-payments and/or deductibles to stop frivolous use
3. Rethinking of provider payment rates and mechanism
4. Redefinition of benefits package
5. Training health workers to become strong gatekeepers
6. Development of practical, equitable, and sustainable exemption policy
7. De-politicization of NHIS to increase enrollment in minority party areas
8. Training district scheme management staff
9. Uniform claims management system for fraud control
10. Rethinking of how ID cards should be implemented

Along with this shift in thinking has come an unraveling of the close alliance between political actors and the private sector consultants. In October 2005, the NHIC board unanimously voted to remove their executive director, who was the former chair of the second and third change teams (Daily Graphic, October 2005). Moreover, all consultants involved in the formulation were ordered to cease activities and have been removed from the process (Daily Graphic, August 2005).

While the alliance between political and private sector actors has diminished, it appears that a new alliance between political and technical actors has grown. With broad political support, an interagency oversight committee was recently formulated consisting of technical actors, many of whom were marginalized during policy formulation. According to those actors, the discussions have been purely technical and met with strong support from the MOH. Separately, the NHIC is in the process of developing a research division, comprising an actuary, medical doctor, pharmacist, nurse, and health economist.

5. CONCLUDING REMARKS

This political analysis of the Ghanaian NHIS provides broad lessons for health reform. First, this study demonstrates the importance of politics in the formulation of health policy. For newly elected governments, especially in emerging democracies, the enactment of social policy can be a powerful instrument for establishing legitimacy with the electorate (Jones et al. 2006). To that end, the newly elected NPP government embarked on the path of least resistance when developing the NHIS. They placed greater emphasis on quick passage than on building consensus with groups that they perceived as obstacles, such as the opposition parties and labor unions. Thus, in order to be effective, it is essential that all actors understand the ruling party's immediate political needs, and to present themselves as supporters, not barriers, to achieving these needs.

This finding is especially crucial for technical actors. This study found that among the different change team members, the technical actors were among the least aware of political considerations. Their uncompromising technical stance rendered them incapable of forming vertical networks and of providing politically palatable recommendations. Their early marginalization led them to take an even more contentious approach by mobilizing state-society networks against the policy – an approach that ultimately failed. As a result, many of their technical inputs were not adequately considered, resulting in some of the design flaws that exist today. Thus, it is essential that technical actors involved in health reform recognize that technical purity is often incongruent with political considerations, and technical recommendations must accomplish both political and technical objectives.

At the same time, this study demonstrates the negative consequences that can occur when politics is the prevailing force. Change team actors with strong vertical networks were able to manipulate their power for selfish gain at the expense of the public good. In the development of the NHIS, the politically connected consultants outmaneuvered and overpowered those with strong state-society and horizontal networks, and thus were able to assert a large degree of influence on the policy process without a substantial countervailing force. Other country studies have found similarly strong influence by unchecked actors (Lucy Gilson et al. 2003; Glassman et al. 1999; Grindle and J. W. Thomas 1991). In a seminal paper on governance in the health sector, Brinkerhoff developed the concept of a 'web of accountability' in which every actor engaged in the policy-making process must be subject to adequate checks and balances to ensure that the public interest is not overtaken by private interests (Brinkerhoff 2004). Thus, policymakers embarking on reforms must periodically assess whether such a web of accountability exists for all actors in the policy development process.

Broadly speaking, many of the problems encountered during the development of the NHIS resulted from a lack of transparency. To maintain electoral popularity, the NPP made a series of technical tradeoffs that undermined the fiscal health of the NHIS. These decisions were made in a manner that was often characterized as opaque, exclusive to dissenting voices, vulnerable to corruption, and largely hidden from civil society. Though no easy or quick solution exists to improve transparency, several important mechanisms could have served to increase the flow of information in Ghana. First, there were no politically neutral, technical intermediary organizations that helped to guide the policy debate and disseminate objective information to the citizenry. Second, there was a dearth of trained media actors that had the technical capacity to separate technical arguments from political rhetoric for the populace. Thus, it is important for countries to carefully identify and empower information channels, so that more actors can be enfranchised in the policy process.

Ultimately, this study demonstrates that the enactment of sound public health policy fundamentally relies on strong health sector governance. While the field of public health has given considerable attention to developing health-specific policy interventions, far less attention has been given to strengthening the governance structures that support these interventions. Political science experts have proposed a variety of approaches to improve governance, most of which ultimately aim to create a system of checks and balances, promote greater civil society participation, improve transparency, and increase overall organizational capacity (Brinkerhoff and Bossert 2008). While the merits and demerits of particular approaches can be debated, it is clear that the overall improvement in health governance requires ongoing, long-term attention. Thus, it is essential that countries and their development partners incorporate governance-related activities into their long-term health sector development plans.

In many ways, the development of the Ghanaian NHIS is not dissimilar to the health reform process in other countries. For instance, the US Medicare program in 1965 and its subsequent prescription benefit program in 2004 were rapidly passed with the support of strong vertical networks despite the serious and unresolved questions of sustainability and technical integrity (Marmor 2000; Rivlin and Sawhill 2004). That said, these policies have ultimately offered financial protection to millions of people – 38 percent of the Ghanaian population was enrolled into the insurance program within the first two years of implementation alone. Thus, recognizing that politics may be a natural part of any policy development process, countries and their development partners can mitigate the adverse effects of over-politicization by carefully understanding the dynamics of the vertical, horizontal, and state-society networks, and building strong governance structures around these networks.

ANNEX. DESCRIPTIVE TIMELINE OF THE GHANA NHIS POLICY PROCESS

Pre-2000	NPP begins national political campaign against NDC. Abolition of cash-and-carry is key campaign promise.
December 2000	Ruling party (NDC) loses national elections to NPP. Strong political will for health insurance.
January 2001	NPP Minister of Health appointed. Top priority is to translate campaign vision into reality.
March 2001	Minister of Health develops task team of technical experts to develop broad framework and financing strategies for health insurance. Task team is chaired by director of planning at MOH.
April 2001	Task team presents recommendations to Minister of Health, who disagrees both on political and ideological grounds. Minister replaces task team chair with close and trusted former associate. Task team asked to develop new recommendations.
June 2001	Cabinet reshuffled and a new Minister of Health is appointed. New minister is strongly committed to the success of the task team.
August 2001	Consultants with political ties brought into task team. Core technical members feel that task team has been hijacked by political motives. They feel that discussion is no longer evidence based. Many members resign.
February 2003	MOH allocates \$2.15 million of HIPC (heavily impoverished poor countries) funds to support the creation of district schemes. Consultants with political ties from the task team are hired to conduct implementation.
July 2003	Bill introduced into Parliament and largely reflective of political actors. One-week timetable given for review and vote. Workers unions produce mass demonstrations aimed at getting more time to review and debate bill. As a result, bill vote is delayed, and Parliament goes to recess.
August 2003	Parliament is recalled and discussions are held. Opposition parties walk out. NHIS bill outlining broad framework, authorizing payroll deductions, and authorizing insurance VAT is passed.
September 2003	MOH forms committees to develop key design components of NHIA, with the aim of rebuilding consensus among many disenfranchised stakeholders. Eight technical committees formed and the process is chaired by former chair of task team. Consultants with political ties from previous the task team are placed on almost all committees.
July 2004	NHIC established as independent body, with mandate to regulate schemes. Chair of MOH committee on health insurance is selected as executive secretary. NHIC board of directors selected from various stakeholders, including labor unions, health worker unions, and network of schemes.
August 2004	Consultants command great influence on technical design. Technical members feel that their inputs are not taken seriously. Many members stop coming to committee meetings. Even before

technical committees provide input, design decisions are made and publicly announced, primarily based on consultant's direct recommendations to the chair.

- October 2004 Legislative instrument passed outlining key technical design. Design reflects views of chair and consultants instead of technical consensus. Without competitive bid, insurance council tasks consultants to set up majority of the schemes.
- July 2005 Many district schemes complain of technical inability and fraud by consultants. Public outcry leads MOH to 'suspend' all consultant activities.
- October 2005 Executive Secretary of NHIA is removed by unanimous vote by NHIC board. Reports indicate that favoritism towards consultants and disagreements with board are key reasons.
- December 2005 Council reports nearly 20% nationwide coverage. Newspapers reports show that many schemes face serious financial difficulties. Schemes complain of over-utilization, actuarially unsustainable premiums, and difficulty producing ID cards.
- January 2006 Interagency taskforce created to review key technical aspects of NHIS design. Taskforce members are all technical, feel that discussion is evidence based, and feel that there is a renewed interest in technical issues.

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